# Service Delivery Plan to include response to COVID -19 Surge (4th wave), Winter Pressures and delivery of key Regional Priorities October 2021 – March 2022

## NORTHERN HEALTH AND SOCIAL CARE TRUST

V8.2 (14/10/2021) – amended to address 1st, 2nd and 3rd set of comments received from HSCB and to incorporate revised COVID surge modelling at the request of the HSCB

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## 1.0 Executive Summary

This Northern Health and Social Care Trust (NHSCT*) Service Delivery Plan, including our response to COVID -19 Surge (4th wave), Winter Pressures and delivery of key Regional Priorities October 2021 – March 2022,* outlines how we plan to respond to additional demand pressures arising during Winter 2021/22 and through the next surge of COVID-19.

Initial regional modeling has predicted a fourth COVID-19 surge will coincide with seasonal pressures and other respiratory viruses such as influenza and respiratory syncytial virus (RSV). There will be a cumulative impact across all our services but predominately our urgent and unscheduled care services. The Trust needs to be agile, responsive and flexible in how we address these pressures and needs to have robust plans in place for all services but especially those for critical care, hospital beds and support to care homes.

Over this autumn and winter period, we need to increase the resilience of our services and as a region have a detailed plan of how to protect those areas likely to come under most pressure. We have been asked to model bed occupancy at 5%, 10%, 15% and 20% above baseline values. Further scenarios have been added to model the potential impact of a COVID surge similar to winter 2020/21.

Access to all our services continues to be impacted by the pandemic and addressing patient and staff safety through social distancing, infection prevention control and testing measures remains a priority for the Trust.

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

1. **Winter Pressures for both adults and paediatrics** including our estimated bed projections, actions to secure the appropriate level of suitably trained staff and our response to the influenza virus.
2. **COVID-19 (4th surge)** – this sets out across key service areas the actions required to meet the demands of the pandemic whilst continuing to apply the key regional planning principles of equity of access for the treatment of patients, minimizing the transmission of COVID-19 and protecting the most urgent services.
3. **The delivery of key regional priorities** for unscheduled care, elective care, cancer services, adult social care, children's services, mental health and physical disability services**.**

The narrative plan is supported by activity projections for October – December 2021 across a range of services (Annexe 1).

The Trust acknowledges and supports the principles (see section 3.0) in preparing this plan for winter and surge as outlined in the Regional COVID19 Pandemic Surge Planning Strategic Framework (1st September 2020) and will strive to adhere to these principles as it delivers services through this challenging autumn / winter period.

The Trust faces significant challenges (see section 4.0) during the winter and the next COVID-19 surge including:

- workforce (in respect of maintaining safe staffing levels),
- ensuring safe environments for patients, clients and staff,
- managing outbreaks in hospitals and care homes,
- maintaining services during refurbishment works for ICU at Antrim Hopsital,
- providing services in sub-standard acute hospital accommodation with lack of single rooms,
- the ability to balance core services with unscheduled care demands, and
- the funding of any increased cost.

The Trust and the wider HSC system has learned from the previous COVID-19 surges. As we prepare for winter and a subsequent surge, we will use this learning to respond in a proportionate, informed and measured way to address the dual challenge of winter and COVID-19. This will include the assessment of a comprehensive range of management information to enable oversight and real-time decision-making.

## 2.0 Introduction

The NHSCT every autumn prepares a winter resilience plan to set out how we propose to address the predicted increase in demand for unscheduled care services each winter. Traditionally this is a period when demand for our services is greater than the capacity of our hospitals, with demand for beds frequently exceeding capacity.

In readiness for a 4th potential COVID 19 surge, which is predicted to coincide with normal winter pressures, influenza and RSV, it is important that there are comprehensive plans in place across Trust services with particular focus on critical care, hospital bed provision, care homes and community services supporting discharge from hospital. Within the NHSCT, our focus has been and will continue to be on ensuring the safety of our patients, service users and staff at all times.

As we enter the winter months, the Trust is committed to taking a carefully considered and balanced approach to the delivery of services, taking into account lessons learned over the past 18 months while also acknowledging that we will continue to live with COVID-19 for some time. The Trust will endeavour to maintain as many services as possible during any further waves, however managing the service demand arising from COVID-19 and winter pressures will take priority over elective care services. As with previous winter periods and COVID-19 surges, this may result in the Trust having to further cap, redirect or stop elective activity and will undoubtedly affect our rebuilding effort. We will continue to prioritise and focus on treating the most urgent cases first and as a result some patients may have to wait longer than we would like.

One positive change from last winter has been the success of the vaccination programme with evidence that as of August 2021, for each 1,000 cases of COVID-19 in Northern Ireland, 22 are currently being admitted to hospital compared with 80 being hospitalised in December 2020. However, we have already seen the impact of variants of COVID-19 over recent months and it is important to acknowledge that given the many variables across different mutations, the impacts of further variants are yet unknown.

During the previous phases of the pandemic staff demonstrated their energy, courage and resilience, many staff having to adapt to new roles and working environments while others have provided training and induction to new colleagues - all have had to demonstrate great flexibility. We will be continuing to work in partnership with all our staff through what is now an extremely challenging period. We will:

- ensure both internal and external Workforce Appeals are progressed to deliver additional resources and make best use of existing capacity to support COVID-19 surge response,
- support resourcing of independent sector care homes through allocating available staff to cover gaps in rotas, and
- adopt the Respond / Support / Promote model set out in the Health, Wellbeing and Inclusion Strategy focusing on attendance and psychological support,

support the return to work of staff absent due to Long COVID and the provision of health and wellbeing support to staff.

The service delivery / surge / winter plan set out in the sections below outlines the approach the NHSCT will adopt to address the anticipated seasonal increase in demand and the next wave of COVID-19.

## 3.0 Planning Principles

The Trust has adopted the following principles in preparing this surge plan as outlined in the DOH Regional Covid-19 Pandemic surge planning strategic framework (1/9/2020):

- Patient safety remains the overriding priority.
- Adequate staffing remains a key priority and Trusts will engage with Trade Union side on staffing matters in relation to relevant surge plans.
- Trusts should adopt a flexible approach to ensure that 'business as usual' services can be maintained as far as possible, in line with the Rebuilding HSC services Strategic Framework. This should allow Trusts to adapt swiftly to the prevailing COVID-19 context.
- It is recognised that there will be a fine balance between maintaining elective care services and managing service demand arising from COVID-19 and winter pressures. Addressing COVID-19 and winter pressures will take priority over elective care services, although the regional approaches announced such as day case elective care centres and orthopaedic hubs will support continuation of elective activity in the event of further COVID-19 surges.
- The HSC system will consider thresholds of hospital COVID-19 care, which may require downturn of elective care services.
- Trusts' Surge Plans, whilst focusing on potential further COVID-19 surges, should take account of likely winter pressures.
- Trusts should plan for further COVID-19 surges within the context of the regional initiatives outlined in Section 7 of the DOH Regional Covid-19 Pandemic surge planning strategic framework.
- Trusts should as far as possible manage COVID-19 pressures within their own capacity first. Should this not be possible the NHSCT will await regional direction on the availability of regional ICU and 'step down' facilities including the Whiteabbey Nightingale ward.
- The Department, HSCB, PHA and the Trusts will closely monitor COVID-19 infections, hospital admissions and ICU admissions to ensure a planned regional response to further COVID-19 surges. This will support continued service delivery.
- The Department will, if COVID-19 infection rates and other indicators give cause for action, recommend further tightening of social distancing measures to the Executive.

The Trust is committed to its legal duties under Section 75 of the Northern Ireland Act 1998 as detailed in its approved Equality Scheme and the Rural Needs Act 2016. In terms of assessment of this plan, the Trust will screen for both equality and rurality to identify potential adverse impact.

*Tackling Health Inequalities*

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

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

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

## 4.0 Challenges

The COVID-19 global pandemic has presented the health and social care system with a number of unique challenges that have dramatically changed the way services were delivered. In spite of the success of the COVID-19 vaccination programme there are likely to be further waves of COVID-19. The 4$^{th}$ COVID -19 surge this autumn and winter is likely to coincide with outbreaks of other respiratory viruses such as RSV and influenza and put further strain on the delivery of health and social care services across the system.

The key challenges in implementing our winter resilience plans and our COVID-19 surge plan include:

- **Balancing safety and risk** through regional agreements in respect of ensuring both effective ongoing response to COVID-19 locally and the need to rebuild elective surgical and diagnostic services for prioritised clinical groups on an equitable basis for the Northern Ireland population, taking account of specific Trust differences, for example, available accommodation

- Assessing **workforce pressures**, including the ability to staff the service delivery / surge / winter plan safely appropriately. We must ensure our staff are supported and feel valued including those staff who are redeployed to service critical areas such as ICU. Over the last year, staff have been working relentlessly and have not been able to take sufficient periods of annual leave, therefore it is important to give them the opportunity to avail of accrued annual leave and provide any psychological and wellbeing support that is required. We also need to take account of the impact of staffing requirements on the delivery of the vaccination programme and other areas that are still required to tackle the pandemic such as the testing team and Occupational Health

- **Maintaining safe staffing levels** across all areas ensuring safe environments for patients and staff aligned to current COVID-19 guidance and policy. Outbreaks of COVID-19 in hospitals and care homes with nosocomial spread are likely to continue and may be exacerbated. The delivery of safe care to **vulnerable adults and children in social care settings within the community** will be challenging in the context of increased demands

- **Building on new ways of working and innovations to provide safe and effective care.** Recognising the widespread adoption of telephone triage, virtual clinics and video calls during COVID-19, we will continue to work innovatively with our primary care/community partners and our clinical leaders to maximise the rapid scale and spread of technology

- Continuing to **maintain effective COVID-19 zoning plans** in line with Infection Prevention and Control advice and guidance, to safely manage separate pathways for flow of staff and patients across all sites, optimise efficient utilisation of Personal and Protective Equipment (PPE) and ensure adequate catering and rest facilities for our staff

- Assessing the ability of our **accommodation and transport infrastructure** to support and enable our plans across our hospital and community sites

- Acknowledging the role of BHSCT as the only provider of a range of **specialist services** and the responsibility to ensure capacity for the region

- COVID-19 has further highlighted the difficulties faced in dealing with a pandemic with **sub-standard hospital accommodation** with limited single room provision and limited ICU capacity. These pressures will continue to intensify in the absence of much needed investment. Activity projections for this winter show a significant shortfall in beds required on both Antrim and Causeway Hospitals that cannot be addressed without additional physical capacity

- Sustaining models for **testing of health care workers and patients/clients** as part of our ongoing response to COVID-19
- Sustaining a reliable supply of **critical PPE, blood products and medicines** to enable us to provide our services safely. In this plan the Trust has assumed a supply of PPE to meet the anticipated activity levels
- Providing necessary **support and resources to the nursing/care home sector** on an on-going basis alongside Trust-based services
- Ensuring we are mindful of the requirement for **co-production and engagement** and informed involvement in key decision-making in our local agreements to service delivery / surge / winter plan
- Providing continued **support to those in need** within our population including those who are vulnerable and at risk of harm
- The **financial constraints**, with limited recurrent growth funding and significant existing pressures we will continue to identify any emerging financial pressures during this winter period and as a result of any further COVID-19 surges. Surge plans are expected to create further financial pressures in an already constrained financial system, with financial resource requirements difficult to predict given known workforce supply constraints (both within the trust and in the community sector) and the interplay between COVID presentations, unscheduled care pressures and on-going risk-based decisions around elective services. Internally we will continue to assess resource requirements and use established channels and processes with HSCB and DOH to secure additional resources as required.
- In order to provide a fit-for-purpose Intensive Care Unit in Antrim Hospital ready to manage further surges of COVID-19, the Trust is carrying out refurbishment work to convert a surgical inpatient ward to an enhanced ICU footprint. This will require a **downturn in bed capacity from mid-August to mid-September**. In order to alleviate the pressure this will create on the Antrim site, all elective surgery will be diverted from Antrim to Causeway and other hospital sites in the Northern Trust. While we will work to minimise the overall impact on elective volumes, it is likely this will reduce our elective capacity over this time.

While the Trust will aim to manage unscheduled care pressures within our own community and hospital system and work collaboratively with the wider HSC system to seek to equalise or smooth demand where possible, the Trust acknowledges that demand will be higher than the available resources over the autumn and winter period.

Initial projections show a potential shortfall of over 200 beds across our acute hospital sites. Even best case scenarios are well in excess of our available hospital bed capacity, and likely to result in significant delays for those seeking to access services.

All Health and Social Care Trusts will work collaboratively along with the Department of Health and Commissioners to address the need for safe staffing levels in their local facilities and regional facilities. Workforce vacancies remain a challenge across the system.

## 5.0 Communications planning (internal and external)

This Service Delivery / Surge / Winter resilience plan is complex and dynamic. As is standard practice, the internal and external communications requirements will be serviced and amended as necessary throughout the delivery period.

### External Communications

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

### Internal Communications

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

## 6.0 Winter pressures (adults and paediatrics)

The focus of a winter pressures plan is patient safety, responding to predictable increases in demand for unscheduled services, particularly from late December through to March 2021. A predicted 4th COVID-19 surge in our population along with seasonal flu and RSV will add even more pressure to the unscheduled care system.

Our approach to patient safety will continue to be a consistent focus on the safety of our acute sites, through robust assessment, patient flow and bed management. This will be achieved through optimising ambulatory pathways to avoid admission to hospital, maximising appropriate discharges and managing complex discharge planning. We will continue with the use of our site escalation policy that offers a common methodology across Trusts.

The Trust will develop, as has been done in previous winters, a detailed costed winter plan and a specific Christmas and New Year Resilience plan detailing staffing rotas for key services over the Christmas and New Year period. This is to ensure there are appropriate levels of staffing in place to maximise discharges and create capacity in our hospitals, maintain patient flow and deal with the high level of pressure across the system normally experienced directly after the Christmas period and into the first weeks in January.

The following table sets out the NHSCT's bed occupancy levels projected for the winter period across both Antrim and Causeway Hospitals detailing any available mitigation to address the identified bed shortfalls. The scale of the pressure on beds is such that it cannot be fully met within existing bed capacity. The table also summarizes the Trust's flu action plan (although this is subject to revision following confirmation of vaccination targets from the DOH).

| Sub-section | Planning requirement | Response |
|---|---|---|
| **Winter pressures (adults and paediatrics)** | | |
| Bed occupancy | Develop plans to meet peak occupancy up to double the usual winter peak | A full summary of the availability of acute beds can be found at Annexe 2 and in the HSCB's regional bed modelling summary that accompanies this plan.<br><br>Northern Trust winter bed modelling will be kept under review as we move towards the winter months. The Trust is developing alongside this template an operational plan to outline the steps needed to achieve the maximum level of demand we can accommodate within our existing bed and workforce capacity. It recognises the continuing competing demands that the Trust will need to manage over the Winter period, including the impact of meeting COVID-19 pressures on elective care and how best to profile both COVID-19 and non-COVID-19 unscheduled care beds across our hospital sites.<br><br>None of the mitigation measures outlined in this plan will be adequate to address the very significant projected shortfall in inpatient bed capacity. The Trust is proposing that a regional winter capacity plan should be developed, identifying where additional inpatient beds can be made available and ensuring that patients potentially requiring admission are redirected accordingly. |
| Bed occupancy | Outline what actions are being taken to secure sufficient and appropriately trained staff to support enhanced respiratory services to support any surge in demand. This will include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period. | • Staff numbers are flexed in line with both COVID volume of patients and acuity.<br>• A programme of refresher/upskilling training for nursing and medical staff is underway, across defined wards, to ensure sufficient capability in managing patients requiring non-invasive ventilated support using various modalities. Annual leave for these upskilled staff will be managed to |

| Sub-section | Planning requirement | Response |
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| | | ensure sufficient skill mix remains available to deal with increased demand.<br>• Capacity is challenging with current number of respiratory consultants and level of acuity with COVID patients.<br>• Leave is to be managed at service level and will ensure that there is adequate cover in respiratory wards/service across the Christmas and New Year period. Contingency plans will be put in place to address any unexpected spike in unplanned staff absences over this period.<br>• Paediatrics: consideration of redeployment of community children's nurses and specialist paediatric nurses to Antrim/Causeway acute wards |
| Flu activity | Provide details of the flu action plan including details of specific actions taken to maximise the number of Trust staff receiving flu vaccinations | • Task & Finish Vaccination Group meeting weekly from 12/08/2021<br>• Vaccination Centre and current staff in Seven Towers to be used initially, with pop-up clinics to follow, planned to commence in September<br>• There is a risk that the flu vaccine may not be available to commence programme in September<br>• Expectation to provide flu and COVID-19 booster to independent sector staff and residents – programme in 2020/21 utilised c. 120 staff from downturned services who may not be available this winter.<br>• Different model of delivery required due to expectation to offer flu to all HCWs and COVID-19 booster to frontline HCWs from late September<br>• Utilisation of existing staff in COVID-19 vaccine centre and previous flu peer vaccinators to assist with programme delivery |

| Sub-section | Planning requirement | Response |
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| | | • To be discussed at team / manager meetings<br>• Disseminate Trust information and uptake levels regularly through SMT / Directorates |
| Flu activity | Provide details of plans for rapid flu testing in ED and assessment areas. The response should explain when rapid flu testing will commence and how this will impact on seasonally adjusted 4-hour performance and bed occupancy. | • NHSCT is planning to introduce the GeneXpert Cepheid test multiplex test. This laboratory based test platform will provide SARS-CoV-2, Influenza A&B and RSV with a 1-hour turnaround time. A target live date is September 2021.<br><br>• Within the wider flu-testing programme we are also proposing using the large batch Seegene platforms to test for Flu A&B and SARS-CoV-2. These large run platforms will give us significant local capacity.<br><br>• Furthermore, for paediatrics we are implementing a rapid POCT for Flu, RSV and SARS-CoV-2 through the Roche Liat platform. This has an implementation date of September 2021. |
| Flu activity | Detail how bed capacity will be increased to manage a flu outbreak this winter, based on previous flu trends (last year excluded). The plan should considered the impact of future Covid surges along-side increased flu related admissions and also consider what hospital at home capacity is available and how will be utilised as part of the response. The Trust should also consider if direct access beds will form part of the response to flu surge particularly for the frail elderly patients. Consideration | • See bed occupancy section above.<br><br>• Site plans will be developed to manage the flow of patients who are admitted because of flu.<br><br>• The NHSCT does not have a formal hospital at home service however cognisance will be given to enhance anticipatory models in care homes and rapid intervention community services. |

| Sub-section | Planning requirement | Response |
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| | should be given to cover over the Christmas and New Year period and the associated seasonal staff sickness absence as part of this response. | • A detailed day-by-day staffing plan for the period around Christmas and New Year will be developed to increase capacity and resilience over these most pressured weeks of the year. |
| Flu activity | Ensure that integrated multi-disciplinary team discharge planning is in place across acute and community settings, particularly over weekends and holiday periods. Consideration should also be given to the impact of associated seasonal staff sickness absence. | • The Trust will ensure additional capacity is in place across multi-disciplinary teams in acute and community services throughout the peak winter period. This will include a detailed day-by-day staffing plan for the period around Christmas and New Year, to increase capacity and resilience over these most pressured weeks of the year. |

## 7.0 Covid -19 Surge (4th wave)

It is acknowledged that any future waves of COVID-19 pandemic would have a significant impact on the ability to sustain our service delivery plans over the next few months. The Trust will continue to apply the regionally agreed service delivery planning principles to decision making to:

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

The below section sets out the Trust response across key service areas as requested out by the Commissioner.

| Sub-section | Planning requirement | Response |
|---|---|---|
| **COVID-19 Surge (4th wave)** | | |
| Critical care | Outline plans, in agreement with the Critical Care Network (CCaNNI) ensuring that there is a co-ordinated approach across and between units and clinical teams to meet the demand | • Northern Trust will participate in the regional Critical Care / Respiratory Hub process to maximise access to Critical Care. Any surge in Critical care will have an immediate impact on elective activity as the area for surge beyond 10 beds in Antrim Hospital is in the 8-bedded elective ward i.e.C8. |
| Critical care | Outline what actions are being taken to secure sufficient and appropriately trained staff to support any surge in demand. This will include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period | • If nurses are required to redeploy to support ICU this will require a downturn of planned elective work. The Unit is staffed the same regardless of time of year therefore the demands to core and / or surge beds will be the same. Leave will be managed to ensure bed numbers are retained / provided. |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | • Recruitment to the recurrent Revenue Business Case for Critical Care will be progressed. |
| Respiratory | Outline plans to ensure that there is management and coordination between estates and clinical teams to monitor the usage of oxygen | • The process commenced during previous surges will continue. Rigorous $O_2$ monitoring will be undertaken at ward level and correlated with Estates flow readings. Wards are fully aware of $O_2$ capacity and associated escalation plans. Trust Medical Gasses Group will convene more regularly during winter to monitor and address $O_2$ issues. |
| Respiratory | Outline what actions are being taken to secure sufficient and appropriately trained staff to support enhanced respiratory services to support any surge in demand. This will include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period | • A programme of refresher / upskilling training for nursing and medical staff is underway, across defined wards, to ensure sufficient capability in managing patients requiring non-invasive ventilated support using various modalities. Annual leave for these upskilled staff will be managed to ensure sufficient skill mix remains available to deal with increased demand.<br><br>• It remains challenging to meet staffing demand with COVID pressures and continued staff isolation etc. |
| Social care | Review Business Continuity Plans to ensure that where they relate to domiciliary care, care homes, hospital, supported living and day care services they are robust and up to date | • Providers' staff contingency plans are discussed as part of the annual assurance statement at annual contract review meetings.<br><br>• The majority of contingency plans for ISP and Homes consist of existing staff covering additional shifts, bank staff and agency workers. Recruitment is a significant problem at present in both sectors and last year a number of Homes availed of the staff made available through the |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | workforce appeal. The Trust may find Homes seek similar support this year.<br><br>• The Contracts Department will engage with IS providers to confirm they have robust Business Continuity Plans in place to support sustainable staffing and maintain capacity.<br><br>• Business Continuity Plan reviews for Trust services with a particular focus on community hospitals, day care and Trust domiciliary care provision has been actioned.<br><br>• Business Continuity plans are routinely reviewed to ensure up to date for Mental Health and Learning Disability Services. |
| Social care | Update contingency plans to address staff absences in both the statutory and independency sector. This will require planning for mutual aid and staff re-deployment as required. Trusts should use Regional Covid-19 Action Plans for Care Homes and Domiciliary Care as the basis for determining priority actions in these sectors | • Similar to Surge 1, 2 and 3, plans are being progressed by Trust HR to co-ordinate a Workforce Appeal. A recent Broadcast has been issued.<br><br>• There are currently twice weekly Care Home Review meetings ongoing to maintain an overview of the situation and assess the need to invoke contingency planning arrangements. Frequency of meetings will be sensitive to the presenting pressures in the care home sector. |
| Social care | Ensure plans are in place for the prioritisation of resources and delivery of services to clients with the most critical level needs. Some areas of service may have to be suspended/ stepped down. Client lists should be reviewed in respect | • All critical care lists have been reviewed and updated for all localities across the Community Care division.<br><br>• Within Mental Health and Learning Disability Services client lists are regularly reviewed, with critical need being prioritised. |

| Sub-section | Planning requirement | Response |
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| | of this and carer contact details updated as required | |
| Social care | Three regionally agreed actions to improve and support discharge planning should be progressed:<br>• Nurse facilitated discharge<br>• Home before Lunch<br>• Discharge / Home to Assess | **Nurse Facilitated Discharge**<br>Work progressing through Corporate Nursing in relation to education/training regarding Nurse Led Discharge. NHSCT performance is currently higher than regional average position.<br><br>**Home before Lunch**<br>NHSCT performance compares favourably with regional average position.<br><br>**Discharge to Assess**<br>Recovery Service will:<br>• Aim to respond within 48 hrs (7 day service in place)<br>• Can accept with minimal level of MDT assessment (although Acute OT and physio tend to have full assessment complete)<br>• If POC required to facilitate discharge – it is temporary and decisions about longer term care needs determined in community setting<br><br>The following actions are required to fully implement:<br>• Review the level of assessment completed by Acute OT and physio<br>• Implement regional referral forms (currently receive separate OT and physio assessment forms)<br>• Review the referral process to streamline<br>• Update coding (LCID) to ensure accurate reporting. |

| Sub-section | Planning requirement | Response |
|---|---|---|
| Social care | Work with Care Home providers to ensure current capacity in the care home sector is fully utilised | • Capacity in Care Homes is available to all community and acute staff via the Brokerage (CBPU) process. All homes are contacted twice a week and availability is put on the system for all staff to access should they be looking for a bed. This availability is broken down by home and bed type so home and bed types are easily identifiable. |
| Social care | Work in accordance with the regional care home guidance, namely that patients should accept the first available care home bed that meets their needs, with the option of transferring to another home of their choice later | • Acute services have implemented this circular but it remains challenging. |
| Long COVID | Support the timely recruitment of staff and implementation services by 31 October 2021 | • The Trust has submitted a Revenue Business Case for temporary funding until March 2022 in line with the regional commissioning plan for Post COVID services.<br>• The five strands of the regionally commissioned Post COVID are being progressed i.e. Strands 2 and 4 have resourcing for substantive WTE posts and EOIs are being progressed.<br>• Strand 1, 3 and 5 will be dependent on flexing existing staff and backfilling services. |
| Long COVID | Work with HSCB and PHA to ensure robust information that is standardised regionally with agreed data definitions and currencies to support data collection and monitoring of key outcomes | • The Trust lead will link with HSCB and PHA and regional colleagues to ensure consistency of data using agreed data definitions and currencies. |
| Vaccine programme | Advise how your Trust targeted, or plans to target, the hard to reach/low uptake areas within the Trust area | • The Trust has worked closely with PHA and a range of partners to identify hard to reach / low uptake areas across the Trust geography including reviewing Vaccination |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | Uptake data from SOAs and Council Areas. A programme of Pop-Up Vaccination clinics commenced with a partnership with a local Community Pharmacist in association with the local council and community association in Ballysally (Coleraine). This was followed by a series of Pop-Up Clinics across the Trust geography. As at 6 September the Trust had delivered over 8,000 First Dose Vaccines across 26 pop-up clinics with further sessions planned through the remainder of September<br>• The mobile Vaccination Clinic initiative has also delivered targeted clinics at a Meat Plant (Moy Park) and included coordination of the timing and access to local clinics for other, similar employers.<br>• The Trust has now commenced an initial programme, in conjunction with the regional Farm Families Initiative, with the first sessions taking place in Ballymena and Swatragh Marts on 10th and 11th of September respectively. This may then be rolled out across appropriate Mart locations across NI in partnership with PHA and other Trust.<br>• The Trust established a range of Vaccination Clinics aimed at Pregnant women attending Trust Ante-Natal Clinics from July 2021. |
| Vaccine programme | Advise how your Trust enabled, or plans to enable, easier access to vaccination at the Trust vaccination centres | • The Trust has operated a Mass Vaccination Centre at Seven Towers Leisure Centre in Ballymena since December 2020. This centre was initially open seven days per weeks, then moving to a five-day week when demand |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | started to reduce. In mid-August 2020 the MVC moved to a three day week when the focus was on 2nd doses only, apart from ongoing support for 16/17 Year old Vaccination.<br>• Dedicated days for Immuno Suppressed young people<br>• Big Jab Weekend |
| Vaccine programme | Advise how your Trust identified, or plans to identify, suitable areas/locations to place mobile vaccination clinics | • Via use of uptake data which informs areas to be targeted, the Trust is working with Multi-Agency partners, including local councils to identify suitable premises in which to host mobile vaccination clinics. This process was also advised by awareness of events, e.g. Armoy Road Races. |
| Vaccine programme | Advise how your Trust ensured, or plans to ensure, maximum uptake of the COVID-19 vaccine amongst your workforce and the actions that were taken, or are planned, to target any staff disciplines identified as having a low uptake | • The Trust strongly encouraged all staff to take the offer of the COVID-19 vaccine. A communication plan was designed and implemented with a regular Weekly Vaccination Update via Broadcast email and circulation to Independent Sector Employers via the Trust Partnerhub to encourage staff to get the vaccine, outline the benefits and address any concerns / myths. This included updates to SMT and TU Engagement forums to promote encouragement of uptake amongst staff<br>• The Occupational Health Team extracted regular reports on uptake, based on the best available information from VMA showing uptake across Divisions, Professions and Age Cohorts of staff. This information was presented to the Senior Management Team in order to inform targeted |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | action to encourage staff in areas of low uptake to take the vaccine. |
| Vaccine programme | Advise what plans the Trust has developed, or plans to develop, to ensure all frontline HSC staff who are Trust and non-Trust employed can be vaccinated with the COVID-19 booster within your Trust area in the autumn of 2021 | • The Trust is currently developing the plan for the roll out of the COVID-19 booster programme to frontline staff. This will include the continuing utilisation of the Mass Vaccination Centre in Seven Towers, Ballymena during October (and possibly early November) and will also, at a later stage, include establishment of a number of satellite mobile clinics to improve access to the booster vaccine for staff across the Trust geography. A comprehensive communications plan will be developed as well as a robust data capture system to enable regular reporting and targeting of areas of low uptake. |
| Vaccine programme | Advise what plans the Trust has developed, or plans to develop, to vaccinate all staff and residents of Care Home facilities within the Trust area with the COVID-19 booster during the autumn of 2021 | • The Trust is currently working to develop the plan to roll out the booster vaccine to staff and residents across all the Care Home facilities across the Trust geography. It is anticipated that this will be a similar programme to that carried out in December 2020 / January 2021 to roll out the initial vaccination programme and will involve mobile vaccination teams visiting each care home. Work is ongoing with the care homes to finalise the model. This process will start as soon as possible after receipt of the relevant JCVI and DoH guidance. |
| Vaccine programme | Advise how your Trust will ensure all house-bound patients are identified and vaccinated | • The Trust is currently working to develop the plan to roll out the booster vaccine to housebound patients across the Trust geography. It is anticipated that this will be a similar |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | with a COVID-19 booster during the Autumn of 2021 | programme to that carried out in early 2021 to roll out the initial vaccination programme and will involve mobile vaccination teams visiting the housebound. This process will be coordinated with General Practice partners. Work is ongoing with the care homes to finalise the model. |

## 8.0 Delivery of key Regional priorities

This section explains the Trust's plans to deliver, during the next COVID-19 surge and winter period, the key regional priorities that are experiencing a significant impact during the pandemic. In developing this high-level plan, the Trust has taken account of regional plans including those for Care Homes, Domiciliary Care, Mental Health and Children's Services and the Critical Care Network Northern Ireland (CCaNNI) and Northern Ireland Cancer Network (NICaN).

The table below outlines details the measures to respond to the next wave of COVID-19 alongside the seasonal winter demands by **key regional service areas**.

<table>
<tr><th>Sub-section</th><th>Planning requirement</th><th>Response</th></tr>
<tr><td colspan="3">Delivery of key regional priorities</td></tr>
<tr><td>Unscheduled care</td><td>Plan for 5%, 10%, 15% and 20% rise in activity for Adult ED Attendances and admissions (COVID and non-COVID)</td><td>The tables below show projected ED attendances for Antrim and Causeway EDs at 5%, 10%, 15% and 20% growth vs 2019 baseline, for average daily attendances across Sept to March. Further detail is given in Annexe 2.
<table>
<tr><th>Average daily attendance projections 21/22 – Antrim</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>Baseline (daily average)</td><td>259</td><td>264</td><td>257</td><td>241</td><td>239</td><td>253</td><td>259</td></tr>
<tr><td>+5% demand</td><td>272</td><td>277</td><td>270</td><td>253</td><td>251</td><td>266</td><td>272</td></tr>
<tr><td>+10% demand</td><td>285</td><td>291</td><td>283</td><td>265</td><td>263</td><td>278</td><td>285</td></tr>
<tr><td>+15% demand</td><td>297</td><td>304</td><td>295</td><td>277</td><td>275</td><td>291</td><td>298</td></tr>
<tr><td>+20% demand</td><td>310</td><td>317</td><td>308</td><td>289</td><td>287</td><td>304</td><td>311</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Sub-section</th><th>Planning requirement</th><th>Response</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Average daily attendance projections 21/22 – Causeway</th><th>Sept</th><th>Oct</th><th>Nov</th><th>Dec</th><th>Jan</th><th>Feb</th><th>Mar</th></tr>
<tr><td>Baseline (daily average)</td><td>142</td><td>139</td><td>134</td><td>127</td><td>127</td><td>134</td><td>137</td></tr>
<tr><td>+5% demand</td><td>149</td><td>145</td><td>141</td><td>134</td><td>134</td><td>141</td><td>144</td></tr>
<tr><td>+10% demand</td><td>156</td><td>152</td><td>148</td><td>140</td><td>140</td><td>148</td><td>151</td></tr>
<tr><td>+15% demand</td><td>163</td><td>159</td><td>155</td><td>147</td><td>146</td><td>154</td><td>158</td></tr>
<tr><td>+20% demand</td><td>170</td><td>166</td><td>161</td><td>153</td><td>153</td><td>161</td><td>165</td></tr>
</table>
<br>As part of its winter plan the Trust will ensure additional staffing in both its Emergency Departments. This will include enhanced levels of medical, nursing, pharmacy and AHP cover.<br><br>It should be borne in mind that the pressure on an ED will be driven by a range of factors besides total attendances, notably any mismatch between capacity and demand in the inpatient bed system – refer to the bed occupancy section above.<br><br>See Annexe 2 for detail.
</td></tr>
<tr><td>Unscheduled care</td><td>Provide detail on plans to provide alternatives to ED including increasing ambulatory and surgical assessment to include:<ul><li>Speciality areas (including surgical assessment)</li><li>Hours/days of operation (including plans to increase)</li></ul></td><td><ul><li>Antrim ED has direct access to the Direct Assessment Unit from Triage with over 50% of referrals coming from ED. NIAS and Primary Care have direct access avoiding ED. The DAU also offers review and hot clinics to support early discharge from hospital. This unit is open from 8.30am to 8.30pm Monday to Friday inclusive of Bank holidays. There are no plans to increase this and it is currently partly funded with transformation monies.</li></ul></td></tr>
</table>

| Sub-section | Planning requirement | Response |
|---|---|---|
| | • Capacity daily/weekly Including plans to increase)<br>• Entry route – direct access GP, Direct Access NIAS, via Urgent Care Centre or ED (if so is this direct from triage) including plans to open up access if not in place for the above | • Antrim Programmed Treatment Unit allows multiple speciality ambulatory care and planned treatments for patients who previously would have been managed as inpatients. This unit runs Monday to Friday 9am to 5pm and is a transformation-funded service.<br><br>• Direct Assessment Unit in Causeway operates a frailty model Monday to Friday and has direct access from Primary Care and ED.<br><br>• Phone First is continuing until the 31/3/2022 and being delivered by Dalriada Urgent Care (DUC). A review of scheduling appointments is underway to improve the flow. The NHSCT has reviewed and updated the Directory of Urgent Care Services and issued to all GPs. The Ambulance arrival and handover area is operational but is supporting the capacity issues at ED.<br><br>• **Surgery**<br>The Emergency Surgical Unit (EmSU) was developed and implemented in Antrim Hospital to help appropriately divert acute surgical patients (pending they meet the pre-defined clinical criteria) away from ED. Patients can also be referred directly to EmSU by a GP, following a discussion between the GP and Ambulatory Consultant / EmSU Reg. This prevents patients interfacing with ED, as they can go directly to EmSU upon arrival.<br><br>The unit is open 24/7, with the single point of access phone for ED and GP contactable 24/7. If a patient |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | requires surgical assessment, this can be done on one of the six trolleys, Monday – Sunday, 24/7; for patients requiring further reviews / investigations / diagnostics, they can be reviewed at the Hot Clinic, which runs from Monday – Friday, 09:30 – 11:30 at pre-assigned time slots (there are eight 15-minute slots available per day).<br><br>• Future plans for EmSU at Antrim Hospital include an increase in the number of daily Hot Clinic slots, by introducing Registrar-Led PM Hot Clinics.<br><br>• A project team has been established to open an Acute Surgical Assessment Unit (ASAU) in Causeway Hospital. The unit will be similar to the Antrim EmSU, which will hold five trolleys for surgical assessment, Hot Clinics, and a waiting area for patients. Similar to EmSU the Causeway ASAU will aim to divert inappropriate footfall from ED. The plan is to open the unit before the end of 2021. |
| Unscheduled care | Provide detail of Discharge Planning in place and plans to improve/increase this. This should include: | |
| Unscheduled care | • Are patients given an estimated discharge date on admission (EDD) (What is the current % of EDD's which are met to date and plans for increase). How is this communicated to the ward teams to facilitate early discharge planning | • All wards have MDT meetings Monday to Friday and EDDs are agreed and reviewed. This is monitored on the Openward system updated at ward level.<br><br>• Both sites Antrim and Causeway operate a site coordination model with daily focus on discharges. This model involves multiple stakeholders in discharge process.<br><br>• In the calendar year January – July 2021 : |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | - 85% of complex discharges have been discharged within 48 hours<br>- 90% of non-complex discharges have been discharged within 6 hours<br>- (both Antrim and Causeway have similar performance). |
| Unscheduled care | • Is Senior Review carried out before mid-day by senior clinicians (specify wards) including weekends? If not in place what are plans to do so | • Yes, ward rounds commence each morning. Depending on the number of admissions and acuity of patients some patients may not be reviewed until later in the morning. A ward round is repeated in the afternoon as required and within job plans. The Acute medicine team operate a live take for admissions with early senior decision-making.<br>• Weekends ward rounds take place as above with the on call consultant doing an additional ward round in the afternoon.<br>• There is also a day and night handover between medical teams. |
| Unscheduled care | • Is twice daily decision making in place on all wards (specify wards) | • Yes - this is routinely the case on our medical wards |
| Unscheduled care | • What is the % of all discharges at weekends and plans to improve | • On average 17% of discharges occur over the weekend.<br>• Additional medical support will be secured during the winter months to support decision making and discharge processing at weekends |
| Unscheduled care | • % patients currently Home before lunch and plans to increase | • On average across the two main sites 8% of discharges occur before lunch (based on regional 12 noon measurement). |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | • We actively promote Home before Lunch with a continued focus on early decision making and preparation for discharge. |
| Unscheduled care | • % patients Discharged to Assess and plans to improve | • Actions are in place to continue to promote the ethos of discharge to assess through meetings with hospital MDT and Recovery in an integrated approach<br><br>• In the meantime, a *Discharge to Assess* ethos is applied to all referrals for Home-based pathway –<br><br>- Aim to respond within 48 hrs (7 day service in place)<br>- Can accept with minimal level of MDT assessment (although Acute OT and physio tend to have full assessment complete)<br>- If POC required to facilitate discharge – it is temporary and decisions about longer term care needs determined in community setting<br><br>• *Discharge to Assess* is not intended to be a separate pathway. It is a gateway to Home based rehab for less complex cases. The work we need to do to fully implement is to –<br><br>- Review the level of assessment completed by Acute OT and physio<br>- Implement regional referral forms (currently receive separate OT and physio assessment forms)<br>- Review the referral process – need to streamline this |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | - Update coding (LCID) to ensure accurate reporting. |
| Unscheduled care | • % of Nurse led discharge in place and plans to improve | • On average 10% of discharges across the two main sites are Nurse Led. Discharge requirements are discussed at daily whiteboard meetings. Nurse practitioners check blood and diagnostic results periodically throughout the day to help progress discharge decision making. |
| Unscheduled care | • Are plans clearly communicated to facilitate these initiatives at weekends? | • Yes, there is a Friday handover meeting between medics regarding potential weekend discharges. Patients requiring complex discharge planning are all co-ordinated via site co-ordination hub process. |
| Unscheduled care | • How are non-acute hospitals used to help manage flows | • Patients transfer to these facilities if and when their clinical and rehabilitation needs can be addressed in such a facility. |
| Unscheduled care | • How are discharges from non-acute hospitals managed to ensure flow across the entire system –including at weekends? | • Whiteabbey non-acute site and community beds operates as the medical wards with daily Monday to Friday MDT. At the weekends discharges can be progressed and admissions managed via Dalriada Urgent Care medical cover. |
| Unscheduled care | • Is your Trust implementing patient choice guidance (yes/no) | Yes |
| Unscheduled care | • Is your Trust operating the repatriation process (yes/no) | Yes |
| GP OOHs Service | | • The COVID Assessment Centre in Ballymena at DUC continues to be operational and the Causeway COVID |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | Assessment Centre located on the Causeway Hospital site commenced testing on 4th October 2021. Approximately 75% of COVID centre appointments are for children (pyrexic children with either no COVID test or those that can't wait to get one before being seen are the major source of referrals at present).<br>• DUC continues to provide out of hours GP services to the Northern Trust population and supports the 24/7 phone first model to reduce ED attendances. |
| Elective care | Evidence how theatre capacity is being managed to ensure the prioritisation of red flag and urgent patients. This information should include the actions (or SOPs) to reduce the number of red flag/ time critical patient cancellations, including the use of the IS or inter trust transfers | • FSSA process in place and well established with weekly meetings to allocate patients to theatre. The Trust will participate fully with the regional prioritisation of elective to ensure those most in need get access to surgery, and with the regional exploration of how 'green' capacity can be protected and potentially expanded. |
| Elective care | Detail the plans in place to increase the utilisation of HSC theatres by the independent sector. This should include theatre capacity not in active use, including the use of HSC theatres in the evenings and the weekends where HSC activity cannot be delivered | • NHSCT has submitted plans to HSCB to support an independent provider using either Whiteabbey or the Mid-Ulster to provide additional endoscopy sessions. This is dependent on being able to secure an appropriate provider.<br>• A similar plan has been submitted for the provision of ECHOs. |
| Elective care | Detail the plans in place to increase the provision of outpatient assessment capacity, including the roll out of mega clinics across a range of specialties. The plans should also detail how the Trust will make the provision of outpatient services more resilient by the continued expansion of virtual outpatient activity. | • Outpatient capacity can only be expanded if Winter / COVID allows. Trust will continue to utilise virtual clinics which are well embedded in service provision. The Trust will work in collaboration with others in the region to progress the elective agenda, acknowledging the potential constraints of COVID and winter pressures |

| Sub-section | Planning requirement | Response |
|---|---|---|
| Cancer care | Provide assurances on progression of staff expansion and service reform as outlined in the Oncology-Haematology Stabilisation (in line with available funding) | • A Revenue Business Case for service has been submitted and will be implemented in line with current funding. Recruitment will proceed as quickly as possible, although those posts funded non-recurrently are likely to be more difficult to fill. |
| Cancer care | Provide assurances on the development of plans for single point of referral and e-triage for red flag referrals for suspect colorectal cancer | • Qfit process well embedded – includes e-triage by GI and surgical teams of Red Flag LGI referrals. |
| Adult social care | Review existing domiciliary care capacity with the intention of re-shaping and prioritising service capacity. Opportunities for increasing capacity, including workforce recruitment activities, should be progressed as a priority | • Review of Unmet Need list being undertaken by all Community Teams.<br>• Paper established and shared across divisions as part of Domiciliary Care workstream to standardise application of Regional Eligibility Criteria for Domiciliary Care provision.<br>• Continued work with Contracts Department to meet assessed need in difficult to cover rural areas.<br>• Local recruitment commenced within Statutory Domiciliary Care – early indications are favourable<br>• Procurement of domiciliary care being progressed by Trust including public consultation from Sept 2021. |
| Adult social care | Ensure SDS and Direct Payments are promoted as a means of increasing choice and capacity, including the use of Emergency Direct Payments to support hospital discharges | • The Trust delivers Social Care Services under the umbrella of Self Directed Support. All Programmes of Care following an identification of critical need discusses options for receiving support with the individual/their carer/family to choose how their support is provided that gives them as much control as they want over their personal budget – this includes:<br>- Taken as a Direct Payment |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | - A managed budget (Where the Trust or a 3rd party organisation holds the agreed budget but the person is in control of how it is spent)<br>- The Trust arranged service<br>- Or a mixture of all three.<br>• This includes option of receiving an Emergency Direct Payment for an initial 8-week period to support hospital discharges. |
| Adult social care | Engage with the independent care home and domiciliary care sectors to ensure and capacity within those sectors is fully utilised and any admission issues are resolved | • The Contracts Department engage with IS domiciliary providers on an ongoing basis to discuss capacity and ensure optimum utilisation.<br>• Capacity issues within care homes are addressed as appropriate and tailored contracts/services are established as required. |
| Adult social care | Planning for timely discharge from hospital should be supported by focus upon the regional discharge priorities of:<br>• Nurse facilitated discharge<br>• Home before Lunch<br>• Discharge/ Home to Assess | **Nurse Facilitated Discharge**<br>Work progressing through Corporate Nursing in relation to education/training re: Nurse Led Discharge. NHSCT performance is currently higher than regional average position.<br><br>**Home before Lunch**<br>NHSCT performance compares favourably with regional average position. Progress is hampered by absence of Discharge Lounge at present.<br><br>**Discharge to Assess**<br>Recovery Service will:<br>• Aim to respond within 48 hrs (7 day service in place) |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | • Can accept with minimal level of MDT assessment (although Acute OT and physio tend to have full assessment complete)<br>• If POC required to facilitate discharge – it is temporary and decisions about longer term care needs determined in community setting<br><br>**Actions required to fully implement:**<br>• Review the level of assessment completed by Acute OT and physio<br>• Implement regional referral forms (currently receive separate OT and physio assessment forms)<br>• Review the referral process – need to streamline this<br>• Update coding (LCID) to ensure accurate reporting. |
| Children's social care including disability and CAMHS | Maintain critical support services for families in the community (particularly short breaks in disability/intensive support in CAMHs/edge of care) are maintained to avoid unnecessary family breakdown | **Children with Disability (CWD)**<br>• Whitehaven and Rainbow lodge provided short breaks throughout Covid and will continue to do so. Outreach, Summer support and uplift of Direct Payments to support families will be ongoing.<br><br>**Childcare**<br>• Intensive social work support service will continue to be prioritised to avoid family breakdowns.<br><br>**CAMHS**<br>• FTF contacts are maintained safely where clinically indicated. Crisis and Eating Disorder services will continue to be protected and prioritised. |

| Sub-section | Planning requirement | Response |
|---|---|---|
| Children's social care including disability and CAMHS | Ensure adequate, safe staffing for residential and in patient services in view of current demand | **CAMHS**<br>• No inpatient (CAMHS) service in NHSCT.<br>• Bank of trained staff available to flex capacity in core services. Core staff can therefore flex to support continuity of service within Crisis and Eating Disorder.<br>• Regional escalation meetings to review inpatient capacity (Beechcroft). Local situation reviewed daily by locality managers and Head of Service.<br><br>**Childcare (incl CWD)**<br>• Staffing residential services remains a priority, use of peripatetic, bank and agency. Flex from community teams in extreme circumstances. |
| Children's social care including disability and CAMHS | Maintain a focus on waiting lists | **CAMHS**<br>• Waiting List management will continue to be routinely managed and reported upon.<br>• The NHSCT Paediatric ASD service is engaging in Diagnostic assessments with children in line with the current regional guidelines devised by the five Trusts. This is delivered both through a clinical setting and through virtual-model. NHSCT introduced a telephone consultation service in response to COVID-19 and continues to offer face to face or zoom new interventions based on need and parental choice. Where telephone consultations identify escalating need for intervention, then these are prioritised for face to face or zoom sessions as appropriate. In addition the service will be holding live webinars commencing October 2021 to enable a greater number of parents to attend training events. Where intervention |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | needs are met through this additional programme, the waiting list will reduce. The NHSCT Trust also have two contracts with Autism NI who continue to provide family support and advice on visual supports for children aged 8 and over.<br><br>**Childcare (incl CWD)**<br>• Unallocated cases in SW teams continues to be closely monitored and reported to the HSCB. Action plan in place to manage, including current recruitment exercise to fill vacancies in frontline teams. Additional recruitment in progress targeted at 'hard to fill' vacancies. Business continuity arrangements invoked dependent upon vacancies. |
| Paediatrics | Demonstrate that sufficient and appropriately trained staff are available to support paediatric services to support any surge in demand. This will include reviewing the planning of staff leave to provide cover over the Christmas/New Year holiday period | • Consideration of redeployment of community children's nurses and specialist paediatric nurses to Antrim / Causeway acute wards.<br>• A detailed day-by-day staffing plan for the period around Christmas and New Year will be developed to increase capacity and resilience over these most pressured weeks of the year. |
| Paediatrics | Detail arrangements in place for local triggers to activate the effective planning and management of their services in the event of a prolonged RSV surge and how will they ensure continued robust and effective communications and links with other Trusts and regional colleagues throughout the period | • Representation at Child Health Partnership zoom calls (regional paeds network) - Head of Service and DMD.<br>• Representation on CCaNNI (Critical care network NI) - Head of Service + Paediatrician rep.<br>• Participation in daily regional conference calls in RSV surge phase – lead Nurse/HoS and Ward Chief |

| Sub-section | Planning requirement | Response |
|---|---|---|
| Paediatrics | Detail arrangements in place to ensure the continued provision of paediatric elective work in paediatric services throughout the autumn and winter 2021. This should include outpatient clinics as well as inpatient elective work | • Close liaison with surgical colleagues re any anticipated further downturn of elective work (at present only very low volume of paeds elective work being undertaken in AAH).<br>• Continued representation (paediatric lead nurse) on surgical low risk pathway meetings. |
| Mental health | Progress work on the Mental Health Post Pandemic Surge and Rebuild Plan 2021-26 | • The COVID-19 pandemic has significantly impacted mental health. Whilst COVID-19 posed unprecedented challenges for the HSC system, prior to COVID, mental health services were already facing significant challenges<br><br>• It is estimated there will be around 32% more new referrals to mental health services over the next three years. It is important to note that referrals *accepted* into mental health services have risen year on year 2016-17 – 2020-21. Modelling for mental health surge is extremely useful for seeing the scale of coming demand and for attracting appropriate attention and the next 18 months could be particularly demanding for services.<br><br>• The Health & Social Care Board have commenced work on modelling and are developing a Task and Finish Group for Mental Health Services Supply/Demand Modelling. A draft Terms of Reference have been developed that sets out the aim, purpose and membership of the Group. The Trust has been invited to identify key individual(s) to be represented on this Group. |
| Mental health | Deliver Year 1 of the DoH Mental Health Strategy 2021-31 Implementation Plan | • The Trust is represented on the Department's Working group to deliver the Mental Health Strategy 2021-31. A workstream will be established by the Department of |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | Health to agree the actions required to establish plans to include the transition to a Regional Mental Health Service.<br><br>This will focus on:<br>• A regionally consistent service in terms of models, service delivery and service structures including service names and language which is delivered by the five health and social care Trusts working with primary care and the community and voluntary sector.<br>• The establishment of new, or the strengthening of existing, regional clinical networks to build capacity and to ensure regionally consistent approaches with appropriate agreed care pathways. These networks can be for more specialist services which share resources across the region, or more generic services providing the same or similar types of services in each Trust area.<br>• Service delivery primarily focussed around community through a population based model, centred upon GP Federation areas, working across primary and secondary mental health care with the full integration of the community and voluntary sector services. This will include integration in the delivery of psychological therapies. |
| Physical disability | Highlight how the needs of adults with Physical and Sensory Disability is ensured in the Adult Social Care Review of existing domiciliary care capacity with the intention of re-shaping and prioritising service capacity. (Refer to sub section – Adult Social Care) | • Review of Unmet Need list being undertaken by all Community Teams.<br>• Paper written as part of Domiciliary Care workstream to standardise application of Regional Eligibility Criteria for Domiciliary Care provision.<br>• Continued work with Contracts Department to meet assessed need in difficult to cover rural areas. |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | • Local recruitment started within Statutory Domiciliary Care – early indications are favourable<br>• Procurement of domiciliary care being progressed by Trust. |
| Physical disability | Highlight how the Trust meets the needs of those service users with complex need, including the use of SDS and Direct Payments | • Adults with complex needs are defined as people needing a high level of support with many aspects of their daily life and relying on a range of health and social care services. Following assessment and identification of critical need for social care tasks the named worker discusses options for receiving support with the individual/their carer/family to choose how their support is provided that gives them as much control as they want over their personal budget – this includes:<br>- Taken as a Direct Payment<br>- A managed budget (Where the Trust or a 3rd party organisation holds the agreed budget but the person is in control of how it is spent)<br>- The Trust arranged service<br>- Or a mixture of all three.<br>• This includes option of receiving an Emergency Direct Payment for an initial 4-week period to support hospital discharges. However for a nursing care task, the nursing care aspect will be procured from a care agency. |
| Physical disability | Highlight what the transition arrangements are between children and older people | • Until the age of 18, the care of children with long-term health conditions is the responsibility of child health and social care services. Between the ages of 16 and 18, the child will start a “transition” of the services when a social worker from children’s disability services will discuss with the young person, their parent/carer a referral to adult |

| Sub-section | Planning requirement | Response |
|---|---|---|
| | | physical disability services. In receiving agreement a Referral will be made to adult physical disability and a social worker from adult services will start attending meetings and get to know the young person, their parent/carer around the 17th birthday (depending on the level and kinds of support needs) becoming the key worker / case manager as of the young person's 18th birthday.<br><br>• The Social Work Service Manager, Children's Disability, liaises with the Service Manager responsible for physical disability quarterly with regard to children approaching the transitional stage.<br><br>• Transitional arrangements are not required from adult physical disability to older people services. |

# ANNEXE 1 – ACTIVITY PROJECTIONS (October to December 2021)

(submitted to HSCB on 8/9/2021 and with a revision on 27/9/2021)

**Rebuilding HSC Services - Phase 7 Data Annex (Activity Projections) - October to December 2021 Projections**

| | | October | | | | November | | | | December | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NORTHERN HSC TRUST** | | **2019 Activity** | **October-21 Projected Activity** | **nn** | **Variance** | **2019 Activity** | **November-21 Projected Activity** | **nn** | **Variance** | **2019 Activity** | **December-21 Projected Activity** | **nn** | **Variance** | **Total Projection for Phase 7** |
| **OUTPATIENTS** | | | | | | | | | | | | | | |
| New | Face to Face | 6946 | 5176 | -1770 | -25% | 6387 | 4971 | -1416 | -22% | 5001 | 3979 | -1022 | -20% | 14126 |
| | Virtual | 43 | 914 | 871 | 2026% | 40 | 877 | 837 | 2093% | 39 | 702 | 663 | 1700% | 2493 |
| | **Total NOP** | **6989** | **6090** | **-899** | **-13%** | **6427** | **5848** | **-579** | **-9%** | **5040** | **4681** | **-359** | **-7%** | **16619** |
| Review | Face to Face | 11907 | 6004 | -5903 | -50% | 10443 | 5769 | -4674 | -45% | 8452 | 4837 | -3615 | -43% | 16610 |
| | Virtual | 667 | 5115 | 4448 | 667% | 827 | 4915 | 4088 | 494% | 706 | 4122 | 3416 | 484% | 14152 |
| | **Total ROP** | **12574** | **11119** | **-1455** | **-12%** | **11270** | **10684** | **-586** | **-5%** | **9158** | **8959** | **-199** | **-2%** | **30762** |
| | **Total OP (New and Review)** | **19563** | **17209** | **-2354** | **-12%** | **17697** | **16532** | **-1165** | **-7%** | **14198** | **13640** | **-558** | **-4%** | **47381** |
| **Inpatients and Daycases** | | | | | | | | | | | | | | |
| Inpatients | | 321 | 280 | -41 | -13% | 293 | 280 | -13 | -4% | 219 | 210 | -9 | -4% | 770 |
| Daycases | | 1315 | 830 | -485 | -37% | 1374 | 830 | -544 | -40% | 1044 | 631 | -413 | -40% | 2291 |
| Endoscopy (4 scopes) | | 1165 | 762 | -403 | -35% | 1045 | 762 | -283 | -27% | 834 | 695 | -139 | -17% | 2219 |
| | | 2801 | | | | 2712 | | | | 2097 | | | | |
| **CANCER SERVICES** | | | | | | | | | | | | | | |
| 14 day | % performance planned | *99%* | 60% | -39% | -40% | *100%* | 50% | -50% | -50% | 46% | 50% | 4% | 10% | 53% |
| 31 day | % performance planned | 92% | 75% | -17% | -19% | *85%* | 75% | -10% | -12% | 96% | 75% | -21% | -22% | 75% |
| 62 day | % performance planned | 60% | 50% | -10% | -16% | 57% | 50% | -7% | -12% | 55% | 50% | -5% | -9% | 50% |
| **DIAGNOSTICS** | | | | | | | | | | | | | | |
| MRI | MRI (inc Cardiac MRI) | 1306 | 900 | -406 | -31% | 1362 | 900 | -462 | -34% | 2067 | 900 | -1167 | -56% | 2700 |
| CT | CT (includes Cardiac CT) | 3283 | 2950 | -333 | -10% | 3222 | 2950 | -272 | -8% | 3131 | 2950 | -181 | -6% | 8850 |
| Non Obstetric Ultrasound | | 4681 | 4500 | -181 | -4% | 4195 | 4500 | 305 | 7% | 4067 | 4500 | 433 | 11% | 13500 |
| ECHO | | 643 | 700 | 57 | 9% | 643 | 700 | 57 | 9% | 583 | 700 | 117 | 20% | 2100 |
| | **Total** | | | **0** | **#DIV/0!** | | | **0** | **#DIV/0!** | | | **0** | **#DIV/0!** | **0** |
| **ALLIED HEALTH PROFESSIONALS** | **Elective /Scheduled Contacts** | | | | | | | | | | | | | |
| Physiotherapy | New | 2,372 | 1,897 | -475 | -20% | 2,307 | 1,845 | -462 | -20% | 1,685 | 1,348 | -337 | -20% | 5090 |
| | Review | 8,083 | 5,667 | -2,416 | -30% | 7,589 | 5,667 | -1,922 | -25% | 5,789 | 4,341 | -1,448 | -25% | 15675 |
| Occupational Therapy | New | 1,198 | 1,004 | -194 | -16% | 1,126 | 935 | -191 | -17% | 789 | 655 | -134 | -17% | 2594 |
| | Review | 2,221 | 1,800 | -421 | -19% | 2,058 | 1,678 | -380 | -18% | 1,444 | 1,174 | -270 | -19% | 4652 |
| Dietetics | New | 692 | 479 | -213 | -31% | 726 | 488 | -238 | -33% | 560 | 346 | -214 | -38% | 1313 |
| | Review | 1,347 | 1,365 | 18 | 1% | 1,349 | 1,388 | 39 | 3% | 913 | 985 | 72 | 8% | 3738 |
| Orthoptics | New | 285 | 301 | 16 | 6% | 231 | 251 | 20 | 9% | 151 | 161 | 10 | 7% | 713 |
| | Review | 1,087 | 1,000 | -87 | -8% | 920 | 900 | -20 | -2% | 578 | 600 | 22 | 4% | 2500 |
| Speech&Language Therapy | New | 234 | 367 | 133 | 57% | 248 | 317 | 69 | 28% | 210 | 204 | -6 | -3% | 888 |
| | Review | 4,845 | 4,529 | -316 | -7% | 4,132 | 3,909 | -223 | -5% | 2,606 | 2,513 | -93 | -4% | 10951 |
| Podiatry | New | 1,120 | 801 | -319 | -28% | 798 | 718 | -80 | -10% | 680 | 612 | -68 | -10% | 2131 |
| | Review | 6,528 | 6,000 | -528 | -8% | 5,590 | 5,031 | -559 | -10% | 5,015 | 4,515 | -500 | -10% | 15546 |
| | **Total** | **30,012** | **25,210** | **-4,802** | **-16%** | **27,074** | **23,127** | **-3,947** | **-15%** | **20,420** | **17,454** | **-2,966** | **-15%** | **65791** |
| **MENTAL HEALTH** | **Contacts** | | | | | | | | | | | | | |
| Adult Mental Health (Non Inpatient) | New | 516 | 464 | -52 | -10% | 489 | 440 | -49 | -10% | 379 | 341 | -38 | -10% | 1245.6 |
| | Review | 6,301 | 5,986 | -315 | -5% | 5,978 | 5,680 | -298 | -5% | 5,040 | 4,763 | -277 | -5% | 16429 |
| Dementia | New | 194 | 175 | -19 | -10% | 157 | 141 | -16 | -10% | 145 | 131 | -15 | -10% | 446.4 |
| | Review | 996 | 896 | -100 | -10% | 886 | 797 | -89 | -10% | 622 | 560 | -62 | -10% | 2253.6 |
| CAMHS | New | 249 | 211 | -38 | -15% | 240 | 193 | -47 | -20% | 154 | 143 | -11 | -7% | 547 |
| | Review | 1,273 | 1,850 | 577 | 45% | 1,150 | 1,691 | 541 | 47% | 877 | 1,251 | 374 | 43% | 4792 |
| Psychological Therapies | New | 239 | 200 | -39 | -16% | 233 | 200 | -33 | -14% | 211 | 180 | -31 | -15% | 580 |
| | Review | 2,533 | 2,100 | -433 | -17% | 2,288 | 2,100 | -188 | -8% | 1,620 | 1,400 | -220 | -14% | 5600 |
| Autism Children's | New Diagnostic | 114 | 89 | -25 | -22% | 82 | 69 | -13 | -16% | 45 | 38 | -7 | -16% | 196 |
| | New Intervention | 51 | 37 | -14 | -27% | 47 | 32 | -15 | -32% | 26 | 18 | -8 | -31% | 87 |
| Autism Adults | New Diagnostic | 22 | 8 | -14 | -64% | 16 | 10 | -6 | -38% | 19 | 12 | -7 | -37% | 30 |
| | New Intervention | 16 | 5 | -11 | -69% | 5 | 4 | -1 | -20% | 7 | 6 | -1 | -14% | 15 |
| | **Total** | **12,504** | **12,021** | **-483** | **-4%** | **11,571** | **11,358** | **-213** | **-2%** | **9,145** | **8,842** | **-303** | **-3%** | **32221.6** |
| **DAY CARE AND DAY OPPORTUNITIES** | | | | | | | | | | | | | | |
| Day Care | Number of Attendances - OP | n/a | 3,419 | #VALUE! | #VALUE! | n/a | 3,419 | #VALUE! | #VALUE! | n/a | 2,564 | #VALUE! | #VALUE! | 9402 |
| Day Care | Cumulative Number of Service Users | n/a | 1,067 | #VALUE! | #VALUE! | n/a | 1,067 | #VALUE! | #VALUE! | n/a | 1,067 | #VALUE! | #VALUE! | 3201 |
| **ADULT SOCIAL CARE** | | | | | | | | | | | | | | |
| Domiciliary Care | Hours Delivered (Stat) | 99,539 | 97,582 | -1,957 | -2% | 99,223 | 97,582 | -1,641 | -2% | 98,154 | 97,582 | -572 | -1% | 292746 |
| | Hours Delivered (Ind) | 136,654 | 153,640 | 16,986 | 12% | 135,376 | 153,640 | 18,264 | 13% | 134,002 | 153,640 | 19,638 | 15% | 460920 |
| Adult Short breaks | Hours of Short Break | 121,411 | 121,411 | 0 | 0 | 121,411 | 121,411 | 0 | 0% | 121,411 | 121,411 | 0 | 0% | 364233 |
| | **Total** | **236,193** | **251,222** | **15,029** | **6%** | **234,599** | **251,222** | **16,623** | **7%** | **232,156** | **251,222** | **19,066** | **8%** | **753666** |
| **COMMUNITY NURSING** | | | | | | | | | | | | | | |
| District Nursing | Contacts | n/a | 28,300 | #VALUE! | #VALUE! | n/a | 28,300 | #VALUE! | #VALUE! | n/a | 28,500 | #VALUE! | #VALUE! | 85100 |
| Health Visiting | Contacts | n/a | 4,042 | #VALUE! | #VALUE! | n/a | 3,638 | #VALUE! | #VALUE! | n/a | 3,092 | #VALUE! | #VALUE! | 10772 |
| **Community Dental** | New | 218 | 146 | -72 | -33% | 218 | 146 | -72 | -33% | 218 | 146 | -72 | -33% | 438 |
| | Review | 1,827 | 876 | -951 | -52% | 1,827 | 876 | -951 | -52% | 1,827 | 876 | -951 | -52% | 2628 |
| | **Total** | **2,045** | **1,022** | **-1,023** | **-50%** | **2,045** | **1,022** | **-1,023** | **-50%** | **2,045** | **1,022** | **-1,023** | **-50%** | **3066** |

## Annexe 2 – Activity Modelling – Winter 2021/22

Including an abridged version of Acute bed modelling submitted to HSCB on 6/10/2021

## 1. Modelling assumptions

DoH/HSCB planning requirements indicate that modelling should be carried out to include:

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

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

- The impact of waning immunity post vaccination and its impact on hospital demand
- The plan and effectiveness of any booster jab programme including target populations.
- Public behaviour
- The instigation of any regional mitigation such as circuit breakers
- The impact of influenza given the potential limited immunity in large parts of the population
- RSV impact which has an impact on children and frail elderly.

NB ICU figures are included in both the bed complement and bed demand

## 2. Non-Elective Inpatient beds

*2.1 Non elective baseline*

Activity projections for October 2021 to March 2022 have been based on the same months in 2019/20. These figures take into account a number of mitigating factors already in operation.

The table below shows these baseline 2019/20 figures, for non-elective beds only:

| Non-elective baseline 2019/20 | Oct-Mar average | Oct-Mar average (95% utilisation) |
|---|---|---|
| **Antrim** | 365 | 384 |
| **Causeway** | 153 | 161 |
| **Total** | 518 | 545 |

*2.2 Projected requirement*

The tables below show the average **non-elective beds** required by month modelled at 0% to 20% growth above 2019/20 figures based on 95% utilisation.

**Antrim**

| Non-elective projections 21/22 | Av Bed Requirement Oct-March |
|---|---|
| **Baseline (average beds required) based on Oct 19-Mar 20 at 95% utilisation** | 384 |
| **+5% unscheduled demand** | 404 |
| **+10% unscheduled demand** | 423 |
| **+15% unscheduled demand** | 442 |
| **+20% unscheduled demand** | 461 |

**Causeway**

| Non-elective projections 21/22 | Av Bed Requirement Oct-March |
|---|---|
| **Baseline (average beds required) based on Oct 19-Mar 20 at 95% utilisation** | 161 |
| **+5% unscheduled demand** | 169 |
| **+10% unscheduled demand** | 177 |
| **+15% unscheduled demand** | 185 |
| **+20% unscheduled demand** | 193 |

**Total**

| Non-elective projections 21/22 | Av Bed Requirement Oct-March |
|---|---|
| **Baseline (average beds required)) based on Oct 19-Mar 20 at 95% utilisation** | 545 |
| **+5% unscheduled demand** | 573 |
| **+10% unscheduled demand** | 600 |
| **+15% unscheduled demand** | 627 |
| **+20% unscheduled demand** | 654 |

## 3. Elective Inpatient beds

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

| Elective beds | SBA volumes |
|---|---|
| **Antrim** | 29 |
| **Causeway** | 17 |
| **Total** | 46 |

## 4. COVID-19 beds

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

Beds are calculated at 95% occupancy and based on bed requirements for peak on

Antrim 10th September 2021= 66

Causeway 7th September 2021 = 28

| Covid-19 beds | Sept 21 peak (4th wave) |
|---|---|
| **Antrim** | 69 |
| **Causeway** | 29 |
| **Total** | 98 |

## 5. Capacity

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

**Antrim base model**

| Antrim | Unscheduled requirement | Elective requirement (SBA) | COVID-19 requirement | Total beds required | Total beds available | Shortfall |
|---|---|---|---|---|---|---|
| 0% | 384 | 29 | 69 | 482 | 367 | -115 |
| 5% | 404 | 29 | 69 | 502 | 367 | -135 |
| 10% | 423 | 29 | 69 | 521 | 367 | -154 |
| 15% | 442 | 29 | 69 | 540 | 367 | -173 |
| 20% | 461 | 29 | 69 | 559 | 367 | -192 |

**Causeway base model**

| Causeway | Unscheduled requirement | Elective requirement (SBA) | COVID-19 requirement | Total beds required | Total beds available | Shortfall |
|---|---|---|---|---|---|---|
| 0% | 161 | 17 | 29 | 207 | 160 | -47 |
| 5% | 169 | 17 | 29 | 215 | 160 | -55 |
| 10% | 177 | 17 | 29 | 223 | 160 | -63 |
| 15% | 185 | 17 | 29 | 231 | 160 | -71 |
| 20% | 193 | 17 | 29 | 239 | 160 | -79 |

**Total base model**

| Total | Unscheduled requirement | Elective requirement (SBA) | COVID-19 requirement | Total beds required | Total beds available | Shortfall |
|---|---|---|---|---|---|---|
| 0% | 545 | 46 | 98 | 689 | 527 | -162 |
| 5% | 573 | 46 | 98 | 717 | 527 | -190 |
| 10% | 600 | 46 | 98 | 744 | 527 | -217 |
| 15% | 627 | 46 | 98 | 771 | 527 | -244 |
| 20% | 654 | 46 | 98 | 798 | 527 | -271 |

## 6. Mitigations

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

Neither acute hospital has the ability to open additional inpatient bed capacity to any significant extent due to the limitations of their physical footprint.

| | Mitigation | Anticipated beds delivered |
|---|---|---|
| **1** | Cap electives at 30%<br>(This is approximately the level currently being delivered) | 32 |
| **2** | Total cessation of inpatient elective activity<br>(This would only be deliverable for a short period of time) | 46 |
| **3** | Open 4 extra beds in Antrim gynae ward | 4 |
| **4** | Open up to a maximum of 7 extra beds across Causeway medical, surgical and gynae wards | 7 |
| **Total** | | **57** |

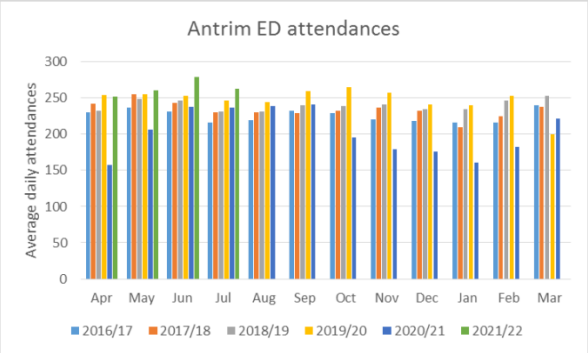
## 7. Summary

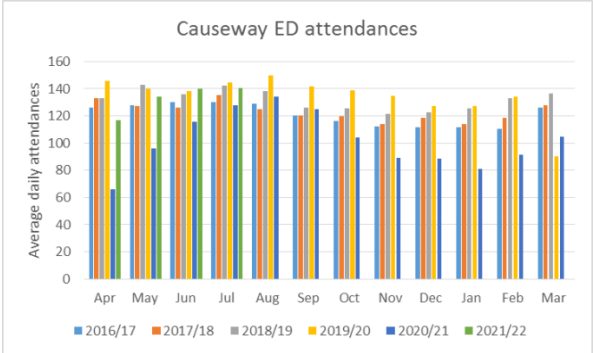
The tables below set out the overall bed requirement and assumed shortfall in capacity before and after the implementation of identified mitigations.

| base | Total beds required | Shortfall | Shortfall plus Mitigations |
|---|---|---|---|
| 0% | 689 | -162 | -105 |
| 5% | 717 | -190 | -133 |
| 10% | 744 | -217 | -160 |
| 15% | 771 | -244 | -187 |
| 20% | 798 | -271 | -214 |

**ED attendances**

Charts for ED attendances at Antrim and Causeway are provided below. They show a very marked reduction in activity experienced during the early part of the COVID pandemic. Activity in Antrim ED had fully recovered by June 2021, and June/July figures this year were 8.3% higher than the same months in 2019. Causeway ED activity has not yet fully recovered to pre-pandemic levels, with attendances still 0.8% below those in 2019.




ED attendances also follow a seasonal pattern, although it is different to the pattern seen when considering bed occupancy. Total ED footfall tends to peak in late spring / early summer, although pressure in ED is most keenly felt in the winter, when high bed occupancy drives delays in patients leaving the department for admission to a hospital bed.

The following tables project average daily ED attendances based on a range of increases above baseline demand. It should be borne in mind however that the pressure on an ED will be driven by a range of factors besides total attendances, notably any mismatch between capacity and demand in the inpatient bed system.

| Average daily attendance projections 21/22 – Antrim | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|
| **Baseline (daily average)** | 259 | 264 | 257 | 241 | 239 | 253 | 259 |
| **+5% demand** | 272 | 277 | 270 | 253 | 251 | 266 | 272 |
| **+10% demand** | 285 | 291 | 283 | 265 | 263 | 278 | 285 |
| **+15% demand** | 297 | 304 | 295 | 277 | 275 | 291 | 298 |
| **+20% demand** | 310 | 317 | 308 | 289 | 287 | 304 | 311 |

| Average daily attendance projections 21/22 – Causeway | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|
| **Baseline (daily average)** | 142 | 139 | 134 | 127 | 127 | 134 | 137 |
| **+5% demand** | 149 | 145 | 141 | 134 | 134 | 141 | 144 |
| **+10% demand** | 156 | 152 | 148 | 140 | 140 | 148 | 151 |
| **+15% demand** | 163 | 159 | 155 | 147 | 146 | 154 | 158 |
| **+20% demand** | 170 | 166 | 161 | 153 | 153 | 161 | 165 |