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 – 26 November 2026	
Title of paper	Obstetrics, Maternity and Gynaecology Services – Trust Board Update Paper	
Accountable Director	**Name**	Colm McCafferty
	Position	Deputy Chief Executive and Director of Children, Young People and Women's Services
Report Author	**Name**	Michelle Harrison, Assistant Director Integrated Maternity and Women's Health Services Andrea Turbitt, Senior Business Manager
	Email	*Michelle.Harrison@southerntrust.hscni.net* *Andrea.Turbitt@southerntrust.hscni.net*
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 implementation of the emergency continuity arrangements approved on 3 November 2026 and seek approval for the next phase of operational assurance, pre-consultation engagement, impact assessment and clinically led options/restoration work. Temporary consolidation at Craigavon Area Hospital (CAH) is a safety measure, not a decision on permanent service configuration. The Trust's preferred position is reinstatement at Daisy Hill Hospital (DHH) when safe to do so.
2. Detailed summary of paper contents:
The paper describes phased consolidation between 9 and 23 November 2026, with elective caesarean sections at CAH from 9 November, and all births planned to consolidate from 23 November. Emergency gynaecology also transfers because of shared consultant rota requirements. Revised emergency and transfer pathways, staff redeployment and training, communications and estates changes support implementation. Registered midwifery staffing supports the temporary model configuration. A reporting dashboard is being refined to monitor activity, outcomes, capacity, workforce and Patient experience and inter-hospital transfers. Next steps in terms of EQIA/RNIA and associated engagement and consultation process are set out.
3. Areas of improvement/achievement:
Women requiring inpatient obstetric, intrapartum, postnatal maternity or emergency gynaecology care at DHH are affected by transfer to CAH. Appropriate antenatal, outpatient, community maternity and women's health services continue locally where clinically appropriate and operationally sustainable. Engagement and impact assessments will examine access, travel, transport, experience and mitigations required for all affected women. Direct contact, accessible information, interpretation and translation and a 24-hour Centralised Maternity Triage Line established from 23 November support communication and access. A proposed cross-border pathway with the HSE and Our Lady of Lourdes Hospital, Drogheda, aims to develop an alternative option for a limited number of deliveries from the South Armagh Corridor, initially on a pilot basis. It is anticipated this could be achieved by early Spring 2027. .
4. Areas of concern/risk/challenge:
Risks will remain under active review through daily reporting, weekly senior clinical oversight, Board assurance and formal three and six-month reviews. Maternity services will be a standing agenda item on Trust Board meetings for the duration of the Temporary consolidation.
5. Impact on Statutory Duties: Provide details on the impact of the following and how.

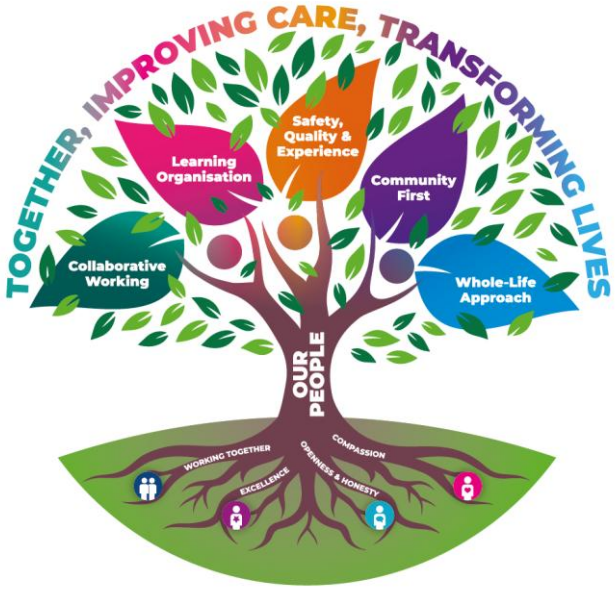
Key risks / matters requiring oversight	Mitigations and controls
Workforce resilience and CAH support-worker vacancies; increased activity, capacity and patient-flow pressures; effectiveness of emergency and transfer pathways; additional travel and access burdens; data quality; and uncertainty about restoration readiness and cross-border implementation.	Recruitment, temporary staffing and daily safe-staffing review; phased estates improvements; multidisciplinary pathway review, simulation and escalation arrangements; direct communication and engagement on access mitigations; dashboard refinement and regular reporting. Restoration requires defined conditions to be demonstrably met, independently assured and formally approved. Review points are not guaranteed reopening dates.

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

Oversight will operate through the Oversight Group, Senior Leadership Team and Trust Board, with continued SPPG, PHA and DoH involvement. The dashboard will bring together utilisation, maternal and neonatal outcomes, capacity, patient flow, workforce, transfers and escalation; further data-quality refinement is required. Clinically led appraisal will assess full reinstatement, phased return and revised cross-site models, informed by operational evidence, service-user engagement and EQIA/RNIA. Proposed three- and six-month reviews and the March 2027 public paper will explain progress, barriers and next steps. Formal consultation will follow the required impact-assessment and options processes; temporary arrangements do not determine permanent configuration.

7. Equality and rural needs considerations

Equality screening	Completed. Screening concluded that a full EQIA, including consultation, is required. The paper acknowledges duties under the Northern Ireland Act 1998 to consider Section 75 groups and address inequalities.
Full EQIA	Commenced and under development. Assessment and engagement will consider all affected women, including emergency gynaecology service users, and identify impacts and mitigating actions. Findings will inform options appraisal and subsequent formal consultation.
Rural needs	An RNIA has been completed and will be reviewed and updated alongside the EQIA and engagement programme. Travel, transport, access and possible mitigations for rural communities will be considered in line with the Rural Needs Act (NI) 2016, including the proposed South Armagh cross-border pathway.



SOUTHERN HEALTH AND SOCIAL CARE TRUST

Obstetrics, Maternity and Gynaecology Services Trust Board Update Paper

26th November 2026

Table of Contents

1.0 Executive summary 5
2.0 Context 7
3.0 Implementation Progress and Operational Assurance since 3rd November 2026 7
3.1 Staff Management of Change 7
3.2 Midwifery Workforce Position 8
3.3 Consultant Workforce 9
3.4 Staff Support, Training and Upskilling 10
3.5 Band 2/3 Workforce Position 11
4.0 Planned Implementation Progress 12
4.1 Pathway Development 12
4.2 Consolidation of Elective Caesarean Sections 14
Table 4.2.1 Breakdown of Births 15
4.3 Estates and Works 15
4.4 Cross Border Pathway 15
4.5 Communication with Public and Pregnant Women 16
4.6 Review, Evaluation and Governance 18
5.0 Changing or Withdrawal of Service 18
5.1 Timeline for Consultation 21
5.2 Governance of the Engagement/ Consultation approach 21
6.0 Future Options and Potential Service Restoration 22
7.0 Decisions Requested of Trust Board 23

1.0 Executive summary

On 3 November 2026, Trust Board approved emergency continuity arrangements in response to deterioration in the consultant obstetric workforce at Daisy Hill

Hospital (DHH), temporarily consolidating inpatient obstetric, intrapartum and postnatal maternity services at Craigavon Area Hospital (CAH). Emergency gynaecology services will also transfer because of the shared consultant rota requirements. **This is a temporary safety measure, not a decision on permanent service configuration. The Trust's preferred position is reinstatement where safe to do so.** Antenatal, outpatient, community maternity and women's health services continue locally where clinically appropriate and operationally sustainable.

Implementation has progressed through a phased approach from 9 to 23 November 2026. Elective caesarean sections consolidated at CAH on 9 November, with early reports indicating a generally smooth transition and operational improvements underway. Emergency and transfer pathways have been developed with multidisciplinary and Northern Ireland Ambulance Service input, supported by staff engagement and planned simulation exercises. Staff redeployment, training and wellbeing supports are in place. Registered midwifery staffing supports the temporary model however, Band 2/3 vacancies at CAH require ongoing recruitment, temporary staffing and daily review.

Estates developments at CAH are facilitating increased in patient activity, with further ward improvements and a dedicated bereavement suite planned. Direct communication with women continues, alongside a 24-hour Centralised Maternity Triage Line planned from 23 November. A cross-border pathway with the Health Service Executive and Our Lady of Lourdes Hospital, Drogheda, is being developed to address travel impacts for a limited number of women in the South Armagh corridor from early Spring 2027.

The next phase has three linked priorities:

1. **Operational assurance:** monitor activity, maternal and neonatal outcomes, capacity, workforce, inter hospital transfers and service-user experience, through a developing reporting dashboard, and respond promptly to emerging pressures;
2. **Pre-consultation engagement and impact assessment:** examine service-user experience, access, travel, transport and mitigations for all affected women, informing the Equality Impact Assessment (EQIA), updated Rural Needs Impact Assessment (RNIA), options appraisal and subsequent formal consultation;
3. **Clinically led restoration assessment:** assess full reinstatement, phased return and revised cross-site models, defining the workforce, supporting services, infrastructure and any investment required. Reinstatement will proceed only when the required conditions are demonstrably met, independently assured and formally approved.

A public Board paper in March 2027 will bring together engagement findings, impact assessment progress, emerging options and recommendations for subsequent formal consultation. Regular oversight through the Oversight Group, Senior Leadership Team and Trust Board will support review and accountability. **Review points are not guaranteed reopening dates or predetermined decisions on permanent configuration.**

Trust Board is asked to approve the post-consolidation assurance, engagement and impact assessment programme, the proposed engagement timetable and clinically led options/restoration workstream.

2.0 Context

The Board's decision on 3 November 2026 responded to an immediate workforce and service-continuity risk and associated emerging patient safety concerns at DHH. It authorised temporary consolidation of inpatient obstetric, intrapartum, postnatal maternity and emergency Gynae services at CAH, while retaining appropriate antenatal, outpatient, community maternity and women's health services at DHH and across the Newry and Mourne area where clinically appropriate and operationally sustainable. **The emergency decision and any future decision on permanent service configuration are distinct.** This paper sets out implementation progress, the information required for ongoing assurance and the proposed process for conducting pre-consultation engagement.

3.0 Implementation Progress and Operational Assurance since 3rd November 2026

3.1 Staff Management of Change

The Trust recognises the significant practical and emotional impact the temporary consolidation has on service users, the community and the staff concerned.

The Trust is very appreciative of the constructive role played by Trade Union colleagues and the pragmatic engagement of staff concerned.

Overall, the transfer and redeployment of midwifery, medical and support staff to support the temporary consolidated maternity service model has progressed well. A structured Management of Change process was undertaken involving the Senior Midwifery Team, Medical Workforce, Human Resources and Trade Union representatives. All staff directly impacted by the service change were offered individual face-to-face meetings to discuss options, concerns and support requirements

All medical staff were offered job plan meetings and those who took up this offer were facilitated by the clinical directors and HR. Temporary job plan changes have been mutually agreed and will be modified with service requirements going forward

Engagement throughout this process was positive and the vast majority of staff were accommodated within their preferred placement choices whilst ensuring safe staffing arrangements across maternity services.

Workforce planning remains under continuous review to ensure safe staffing levels are maintained within the consolidated service model. Recruitment activity continues across a number of staff groups to strengthen workforce resilience and support service sustainability.

3.2 Midwifery Workforce Position

A detailed review of Band 5/6 midwifery staffing across the service demonstrates that the workforce is in a strong position to support the temporary consolidated model.

Table 3.2.1 Midwifery Staffing Position (Band 5/6) as of 23rd November post consolidation

Area	Funded WTE	In Post	Vacancy	Available Staff (including sickness/maternity/other leave)
Daisy Hill Hospital	15.16	13.43	1.73	8.70
Craigavon Hospital	116.57	113.21	3.36	93.53
Community Services	65.96	59.22	6.74	57.36
Total	**197.69**	**185.86**	**11.83**	**159.59**

Across all inpatient and community maternity services there are 197.69 WTE funded Band 5/6 posts, with 185.86 WTE currently in post. Whilst there are 11.83 WTE vacancies, the majority of staffing reductions relate to temporary absences including sickness, maternity leave and career breaks, rather than substantive workforce deficits.

The current position shows that 159.59 WTE midwives are available for deployment across services, representing 86% of the workforce available before annual leave and study leave are taken into account. The Craigavon Hospital inpatient areas remain particularly well-staffed, with a substantive workforce of 113.21 WTE in post against an establishment of 116.57 WTE.

Community services continue to experience some vacancy pressures, particularly within the Armagh & Dungannon and Craigavon & Banbridge localities. However, these are being actively managed through recruitment activity and workforce planning arrangements. The temporary service consolidation has enabled staffing

resources to be aligned to areas of greatest clinical demand while maintaining continuity of community maternity services.

The temporary transfer of staff from Daisy Hill Hospital into the consolidated model has strengthened workforce resilience and increased opportunities for staff to maintain and develop skills within a higher acuity maternity environment. As a result, the service is well positioned to safely support current activity levels and maintain safe staffing across antenatal, intrapartum and postnatal care.

3.3 Consultant Workforce

The temporary consolidation of inpatient maternity services on 23 November 2026 has enabled the Trust to stabilise consultant medical rotas and maintain safe service delivery across the consolidated service. Consultant rotas for November and December 2026 have been successfully covered, providing assurance regarding immediate service continuity during the initial implementation period. However, despite the benefits realised through consolidation, the consultant workforce remains under significant pressure. The service continues to rely on locum medical staff to support both planned daytime activity and the out-of-hours on-call rota. This reflects the ongoing challenges associated with consultant workforce shortages and the requirement to maintain safe staffing levels across the full spectrum of obstetrics and gynaecology services.

There are currently six substantive consultant vacancies within the workforce establishment. These vacancies continue to create a level of fragility within the consultant rota and limit the Trust's ability to reduce its reliance on temporary staffing arrangements. While consolidation has improved the sustainability of medical cover, it has not eliminated the requirement for locum support.

Recruitment activity remains ongoing to strengthen the substantive consultant workforce. At present, two consultant posts are actively being advertised, comprising one Consultant Obstetrician post and one Consultant Obstetrician and Gynaecologist post. These recruitment exercises are a key component of the Trust's workforce sustainability plans and are intended to improve long-term rota resilience, reduce dependency on locum staffing, and support the delivery of high-quality, safe maternity and gynaecology services.

The Trust will continue to closely monitor workforce capacity and recruitment outcomes over the coming months. Further work is underway to develop longer-term workforce solutions, recognising the wider regional and national challenges in recruiting and retaining consultant obstetric and gynaecology staff. The position remains under regular review to ensure that safe, sustainable consultant medical cover is maintained and that risks associated with workforce shortages are appropriately managed.

Overall, while temporary consolidation has delivered enhanced resilience within the consultant workforce and has enabled rotas to be maintained in the short term, substantive workforce gaps remain a significant challenge. Continued recruitment, combined with the ongoing use of locum support where required, will be necessary to ensure the safe delivery of services pending the successful appointment of substantive consultants.

Table 3.3.1 Consultant Workforce post 23 November

	CAH – Consultant Staffing Post Consolidation
Required Staffing	12 WTE to contribute to on-call rota
Current Substantive staff in post	18 Head Count
Current available Substantive Consultant Staffing that contribute to On-call rota	13.9 WTE
Vacancies	6 WTE
Maternity	2 Head count, which equates to 1.5 WTE contribution to on call
Sick	2 Head count which equates to 1 WTE contribution on call
Current consultant availability for on call	11.4 WTE
Available long-term locums	3 WTE
Consultant availability from 23rd Nov 2026, and including locums	**14.4 WTE**

3.4 Staff Support, Training and Upskilling

Recognising that some midwives transferring from Daisy Hill Hospital may have had less frequent exposure to complex maternity cases due to the lower risk profile of the unit, significant support arrangements are in place.

The Practice Development Midwife Team and Clinical Skills Midwives are working closely with staff to ensure they feel supported and confident within the consolidated service model. This includes targeted clinical support, supervised practice opportunities, simulation training and skills development focused on the management of higher acuity and more complex maternity presentations.

Feedback from staff has been positive and this enhanced support model is helping to ensure that all midwives have the skills, competence and confidence required to deliver safe, high-quality care within the expanded service configuration.

In addition to clinical support and development opportunities, a range of staff wellbeing measures have been established to support colleagues through the transition to the temporary consolidated service model. Dedicated support sessions have been offered through the Health and Wellbeing Team and Clinical Psychology Services, with both pre-booked and drop-in sessions available to staff. Dates and access arrangements have been shared widely to ensure all staff have the opportunity to avail of this support. A bespoke support and development session is also planned for the Senior Midwifery Leadership Team following implementation on 23 November. This will focus on supporting leaders as they manage the integration of teams, promote staff wellbeing and maintain positive team culture during the transition period.

3.5 Band 2/3 Workforce Position

A review of the Band 2/3 workforce has been undertaken to assess the staffing position following implementation of the temporary consolidated maternity service model. The position differs from the registered midwifery workforce, with a number of vacancies across inpatient services, particularly within Craigavon Area Hospital.

As part of the Management of Change process, Band 2/3 staff affected by the temporary cessation of inpatient maternity services at Daisy Hill Hospital were offered a range of options, including transfer to Craigavon Area Hospital or redeployment to alternative roles within Daisy Hill Hospital. A number of staff chose to remain within Daisy Hill Hospital due to personal circumstances and the implications associated with additional travel requirements. This was fully supported through the Management of Change process but has reduced the number of support staff available to transfer into the consolidated service model.

Table 3.5.1 Band 2/3 Staffing Position Following Consolidation

Area	Funded WTE	In Post	Vacancy	Available Staff*
Daisy Hill Hospital	8.97	10.57	-1.60	7.74
Craigavon Area Hospital	52.39	34.26	18.13	27.34
Community Services	6.40	6.60	-0.20	6.60
Total	**67.76**	**51.43**	**16.33**	**41.68**

*Available staff excludes those on sickness absence, maternity leave, authorised absence and career break.

Across maternity inpatient, outpatient and community services there are 67.76 WTE funded Band 2/3 posts, with 51.43 WTE staff currently in post. This represents an overall vacancy position of 16.33 WTE. After accounting for sickness absence, maternity leave, authorised absence and career break, 41.68 WTE staff are currently available to support service delivery.

The most significant workforce pressures are within Craigavon Area Hospital, where there are 18.13 WTE vacancies across inpatient maternity services.

The Trust continues to actively manage these workforce pressures through ongoing recruitment activity, temporary staffing arrangements where required, and daily workforce reviews. Staffing levels are monitored through established safe staffing processes, and escalation arrangements remain in place to ensure safe and effective care is maintained across all maternity services throughout the period of temporary consolidation.

4.0 Planned Implementation Progress

4.1 Pathway Development

A significant programme of work has been undertaken to review, develop and implement the pathways required to support the temporary service model. Emergency and transfer pathways have been developed with input from Emergency Department, Obstetrics and Gynaecology, Anaesthetics and Northern Ireland Ambulance Service (NIAS) colleagues. The various pathways developed are outlined below including a brief descriptor and key outputs:

- ***Emergency Department pathways for obstetrics and gynaecology (daytime and out-of-hours)***: The pathways set out arrangements for assessing, stabilising and managing women presenting to Daisy Hill Hospital (DHH) with urgent and time critical maternity, obstetric or gynaecological concerns following the temporary relocation of services to Craigavon Area Hospital (CAH). They cover local assessment and follow-up where clinically appropriate, access to specialist advice, escalation and transfer to CAH for ongoing care. For clinically unstable patients, senior multidisciplinary teams determine whether transfer is appropriate or emergency intervention at DHH is required. The arrangements remain subject to ongoing audit and review.

  On-site obstetric and gynaecology medical cover at DHH has been confirmed, with a SAS doctor available during daytime hours and a Clinical Fellow out of hours as the first point of contact when required. Clear arrangements are in place for escalation to senior clinical input. On-site maternity advice and support will be available from 8am to 8pm. Out of hours, advice will be provided by the CAH Delivery Suite, which will arrange midwifery support at DHH if required in urgent and time critical presentations

- ***Neonatal/Paediatric Pathway*** - The pathway sets out the arrangements to support the temporary consolidation of maternity services at CAH, while maintaining an effective neonatal pathway across both CAH and DHH. The model strengthens paediatric cover at CAH, retains the DHH Special Care Baby Unit (SCBU) as a step-down facility, and establishes criteria for the

planned transfer of clinically appropriate babies from CAH to DHH, primarily following maternal discharge and where this supports care closer to home. Transfers will be coordinated through NISTAR/NIAS, with clear clinical acceptance and staffing requirements. The pathway identifies additional transitional care nursing and equipment requirements, alongside ongoing simulation training, clear communication with families, comprehensive data monitoring, and regular multidisciplinary review. Overall, the arrangements are designed to maintain safe neonatal care, minimise unnecessary mother-and-baby separation, preserve capacity at CAH for higher-acuity neonatal care, and ensure the model can be adjusted quickly in response to emerging demand or risk.

- ***NIAS bypass protocol*** – DHH Emergency Department remains open 24/7 for a wide range of medical and surgical presentations, with crews encouraged to discuss uncertain cases directly with DHH clinicians. However, the protocol identifies specific exclusions where patients require direct conveyance elsewhere. Importantly, following the removal of obstetric/gynaecology services from DHH, maternity or obstetric emergencies and pregnant women over 20 weeks with non-obstetric emergencies should normally be conveyed to Craigavon Area Hospital, subject to immediate life-threatening situations where the nearest appropriate Emergency Department should be used. The overall intention is to ensure patients reach definitive specialist care as quickly as possible, minimise avoidable secondary transfers between DHH and Craigavon, and protect NIAS emergency response capacity for the South Down and South Armagh localities.

All pathways have been reviewed and revised to reflect the new service configuration and to ensure clarity regarding referral pathways, transfer arrangements, escalation processes and ongoing management of women throughout pregnancy, labour and the postnatal period.

Clinical teams continue to review pathways following implementation and amendments are being made where required to reflect learning, operational experience and feedback from women and staff.

A dedicated staff engagement session was held on 20 November to review all revised pathways in detail and ensure staff have a clear understanding of the new processes and responsibilities. The pathways have also been shared with Staff Side colleagues for review and feedback as part of the ongoing consultation process. Throughout the planning and implementation phases, staff engagement sessions have provided valuable opportunities for frontline colleagues to review, challenge and influence the proposed pathways, with feedback used to shape and refine processes to ensure they are practical, safe and operationally effective.

To further support implementation and provide assurance regarding the effectiveness of the revised arrangements, multidisciplinary simulation sessions progressed during the week commencing 16 November. These sessions have been designed to test key pathways and operational processes, allowing staff to rehearse roles, responsibilities, escalation procedures and transfer arrangements within the temporary service model. Recognising that not all staff are able to attend in person, Communications colleagues support the sessions by recording them and making the recordings available to all staff to ensure consistent messaging, maximise accessibility and support ongoing learning and familiarisation with the new pathways.

Implementation of the temporary service model has been undertaken through a phased approach between 9 November and 23 November, enabling services to transition safely, allowing staff to become familiar with revised arrangements and ensuring any issues identified could be addressed in a timely manner. Throughout implementation there has been ongoing monitoring and review to ensure patient safety and service continuity.

4.2 Consolidation of Elective Caesarean Sections

Elective caesarean sections ceased at DHH on 8 November 2026 and were formally consolidated at CAH from 9 November 2026, in advance of the planned consolidation of all births from 23 November 2026. Early operational reports indicate a generally smooth transition, with elective lists completing on time, good consultant support and minimal impact on evening services. Escalation processes and communication arrangements between Obstetric and Anaesthetic teams have been established to address operational issues as they arise.

Feedback from clinical teams identified some delays associated with patient arrival and admission processes, impacting the timely completion of anaesthetic reviews, consent and admission documentation. In response, revised patient pathways and arrival times have been implemented to support more efficient list management and timely preparation for surgery.

Operational oversight has been strengthened through the introduction of structured multidisciplinary team (MDT) briefings before each elective list and formal debrief processes following list completion to identify learning and improvement actions. Daily Band 7 leadership oversight is being embedded to provide consistent operational management and support service delivery. Standard operating procedures for the elective caesarean section service are also being finalised and will clearly define roles, responsibilities and escalation arrangements across the multidisciplinary team.

A small number of operational challenges remain under review, including theatre turnaround times, environmental cleaning arrangements and consultant availability

where elective activity coincides with other clinical commitments. Actions are in place to address these issues and support continued service improvement.

The table below reports births by delivery method at CAH and DHH from 9 to 17 November 2026, following the scheduled consolidation of elective caesarean sections. It reports 103 births in total: 79 at CAH and 24 at DHH. These activity figures do not, by themselves, demonstrate clinical outcomes or capacity adequacy.

Table 4.2.1 Breakdown of Births

Births by method from 9 November to 17 November		
	CAH	DHH
C-Section Elective	33	0
C-Section Emergency	18	7
Vaginal spontaneous	19	15
Forceps	5	2
Vaginal Ventouse	3	
None of the above	1	
	79	24
Total Births	**103**	

4.3 Estates and Works

Estates works at CAH have progressed in recent weeks to accommodate the increased demand and activity associated with service consolidation. The Grace Clinic has relocated from 1 East to a repurposed area within Maternity Outpatients. This has enabled 4 induction beds to move from Maternity Theatres to the space vacated on 1 East, and creation of a dedicated recovery area in Maternity Theatres for women undergoing planned caesarean sections.

Further improvements to 1 East ward are underway, including reconfigured storage and improved toilet and shower facilities. The works are being carefully phased to minimise disruption and maintain service continuity, with completion expected by the end of December 2026.

A separate programme of works is planned to create 2 additional rooms outside the main 1 East ward area, providing a dedicated bereavement suite for mothers experiencing baby loss. Work is scheduled to begin after Christmas 2026 and is expected to take 8–10 weeks.

4.4 Cross Border Pathway

The Trust continues to engage with the Health Service Executive (HSE) in Ireland, particularly colleagues at Our Lady of Lourdes Hospital, Drogheda, to develop a cross-border care pathway for women in the South Armagh corridor. The proposed

pathway would address the travel impact of consolidation at CAH for women in one of the areas most affected.

An Oversight Group has been established, with agreed senior representation from the Southern Trust and the HSE. Three working groups - Clinical, Operational and Finance have also been established to develop the pathway and eligibility criteria, governance and implementation arrangements, performance measures, risk management, and financial costs and controls.

No formal timetable has been agreed for completion of the working groups' activity. The current expectation is that a workable pathway will be agreed and ready for implementation in the new year; this is not yet a confirmed implementation date. This will initially be on a pilot basis for a maximum of 10 episodes per month for a limited number of interested parties from the South Armagh Corridor

4.5 Communication with Public and Pregnant Women

A comprehensive communications and engagement programme is in place to ensure women and families receive accurate, timely and accessible information regarding the temporary consolidation of maternity services.

Since news of the service change was first reported on 21 September 2026, the Senior Midwifery Team has undertaken a significant programme of direct engagement with women booked for maternity care within Southern Trust services. Midwifery Leads have contacted women due to give birth between 23 November 2026 and the end of January 2027, providing personalised information, reassurance and an opportunity to discuss any concerns regarding the temporary service arrangements.

This engagement programme will continue, with plans to contact all women due to give birth up to the end of February 2027. Women are being contacted in date order based on their estimated date of delivery to ensure those most immediately affected receive information and reassurance at the earliest opportunity.

In addition, the Trust intends to contact all women due to have their baby at either Craigavon Area Hospital or Daisy Hill Hospital between now and the end of February 2027 to confirm their preferred communication method and contact details. This will allow information to be distributed electronically through email and the MyCare App, according to individual preference.

Detailed information tailored specifically for women and families using maternity services has been shared through Trust communication channels, including the Trust website, social media platforms, local media, stakeholder networks and directly with women through maternity teams. Information is also being made available through the MyCare App where possible, with discussions continuing with Encompass colleagues to maximise this communication channel.

Communication materials have been developed in consultation with a service user representative and the Patient and Client Council to ensure they reflect the information needs and concerns raised by women and families. Resources include clear information regarding the temporary service arrangements, details of services available at each hospital site, key contact information, frequently asked questions, patient information leaflets, posters, a familiarisation video supporting navigation to Craigavon Area Hospital and messages from the maternity team.
Maternity Updates | Southern Health & Social Care Trust

Feedback received through engagement activity has highlighted the importance of providing clear, consistent and accurate information, as well as practical information regarding travel, access arrangements and familiarisation with the Craigavon Area Hospital site. Communications continue to be refined in response to this feedback and emerging information needs.

Recognising the diverse needs of the population served by the Trust, information has been developed with accessibility and inclusion at its core. Service users can access an automated translation facility via the Trust website and professionally translated versions of key information are being developed in a range of languages commonly spoken within the Trust area. Interpretation services are also available on request and communication requirements continue to be reviewed in partnership with the Equality Team and Social Complexity Midwife to ensure information is accessible to all women and families.

In addition to the direct engagement programme, the dedicated Maternity Information Line continues to operate Monday to Friday from 2.00pm to 5.00pm. This service provides women and families with direct access to maternity staff who can respond to questions or concerns relating to the temporary service arrangements, ensuring timely access to information, advice and reassurance.

Further improvements to communication and access arrangements will be introduced from 23 November 2026 through the implementation of a Centralised Maternity Triage Line. Operating 24 hours a day, 7 days a week, the service will provide a single point of contact for women with concerns relating to their pregnancy or who believe they may be in labour. Women contacting the service will speak directly with an experienced midwife who will undertake an assessment, provide advice and determine the most appropriate care pathway based on clinical need.

The service is intended to improve accessibility, enhance consistency of advice and ensure women receive the right care, in the right place, at the right time.

Alongside direct engagement with women, the Trust has maintained an extensive programme of communication through local media, social media platforms,

stakeholder briefings, community networks and public information channels to ensure women, families, partner organisations and the wider public continue to receive consistent and accurate information throughout implementation. All communication and engagement activity remains under review and will continue to be developed in response to feedback from women, families, staff and stakeholders.

4.6 Review, Evaluation and Governance

Operational assurance is a core workstream of the proposed post-consolidation programme. It will assess the impact of the temporary arrangements, identify emerging pressures and support a prompt response to concerns. Activity data, clinical outcomes and service-user experience will be considered together to evaluate the effects of consolidation.

The Trust's Informatics Team has worked with operational and planning colleagues to develop a reporting dashboard covering service utilisation, maternal and neonatal outcomes, capacity and patient flow, workforce resilience, transfers and escalation.

Staff from affected services, alongside colleagues from the Strategic Planning and Performance Group (SPPG) and Public Health Agency (PHA), have helped test the dashboard's ability to support both day-to-day operational management and strategic reporting. Further refinement of data quality and presentation is required. There is, however, broad confidence that robust reporting will be available from 23rd November to support ongoing review and monitoring.

5.0 Changing or Withdrawal of Service

As noted at Trust Board on 3rd November 2026, 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 approved implementation of the Business Continuity Plan in advance of consultation.

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.

The table below sets out the key requirements of the circular and the Trust's conformation of compliance with these requirements.

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

Circular Requirement	Trust Response
Notify early: Inform the Department through SPPG before any major or controversial temporary service change	The SPPG and DoH have been involved in the process of managing the vulnerabilities within the Maternity Service within the Trust and in particular at DHH. The SPPG was advised immediately after the Trust was informed of the notifications of consultants to resign from the Trust. The Trust and SPPG have worked in partnership as the Continuity plan has been developed and will continue to do so.
Involve the public: Engage affected communities as far as practicable and decide whether formal consultation is required	The Trust has engaged as far as practicable in developing the continuity plan and informing patients, interest groups and public representatives of the changes. An equality screening & rural needs impact assessment have been completed on the change to service which has concluded that a full EQIA (including consultation) will be required. The Trust has now commenced the completion of the full EQIA and will review the completed Rural Needs Impact Assessment as the EQIA process proceeds. The Trust is continuing to engage with stakeholders and will monitor the impact of the temporary changes as we progress.
Consult where necessary: If urgent action precedes consultation, consult afterwards and consider reinstatement or permanent change	The Trust will carry out formal consultation, following the normal process of EQIA/Rural Needs Impact Assessment, pre-consultation engagement and full options assessment (including reinstatement of services at DHH), as outlined below.
Maintain transparency: Temporary arrangements must not be used to avoid statutory involvement or consultation duties	The Trust confirms that the purpose of the temporary arrangements was in response to changes in staffing that meant the service would not be safe to continue at DHH. The Trust's preferred position is the re-instatement of the service where that is safe to do so. As outlined above, the Trust will now commence the process of EQIA, pre-consultation engagement and options appraisal to inform

Circular Requirement	Trust Response
	consultation (noting that a high level options appraisal was carried out as part of the decision for the temporary change).
Secure approvals: Obtain Departmental approval for consultation documents referencing regional policies, strategies or standards	The Trust will work closely with the SPPG and DoH in developing documents for consultation.
Consider regional advice: Consult SPPG on major, controversial or policy-divergent changes and consider Departmental, PHA and other relevant views	As noted above, the Trust has been working closely with the DoH, SPPG and PHA as we work through the process of emergency change and will continue to do so as we move to post change consultation processes.
Retain accountability: The HSC body makes the final decision and must clearly document its rationale, particularly where Departmental support is absent	The Trust acknowledges its decision-making responsibilities in this regard. SPPG support for the rationale for the change has been received and formed part of the information provided to the Trust Board on 3rd November in relation to the change**.**
Set review points: Temporary changes must be time-limited, regularly reviewed and progressed to formal permanent-change processes if prolonged	The Trust will monitor the change regularly and within agreed KPIs. Reporting to the SPPG/DoH will be via the Support & Intervention Framework mechanism as well as at operational level within agreed mechanisms.

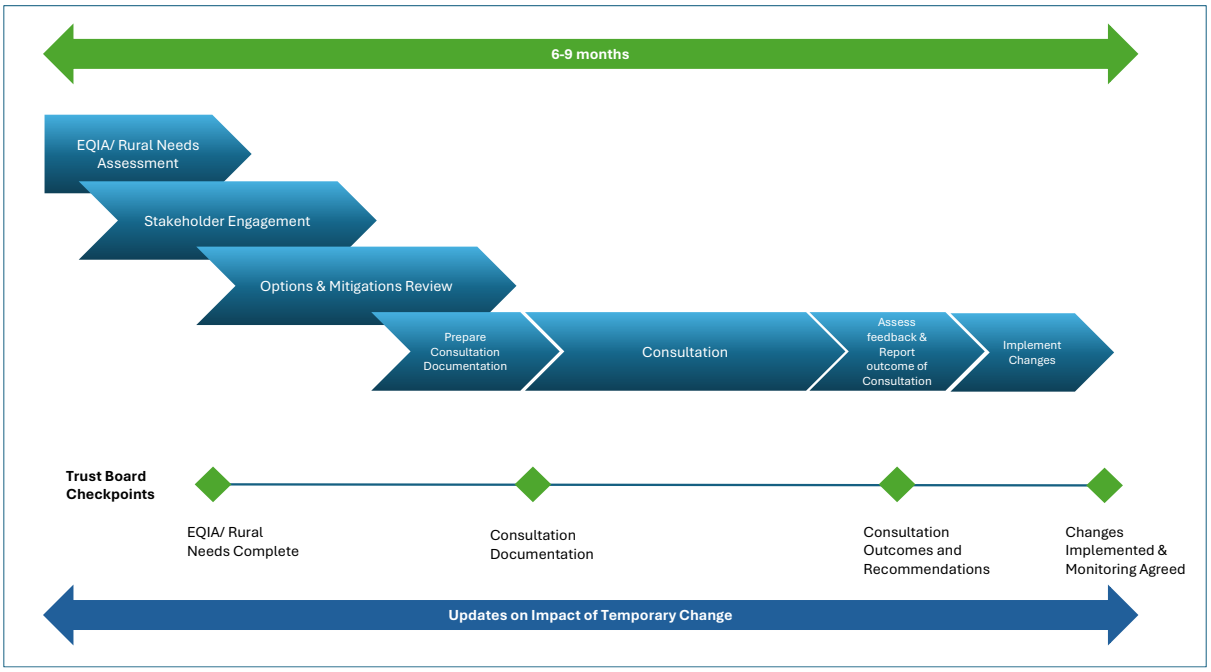
The implementation plan and significant service mapping process that has been carried out to date has identified that consolidation of all inpatient maternity services will not have an impact on patients in any of the service areas assessed, with the exception of inpatient maternity and emergency gynaecology services at DHH, which will also transfer to CAH due to the need for input from Obstetrics & Gynaecology consultants. The Trust has reviewed the number of women attending DHH who have been admitted due to an emergency gynaecology episode, and these have been identified as c. 1-3 per month. Given these numbers, and the inextricable link between the O&G rotas which result in the change, the Trust has assessed the impact of service change on all women, not just those in receipt of maternity services. The EQIA and updated Rural Needs Impact Assessment (following completion of the continuity plan) will assess the impact on all affected and consider mitigating actions for all groups, including engagement and consultation with those impacted.

5.1 Timeline for Consultation

Given the timelines to complete all phases of the change process, i.e. Equality Screening, EQIA and Rural Needs, pre-consultation engagement, options assessment, formal consultation, and evaluation of consultation feedback, the Trust determined that a retrospective consultation was 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. This also allows for a robust and thoughtful engagement, options assessment and consultation approach to be completed, which the Trust considers to be in the best interests of the service users and the public, rather than a rushed process in advance of the emergency temporary service change.

A summary of the key stages that the Trust is embarking on are shown below.

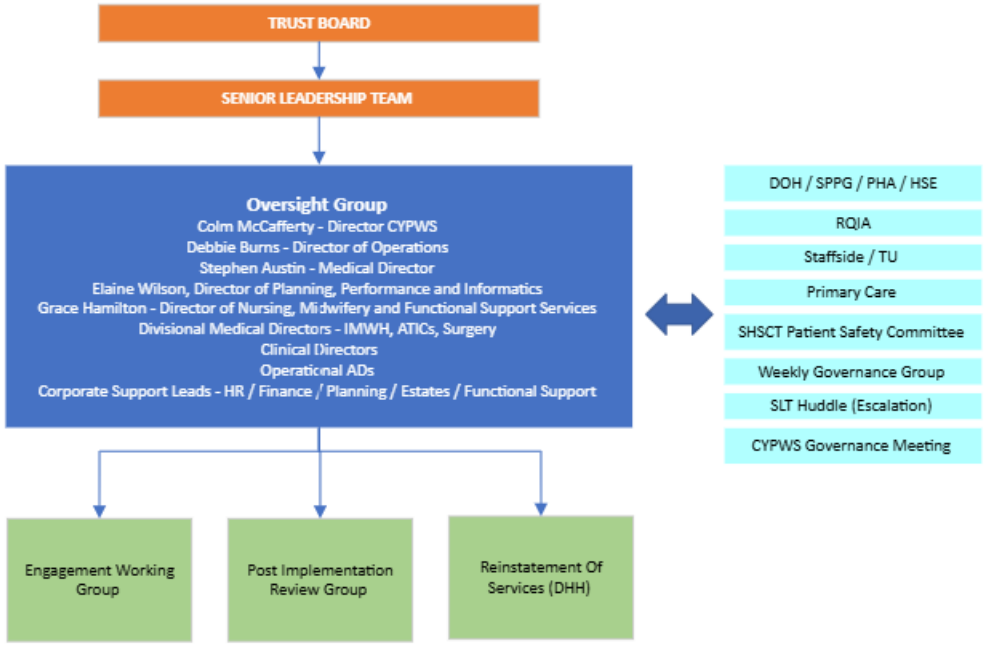
Figure 1: Change of Service Engagement/Consultation Process



5.2 Governance of the Engagement/ Consultation approach

The Trust established governance arrangements to oversee the development of the Continuity plan and associated implementation plan. Following the implementation of the plan the Trust will review the governance to ensure that adequate oversight is given to review of the impact of the changes, learning from the temporary change, feedback from service users and relevant stakeholders and processing through the consultation process. The structures that the Trust will move to implement are shown in Figure 2 below.

Figure 2: Change of Service Engagement/Consultation Process



6.0 Future Options and Potential Service Restoration

A clinically led reinstatement programme is proposed to establish how maternity, obstetrics and gynaecology services could return safely and sustainably to Daisy Hill Hospital (DHH). The programme will assess full, phased and revised cross-site models, define the conditions required for each, and identify the workforce, supporting services, infrastructure and investment (if any) needed. It will report through the Oversight Group to the Senior Leadership Team and Trust Board, drawing on operational evidence, pre-consultation engagement and the Equality Impact Assessment (EQIA) and Rural Needs Impact Assessment (RNIA). **Reinstatement will proceed only when the required conditions have been demonstrably met, independently assured and formally approved.**

Scope and evidence. The programme will define the services considered for return or expansion at DHH, including inpatient maternity, intrapartum and postnatal care and emergency gynaecology. Demand, activity, workforce, facilities, supporting services, access and the impact of temporary consolidation will inform the assessment.

Restoration options. Clinical teams, staff, service users and regional partners will assess full reinstatement, phased return and revised cross-site models. Temporary consolidation with enhanced local provision remains an interim comparator, not abandonment of reinstatement. Options will be assessed for safety, workforce sustainability, access, patient experience, deliverability, affordability, training, resilience and impact on CAH.

Board oversight and public accountability. Regular Board reports, aligned with the proposed three- and six-month reviews, will explain progress, barriers, actions and next review points. The March 2027 public paper will combine engagement findings, EQIA/RNIA progress, options, readiness and next-step recommendations, informing any formal consultation required. **These review points are not guaranteed reopening dates or predetermined decisions on permanent configuration.**

7.0 Decisions Requested of Trust Board

Trust Board is asked to:

1. **Approve** the post-consolidation programme of operational assurance, pre-consultation engagement, EQIA/ RNIA.

2. **Approve** a clinically led options/restoration workstream to define conditions for safe restoration of appropriate services to DHH.

3. **Agree** a public Board paper in **March 2027** covering engagement outcomes, EQIA/RNIA progress, emerging options and recommendations for subsequent formal consultation.