Southern Health and Social Care Trust

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Rural Needs Impact Assessment

Section 1: Define activity subject to Section 1(1) of Rural Needs Act (NI) 2016

1A. Short title describing activity being undertaken that is subject to Section 1(1) of the Rural Needs Act (NI) 2016:

Southern Trust (SHSCT) Integrated Maternity & Women's Health Business Continuity Plan: Temporary Consolidation of inpatient maternity and birth services from Daisy Hill Hospital to Craigavon Area Hospital

1B. Are you Developing, Adopting, Implementing or Revising a Policy a Strategy or a Plan? (Underline or Circle)
Or are you delivering or designing a public service? (Underline or Circle)
What is official title of this Policy, Strategy, Plan or Public service (if any)?

This is a new proposal to implement the contingency arrangement contained within the approved Business Continuity Plan.

1C. Give details of the aims and/or objectives of the Policy, Strategy, Plan, Public Service or initiative:

Southern Trust (SHSCT) Integrated Maternity & Women's Health Business Continuity Plan: Temporary Consolidation of inpatient maternity and birth services from Daisy Hill Hospital to Craigavon Area Hospital

Introduction

The Trust is committed to delivering the best possible outcomes for women requiring Obs & Gynae services across the Southern Trust by providing access to safe and sustainable services for women and babies staffed by highly skilled and trained clinicians.

The Trust has an approved Integrated Maternity and Women's Health Clinical Services Business Continuity Plan which includes a contingency arrangement for the temporary consolidation of inpatient maternity and birth services from Daisy Hill Hospital (DHH) to Craigavon Area Hospital

(CAH) should safe consultant staffing levels be unable to be maintained. In the event that the contingency arrangement has to be implemented, antenatal, postnatal and outpatient maternity services would continue to be provided locally, wherever possible.

The Business Continuity Plan has been developed to ensure patient safety, maintain service continuity and support the delivery of safe, high-quality maternity care during periods of significant workforce risk. The Trust has developed detailed implementation and governance arrangements to support any activation of the Plan ensuring a safe and coordinated transition of services. The Plan provides a controlled response in circumstances where workforce deterioration threatens safe service delivery.

The Trust's preferred position remains to maintain inpatient maternity and birth services at DHH where these services can be delivered safely and sustainably.

Current Workforce Position

Midwifery staffing is stable in both CAH and DHH; however, substantive consultant capacity is below establishment across both sites.

The required consultant obstetric workforce at DHH to safely sustain the service is 8.0 whole-time equivalent (WTE) consultants contributing to the on-call rota. The DHH position reported to Trust Board on 24 September 2026 included three consultant vacancies, and two consultant resignations with departures effective in October and November 2026. Following these departures, the available substantive consultant workforce contributing to the on-call rota is projected to reduce to approximately 3.0 WTE, supplemented by two agency locum consultants. More recently, a request for transfer to the CAH site from one of the remaining 3.0 substantive consultants in DHH will further reduce the availability of medical cover at DHH.

The Trust cannot safely sustain an inpatient maternity and birth service without sufficient appropriately qualified consultant obstetric cover. The service continues to rely heavily on short-term locum consultants due to ongoing difficulties recruiting substantive consultant staff, which is not a sustainable solution. Recent recruitment campaigns have been unsuccessful, and the Trust recognises that workforce challenges are unlikely to be resolved in the short term.

Between 2024 and August 2026, fourteen consultant recruitment campaigns were advertised in total for Southern Trust. The Trust has exhausted all reasonable routes to recruit Consultant Obstetricians for DHH. One appointment was secured for DHH from five unique consultant advertisements

over the preceding three years. The most recent campaign closed on 17 September 2026 after being extended to maximise applications. Two applications were received, but neither met the essential criteria for interview.

A range of options has been explored to seek to maintain safe inpatient maternity services at DHH including:

- national and international recruitment searches;
- use of specialist medical recruitment agencies;
- framework and off-framework agency approaches;
- alternative recruitment models;
- direct engagement with potential candidates;
- regional mutual support;
- engagement with the Department of Health, SPPG, neighbouring Trusts and other regional stakeholders;
- exploration of potential assistance from HSE colleagues in Ireland;
- consideration of alternative staffing arrangements;
- consideration of modified models of obstetric care; and
- consideration of different service configurations.

The Trust has also considered alternative workforce solutions, including increased cross-site cover from CAH, expanded roles for Specialty (SAS) doctors and additional locum arrangements. None have been assessed as capable of providing a safe and sustainable solution. CAH itself operates within a constrained consultant workforce and does not have sufficient available capacity to provide resilient consultant cover across two acute maternity sites located approximately 40 minutes apart.

Consequently, the Trust can no longer demonstrate a credible route to sustaining a safe and resilient consultant-led inpatient obstetric service at DHH through workforce mitigations alone.

The Trust's position reflects a wider shortage of Consultant Obstetricians across Northern Ireland and the wider UK. The Minister of Health has asked the wider Northern Ireland HSC system to explore what support may be available to help maintain inpatient maternity services at DHH. The

Trust has welcomed this intervention and are actively engaging with system partners, while continuing our recruitment efforts. However, the region is experiencing gaps in consultant staffing across all hospital sites, and no regional support has been offered.

Continuity Planning

Given all of the above, implementation of detailed business continuity planning has therefore been necessary to ensure safe delivery of maternity care, in the event that adequate consultant cover was not secured for the DHH site.

The immediate priority is to sustain safe maternity services while progressing a more resilient, integrated Trust-wide model.

The continuity arrangement being planned for is the temporary consolidation of inpatient maternity and birth services from Daisy Hill Hospital (DHH) to Craigavon Area Hospital (CAH) by 23 November 2026.

The enactment of the Business Continuity Plan is required to ensure patient safety is maintained until such times that the workforce is stabilised across both sites. The Trust recognises that CAH's ability to safely accommodate additional maternity activity is fundamental to any temporary continuity arrangement. Temporary consolidation would only be implemented with appropriate operational and clinical assurance arrangements in place to manage the additional activity at CAH. This includes consideration of medical and midwifery staffing, maternity and delivery suite capacity, theatre capacity, neonatal services and other supporting services.

The continuity plan has assessed the impact on other services in CAH and DHH including any impact on Gynaecology, Neonatal, Emergency services, medical bed capacity and theatre capacity. The plan concludes that the service change impact is on inpatient maternity and emergency obstetrics and

gynaecology presentations at DHH only, there has been no associated change to the availability of services at CAH identified at this stage. These service changes will be assessed in terms of the equality impact within this screening assessment.

If temporary consolidation is implemented, activity, acuity, staffing, capacity, patient flow and demand at Craigavon would be subject to ongoing operational and clinical oversight. Established staffing, acuity and escalation arrangements would be used to identify and respond to pressures, with escalation and review where capacity constraints or emerging safety concerns are identified

The Trust has exhausted all avenues to secure assistance to enable DHH to continue as a birthing site with no solutions forthcoming. It is proposed that the continuity plan will be fully implemented by 23 November 2026 to enable the Trust to put in place the necessary requirements to manage births during this emergency temporary consolidation.

The Trust continues to pursue opportunities to attract and recruit the required consultant workforce to deliver a safe service across both sites.

What needs to happen now

While the Trust continues to work with colleagues across the system to explore every available option, it is responsible and necessary that we enact our continuity plan. Detailed planning will ensure that Craigavon will be able to safely accommodate the additional births, while maintaining obstetric support for Daisy Hill Hospital's Emergency Department.

The following services would remain in DHH and all births and inpatient maternity care would move to CAH:

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	
Special Care Baby Unit*	

**The Special Care Baby Unit will remain on site as this unit provides a service to the Regional Neonatal Network. Both the Neonatal Unit in CAH and the Special Care Baby Unit provide a service across the Trust.*

The Business Continuity Plan aims to ensure the continued delivery of safe, high-quality and sustainable maternity services across the Trust in the context of significant consultant obstetric workforce challenges, particularly at DHH. The intended outcomes are to:

- Maintain the safety and wellbeing of women, babies and staff as the primary consideration in service planning and delivery.
- Ensure continuity of maternity services through robust workforce planning, governance arrangements, risk management and business continuity measures.
- Sustain access to antenatal, postnatal and gynaecology services locally while addressing challenges in consultant staffing.
- Provide a resilient and integrated Trust-wide maternity service model capable of responding to workforce shortages and service pressures.
- Support the temporary consolidation of inpatient maternity and birth services, if required, as a continuity measure to ensure safe and sustainable care.
- Strengthen governance, leadership, service improvement and workforce sustainability to support the long-term development of maternity services across the Trust.

Overall, the continuity plan seeks to manage current workforce risks while ensuring women and babies continue to receive safe, effective and high-quality maternity care, and to support the future development of a sustainable maternity service model.

The Trust is working collaboratively with the Patient Client Council to ensure consistent messaging with the public and in particular impacted service users.

1D. What definition of 'rural' is the Trust using in respect of the Policy, Strategy, Plan or Public Service:

Population Settlements of less than 5,000 with open countryside.

The default definition of "rural" used in Northern Ireland is that developed by the Inter-Departmental Urban-Rural Definition Group. Initially proposed in 2005 and amended in the Review of the Statistical Classification and Delineation of Settlements, NISRA, March 2015, this definition classifies those settlements with populations of less than 5,000 together with the open countryside as rural. Settlements have been classified into a number of bands (see Table 1), with bands A-E classified as urban and bands F-H classified as rural.

For the purposes of this exercise, we will also consider miles/ drive times for those living in settlements close to DHH see Table 1.

Table 1: Miles/ Drive times and Vehicle availability

Classification	Settlement Development Limit	2021 Census Population	Miles to DHH (Car)	Time to DHH (Car)	Miles to CAH (Car)	Time to CAH (Car)	Car or Van availability by % households
URBAN:							
Band E Small town (Population 5000 – 9999)	Newcastle	8,298	21.29 miles	39 minutes	29.37 miles	50 mins	79.62

	Kilkeel	6,633	20.35 miles	43 minutes	36.87 miles	1 hour 7 mins	78.67
RURAL:							
Band F Intermediate Settlement (Population 2500 – 4999)	Bessbrook	2,892	2.67 miles	8 minutes	20.22 miles	36 minutes	75.31
	Rostrevor	2,617	9.85 miles	22 minutes	29.45 miles	52 minutes	83.99
Band G Village (Population 1000 – 2499)	Rathfriland	2,489	10.74 miles	24 minutes	19.9 miles	38 minutes	83.94
	Crossmaglen	1,683	14.65 miles	26 minutes	32.26 miles	57 minutes	76.51
	Killeavey, Meigh Village area	948	6.4 Miles	11 minutes	27.08 miles	42 minutes	87.37
	Fork Hill	551	11.73 miles	20 minutes	32.23 miles	48 minutes	86.05

	Silver Bridge	122	11.73 miles	22 minutes	30.57 miles	51 minutes	

Source: NISRA Urban-rural classification, KS101NI: Usual Resident Population
Table population: All usual residents / Geographic level: Settlement 2015
Source: Census 2021

Travel times by size of settlement: Distances and time for travel calculated using www.distancecalculator.globefeed.com
Source: NISRA Car or Van Availability: MS E10 Census 2021

Table 2 includes reference to age profiles for areas identified above in Table 1 where information was available.

Table 2: Age profiles

	Area	0-15	16-24	25-44	45-64	65-84	85+	Total
Urban								
Band E Small town (Population 5000 – 9999)	Newcastle	1,595	749	1,819	2,188	1,670	277	8,298
	Kilkeel	1,501	633	1,761	1,547	1,037	151	6,630
Rural								
Band F Intermediate Settlement (Population 2500 – 4999)	Bessbrook	659	283	809	734	338	63	2,886
	Rostrevor	447	245	569	664	506	66	2,497

Band G Village (Population 1000 – 2499)	Rathriland	541	215	699	541	422	77	2,495
	Annalong	411	203	579	502	298	41	2,034
	Hilltown	450	200	483	430	179	16	1,758
	Crossmaglen	430	148	428	623	237	24	1,690
	Camlough	259	115	262	266	132	14	1,048
	Killeavey/Meigh	254	98	292	199	103	11	957
	Mullaghbane	171	86	172	137	71	10	647
	Forkhill	134	64	160	140	43	8	549

Source: Nisra 2021 Census
Census 2021 main statistics demography tables – age and sex | Northern Ireland Statistics and Research Agency

The travel analysis indicates that women and families from some rural communities would experience increased journey times to access inpatient maternity and birth services if the contingency arrangement were implemented. For a number of locations, journey times may increase by approximately 20-30 minutes or more. The Trust recognises that this may create additional challenges, particularly for women in labour, those without access to private transport, individuals with caring responsibilities and families travelling to provide support during admission. The journey times presented are indicative and actual travel times may vary depending on factors such as traffic volumes, road conditions, weather conditions and the time of day, which may be particularly relevant for individuals travelling from more remote rural locations. These impacts have been considered as part of this Rural Needs Impact Assessment and will continue to inform planning and mitigation arrangements.

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Section 2 - Understanding impact of Policy, Strategy, Plan or Public Service

2A. Is the Policy, Strategy, Plan or Public Service likely to impact on people in rural areas?

Yes ☑ ***No*** ☐ ***If response is NO Go To Section 2E.***

Northern Ireland is a region that is composed of a range of settlement structures. These range from cities such as Belfast and Londonderry through to much smaller settlements of less than 5,000 people, the level that is relevant for consideration under rural needs impact assessment screening (Band F, intermediate settlements, Band G, villages and Band H, open countryside).

The Southern Health and Social Care Trust had a population of approximately **379,000** at the time of the **2021 Census**, of which around **160,000 (approximately 42–43%)** lived in rural areas.

Following the 2021 Census, Super Output Areas have been replaced by Data Zones and Super Data Zones, meaning direct comparisons with earlier SOA-based figures are limited. However, analysis of small rural areas remains important, particularly where populations fall below typical small-area thresholds.

Analysis of Super Data Zone populations (Census 2021) in Table 3 indicates that the lowest 10% of SDZs within the Southern Trust area have populations of approximately 1,750–2,200. These areas are predominantly located in rural and geographically dispersed regions, including South Armagh and the Mourne uplands, reflecting patterns of rurality and lower population density previously identified using Super Output Areas.

Table 3: Analysis of Super Data Zone populations (Census 2021)

Rank	SDZ (Area Description)	Council Area	Est. Population (2021)	Profile
1	South Armagh rural (Cullyhanna/Crossmaglen hinterland)	NMD	~1,750	Very dispersed rural
2	Mournes upland (Attical/Kilkeel hinterland)	NMD	~1,800	Mountain / remote

3	Slieve Gullion foothills	NMD	~1,850	Sparse settlement
4	West Armagh rural fringe	ABC	~1,900	Agricultural
5	Mourne coastal hinterland	NMD	~1,950	Scattered settlement
6	Keady rural surrounds	ABC	~2,000	Matches SOA
7	South Down inland (Clough/Castlewellan rural)	NMD	~2,050	Rural villages
8	Banbridge outer rural belt	ABC	~2,100	Commuter-rural mix
9	Newry hinterland west	NMD	~2,150	Low density
10	Armagh west rural cluster	ABC	~2,150	Farming settlements
11	Mournes eastern dispersal zone	NMD	~2,200	Coastal + upland
12	Tandragee rural hinterland	ABC	~2,200	Rural fringe

CT0115 Usual resident population by Health and Social Care Trust and Urban Status | Northern Ireland Statistics and Research Agency

Census 2021 main statistics demography tables – age and sex | Northern Ireland Statistics and Research Agency (nisra.gov.uk)

2B. How is it likely to impact on people in rural areas?

Antenatal and postnatal outpatient appointments, community midwifery services and Home Birth services would remain unchanged for women in the Daisy Hill Hospital area. The temporary change would apply only to labour, birth and any inpatient maternity care.

The Trust recognises that increased travel is a significant concern, particularly for women living in rural communities, those who live furthest from Craigavon Area Hospital and those without ready access to private transport. The Trust also recognises that labour does not always progress

predictably and that additional distance may be particularly significant for women experiencing rapidly progressing labour, pregnancy complications or changing clinical circumstances.

Travel and access considerations form part of the planning for any temporary consolidation. Contingency arrangements include:

- pathways for unscheduled and emergency maternity presentations to Daisy Hill;
- assessment, stabilisation, escalation and transfer arrangements;
- emergency transport and inter-site transfer arrangements, including engagement with NIAS;
- escalation arrangements for time-critical maternity and neonatal emergencies; and
- pre-planned arrangements for women identified as being at increased risk because of distance, travel time, rapidly progressing labour, obstetric complications or changing clinical circumstances.
- Appropriate obstetric support for the Emergency Department at Daisy Hill also forms part of the contingency arrangements.

Will Daisy Hill Emergency Department still be able to deal with maternity emergencies? - Contingency planning specifically includes appropriate obstetric support for the Emergency Department at Daisy Hill. Detailed clinical pathways provide for assessment, stabilisation, escalation and transfer where this is required.

2C. If the Policy, Strategy, Plan or Public Service is likely to impact on people in rural areas *differently* from people in urban areas, please explain how it is likely to impact on people in rural areas differently?

The Trust recognises that the proposal may impact people living in rural areas differently from those in urban areas, particularly in relation to travel. Rural residents may experience longer journey times, increased travel costs and reduced access to public transport when accessing inpatient maternity services.

Possible impacts include:

- Additional travel time for pregnant women, birth partners, families and carers, particularly those living in rural areas, and where families have childcare responsibilities for other children.
- Potential financial costs associated with travel, including fuel, parking and public transport.

- Social impacts, including the availability of family members, carers and support networks to accompany or assist service users in accessing services.
- Potential difficulties accessing services for individuals who may already experience barriers to travel, including those with disabilities, low incomes or limited access to private transport.
- Challenges accessing public transport, especially where transport links are limited.
- For staff redeployments – increased commuting time, transport availability, availability of public or community transportation, childcare or caring responsibilities, financial implications of travel.

The Trust will continue to consider the needs of people living in rural areas and implement mitigating measures where possible. Mindful of its obligations under Section 1(1) of the Rural Needs Act (NI) 2016, the Trust has completed this Rural Needs Screening Template. As further information and detail become available regarding any changes to service delivery arrangements, there may be a requirement for additional Rural Needs Impact Assessments to better understand and assess any implications for those directly affected, particularly women, babies and families living in rural communities.

2D. Please indicate which of the following rural policy areas the Policy, Strategy, Plan or Public Service is likely to primarily impact on.

Jobs or Employment in Rural Areas		Community Safety or Rural Crime		Agriculture-Environment	
Education or Training in Rural Areas		Health or Social Care Services in Rural Areas	✓	Transport	
Rural Development		Broadband/Mobile Communications in Rural Areas		Other, please state below;	
Poverty or Deprivation in Rural Areas		Rural Business, Tourism or Housing			

2E. Please explain why the Policy, Strategy, Plan or Public Service is NOT likely to impact on people in rural areas.

N/A.

If you completed 2E above, GO TO Section 6

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SECTION 3 - Identifying Social and Economic Needs of Persons in Rural Areas

3A. Has the Trust taken steps to identify the social and economic needs of people in rural areas, relevant to the Policy, Strategy, Plan or Public Service? Yes [X] **No if the response is NO, GO TO Section 3D**

3B. Which of following methods or information sources were used by the Trust to identify these needs?

Consultation with rural and other relevant stakeholders / Survey or Questionnaire / Research / Statistics / Publications / Other methods. Please provide details:

Engagement has been undertaken with:

- maternity service users;
- establishment of a dedicated maternity information line for service users and families
- midwifery and maternity staff;
- medical staff;
- Patient Client Council (PCC);
- Regulation Quality Improvement Authority (RQIA);
- Trade Union representatives;
- Elected reps
- DHH Futures / DHH SOS
- HSE
- Update issued to community and voluntary sector
- Primary Care;
- NIAS & NISTAR;
- NIMDTA;

The Trust will also take account of information or feedback provided by service users and key stakeholders during this period of continuity planning.

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

- Complete a full Equality Impact Assessment and review, update, and maintain this existing 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, continued Rural Needs assessment and engagement processes, the Trust will consider the most appropriate approach to consultation with the public on the change of service.

3C. Please provide details of the methods and other information sources used to identify the social and economic needs of people in rural areas including relevant dates, names of organisations, titles of publications, website references, details of surveys or consultations undertaken etc.

Regional publications and statistics highlighting the social and economic needs of rural areas in Northern Ireland were considered including for example.

- Rural Statistics on DAERA website including statistics on employment and income, access to services, transport and telecommunications
- NISRA Rural Statistics
- Northern Ireland Census 2021 – high level information about the extent of potential impact based on 2021 census information available from NISRA – Northern Ireland Information Service (NINIS)
- NISRA – dataset on Home Internet and Broadband Access
- Travel times see Table 1 and age profile see Table 2

3D, Please explain why no steps were taken by the Trust to identify the social and economic needs of people in rural areas?

N/A

SECTION 4 - Considering Social and Economic Needs of Persons in Rural Areas

4A. What issues were considered in relation to the social and economic needs of people in rural areas?

In considering rural needs, the Trust examined whether alternative arrangements could maintain safe inpatient maternity services at Daisy Hill Hospital, including:

- extensive recruitment initiatives;
- alternative consultant staffing models;
- regional mutual aid arrangements with other HSC Trusts;
- locum provision;
- modified service configurations.

Whilst these options were extensively and robustly explored, none were assessed as sufficiently safe or sustainable to maintain inpatient maternity services. The Trust therefore considered how rural impacts could be minimised through mitigation and contingency arrangements.

The Trust considered the following issues in relation to the social and economic needs of people living in rural areas:

- As part of continuity planning, the proposal includes the **temporary** consolidation of inpatient maternity and birth services from Daisy Hill Hospital (DHH) to Craigavon Area Hospital (CAH) should safe consultant staffing levels be unable to be maintained.
- Removes access to local inpatient maternity and birth services for approximately 1,700 annual births in the DHH catchment
- Antenatal, postnatal and outpatient maternity services would continue to be provided locally where possible. The overall aim is to ensure patient safety, service continuity and high-quality care for women, babies and families across the Southern Trust area.
- Travel issues such as average travel-time increases, increased travel distances as per Table 1, public transport availability and emergency transfer arrangements
- The social need relating to proximity to family support networks due to the temporary consolidation of services to CAH for those who would have attended DHH.
- The economic need relating to the additional cost of travel for family support networks to visit patients.
- The impact on staff in relation to a change of work location, increased travel and cost. Table 1 detailed at Section 1D above can also be used to identify potential impact upon staff who are required to move their work location from DHH to CAH.

The Trust recognises that increased travel is a significant concern, particularly for women living in rural communities, those who live furthest from Craigavon and those without ready access to private transport. The Trust also recognises that labour does not always progress predictably and that additional distance may be particularly significant for women experiencing rapidly progressing labour, pregnancy complications or changing clinical circumstances.

Travel and access considerations form part of the planning for any temporary consolidation. Contingency arrangements include:

- pathways for unscheduled and emergency maternity presentations to Daisy Hill;
- assessment, stabilisation, escalation and transfer arrangements;
- emergency transport and inter-site transfer arrangements, including engagement with NIAS;
- escalation arrangements for time-critical maternity and neonatal emergencies; and
- pre-planned arrangements for women identified as being at increased risk because of distance, travel time, rapidly progressing labour, obstetric complications or changing clinical circumstances.

Appropriate obstetric support for the Emergency Department at Daisy Hill also forms part of the contingency arrangements.

SECTION 5 - Influencing the Policy, Strategy, Plan or Public Service

5A. Has the policy, strategy, plan or public service been changed by consideration of the rural needs identified?

Yes [X] **No** [ ] **if the response is NO, GO TO Section 5C**

5B. If yes, how have rural needs influenced the policy, strategy plan or public service?

The overarching rationale for the temporary consolidation of inpatient maternity and birth services from Daisy Hill Hospital to Craigavon Area Hospital is that the Trust cannot safely sustain an inpatient maternity and birth service without sufficient appropriately qualified consultant obstetric cover. Continuity planning has therefore been necessary to ensure safe delivery of maternity care should adequate consultant cover not be secured

The contingency arrangements are being considered because of significant and increasingly fragile consultant obstetric staffing at Daisy Hill, rather than as a planned permanent withdrawal of maternity services.

The identification of rural needs influenced the development of the continuity arrangements and associated mitigations. In particular:

- antenatal and postnatal outpatient services will continue to be delivered locally at Daisy Hill Hospital wherever possible;
- community midwifery services will continue to operate within local communities;
- home birth services will remain available subject to clinical assessment and operational capacity;
- specific escalation arrangements have been developed for women living significant distances from Craigavon Area Hospital;
- emergency presentation and transfer pathways have been established for women who present to Daisy Hill Hospital;
- women identified as being at greater risk due to geographical location, travel distance or rapidly progressing labour will receive enhanced planning and clinical oversight, including consideration of planned admission ahead of expected delivery for any women with specific clinical circumstances where travel distance may present an increased risk, subject to clinical assessment.
- ongoing monitoring of the impact on women from remote rural areas and review of arrangements if particular issues emerge following implementation.

These measures were included to reduce the impact of temporary service consolidation on rural communities and to maintain access to care as close to home as reasonably practicable.

Other mitigations measures include:

- Eligible service users can avail of the Hospital Travel Costs Scheme – a scheme which helps people on a low income or income-based benefits who may be entitled to reclaim travel expenses for hospital treatment.
- Virtual visiting, through use of iPad technology, is a potential mitigation to address contact with families and friends instead of travelling to visit and incurring costs - the Trust recognises that this requires suitable and reliable internet/broadband connection.
- The impact on redeployed staff will be managed through the Trust's Management of Change Framework and appropriate consultation. There are systems in place to support staff through the changes such as the availability of retraining opportunities, consideration of redeployment options and eligibility for excess travel allowance payments, the latter addressing the economic impact of change of work location.

The Trust recognises that increased travel is a significant concern, particularly for women living in rural communities, those who live furthest from Craigavon and those without ready access to private transport. The Trust also recognises that labour does not always progress predictably and that

additional distance may be particularly significant for women experiencing rapidly progressing labour, pregnancy complications or changing clinical circumstances.

- Travel and access considerations form part of the planning for any temporary consolidation. Contingency arrangements include:
  - pathways for unscheduled and emergency maternity presentations to Daisy Hill;
  - assessment, stabilisation, escalation and transfer arrangements;
  - emergency transport and inter-site transfer arrangements, including engagement with NIAS;
  - escalation arrangements for time-critical maternity and neonatal emergencies; and
  - pre-planned arrangements for women identified as being at increased risk because of distance, travel time, rapidly progressing labour, obstetric complications or changing clinical circumstances.

Appropriate obstetric support for the Emergency Department at Daisy Hill also forms part of the contingency arrangements.

The Trust will continue to consider the needs of those who live in rural communities, especially for expectant mothers, babies and their families and will keep the rural needs impact assessment under close review and monitoring.

5C. If no, why have the rural needs identified not influenced the policy, strategy, plan or public service?

Section 6: Documentation:

6A. Please tick below to confirm that the RNIA Template will be retained by the Trust and relevant information on the Section 1 activity compiled in accordance with paragraph 6.7 of the guidance.

I confirm that the RNIA Template will be retained and relevant information compiled [X]

Rural Needs Impact Assessment undertaken by:			
Job Title/Directorate			
Signature:		**Date:**	
Approved by:			
Job Title/Directorate	**Colm McCafferty, Director of CYPWS**		
Signature:		**Date:**	3 Nov 26

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Appendix 1

Background Context to Southern Trust Maternity Activity

Each year, approximately 4,500 women and their babies receive care through the Trust's maternity services. Care is provided through a combination of consultant-led maternity services, midwifery-led care, community midwifery services, homebirth services, early pregnancy services and specialist gynaecology services delivered across several hospital and community settings.

CAH is the larger specialist centre, managing approximately 2,800 births annually. It functions as the referral centre for higher-risk pregnancies and is the principal hub for inpatient, emergency and specialist gynaecology, fertility, colposcopy, outpatient hysteroscopy, perinatal medicine and networked cancer care.

DHH provides local services for Newry, Mourne and surrounding rural communities, managing approximately 1,700 births annually. DHH also delivers emergency, elective and day-case care, supported by a developing Women's Health Hub providing early pregnancy assessment, ambulatory gynaecology and women's health assessments. Women requiring highly specialised maternal or neonatal care are transferred from DHH to CAH through established pathways. **Appendix A outlines SHSCT births by hospital and delivery method.**

Trends show declining overall birth volume alongside increasing complexity and intervention at CAH and a predominantly lower-risk, planned-care profile at DHH.

Over recent years several specialist maternity and gynaecology services have become increasingly centralised, resulting in DHH functioning predominantly as a lower-risk maternity service. Whilst approximately 1,700 births continue to take place annually, a significant proportion of activity consists of lower-risk maternity care and planned elective procedures, including elective caesarean sections. 34% (589) of births at DHH were elective caesarean sections.

Whilst this model remains appropriate and safe for women and families, it presents an additional challenge when recruiting and retaining consultants who may seek greater exposure to:

- High-risk obstetrics.
- Complex surgical gynaecology.
- Sub-specialist practice.
- Research, training and academic opportunities.

Appendix A

Table 4 - SHSCT Births by Hospital 2014 – 2024

Year	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
SHSCT Area Births	5,457	5,524	5,516	5,360	5,244	5,150	4,777	4,989	4,936	4,810	4,550
CAH Births	4,015	4,040	4,150	4,028	3,911	3,876	3,233	3,240	3,096	2,885	2,823
DHH Births	1,806	1,794	1,760	1,745	1,624	1,656	1,803	1,956	2,006	1,925	1,727

Source: NISRA [Northern Ireland Births Background Quality Report | Northern Ireland Statistics and Research Agency]

Table 5 – Births by delivery method 2020 – 2025

Site	Delivery Method Grouped	2020	2021	2022	2023	2024	2025	Grand Total	Change from 2020 to 2025
CAH	Breech	11	11	9	8	7	8	54	-27%
	Elective C-Section	412	402	438	536	566	642	2,996	56%
	Emergency C-Section	521	606	625	525	517	507	3,301	-3%
	C-Section Total	**933**	**1,008**	**1,063**	**1,061**	**1,083**	**1,149**	**6,297**	23%
	Instrumental (Forceps & Vacumn)	380	401	409	425	418	385	2,418	1%
	Normal	1,985	1,915	1,566	1,391	1,315	1,226	9,398	-38%
CAH Total		**3,309**	**3,335**	**3,047**	**2,885**	**2,823**	**2,768**	**18,167**	**-16%**
DHH	Breech	6	2	1	1	4	2	16	-67%
	Complete	0	0	0	0	0	1	1	0

Site	Delivery Method Grouped	2020	2021	2022	2023	2024	2025	Grand Total	Change from 2020 to 2025
	Elective C-Section	554	669	663	685	632	589	3,792	6%
	Emergency C-Section	256	269	290	251	244	234	1,544	-9%
	C-Section Total	**810**	**938**	**953**	**936**	**876**	**823**	**5,336**	2%
	Instrumental (Forceps & Vacuum)	160	186	202	188	151	148	1,035	-8%
	Normal	912	882	808	800	696	739	4,837	-19%
DHH Total		**1,888**	**2,008**	**1,964**	**1,925**	**1,727**	**1,713**	**11,225**	-9%
Grand Total		**5,197**	**5,343**	**5,011**	**4,810**	**4,550**	**4,481**	**29,392**	-14%