Belfast Health and Social Care Trust

Winter Service Delivery Plan
Belfast Health and Social Care Trust
October 2021- March 2022

14th October 2021

Working together Excellence Openness & Honesty Compassion

** This plan has been completed on a template provided by HSCB

Contents

1.0 EXECUTIVE SUMMARY

This Service Delivery Plan constitutes what Belfast Trust will need to do to respond to additional demand from the pressures of Winter 2021 and a potential further surge of COVID-19 from October 2021 until March 2022. Winter pressures have a major impact across the entire health and social care system. Another surge of COVID-19 will have a wide reaching impact on our ability to deliver many of our services. It is predicted a further wave will arrive and like last year, coincide with colder weather and winter pressures. A resurgence of COVID-19 is likely to coincide with outbreaks of other respiratory viruses such as Respiratory syncytial virus (RSV).

1.1 Impact of combined Winter and COVID-19 pressures

It is important to acknowledge the cumulative impact of Winter pressures and any further surges of COVID-19 will have on our ability to provide services across the Trust or to work to increase activity levels. As a provider of integrated health and social care and an employer of more than 20,000 staff, the Trust needs to remain agile, flexible and responsive to these pressures. Crucially we need comprehensive surge plans for critical care, hospital beds and support to care homes. The global pandemic continues to present the health and social care system with unprecedented challenges which impact on how services can be safely delivered. As has been the case throughout the pandemic, the Trust is committed to planning and working as a collective with the whole HSC system and in accordance with the COVID-19 Guidance-Framework.pdf (hscni.net).

1.2 Further COVID-19 Surge

COVID-19 has fundamentally affected the work we do for the past 18 months and will continue to do so for some time. Modelling is being updated and the HSC system is continuing to work on the basis that there will likely be a further surge during this winter period. Admission rates for COVID-19 are predicted to increase requiring further measures to help meet additional demand on our resources.

1.3 Challenges faced during Winter and any further COVID-19 surges

The key challenges for Belfast Trust in the context of this Winter Pressures and COVID-19 Surge Service Delivery Plan relate to workforce in respect of maintaining safe staffing levels across all areas, ensuring safe environments for patients and staff aligned to current COVID-19 guidance and policy, and funding to support the necessary actions required to address our challenges. Outbreaks of COVID-19 in hospitals and care homes with nosocomial spread are likely to continue.

1.4 Oversight and Learning from COVID-19

The Trust Executive Team continues to meet regularly to assess the comprehensive range of management information to enable oversight and real-time decision-making.

We have learnt much throughout the pandemic and we are committed to ensure that we will respond in a proportionate, informed and measured way to address the dual challenges posed by the Winter and COVID-19. We have seen that subsequent strains of the virus comprise different variables and so whilst we have benefitted much by the learning from experience, there remains a degree of unpredictability. We remain committed to providing safe, effective and compassionate care and will continue to operate on this premise with patient safety and safe levels of staffing and associated risk assessments as key determinants in how we do this.

1.5 Partnership working

This plan has been developed with staff focusing on the combined pressures of Winter and a further surge of COVID-19 that will challenge our services over the next 6 months.

We will continue to work in partnership with our stakeholders to support an agile and responsive change of services in accordance with our statutory equality and rural needs considerations. We will continue to work closely with our key partners including Primary Care, Voluntary and Community Sector, Independent Sector and Trade Unions to ensure our plans are representative, realistic and well-informed. The Trust and GP Partnership Group meets on a fortnightly basis and has consolidated closer partnership working and improved mutual communication and joint decision making. This group comprises Trust representatives and GPs and colleagues from the Health and Social Care Board and the Public Health Agency.

1.6 Tackling Health Inequalities

The 'Health Inequalities Annual Report 2020' (https://www.health-ni.gov.uk/publications/health-inequalities-annual-report-2020) clearly demonstrates that inequalities in health outcomes continue to be a key issue and challenge in Northern Ireland. Given the multi-faceted causes of inequalities in health, tackling this issue needs sustained focus within the health and social care system and increased collaboration across departments and agencies, local government, the community and voluntary sector, and with communities themselves to address the factors which impact on health and wellbeing locally and regionally.

Making Life Better (https://www.health-ni.gov.uk/articles/making-life-better-strategic-framework-public-health) is the overarching strategic framework for public health through which the Executive committed to creating the conditions for individuals, families and communities to take greater control over their lives, and be enabled and supported to lead healthy lives. It is vital that the Health and Social Care System continues to support the delivery of Making Life Better, particularly as COVID-19 is likely to have exacerbated the inequalities that already exist and this will require a continued focus and population health approach to address in the long term. Improving health and wellbeing, increasing health literacy and reducing

inequalities in health outcomes, will be a key part of ensuring we build greater health resilience in the population into the future and help to reduce the impact of potential future pandemics.

This plan incorporates short-term actions to begin tackling our health inequalities, although it is recognised that this is a long-term continuous process.

1.7 Equality screening and rural needs assessment

As with previous plans, the Trust will carry out an overarching Section 75 Equality screening and Rural Needs assessment in accordance with our statutory duties.

2.0 INTRODUCTION

Each year Belfast Trust prepares an annual Winter Plan to illustrate how we plan to address the expected increase in demand for unscheduled care services. The ongoing COVID-19 pandemic has had a detrimental impact on services across all areas of the Trust and the wider health and social care system. Our focus has been and will continue to be ensuring the safety of our patients, service users and staff at all times. In readiness for a potential further surge, which could coincide with colder weather and winter pressures, we will have comprehensive surge plans in place for critical care, hospital beds, community services and care homes. This Plan outlines the approach Belfast Trust will adopt in working to address the anticipated seasonal increase in demand and any further waves of COVID-19.

Belfast Trust is responsible for the provision of a range of regional specialist services and will maximise its capacity to continue to provide these on behalf of the region. Access to all our services continues to be impacted by the pandemic and addressing patient and staff safety through social distancing, infection prevention control and testing measures remains a priority for the Trust. It is therefore important to acknowledge that this impacts not only on people in Belfast but also across Northern Ireland. The Trust will endeavour to maintain as many services as possible during any further COVID-19 surges. Managing service demand arising from COVID-19 and winter pressures will have to take priority over planned or elective services.

The Trust has developed operational plans in relation to the need for additional beds in the community to support hospital step down care in terms of palliative care and/or rehabilitation towards getting COVID-19 patients home after their illness. This winter period will bring additional challenges to the delivery of health and social care alongside the normal demands from Respiratory syncytial virus etc. and further pressure on our workforce.

Depending on the scale of COVID-19 cases requiring hospital admission, there may be an additional impact on elective surgery capacity. We are continuing to work with the independent sector to secure additional capacity across both hospital and domiciliary care sectors to support Trust services. It is vital that patients who are fit for discharge are able to go home in a timely manner to ensure other patients can be admitted. The support of families and carers has been tremendous as we work together to return family members home and out of hospital services. We will continue to prioritise and focus on treating the most urgent cases first, and as a result, some patients may have to wait longer than we would like.

We will continue to focus on supporting the most vulnerable in our community including those residents we have placed in care homes. The Trust will operate in accordance with regional guidance on visiting which will likely need to introduce further restrictions when faced with a further surge.

The summer months saw Northern Ireland's infection rate (per 100,000 population) at more than three times that of Wales and Scotland and twice that of England. Approximately 70% of positive cases were in people aged under 40. The vaccination programme has been effective – by way of illustration in December 2020, for every 1000 cases of COVID-19 in NI, around 80 were admitted to hospital whereas recent data has shown that this has dramatically reduced to approximately 22 hospitalisations per 1000 cases.

We have already seen the impact of variants of COVID-19 over the last 18 months and much has been learned. However, it is important to acknowledge that given the many variables across different mutations that the impacts of further variants are unknown and exact modelling is therefore more difficult. Whilst the modelling is able to show the overall impact on demand under various scenarios there remain a great deal of unknowns that make this winter extremely unpredictable. These will include but not be limited to:

1. The impact of waning immunity post vaccination and its impact on service;

2. The plan and effectiveness of any booster jab programme;

3. Public behaviour;

4. The instigation of any regional mitigation such as circuit breakers; and

6. RSV prevalence and its resulting impact on secondary care.

This means that a wide range of scenarios are plausible. Covid modelling also needs to be considered alongside demand for other unscheduled activity particularly those under the medical specialties. Again, there remain significant unknowns and confounding factors that make any assumptions on likely future activity based on previous activity potentially unreliable.

Staffing levels continue to be directly impacted by the COVID-19 pandemic through either testing positive, or being a close work contact, or self-isolating because they are symptomatic or a member of their household has been in contact with a COVID-19 positive case in the community. There has been a significant impact on staffing as a result of local outbreaks. It is important to acknowledge upfront the significant and unprecedented pressures under which our staff have been working throughout this pandemic. There would appear to be not only little opportunity for respite but rather the challenges are going to increase. This is taking a significant toll on staff. Trusts, in partnership with Trade Unions, will continue to work together to support the workforce.

Hospital mitigation and control measures have been put in place and efforts continue to be focused in managing this difficult situation. During the last 18 months, this has resulted in staff numbers in excess of people isolating at any one time in our hospitals and the need for flexible approaches to redeploy staff and facilities to maintain safety.

It is in this context that this Winter/surge plan is set. The Trust has used the service delivery guidance as set out by the Health and Social Care Board and the only divergence from their prescribed template is whereby there were several questions in regard to staffing across different sections and to avoid duplication, these have been grouped together in a separate section. This paper outlines how we plan to address the anticipated seasonal increase in demand and any further waves of COVID-19.

The Trust will endeavour to maintain as many services as possible during any further waves, however managing service demand arising from COVID-19 and winter pressures will take priority over elective care services, this may result in the Trust having to further 'cap' elective activity and will impact our ability to deliver against our rebuilding effort. We will continue to prioritise and focus on treating the most urgent cases first, and as a result, some patients will have to wait longer than we would like.

This plan focuses on three areas describing how the Trust will deliver increased resilience through this challenging autumn and winter period:

1. **Winter Pressures for both adults and paediatrics** including our estimated bed projections, actions to secure the appropriate level of suitably trained staff and our response to the influenza virus and to Respiratory syncytial virus.

2. **COVID-19** – this sets out across key service areas the actions required to meet the demands of the pandemic whilst continuing to apply the key regional planning principles of equity of access for the treatment of patients, minimizing the transmission of COVID-19 and protecting the most urgent services.

3. **The delivery of key regional priorities** for unscheduled care, elective care, cancer services, adult social care, children's services, mental health and physical disability services**.**

3.0 PLANNING PRINCIPLES

The Trust has adopted the following DOH system principles in preparing this surge plan as outlined in the Regional COVID-19 Pandemic Surge Planning Strategic Framework (1 September 2020):

- **Patient safety** remains the overriding priority.
- **Safe staffing** remains a key priority and Trusts will engage with Trade Union side on safe staffing matters in relation to relevant surge plans.
- Trusts should adopt a flexible approach to ensure that **'business as usual' services can be maintained as far as possible,** in line with the Rebuilding HSC services Strategic Framework. This should allow Trusts to adapt swiftly to the prevailing COVID-19 context.
- It is recognised that there will be a fine balance between **maintaining elective care services and managing service demand** arising from COVID-19 and winter pressures. Addressing COVID-19 and winter pressures will take priority over elective care services, although the regional approaches announced such as day case elective care centres will support continuation of elective activity in the event of further COVID-19 surges.
- Community services are continuing to manage routine and urgent work – whilst also required to support hospital discharge and responding to urgent work
- The HSC system will consider **thresholds of hospital COVID-19 care,** which may require downturn of elective care services.
- Trust's Service Delivery Plans, whilst focusing on potential further COVID-19 surges, should take account of **likely Winter pressures.**
- Trusts should plan for further COVID-19 surges within the context of the **regional initiatives** outlined in Section 7 of this document.
- Trusts should as far as possible **manage COVID-19 pressures within their own capacity first.**
- The Department, HSCB, PHA and the Trusts will closely monitor COVID-19 infections, hospital admissions and ICU admissions to ensure **a planned regional response** to further COVID-19 surges. This will support continued service delivery.
- The Department will, if COVID-19 infection rates and other indicators give cause for action, **recommend further tightening of social distancing measures to the Executive.**

4.0 CHALLENGES

The COVID-19 global pandemic has presented the health and social care system with a number of unique challenges which have impacted on the way services were delivered by the Belfast Trust due to various reasons including clinical, patient and staff safety. In spite of the success of the vaccine programme, we continue to risk future COVID-19 pandemic waves. Vaccination may reduce the impact of subsequent waves of the pandemic on health care services. We have seen the impact of variants of COVID-19 over the summer months however, the impacts of further variants are unknown. A resurgence of COVID-19 is likely to coincide with outbreaks of other respiratory viruses such as Respiratory syncytial virus.

The Trust has carried out scenario planning to model bed requirements in the absence of regional modelling. This highlights shortfall in bed capacity across winter 2021/22 if realised.

The Trust is actively working to address the following challenges:

- Balancing safety and risk through regional agreements in respect of ensuring both effective ongoing response to COVID-19 locally and the need to rebuild elective surgical and diagnostic services for prioritised clinical groups on an equitable basis for the Northern Ireland population.
- Service delivery pressures from normal winter illness and respiratory viruses as well as any potential COVID-19 outbreak.
- Addressing the backlog of non-COVID-19 care remains a challenge.
- Maintaining effective COVID-19 zoning plans in all hospitals and community facilities in line with Infection Prevention and Control advice and guidance.
- Safely manage separate pathways for flow of staff and patients across all acute sites, optimise efficient utilisation of PPE and ensure safe and appropriate catering and rest facilities for our staff.
- Staff resilience and workforce capacity issues, including clinical vacancies and absences associated with COVID-19.
- Limitations posed by accommodation and transport.
- Establishing sustainable models of swabbing and testing.
- Securing a reliable supply of critical PPE, blood products and medicines.
- Providing necessary enhanced support and resources to the nursing/care home sector.
- Continued support to the GP led COVID-19 Assessment Centre and Vaccination centres.
- Our commitment to co-production and engagement.
- Provision of continuing support to those most in need in our community.
- Limited capacity within domiciliary care.
- The need to secure some capital or revenue funding to rebuild certain parts of our service.

The Trust has significant financial constraints, with limited recurrent growth funding and significant existing pressure. Surge plans are expected to create further financial pressures in an already constrained financial system, with financial resource requirements difficult to predict given known workforce supply constraints (both within the trust and in the community sector) and the interplay between COVID presentations, unscheduled care pressures and on-going risk-based decisions around elective services. Internally we will continue to identify any emerging financial pressures during this winter period and as a result of any further COVID-19 surges to assess additional resource requirements and use established channels and processes with HSCB and DOH to secure additional resources as required.

We also recognise that the need to maintain social distancing and to have separate COVID-19 and Non-COVID-19 pathways adds a further pressure to service delivery arrangements.

Workforce vacancies remain a challenge across the system and all Health and Social Care Trusts will work collaboratively along with the Department of Health to seek to address the need to support safe staffing levels in facilities.

5.0 COMMUNICATIONS PLANNING

Communications planning (internal and external) will be amended as necessary throughout the delivery period.

External Communications

- We will promote our key messages to help alleviate winter pressures throughout the Trust.
- We will continue to prioritise crucial information about the current COVID-19 surge, remaining open and transparent to ensure the media, the public and our stakeholders are fully informed about the Trust's strategy to deal with the ongoing pandemic.
- We will continue to promote the Trust's COVID-19 vaccination programme and devise imaginative concepts to encourage everyone, particularly the younger population to be vaccinated.
- Working closely with the Department of Health, the Public Health Agency and Health and Social Care Board, we will make every effort to promote the COVID-19 booster jab and the annual flu vaccination programme.
- As ED pressures increase we will, when required, communicate alternative locations where the public can access medical help and support.
- We will liaise with the media when necessary to highlight ongoing difficulties in the Trust in order to try an alleviate pressure in the system.

Internal Communications

- We will keep staff informed about the current COVID-19 pressures on a weekly basis and work with them to communicate challenges externally.
- We will engage with the Trade Unions and provide information as required.
- We will engage with our staff and continue to prioritise crucial information about the current COVID-19 surge, remaining open and transparent to ensure colleagues are fully informed about the Trust's strategy to deal with the ongoing pandemic.
- Working closely with the Department of Health, the Public Health Agency and Health and Social Care Board, we will make every effort to promote the annual flu vaccination programme.

6.0 WINTER PRESSURES (Adults and Paediatrics)

HSCB request	Trust response
6.1 Bed Occupancy Modelling is being updated, but Trusts should develop plans to meet peak occupancy up to double the usual winter peak.	Belfast Trust winter bed modelling has been developed and will be regularly reviewed. The Trust has developed alongside this template an operational Winter/Surge Bed Plan to outline the steps needed to achieve the optimum level of beds we can achieve within our existing bed and workforce capacity. It recognises the continuing competing demands that the Trust will need to manage over the Winter period, including the impact of meeting Covid-19 pressures on elective care and how best to profile both Covid-19 and non-Covid-19 unscheduled care beds across our hospital sites.
6.2 Flu Activity Details of flu action plan including details of specific actions taken to maximise the number of Trust staff receiving flu vaccinations.	The Trust is mindful that the DOH target for the flu vaccine for 2021-22 is 75% and all staff will be offered and actively encouraged to avail of the flu vaccine. On 14th September 2021 the Joint Committee on Vaccinations and Immunisations (JCVI) issued their advice in regard to COVID-19 boosters. They advise that those who received vaccination in Phase 1 of the Covid-19 vaccination programme, should be offered a third dose Covid-19 booster vaccine, including: • those living in residential care homes for older adults, • all adults who are 50 and over, • frontline HSC workers and all those aged 16-49 with underlying health conditions, that put them at risk of severe Covid-19, and, • adult household contacts (16+) of individuals who are immunosuppressed. They have advised that this should begin as soon as is operationally practicable. JCVI advice also recently confirmed that their preferred vaccine produce is Pfizer. In line with regional direction at the time of compiling this report, initially in terms of staff, vaccination, both Flu and Booster (Pfizer) will be provided to front line staff and the over 50s at the Trust's vaccination centre. This will coincide with the vaccination of care home residents and staff. Mobile vaccination teams will provide clinics for hard to reach staff upon review of initial booster and flu vaccine uptake.

HSCB request	Trust response
Details of plans for rapid flu testing in ED and assessment areas. The response should explain when rapid flu testing will commence and how this will impact on seasonally adjusted 4 hour performance and bed occupancy. The Trust should detail how bed capacity will be increased to manage a flu outbreak this winter, based on previous flu trends (last year excluded).	Diagnostic laboratory capability planning is based on the expectation of a reconstituted Winter virus season with substantial demand for Respiratory syncytial virus, Influenza and SARS CoV2. The demand for extended respiratory viral testing is likely to also increase. The current provision in Emergency Departments is as follows: MIH ED- have Point of care flu & SARS CoV2 PCR testing (and also for patient discharge). Paediatric ED: have Point of care flu/SARS CoV & Respiratory syncytial virus PCR testing. RVH ED and assessment areas: Have Lumira antigen based testing for SARS CoV2 ONLY to facilitate patient flow and management. (12 minute turnaround). Testing in MIH and Paediatrics for the Winter will be scaled up and this process has already started. For the RVH ED this will be more challenging given the numbers. The current plan is to install a PCR based flu & SARS CoV2 combined test but this will not be enough to meet the potential RVH ED demand for flu testing and testing will have to be restricted to small numbers as there are restricted kit allocations in place globally. The Lumira system currently in place is set to release a flu & SARS CoV2 combined antigen kit, but at the time of drafting this report this is yet to come on the market. The ability to rapid flu test in our EDs does have a small impact on our 4 hour performance and bed occupancy, however it will help prevent bed closures in relation to outbreaks etc.

HSCB request	Trust response
The plan should consider the impact of future COVID-19 surges alongside increased flu related admissions and also consider what hospital at home capacity is available and how it will be utilised as part of the response. The Trust should also consider if direct access beds will form part of the response to flu surge particularly for the frail elderly patients. In order to ensure patients admitted with flu are discharged when clinically fit	**Acute Care at Home** The Acute Care at Home Team (ACAH) provides a model of acute care to frail older people to support them to remain at home and avoid hospital admission, if appropriate. The multi-professional team is Consultant Geriatrician led and aims to provide the right care to the right patient, at the right time and in the right place. Over the past 18 months, the team has experienced an increase in referrals and redeployment of additional staff has enabled the team to respond to this demand. With regard to COVID-19-positive patients, the ACAH team will work in collaboration with community nursing to provide assessment, treatment and support to patients in the community setting. The Team will also work in collaboration with the Care Home Support Team, to provide a timely service to people in nursing home and residential units to assess, treat or provide onward assessment of residents where necessary. The aim is to minimise the need for residents to attend an acute care setting or Emergency Department, unless it is in the best interests of the patient. Where acute care is needed, clinical and diagnostic pathways have been developed to ensure the patients gets access to the right service promptly. This includes palliative and end of life care, for patients whose preferred place of care is at home. The team continue to support most vulnerable in their homes and prevent unnecessary attendances at Emergency Departments. The ACAH Team will also support the appropriate discharge of patients from hospital, whilst adhering to regional COVID-19 Testing Protocol. Over the last 18 months a total of 2505 patient referrals have been followed up and actioned by providing clinical advice and consultation to the GP or through patients being accepted onto the ACAH Service. The average length of stay in the service is 8 days. The majority of referrals are received from Primary Care. The service is currently working with an average daily caseload of 23 patients a day and has accepted 1428 patients with an additional 651 GP consultations. Through the continued use of our Community Nurse in-reach team and the implementation of our ANP model in ACAH, we anticipate achieving an increase in both ACAH caseload volume and inpatient discharge, including those patients who require intravenous antibiotic therapy for a clinical condition. Alongside the extension in our respiratory medical beds (+22) and the retention of CoE beds on both RVH and Mater sites, BHSCT will continue to amend local arrangements in light of the multiple daily patient flow reviews underway. Based on 20/21 figures it is anticipated that 390 to 500 patients will be seen in Residential Units, this allow for a 28% increase in 20/21 activity figures. This reflects the potential that a percentage of older

HSCB request	Trust response
	people in residential units will have decreased antibody reduction to the original Covid vaccination as well as a percentage who may not accept a Covid booster. It is planned to develop the ACAH Advanced Nurse Practitioner/ Nurse Practitioner Caseload. The ANP/NP will complete a holistic nursing assessment and physical examination; develop and implement a treatment plan of care including diagnostics. ACAH Consultant caseload - The Consultant Geriatrician will complete a Comprehensive Geriatric Assessment (CGA), develop and implement a treatment plan of care including diagnostic investigation to acutely unwell patients. **Hospital admission** – following CGA, where necessary and appropriate, acutely unwell patients will be admitted to hospital. The BHSCT plan is to strengthen and streamline the ACAH service by actively participating in a review of the Older Person Pathway; with a view to co-ordinating and co-designing both the acute and community care service. This will require a full MDT approach with the purpose to have the ability and capacity to escalate acutely unwell patients directly to an acute hospital bed, as opposed to attending ED. This will also involve de-escalating patient back to ACAH Team to continue the treatment interventions. **Community Nurse In-Reach** The CNIR team, based in hospital, provide the interface between community services, primary care and acute secondary care. Over the past 18 months, the team have received 1,361 referrals from a variety of acute wards and Emergency Department to assist with safe, effective, early patient discharge. The team have expert clinical knowledge, skill and experience in relation to patient antimicrobial management including PICC lines. The team communicate and share expertise, knowledge and training with both secondary care colleagues and community staff to facilitate safe, effective, seamless patient discharge of patients who continue to require intravenous antibiotic therapy for a clinical condition. Over the past 18 months, the team have successfully discharged 234 patients to receive intravenous antibiotics in the community setting to both District Nursing and ACAH Team. The CNIR team provide advice and support to patients in the BHSCT as well as other Trust in Northern Ireland. In preparation for winter plan the team plan to continue to discharge 230-250 patients from the acute hospital.

HSCB request	Trust response
	The Trust is maximising use of alternative pathways to avoid unnecessary Emergency Department attendances – particularly for frail older people. General Practitioner referrals into the Hospital at Home Service can facilitate direct access into hospital beds. For example, the Trust will step patients up into intermediate care beds if they cannot be managed at home and do not require hospital admission. The Trust has worked in partnership with Whiteabbey Nightingale and will make use of the fracture and rehabilitation pathways. The Trust intends to develop a direct access pathway for frail older people to ensure that wherever possible, they can bypass our Emergency Departments. Ward F in the Mater will support respiratory patients until Spring 2022. This is in direct response to the increased volume of extremely sick respiratory patients in our hospitals and the need for specialist respiratory nursing.

7.0 COVID-19 SURGE

HSCB Request	Trust response
7.1 Critical Care Trusts are asked to outline their plans, in agreement with the Critical Care Network (CCaNNI) ensuring that there is a co-ordinated approach across and between units and clinical teams to meet the demand.	The Trust will continue to deliver Critical Care on both the RVH and BCH sites. The Trust will continue to work with CCaNNI as plans for any increased surge levels are developed. 'Both sites will treat a combination of COVID-19 and Non-COVID-19 patients and the RVH ICU will remain the Regional ICU. Based on the maximum levels in the current CCaNNI surge plan the Trust will be asked to maintain a maximum of 50 level 3 critical care beds compared to a commissioned baseline of 34.5 level 3 beds. A Post Anaesthetic Care Unit (PACU) will be maintained on the BCH site to support patients following surgery to minimise the demand on ICU bed where possible. The CCaNNI critical care plan will be based on all Trusts increasing their critical care capacity to manage COVID-19 pressures. There is no plan or ministerial direction to stand up the Nightingale ICU. The Trust has ministerial direction, to maintain BCH site, as far as possible, to undertake regional complex cancer and urgent surgery. There are significant pressures at the moment on emergency and urgent surgery which is a competing priority for access to theatres and critical care. The Critical Care team continues to work very closely with respiratory and acute medicine teams to support patients at ward level for as long as possible, to avoid an ICU admission. The Trust will participate in the regional Critical Care / Respiratory Hub process to maximise access to Critical Care. Any surge in Critical care will have an immediate impact on elective activity **Theatres** The Trust will continue to deliver emergency surgery and fracture surgery. Surgery for planned patients will be delivered but the number of available lists is dependent on the number of theatre staff needing to be redeployed to assist in Critical Care to facilitate further COVID-19 surges. For each additional bed required to open a further 4 staff are needed to be redeployed. For every bed opened and staffed by theatre staff there would be a reduction of 7 theatre lists per week. AHP staffing will where possible profile to the regional sequencing of patients.

HSCB Request	Trust response
7.2 Respiratory Trusts are asked to outline their plans to ensure that there is management and coordination between estates and clinical teams to monitor the usage of oxygen	Estates continue to monitor oxygen usage and stock levels and ward staff are now acutely aware of the various system constraints and know when to contact us. The installation of oxygen flow meters, is assisting this management and will progress over the next number of months. In relation to the management of staff and provision of adequate cover on our sites, this forms part of weekly discussions at the Estates operations managers meeting and is under constant review. Estates remain committed to supporting the delivery of clinical services.
7.3 Social Care Trusts should review their Business Continuity Plans to ensure that where they relate to domiciliary care, care homes, hospital and day care services they are robust and up to date. Trusts should update contingency plans to address staff absences in both the statutory and independency sector. This will require planning for mutual aid and staff re-deployment as required. Trusts should use Regional COVID-19 Action Plans for Care Homes and Domiciliary Care as the basis for determining priority actions in these sectors. Trusts should have plans in place for the prioritisation of resources and delivery of services to clients with the most critical level needs. Some areas of service may have to be suspended / stepped-down. Client lists should be reviewed in respect of this and carer contact details updated as required. Hospital pressures are likely to remain a key feature during a further surge. Access to in-patient beds can be impacted upon by	The Trust has reviewed its Business Continuity Plans to ensure that they are robust and up to date in relation to domiciliary care, care homes, hospital and day care services. Adult Community and Older People Services have responsibility for the delivery of a wide variety of services for older people and those with sensory and physical disability. Faced with Winter pressures and an anticipated further surge in the Autumn and the resultant impact on service delivery, it is likely that ACOPS will be required to urgently step down and redeploy staffing resource to critical areas: The Trust has reviewed its contingency plans to reflect the increased requirement for mutual aid from the care home and domiciliary care sectors. Service delivery has been reviewed and the decision has been taken to maintain essential services resulting in non-essential services, where safe to do so, will be able to be stood down. The rationale for this is to ensure that resources, are available to be redeployed to those services who require them most, which will be centred around: • Life preserving care • Essential personal care delivered by the Statutory and Independent domiciliary care • Maintaining People living in 24 hour care facilities – residential care/ care homes and supported living • Patients receiving inpatient care • Maintaining flow out of hospital • Safeguarding • Statutory requirements. The focus will be on maintaining essential service delivery, which will be prioritised as maintaining hospital flow, avoidable admission preventing and sustaining essential services to frail older people living in care homes and the community and maintaining end of life care. The Trust is using an additional 20 beds in Musgrave Park Hospital for medically fit delayed discharge patients.

HSCB Request	Trust response
patients medically fit for discharge and awaiting social care services. Trusts should work with Care Home providers to ensure current capacity in the care home sector is fully utilised. Trusts should work in accordance with the regional care home guidance, namely that patients should accept the first available care home bed that meets their needs, with the option of transferring to another home of their choice later	The Trust works with Care Home Providers to ensure current capacity in the sector is fully utilised. The Trust is closely monitoring and maximising domiciliary care capacity. **Independent Sector Care Homes** The Trust works in accordance with the regional guidance and at point of admission where the person is being discharge from hospital or an emergency admission from the community, patients should accept the first available care home bed that is suitable for their needs and given the option to transfer to their home of choice when there is availability. The Trust has a statutory responsibility to ensure residents in these homes are safe and their needs are being met, to avoid unnecessary hospital admissions and be able to respond promptly to outbreak situations where Homes, after exhausting their own Business Continuity Plans require additional nursing and care assistant staffing (mutual aid) to maintain safe staffing levels. It is essential to ensure that all required enhanced COVID-19 supports and outbreak management to Independent Sector Care Homes can continue. 6 key requirements as aligned with the HSCB Regional Care Home Surge Plan: 1. Trust IPC on site visits to Care Homes in the event of an outbreak are being delivered as per CMO letter dated 15th May 2020. 2. Trusts to provide an over-arching clinical pathway in place for both residential and nursing homes, to support early identification and optimal management of residents with COVID-19 as per CMO letter dated 15th May 2020. 3. Trusts to review their COVID-19 workforce contingency and mutual aid plans to ensure that they are up to date and the Trust can respond quickly to any new COVID-19 workforce pressures in the care home sector. As part of this work, Trusts must review the components of their current services that can be changed, re-purposed or stepped down in the event of escalating COVID-19 pressures.

HSCB Request	Trust response
	4. Trusts to engage with care homes to ensure the Business Continuity Plans noted above are in place, robust and fit for purpose in terms of responding to COVID-19 pressures. 5. Trusts to interrogate existing RQIA dataset regarding care home staff and resident vaccination uptake rates and proactively contact those care homes whose uptake rates are low with a view to increasing these. 6. Trusts to ensure Outbreak testing is carried out in line with Regional Testing Policy. The Trust will continue to work in partnership with Care Homes to ensure safe, person-centred care continues to be delivered to all residents irrespective of COVID-19 status, supporting care home staff and resident recovery from an outbreak.
	Mutual Aid support has been introduced recognising that the Care Home sector will continue to be dependent on a large and mobile workforce with the potential for some working in more than one setting and frequent bank and agency staff use; this will increase risk of cross infection. In addition, the Trust continues to have a legal and statutory requirement to ensure all required Mental Capacity and Care Review activity continue however, completion of this work may be impacted by the need for the Trust to prioritise resource and to respond to urgent and emergency referrals. Support to nursing and residential homes remains a key part of our plan. There are 89 care homes in the Belfast Trust area, caring for over 2,200 residents.
Three regionally agreed actions to improve and support discharge planning should be progressed: • Nurse facilitated discharge • Home before Lunch	**Discharge to Care Homes** On 23 December 2020, the Department of Health wrote to all independent care home providers to advise that in the event of an unreasonable refusal by a Care Home to accept an admission from hospital, income guarantee will cease. As a result, the Trust has devised an escalation protocol for unnecessary delay – for example, when a Care Home refuses an admission until a COVID-19 swab result is available or until a patient is vaccinated. **Reluctant Discharge** The Trust has reminded all service areas of the need to implement the reluctant discharge policy, (Discharge and Transfer of Care Policy for General Acute Hospital Sites and Intermediate Care Settings - incorporates Adults Discharge Escalation Guidance Oct 2020), which outlines the roles and responsibilities of all staff in the management of discharge pathways. From the point of admission, early and consistent communication with patients and their families/carers regarding discharge planning should be promoted with all patients and families.

HSCB Request	Trust response
• Discharge/ Home to Assess	**Additional Discharge Pathways** In preparation for previous surges, additional discharge pathways were established for post-COVID-19 and non COVID-19 patients to be discharged from hospital. The Trust will maintain sufficient capacity in its stepdown facilities allowing for both COVID-19 and non COVID-19 pathways and will keep the step down and intern beds under review. The Trust recognises the need for discharge pathways for patients with delirium requiring both COVID-19 recovery and non-COVID-19 support, and has a temporary community Delirium Recovery Unit in place for non COVID-19 patients. The Trust will explore the potential use of Statutory Supported Living capacity to be utilised as an interim community placement /discharge to recovery pathway to provide a further pathway for flow out of hospital for those who are medically fit for discharge but awaiting a package of care or requiring rehabilitation/recovery support. **Discharge to Assess** An 'assess on discharge' model has been operating in the RVH within acute medical and respiratory wards only with a focus on facilitating AHP led discharges home. Referrals are also accepted from the Emergency Departments in both RVH and Ulster Hospitals preventing admission to hospital. Ongoing lack of domiciliary care capacity is continuing to impact on the service being able to accept new referrals as they are currently holding patients who have been assessed and are unable to be discharged to domiciliary care – 35% of service users are awaiting discharge. In addition, the service is currently not able to meet the target of assessment within 48 hours of discharge home (waiting times can be up to 10 days). The Trust has issued a workforce appeal to attract additional Occupational Therapists and Physiotherapists to join the Community Discharge / Intermediate Care services and other recruitment into is progressing, however the Trust will continue to lobby for additional investment for further expansion of this service as it is currently only operating for one hospital site (RVH). **Additional Multi-Disciplinary Input to Facilitate Discharge Processes** Through the July 2021 surge in hospital admissions and delayed discharges resulting in regional pressures across Emergency Departments, senior practitioners were deployed to support discharge processes across hospital sites. This identified the positive impact that expanding and consolidation Discharge Hubs, increasing Discharge Coordinators and expanding SW and AHP teams across 7 days could bring – the Trust will continue to lobby for additional investment to support expansion of these roles and teams.

HSCB Request	Trust response
	Nurse Facilitated Discharge The regional dashboard data demonstrates 7% NFD activity across the acute sites in BHSCT. The Trust Discharge Steering Group has been re-convened to develop the Trust's Implementation plan and allocate timeframes for improvements required. An audit of all inpatient wards –'Red Green Audit' focused on discharge pathways, this offered the assurance that nursing coordinate all patient discharges. A process mapping exercise is underway to determine how and where this activity is or should be captured. The range across Trust wards of Nurse Facilitated Discharge activity does vary – with particular variation across elective and unscheduled wards. Further work is required to understand the current position, learn from existing good practice and plan to scale up and spread across other relevant clinical specialties and areas. A Red Green audit was completed in June 2021 with a baseline data analysis completed in August 2021. The Process mapping will be completed by end of September 2021 **Home for Lunch** The Trust implemented a Home For Lunch initiative across all sites in 2016. This captured activity on discharge up until 2pm. In line with the requirement outlined by the Regional Discharge Group the Trust will now be targeting this to mean 12pm. As of June 2021, the regional dashboard data demonstrated 9% compliance with 12pm discharge. There are a number of pieces of work underway to inform improvement initiatives: 1. Pharmacy provisions 2. Transport arrangements On all sites there is a daily oversight group meeting which focuses on all complex delays and a daily report is sent through to all Trusts required to facilitate out of Belfast Trust complex discharges. There are community escalation meetings twice daily.

HSCB Request	Trust response
	The Trust set up a contract with the British Red Cross in 2019 to provide transport home and short term support for vulnerable patients for up to 6 weeks eg shopping, prescription collection and follow up calls to help with patients who are isolated. We have implemented the SAFER bundle. Maximising use of the discharge lounge continues to improve and facilitate patient flow. **Home first/Discharge to assess** A significant amount of work has been completed to date on this element both in Trust and as part of the regional task and finish subgroup of the regional discharge group. Information on Discharge to assess and criteria has been shared with wards across unscheduled care. • 1 page information Flow chart regarding suitability of patients is on display on unscheduled wards. • Workshops completed with relevant professional groups regarding the discharge to assess function –AHPS/Nursing/Medical/Social Work • SQB project included BHSCT staff from acute unscheduled ward and intermediate care • One point of referral agreed for discharge to assess via Community Discharge Hub • Discharge information/assessment forms provided with relevance to complexity of discharge • Regional referral template used which is completed by an AHP for minimal-moderate complexity • Regional transitional forms used for bed-based setting in keeping with RQIA requirements • BHSCT main aim to ensure care is provided right place, right person, right time • BHSCT inclusion criteria for discharge to assess includes patients with complex needs and requiring assistance x 2 staff as long as able to safely discharge home. • Due to increased demand in referrals BHSCT are unable to meet the demand and as a result the response time is not meeting the KPI of <48hrs response time. • There is a risk mitigation/management prioritisation criteria currently in place • Since April 2020 there has been a significant increase in demand. • Other variables affect performance –ongoing domiciliary care crisis impacts on the service being able to accept new referrals as they are currently holding patients who have been assessed and need to move on –recent average is 35% of service is blocked. • The Trust has issued a workforce appeal to attract additional Occupational Therapists and Physiotherapists to join the Community Discharge / Intermediate Care services

HSCB Request	Trust response
	Learning Disability With regard to Trust Inpatient Services for adults with a learning disability, Muckamore Abbey Hospital will continue to provide care for its existing patients. Dependant on the severity of the winter pressures and the resurgence of COVID-19, resettlement of patients from MAH may have to be deferred. In terms of our Day Centres and Day Opportunities for people with a learning disability, if required Day Centres may have to temporarily close however, outreach into people's homes will continue to support service users and carers and families. Our Learning Disability Residential and Supported Housing will continue as normal although restrictions with visiting will be in line with Regional Care Home Guidance. If required Short Breaks will cease and limited surge beds used for emergencies Community Outpatient clinics will be facilitated by virtual and/or telephone appointments and face-to-face appointments if required (i.e. no anticipated change).
7.4 Long COVID-19 It is expected that all Trusts will have identified as senior decision maker to: support the timely recruitment of staff and implementation services by 31 October 2021 and work with HSCB and PHA to ensure that is robust information that is standardised regionally with agreed data definitions and currencies to support data collection and monitoring of key outcomes.	The Trust has developed proposals in tandem with HSCB/DoH & Primary Care and regional Trusts to support people who continue to experience longer-term physical, mental health and cognitive effects following coronavirus infection. The Assessment clinic is planned for October 21 to see GP referred patients for assessment and follow up support. Five services are planned for Autumn 2021*. 1. Post COVID-19-19 Syndrome patients referred by primary or secondary care to a one-stop-shop MDT assessment service; 2. Bespoke pulmonary rehabilitation / dysfunctional breathing service for patients with significant respiratory symptoms post COVID-19-19; 3. Patients discharged from critical care (both COVID-19-19 and non-COVID-19-19); 4. Strengthening psychology support to all Trusts; and, 5. Signposting and access to self-management resources. *(based on current staffing availability) BHSCT has set up an implementation team with leads assigned to the relevant strands. Where required, recruitment processes have commenced and the leads continue to engage with the HSCB / PHA in the development of referral mechanisms and recording requirements. Further discussions will be needed with Primary Care to finalise referral criteria and post clinic attendance information transfer. The Trust is aiming to commence strand 1 MDT assessment clinics by the end of October 2021

HSCB Request	Trust response
7.5 COVID-19 Vaccine Programme Advise how your Trust targeted, or plans to target, the hard to reach/low uptake areas within the Trust area;	Belfast Trust in line with the Regional Vaccination Programme continues to work with PHA, Belfast City Council, Primary Care Services, Community Services and Groups, including Voluntary Organisations, Teaching facilities and Universities, plus many others, to identify those areas who demonstrate low uptake of vaccination or indeed high cluster of COVID-19 infection rates. Using the DOH data and supporting evidence the BHSCT specifically plans to coordinate Mobile 'Pop-Up' Clinics, targeting these population groups, who may for various reasons, may not have previously accessed the Vaccination Centres. Long term inpatients will also be offered the vaccine. Engaging with their local Community Leads, BHSCT takes their expert advice on how best to facilitate accessible mobile clinics and provides education, support and help for those who may have anxiety or fear around receiving the vaccine. The Trust have been working, and continue to work, with PHA and colleagues in other Trust to ensure the availability of translated educational material on COVID-19 and on the vaccination. This has included information on "myth busting". There has been targeted work with both the Romanian and Bulgarian Roma communities, with information made accessible via short videos and audio clips due to the low literacy levels within this community. These were circulated via relevant Facebook and WhatsApp groups. The Trust continues to participate at the BME COVID-19 response group chaired by PHA to ensure a regionally consistent approach and sharing of best practice.

HSCB Request	Trust response
	NINES is a holistic nurse-led service that provides initial access to health care to individuals recently arrived to Northern Ireland from outside the United Kingdom and Republic of Ireland and not yet registered with primary care, termed new entrants. (NINES) worked in partnership with PHA, RVH vaccination Centre and MEARS Housing Association to facilitate COVID-19 vaccinations for new entrants with first vaccinations in May with second vaccines in September. Pfizer and Astra-Zeneca vaccines were offered depending on the age of the service user. Countries of origin include: Sudan, Nigeria, Somalia, China, Iran, Iraq, India, Nepal, Russia, Ghana, Congo, East Timor, Algeria, Albania, Eritrea, Bengal and Uganda. The MEARS have hosted a number of walk in days were this population group have been able to attend. Belfast Trust convened a similar event in Mid-September to help increase the vaccination update for the Roma Community. The Belfast Inclusion Health Service BHSCT is a dedicated Nurse-led multidisciplinary service for those experiencing homeless with the Belfast Trust area. The service operates a doorstep delivery model of service delivery reaching 23 hostel facilities including day and night shelters, crash facilities, non-standard B&B accommodation and to those who sleep rough. Throughout the COVID-19 pandemic the service has been frontline in:- • Coordinating education/information pre and throughout the pandemic updating guidance advice as necessary to all facilities and assisting regional areas with information and training. • Setting up a daily triage system to all facilities throughout the COVID-19 surges • Screening testing and vaccinating this population • The service has also been the lead with PHA in a pilot that looked at the prevalence of COVID-19 among this population. Three facilities took part with service users and staff involved in blood sampling for COVID-19 antibodies and swabbing for COVID-19. • The service also assessed those over 50 within the population for underlying health conditions and who should have received a screening letter. • Active participation on Multiagency Weekly COVID-19 Steering group with DOH, DFC.PHA, NIHE, CVS agencies and Regional Trust areas.

HSCB Request	Trust response
Advise how your Trust enabled, or plans to enable, easier access to vaccination at the Trust vaccination centres; Advise how your Trust identified, or plans to identify, suitable areas/locations to place mobile vaccination clinics; and	Since the commencement of the Vaccination Programme, the Vaccination Centre has enhanced the service greatly, to ensure every effort is made to ensure accessibility for staff, including mobile clinics attending Care Homes, Community Day Centres, Learning Disability & Supported Living Units, etc. These mobile clinics supported the Vaccination programme delivery not just to patients/service users/public but enabled staff to avail of the COVID-19 Vaccine too. The vaccination centre at the RVH operates Monday – Sunday from 8.30am – 7pm daily. It is accessible from the M1 Motorway and is well signposted on the RVH site. Car parking for disabled badge users is available at the centre with the visitors' car parking being a short 5 minute walk to the vaccination centre. In line with regional guidance, the RVH Vaccination centre is now offering a walk in service for 16 and 17 year olds as well as those CEV Children aged 12-15 years where no prior appointment is required.
Advise how your Trust ensured, or plans to ensure, maximum uptake of the COVID-19 vaccine amongst your workforce and the actions that were taken, or are planned, to target any staff disciplines identified as having a low uptake.	Our mobile vaccination team has been to a number of venues across the city covering all geographical areas. Based on the DOH data published regarding the lower uptake areas we have had a specific focus to support with increasing the vaccine uptake in those areas identified. We have worked with a number of stakeholders including the PHA, Queens University, Belfast City Council and local community groups to secure local and accessible venues for all the population. Considerations such as access to building and car parking has also been undertaken in the planning of mobile vaccination clinics. **Vaccines for staff** Whilst it is not a mandatory requirement for staff to avail of the COVID-19 Vaccination within the NHS and Health and Social Care settings, BHSCT strongly encourages all staff to take up the offer of the COVID-19 vaccine. On the 30 November 2020, BHSCT undertook a COVID-19 Vaccine Confidential BHSCT Staff Survey. The purpose was to identify potential staff uptake and reasons why staff may not uptake the vaccination. The information was used to inform a comprehensive communication plan and programme with staff, to encourage vaccine uptake, including the benefits in protecting themselves, their families, patients and clients and it informed frequently asked questions for staff. Through the Vaccination Steering Group we continue to work with HR, OH, Trade Union Colleagues, Corporate Communications, Pharmacy and the in-service team to review, plan and drive the Vaccination programme, to ensure our workforce remain a key target, focusing on our staff accessibility to avail of the COVID-19 Vaccine.

HSCB Request	Trust response
	As aforementioned, the JCVI advice was issued in relation to the Covid-19 booster on 14th September. In line with regional direction at the time of compiling this report, initially in terms of staff vaccination, both Flu and Booster (Pfizer) will be provided to front line staff and the over 50s at the Trusts vaccination centre. This will coincide with the vaccination of care home residents and staff. Mobile vaccination teams will provide clinics for hard to reach staff upon review of initial booster and flu vaccine uptake. The Trust is mindful that the DOH target for the flu vaccine for 2021-22 is 75% and all staff will be offered and actively encouraged to avail of the flu vaccine.
Advise how your Trust targeted, or plans to target, the hard to reach/low uptake areas within the Trust area;	Robust planning will now be possible having received the JCVI advice in regard to the boosters. Staff continue to being encouraged to receive their COVID-19 vaccination through regular corporate communication notices. Colleagues from occupational health support with vaccination planning within the Trust.
7.6 Staffing The Trust should ensure that integrated multi-disciplinary team discharge planning is in place across acute and community settings, particularly over weekends and holiday periods. Consideration should also be given to the impact of associated seasonal staff sickness absence.	The Trust is committed to providing safe and effective care for patients during the future surges of this pandemic and it is also important that the Trust reflects, reviews and engages on how best services may be delivered over the Winter months and during future surges. In reviewing options to support clinical/critical services during current and any future surges of Covid-19 pandemic and over the winter period, the Trust is exploring the potential for: • The redeployment of specialist nurses and nurses from Outpatients and will adopt a dynamic and commensurate risk assessed approach when considering redeployment to create additional capacity and based on unscheduled and future surge demand. • The deployment of CMTs into ICU/Surgical wards and possibly operating theatre for a fixed period of time. It should be noted that the demands on our nursing workforce are increasing as we endeavour to maintain emergency and critical services; support to Nursing Homes; and increased ICU capacity associated with COVID surge. The Trust has compiled a Winter Staffing plan to try to address these challenges. The key challenges for Belfast Trust in the context of this Winter Pressures and COVID-19 Surge Service Delivery Plan relate to workforce in respect of maintaining safe staffing levels across all areas, ensuring a safe

HSCB Request	Trust response

	environment is provided for patients and staff aligned to current COVID-19 guidance and policy, and funding to support the necessary actions required to address our challenges. The Trust Community Discharge Hub and Hospital Social Work provide a seven-day service. For all areas, leave will be reviewed and planned to ensure appropriate cover especially during peak holiday periods
The availability of staff will continue to be a key challenge in the coming months and Trusts are asked to outline what actions are being taken to secure sufficient and appropriately trained staff to support any surge in demand. This will include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period. The availability of staff will continue to be a key challenge in the coming months and Trusts are asked to outline what actions are being taken to secure sufficient and appropriately trained staff to support enhanced respiratory services to support any surge in demand. This will include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period.	The availability of staff will continue to be a key challenge in the coming months. Workforce vacancies remain a significant challenge across the HSC systems. We remain committed to providing safe, effective and compassionate care and will continue to operate on this premise with patient safety, and safe levels of staffing and associated risk assessments as key determinants in how we do this. The Trust will undertake the following actions: • Work collaboratively with the Department of Health and other Trusts to try to address the need for support safe staffing levels. • Rollout of Lateral flow and LAMP testing. This will include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period. As with every Christmas and New Year period, there's a natural downturn in activity during the festive period. The Trust will ensure the careful management of rotas and requests for annual leave to maintain appropriate staffing levels and the safe delivery of services. This year, however, it is important to acknowledge that this is likely to be even more challenging to plan with the ongoing pandemic and the impact of staff absences. Consultant and junior medical staff have received training on bronchiolitis management. Nursing staff have received training on a range of specialisms Training and support is being provided for PICU staff**.** **Options to address nursing gap** • Ongoing backfill. • HSC Workforce appeal. • Newly qualified nurses awaiting registration- Band 3 posts. • Downturn of Services. • Redeployment of staff • Ongoing monthly rolling recruitment campaign for registered nurses
HSCB Request	**Trust response**
	• Focus on international nurse recruitment.

	AHP's will continue to be flexible to meet the needs of the Trust. Workforce may be reliant on downturn of other activity and /or prioritisation to meet the needs of surge planning. Additional resources may be required. Options include additional hours, bank staff, peripatetic staff, workforce appeal & agency.

8.0 DELIVERY OF KEY REGIONAL PRIORITIES

HSCB request	Trust response
8.1 Unscheduled Care It is likely that we will see increased unscheduled pressures from the backlog in elective activity and a further modelling by specialty will be provided by the beginning of September. In the interim Trusts should plan for 5%, 10%, 15% and 20% rise in activity for Adult ED Attendances and admissions (COVID-19 and non-COVID-19). In order to help deal with an expected rise in demand the Trust should provide detail on plans to provide alternatives to ED including increasing ambulatory and surgical assessment to include: • Speciality areas (including surgical assessment) • Hours/days of operation (including plans to increase) • Capacity daily/weekly Including plans to increase) • Entry route – direct access GP, Direct Access NIAS, via Urgent Care Centre or ED (if so is this direct from triage) including plans to open up access if not in place for the above.	In previous years, figures showed that the increased number of people attending Emergency Departments led to an increased number of admissions with approximately 19% of patients requiring admission to an inpatient bed. This then reduces the capacity in the Winter to deliver planned elective care. It is anticipated that any further waves of COVID-19 will result in additional hospital attendances and admissions and will further limit the capacity for elective care. This includes access to diagnostics such as imaging, laboratory testing, critical care capacity etc. This will impact on the Trust's ability to rebuild our service capacity on an incremental basis. Statistics showed the continuing toll that COVID-19 is having on waiting times with the number waiting over 12 hours in ED for treatment increasing from 1840 to 5492 between June 2020 and this year. DOH figures revealed that there was a 24.6% increase in those attending ED in June 2021 in comparison to the same month the previous year. The Trust will participate in the Royal College of Emergency Medicine (RCEM) led 'Winter Flow Project which commences in October 202. The following data points will be collected as part of this: a) The number of acute beds in service b) The number of patients spending more than 12 hours in an Emergency Department from arrival to departure c) The number of unplanned attendances at your Emergency Department(s) each week d) The number of cancelled elective procedures each week e) Four-hour performance f) The number of patients in hospital for seven or more days following admission. The project will run from the beginning of October 2021 until the end of March 2022

HSCB request	Trust response
	Demand Modelling Summary For this Winter we are planning: A proposal to establish as part of streamlining the GPOOH service, through the integrated urgent care model, by providing a centralised nurse triage service 7 days per week. This would be managed by a senior nurse, where the Band 7/6 nurses would be responsible for triaging and deciding on what actions that need to be taken using the Odyssey triage system during the OOH period. The nurses will also be able to complete non-medical prescribing and use this as part of the assessment and treatment of the service user on triage. This will include the GPOOH being available to handle the urgent calls which require a GP input and review service users at the bases with paramedic support for home visits as well. The introduction of a pharmacist to assist the GPOOH service will commence in the new year.

HSCB request	Trust response
	The plan would be to commence a pilot at the weekends using Band 7 (can prescribe) /6 nurses– Timescale to commence in December 2021 to allow for the following to take place: - Implementation of IT support (Odyssey) - Set up of Nursing bank to support - Training/ competency framework for nursing staff - Implementation of governance structure - Development of a nursing development framework for GPOOH looking to the future **Urgent Assessment, Advice and Treatment Service (UAAT).** Hours of operation of central triage pilot Commencing with: Friday evening – 6pm to 12 pm Saturday – 8am to 12pm Sunday – 8am to 12pm Bank holidays – 8am to 12mn Following the pilot this would then be expanded to the weekdays and include Monday to Friday – 6pm to 12pm Saturday – 8am to 12pm Sunday – 8am to 12pm. There may be an opportunity to trial using Dalriada Urgent Care nurse triage (but there would be cost implications). The contingency option, if insufficient workforce available, is to amalgamate both bases onto one site at those times when GP cover limited i.e. weekend afternoons/early evenings, bank holiday afternoons/early evenings and the Redeye period, similar to the summer months contingency. The DOH are also considering a Regional GPOOH rota for the redeye period, which BHSCT are in full support.

HSCB request	Trust response
	Longer term, Urgent Care Centres, GPOOHs & COVID-19 Centres should be merged together and a separate paper has already been submitted. The Minister for Health has confirmed that no services are to be stood down in 21/22 and all areas should proceed with implementation of the 10 Key Actions. Phone first is also to be progressed, including a single number for Northern Ireland in line with the move towards the regional integrated urgent care model. All plans need to include, as a minimum, Urgent Care Centres, Phone First and scheduling of urgent care services post clinical triage at Phone First to enable EDs to be kept for emergencies. **Urgent Care Centre / Expanding GP Direct Access Services & Ambulatory Care Pathways (NMS investment)** The Trust was informed that we would be allocated for 2021/22 £2.7m for NMS, £1m of which would be recurrent and the other £1.7m non-recurrent. This funding will ensure the RVH Urgent Care Centre will be operational from 8am to 12pm seven days a week. It will also fund the Hospital at Home service to be provided over seven days between 8am and 9pm. The weekend service will focus on the implementation of treatment plans and undertaking case finding in ED. Supplemented by the £52k winter pressures allocation, this will provide a 3 month service commencing September to November 2021. This will deliver a partial workforce team for community discharge and social work hub across 7 days providing essential discharge co-ordination and assist with in reach support to Ulster discharge planning and contribute to the reduction in 4 and 12 hour waits. Whilst it will assist in implementing the discharge to assess model alongside MDT intermediate team it will not enable full implementation of the discharge to assess pathways across all hospital sites.

HSCB request	Trust response
In order to help improve hospital flows and deal with the expected increase in admissions (COVID-19 and non COVID-19), the Trust should provide detail of Discharge Planning in place and plans to improve/increase this. This should include: • Are patients given an estimated discharge date on admission (EDD) (What is the current % of EDD's which are met to date and plans for increase). • How is this communicated to the ward teams to facilitate early discharge planning • Is Senior Review carried out before mid-day by senior clinicians (specify wards) including weekends? If not in place what are plans to do so • Is twice daily decision making in place on all wards (specify wards) • What is the % of all discharges at weekends and plans to improve. • % patients currently Home before lunch and plans to increase • % patients Discharged to Assess and plans to improve • % of Nurse led discharge in place and plans to improve	**Additional Hospital Beds to meet anticipated surge in both COVID-19, winter flu etc** **Mater** In the Mater Ward F, 21 beds will remain open for Respiratory inpatients. We will also plan to open an additional 7 beds in Ward D and a further 6 beds in Ward E. **Royal and BCH** The Trust will also provide an additional Winter Swing Ward in the RVH for acute medical beds. (Probably Ward 5A, at least 20 beds), and to achieve this we are conducting a feasible study to consider transferring Neurology and or Thoracic Surgery to the BCH to free up the necessary beds. The Trust is also planning to move some cardiology cath lab whiteboard work to BCH and this will free up another 6 beds. **Musgrave Park Hospital** We are already using an additional 20 beds in Meadowlands at Musgrave Park Hospital for cohorting medically fit delayed discharge patients. **Downturn of Electives** As the modelling is made available, the Trust will continue to review on a daily basis to assess its capacity using the elective prioritisation system to maintain time critical and elective surgery alongside the delivery of unscheduled care and COVID-19 services. **Escalation Measures** Director Led Safety Huddle each morning at 8am, followed by two hourly Site Coordinator led Safety Huddles. Daily 11am Executive Team Safety Huddle. Updated Adult Patient Flow Internal Escalation Policy and Plan in place. ED Full Capacity Protocol in place. SAFER patient flow bundle requires that all patients have a documented and communicated EDD within 14 hours of admission, this is visible on ward patient journey display boards, PJs+ is in place on the RVH, BCH, MIH sites. This is visible on the ward patient journey display boards on the acute adult sites.

HSCB request	Trust response
• Are plans clearly communicated to facilitate these initiatives at weekends? • How are non-acute hospitals used to help manage flows • How are discharges from non-acute hospitals managed to ensure flow across the entire system –including at weekends? • Is your Trust implementing patient choice guidance (yes/no) • Is your Trust operating the repatriation process (yes/no).	This is measured via 'medical management plan' on PJs+ Implementation of the SAFER patient flow bundle in 2016, focused on twice daily decision making, we would need to carry out a ward specific audit to assure us that this is still occurring and where, this is not currently captured on an electronic system. An audit of compliance is undertaken on a quarterly basis and shared with wards/service area and an improvement plan put in place to identify and address any gaps. **Improving Hospital & Community Discharge Process** Yes, BHSCT will continue to reinforce the 'Patient Choice Policy' to support prompt patient discharge at this time. Yes, BHSCT is operating the repatriation process. Other Improvements for consideration this winter: **Hospital** • Building on work of BHSCT discharge group and regional priorities • Refresher for medical/nursing staff on discharge expectations • Review Lumira testing and steps to improve for winter pressures • Review the Discharge assistant role – to go on ward rounds and have additional resource for band 3 discharge assistants • Additional step down beds on Musgrave Park site • Have larger space for discharge lounge. • Additional ED porters and/or worktimes to reduce delay ED patients to wards. • Dedicated Silver Assessment area • Additional discharge support for wards/clinicians • Pharmacy dispensing ward level • Developing Discharge Early Warming (DEWs) algorithm & agreed key actions • Developing Community Early Warming (CEWs) algorithm & agreed key actions.

HSCB request	Trust response
	Community • 7 day working for Hospital Social Work (Service currently operates across 7-days. The model has two elements; firstly, the core hospital Social Work teams which operate Monday – Friday 9 am – 5 pm and secondly a team of Band 6 and Band 7 Social Workers operating at Weekends and Bank Holidays comprised of core hospital Social Workers and Social Workers from other service areas. A review of the existing model is currently underway with a proposal to move the core Hospital Social Work teams to a 7-day (Monday – Sunday) 9 am- 5 pm operational model) • Additional 8a and band 6 investment in hospital social to help facilitate 7-day model and part of responding to major incident and escalation planning. • Development and investment in intermediate care • Revision and implementation of No More Silos discharge bid • Social work and social care bank • 7 day Rehab model for bed based rehab • 2 daily sit rep reports by member of Collective Leadership Team Daily division sit rep report. Twice daily discharge sit report • Split of Social Work statutory and discharge function – move SW discharge function • Discharge Hub • Implementation of PJs on Musgrave Park Site • Implementation of Click Sense to full overview of Domiciliary Delays • Modernisation of home care • Additional investment in domiciliary/ community care – staff and resource • Senior Management oversight at weekends. Protocol for the repatriation of patients between Trusts. This protocol would work for DGH scheduled or unscheduled work and will focus on tertiary, particularly whiteboard patients at least in the first instance.

HSCB request	Trust response
8.2 Time Critical Surgery and Elective Care The Trust should evidence how theatre capacity is being managed to ensure the prioritisation of red flag and urgent patients. This information should include the actions (or SOPs) to reduce the number of red flag/ time critical patient cancellations, including the use of the IS or inter trust transfers.	The Trust will focus on increasing theatre sessions dependent on available staff and COVID Critical Care demands. Sessions will be prioritised for Emergency surgery, fracture surgery and time critical Regional Cancer and Regional Orthopaedic Surgery. The Trust will engage with the Regional Prioritisation Operational Group (RPOG) to identify alternative pathways for other urgent/elective surgical procedures eg Day Case elective care centres, IS, Weekend sessions or other centres etc. BHSCT has in-reach arrangements in place with an Independent Sector provider for delivery of weekend Endoscopy sessions. These are expected to continue during 21/22. Due to the impact of the Covid-19 pandemic on increasing waiting times for patients waiting to be seen and treated, we are seeing an increased number of patients whose condition has deteriorated. Modelling data (has been used to support the projections for elective surgery for the period of this plan Depending on the pressures to respond to the pandemic it is recognised there may be no alternative but to further downturn surgery across the region.
The Trust should detail the plans in place to increase the utilisation of HSC theatres	Outpatient capacity is being delivered across all specialties with COVID-19 secure measures in place.
HSCB request	**Trust response**
by the independent sector. This should include theatre capacity not in active use, including the use of HSC theatres in the evenings and the weekends where HSC activity cannot The Trust should detail the plans in place to increase the provision of outpatient assessment capacity, including the roll out of mega clinics across a range of specialties. The plans should also detail how the Trust will make the provision of outpatient services more resilient by the	Every effort will be made to ensure theatre usage is maximised to protect green capacity in line with available staff and resources and to comply with COVID-19 secure measures. Specialties continue to utilise virtual consultations where possible, with some specialties such as Urology already moved a majority of their activity to virtual. However the suitability and volume of this is dependent on the individual specialty and whether the patient requires physical assessment by a clinician. In the last fiscal year prior to the pandemic FY 2019/20, the average weekly new and review attendances for the Belfast Trust was 9318 attendances. For FY 2020/21, this was 7334 (79% of pre COVID total) and for FY 2021/22 to date, the average is 8156 attendances (88% of pre COVID total), showing an increasing trend inclusive of the current surge and an underlying increase in the proportion of virtual activity. The current average for this FY will increase in the winter months as current figures take account of usual downturn of activity in the summer, and is unlikely to be significantly impacted by further surges. There are plans to hold mega clinics by a number of specialties e.g. General Surgery, Orthopaedics and Vascular which will help to expand capacity further. Clinics have already been held by specialties such as Rheumatology, and other

continued expansion of virtual outpatient activity be delivered	specialities are developing plans to progress mega clinics. Initial plans were scuppered by availability of staffing, but it is hoped the new enhanced payment rates for additional work will support delivery of these clinics.
	The daily Executive Team Safety Huddle reviews theatre utilisation and availability to maximise green capacity. Belfast Trust has established the Outpatients Modernisation Programme to ensure that patients and service users receive the right care in the right place at the right time. Addressing the backlog in waiting lists is one of the main principles of the Programme. We are doing this through a number of different workstreams looking at Patient Access & Administration, Governance, and Data, alongside supporting the 8 specialties working closely with the Programme to develop innovative, evidence-based initiatives that are driven by management information and developed in partnership with all stakeholders. In addition to developing an overarching framework to direct the modernisation of outpatient services across the Trust, the Programme is: - Supporting the specialties in process mapping their patient pathways to identify opportunities to optimise the service to best meet patient need and demand. - Extending the use of virtual and video consultations given the restrictions imposed by Covid – clinics across 12 specialties have been on-boarded for video clinics so far, with almost 35% of activity being delivered virtually across the Trust over the last 6 months.

HSCB Request	**Trust response**
	- Standardising how outpatients appointments are made and recorded so that we can better understand our demand, capacity and activity. - Working with GPs to ensure the seamlessness of service between primary and secondary care for the patient and to ensure that we are working together to reduce inappropriate referrals. - Scoping the current workforce involved in the delivery of outpatient clinics to identify opportunities to enhance the wider multi-disciplinary team and staff skill mix to best meet the needs of the patient. - Investigating the digitisation of the clinic management and booking processes to improve efficiencies and to prepare for the introduction of Encompass. - Aligning this work with the action plan from the RQIA inspection to ensure issues such as safeguarding and governance are addressed.

	The Programme has robust executive sponsorship and its progress is being supported by the Chief Executive and the Executive Team, with regular communications on progress delivered and feedback sought across teams and services through existing Trust forums including the Senior Leadership Group.
8.3 Cancer Services In addition to plans in relation to the elective priorities outlined above, cancer services are asked to provide assurances on the following: Progression of staff expansion and service reform as outlined in the Oncology-Haematology Stabilisation (in line with available funding).	Radiotherapy services will endeavour to continue to deliver all radiotherapy treatments. In the event of further surges in COVID-19 which may impact upon service delivery, priority will be given to patients on treatment to complete those treatment courses already commenced and those patients receiving treatment with curative intent. Oncology ambulatory assessment and chemotherapy will continue to deliver services at normal levels based on patient need, maximising virtual assessments where clinically safe to do so. A key assumption is that service can continue to protect its services on BCH site. Oncology and Haematology patients are supported by clinical nurse specialists and have access to the 24/7 Oncology and Haematology telephone helpline service. Following triage patients may be invited for rapid assessment and treatment at the Acute Oncology and Haematology Unit located at the NI Cancer Centre. The Haematology specialist regional service will continue to provide high dose chemotherapy and stem cell transplantation. Ambulatory haematology assessments and treatments will continue as per normal seasonal activity, maximising virtual assessments. The Trust is unable to proceed with the full implementation of the staff expansion and service reform due to funding constraints.
HSCB Request	**Trust response**
Development of plans for single point of referral and e-triage for red flag referrals for suspect colorectal cancer.	BHSCT will work towards a single point of referral, timescale by October.
8.4 Adult Social Care Trusts should review existing domiciliary care capacity with the intention of re-shaping and prioritising service capacity. Opportunities for increasing capacity, including workforce recruitment activities, should be progressed as a priority. Trust should ensure SDS and Direct Payments are promoted as a means of increasing choice and capacity, including	**Domiciliary Care** The Trust has experienced an increase in demand for domiciliary care with some service users waiting for services and unmet need. The service area anticipates that Winter Pressures and a further surge will present increased challenges to manage the ongoing demand due to domiciliary care sector reporting recruitment difficulties as care workers are returning to previous employment as society opens up and increased numbers absent due to range of COVID-19 related issues. In order to manage the increased demands, the service area has the following actions in place:

the use of Emergency Direct Payments to support hospital discharges. Trusts should engage with the independent care home and domiciliary care sectors to ensure and capacity within those sectors is fully utilised and any admission issues are resolved. Planning for timely discharge from hospital should be supported by focus upon the regional discharge priorities of: • Nurse facilitated discharge • Home before Lunch Discharge/ Home to Assess	• Fortnightly engagement sessions with all independent sector domiciliary providers to discuss operational/governance issues and is an opportunity to ensure business continuity plans are in place. • Prioritisation system in place for end of life and vulnerable service users at risk • Rapid Responsive Domiciliary Contracts available over 7 days to facilitate hospital discharges. • Robust process in place to ensure provision of PPE to providers and carers. • Anyone delayed in hospital awaiting domiciliary care is offered Emergency Direct Payments • Service users in the community will be offered Direct payments The Trust is finalising a framework for prioritisation of the delivery of domiciliary care should this be required The Trust has developed a process for the monitoring and audit of its unmet need list, which will include a policy to manage service user choice The Trust also adheres to the HSCB domiciliary surge plan, which outlines key actions in terms of IPC requirements/support, carer support, service user reviews.

HSCB Request	Trust response
8.5 Children's social care including disability and CAMHS Maintain critical support services for families in the community (particularly short breaks in disability/intensive support in CAMHs/edge of care) are maintained to avoid unnecessary family breakdown. Ensure adequate, safe staffing for residential and in patient services in view of current demand. Maintain a focus on waiting lists.	**Children with Disabilities** • The Trust continues to engage in local and regional recruitment processes in order to maintain adequate staffing levels across community teams to ensure the continued delivery of Delegated Statutory Functions in respect of its Corporate Parenting and Safeguarding responsibilities. • Community Social Work teams , the Edge of Care and Fostering Services will continue to provide wrap around support services to ensure the safety and wellbeing of children living with their families in the community. • The Trust will continue to maintain critical support services for families in the community, particularly the re-establishment of short break residential and fostering provision for children with disabilities so as to avoid family breakdown. • Despite the significant demands on the fostering provision due to the increased numbers of Looked After Children, the Fostering Service will to continue to provide short and long term placements for Children in the care system. • Similarly Children's residential homes have increased their intake capacity in order to meet the demands for placements in the care system. • We will ensure that those children and families who are waiting a social work assessment are prioritised for assessment / support. **Psychological services** Psychological services have continued to deliver across all areas of care, providing psychological support and therapies both on an inpatient and outpatient basis, moving as much as appropriate to the delivery of telephone or virtual therapy. Services most affected by COVID-19 have been where diagnostic tools are necessary such as for assessments for neuropsychological psychometrics, learning disability and autism. Psychological services provided a psychologist at Trust clinics at 6 and 12 weeks, both in terms of ICU follow up and follow up by respiratory physicians for those patients admitted to wards or provided referral pathway for follow up. There are a group of patients who require further psychological support after 12 weeks and we are supporting them as best possible within the Clinical Health Psychology resource. Psychology continues to link with wider MDT colleagues to look at ways of more widely supporting recovery for COVID-19 patients – there is a significant psychological morbidity eg exploring the potential of group webinars on psychologically related sequelae.

HSCB Request	Trust response
	As Psychological services we have regionally developed a booklet: “Psychological Recovery after being hospitalised with COVID-19” –can be given to patients on discharge or at 6 week review. A regional group developed a Psychological Follow-up pathway – passed upwards to DOH. In Belfast we are following this pathway. Psychological services have developed in collaboration with colleagues from Sleep service a booklet – “Sleep in time of a Pandemic” which is also being given to patients at psychological follow up. Further psychological resources for patients are in discussion. AHP services will continue to work with the PHA and EA in the planning services to special schools based on the increase in pupil numbers this year and the delivery of services within the resources allocated
	Acute CAMHS Inpatient Service/Crisis Assessment and Intervention Team (CAIT) These teams will remain operational. A review of services within CAMHS has been carried out: inpatient services and CAIT identified as an essential service that must be maintained. Surge plan in place to ensure safe staffing. Crisis team in place to provide additional stepdown provision to support safe and effective discharge from hospital. **Community Mental Health Teams** Community teams will remain operational. All clients reviewed and RAG list maintained. A combination of face to face and virtual assessments in place. Step 3 CAMHS have evening clinics in place to facilitate increase in face to face appointments whilst adhering to IPC guidance. Central Point team in place to triage all referrals and offer assessment where clinically indicated. Crisis assessment and intervention team will continue to respond face to face to emergency/urgent assessment where clinically indicated and provide intensive treatment where necessary to prevent admission to Beechcroft. The Trust is seeking to secure additional resource for eating disorder team to provide intensive day treatment and prevent admission to hospital.

HSCB request	Trust response
8.6 Belfast Trust Paediatric Plan Based on planning arrangements outlined above the availability of staff will continue to be a key challenge in the coming months. Trusts are asked to highlight arrangements that demonstrate that sufficient and appropriately trained staff are available to support paediatric services to support any surge in demand. This will include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period; Trusts should detail arrangements in place for local triggers to activate the effective planning and management of their services in the event of a prolonged Respiratory Syncytial Virus (RSV) surge and how will they ensure continued robust and effective communications and links with other Trusts and regional colleagues throughout the period; Trusts should detail arrangements in place to ensure the continued provision of paediatric elective work in paediatric services throughout the autumn and winter 2021. This should include outpatient clinics as well as inpatient elective work.	Respiratory viruses are the largest cause of paediatric morbidity and hospital admission. These viruses typically surge over winter and contribute to massive pressure on available resources. The winter virus Respiratory syncytial virus (RSV) surge for 21/22 is anticipated to be significantly worse than usual: 1. The majority of children and young people will not have received a COVID-19 vaccine and COVID-19 is currently surging in the community [Aug 2021]. 2. Experience from Australia indicated that their Respiratory syncytial virus /bronchiolitis season was 50% worse than usual following COVID-19 surges. 3. An entire birth cohort of children have not been exposed to respiratory viruses last year due to lockdown and this is likely to increase the age range for bronchiolitis to 2 years. The Trust has prepared a robust paediatric plan. Within the Royal Children's Emergency Department, LIAT rapid COVID-19 testing has been introduced in ED to identify COVID-19, Flu and Respiratory Syncytial Virus (RSV) within 30 minutes to allow safer cohorting where required. Consultant and junior medical staff have received training on bronchiolitis management. Nursing staff have received training on a range of specialisms for example care of ventilated children and CC patients, management of children with bronchiolitis to include simulation training, management of chronic respiratory patients including tracheostomy care and ventilation and management of diabetic patients. Training and support is being provided for PICU staff as they undertake a Nightingale type model of working. Paediatrics have developed a robust escalation plan and a PICU surge plan which outlines that any further surge could result in the need to downturn outpatient activity and the temporary suspension of elective work. The plan shows how the number of paediatric hospital beds would increase from 96 up to a maximum of 111 of which 87 will be ward beds and 8 will be in the short stay unit and 16 will be in Paediatric ICU (an increase of 4 PICU beds). The plan is based on the following 3 phases: PHASE 1 Triggers for Phase 1: when 2 triggers are met • Requirement for 2 cohorted winter virus in-patient areas (up to 8 patients) • 2 patients requiring (or likely to require) HFNoC at ward level • Delay in transfer of DTA patients from ED > 2 hours • An amber / red bed state. • PICU has one bed available for Level 3 acute admission.

HSCB request	Trust response
	PHASE 2: Triggers for Phase 2 when 2 triggers are met • Insufficient capacity to accommodate further cohorting according to current respiratory virus infection • Allen ward capacity at 18 beds. • PICU occupancy= 100% of staffed beds PHASE 3: Triggers for Phase 3 when 1 Trigger met • RBHSC capacity insufficient to accommodate required admissions (ie DTAs . available beds) • PICU occupancy = 15/16 and or patient placement in Theatre Recovery/for more than 48 hours. The ability to flex beds is linked to workforce and an ongoing need to cover essential Regional Services and Winter Virus pressures. It has been established that the opening of a 2nd PICU area in Knox ward is not viable. A rota plan for paediatric doctors has been devised which is aligned to the 3 aforementioned phases across medical wards, ED, PICU and Theatres. A full nursing workforce analysis has been completed and it is anticipated that additional registered nursing requirements will be met by a phased increase in the redeployment of nurses from areas where there will be a service downturn. Allied Health Professionals, as per the nursing workforce will be reliant on the downturn of other activity to meet surge requirements This will be complemented by ongoing backfill. Other measures: • HSC Workforce appeal. • Newly qualified nurses awaiting registration- Band 3 posts. • Downturn of Services RBHSC to include OPD, Day surgery, Elective surgery. • Redeployment of Specialist Nurses RBHSC. • Redeployment of staff from EENT day ward and/ or MPH Children`s ward. • Redeployment of staff from Region to wards and/ or PICU.

HSCB Request	Trust response
8.7 Mental Health and CAMHS Progress work on the Mental Health Post Pandemic Surge and Rebuild Plan 2021-26.	The Mental Health/CAMHS Surge plan, locally and regionally, details contingency arrangements and escalation measures for provision of services during the containment/surge phases of the COVID-19 outbreak. This is a co-ordinated response to support service users/staff & ensure clear and consistent communication & collaboration with internal/ external stakeholders. All sites remain open. Services work regionally to access beds if required for adult mental health. A review of all services within Mental Health has been carried out and essential services that must be maintained have been identified. All other services will be maintained for as long as possible. However, as the effects of the pandemic impact on essential services, other services identified as non-essential will be stood down for example Day Centres. Other outreach initiatives and support packages will be delivered in the event that day centres do need to close. All wards, teams and services have developed local surge plans. Staff from services that have been stood down will be redeployed, to help maintain essential services in line with HR guidance. All services and community teams will review their current caseloads and RAG rate, to identify clients and patients who will require ongoing follow-up during the COVID-19 surge. Alternatives to face to face contact should be considered. Each service will have in place governance mechanisms and supervision by senior staff over any triage process. Documentation should be maintained to reflect clinical decision making.
Deliver Year 1 of the DoH Mental Health Strategy 2021-31 Implementation Plan.	The Trust has also submitted a number of bids to help fulfil and deliver actions in the Mental Health action plan and strategy – for example, to establish a new service model for specialist perinatal mental health services new multidisciplinary community perinatal team and for CAMHS to assist with the planned rollout Emotional Wellbeing Teams in Schools, further monies are being sought for the eating disorders service given the increased prevalence. Others focus on Mental Health Liaison, bed capacity and staffing, implementation of the Mental Capacity Act, tackling substance misuse and Towards Zero suicide The Trust Mental Health Teams meet regularly with primary care in the Mental Health Liaison forum.

HSCB Request	Trust Response
8.8 Physical Disability Trust is asked to highlight how the needs of adults with Physical and Sensory Disability is ensured in the Adult Social Care Review of existing domiciliary care capacity with the intention of re-shaping and prioritising service capacity. (refer to sub section – Adult Social Care) Trust is asked to highlight how it meets the needs of those service users with complex need, including the use of SDS and Direct Payments. Trust is asked to highlight what the transition arrangements are between children and older people.	Trust Day Centres will prioritise attendance for those most at risk whilst adhering to social distancing and infection prevention control guidelines. Alternative options will be put in place for those unable to attend. Meeting the needs of those service users with complex needs, including the use of SDS and direct payments remains a challenge for the service area due to the difficulty sourcing appropriate placements for adults with complex needs in Care Homes and high cost packages in the community. We continue to respond quickly to hospital discharge referrals to avoid delays and ensure that we source Care Homes to meet service users' needs. We continue to offer direct payments and self-directed support options for adults in the community so that they can have the option of direct payments, Trust core services, or a mixture of both. The pandemic has exacerbated some of the pressures but we continue to deliver person centred services through good assessments, care planning and reviews. We also provide support to carers through assessments and offering grants and complementary therapies. Close partnership working between colleagues in Physical Disability and the Children with Disabilities service areas helps to prepare well in advance for transitions. The teams engage with young people and their families regarding transitions and work to ensure that adult services are tailored to their needs and they feel supported during this process.

9.0 CONCLUSION

The health and social care service across Northern Ireland has worked closely together to meet the challenges associated with COVID-19 over the last 18 months. Our workforce have continued to demonstrate resilience and flexibility throughout the Covid surges.

The next six months will continue to be challenging with the on-going threat of further surge alongside normal winter pressures and the potential for further local outbreaks. This is further compounded by the impact of previous surges on the health and social care system including the workforce challenges, long waiting times, longer waiting lists and the inequalities which have been exacerbated by the pandemic. These are undoubtedly unprecedented times for the delivery of services within health and social care, which will impact on demand for services, capacity to deliver and availability of workforce. In response to the ongoing Pandemic the Trust may be faced with situations where they have to take necessary actions at short notice to ensure that patient and staff safety remains our priority focus.

ANNEX 1: Belfast Trust: Acute Bed Modelling – Winter 2021/22

1. Modelling assumptions

This paper sets out a number of scenarios based on the following modelling assumptions provided to Trusts by DoH/HSCB:

- Average activity projections for October 2021 to March 2022 are based on the same months in 2019/20.
- Each Trust has assumed a bed utilisation of 95%. It is accepted that this is in excess of 89% which is regarded as the safe standard. However Trusts have reported that they are currently working beyond this level in many settings.
- Trusts required to plan for a 5%, 10%, 15% and 20% rise in admissions.
- COVID-19 bed requirement calculations are based on COVID-19 beds required during peak September 2021.
- Trusts have expressed concern that demand may exceed peak September 2021 levels and should be based on January 2021 peak levels for COVID-19 and unscheduled care. However, this would sit outside the parameters that have been set by the DoH Regional Modelling Group.
- It is acknowledged that all beds included in the calculations may not be available at all times due to constraints in staffing and infrastructure.
- For consistency, elective bed modelling has been based on the beds required to deliver SBA volumes. It is noted that historically the achievement of the elective SBA has been challenging due to the change in patient pathways and working practices.

In addition, it is acknowledged that Trusts are seeing patients with higher levels of acuity requiring longer lengths of stay/more bed days and access to critical care etc. Whilst this will not necessarily be in line with the original SBAs, Trusts have accepted this approach for planning purposes.

It is noted that there is a very broad range of uncertainty for scenario planning this winter, including factors such as:

- The impact of waning immunity post vaccination and its impact on hospital demand.
- The plan and effectiveness of any booster jab programme including target populations.
- Public behaviour.
- The instigation of any regional mitigation such as circuit breakers.

- The impact of influenza given the potential limited immunity in large parts of the population
- RSV impact which has an impact on children and frail elderly.

1.1 Current Beds

We currently have 1,178 beds across our sites (1,122 inpatient beds and 56 ICU beds - 42 ICU beds & 14 Cardiac ICU beds):

Current Bed Availability as at 10/09/21 (excluding ICU)
BCH, NICC, RV, MPH and Mater included

	Beds	Ambulatory
BCH	115	20
Mater	157	
RVH	584	5
MPH	217	
NICC	49	18
Total	**1,122**	**43**

This includes additional unscheduled care beds that the Trust has opened since April 2021 as part of its Surge 4 plan, 47 beds in total - 21 beds Ward F Mater; use of 20 beds being used for delayed fracture rehab at MPH; and 6 cardiology beds to be opened in BCH.

2. Non-Elective Inpatient beds

2.1 Non elective baseline

Activity projections for October 2021 to March 2022 have been based on the same months in 2019/20. These figures take into account a number of mitigating factors already in operation. The table below shows these baseline 2019/20 figures, for non-elective beds only:

Non-elective baseline 2019/20	Oct – Mar average
Belfast Trust	989

2.2 Projected requirement

The tables below show the average **non-elective beds** required by month modelled at 0% to 20% growth above 2019/20 figures based on 95% utilisation (including patients who received a decision to admit but did not progress).

There were 1,084 patients who received a decision to admit but did not progress to an admission between October 19 and March 20. It is assumed that these patients would be short stay patients as such we have estimated a length of stay on 1 day, therefore this equates to 6 beds at 95% occupancy.

Belfast Trust

Non-elective projections 21/22	Overall Ave Bed Requirement Oct-March
Baseline (average beds required) based on Oct 19-Mar 20 at 95% utilisation	995
+5% unscheduled demand	1,045
+10% unscheduled demand	1,095
+15% unscheduled demand	1,144
+20% unscheduled demand	1,194

3. Elective Inpatient beds

The table below shows the number of elective beds to deliver expected SBA volumes.

For consistency elective bed modelling has been based the beds required to deliver SBA volumes. It is noted that historically the achievement of the elective SBA has been challenging due to the change in patient pathways and working practices.

Elective beds	SBA volumes
Belfast Trust Total	390

4. COVID-19 beds

The following tables set out the total COVID-19 occupied beds by hospital based on peak during September 2021 from daily sitrep information and peak during January 2021.

Covid-19 beds	Sept 21 peak (4^{th} wave)	Jan 21 peak (overall)
Belfast Trust Total	148	272

5. Capacity

The table below summarises bed requirement versus beds available including anticipated shortfall:

Total Base Model

Belfast Trust	Unscheduled requirement	Elective requirement (SBA)	COVID-19 requirement	Total beds required	Total beds available	Shortfall
0%	995	390	148	1,533	1,122	411
5%	1,045	390	148	1,583	1,122	461
10%	1,095	390	148	1,633	1,122	511
15%	1,144	390	148	1,682	1,122	560
20%	1,194	390	148	1,732	1,122	610

6. Mitigations

The table below sets out the range of mitigations available and the number of anticipated beds delivered following implementation.

	Mitigation	Anticipated beds delivered
1	BCH – increase 15 surgical beds with a move of 15 existing surgery beds from RVH to BCH (providing for an additional 15 non-covid USC beds in RVH)	15
2	MIH – increase of 18 covid +ve beds (6 Ward D, 6 Ward E, 6 Ward B)	18
3	RVH – 19 non-covid USC beds (2 Ward 5E, 6 Ward 4E, 3 Ward 4F, 8 Level 8)	19
4	Other sites – 20 additional covid beds to meet demands across sites as needed (across MPH, RMH, RBHSC, MAH and Beechcroft)	20
5	Cap Elective at Summer 2021 levels i.e. 169 beds	221
Total		293

7. Summary

The tables below set out the overall bed requirement and assumed shortfall in capacity before and after the implementation of identified mitigations.

Total Base Model

Belfast Trust	Total beds required before Mitigations	Shortfall	Mitigations	Total beds required after Mitigations
0%	1,533	-411	293	-118
5%	1,583	-461	293	-168
10%	1,633	-511	293	-218
15%	1,682	-560	293	-267
20%	1,732	-610	293	-317