TRUST BOARD / SLT COVER SHEET

	The cover sheet purpose is to provide the Trust Board/Committee with a clear summary of the paper being presented, how it impacts on the people we serve, key matters for attention and the ask of the Trust Board/Committee *The Accountable Director must satisfy themselves that the cover sheet is accurate and fully reflects the paper. The expectation is that the Accountable Director has read and agreed the content of both the cover sheet and paper.*	
Meeting and Date of meeting	Trust Board – 3 November 2026	
Title of paper	Obstetrics & Gynaecology Service – Continuity Planning	
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This paper sits within the Trust Board role of:		Accountability
This paper is presented for:		Approval and Assurance

Links to Trust Strategic Priorities 	☒	Collaborative Working
	☐	Learning Organisation
	☒	Safety, Quality & Experience
	☒	Community First
	☐	Whole-Life Approach

1. Reason for Presentation of Paper / Report

To update Trust Board on the continuing fragility of obstetrics and gynaecology services at Daisy Hill Hospital (DHH) and seek approval, on patient-safety grounds, to activate the agreed continuity plan and temporarily consolidate inpatient maternity services from the 23rd of November 2026. The proposed emergency and temporary measure would consolidate inpatient antenatal, intrapartum and postnatal services at Craigavon Area Hospital (CAH) from 23 November 2026. This does not determine the permanent future configuration of services.

2. Detailed summary of paper contents:

Despite sustained local, regional, agency and cross-border recruitment and mutual-aid efforts, the Trust has not secured the stable consultant workforce required to maintain a safe and resilient inpatient maternity service at DHH beyond the end of November. The departure of two consultants, together with a further transfer request, means sufficient consultant cover will not be available from late November. For the past number of years, the service has become increasingly reliant on Agency Locum medical cover, and whilst this is a much-valued resource, it does not lend itself to a stable and sustainable service.

Subject to Trust Board approval, elective caesarean sections will consolidate at CAH from 9 November and all inpatient and intrapartum maternity care from 23 November. DHH will retain antenatal outpatients, maternal and fetal assessment from 8.00am–8.00pm seven days a week, A Day Obstetric Unit, appropriate outpatient induction, community midwifery, home birth and continuity-of-care services, alongside outpatient, ambulatory and elective gynaecology.

Modelling indicates CAH can accommodate the additional activity, provided planned estates, staffing, equipment, medical-bed relocation and 24-hour support arrangements are delivered. Implementation will be phased, supported by clinical pathways, staff management-of-change arrangements, communications and formal reviews at three and six months and throughout the temporary consolidation.

3. Areas of improvement/achievement:

The Trust has currently exhausted available workforce mitigations and developed a planned, phased continuity response to an increasingly fragile consultant rota and emerging patient safety considerations from the end of November 2026. CAH capacity modelling covers delivery rooms, maternity theatres and up to 47 antenatal/postnatal and gynae beds.

Medical beds will be relocated without a net reduction in medical capacity. DHH will continue to provide a substantial range of local maternity and gynaecology services. Centralised telephone triage agreed transfer and emergency pathways, workforce support, regional oversight and defined outcome measures provide additional assurance. A potential cross-border pathway for women in the South Armagh corridor remains under development for 2027, subject to feasibility and approvals.

4. Areas of concern/risk/challenge:

The principal risk is that insufficient substantive consultant cover at DHH would make continued inpatient maternity provision unsafe and unsustainable. Implementation risks include capacity and flow pressures at CAH; simultaneous emergency demand; staff redeployment and wellbeing; ambulance and transfer responsiveness; winter pressures; and maintaining neonatal, theatre, anaesthetic and diagnostic support.

Women and families in South Armagh, the Mournes and other rural areas may experience longer journeys, higher travel costs and transport difficulties. These risks will be mitigated through retained local services, individual care planning, central triage, clear escalation and transfer pathways, flexible capacity, daily operational oversight, regional engagement and monitoring of safety, quality, access and patient experience.

5. Impact on Statutory Duties: Provide details on the impact of the following and how.

Financial Impact	*Safety and Quality Impact*
Impact identified. Existing staff and targeted temporary redeployment will support the model. Capital and implementation costs, including estates works at CAH and resources required to maintain retained DHH services and clinical mitigations, are being quantified.	**Significant positive safety impact.** Temporary consolidation addresses the immediate risk created by inadequate consultant cover and provides access at CAH to consultant-led maternity care, neonatal intensive care, critical care, dedicated maternity theatres and 24-hour supporting services. Maternal and neonatal outcomes, transfers, capacity, workforce resilience, incidents, patient experience and DHH Emergency Department impact will be monitored against a pre-implementation baseline.

6. Risk Assessment (Risk level and state if a risk assessment be completed)

High and immediate clinical service risk if the continuity plan is not activated. The paper records that the required minimum stable 1:8 consultant rota cannot be sustained at DHH from late November 2026. Continuity, equality and rural-needs screening assessments have been undertaken, with detailed operational pathways and governance arrangements developed. Risks will remain under active review through daily reporting, weekly senior clinical oversight, Board assurance and formal three and six-month reviews. This will be a standing agenda item on Trust Board meetings for the duration of the Temporary consolidation.

7. Other Business Intelligence/data (If appropriate)

Key planning assumptions include:

- a minimum 1:8 consultant rota requiring at least eight suitably qualified Trust-employed consultants;
- peak demand of up to 10 women requiring Delivery Suite care and three requiring the Midwifery-Led Unit;
- annual demand of approximately 1,200 planned and 740 emergency caesarean sections;
- peak need for 44 antenatal/postnatal beds;
- 64 ambulance arrivals at DHH Emergency Department over 16 months, with six of 64 clinically reviewed cases expected to require transfer to CAH under the continuity plan.

8. Impact: Provide details on the impact of the following and how. If this is N/A you should explain why this is an appropriate response.

Corporate Risk Register	The obstetric consultant workforce fragility and associated continuity risk should remain aligned to the relevant corporate risk entry. Activation of the plan is the principal control for the immediate patient-safety risk; residual risks relating to implementation, capacity, workforce, access and transfers require ongoing monitoring and escalation.
Board Assurance Framework	Provides Board assurance on safety, quality, governance and service continuity. Daily operational reporting will inform weekly programme oversight and scheduled executive and Board reporting, with material risks

	escalated immediately. External assurance will continue with SPPG, PHA, the Department of Health, RQIA and other relevant regional partners.
Equality and Human Rights	Equality screening and Rural Needs screening identify potential disproportionate impacts arising from longer travel, cost, limited public transport, disability, caring responsibilities and communication needs, particularly for women and families in South Armagh and the Mournes. Mitigations include retaining local services where possible, accessible information and interpreting support, individual care planning, emergency assessment and transfer pathways, and monitoring of access and experience. A full Equality Impact Assessment and detailed Rural Needs Assessment will follow implementation, alongside continued engagement and consideration of public consultation.



Obstetrics & Gynaecology Service

Continuity Planning

3 November 2026

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1 Executive Summary

This paper updates Trust Board on the continuing fragility of obstetrics services at Daisy Hill Hospital (DHH) and seeks approval to activate the agreed continuity plan. Despite sustained recruitment efforts including both on and off contract agency engagement, regional mutual-aid requests and consideration of alternative workforce models, the Trust has not secured enough substantive obstetric consultants to maintain a safe and resilient inpatient service at DHH. The departure of two substantive and experienced consultants has further reduced rota capacity from November 2026. In addition, another substantive consultant has requested a transfer out of the service from the end of November citing patient safety concerns in the event on insufficient Consultant cover being available as outlined above. Therefore, and at present, there will not be sufficient consultant cover to maintain a safe Inpatient maternity service at Daisy hill hospital from late November.

The continuity plan proposes the temporary transfer of all inpatient antenatal, intrapartum and postnatal services including Emergency Gynae from DHH to Craigavon Area Hospital (CAH) from 23rd November 2026. This is a temporary patient safety measure; it is not a decision on the permanent future configuration of services. Any longer-term change would require separate appraisal, engagement, consultation and Ministerial approval.

Daisy Hill Hospital maternity services will continue to provide a significant range of local services, including antenatal outpatients, maternal and fetal assessment, A Day Obstetric Unit, appropriate outpatient induction of labour, community midwifery, home birth and continuity-of-care services, together with outpatient, ambulatory and elective gynaecology services and will retain the Special Care Baby Unit (SCBU). Clear clinician developed and led pathways will support women who require transfer to CAH for inpatient or consultant-led care.

Capacity modelling indicates that CAH can accommodate the additional maternity activity through its delivery suite, Midwifery-Led Unit, maternity theatres and flexible antenatal and postnatal bed capacity. Safe delivery depends on relocation of the medical beds without a net reduction in general hospital medical capacity, appropriate staffing and equipment, and 24-hour access to anaesthetic, theatre, neonatal, diagnostic and escalation support.

The workforce plan combines existing staff and temporary redeployment. Staff affected by the change will be supported through the agreed management-of-change process, including trade union engagement, induction, training, supervision and wellbeing arrangements. Communications with service users, staff, elected representatives and regional partners will continue before and after implementation.

Subject to Trust Board approval, implementation would be phased, including the temporary consolidation of all Elective C Sections from the 9th November and all inpatient and intrapartum maternity services provided by CAH from 23rd November 2026. Safety, capacity, workforce, patient experience, equality impacts and maternal

and neonatal outcomes will be monitored through established governance arrangements, with formal reviews at three and six months.

On patient safety considerations, Trust Board is asked to approve activation of the continuity plan and the temporary consolidation of inpatient obstetric, intrapartum and post-natal services at CAH.

2 Updated position since last Trust Board position paper

A detailed position paper was tabled at the public Trust Board meeting on 24th September 2026 highlighting the ongoing fragility and challenge regarding the sustained service delivery of obstetrics and gynaecology services across both hospital sites, but particularly within Daisy Hill Hospital (DHH).

This paper provides an update on actions progressed since the Trust Board meeting of 24th September 2026 and an outline of next steps to ensure safe services provision. The paper seeks Trust Board approval to enact continuity arrangements and support safe transfer of all inpatient and intrapartum obstetric services on a temporary basis from DHH to CAH.

Actions progressed from September 2026
The Trust has undertaken sustained action to address and where possible avoid the obstetric consultant workforce shortfall at Daisy Hill Hospital, including:

- planned local, national and international recruitment campaigns;
- framework and off-framework agency engagement;
- enhanced remuneration arrangements to attract temporary consultant staff from the region;
- regional mutual-aid requests; and
- cross-border discussions with Health Service Executive (HSE) partners.

Alternative workforce models including increased cross-site cover from CAH, expanded Specialty (SAS) doctor roles where feasible and based on capacity and additional locum support have been assessed but have not provided a safe or sustainable solution.

Workforce modelling has confirmed that a minimum stable 1:8 consultant rota is required, supported by appropriately skilled junior, middle-grade, midwifery, anaesthetic, theatre, paediatric and neonatal staff. Current and projected substantive consultant capacity at DHH remains materially below this requirement, with continued dependence on locum agency cover providing only short-term resilience.

All consultant post job descriptions continue to be developed through established Royal College of Obstetrics and Gynaecology (RCOG) scrutiny arrangements ensuring consistency with agreed standards and expectations of the role.

The Trust has therefore concluded at this juncture, that workforce mitigations alone cannot provide a credible route to sustaining a safe and resilient consultant-led inpatient obstetric service at DHH, and that a planned temporary change in service

delivery is required to protect safe care and support retention of the remaining substantive workforce.

Update on Engagement with Health Service Executive (ROI)
The Trust has engaged senior Health Service Executive (HSE) colleagues and management at Our Lady of Lourdes Hospital, Drogheda, to explore cross-border maternity support in response to the DHH obstetric workforce pressures. While direct consultant support to DHH was not feasible, discussions have progressed on a potential alternative maternity pathway for women in the South Armagh corridor, one of the geographical areas (the other being Kilkeel locality) where consolidation at CAH would have the greatest travel impact.

Initial engagement has identified broad alignment in clinical standards and pathways, with further work required on eligibility, clinical governance, information sharing, funding, commissioning, antenatal planning, emergency transfer arrangements and cross-jurisdictional approvals. Whilst no formal arrangement has been agreed; the pathway remains a potential medium-term mitigation from early 2027, subject to feasibility and capacity, and does not replace the approved continuity plan or address the immediate consultant workforce gap from November 2026. If feasible, this pathway would only be implemented if there is an expressed desire by women in identified geographical localities to avail of same.

SPPG / DOH Engagement
The Trust has worked closely with its HSC partners to seek alternative solutions to support continuation of all obstetrics and gynaecology services in DHH. This has included detailed conversations and engagement with other regional Trusts regarding ability and interest of their medical staff to support DHH in the immediate term. This has been unsuccessful in respect of attracting the required additional workforce capacity into DHH. There were two expressions of interest to offer occasional shifts, however this did not address the fundamental challenge of substantive consultant vacancies and associated patient safety considerations.
The Trust received formal notification from SPPG on the 26th of October advising as follows:

"The SPPG and PHA team have been reviewing the regional position which has been discussed with all Chief Executives (CXs) and formalised in correspondence of 9th October. In this letter all Trusts were shared with a summary of the Obstetric commissioned baseline staffing information which had previously been provided to the Women, Children and Sexual and Reproductive Joint Commissioning Team. Confirmation by CXs of this baseline information was requested by return.
All Chief Executives have confirmed that they are content with our summary of the baseline information their teams provided and Trusts have set out their respective position regarding support. All have advised that, whilst they are unable to safely release consultant manpower from their own units to support DHH, support was indicated for the Southern Trust in other ways, including facilitating patient transfers for births and elective and emergency gynaecology activity, subject to capacity at time of transfer for unscheduled transfers and in discussion for elective gynaecology capacity.

SPPG and PHA have reviewed the assessments provided by all Trusts and concur with their conclusions, reflective of the ongoing medical workforce challenges within the HSC and nationally. It has been discussed at the Regional Chief Executive's group and is perhaps unsurprising that no Trust has identified sufficient capacity to

release an additional 3 WTE consultants to support DHH on an immediate basis, noting that Southern Trust indicated this would need to increase to 5 WTEs for a sustainable service".

Summary of Mitigations Undertaken

Despite extensive efforts, the Trust has not secured sufficient substantive obstetric consultant capacity to sustain a resilient inpatient service at Daisy Hill Hospital. The departure of two consultants and transfer request of another consultant by November 2026 combined with the Trust's inability to recruit will increase reliance on locums significantly reducing rota availability and reduce resilience / capacity for leave, sickness and activity pressures. Without a local or regional solution to support the continuation of services at DHH, the Trust is now seeking formal approval to enact its approved continuity plan.

Table 2-1 - **Update on DHH Consultant availability and recruitment efforts**

From an agreed patient safety perspective DHH requires 8 WTE equivalent consultants to maintain required standards. As reported at Trust Board on the 24th of September, and confirmed at this juncture the available workforce from the end of November is outlined in the table below:	**DHH – Consultant Staffing**
Required Staffing to support on call rota	8 WTE
Current Substantive staff in post	3 WTE
Current available Substantive Consultant Staffing that support on call rota	3 WTE
Vacancies	5 WTE
Maternity	0
Sick	0
Resignations	0
Available locums	2 WTE for DHH 0.5 WTE for DHH from 1 WTE Cross-trust agency locum
Consultant availability from Nov 2026, following resignations and including locums	**5.5 WTE****

**One substantive Trust consultant requesting transfer from DHH from the end of November citing patient safety concerns and isolation from required peer support (arising from significantly diminished Consultant availability).

The Trust continues to engage with all relevant Agencies, however, to date (as at 30/10/26), there has not been any success in identifying viable offers of available consultants to take up work in DHH to stabilise the service in the short to medium term.

3 Continuity Planning Arrangements

The Maternity and Gynaecology Service Continuity Plan was approved by the Trust Senior Leadership Team and SPPG in January 2026 which was to be implemented in the context of presenting patient safety considerations. Prior to implementing any delivery / temporary consolidation, the Trust would initiate immediate actions in an effort to sustain services and only after exhausting available options the continuity plan would be enacted.

The Trust has now concluded it is not possible to implement any mitigating actions which will enable continued inpatient maternity service in DHH from 23rd November. This is a temporary measure which will be kept under review whilst the Trust also explores all avenues to reinstate the service in a safe way.

The proposed consolidation is **a temporary continuity measure** developed in response to an immediate and unforeseen deterioration in consultant staffing at DHH. Formal notification in August and September 2026 that two long-standing substantive consultants would leave their posts created a significant and unplanned reduction in rota capacity from November 2026 onwards, requiring the Trust to consider activating its approved continuity arrangements. Since then, as referenced above, another Substantive consultant, citing patient safety concerns and isolation from required peer support (from the end of November) has formally submitted a transfer from DHH to CAH.

The plan is intended to maintain safe service delivery while recruitment and other workforce mitigations continue; it does not represent a decision on the permanent configuration of obstetrics and gynaecology services. Any longer-term service change would require a separate strategic appraisal, appropriate engagement and consultation, and formal Ministerial approval processes.

Options considered and evaluated
As part of due diligence processes in developing a robust continuity plan, the Trust considered a range of solutions and options including:

- alternative staffing arrangements
- regional mutual aid
- cross-border support
- revised obstetric models
- a Midwifery-Led Unit option at DHH
- alternative site configurations, including whether services could be consolidated at DHH.

Assessment criteria included consideration of clinical safety, neonatal and critical-care dependencies, workforce availability, capacity, accessibility and deliverability. None of the alternatives was assessed as capable of providing a safe, sustainable and resilient inpatient service within the available workforce and physical layout of DHH. Therefore, temporary consolidation at CAH was identified as the safest continuity arrangement because of its greater maternity capacity and access to neonatal intensive care, critical care and specialist clinical support.

The following O&G related services will remain at DHH:

Table 3-1 – Services Being Retained in DHH

Services being Retained in DHH	
Maternity Services	**Gynae Services**
Antenatal outpatients	Gynae Outpatient clinics
Maternal and Fetal Assessment Unit *(8am – 8pm, 7 days a week with dedicated medical support)*	Ambulatory Gynaecology
Day obstetric Unit *(9am-5pm, 5 days a week)*	Elective gynae theatre
Outpatient induction of labour for SHSCT *(8am-5pm, 6 days a week)*	Colposcopy and Hysteroscopy
Home birth services	Women's health hub
Continuity of midwifery care	Early pregnancy services (9am-5pm, 2 days a week)
Community midwifery services	

4 Management of Implementation

A detailed implementation plan is being developed to support the operational moves to ensure smooth and safe transfer of inpatient and intrapartum births to CAH. A phased approach has been applied to support a managed transition of services across sites. The various elements are detailed below:

Pathway Development (post service consolidation)
A review group has been working with senior clinical, operational and management colleagues across all impacted services to understand and develop a robust set of pathways to both planned deliveries and service responses to emergency presentations of patients at DHH ED, either through self-presentation or via ambulance.

Maternal and Fetal Assessment Units
Maternal and Fetal Assessment Units will be available on both the Daisy Hill Hospital (DHH) and Craigavon Area Hospital (CAH) sites, supported by a single centralised maternity triage telephone line. The centralised triage service will provide consistent advice, assessment and signposting, ensuring women are referred to the most appropriate site based on their clinical needs.

The Maternal and Fetal Assessment Unit at DHH will operate from 8.00am to 8.00pm, seven days per week, while the unit at CAH will provide a 24-hour, seven-day service. Dedicated medical and midwifery support will be available within each unit to ensure timely assessment, review, treatment and escalation of care where required.

This model will support consistent decision-making across the Trust, improve access to senior clinical advice, and ensure women receive care in the most appropriate setting, with activity, demand and waiting times monitored on an ongoing basis.

Intrapartum
Modelling indicates that, at the busiest times, post consolidation in CAH up to 10 women may require Delivery Suite care and three may require the Midwifery-Led Unit which can be accommodated within the existing footprint of available space. Plans include additional flexibility for emergencies and periods of higher demand.
The Midwifery-Led Unit will support women who meet agreed clinical criteria, helping to keep Delivery Suite capacity available for those who need consultant-led care. Safe transfer and escalation arrangements will operate between both areas.

Current CAH Capacity
- 8 Delivery Suite birthing rooms
- 8 Midwifery-Led Unit birthing rooms

Trust modelling has identified an expected demand for 1,200 planned and 740 emergency Caesarean sections each year. The Trust will be able to deliver this total demand in CAH through reconfiguration of existing maternity theatres. Theatre, anaesthetic, neonatal and support services will be planned to meet this demand and minimise delays or cancellations.

Theatre Capacity

- Dedicated elective maternity theatre with recovery facilities (Maternity Theatre 2).
- Dedicated emergency maternity theatre with recovery facilities (Maternity Theatre 1).
- Access to main theatre capacity for a second emergency caesarean section when required.

Dedicated maternity theatres provide capacity for planned and emergency procedures, with access to main theatres if two emergencies occur at the same time. Theatre demand, staffing and recovery capacity will be reviewed daily, with agreed action taken if pressures increase.

The Trust will utilise of one the maternity theatres to provide dedicated elective caesarean section lists. In 2025, 1,231 elective c-sections were completed. Based on theatre capacity modelling for one theatre, a total of 1,250 c-sections per year can be carried out demonstrating confidence the Trust can manage expected demand.

Antenatal, Postnatal and Induction of Labour Capacity

Modelling post consolidation indicates a peak need for 44 antenatal and postnatal beds. Existing wards, flexible maternity space and the Midwifery-Led Unit can provide this capacity when required, supported by active bed management and appropriate staffing.

Current CAH Capacity

- 30 postnatal beds within 2 West
- Flexible use of 17 beds within 1 East for antenatal care, including up to 4 inpatient inductions of labour beds
- 8 Midwifery-Led Unit rooms available for postnatal care when required
- Where clinically appropriate, outpatient induction of labour will continue at DHH, with clear arrangements for transfer to CAH if needed.

Estates works have been planned to reconfigure the existing 1 East ward in CAH, providing 17 beds with flexibility to accommodate both antenatal and gynaecology admissions. The ward design will ensure appropriate separation between these patient groups, recognising the sensitivities involved and the need to protect patient privacy, dignity and maintain compassionate care.

More recently the 1 East ward has been used for general medical inpatients. A detailed implementation plan has been developed to support the relocation of these medical beds to a vacated ward area in CAH. Consequently, there will be no net loss of medical beds to support medicine and unscheduled care specialties. This is an important assurance in the context of emerging winter pressures and existing demand on ED in CAH.

Furthermore, the Trust is not envisaging any negative impacted Elective care.

Neonatal and Paediatric Impact

Recent transfer activity shows that neonatal care continues to be shared between CAH and DHH, with babies moved between sites according to their clinical needs and available capacity. Current neonatal and Special Care Baby Unit (SCBU)

capacity is expected to meet demand. DHH will continue to provide step-down care, supported by regional transfer arrangements when required.
Paediatric cover will continue, with senior clinical support available when needed. Demand and staffing will be kept under close review, including during winter pressures.

The Special care Baby unit (SCBU) will remain in Daisy Hill Hospital with revised transfer arrangements from CAH and noting SCBU remains as part of the regional Neo Natal Network.

Northern Ireland Ambulance Service

The Trust has engaged with NIAS colleagues to develop bypass and transfer arrangements for patients. Demand modelling indicates that the number of obstetrics and gynaecology patients conveyed to hospital is low. Over a 16-month period, 64 ambulance arrivals were recorded at DHH Emergency Department, averaging approximately four per month. A separate detailed clinical review identified 62 referrals for obstetric or gynaecological opinion or assessment at DHH Emergency Department. Of these, six patients would have required transfer to CAH under the proposed continuity plan. NIAS and SPPG are engaging in relation to the provision of additional ambulance cover to ensure a responsive service is available to meet any unscheduled demand, particularly in the more geographically impacted areas associated with temporary consolidation.

Emergency Department Interface

Lead clinicians from both ED and Obstetrics & Gynaecology have developed a pathway to safely respond to any presenting emergencies in DHH ED. This will consist of stabilisation in the first instance and then transfer to CAH. Should there be a medical requirement of an O&G consultant to attend DHH, this will be accessible following consultant to consultant agreement via CAH on a 24/7 basis. In addition, on call midwife input will be available to respond to unplanned presenting case episodes in DHH ED.

Continuity Planning

Based on work undertaken on a cross-directorate basis with engagement with Senior management and expert medical colleagues, the Trust is confident that safe pathways have been developed to facilitate temporary consolidation of all inpatient maternity services to CAH. These plans continue to be overseen by PHA and SPPG colleagues with expert input via 2 external colleagues.

SPPG and PHA overview

Since the most recent consultant workforce issues emerged as a presenting risk, the Trust has engaged with SPPG and PHA to discuss the sustainability of the Trust's Gynaecology and Maternity services.

The Trust Board update of 24th September outlined the challenges for sustaining these services safely within the Daisy Hill site. This was due to a predicted shortfall in Consultant grades and therefore safely maintaining the 24/7 rota.

While the Trust was working to avoid the need for a contingency plan to be enacted, engagement with SPPG and PHA colleagues have taken place to consider implications and mitigations of any temporary changes which might have been required. The contingency planning work has considered the impact of regional

support, impacts on all elements of the relevant service pathways and impact on other interlinked services in the HSC network.

This has consisted of weekly meetings involving senior managerial and relevant medical leads and expert SPPG and PHA personnel. This is a very helpful forum which is enabling the Trust to develop required plans based on both safety and quality considerations in the event of Temporary consolidation.

The Department has taken account of the work to date and in line with the 'Change or Withdrawal of Services' guidance circular, has indicated support for the contingency plan, noting that there are still areas progressing and SPPG and PHA will continue to engage with the Trust in terms of building assurances. If a decision is taken to temporarily consolidate services the post monitoring and importantly the key actions to reestablish commissioned services will be through the Department's formal 'Support and Intervention' process.

Since the most recent consultant workforce issues emerged as a presenting risk, the Trust has engaged on a weekly basis with SPPG in respect of Business continuity and seeking to explore all available support options for DHH Maternity as outlined in this report, and previously shared during the Trust Board update on the 24th of September.

In addition, and in the event of the Trust having to enact temporary consolidation, the Trust has been engaging with SPPG and PHA colleagues in developing a consolidation plan including associated interface and pathway work. This has consisted of weekly meetings involving senior managerial and relevant medical leads and expert SPPG and PHA personnel. This is a very helpful forum which is enabling the Trust to develop required plans based on both safety and quality considerations in the event of Temporary consolidation.

SPPG have indicated satisfaction with how plans are progressing and will continue to engage with the Trust in terms of building assurances, both in preparation for temporary consolidation and importantly in the post go live phase.

Equality & Rural Needs Considerations

The Trust recognises that the change, namely temporary consolidation of inpatient maternity services from DHH to CAH may have a greater practical impact on some women, families and staff, particularly because of additional travel, caring responsibilities, disability, access to transport and communication needs. The Trust has completed an Equality Screening and Rural Needs Assessment, the conclusion of which is that this change has the potential to have a major impact on a number of Section 75 categories and those living in rural areas and therefore meets the threshold for a full Equality Impact Assessment and will need to continue to consider the needs of those who live in rural communities as the plans develop.

As part of the continuity plan development, a range of measures will be put in place to reduce these impacts, including retaining antenatal, postnatal, community midwifery and gynaecology outpatient services at Daisy Hill where possible; providing accessible information and interpreting support; considering individual staff circumstances; and monitoring access, capacity, safety and service-user experience. The screening will remain under review, with feedback informing any further action required to ensure services remain safe, accessible and equitable. See appendix 1 for full equality screening document.

The Rural Needs assessment recognised additional challenges for those without private transport, on lower incomes, with disabilities or caring responsibilities, and for women requiring urgent maternity care. In response, antenatal, postnatal, community midwifery, home birth and outpatient services will continue locally wherever possible, supported by individual care planning, emergency assessment and transfer pathways, and enhanced arrangements for women at greater risk because of distance or clinical circumstances.

The Trust will continue to engage with affected communities, monitor the impact of the temporary arrangements and review the assessment as further information becomes available. See appendix 2 for Rural Needs Assessment.

Staffing impacts – management of change
Staff affected by the change is being supported through an agreed management-of-change process, including engagement with trade unions. Clear arrangements are in place for temporary re-deployment, rotas, work locations, induction, training, wellbeing and supervision. Workforce plans will support safe staffing at CAH while maintaining outpatient, community, early pregnancy and gynaecology services at DHH.

The Trust is committed to maximum flexibility to ensure staff members are not financially impacted upon and are committed to taking all personal circumstances into account in respect of impact of temporary transfer of staff.

Workforce Requirements
The planned maternity model can be delivered through existing staff and targeted redeployment.

Trust-wide the midwifery service has 192 whole-time equivalent (WTE) midwives. There are currently 181 WTE in post, and 16 new recruits are expected to increase staffing to approximately 197 WTE by January 2027, subject to staff turnover and absence.

Around 20 WTE Band 6 midwives (approximately 40 headcount reflecting working hour contracts) and 11.6 WTE maternity support workers or healthcare assistants would move temporarily from DHH to CAH. Any remaining gap in support staff will be actively managed, with induction, training, supervision and wellbeing support in place to help staff transition safely.

The Trust will provide more detail in due course regarding the outworkings of the management of change discussions across various staff groupings. The Trust are managing preferences and taking into account personal circumstances to support staff as flexibly as possible. The Trust will operate to the maximum flexibilities and pragmatism to support staff in this temporary transition.

Financial impacts
As part of review of safe transition of inpatient and intrapartum births to CAH, the Trust has reviewed any additional resource requirements to facilitate and support the temporary consolidation. This includes ensuring continued safe delivery of retained service provision in DHH, largely focused on outpatient and elective work, as well as clinical mitigation measures of unplanned attendance patients presenting to DHH ED with either obstetric or gynaecology complaints. Capital costs associated

with estates works to create sufficient accommodation capacity in CAH will form part of the detailed resource paper that is in development and will be discussed with SPPG as part of implementation requirements for the continuity plan.

Timeline for implementation
The Trust is working to an operational implementation date of 23rd November for transition of all inpatient births to CAH site. To support a measured approach to implementation, a phased plan as outlined below has been developed to support safe transition of services to CAH.

The table below summarises a timeline to implement the continuity plan.

Table 4-1 -Indicative Timescale

Action / Activity	Indicative Timescale
Trust Board approval to enact Continuity plan and date confirmed	3rd November 2026
Communications & engagement	Ongoing with all stakeholders from 22nd September 2026
HR Management of Change	Commenced 8th October 2026 and due to end October 2026
Equality Considerations (equality screening and rural needs)	Final Draft complete Friday 23rd October 2026 and shared as part of Trust Board papers
Agreement on Baseline metrics & monitoring arrangements	End October 2026
Medical Beds to be relocated from 1 East to 2 South	6th November 2026
Grace Clinic to relocate to ground floor maternity outpatients	6th November2026
Induction of labour beds to relocate to 1 East	9th November 2026
Elective c-sections to relocate to CAH	9th November 2026
Emergency Gynae relocates to CAH	16th November 2026
All new inpatient admission for antenatal and postnatal patients to cease in DHH	16th November 2026
Active induction of labour patients to attend CAH in active labour	20th November 2026
Cessation of all intrapartum and inpatient maternity services in DHH	2nd r November 2026
All intrapartum and inpatient services provided from CAH	23 November 2026
Review Reporting	3 months post implementation
Review reporting	6 months post implementation

Detailed communications and engagement approach
A detailed communications strategy and plan have been developed to ensure consistent, timely and regular engagement with all key stakeholders. The communications and engagement approach provides for early updates to senior

leaders, the Department of Health, SPPG, staff, trade unions, elected representatives and community stakeholders.

A summary of key engagement sessions since the initial public announcement on the 21st September 2026 has been included below:

Staff

- 21.09.26 – meeting all staff (CAH & DHH) to advise of challenges within the service
- 21.09.26 – follow up letter issued to all Integrated Maternity and Women's Health staff
- W/C 21.09.26 - Senior Leadership visits to both sites
- 05.10.26 – further letter issued to all Integrated Maternity and Women's Health staff
- W/C 05.10.26 – individual meeting with directly impacted staff to discuss management of change and options
- W/C 05.10.26 - Internal socialisation of continuity plan and pathways
- 05.10.26 - First weekly Maternity update
- 08.10.26 – Cross directorate live update to staff
- Weekly update via Chat with the Chief

Service Users

- 21.09.26 – establishment of dedicated maternity information line for service users and families
- Ongoing proactive contact with all women due to have their baby at DHH between 21st September and 30th November
- Development of standardised communications message for maternity patients – to be shared during antenatal appointments and attendances
- Plans to develop maternity tour videos of CAH site

External Stakeholders

- 21.09.26 – press release issued/website page set up
- Ongoing and regular engagement with DOH/ SPPG/ PHA
- Ongoing engagement with media / FOIs / AQs
- 24.09.24 – Public Trust Board meeting
- 25.09.26 – Briefings with elected representatives
- 01.10.26 – Meeting with Regulation Quality and Improvement Authority
- 06.10.26 & 16.10.26 – Meeting with NIAS
- 13.10.26 – Meeting with Patient Client Council
- 15.10.26 – Meeting within Health Committee/update issued internally and externally.
- 16.10.26 – Meeting with NISTAR
- 20.10.26 – Meeting Health Service Executive colleagues
- 22.10.26 – Update issued to primary care
- 23.10.26 – Update issued to community and voluntary sector
- 03.11.26 – Briefings with elected representatives
- Ongoing engagement with DHH SOS and DHH Future Groups

Pending approval to enact continuity arrangements, a further update will be issued internally and externally confirming the decision (post Trust Board 3 November).

This will be followed by a detailed internal and external communications plan to advise staff, patients and other stakeholders how the continuity arrangements will impact them, prior to go live on 23 November.

Trade Union engagement
Since the announcement on the 21st of September that the Trust was having to prepare for the potential to temporarily consolidate inpatient maternity services to CAH from November due to emerging Consultant workforce shortages and associated patient safety considerations, the Trust has embarked on a series of engagements with staff-side organisations including the BMA and relevant Agenda for Change staff representative organisations.

This includes direct engagement regarding any specific individualised matters and formal inclusive weekly meetings with relevant staff side organisations chaired by the Director of HRD and attended by the Director of CYPWS.
The Trust is very appreciative of the constructive and helpful approach of Trade Union colleagues through this challenging episode. This level of engagement will continue for as long as necessary.

The Trust has engaged with Patient and Client Council to seek their advice on patient and public involvement and communications; the Trust will work collaboratively with PCC to ensure robust and consistent messaging and engagement.

A service user information phone line has been made available since 21st September to provide advice and guidance to women and families. To date a total of 26 calls have been received, 11 of which occurred on the first day. The Trust will retain the information phone line until post implementation of the continuity plan (date to be confirmed).

Public, staff and political communications.
Since the announcement on the 21st of September and subsequent Trust Board meeting on the 24th of September detailing the circumstances leading to, and the need for, likely temporary consolidation the Trust has:

1. Set up a patient information line: 27 calls received to date
2. Responded within time frames to 44 Assembly questions and 4 FOIs
3. Attended the Health committee on the 15th of October
4. Responded to 108 correspondence received from interested parties and individuals
5. Facilitated weekly live briefing to IMWH staff
6. Convened weekly meetings with relevant Trade Union organisations

5 Measuring Impact and Outcome

The effectiveness of the continuity plan will be evaluated against a pre-implementation baseline, with metrics reported monthly and reviewed for trends, variation and unintended consequences. The evaluation framework will cover the following domains outlined below. It should be noted that baseline data is being gathered to support a clear baseline position in advance of the implementation to support comparative analysis. While the Trust will closely monitor the impact post implementation through operational lines, a formal review will be conducted at 3 and 6 month intervals.

A weekly Senior Leadership and clinician oversight forum will be convened to review progress and manage challenges.

Table 5-1- Continuity Evaluation Metrics

Domain
Birth activity and service utilisation
Maternal and neonatal outcomes
Capacity and flow
Workforce resilience
Timeliness, transfers and escalation
Safety and governance
Patient experience
DHH Emergency Department impact
Neonatal and Special Care Baby Unit utilisation

Regular reporting framework

Daily operational reporting will feed weekly programme oversight and scheduled executive and Board assurance, with material risks and exceptions escalated immediately. External reporting will be agreed with SPPG, PHA and the Department of Health to cover workforce, activity, quality, finance, equality impacts and compliance with continuity conditions.

Temporary arrangements will have explicit review dates, documented decisions and a route to independent review if the change becomes prolonged or remains major or controversial.

The Trust has established a governance reporting structure to oversee, monitor and support development of necessary actions to support the service consolidation. The structure includes Trust Board and Senior Leadership Team oversight along with regular engagement with HSC Regional partners, namely SPPG and PHA.

6 Change or Withdrawal of Services Guidance

The Trust fully accepts its obligations (under the NI Act 1998) to take appropriate steps to lessen the impact of any of its proposals in the best interest of all S75 groups and in protecting the most vulnerable by continuing to address inequalities and its obligations under the Rural Needs Act (NI) 2016 to consider the impact on those people living in rural areas. However, given the time-critical requirement for an emergency service change, Trust Board will be asked to approve implementation of the Business Continuity Plan in advance of consultation. It is important to note that this proposal departs from the customary Trust process, which places consultation prior to implementation of decisions.

In this case we are faced with competing legal requirements, which include legal obligations to:

- ✓ maintain high standards of quality and safety in all services;
- ✓ promote equality of opportunity and good relations; and
- ✓ consult and engage with service users and the wider public.

In line with the DOH HSC Circular ECCPD 1/25 'Change or Withdrawal of Services' the Trust is advised of the steps and process to undertake should a temporary change or withdrawal of service be required. Under the circular, **emergency action is permissible where necessary for safety or service sustainability.** The Department recognises that circumstances can change rapidly and may require urgent action before the normal planned-change process can be completed. However, this does not remove the need for clear governance and oversight of the change.

DOH HSC Circular ECCPD 1/25 'Change or Withdrawal of Services'

- **Notify early**: Inform the Department through SPPG before any major or controversial temporary service change.
- **Involve the public**: Engage affected communities as far as practicable and decide whether formal consultation is required.
- **Consult where necessary**: If urgent action precedes consultation, consult afterwards and consider reinstatement or permanent change.
- **Maintain transparency**: Temporary arrangements must not be used to avoid statutory involvement or consultation duties.
- **Secure approvals**: Obtain Departmental approval for consultation documents referencing regional policies, strategies or standards.
- **Consider regional advice**: Consult SPPG on major, controversial or policy-divergent changes and consider Departmental, PHA and other relevant views.
- **Retain accountability**: The HSC body makes the final decision and must clearly document its rationale, particularly where Departmental support is absent.
- **Set review points**: Temporary changes must be time-limited, regularly reviewed and progressed to formal permanent-change processes if prolonged.

This is an emergency change of service driven by safety concerns in relation to imminent changes in staff complement in the Trust. As a result, we have determined that a retrospective consultation is the only feasible approach, seeking views from the public and any other relevant stakeholders on the adequacy of our proposed mitigations, or whether there are feasible measures which the Trust can implement as alternatives in the short term.

The Trust has engaged with the SPPG and DoH in working through the development of the Continuity Plan and SPPG have confirmed support for this emergency service change including required oversight via the Support and Intervention Framework.

The Trust has been and will continue to consider the DOH HSC Circular ECCPD 1/25 'Change or Withdrawal of Services' at every appropriate juncture. In line with preparations for the emergency temporary change through consolidation, the Trust has developed an equality screening and rural needs assessment. The conclusion of the Equality Screening is that, given the scale of service change and the concentration of impact on a number of Section 75 categories in particular women, rural populations and those with dependants, this meets the threshold for a full Equality (EQIA) and Rural Needs Impact Assessments.

The circular states that while there may be insufficient time for public consultation in advance of an emergency change, engagement should still take place including with patients, staff and relevant stakeholders. Engagement has been a key focus of the Trust over the last number of weeks and will continue to be a pivotal action as part of pre and post implementation of any changes.

Following the implementation of the continuity plan, the next steps will be:

- complete full Equality Impact Assessment and review, update and maintain Rural Needs Assessment.
- Continued (pre-consultation) engagement with affected parties, to include (but not limited to) service users, staff, other HSC service providers (e.g. GPs), interest groups, local councils and elected representatives.
- Consideration of options and required conditions to re-instate services at DHH including a sustainable service model.

It is likely that the pre-consultation engagement will take a period of 2-3 months (noting Christmas leave period swiftly following the service consolidation). Over the coming weeks the Trust will develop a robust engagement plan to continue the engagement that has already commenced and widen it to other relevant stakeholders and interested parties. Following the completion of the EQIA, Rural Needs Assessment and engagement processes, the Trust will consider the most appropriate approach to consultation with the public on the change of service.

7 Next Steps

In the absence of sufficient capacity to support Daisy Hill hospital inpatient maternity services, the Trust is committed to implementing a consolidation of service provision as an emergency temporary measure that will be managed carefully, sensitively and in a well-planned process. The focus will always be on safety and maternal and infant wellbeing.

The Trust has proposed several next steps below that will be important to support careful and planned management of the continuity plan.

- Trust Board agreement to enact the continuity plan and associated temporary service consolidation from the 23rd of November 2026
- Post agreement to implement Continuity plan – Trust will share completed and approved detailed continuity plans, with staff, patients and public – including stakeholder partners as outlined in Trust Communication and Engagement Plan.
- The Trust will maintain structured review and monitoring arrangements following implementation, including formal reviews at three and six months. This will include continued engagement with RQIA and relevant regional partners, routine reporting against the agreed quality and safety metrics, and timely escalation of any emerging risks, adverse trends or unintended consequences. Findings will be reported through the established governance structure and used to inform corrective action, further assurance requirements and decisions on the continuation, modification or cessation of the temporary arrangements.
- Full EQIA and review, update, and maintain the existing Rural Needs Assessment completion and consideration of approach to consultation on service change.
- Weekly reporting to SPPG will be initiated from the 23rd of November
- SPPG and PHA oversight arrangements will be established to monitor progress and associated matters.

Conditions Required to Restore Service Provision in DHH

The Trust is committed to working proactively towards the safe reinstatement of obstetrics and gynaecology services at DHH. This will require a clear, evidence-based plan, developed with staff, regional partners and external stakeholders, that demonstrates the service can be delivered safely, sustainably and with appropriate clinical governance.

Reinstatement will take place only when an agreed set of clinical, workforce, operational and governance conditions has been met and independently assured. These conditions will provide a transparent basis for assessing readiness, managing risk and determining when services can return safely to DHH.

A central requirement is a stable and sustainable consultant-led workforce. This includes a minimum 1:8 consultant on-call rota, supported by appropriately skilled middle-grade and junior medical staff. The rota requires at least six suitably qualified Trust-employed consultants (supported by a minimum of 2 Substantive Agency Locums, in the absence of an ability to recruit all substantive consultants), who can

participate fully and provide prospective cover for annual leave, study leave, sickness and other foreseeable absences.

Before reinstatement, the consultant workforce must collectively demonstrate the capacity and competencies to provide:

- continuous senior clinical decision-making and timely consultant attendance for obstetric and gynaecological emergencies;
- safe labour ward, inpatient, antenatal, elective and emergency gynaecology cover;
- appropriate daytime presence alongside a sustainable out-of-hours commitment;
- clinical leadership, governance, incident review, audit and quality improvement;
- resilient arrangements for simultaneous emergencies, peaks in activity and unexpected absence; and
- effective cross-site working, escalation and transfer pathways for women and babies requiring higher-level specialist care.

Any proposed rota will be subject to formal workforce, clinical and governance assurance. It must be staffed by clinicians with verified competencies, include sufficient prospective cover, comply with contractual and working-time requirements, and avoid an on-call frequency that could increase fatigue or reduce capacity for planned care, governance, training and service improvement. Short-term locum cover may support the service during periods of pressure, but it cannot form the basis of the reinstatement plan because it does not consistently provide the continuity, team stability, clinical leadership and long-term resilience required.

A 1:8 rota is considered the minimum sustainable model because it provides an appropriate balance between safe out-of-hours cover, daytime clinical responsibilities, staff wellbeing and the ability to recruit and retain consultants.

Retaining the DHH Maternity physical infrastructure

In the interim the Trust will retain the existing inpatient maternity wards in DHH.

As part of the continuity plan, the Trust will be developing and expanding a range of outpatient maternity services to support local choice for women accessing outpatient, assessment and elective services.

The Trust welcomes and will fully engage and support the planned DOH regional recruitment initiatives for Northern Ireland.

The Trust will retain Maternity Services as a standing agenda item on Trust Board meetings for the duration of the temporary consolidation

Conclusion

In conclusion, despite extensive local, regional, international and cross-border efforts, the Trust has been unable to secure the sustainable consultant workforce required to maintain a safe and resilient inpatient obstetric service at Daisy Hill Hospital from late November 2026.

The temporary consolidation of inpatient, intrapartum and postnatal services at Craigavon Area Hospital is therefore a necessary patient-safety measure and does not determine the permanent future configuration of services. The Trust is satisfied

that the change can be implemented safely through phased operational arrangements, appropriate capacity and staffing, clear clinical pathways and robust governance, while retaining a significant range of maternity and gynaecology services at DHH.

The temporary arrangements will remain under close review, with ongoing engagement, monitoring of safety, access, equality and patient experience Formal reviews will take place at three and six months post implementation. Reinstatement of inpatient services at DHH will continue to be actively pursued but can occur only when the required workforce, clinical, operational and governance conditions are demonstrably met and independently assured.