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REBUILDING HEALTH AND SOCIAL CARE SERVICES

STRATEGIC FRAMEWORK

DEPARTMENT OF HEALTH

JUNE 2020

CONTENTS

		Page
	MINISTERIAL FOREWORD	3
1.	INTRODUCTION	5
2.	COVID-19 IMPACT ASSESSMENT	7
3.	MISSION	18
4.	SERVICE INNOVATION	19
5.	INCREMENTAL SERVICE CAPACITY PLANS	27
6.	IMMEDIATE PRIORITIES	32
7.	EXAMPLE PATHWAYS	42
8.	ANNEX A: ACTION LIST	55

APPENDIX A: COVID-19 IMPACTS ON HSC SERVICES, EXCLUDING SECONDARY CARE (TO BE PUBLISHED SEPARATELY)

APPENDIX B – IMPACT OF COVID-19 ON SECONDARY CARE SERVICES (TO BE PUBLISHED SEPARATELY)

APPENDIX C: COVID-19 IMPACT ON PROGRAMMES AND PROJECTS (TO BE PUBLISHED SEPARATELY)

MINISTERIAL FOREWORD

Before the introduction of social distancing almost three other people were infected by each COVID-19 patient in the community. As a result of social distancing and other restrictions, each COVID-19 patient now infects less than one other individual in the community. The result of this is that we are now seeing a slow decline in the number of community acquired COVID-19 cases, hospital admissions, ICU occupancy and deaths.

This Strategic Framework for Rebuilding Health and Social Care (HSC) Services will only be successfully implemented by ensuring that the number of Covid-19 infections remains at the current level or less in the future. If this increases above one there will be the risk of a second wave of the pandemic. Consequently, our ability to rebuild HSC services will be derailed by having to divert HSC resources to manage the impact of a second wave of the pandemic.

My position as Minister of Health has given me a particularly privileged vantage point to witness the impact of this terrible virus on our community. This has both humbled me and sharpened my determination to ensure that we use every available measure we can to keep the rate of infection below one.

The number of our fellow citizens who have been infected or sadly lost their lives has already been too great. As of 2 June 2020, over 76,000 people had been tested. Sadly, 705 COVID-19 related deaths had been registered up to 22 May. I send my sincere condolences to the families and loved ones who have suffered the loss of their family member. I pray that those who are recovering from COVID-19 will make a full recovery and return to a happy and healthy life. The impact of COVID-19 on our older citizens living in care homes has been particularly devastating and my thoughts are with their families and friends at this difficult time for them.

I am immensely proud of the response to COVID-19 of everyone involved in our health and social care sector. Our nurses, midwifes, allied health professions, doctors, pharmacists, care workers and other front line health and social care workers and those individuals who volunteered to return to work have bravely and tirelessly put themselves at risk to save the lives of others. In addition, staff in our arms-length bodies and in my Department have put in many long hours planning for and managing the emergency response. I know that I can rely upon their continuing commitment to deliver the highest quality health and social care services across the community as we begin the task of rebuilding the HSC.

COVID-19 has presented our HSC system with its biggest challenge since inception. We faced huge strategic challenges prior to COVID-19, which included an ageing population, increasing demand, long and growing waiting lists, workforce pressures, the emergence of new and more expensive treatments and ongoing budget constraints. These challenges have been compounded by COVID-19.

I am deeply concerned about the impact of this activity downturn on long term health outcomes across the population. In total, 643 excess deaths have occurred up to 22 May 2020. Throughout the pandemic the HSC has continued to provide high priority and urgent services such as emergency care and many cancer treatments. Despite the action I took to protect our highest priority services, a terrible consequence of the pandemic is that for some people conditions will have gone undetected or untreated longer than they otherwise would have. I am also deeply concerned about the impact of the pandemic and the lockdown on mental health, especially for our most vulnerable citizens.

We are now emerging from the peak of the first COVID-19 wave and we must now seek to rebuild services as quickly as possible in that context. My immediate focus will be on supporting services where further delay would seriously risk the condition of patients worsening. As we do so, patient and staff safety will remain an absolute priority. We will therefore create an environment where it is safe for patients to attend appointments in both primary and secondary care settings.

I conclude by again thanking all health and social care staff for the incredible efforts to date. We will not be able to return to business as usual as quickly as we would want to and some services will take a considerable period of time to return to activity levels similar to those prior to COVID-19. At the same time we need to mainstream the important innovations that have emerged, we must retain flexible capacity to continue to manage COVID-19 patients and we must plan for the future, all at the same time.

This Strategic Framework that I have published is an honest attempt to plot the way forward to rebuilding HSC services. Because of the uncertainty about our ability to control further outbreaks of the virus our planning horizon will look no further than three months ahead as we seek to rebuild service capacity over the next 2 to 3 years. The road to achieving full recovery of services will be long and testing for all involved.

I am convinced that as a system we will rise to this complex challenge.

Robin Swann
Minister for Health, Northern Ireland

1.0 INTRODUCTION

1.1 COVID-19 has posed unprecedented challenges for the Health and Social Care (HSC) system, which already prior to COVID-19 was facing huge strategic challenges in the form of an ageing population, increasing demand, long and growing waiting lists, workforce pressures and the emergence of new and more expensive treatments as outlined within *'Health and Wellbeing 2026: Delivering Together'*. This is against a backdrop of financial constraints and single year budgets. Elective and diagnostic services have had to be curtailed with adverse impacts on existing waiting lists. At the end of March 2020 there were some 307,000 patients on the outpatient waiting list, almost 94,000 waiting for inpatient and day case admissions and more than 131,000 patients waiting for diagnostic tests. The existing challenges confronting the social care sector, as described in the 'Power to People' report, have also been compounded by the pandemic.

1.2 The impact of COVID-19 on HSC will be profound and long lasting. Services will not be able to resume as normal for some time due to the continued need to adhere to social distancing and for Personal Protective Equipment (PPE) at volumes not required prior to the pandemic. In addition, the resilience of the HSC workforce is likely to have been eroded and will continue to be impacted with pressures from parts of the social care sector, with care homes still managing a significant number of COVID-19 outbreaks, for instance. This could require the continued deployment of additional staff into the independent sector, which, if delivered, will further constrain staffing capacity to fully resume other HSC services. Ongoing pressures and the need to operate in new ways will likely impact the pace of stabilisation across primary, secondary, community and social care services.

1.3 Whilst the restrictions imposed by The Health Protection (Coronavirus, Restrictions) (NI) Regulations 2020 ('the Regulations') were necessary, they have impacted on the wider economic and social environment, with both long and short term effects on population health. Emerging research indicates that population health is, on balance, likely to be negatively affected by the wider impacts of COVID-19. Furthermore, the greatest effects are likely to be felt by our most disadvantaged citizens.

1.4 In addition, given the very significant downturn in HSC services, many people have not had access to the screening, testing or treatments that they otherwise would have had. In that context, the Department took action to preserve the highest priority essential services to mitigate this impact. Inevitably, however, the downturn in normal business will have resulted in some diseases going undetected or untreated longer than is desirable, with potential impact on long term health outcomes. The uncertainty and concern about the pandemic combined with the impact of the lockdown will also likely have had an adverse

impact on mental health, especially for the most vulnerable in society. Additional support for mental health and resilience have been provided, however it is likely that there will be significant need coming forward as we emerge from the lockdown. Delivering on the mental health action plan launched on 19 May 2020 will be essential if we are to meet this particular challenge.

1.5 COVID-19 has disrupted the clinical education and progression of a number of health professions resulting in a disruption in progression and future workforce supply. This disruption has been particularly acute in elective services which have been stood down, multidisciplinary community teams and district nursing teams where student training would have generated additional footfall. The third sector has also been negatively impacted by COVID-19 and HSC are reliant on the sector to provide support.

1.6 Careful consideration will also need to be given to the delivery of long term support for people in the community, including that provided through HSC domiciliary, residential and nursing home care and through the vital support provided by informal carers. There will need to be a careful balance struck between continuing to protect people and ensuring that other aspects of people's health and wellbeing – and their rights – are respected and looked after.

1.7 A further issue that will increasingly come into focus during 2020 is the need for readiness for EU Exit, ahead of the end of the transition period on 31 December 2020. This includes understanding the implications for the HSC sector of the implementation of the Northern Ireland Protocol and ensuring that the sector is prepared and risks are managed in areas such as workforce, health security and healthcare supplies.

1.8 The Department's budgetary position continues to be hugely challenging, with the Department facing a funding shortfall in respect of forecast inescapable pressures necessary to maintain existing services. Rebuilding HSC services whilst simultaneously dealing with the ongoing COVID-19 pandemic will require additional sustained funding and investment.

2. COVID-19 IMPACT ASSESSMENT

2.1 The Department has collated a comprehensive assessment of the impact of COVID-19 across primary care and community services; secondary care; and a wide range of programmes and projects. This detailed assessment has been published in three separate Appendices[1], alongside this Strategic Framework. This section summarises the key impacts across these areas and also highlights some of the emerging wider population health impacts.

2.2 It is important to stress that the information included in this section and in the separate appendices was collated quickly with the intention of providing a high level illustration of impact. Please note that waiting time figures only include data that was available on the Patient Administration System at the time of reporting, with some data excluded[2]. Given the urgency in developing this Strategic Framework and associated service rebuilding plans, the data in this section and in the appendices has not been subject to any detailed data verification processes. The data is therefore provisional only and is subject to change. It has nevertheless been published in the spirit of openness and transparency.

Primary and Community Care

GP / Dental / Ophthalmic Services

2.3 COVID-19 has had an adverse impact across primary care and community services. GP appointments have reduced by 19.4% compared to last year. In addition to normal business, GP practices are receiving large numbers of COVID-19 related queries.

2.4 There has also been a marked reduction in the availability of dental and ophthalmic services with a minimum service focused on emergency care. In respect of emergency dental care this is provided through the Urgent Dental Care Centres that have been established in each HSC Trust. The net impact of the restrictions is that whilst 50,000 patients would have visited a dental practice each week in normal circumstances, this has reduced to around 2,000 (a 96% reduction) currently whilst there has been a 72% reduction in sight tests.

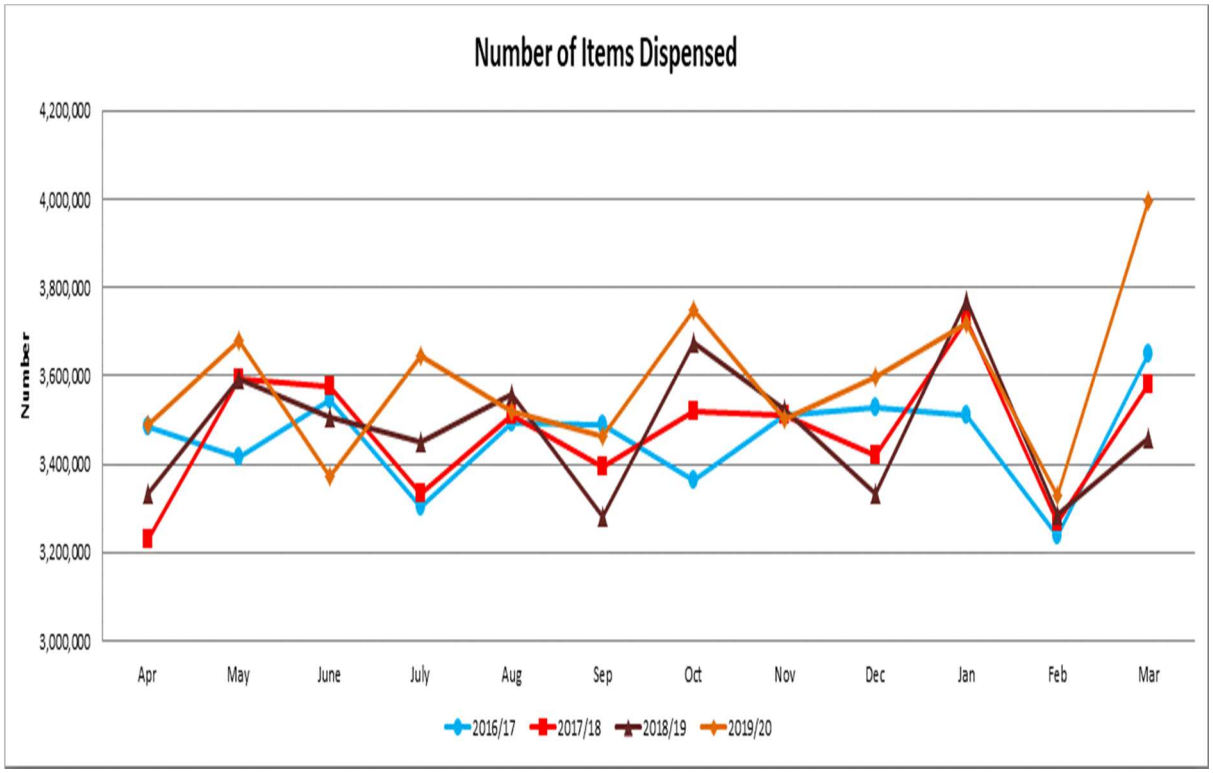
[1] Appendix A: Impact on HSC Services, excluding secondary care.
Appendix B: Impact on secondary care.
Appendix C: Impact on programmes and projects.

[2] The following Trust data is not included: Belfast - Community Paediatrics, Rehabilitation, Learning Disability, Old Age Psychiatry, Genito-urinary Medicine; Northern – Community Paediatrics; Southern – Genito-urinary Medicine; and Western – Learning Disability, Genito-urinary Medicine.

Community Pharmacy Services

2.5 Information is only now emerging on the impact of COVID-19 on community pharmacies. This is exemplified in prescription volumes which show an increase of 15.2% in total prescription items dispensed, which exceeded 4 million items in March. In reality, community pharmacies across the country experienced a huge surge in demand for prescription and over the counter medicines from mid-March (figure 1 below), placing acute strain on pharmacy staff and business owners.

Figure 1: Prescription Volumes by Month



2.6 A number of rapid interventions were needed to sustain the service through the initial emergency phase. These interventions saw the standing down of non-essential services and commissioning of new services to meet emerging population health needs.

2.7 Additional pressures also emerged. The high numbers of people shielding, self-isolating and the government message to “Stay at Home” resulted in an increase in requests for prescription deliveries. General practices encouraged the public to use prescription collection services to reduce footfall through GP practices. This resulted in a greater expectation from the public for collection and delivery services for prescription medicines, none of which was

commissioned. Against rising demand, community pharmacy experienced significant pressure in relation to workforce resilience. In the earlier stages of the pandemic response, staff capacity fell to below 70%. In recent weeks, it has improved to 80%.

Community teams

2.8 Community Allied Health Professional (AHP) services and community nursing services have been severely disrupted, negatively impacting patient access to community rehabilitation and recovery; assistance to support and maintenance of independent living; and the management and control of long term conditions. The demands on community teams has increased with district nursing and acute in-reach teams supporting vulnerable clients in care homes.

2.9 Health visitors have been relocated to provide care and services where needed resulting in a reduction of the number of health assessments and home visits which means issues in relation to health and development of children may not have been identified early. Closure of the schools has meant the school vaccination programme and health appraisals have been unable to be completed. This will need to be addressed when schools reopen.

Screening Programmes

2.10 Many adult screening programmes were paused from the second week of March 2020 in response to the COVID-19 pandemic. The purpose in pausing these programmes was to reduce the risk of COVID-19 infection in people eligible for screening programmes and to ensure that adequate healthcare and laboratory resources could be redirected to the pandemic response. As a result, the number of screening tests carried out in the adult programmes which were paused has fallen very significantly since the middle of March 2020.

2.11 Screening has continued to be offered for people who require higher risk breast screening, diabetic eye screening for pregnant women, newborn blood spot screening, newborn hearing screening, antenatal infections screening in pregnancy and ‘smear’ tests for non-routine cervical screening such as repeat tests requested by colposcopy or the laboratory.

2.12 Breast assessment clinics for women who have previously been recalled for assessment following mammography continue to be held within our screening centres.

2.13 Colposcopy clinics offering further assessment following a cervical screening test are also still being held where possible and tests for people who have recently been screened will continue to be processed and results sent to GPs for onward communication to patients.

Mental Heath

2.14 The impact of COVID-19 on mental health is expected to be severe. International evidence indicate short and long term direct effects on mental health and psychological wellbeing, and in some cases increased suicide and posttraumatic stress disorder (Lancet 2020; 395: 912–20). The causes of the direct effect on psychological wellbeing are identified as social distancing and isolation, bereavement, unemployment, financial hardship, inability to access health and social care services and increased stress due to work pressures. Further it is expected that the prevalence of mental disorder and mental illness will increase. Evidence from World Health Organisation (WHO) and academic research indicate that the pressures are expected in already vulnerable groups, with an increase of depression in women, increased rates of depression and anxiety in the older population, and those with severe mental disorders felt to be especially vulnerable during emergency situations.

2.15 Early indications in Northern Ireland support this research. Whilst most early intervention, prevention, mental health and suicide services reported an initial decrease in demand, this has now turned into an increase in pressures. Mental health in-patient bed occupancy (for those with the most severe mental illness) showed a 15% drop in demand between middle of February and end of March. However, since the second half of April demand has increased significantly and the daily bed occupancy levels are now around 95%.

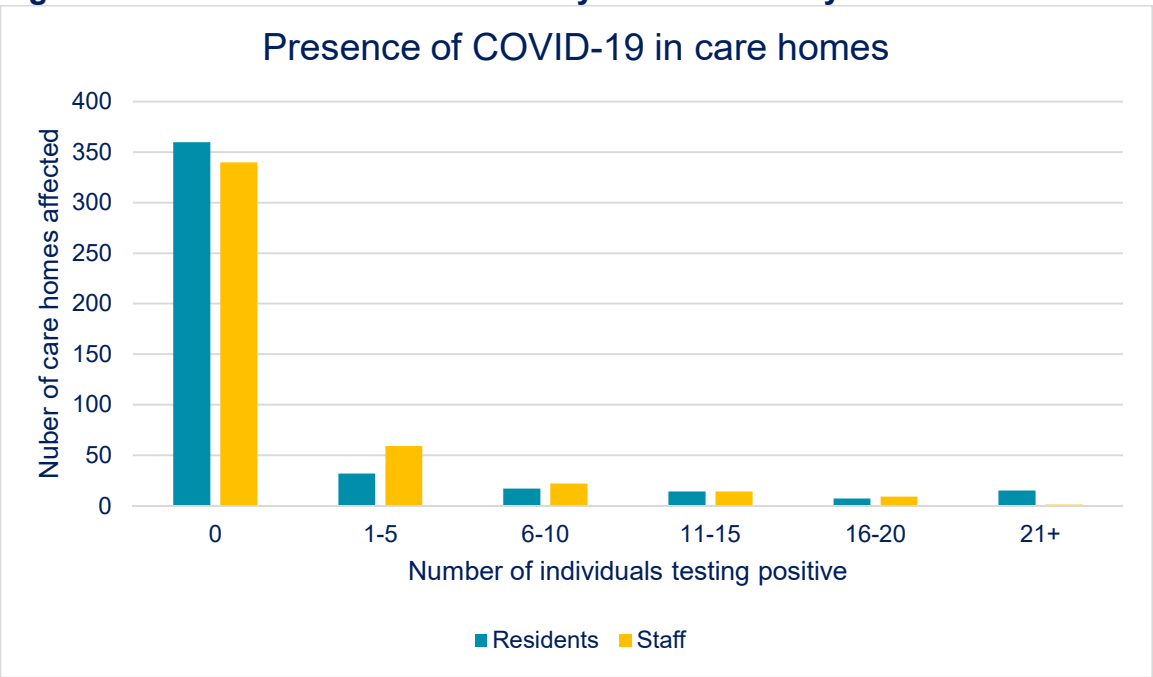
2.16 Anecdotal evidence from clinicians also indicates an increase in acuity of those presenting with severe mental health problems, and a larger number of new presentations, previously unknown to mental health services. Early indications links this with the effects of reduction in face to face contacts, in the health services and wider society, and stress related to the pandemic.

Social Care

2.17 COVID-19 has highlighted the fragility of the adult social care sector and a wider and fundamental reform of adult social care will be required. In contrast to other areas of the health system, the ongoing nature of the service limits the potential to create capacity by reducing or restricting access to the service. In particular, care homes remain in the surge period of the pandemic with pressures evident in the presence of COVID-19 among care home residents and staff.

2.18 A recent survey of care home providers indicated that 19% of providers who responded were caring for a resident who had tested positive, while 23% of providers who responded had employees who had tested positive. The chart below shows both the number of care homes affected by COVID-19, and the extent of COVID-19 presence within those homes through analysis of the number of positive tests within each home:

Figure 2: Number of homes affected by COVID-19 - May 2020



2.19 The provision of domiciliary care has also been affected, with many recipients choosing to rely on informal care due to concerns about the transmission of COVID-19 by domiciliary care workers entering their home. Anecdotally these concerns have also impacted on the way some direct payments are used. The long term impact of this is difficult to forecast but, anecdotally, demand for formal care packages is returning. There may be a requirement for increased levels of care – whether in care homes or in people's own homes – where individuals have suffered from COVID-19 and their longer term care needs are more acute as a result.

2.20 A number of other important support services have been affected by COVID-19. For instance, Trust day centres and respite services have generally stopped. The staff and resources associated with those services have been redirected to provide more intensive support to families in their own homes. Trusts are currently discussing how services can be restarted in a way that provides much needed support and respite but also minimises infection control risks.

Vulnerable Children

2.21 The lockdown regulations and public health restrictions have created new, or exacerbated existing challenges and risks for many vulnerable children, young people and their families. Children and young people are potentially at a greater risk of harm in the home, as evidenced by increased domestic abuse rates. They are also exposed to risk from outside the home, including the risk of online grooming and exploitation. Lockdown restrictions have created a

range of pressures, including financial pressures. Many families, including those with a child with a disability or complex health problem, are not able to access the same level of support from services as pre-lockdown. Access to health services has been more limited and school closures have created particular challenges for families as they try to balance home life and online learning. Families are more isolated, prevented from accessing the support of wider family networks. Children generally have been less visible than before and this was reflected in a reduction in the number of referrals in the early stages of the pandemic. However, the number has steadily increased over time and now exceeds the number received during the same period last year; this is likely to be as a result of building pressure and challenges within the family home.

2.22 Since the introduction of stay at home policy, leading to school closures, there has been a shift in the source of referrals. Referral sources (from three HSC Trusts for which we have information), show half (47%) are from police, compared with 31% in year ending 31 March 2019. Referrals from schools are down from 9% to 1%.

2.23 Throughout the period Social Services Gateway Teams have continued to operate in line with normal operating arrangements and statutory duties, maintaining contact with families, using technology where face-to-face visits were not possible. Social Work Managers have closely overseen all cases to ensure appropriate risk assessments were carried out, taking full account of public health advice and guidance relating to COVID-19.

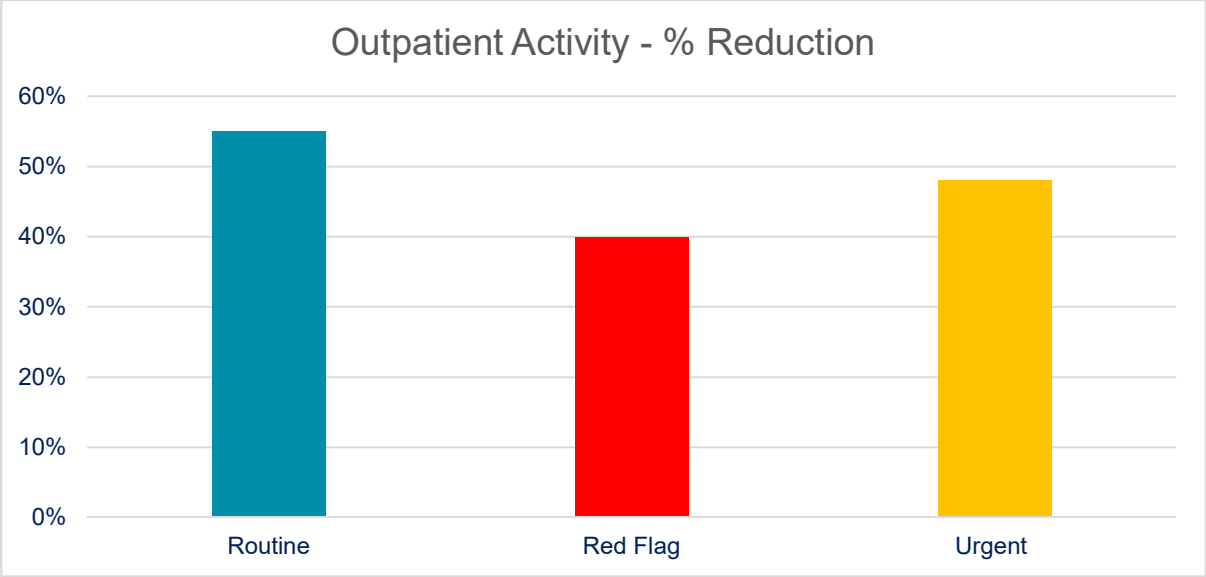
2.24 It is anticipated and evidence is beginning to emerge that that the prolonged period of lockdown will result in increased demand for children's social services.

2.25 The Department is leading on the development of a cross-departmental plan that reflects the activities that will be or have been undertaken across government to meet the needs of vulnerable children, young people and their families during this time and to prepare for service recovery.

Secondary Care

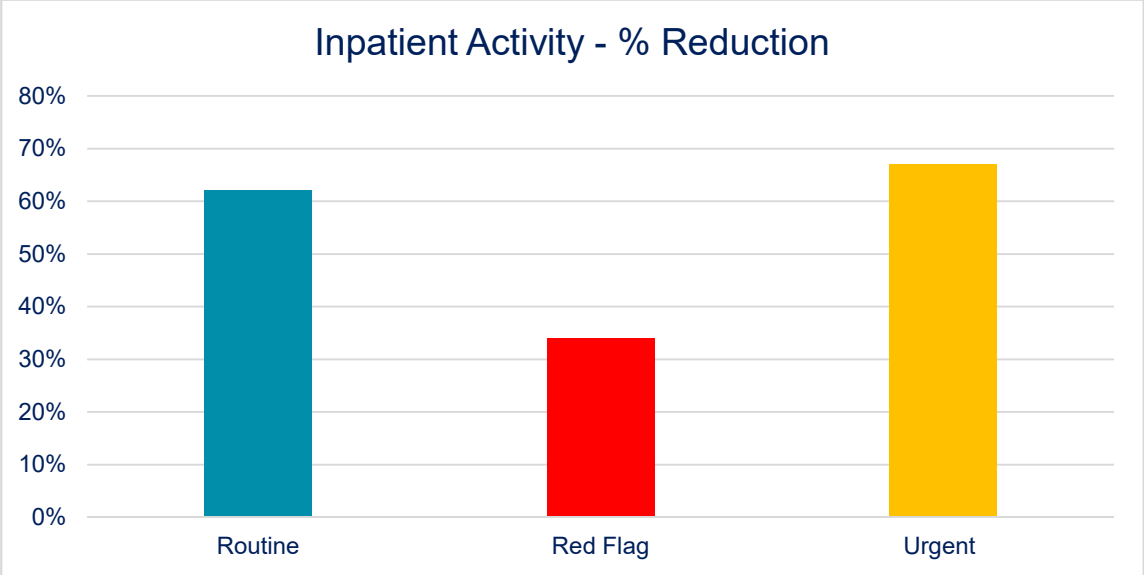
2.26 The pandemic has had a devastating short term impact on secondary care activity, particularly elective care. Figure 3 below shows the reduction in outpatient activity, compared to same 6 week period last year:

Figure 3: Reduction in Outpatient Activity 9 March – 13 April 2020



2.27 The situation is similar for inpatient activity, with severe reductions in activity compared to the same 6 week period last year:

Figure 4: Reduction in Inpatient Activity 9 March – 13 April 2020



2.28 The very significant downturn in secondary care activity has also, as expected, impacted on waiting lists (except for the urgent inpatient waiting list, which has reduced marginally compared to 1 April 2019). As of 1 April 2020, compared to 1 April 2019, waiting lists were impacted as follows:

- Routine inpatient waiting list grew by 5%.
- Urgent inpatient waiting list grew by 31%.
- Routine outpatient waiting list grew by 4%.
- Urgent inpatient waiting list reduced by 1%.

2.29 Projections by the Trusts suggests that the 6 weeks to June resulted in similar reductions in activity. This will further impact adversely on the waiting lists. Also, since the latest available comparable waiting list data is as of 1 April, waiting lists will already have increased in the intervening period.

2.30 Urgent and Emergency care has also been impacted with a 47% reduction in Emergency Department activity across Northern Ireland, compared to the same period in 2019 (9 March – 13 April).

Cancer Services

2.31 The down turn in red flag demand through April and into May means that all Trusts outside of Belfast currently report that all patients who are suitable to be listed for surgery have a scheduled date, either locally, or within the Independent Sector facilities secured by HSC. However, red flag demand is starting to increase again and this will result in an increase in the demand for surgery.

2.32 The development of the Nightingale Hospital on surgical and ICU capacity across the Belfast Trust has inevitably impacted on specialist surgical provision. The Belfast Trust has introduced measures to mitigate against this. The Belfast Trust recommenced specialist surgery w/c 25 May 2020 in Belfast City Hospital now that the Nightingale Hospital has been stood down.

Programmes and Projects

2.33 COVID-19 has curtailed a large range of projects and programmes across the Department, as staff have been redeployed to manage the pandemic. Of particular note is the impact on delivery of the priorities set out in the New Decade New Approach document. These are summarised below:

Table 1: NDNA Priorities

NDNA Priorities	Risk Rating – Anticipated delay in Delivery
Extend publicly funded IVF Cycles from 1 to 3	Amber
Develop Cancer Strategy by December 2020	Red
Improvements will be made in day case elective care by the end of 2020	Red
Improvements will be made in Urgent and Emergency care by the end of 2020	Red
Improvements will be made in stroke by the end of 2020	Red
Improvements will be made in breast assessment by the end of 2020	Red
Deliver reforms of health and social care as set out in Bengoa, Delivering Together and Power to People Reports	Amber
Mental Health Action Plan within 2 months.	Green[3]
Mental Health Strategy by December 2020.	Red
Successor strategy and action plan to the Strategic Direction for Alcohol and Drugs Phase 2?	Amber
An extra 900 Nursing and Midwifery undergraduate places over three years	Green
Introduce a new Action Plan on Waiting Times	Red
No one waiting over a year at 30 September 2019 for outpatient or inpatient assessment/treatment will still be on a waiting list by March 2021	Red
Build capacity in general practice through the ongoing rollout of Multi Disciplinary teams to cover a further 100,000 patients by March 2021.	Amber
The Executive will provide increased investment to fully implement service improvements for palliative and end of life care including enhancing the contribution of hospices; and to increase support for palliative perinatal care.	Red
The Executive will expand university provision at Magee in line with commitments made by the previous Executive, including through the establishment of a Graduate Entry Medical School.	Amber (from DoH perspective - cross cutting issue)

Key: Red: High Risk of Delay; Amber: Medium risk of delay; Green: On target for delivery.

[3] Mental Health action Plan published on 19 May 2020.

2.34 As well as recognising the impact of COVID-19 on these projects and programmes, it is also important to record that the Department's Budget 2020/21 outcome did not provide any additional funding to support the delivery of these priorities. Public expectations were raised considerably by the New Decade New Approach document, but the accompanying financial settlement did not provide the funding necessary to deliver these priorities.

2.35 The ability of the Department to re-engage and deliver on these projects will continue to be constrained against the backdrop of COVID-19 and in the absence of additional funding.

Population Health Impacts

2.36 The introduction of the lockdown regulations was essential in controlling the spread of COVID-19. However, they have impacted on the wider economic and social environment, with both long and short term impacts on population health. Emerging research indicates that population health is highly likely to be negatively affected by the wider impacts of COVID-19, with the greatest effects felt by the most disadvantaged. There is emerging evidence that many key health behavioural risk factors, such as consumption of alcohol, are likely to be worsening. In addition, public health surveillance has been disrupted and emerging evidence also suggests that the disease burden from conditions such as mental health is already rising. The development and management of long term mental health conditions is also likely to be negatively affected.

2.37 The Department commissioned an initial analysis of the wider impacts of COVID-19 and the associated regulations on population health outcomes. This has been supplemented with analysis at the UK level. This analysis considered economic factors; reduced access to public sector services; interrupted access to social/family networks, and reduced access to other goods and services. While there are both positive and negative impacts of the regulations on wider public health, overall the analysis suggests that the net effect of the measures (excluding direct COVID-19 related mortality and morbidity) is negative. There is comparatively little research into the longer-term health impacts of economic crises. However, it is widely observed that structural changes and/or deep economic downturns tend to have very strong impacts, mainly through deprivation, which can be very long lasting. The literature also points to long term impacts on chronic disease prevalence due to recessions.

2.38 It is therefore likely that any growth in life expectancy will stall and perhaps even flatten in the wake of COVID-19. In terms of the social determinants of health, there are likely to be negative impacts on poverty, employment, economic security, and potentially educational attainment. The impact on housing and

social capital is unclear at this stage. There are likely to be positive impacts on air quality and water quality, which will counterbalance some of these impacts.

2.39 There have also been changes emerging in terms of health related behaviours, such as smoking, alcohol consumption, physical activity and road safety. While these impacts differ for each behaviour, again the net effect is likely becoming increasingly negative the longer the restrictions remain in place. The biggest negative impacts on disease outcomes are likely to be in respect of mental wellbeing and the development and management of long-term mental health conditions.

2.40 The analysis also highlights that the wider impacts of COVID-19 are likely to increase health inequalities, with those who live in the most deprived communities most at risk.

3. MISSION

3.1 The impact of the pandemic across HSC services, programmes and projects has been devastating, as resources have rightly been focused on the required emergency response. COVID-19 will be with us for some time and will continue to constrain service delivery across the HSC sector. In that context, the following mission statement will apply as an overarching principle:

To incrementally increase HSC service capacity as quickly as possible across all programmes of care, within the prevailing COVID-19 conditions. The aim will be to maximise service activity within the context of managing the ongoing COVID-19 situation; embedding innovation and transformation; incorporating the Encompass programme; prioritising services; developing contingencies; and planning for the future all at the same time. Specific service activity targets will be developed for each programme of care.

3.2 The remainder of this document sets out a road map on how this mission will be achieved. Service innovations that have emerged in recent months are set out in Section 4. In addition to those innovations, the intention is to, where possible, incorporate 'quick wins' from the transformation programme that had been gathering pace until the pandemic emerged, with the purpose of increasing service capacity. It will also be important that the ongoing Encompass programme is at the heart of rebuilding services.

3.3 Section 5 sets out the overarching approach to developing service stabilisation plans, with the aim to maximise activity in the context of the constraints and issues that COVID-19 presents. This will lead to incremental service activity plans and targets being developed for each programme of care / specialty to be updated in three monthly cycles for the period June 2020 to March 2022. If possible, the planning cycles will be extended if the prevalence of COVID-19 in the community improves. Section 5 also includes information on the regional approaches taken to treating COVID-19 patients; guidance on prioritisation of surgery; and the Testing Strategy, amongst other things.

3.4 Section 7 presents some early example demonstrators indicating what service delivery might look like in the next three months. These demonstrate that services will only be able to be switched on slowly and incrementally. Given the huge amount of uncertainty around the continued spread of the pandemic, it is only considered feasible to take a 3 month planning horizon at this stage.

4. SERVICE INNOVATION

4.1 The emergency response across primary, community and secondary care services has resulted in innovative new practices that could potentially be mainstreamed as normal services are resumed. Innovation has emerged across all services and some examples of these innovations are described in this section.

4.2 Embedding recent innovations, along with transformation activities already underway, into service delivery will be an important strand in achieving the mission set out in Section 3 above.

Primary Care

COVID-19 Centres

4.3 Eleven Primary Care COVID-19 Centres have been established across Northern Ireland. Between 9 April and 6 May 2020, GP practices dealt with 23,441 COVID-19 related queries. A total of 3,702 patients who contacted their GP, or out of hours service, were triaged and referred to one of the COVID-19 Centres. 75% of these patients were provided with advice on self-management; 15% were referred to secondary care; and 10% were referred to other services.

4.4 The COVID-19 Centre model has been successful in separating Covid and non-Covid services, reducing the risk of infection and allowing GPs to protect and continue a range of ordinary primary care services such as vaccinations. The COVID-19 Centres have also proved highly effective in dealing with a high level of demand and in effectively triaging and advising patients. This has undoubtedly reduced pressures on our Emergency Departments.

4.5 In view of the potentially lengthy timescales before a vaccine is available, it is likely that COVID-19 Centres will continue to be needed in the short to medium term. However, some changes in configuration may be required in response to the emergent contours of the pandemic. Given the clear benefits of the approach, consideration will need to be given to what can be learned from the model and what elements ought to be retained to support longer term transformation of the HSC. In particular, the effectiveness of the primary care partnership with HSC Trusts and the benefits of greater joint working and resource sharing between primary and secondary care.

4.6 The model has also demonstrated the value of an independent, federated primary care sector. With strong leadership from the Health and Social Care Board (HSCB), the British Medical Association (BMA) and the Royal College of General Practitioners Northern Ireland (RCGPNI), GPs were able to move quickly to establish and operate the COVID-19 Centres. The first centre

opened within 12 calendar days of the first discussion of the potential for the model. This swiftness was made possible by active and committed leadership in the sector capable of bringing GPs with them.

4.7 The Department and HSCB will now consider the future use of COVID-19 Centres in discussion with BMA and RCGPNI.

Telemedicine / Video Consultations

4.8 The use of telephone triage and video consultations is now widely embedded within the primary care sector. All patients are now subject to telephone triage for around 5 minutes. Whilst exact figures are not available, it is clear that this triage addresses issues for a significant number of patients, thereby reducing numbers needing a more detailed consultation. This consequently reduced pressures on GP surgeries. The outcome has delivered a transformational impact and there are therefore clear benefits to continuing this operating model.

4.9 Video consultations, which were previously only carried out in very low numbers, are now also widely embedded within the service. Where a face-to-face appointment is not necessary, video consultations provide a more efficient model of GP to patient contact and the widespread use of technology should be incorporated into the service going forward. It is recognised that for some patients, face-to-face consultations remain the most appropriate model and will be retained in those cases. Looking ahead, there is also the potential to use this technology to work more closely with secondary care, for instance with video consultations between patients, GPs and hospital specialists.

4.10 The primary care sector will now consider the continued and expanded use of telephone and video technology in delivery of GP services. The sector will also consider ways to integrate more effectively with other sectors.

4.11 Face-to-face interpreting involving deaf service users also virtually stopped except in very exceptional cases. By way of mitigation, a new temporary free remote interpreting service for British Sign Language (BSL) and Irish Sign Language (ISL) users to access NHS111 and HSC services was procured. This was funded by the Department with support from the Department for Communities and ensures that deaf people can access vital information and support during the COVID-19 pandemic.

Multidisciplinary Teams (MDTs)

4.12 During the pandemic, MDTs including nursing, physiotherapy, mental health practitioners and social workers have emerged as an essential part of the primary care response, delivering essential support to vulnerable people at a

time of extreme need in the community. Anecdotally, GPs report that access to these workers has demonstrated significant benefits for the wellbeing of patients and for the effective delivery of primary care services in relevant practices.

4.13 In view of the substantial mental health challenges that are evident, there is a strong argument that MDTs could form part of the recovery effort in this regard, bringing mental health support to the community level, accessible directly through GPs. As COVID-19 Centres have demonstrated, when properly resourced, primary care can successfully reduce demand on secondary care services. Indeed, more broadly, there is clear potential in the MDT framework to improve access to patients for a range of services and to further reduce demand on secondary care. On this basis there is clear merit in exploring the role that MDTs and primary care could play in reshaping the system during the rebuilding phase.

4.14 The primary care sector will be asked to produce proposals for the role of MDTs in the future delivery of health services.

Allied Health Professional (AHP) Workforce

4.15 During the pandemic the value of skill mix and staff working at the top of their professional licence in advanced and extended roles has enabled primary and secondary care services to be responsive to the emerging complexity and volume of demand. There is clear potential to extend the role and scope of advanced nurse practitioners, specialist AHP's and consultant nurse and AHP roles to maximise the capability and flexibility of the workforce to aide rebuilding of services.

Pharmacy

Community Pharmacy Services

4.16 Community pharmacies adapted their working practices and many introduced technology to streamline prescription ordering and collection services and reduce waiting times for patients. A new emergency supply service was introduced which provided access to prescription medicines in the event that a patient had run out of their repeat medicine and they could not access their GP. Pre COVID-19, this would have been a key component of the GP Out of Hours Services workload. An enhanced on-call palliative care medicines service was also provided to support end of life care for patients at home and in care homes. To manage some of the demand on pharmacies for medicines deliveries, the HSCB worked with the Community Development Health Network to incorporate the use of volunteers to support deliveries of medicines from pharmacies. By

the end of May a total of 252 pharmacies and 120 community groups had registered for the scheme and over 33,000 prescriptions have been delivered by volunteers registered on the scheme.

Pharmacy Services in Trusts

4.17 Pharmacists and pharmacy teams in Trusts adapted their working practices and introduced new and innovative solutions to ensure that their patients received the right medicines, safely and effectively. This included a wide range of initiatives across all sectors, developed in collaboration with a wide range of stakeholders.

4.18 In Intensive Care, clinical pharmacists and clinical technicians joined their colleagues in critical care teams. Aseptic services in hospitals produced batch IV medicines to meet rising demand. Processes for the standardisation of critical medicines and a dedicated COVID-19 Kardex were introduced. Trusts skilled up their clinical pharmacy teams to provide seven day services. Pharmacists used technology to hold virtual clinics to maintain contact and support for patients taking specialist treatments including anticoagulants, ESA, chemotherapy and rheumatology. Renal transplant education for carers was provided for 42 transplant patients via Zoom. Specialist medicines home delivery systems, using Trust transport, were implemented to ensure that patients in high risk shielding groups received their treatment without interruption. Rapid sequence induction packs were introduced in ED and changes introduced to addiction services and to introduce in-possession medicines in prisons.

4.19 New regional systems were established to model and monitor critical healthcare supplies essential for the COVID-19 response including critical care medicines, oxygen and clinical consumables. Victoria Pharmaceuticals worked with the HSCB to supply medicines to COVID-19 and Out of Hours Centres. New systems were developed to monitor stock remotely and conduct stock checks in COVID-19 Centres and action cards and standard operating procedures for medicine management were established.

Pharmacy support for care homes

4.20 Pharmacy teams from the HSCB implemented a system to provide anticipatory care boxes to care homes for palliative care and to provide increased access to oxygen. Consultant pharmacist team members in Trusts joined with practice based pharmacists to participate in virtual ward rounds for care homes. Training sessions were provided by pharmacists to care homes staff on swallowing, pandemic packs and palliative care. Trust pharmacy teams supported the

establishment of the community hospitals at the Ramada and Everglades hotels.

Ophthalmology

4.21 Ophthalmology is a high volume specialty and one which is particularly susceptible to demographic pressures. As a specialty it currently accounts for 10% of all outpatient appointments, and, in elective care, cataract surgery is the highest volume surgical procedure in the developed world, and one which scores highly in terms of quality of life benefits. COVID-19 has given an opportunity for ophthalmology teams to take forward significant innovations such as:

- reviewing care pathways;
- reviewing referrals and patient notes;
- carrying out risk assessments and prioritisation in preparation for re-engagement of services;
- validating waiting lists, discharging where appropriate; and
- a move to virtual video and telephony consultations where possible.

4.22 Throughout this process ophthalmology has focused on its communications with patients, with many being contacted by telephone to discuss concerns and arrange appointments as required. Approximately 75% of urgent appointments were converted to telephone or video reviews. A video was produced to inform patients of safe practices in the Macular Unit to encourage attendance, as most patients are at increased risk due to age and diabetes. The short video clip, which has been shared on social media, reassures patients attending appointments about the measures put in place to best protect patients attending the unit.

4.23 The Belfast Trust Cataracts Team has maintained approximately 15% of cataract surgical activity through Lockdown, focused on patients most in need. This allowed the service the opportunity to test the cataract surgery pathway in the COVID-19 climate. The diabetic eye service has continued to provide treatment (laser and injection) appointments for the most urgent of patients at high risk of irreversible sight loss.

4.24 The Belfast Trust identified hundreds of review patients on glaucoma waiting lists who required only a check of their intraocular pressure. The Trust wanted to offer patients a way of getting their pressure checked without needing to attend the clinic. They developed the concept of a ‘drive thru’ where the patient gets a pressure check with the new ICare device whilst they remain in their car.

4.25 During the COVID surge, the Paediatric Eye Team ran all day clinics and accepted all paediatric eye emergencies from A&E. Across ophthalmology the

focus is now on incrementally rebuilding services taking account of the constraints arising from COVID-19 and ensuring that the new and innovative practices are permanently embedded.

Secondary Care

Use of Technology

4.26 The secondary care sector has, like primary care, now adopted use of technology such as telephone and virtual clinics to a much greater extent. This is the case across all of the Trusts and across a range of specialities. Within Belfast Trust, for example, Outpatients appointments have, where possible, moved to telephone appointments, consultations and essential communications. Before COVID-19 phone appointments accounted for 3% of new, and 2% of review, outpatient appointments. The comparable figures now stand at 36% and 46% respectively. Also within Belfast Trust the number of specialties using telephone clinics has increased from 25 to 55. In addition, a growing number of specialties are adopting virtual clinics using video conferencing. This approach to use of technology is replicated across the HSC Trusts.

4.27 Broadly the benefits of these technology models include reduced travel time and easier access to services for patients; less time spent in hospital for patients; and more flexible working and timetabling for staff. Technology should continue to play a significant role in the delivery of secondary care, where possible and appropriate. It will be important that clear criteria are adopted identifying which patients are suitable and the circumstances in which virtual or telephone clinics are appropriate.

4.28 Some of the early experiences of using technology suggests some issues such as withheld numbers or patients not answering. It will be important to collect data on these issues to ascertain if missed appointments are more prevalent using technology than face-to-face.

4.29 Trusts must now consider the continued use of technology in delivery of secondary care services, where appropriate.

Social Care

4.30 Many adult social care services have adopted new and innovative ways of working. For instance, care homes have made use of technology to connect residents with their families, through video-calls, and to enable 'virtual ward rounds' by GPs or other professionals with care homes residents. This has helped limit the physical footfall in and out of homes. The use of technology to monitor vital signs and residents' activities of daily living via a digital remote monitoring platform is being implemented by all Trusts. The identification of

residents requiring timely clinical assessment by a Registered Nurse or Doctor at an early stage is a key step in minimising the numbers of residents who clinically deteriorate in residential settings with presentations of COVID-19.

4.31 Many care homes have adopted innovative new ways of working, such as staff living in homes or creating separate changing areas as ways of trying to minimise the spread of infection. Homes have also been innovative in running activities for residents, while complying with social distancing rules.

Mental health

4.32 Mental health services have, like many other services areas, adapted to remote working, with extensive use of phone services and video communication. There are some indications that the use of remote working has improved efficiency of services, which may help reduce waiting lists post COVID-19. Further work is ongoing to evaluate this.

4.33 Other alternative methods have also been used. The HSC has partnered with ORCHA (The Organisation for the Review of Care and Health Apps) to create a library of health and wellbeing apps that have been reviewed and rated as helpful, safe and secure. As the library develops it will allow clinicians and wider professionals to "prescribe" and allocate apps to clients as appropriate.

4.34 Stress management support has also been provided using alternative channels, through Stress Control. This is a clinician-led service, available free of charge online through a collaboration across the UK nations and Ireland. It comprises of a six-session, cognitive-behavioural therapy class and is available free of charge. It runs over three weeks with two sessions a week. Work has also been escalated to develop and make psychological first aid available across Northern Ireland. The HSC has, in collaboration with the Red Cross and NHS Education Scotland, made available interim guidelines and a short E-Learning module on Psychological First Aid.

4.35 Subject to funding, Multidisciplinary Teams (MDTs) could enhance their focus on delivering mental health services to help meet the need emerging in the post lockdown period. MDTs provide direct, swift access to community services and could, if properly resourced, provide early access through general practice to mental health support and other related services. This could take the form of increased recruitment of mental health workers and social workers; better connections with community services; social prescribing; and developing shared services with secondary care; for example, Talking Therapies Hubs. Such an approach would both provide direct access to mental health services to meet the anticipated surge and would divert demand away from more specialist secondary services for those with more acute mental health issues.

4.36 As part of the COVID-19 Mental Health Response Plan published on 19 May 2020, review mechanisms will ensure that learning from alternative ways of working will be incorporated in service developments moving forward.

5. INCREMENTAL SERVICE CAPACITY PLANS

Overarching Approach

5.1 All HSC service providers will adopt a systematic and consistent approach to developing service specific incremental plans to increase capacity, under the auspices of this Strategic Framework. This will involve mandating the wide range of existing managerial clinical networks, project boards, task and finish groups or other service improvement vehicles to produce service specific incremental plans for their respective areas on an integrated and coordinated regional basis.

5.2 This will be achieved by reviewing the existing patient pathways, applying a range of COVID-19 factors (as summarised in the Checklist below) and producing revised patient pathways to implement rebuilding of services within the context of prevailing COVID-19 conditions.

5.3 The revised pathways will address the checklist considerations set out below and will produce revised activity levels for service providers to aim to deliver. The initial set of activity levels will cover the 3 months from July to September 2020. It is not considered feasible, at this stage, to produce plans beyond a three month planning period.

Checklist

5.4 A range of factors are likely to apply in the consideration of revising pathways and activity levels in the context of COVID-19. These are likely to include all, or some, of the issues set out below. Service providers must take account of all items that are applicable:

Communication with Patients

- Provide clear and consistent information to patients, clients and their carers, in an appropriate format, to reassure them that services are of the highest possible quality and they can re-engage with health and social care with confidence.

Staff Involvement

- Ensure you have a consistent approach to meaningful involvement of staff in developing solutions and in decisions which affect their working lives.

Working Environment Risk Assessment

- Ensure that you have an up-to-date risk assessment of the holistic working environment (reflecting the interdependencies between different services) in

which you will be seeing patients, clients and individuals who accompany them. You must ensure that the risk assessment addresses the risk of COVID-19 to reduce risk to the lowest practicable level by taking preventative measures, in order of priority, recognising that you cannot completely eliminate the risk of COVID-19.

- If feasible and appropriate, share the risk assessment with your workforce and the public by placing this on your website.

Infection Prevention and Control Measures

- Assess the need and provide appropriate Personal Protective Equipment (PPE) for HSC staff, by following PHA guidance, required for screening, diagnostics, treatment and social care in all HSC settings.

- Assess the need and provide appropriate Personal Protective Equipment (PPE) for specific patient groups or individuals on a risk-assessed basis within the context of regional and national guidance on PPE and taking into account the regional electronic PPE Modelling system.

Social Distancing

- Adhere to the extant social distancing requirements within all screening, diagnostic and treatment/care settings across primary, community secondary and social care sectors.

- Assess the impact of constraints on physical space for service delivery, for both patients and staff, arising from social distancing requirements.

- Assess the requirement for patients to be accompanied, taking account of the procedure or service being accessed and the individual needs of the patient and put in place protocols for safe practice.

Workforce

- In line with the Workforce Strategy, protect and support the HSC workforce by taking action to ensure the care and resilience of staff working in all HSC disciplines.

- Induction and training should be provided for staff members whose working environment has changed or who are redeployed to areas outside their normal practice.

Planning Service Delivery

- Where possible an appraisal of patient waiting lists should be undertaken to re-evaluate clinical urgency, with those with the highest clinical need appointed as a priority. This should be taken forward on a regional basis as appropriate. Patients should be updated on the rationale for any delays to their appointment in an appropriate format and signposted to support/information in the interim.

- In the planning of screening, diagnostic and treatment/care service delivery in all settings across primary, community secondary and social care sectors, assess the risk of reduction in activity throughput arising from requirements for social distancing and PPE.

- In the planning of appointments in all settings take account of the requirements for social distancing in HSC premises and public transport.

- Assess the available capacity and timescales for the reintroduction of aerosol generating procedures (such as with minimally invasive surgical techniques) and the impact on theatre schedules, length of stay and waiting times; and, align these factors with PPE requirements.

- Planning for rebuilding HSC services should take account of the potential for a further significant COVID-19 surge during autumn/winter which, if it materialises, would impact adversely on rebuilding HSC services.

Diagnostic Services

- Take account of the impact of the additional demand for COVID-19 testing in Labs and its potential impact on the capacity for diagnostic testing for non-COVID-19 service delivery when planning scheduled elective treatment, primary and community care service delivery.

- Recognise that COVID-19 testing capacity is managed as a regional resource.

Medicines and Critical Healthcare Supplies

- Take account of constraints on the supply of critical care medicines in the UK that have the potential to impact on plans for recovery in elective surgery and other treatment interventions.

- Take account of how the public will maintain access to prescription medicines, treatments for common conditions and the advice of pharmacists through community pharmacies.

- Consider how the public will maintain access to specialist pharmacy services, medicines and treatments e.g. palliative care.

Pre-admission to Hospital

- In planning elective treatment for patients who are being admitted to hospital, take account of advice to require patients to self-isolate beforehand and that they may need to be tested for COVID-19 prior to surgery.

- The timescales will be informed by national guidance (which is not a strict requirement but guidance for clinicians). Recognising that this is an evolving environment, service providers should take account of the latest guidance, advice and protocols on testing and isolation. Please note decisions should be taken on the prevailing balance of risk for the patient.

New Ways of Working

- Identify opportunities to embed, build upon and sustain innovations in service delivery achieved during the initial COVID-19 surge, including digital innovation and skills mix in order to increase resilience.

- Ensure the principles of co-production are embedded in the rebuilding of HSC services going forward, along with the monitoring of activity and outcomes for our service user and patients.

Expert Advice

- Take account of advice from subject cells or expert groups which provide ethical, modelling, testing, PPE and social distancing policies, assessments and guidance.

Ethical Advice and Support Framework

- Guidance will be available to assist clinicians and managers in their decision making.

Discharge to Nursing or Residential Setting

- Take account of COVID-19: Guidance for Nursing and Residential Care Homes in Northern Ireland (April 2020) with reference to discharge, testing and isolation.

Testing Strategy

5.5 On 27 May 2020 the Department published its contact Tracing Strategy[4]. This Strategy aims to minimize COVID-19 transmission in the community, thereby saving lives.

5.6 The Department is also developing a Testing Strategy, which aims to reduce harm to individuals from COVID-19 and to support measures needed to protect the general population. Delivery of the Strategy is underpinned by an Interim Protocol on Testing, this is an operational tool which sets out the priority groups for testing. The protocol is subject to regular review by the Department's Expert Advisory Group on Testing and each update is cascaded to HSCB, PHA and Trusts. Service providers should deliver services taking account of testing priorities established in the Interim Protocol. The Protocol will continue to be reviewed on an ongoing basis and will be adjusted over time as additional testing capacity becomes available and as priorities for testing change as the pandemic evolves.

Co-production

5.7 It will be important that the incremental service rebuilding plans are developed through the application of co-production principles as far as that is possible. The speed at which these plans will need to be developed and adapted will undoubtedly act as a constraint on applying full co-production principles. However, where at all possible, service providers should engage in a timely manner as widely as possible in the development of their incremental service plans.

[4] https://www.health-ni.gov.uk/sites/default/files/publications/health/Test-Trace-Protect-Support-Strategy.pdf

6. IMMEDIATE PRIORITIES

6.1 It is recognised that developing the incremental service plans will take some months. However, there is a need for immediate action in terms of increasing normal HSC service delivery. HSC Trusts have already commenced, where possible and safe in the COVID-19 context, the scaling up of services. HSC Trusts have produced and published plans for scaling up services in the period to 30 June to ensure action is taken in parallel with development of the incremental service plans. In developing the short terms plans, Trusts had regard to the above Checklist.

6.2 Further service rebuilding plans will then be produced covering successive three month periods from July 2020 to March 2022. These three month planning cycles will be kept under review and may be extended if the prevalence of COVID-19 in the community improves.

HSC Trusts Rebuilding Plans

6.3 The initial phases of COVID-19 significantly changed the level of service that Health and Social Care Trusts ("Trusts") were able to provide, both in order to prepare for the predicted demands of the pandemic, and in order to adapt to the new ways of working necessary to sustain services. As a first stage in developing the new Strategic Framework for Rebuilding HSC Services, Trusts have produced plans setting out how they intend to increase the level of service provision for the period to 30th June while also maintaining key elements of the COVID-19 response.

6.4 In developing their plans, HSC Trusts have adopted the following three principles:

- Ensure equity of access for the treatment of patients across Northern Ireland.
- Minimise the transmission of COVID-19.
- Protect access to the most urgent services for our population.

6.5 While there is some unavoidable variation of approach depending on local circumstances, Trusts have worked together to ensure that they take a consistent approach to rebuilding services. For all Trusts, the overriding priority is to keep patients, service users, and staff safe at all times while incrementally increasing activity.

6.6 During the first surge period, Trusts took steps to prioritise urgent or time critical activity in terms of both surgery and other cancer treatments, and other urgent conditions. As we move into the rebuilding phase, Trusts will continue to see and treat patients according to clinical need and services will be prioritised on this basis.

6.7 Similarly, in relation to daycase and diagnostics, including endoscopy, Trusts have prioritised inpatient, urgent and red flag investigations across all sites. Patients falling into these categories will continue to be the priority, but all Trusts are also increasing scheduled routine activity for daycase and diagnostics, albeit with reduced capacity due to infection control constraints.

6.8 All Trusts have maintained full access to urgent and emergency care services throughout the pandemic. Some of the short term service models introduced to allow Trust to do so will need to remain in place to allow Trusts to deal effectively with COVID and non-COVID activity. Further details can be found in individual Trust plans.

6.9 Across Trusts, some of the services that have been hardest hit have been those dealing with mental health, learning disability, and long term condition management for children and adults. Each organisation is therefore taking steps to increase provision or introduce new ways of working to allow these services to recommence. Trusts are also prioritising services relating to Looked After Children and Child Protection visits. In all cases, it is likely that continuing to deal with COVID-19 will continue to impact negatively on overall capacity.

6.10 In all Trust areas, staff have adopted and embraced new ways of working that have allowed them to maintain more of their professional and service roles with their patients and service users. In many cases, these changes have been technology enabled and have reduced the need for face to face contact while delivering safe and effective outcomes. The learning and sharing of best practice from these initiatives will help the service to maintain and increase activity in the coming months and years.

6.11 Further detail on the Trusts priorities to resume services in the immediate term is set out in their respective plans, published concurrently with this Strategic Framework.

Planning for a further potential COVID-19 Surge

6.12 Early in the preparations for the initial surge period, it was necessary to make assumptions about the percentage of hospitalised patients in different age bands who would be admitted to critical care. At this stage the best available modelling showed a significant increase in demand for hospital capacity and, potentially, a catastrophic impact on critical care. Acute service planning therefore focused on the rapid expansion of critical care and hospital capacity to ensure that every patient requiring treatment would receive it.

6.13 During the course of the epidemic clinical practice in relation to COVID patients has evolved and additional data have accumulated. It has become apparent that a smaller percentage of hospital patients are admitted to critical care, particularly in older age groups, than was originally assumed. Based on the

experience of Wave 1 it will be possible to refine the modelling to account for this in the event of any further waves.

6.14 Outside the hospitals, while there was a focus on planning for the impact of COVID-19 in care homes from the early stages of the pandemic, protecting care homes has been a significant challenge for the system as a whole. While significant support has been provided to care homes, this is clearly an area that will continue to be a priority for further waves and where we will need to redouble our efforts.

6.15 It is expected that there will be a second wave of Covid-19 later in the year. At this stage, the timing and scale of a 2nd wave is unpredictable as it will depend on a range of factors, including the future approach to social distancing and population adherence to these measures.

6.16 However, given that a 2nd wave could potentially coincide with colder weather and winter pressures, it will be important that there are detailed surge plans in place for critical care, hospital beds and care homes. The Department is currently carrying out detailed work to model the possible capacity requirements in these areas in range of scenarios.

6.17 In planning for a second wave, there will also be significant focus on the system maintaining higher levels of non-COVID services while ensuring that there is sufficient capacity to treat every COVID patient appropriately.

Managing planned Non-Covid-19 services in hospital settings during COVID-19

6.18 The HSC has made enormous efforts to create additional surge capacity for the first wave of COVID-19 patients. As a result of these efforts, every patient requiring treatment for confirmed COVID-19 has been able to receive it.

6.19 However, the challenge that our health and care services now face, as we move into this phase of response to the pandemic, is how to maintain the capacity to provide care for patients with COVID-19, while simultaneously increasing other urgent clinical services, important routine diagnostics and planned surgery.

6.20 As we increase the amount of planned activity in hospitals over time, we will adopt the following principles:

- The HSC will immediately start to step up services on a prioritised basis while maintaining the necessary level of care for COVID-19 patients;
- Patients across Northern Ireland should have equitable access to specialist services according to their clinical need;

- In order to minimise the risk of infection, COVID-19 patients and staff providing care to them should be separated from non-COVID patients and staff where possible;
- The volume of planned activity to be delivered will align with other dependencies such as testing capacity, medicines supply, and PPE.
- The HSC will need to retain the capacity to quickly repurpose and 'surge' capacity if required.

6.21 As we increase the amount of planned activity, one of the key objectives must be to minimise the transmission of COVID-19 infection within hospitals, also referred to as hospital-onset infection or nosocomial transmission.

6.22 All Trusts have taken steps to put in place effective safe zoning plans in order to maintain safety of patients and staff on sites where elective care is delivered alongside urgent and emergency care. Where possible, we will also consider the possibility of physical separation of staff and patients delivering planned care from those dealing with unscheduled care.

6.23 Prior to the pandemic, the Department had been progressing the development of a regional network of elective care centres. The essence of these centres was to organise specialised procedures on a smaller number of hospital sites, completely separated from urgent and emergency care. The main benefits of this approach were considered to be: staffing resilience; productivity; standardisation of care; reliability and efficiency; and, better patient experience and equity of access.

6.24 Many of these factors are equally, or even more, important in the context of the ongoing pandemic. Furthermore, if there is a second wave of COVID-19 cases, the creation of dedicated elective care centres would facilitate the continuation of some planned activity even in the face of increasing demand for COVID-19 treatment. Through the first wave of COVID-19, the HSC has also used independent sector facilities to increase capacity to maintain the most urgent planned care. The Department is now considering how best to utilise the independent sector facilities in rebuilding health service capacity.

Prioritisation / Delivery of Health Services

6.25 It will continue to be important that hospital services are prioritised to ensure that treatments that have the highest impact on reducing mortality and morbidity are prioritised. The overriding principles that will continue to apply are that patient safety is paramount and that equity of service across Northern Ireland must be ensured as far as possible. The development of service plans on a regional basis will encourage equity of provision across Northern Ireland.

6.26 Clinical teams are skilled at making complex decisions about patient prioritisation on a daily basis, in the context that they find themselves in.

COVID-19 will continue to impose significant constraints and clinical decision making will therefore need to adapt to circumstances as they change. In taking decisions, clinical teams should have due regard to the NHS England / Royal College of Surgeons specialty guide[5]. In addition, the Royal College of Surgeons has recently published two COVID-19 toolkits: *'Safety considerations and risk assessment for patients and surgical teams'*[6] and *'Checklist for restarting elective surgical services'*[7]. Clinical teams should also consider these toolkits in their decision making.

6.27 Likewise the Royal College of Paediatrics and Child Health (RCPCH) has published guidance in respect of the reconfiguration and delivery of children's health services in the context of COVID-19: '*Reset, Restore, Recover - RCPCH principles for recovery*'[8]. Paediatric clinical teams should consider the principles set out in the RCPCH guidance.

6.28 Clinical teams should consider further guidance from professional bodies as it becomes available.

Cancer Services

6.29 COVID-19 has had a severe impact on a range of key cancer services. While emergency and urgent cancer services have continued throughout the surge, unfortunately, and out of necessity to reduce the risk of infection to both patients and staff, many procedures and diagnostic appointments have had to be postponed or delayed. These decisions are not taken lightly and will undoubtedly have an impact on waiting times for cancer treatment which are likely to persist for many months.

6.30 As part of the response to COVID-19 many patients' treatments plans have been modified to reduce the need for hospital visits and as a consequence the risk of infection; examples include measures such as the provision of hormone therapy or radiotherapy as an alternative to surgery, and the use of alternative drug regimens. When a decision is taken to delay diagnostics or modify treatment it is done so according to strictly observed and regionally agreed NICaN guidelines and on the basis of an individual assessment of risk / benefit. Trusts have put in place safety netting processes to ensure that any patients who has had a treatment paused or delayed resumes treatment on the appropriate pathway as soon as it is safe and possible to do so. Cancer waiting

[5] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf
[6] file:///C:/Users/1375921/Downloads/Recovery%20Toolkit%20Tool%201%20%20Checklist%20for%20restarting%20elective%20surgery.pdf
[7] https://www.rcseng.ac.uk/coronavirus/recovery-of-surgical-services/tool-2/
[8] https://www.rcpch.ac.uk/resources/reset-restore-recover-rcpch-principles-recovery

times guidance has been updated to reflect any changes to treatment pathways.

6.31 Work has now started to implement the reset of the full range of cancer services whilst taking into account the need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC. This work will be taken forward by the COVID-19 Regional Cancer Reset Cell. As part of our rebuilding programme, all patients across Northern Ireland will be prioritised in the same way and Trusts will be expected to work together in order to offer the earliest available appointment to a patient requiring diagnostics or surgery.

6.32 The Department recognises that the need to increase access to cancer services whilst minimising the transmission of COVID-19 infection within hospitals will require careful planning and organisation of services. Critical to this will be communication with the public and NICaN will continue to work with Trusts and third sector partners to ensure the provision of timely patient information.

General Dentistry / Ophthalmic / Other Allied Profession Services

6.33 The Department and the HSCB will work with the British Dental Association and Optometry NI to rebuild the services provided by General Dental Practitioners and General Ophthalmic Practices guided by the available medical and scientific guidance.

6.34 Likewise the Department and the HSCB will work with relevant professional bodies in respect of other Allied Health Professions such as physiotherapists, chiropodists etc. to rebuild services guided by the available medical and scientific guidance.

Adult social care

6.35 Across adult social care services there will be an important balance to be struck between protecting those who may be particularly vulnerable from COVID-19 and recognising the impacts this could have on their general health and wellbeing. The large majority of care homes have not had a COVID-19 outbreak and a key priority will be ensuring that this remains the case while considering how steps can be taken to facilitate engagement with families. Services such as respite and day care will need to operate differently than usual to manage infection control risks. Across adult social care there will need to be a separation of into groups of service users to try to minimise infection control risks, ongoing use of PPE and other mechanisms to minimise risks. This will include Trusts continuing to support unpaid carers, providing PPE when needed, and ensuring they have the support they need to continue providing

care. Sector specific guidance will be issued providing more details on the approaches to be adopted.

Children's Services

6.36 Regulations which provided flexibility in relation to the provision of services to looked after children during the pandemic came into operation on 7 May and, subject to flexibility continuing to be required, will expire on 7 November 2020. In addition, procedural changes have been implemented in children's services to take account of public health measures put in place to prevent the spread of infection. In some cases, this has promoted innovative service responses. A COVID-19 Childcare Support Scheme has been established to meet the childcare needs of key workers and to sustain large parts of the childcare sector forced to close as a result of reduced demand for childcare. Rebuilding planning is underway, which will align with the Executive's 5-stage plan and will be guided by up-to-date medical and scientific evidence.

Mental Health

6.37 Work is ongoing to consider both the safest and most effective ways to deliver services, building on emerging innovative approaches. In particular, consideration is being given to how to meet the challenge of the likely increase in demand for mental health services, linked to COVID-19 and recognising that very significant capacity challenges were faced by mental health services before the onset of COVID-19.

Workforce

6.38 The HSC workforce has been under significant strain during the pandemic and it will be necessary to consider the implications for staff with mental health issues, ensuring appropriate support.

6.39 It will also be important that proper induction and training is provided for staff members who are redeployed to areas outside their normal practice or working environment. Equally employers must ensure that proper risk assessments are carried out for all staff. This will include application of social distancing, to help avoid contact with COVID-19 wherever possible, and to manage that contact safely when there is no alternative. This should include particular risk factors for staff who are shielding; Black, Asian or Minority Ethnic; pregnant etc., and proper training for managers.

6.40 Early consideration must also be given to utilising learning from the COVID-19 response in relation to recruitment, resourcing and job banding. This will include a critical look at, and changes to be recommended in respect of, speeding up recruitment as well as proposals to develop a "reserve" of appropriately-qualified staff who can be called on in an emergency scenario.

Childcare and 7-day working patterns will also be considered. It will also be important to consider incorporating existing work on safe staffing, and agency and locum reduction within the rebuilding services agenda. It will also be important to provide clarity on means and timing of re-establishing pre-registration training and education.

6.41 Employers should engage with trade union representatives in a timely manner on all workforce issues.

Encompass Programme

6.42 The Encompass programme is the flagship digital investment that replaces ICT systems that are urgently end-of-life; supports regional reform initiatives; enables patient safety, quality and efficiency requirements; and supports the service in addressing rising demand within constrained resources.

6.43 Encompass working with Epic alongside frontline staff, operational management, and patients and carers, will implement a single Digital Care Record for every citizen, including a fully integrated patient portal. This will enable services to consolidate standardised digital workflows and revised patient pathways, naturally building on the integrated and coordinated regional basis for developing service incremental plans.

6.44 Encompass gives us the opportunity to develop the 'digital front door' to the HSC in terms of access, triage, support for self-care and even treatment; the urgency of which has been underlined by COVID-19. For example, using the Epic platform, NYU Langone Health[9] expanded video visits on March 2019 to all of its ambulatory care settings, reaching more than 7,000 visits within 10 days and representing more than 70 percent of total ambulatory care volume during this time.

Finance

6.45 The Department's budgetary position continues to be hugely challenging, with the Department facing a funding shortfall in respect of forecast inescapable pressures necessary to maintain existing services. Effectively, this means making difficult choices in the prioritisation of available limited resources to ensure we maintain safe services and achieve the best outcomes for citizens.

6.46 There are ever increasing demands on funding across a range of services. In addition, there are also delivery risks associated with the opportunity to lead on and make progress on significant savings targets across the HSC system in 2020/21. Inescapable cost pressures also exist across the Health Transformation programme. There have been significant additional funding requirements in our response to the unprecedented challenges of COVID-19;

[9] NYU Langone Medical centre is an academic medical centre located in New York, affiliated with New York University. The Medical Centre comprises the NYU School of Medicine and several hospitals.

the Department has secured additional funding from the Executive to respond to COVID-19 and continues to liaise with the Department of Finance to secure further required funding. Rebuilding health and social care services, whilst simultaneously dealing with the ongoing COVID-19 pandemic will likely require additional resource funding. The incremental service plans will identify further funding requirements.

Capital Investment

6.47 From a capital investment perspective, the COVID-19 outbreak has seen a delay to many of our projects that were under construction, whilst others have been fast-tracked and repurposed to assist with the response.

6.48 With construction workers increasingly returning to sites, it is clear that the timescales for ongoing projects will be extended, not just because of the inherent delay but because the need for social distancing will reduce the number of people who can safely work on sites at one time. The impact of this will only become clear once work recommences and timeframes can be reassessed in the light of experience of working with these adjustments.

6.49 Similarly, plans for new developments have been delayed whilst staff across the HSC have been focusing efforts on the immediate needs of the pandemic. This work will now need to be reinvigorated and clear priorities set to ensure that our efforts are collectively applied to move key projects forward. This will enable us to make the best use of the capital funding we have in 2020/21 and to bring forward plans for 2021/22 and beyond so that we are ready to maximise the use of future allocations. The incremental plans will identify any further capital investment requirements.

HSC Governance

6.50 Given the unprecedented challenges posed by COVID-19 and in order to achieve the mission set out in Section 3, a number of changes to the governance framework will also be implemented. The Department, through temporary amendments to the Framework Document, and the establishment of a new management board, will give clear direction to the Health and Social Care Board (HSCB), Public Health Agency (PHA), Health and Social Care Trusts and the Business Services Organisation (BSO) to reflect the Minister's priorities. These revised governance arrangements are intended to be in place over the next two years to facilitate rapid decision making in rebuilding HSC services.

6.51 The rebuilding of services will take some time and will require a response that is both agile and adaptable to ensure the system can respond to further surges of COVID-19, whilst optimising its ability to stabilise and move forward. The HSC system will continue to be significantly constrained in the delivery of services due to the ongoing prevalence of COVID-19. In this context the

analysis of performance levels against pre-COVID-19 indicators and targets would be not be an appropriate basis for performance monitoring and management in the current environment.

6.52 The performance targets will therefore need to be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22.

7. EXAMPLE PATHWAYS

Introduction

7.1 This section provides illustrative examples to show how the delivery of a number of key services may be impacted over the next three months. Each example describes the previous pathway, the new constraints and opportunities that need to be considered by service providers, the possible revised pathway and the anticipated activity in the three months period from July to September 2020.

Urology Red Flag Pathway

Previous Pathway

7.2 Red Flag referrals were previously triaged by a consultant and at time of triage the consultant would indicate what diagnostics would be required for the patient's visit. This clinical work up could involve a range of diagnostics including bloods, urinalysis, flexible cystoscopy, biopsy and ultrasound. The patient was then added to an outpatient waiting list where the wait for an appointment depended on the clinical priority of the patient.

7.3 At the start of the clinic, the clinical team would meet and discuss the treatment plan for each patient. The nursing staff would then see the patient and undertake the relevant diagnostic tests. The Consultant/Registrar would then see the patient, discuss the findings of the diagnostic test and discuss the treatment options and next steps. Often this would result in patients being added to waiting lists for treatment or sent for further diagnostic tests. Again this would result in a lengthy wait for the patient.

Key Constraints & Opportunities

7.4 The key constraints pertaining to the well-publicised risks associated with the COVID-19 pandemic and availability of capacity in all aspects of the pathway ultimately resulted in long waits and delayed diagnosis.

7.5 The availability of new technology, the willingness to embrace this technology and the challenges presented by the COVID-19 pandemic have provided the key opportunities to change the clinical pathway. The clinical team had already started adopting the virtual triage model and the embedding of this new pathway was reinforced further once traditional face-to-face clinics ceased due to COVID-19. The pandemic has also provided the opportunity for cross Trust working which is helping equalise waiting lists.

The Revised Pathway

7.6 The new pathways were implemented in line with guidelines agreed and provided by the British Association of Urological Surgeons (BAUS). All new red flag referrals are reviewed via electronic triage by one consultant, with back-up during times of leave. The non-red flags referrals are triaged by other consultants within the team.

7.7 The outcome from this triage can result in the patient being sent direct to test or managed virtually using a telephone clinic slot. Where it is deemed that a patient needs further diagnostic tests, new pathways have been established to allow safe and accessible treatment.

7.8 *Cross Trust Working*- Working across Trust boundaries has continued to expand with teams working collegially to help reduce patient waiting times. Southern Trust patients are now being sent to the South Eastern Trust (SET) for their Transperineal (TP) biopsy, under anaesthetic. This work has been able to proceed as the SET TP machine has been set up in a separate clean unit which has allow elective procedures to continue in a COVID-19 free environment.

7.9 *Cross site Working*- The new pathways have been developed in response to the challenges presented by staff being redeployed to support ICUs and the risk of COVID-19 infection on the Craigavon site. Flexible Cystoscopies are now being undertaken in Daisy Hill Hospital following the closure of the day surgery units in Craigavon and South Tyrone.

7.10 *Results reporting* - Where possible, the consultant will now telephone the patient with their cancer results and this will be followed by a clinic letter. This new pathway helps reduce the waiting times for cancer results, avoid unnecessary outpatient attendances and reduce the risk of infection.

Anticipated Activity: 3 months to 30 September 2020

7.11 It is anticipated that the 'new' pathway will continue for the next number of months due to the need for social-distancing and reduction of face to face. This will have an impact on the waiting times of those patients who are not deemed as an urgent patient. It is planned that as staff become available to reopen day surgery facilities then more flexible cystoscopies can be carried out for those patients deemed 'less' urgent, and it is hoped that the SET will continue to facilitate the TP biopsies.

Introduction of Faecal Immunochemical Testing (FIT) for Suspected Bowel Cancer Outpatient & Colonoscopy Referral Triage

Previous Pathway

7.12 Patients with suspect bowel cancer 'red flag' symptoms are referred into Secondary Care from Primary Care according to the Northern Ireland Referral Guidance for Suspected Cancer (https://nican.hscni.net/wp-content/uploads/2019/11/NICaN-GP-Referral-Guidance-2019.pdf). Following consultant triage, patients would either attend outpatients or, if appropriate, be referred direct to test. NICE guidance states that colonoscopy is considered to be the gold standard for diagnosing colorectal cancer. CT colonography (CTC) can be offered as an alternative for people with comorbidities that make colonoscopy unsuitable.

Constraints and Opportunities

7.13 In response to the COVID-19 pandemic the British Society of Gastroenterology (BSG) developed guidance on 'GI Endoscopy Activity and COVID-19: Next steps – Updated 3 April 2020'[10] which advised stopping all non-emergency, non-essential endoscopy immediately. In addition, the majority of patients referred as a suspected cancer referral during COVID-19 are assessed virtually/by telephone.

7.14 Within NI there were already patients waiting for an outpatient appointment or for an endoscopy procedure / CTC having been referred by their GP for suspected bowel cancer. Given the constraints on endoscopy related to the response to the COVID-19 pandemic, there are grave concerns of long waits and delayed diagnosis of cancer.

7.15 Most outpatient red flags/urgent referrals will not have cancer. The current NICE guidelines are based on a Positive Predictive Value threshold of 3% for symptoms being caused by cancer. Following the guidance on stopping non-emergency colonoscopy during the COVID-19 pandemic, the British Society of Gastrointestinal and Abdominal Radiology (BSGAR)[11] produced guidance for patients requiring investigation for possible colorectal cancer. They suggest that under a 2 week wait referral pathway, patients should be risk-stratified using symptoms and faecal immunochemical (FIT) testing.

7.16 FIT tests are designed to detect small amounts of blood in stool samples using antibodies specific to human haemoglobin. They have been developed as an

[10] https://www.bsg.org.uk/COVID-19-advice/gi-endoscopy-activity-and-COVID-19-next-steps/
[11] https://www.bsgar.org/society/COVID-19-and-bsgar-updates-1/

alternative to guaiac-based FOB tests, but as the faecal immunochemical tests are designed to specifically detect human haemoglobin, they may give more accurate test results than guaiac-based tests.

7.17 FIT testing was to be introduced for the Bowel Cancer Screening Programme in the first quarter of 2020. The availability of this test and the willingness of the NICaN Colorectal Clinical Reference Group provided the key opportunities to determine a regionally agreed process for the use of FIT to support the risk stratification of patients in Secondary Care during the response to COVID.

Revised Pathway

7.18 Patients waiting for colonoscopy / CTC or red flag / urgent referrals are identified by Secondary Care and sent a FIT testing kit for completion. The kit is returned via Primary Care and transferred to a central lab for processing. The Consultant will review the chart and the patients FIT results, which will allow risk stratification according to different regionally agreed categories. If the FIT <10, the referring Consultant will review the chart and if patient not anaemic consider discharge, with advice to return to their GP if persistent symptoms. If FIT>10, the patients remain on the waiting list but prioritised in order of highest FIT to lowest and imaged as per available resource.

Anticipated Activity: 3 Months to 30 September 2020

7.19 Funding is currently in place to support the use of FIT testing to allow risk stratification of urgent and suspect cancer patients until the end of June 2020. A proposal is being developed which subject to funding availability, will allow for that process to continue for the remainder of the financial year. NI is the first region in UK to use this technology in such an innovative way which offers the potential to make best use of reduced endoscopy capacity.

7.20 A phased restoration of cancer screening programmes will commence as quickly and safely as possible. It is obviously important that this is aligned to and is consistent with restoration of capacity and addressing any backlogs in the parts of the cancer screening pathways which sit in primary care (cervical screening ‘smear’ taking) and secondary care (breast assessment and breast cancer treatment services, bowel colonoscopy and bowel cancer treatment services and cervical colposcopy and cervical cancer treatment services).

Breast and Cervical Cancer Screening

Previous Pathways

7.21 Cancer screening programmes play a key role in the early detection of disease.

7.22 The NI breast screening programme calls women aged 50-70 who do not have symptoms for a mammography scan every three years. Where necessary (in around one in four cases) they are recalled for a screening assessment. Around 4% of those recalled for assessment will receive a cancer diagnosis and be placed on a treatment pathway. Breast screening mammography and assessment clinics are currently provided across four Trust sites: Altnagelvin, Antrim, Craigavon and Linenhall Street, Belfast. Women in a higher risk group from across the region are screened at the higher risk screening unit in Antrim Area Hospital.

7.23 Cervical Screening aims to prevent cervical cancer by detecting early pre-cancerous changes in the cells that line the cervix. It is recommended that all women aged between 25 and 64 years, who have ever been sexually active, have regular screening tests. Women aged 25-49 are invited every three years, while those aged 50-64 are invited every five years. Most women's test results show that everything is normal, but for around 1 in 10 women the test will show some abnormal changes in the cells of the cervix. Screening is carried out by a nurse or doctor at your GP practice or at a sexual and reproductive health (family planning) clinic.

Constraints and Opportunities

7.24 Screening programmes were paused from the second week of March 2020 in response to the COVID-19 pandemic. The purpose in pausing these programmes was to ensure that adequate healthcare and laboratory resources could be redirected to the pandemic response and to reduce the risk of COVID-19 infection in people eligible for screening programmes, many of whom are in population groups vulnerable to serious adverse health outcomes due to coronavirus infection.

7.25 Public Health England (PHE) has stated that disruption to screening programmes will most likely lead to an increasing disease burden and an increase in health inequalities, in addition to having a negative impact on the economy due to increased morbidity. In light of this, rebuilding NI screening services is a priority for the Department of Health.

7.26 Work is underway by the PHA in Northern Ireland to plan for the restoration of each of the paused programmes as quickly as possible, however the rate of rebuilding will be impacted by the need for social distancing and PPE, as well as the interdependency with other key diagnostic (imaging and laboratories) and treatment services across Trusts. In most instances it would not be

appropriate to offer a screening test if the remainder of the screening pathway (diagnostics and treatment) is not available for those who receive a positive screening test result.

7.27 Furthermore, the cohorts eligible for a number of the programmes include people who are at increased risk of severe COVID-19 if they become infected, because of underlying conditions (such as diabetes) and/or age.

7.28 Staff absence in provider services has increased due to the requirement to self-isolate because of staff or household symptoms. Some staff have been redeployed, some staff are in the vulnerable or shielding group and some staff have been or are currently ill.

7.29 Consideration will also need to be given to the availability and suitability of some screening venues in terms of hygiene and social distancing measures.

7.30 In light of these constraints, return to pre-COVID levels of activity and clearing the backlog of people who have missed out on the offer of screening during the pause is likely to take many months and will depend on the progress of the pandemic. Typically, based on average 2019 activity levels, around 5,200 breast mammograms and 15,000 cervical tests would be carried out per month across Northern Ireland. The estimated backlog at 31 May 2020, due to the pause in these programmes, is 12,800 mammograms and 45,000 cervical tests.

Revised Pathways

7.31 A risk-based and consistent approach will be adopted in order to make the best use of the available resources, whilst also taking account of the logistical issues and risks specific to each programme. The approach will be underpinned by a number of key principles:

(i) All screening services should prioritise activity to ensure a consistent approach, with emerging capacity used first for people at highest risk.

(ii) Screening should be offered to people where the benefits of screening are greater than the risk of contracting COVID-19 as a result of participating in the programme. This will differ between programmes and between groups of people eligible for each screening programme. The different risks and benefits associated with different programmes will require a phased approach, with some programmes being phased in before others.

(iii) There needs to adequate staffing and facilities for testing, diagnosis, high quality treatment and programme management. This needs to be supported by appropriate quality assurance arrangements to minimise risk and maximise benefits.

Anticipated Activity: 3 Months to 30 September 2020

7.32 Whilst it is relatively straightforward to pause population screening programmes, the task of restarting these programmes and restoring them to previous levels is much more complex and needs to take into account a wide range of variables which are compounded by the ongoing COVID-19 pandemic.

7.33 Breast assessment clinics for women who have previously been recalled for assessment following mammography continue to be held within our screening centres. In addition, women who have been identified as being at higher risk of breast cancer will continue to receive invitations to attend for surveillance screening at the regional higher risk screening unit at Antrim Area Hospital.

7.34 Colposcopy clinics offering further assessment following a cervical screening test are still being held where possible at the moment. Tests for people who have recently been screened will continue to be processed and results sent to GPs for onward communication to patients.

7.35 Those considered to be in the extremely vulnerable group, those who have, or had symptoms of COVID-19 and are self-isolating, and those who are currently self-isolating due to a household member having symptoms are advised not to attend these clinics. Alternative appointments may be made by contacting the clinic.

7.36 The restoration of cancer screening programmes will commence as quickly as possible. This will be aligned to and consistent with restoration of capacity and addressing any backlogs in the parts of the cancer screening pathways which sit in primary care and secondary care. The PHA, working with HSCB and Trusts, will lead a process to develop a phased plan for the restoration of each of the five paused screening programmes using a risk based approach. The plan will consider effective action that can be taken in the short, medium and long-term. This plan will be based on the principles outlined above and take into consideration the actions required in relation to the screening, diagnostic and treatment components of screening programmes, as part of the wider primary and secondary care recovery plans.

Cataracts – Belfast Health and Social Care Trust (BHSCT)

Previous Pathway

7.37 Prior to the COVID-19 Pandemic, the NI Cataract Pathway reform was well underway. The BHSCT surgical waiting lists stands at some 8000 patients, with some 9500 on the outpatient waiting list. The cataract surgical and outpatient waiting lists have been successfully amalgamated for BHSCT, Northern Health and Social Care Trust and South Eastern Health and Social Care Trust, therefore helping to establish equity of access.

Opportunities and Constraints

7.38 As the waiting lists in Northern Ireland are very long, a list of patients who were "certifiably blind" due to cataract was identified and these patients were prioritised for surgery (in limited numbers) in Kingsbridge Hospital and Ulster Independent Clinic during lockdown. This approach was constrained as some patients were unwilling to attend.

7.39 This allowed the service the opportunity to test the cataract surgery pathway in the COVID-19 climate. This has resulted in BHSCT maintaining approximately 15% of cataract surgical activity through Lockdown.

Revised Pathway

7.40 Cataract surgery has now had to adopt new processes and approaches as follows:

- Prioritisation of patients in terms of visual requirement and COVID-19 risk status.
- Contact patient to ascertain if prepared to attend (very time consuming)
- Attend 48 hours prior to scheduled surgery for COVID-19 testing, pre-assessment and biometry, if required.
- Self-isolation was not a requirement during lockdown but is now a requirement.
- Reduced surgical lists from 7 to 5 during lockdown but have strategies to improve flow once routine theatres open.
- Post-operative reviews carried out by telephone in most cases.

7.41 Improvements in flow have been made by staggering the arrival of patients on the list to avoid contact with others and the surgical day visit can be shortened by giving patients drops for self-dilation when they come for their COVID-19 testing.

Anticipated Activity: 3 Months to 30 September 2020

7.42 Pre-COVID capacity for BHSCT cataract surgery was 5418 patients per annum.

7.43 Currently the BHSCT is operating at 12% of cataract capacity. This can expand rapidly if the Day Case Elective Care Centre open for surgery. Going forward BHSCT has applied for the services of two medical students to help with prioritisation of cataract patients on the surgical waiting list, so that surgical capacity is used in the most effective manner.

Urgent & Emergency Care

7.44 Prior to COVID-19, there was clear evidence that our urgent and emergency care services were under increasing pressure with growing numbers of people experiencing long waits to be seen in overcrowded Emergency Departments (EDs). This was already an unsustainable position requiring radical transformation.

7.45 However, the impact of COVID-19 and the accompanying focus on infection prevention and social distancing, have driven home the urgency of ensuring that we do not allow EDs or hospitals to reach these levels of crowding in future. The way we provide care must change to prevent this.

Opportunities and Constraints

7.46 Attendances at EDs dropped during the first two months of the pandemic but numbers are starting to rise again and it is expected that they will eventually rise to pre-pandemic levels. Even with reduced numbers, our EDs are encountering difficulties with social distancing in waiting areas and, particularly, in ambulance turnaround times. Crowded EDs are unsafe for staff and patients.

Revised pathway

7.47 EDs are having to adopt new ways of working order to ensure that they do not become overcrowded. Some of the new approaches include:

- Segregation and streaming of patients to separate those more likely to have COVID-19 from those less likely;
- Closer working with primary care – including scheduled access to some urgent services;
- Maximum occupancy thresholds in all areas to allow for adequate social distancing;
- Walk-in patients triaged as low risk to wait in cars or nearby until called;
- Increasing the use of telemedicine and remote consultations;
- Expansion of anticipatory care models and acute care at home to prevent unnecessary or inappropriate attendance;
- Patients under active specialist care to be managed by their existing specialist team;
- Patients discharged as soon as they are medically fit.

7.48 Further areas to be explored include the establishment of a regional telephone triage system, alternative pathways for urgent patients including access to scheduled appointments.

7.49 As we move towards the busier winter period, it will be essential to consider more radical transformation of urgent and emergency care services. EDs must

be able to provide their core purpose of assessing and stabilising seriously ill and urgent patients.

SH:24 Pilot – Sexually Transmitted Infection (STI) Testing

Existing pathway

7.50 People in Northern Ireland that are either concerned about, or symptomatic with, a possible STI can either attend a Genitourinary Medicine (GUM) clinic or consult their GP for testing. Many do not do so either out of embarrassment, limited access to appointments, or other reasons like not knowing where to go and obstacles to travel. This contributes to ongoing transmission of STIs and rising STI levels in the population.

7.51 This imposes costs for treatments and in managing the long term consequences of STIs like birth defects, fertility problems, persistent pain, comorbidities and palliative care. For example, the life time costs of treating an HIV patient are estimated to be £380,000. Until recently approximately 100 people were newly diagnosed in Northern Ireland with HIV every year. The most effective way of reducing STI transmission is testing and treatment of those who are diagnosed with an STI. However, in Northern Ireland due to clinic and laboratory constraints the number of STI tests performed annually has not increased significantly over the last five years.

Revised Pathway

7.52 In response to this, PHA, HSCB and Health and Social Care Trusts commenced a six month pilot in October 2019 with SH:24, an online STI testing service provider. SH:24 is a not for profit community interest enterprise developed by clinicians and service designers. It offers testing for Chlamydia, Syphilis, Gonorrhoea, HIV and Hepatitis B and C.

7.53 The patient pathway is individualised, rapid and convenient. The costs are lower than for face-to-face consultations and the quality of the service is consistently high. Sophisticated algorithms analyse the information provided by the patient via their phone or other digital communication device and determine what kind of test kits are needed. These are discreetly posted to the patient with instructions on how to take swabs, urine and blood tests. The patient returns these by post to a designated highly accredited laboratory outside Northern Ireland and receives the results usually within 24 hours by text or telephone. Effective safeguarding mechanisms for children or sexually assaulted adults are also in place. Details of patients testing positive for STIs are shared with the relevant Trust GUM team, who takes over the management of complex patients. Simple STIs like Chlamydia can be treated via SH:24 through a postal of kiosk click and collect local pharmacy service without local GUM team involvement.

7.54 During the six months pilot October 2019- March 2020, nearly 7000 people accessed SH:24 online testing, which exceeded originally anticipated demand

by over 100%. Over 40% of NI SH:24 users had never been to a GUM clinic, and a further 15% had not been to one in over a year. This means that SH:24 reached a different group of people than traditional GUM services.

Constraints and Opportunities

7.55 Experience during COVID-19 in Belfast Health and Social Care Trust (BHSCT), to date shows that between April 1st and May 15th 2020, patient contacts reduced from an average of 1500 to 528 for the six week period. Of these, only 30 needed a face-to-face consultation. This means that 93% of the usual demand for GUM services in BHSCT could have been dealt with through SH:24.

7.56 BHSCT estimates that its service capacity will remain less than 50% of its pre-COVID-19 capacity due to staff redeployment, shielding and sickness absence, the requirements of social distancing and use of PPE during unavoidable face to face patient contact.

7.57 SH:24 provides an opportunity to ensure a safe, continued STI testing provision through the COVID-19 pandemic.

Anticipated activity to 30 September 2020.

7.58 Without advertising, it is estimated that SH:24 STI testing service will be accessed by 1500-2000 patients per month between April and June 2020 inclusive. Thereafter this is likely to stabilise at 2000 per month but could rise further. Monthly monitoring will help to determine this in coming weeks and months.

7.59 Service continuation beyond June 2020 is subject to funding being made available.

ANNEX A: ACTION LIST

Section 5 in the 'Rebuilding Health and Social Care Services Framework' document sets out the overarching approach to developing service stabilisation plans, with the aim to maximise activity in the context of the constraints and issues that COVID-19 presents. This will lead to incremental service activity plans and targets being developed for each programme of care / specialty to be updated in three monthly cycles for the period June 2020 to March 2022. If possible the planning cycles will be extended if the prevalence of Covid-19 in the community improves. The following actions will underpin the planning to be taken forward over the next two years.

Cancer Care

- Work has now started to implement the reset of the full range of cancer services whilst taking into account the need for the HSC to respond to further Covid-19 surge(s) in 2020 and the existing capacity constraints in HSC. This work will be taken forward by the Covid-19 Regional Cancer Reset Cell.

- The Belfast Trust has recommenced specialist surgery in Belfast City Hospital now that the Nightingale Hospital has been stood down.

- The Northern Ireland Cancer Network (NICaN) has produced regional guidelines for cancer care and changes to pathways have been implemented accordingly.

- NICaN and MCRN have collaborated to produce guidelines to support decisions around the prioritisation of patients in the event of a reduction in capacity due to the COVID-19 response.

- Regional guidance documents were compiled to support doctors in their decision-making and treatment planning across both haematology and oncology.

- Some patients' treatments plans have been modified in light of the current pandemic, in line with the regional NICaN guidelines.

- A testing protocol has also been developed for use within cancer services and incorporated into the regional testing protocol.

- NICaN has produced a patient information leaflet.

Adult Social Care

- The learning from the new and innovative ways of working adopted by adult social care services in response to the pandemic, such as the use of technology to connect care home residents with their families, will be utilised to further transform the delivery of this service.

- Across adult social care there will need to be a separation into groups of service users to try to minimise infection control risks, ongoing use of PPE and other mechanisms to minimise risks. This will include Trusts continuing to support unpaid carers, providing PPE when needed, and ensure they have the support they need to continue providing care. Sector specific guidance will be issued providing more details on the approaches to be adopted.

- Careful consideration will be given to the delivery of long term adult care services – both those delivered in institutional settings such as care homes, and in people's own homes, which serve many of those who are most vulnerable to the virus. There will need to be a careful balance struck between continuing to protect people and ensuring that other aspects of people's health and wellbeing – and their rights – are respected and looked after. There is also a continued reliance on unpaid carers, and the support of family and friends, alongside our formal health and social care services. Making sure this support can continue, or re-start, safely is as important as re-opening any hospital-based service.

Capital Investment

- Plans for new developments have been delayed whilst staff across the HSC have been focussing efforts on the immediate needs of the pandemic. This work will be reinvigorated and clear priorities set to ensure that our efforts are collectively applied to move key projects forward. This will enable us to make the best use of the capital funding we have in 2020/21 and to bring forward plans for 2021/22 and beyond so that we are ready to maximise the use of future allocations. The incremental plans will identify any further capital investment requirements.

Children's Social Care Services

- Planning for the rebuilding of children's social care services is underway, which will align with the Executive's 5-stage plan and will be guided by up-to-date medical and scientific evidence.

Co-production

- The incremental service rebuilding plans will be developed through the application of co-production principles as far as that is possible. The speed at

which these plans will need to be developed and adapted will undoubtedly act as a constraint on applying full co-production principles. However, where at all possible, service providers should engage in a timely manner as widely as possible in the development of their incremental service plans.

Encompass Programme

- The Encompass digital healthcare programme working with Epic, alongside frontline staff, operational management, and patients and carers, will implement a single Digital Care Record for every citizen, including a fully integrated patient portal. This will enable services to consolidate standardised digital workflows and revised patient pathways, naturally building on the integrated and coordinated regional basis for developing service incremental plans.

EU Exit

- Action will be taken to ensure that the HSC will be ready for EU Exit ahead of the end of the transition period on 31 December 2020. This includes understanding the implications for the health and social care sector of the implementation of the Northern Ireland Protocol and ensuring that the sector is prepared and risks are managed in areas such as workforce, health security and healthcare supplies.

Governance of the HSC

- Given the unprecedented challenges posed by COVID-19, a number of changes to the governance framework will be implemented. The Department, through temporary amendments to the Framework Document, and the establishment of a new management board, will give clear direction to the Health and Social Care Board (HSCB), Public Health Agency (PHA), Health and Social Care Trusts and the Business Services Organisation (BSO) to reflect the Minister's priorities. These revised governance arrangements are intended to be in place over the next two years to facilitate rapid decision making in rebuilding HSC services. This arrangement will be kept under review on a 6 monthly basis

- Service delivery performance targets will be reviewed by the Department to determine the optimum method for assessing the performance of Trusts in the delivery of services during the years 2020/21 and 2021/22.

Managing planned Non-Covid-19 services in hospital settings during COVID-19

- As we increase the amount of planned activity in hospitals over time, we will adopt the following principles:

    - The HSC will immediately start to step up services on a prioritised basis while maintaining the necessary level of care for COVID-19 patients;

- Patients across Northern Ireland should have equitable access to specialist services according to their clinical need;
- In order to minimise the risk of infection, COVID-19 patients and staff providing care to them should be separated from non-covid patients and staff where possible;
- The volume of planned activity to be delivered will align with other dependencies such as testing capacity, medicines supply, and PPE.
- The HSC will need to retain the capacity to quickly repurpose and 'surge' capacity if required.

- HSC Trusts will aim to minimise the transmission of COVID-19 infection within hospitals.

- All Trusts have taken steps to put in place effective safe zoning plans in order to maintain safety of patients and staff on sites where elective care is delivered alongside urgent and emergency care. Where possible, we will also consider the possibility of physical separation of staff and patients delivering planned care from those dealing with unscheduled care.

- The use of telephone triage and video consultations will be expanded within secondary care.

- The use of virtual clinics will be expanded within secondary care.

- Further work will be carried out to explore the feasibility of establishing dedicated elective care centres to potentially facilitate the continuation of some planned activity in the event of increasing demand for COVID-19 treatment arising from a second wave of the pandemic.

- The potential to continue the use of Independent Sector facilities to maintain the most urgent planned elective care will be explored.

Mental Health Services

- The remote ways of working introduced to support mental health services during the pandemic will be reviewed to explore the potential to further improve the efficiency of services.

- The library of health and wellbeing Apps to allow clinicians and wider professionals to "prescribe" and allocate apps to clients for mental health services will be further developed.

- The potential for Multidisciplinary Teams (MDTs) in primary care to enhance their focus on delivering mental health services, to help meet the need emerging in the post lockdown period, will be explored.

- As part of the COVID-19 Mental Health Response Plan published on 19 May 2020 review mechanisms will ensure that learning from alternative ways of working will be incorporated in service developments moving forward.

General Ophthalmic Services

- The learning from the innovations introduced in Ophthalmology patient pathways and communication with patients during the pandemic will be utilised to further strengthen patient access to this service.

- The Department and the HSCB will work with the Optometry NI to rebuild the services provide by Ophthalmic Practices guided by the available medical and scientific guidance.

General Dental Services

- The Department and the HSCB will work with the British Dental Association to rebuild the services provided by General Dental Practitioners guided by the available medical and scientific guidance. The restrictions on dental services are due to be eased on a phased basis with the first stage, starting from 8 June, being the extension of face to face urgent dental care to all practices where possible. In the second phase, non-urgent care is due to be provided with the exception of treatments involving Aerosol Generating Procedures (AGPs). The range of available treatments will be extended to include AGPs under the third phase.

Other Allied Health Professions

- The Department and the HSCB will work with relevant professional bodies in respect of other Allied health professions such as physiotherapists, chiropodists etc. to rebuild services guided by the available medical and scientific guidance.

Patient Pathways

- All HSC service providers will adopt a systematic and consistent approach to developing service specific incremental plans to increase capacity. This will involve mandating the wide range of existing managerial clinical networks, project boards, task and finish groups or other service improvement vehicles to produce service specific incremental plans for their respective areas on an integrated and coordinated regional basis.

- The existing patient and client pathways will be reviewed, applying a range of COVID-19 factors, summarised in the Checklist, producing revised patient

pathways to implement rebuilding of services within the context of prevailing COVID-19 conditions.

Pharmacy

- The learning from the new approaches in working practices and the use of technology, introduced in Community Pharmacy and HSC Trust Pharmacy to respond to the pandemic, will be utilised to identify opportunities to build upon these innovations to further transform pharmacy services.

- The learning from the new pharmacy support services provided to Care Homes during the pandemic will be utilised to identify opportunities to build upon these innovations to further transform the services provided to the care homes sector.

Planning for a Further Potential Covid-19 Surge

- Planning will continue to ensure that the HSC will be ready to respond to further potential surges of the Covid-19 pandemic.

- HSC Trusts will retain critical care capacity in line with the NI Critical Care Network's 'Low Surge' scenario, providing the recommended 112 critical care beds capacity.

Primary Care

- The Department will aim to continue to provide the primary care COVID-19 Centres in the short to medium term subject to some changes in configuration to respond to the emergent contours of the pandemic.

- The learning from the COVID-19 Centre approach will be utilised by identifying opportunities to build upon the benefits of this service delivery model to support the further transformation of HSC services by strengthening the effectiveness of the primary care partnership with secondary care through joint working and resource sharing.

- The Department and HSCB will discuss with the BMA and RCGPNI the future use of COVID-19 Centres.

- The use of telephone triage and video consultations will be expanded within primary care.

- The potential to use telecommunications in primary care to work more closely with secondary care, for example, with video consultations between patients, GPs and hospital specialists, will be explored.

- The primary care sector will be asked to produce proposals to expand the role of Multi-Disciplinary Teams (MDTs) in the future delivery of health services, in particular during the rebuilding phase to bring mental health support to the community level, accessible directly through GPs.

Prioritisation / Delivery of Health Services

- Hospital services will be planned to ensure that treatments that have the highest impact on reducing mortality and morbidity are prioritised. Ensuring patient safety is paramount and that equity of service across Northern Ireland must be ensured as far as possible.

- Where possible service plans will be developed on a regional basis to ensure equity of provision across Northern Ireland.

Testing Strategy

- Service providers should deliver services taking account of testing priorities established in the Interim Protocol. The Protocol will continue to be reviewed on an ongoing basis and will be adjusted over time as further capacity becomes available and as priorities for testing change as the pandemic evolves.

Workforce

- The HSC workforce has been under significant strain during the pandemic and it will be necessary to continue to consider the implications for staff with mental health issues, ensuring appropriate support.

- Induction and training will be provided for staff members who are re-deployed to areas outside their normal practice or working environment.

- Employers must ensure that proper risk assessments are carried out for all staff. This will include application of social distancing, to help avoid contact with COVID-19 wherever possible and to manage that contact safely when there is no alternative. This should include particular risk factors for staff who are shielding; Black, Asian or Minority Ethnic; pregnant etc. and proper training for managers.

- Employers should engage with trade union representatives in a timely manner on all workforce issues.

- Early consideration will be given to utilising learning from the COVID-19 response in relation to recruitment, resourcing and job banding. Potential improvements to childcare and 7-day working patterns will also be considered. The existing work on safe staffing, and agency and locum reduction will be incorporated within the rebuilding services agenda.

- Clarity will be provided on the means and timing of re-establishing pre-registration training and education for those disciplines that have had training disrupted by the pandemic.