Department of Health
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COVID-19 PANDEMIC

SURGE PLANNING STRATEGIC FRAMEWORK

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MINISTERIAL FOREWORD

1. INTRODUCTION

1.1 Medical surge capacity refers to the ability to evaluate and care for a significantly increased volume of patients—one that challenges or exceeds normal operating capacity.

1.2 The main steps of surge planning are:

- Identify the need;
- Identify the resources to address the need in a timely manner;
- Move the resources at the appropriate time to locations to meet population need (as applicable);
- Manage and support the resources to their absolute maximum capacity.

1.3 The coming period is highly uncertain. It is expected that there will be a second COVID-19 wave later in the year. At this stage, the timing and scale of a second wave is unpredictable as it will depend on a range of factors including the future approach to social distancing; population adherence to these measure; continued frequent hand washing, good respiratory practice; and appropriate use of face coverings.

1.4 The Health and Social Care (HSC) system coped well through the first COVID-19 wave, partly due to the fact that it was not as severe as initially feared but also because attendances at Emergency Departments reduced significantly during that period. This released capacity to assist with managing the pandemic. This may not be the case in the coming months. A high degree of uncertainty about the future path of the pandemic remains, however a second wave may coincide with winter pressures and this could lead to the most challenging winter ever faced by our HSC system.

1.5 Given that a second wave could potentially coincide with winter pressures, it will be important that there are comprehensive surge plans in place for critical care, hospital beds, care homes and all other health and social care services. Even without a second COVID-19 wave, our health and care system comes under significant pressure each winter.

1.6 In recent winters, HSC Trusts have routinely been close to, or have exceeded, their available capacity and this has led to long waits for patients and crowded hospitals. Furthermore, in the first wave, Trusts reconfigured services significantly in order to respond to the pandemic challenge and to reduce the risk of COVID-19 transmission in health and care settings. It is likely that these changes will further reduce the existing capacity of the system to deal with large numbers of patients.

1.7 This Surge Planning Strategic Framework (the 'Framework) provides the overall structure and parameters within which HSC Trusts will develop plans for managing the response to COVID-19 in the event of further waves. This Framework:

- Highlights important learning from the first wave.
- Sets out our approach to surveillance and modelling.
- Reviews actions to minimize COVID-19 transmission and impact.
- Summarises key regional initiatives to organise health and social care services to facilitate effective service delivery;
- Highlights actions around the key issues of workforce, medicines and testing.
- Confirms a number of principles for our Health and Social Care Trusts to adopt when developing their individual surge plans.

1.8 It is important to highlight that in developing this Framework learning from the first wave has been applied to inform planning and preparation for managing further potential Covid-19 waves. This Framework does not cover all potential issues and services but instead highlights the key strategic issues involved with planning for further COVID-19 surges.

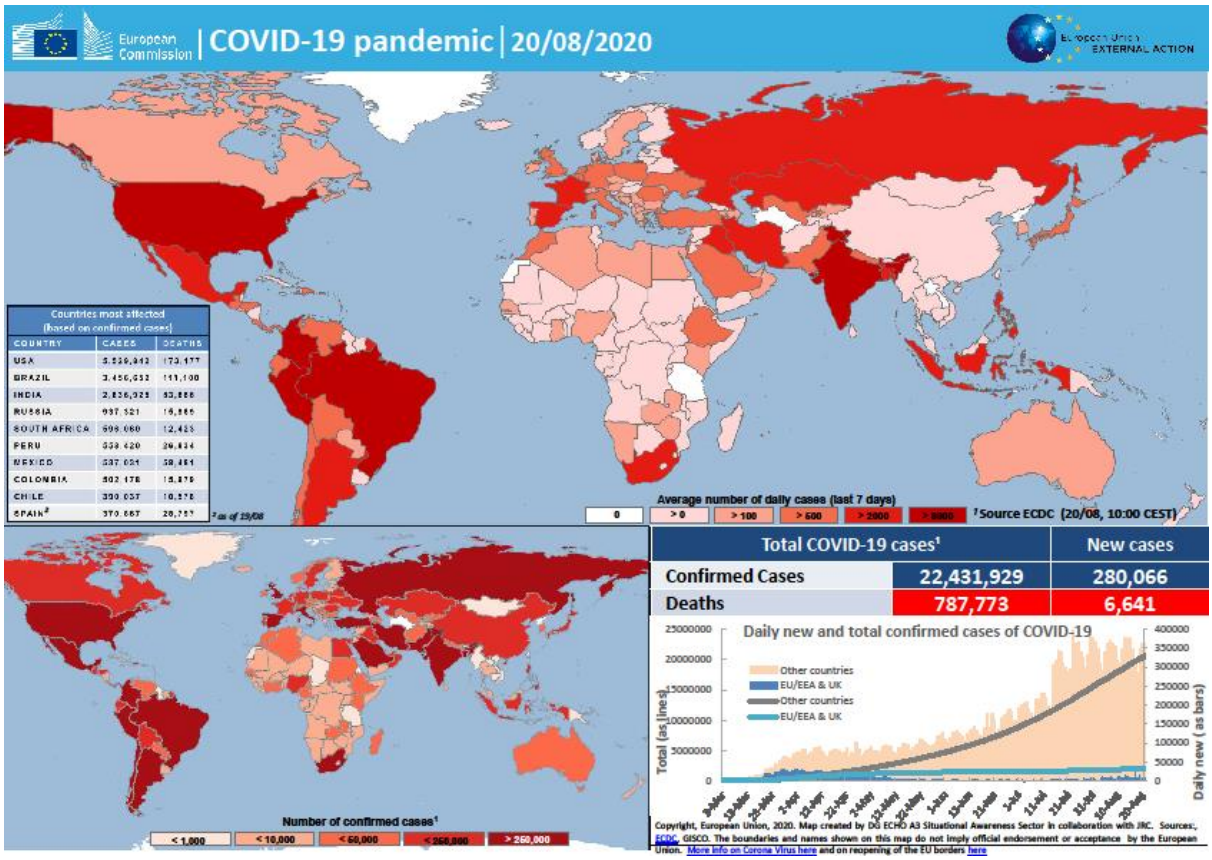
2. COVID-19 PANDEMIC PATH

2.1 The first wave of the pandemic impacted significantly on our population and our HSC services. To date the impact has been:

- As of 21st August, there have been 6,576 individuals with a positive laboratory completed test.
- At 21st August 2020, 559 deaths had been reported to the PHA where an individual died within 28 days of a positive laboratory completed test.
- A significant reduction in many HSC services such as elective care and screening as set out in the Rebuilding HSC Services Strategic Framework.
- An adverse impact on population health, including mental health associated with anxiety and lockdown isolation.

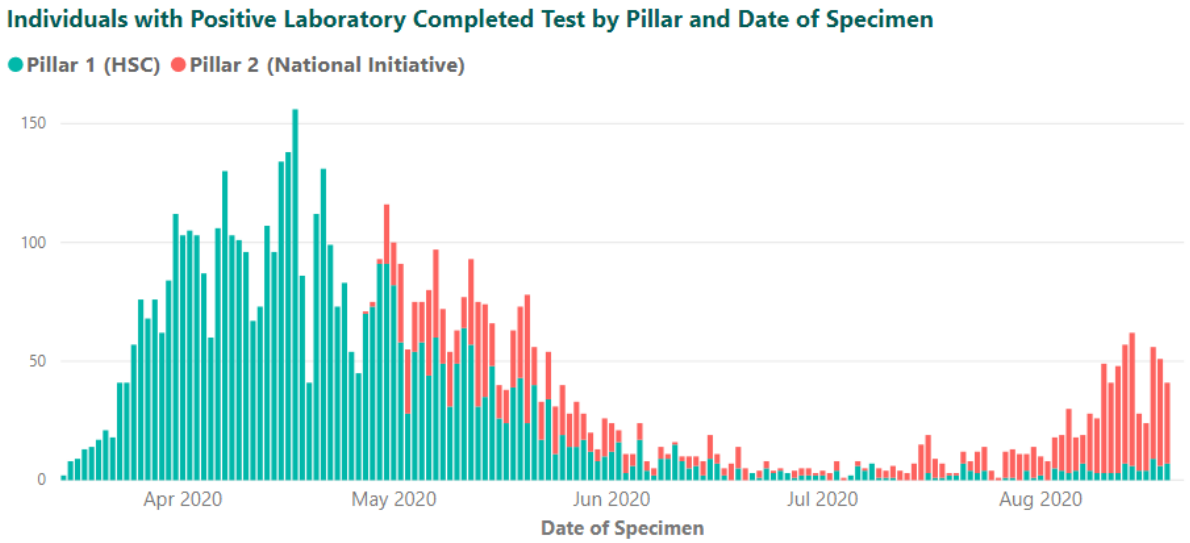
2.2 Figure 1 below shows the spread of COVID-19 worldwide as of 20 August 2020.

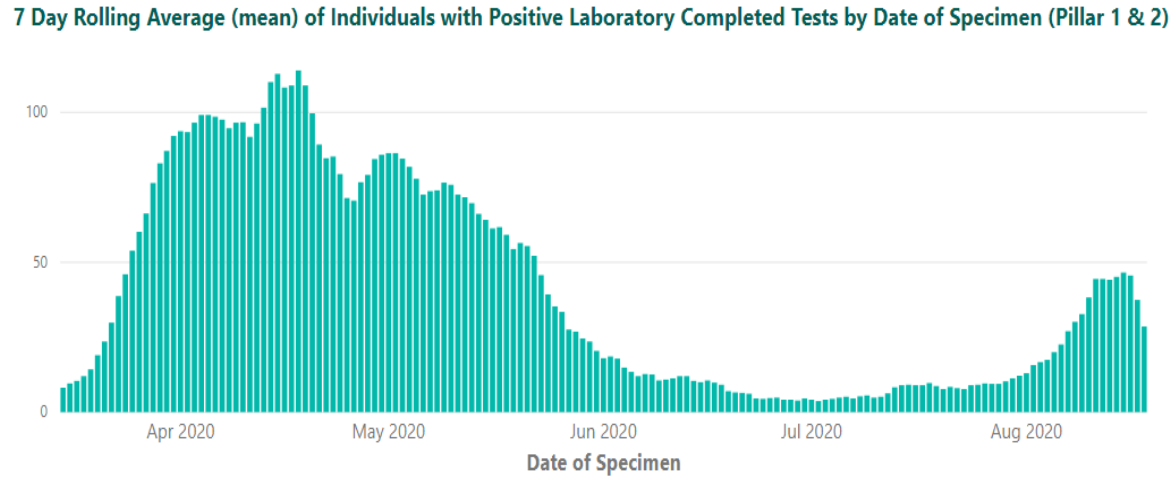
Figure 1: COVID-19 Spread in Europe



2.3 In terms of Northern Ireland, the chart below shows that the number of COVID-19 cases during the first wave peaked in April 2020, with the highest number of daily cases reported on 17th April 2020 (156).

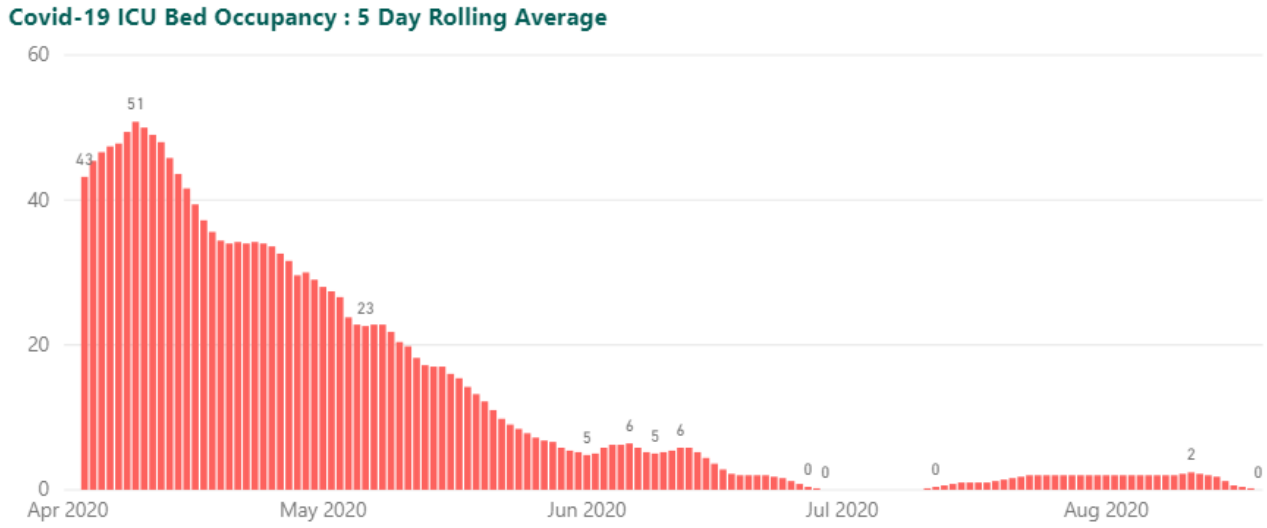
Figure 2: Northern Ireland Confirmed COVID-19 cases





2.4 The number of occupied ICU beds due to COVID-19 also peaked during April as demonstrated in figure 3:

Figure 3: COVID-19 Occupied ICU Beds



2.5 The COVID-19 reproduction number, R, plays an important role in monitoring the spread of the virus. The Department has been publishing estimates of the R number since 4 June 2020 and continues to publish on a weekly basis. When R is below 1, the number of new COVID-19 cases, hospital admissions and deaths are generally declining, whilst the opposite is true when R is above 1. R has generally been estimated at around or below 1 during June and July but have been rising during August. Whilst this increase in R has been reflected in rising numbers of infections, the impact on hospital admissions has been modest to date, compared to that seen during the first wave. There are likely to be two main explanations for this. The first is that there is lag from when infections are detected and this manifesting itself in increased hospital admissions. The second is that with much increased testing capacity a higher proportion of cases are detected, including those that are less acute and do not require hospital admission.

2.6 The future path of the pandemic depends on a wide range of factors, including continued community adherence to social distancing and other measures; the timing of any possible effective vaccination; its availability for our population and attitudes to such a vaccination. The Department will continue to monitor the path of the pandemic in the coming weeks and months.

3. LEARNING FROM THE FIRST SURGE

Introduction

3.1 In planning for further COVID-19 waves, there is significant learning to be derived from our experience of the first wave of the pandemic. Much of this learning was set out in the Rebuilding HSC Services Strategic Framework[1], along with the impact on HSC services and will not be repeated here.

Surge Capacity Planning

Response to the First Wave

3.2 As COVID-19 is a new virus, the response to the initial surge was implemented in the face of significant uncertainty about its behaviour, severity and impact. Early in the preparations for the initial surge period, it was necessary to make assumptions about the percentage of patients in different age bands who would be admitted to hospital and the likely outcomes for those patients.

3.3 At that 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 acute bed capacity to ensure that every patient requiring treatment would receive it.

3.4 In response to the fast spread of COVID-19, the Critical Care Network for Northern Ireland (CCANNI) was tasked with rapidly developing a regional critical care surge plan. In parallel, the Belfast City Hospital was designated as Northern Ireland's first Nightingale hospital providing an additional 75 critical care beds. The CCANNI surge plan allowed for a total capacity of 286 critical care beds with triggers built in to facilitate transfers of patients to the Nightingale hospital as needed. Additional logistical support was also put in place urgently through an arrangement with the army.

3.5 Significant work was also carried out on major hospital sites to ensure sufficient capacity for medical gases in the event of a major surge in demand. This work was completed in advance of the initial surge. In collaboration with the Health and Social Care Board (HSCB) and HSC Trust teams, the Department will continue to monitor this and ensure any further works or maintenance are carried out as required.

[1] https://www.health-ni.gov.uk/publications/rebuilding-hsc-services

3.6 Urgent action was also taken across primary care, community care, social care and dental and ophthalmic services. These actions are described later in this section. All of these actions meant that a comprehensive surge plan was rapidly put in place to ensure critical care was available to those people who might need it and that other services adjusted quickly to the evolving situation.

Impact on Hospital Capacity

3.7 In the event, the impact of social distancing and other behaviours resulted in lower levels of community transmission and hospital admissions than the worst reasonable case modelling suggested. Similarly, the number of patients requiring critical care following admission to hospital was much lower than expected. Information from CCANNI suggests that the conversion rate into critical care may have been as low as 10%, rather than the 30% anticipated by the Imperial College COVID-19 Response Team. In fact, many patients admitted to hospital were able to be clinically managed outside a critical care setting.

3.8 Similarly, the expected demand for medical beds did not rise to the levels identified within the Department's reasonable worst case scenario. This, allied to lower than normal attendance at urgent and emergency departments, meant that at no point during the first wave were our acute services at risk of being completely overwhelmed. However, there was significant pressure experienced by HSC staff in having to rapidly respond to the additional demand.

Non-COVID-19 Hospital Services

3.9 With a finite amount of physical capacity and staffing resources within the HSC system in Northern Ireland, it is not possible to provide the same level of mainstream healthcare service during a period of surge. Emergency departments, inpatient bed capacity, and associated services such as operating theatres, will be particularly pressurised during peak surge weeks.

3.10 Pausing the delivery of services has a detrimental impact on patients, and so it is essential to protect as much of the normal healthcare system as possible. In order to do this, the Department approved a staged approach for non-COVID specialities, cancer services and temporary reconfiguration of in-patient paediatric and maternity services. In line with nationwide clinical guidance, the approach outlines the phasing of service reduction to be applied regionally, based on the level of COVID-19 surge, to aid clinicians in their decision-making.

Surgical Prioritisation

3.11 During the first COVID-19 wave, the HSCB, in conjunction with Trusts and clinical networks, identified those interventions within each specialty which have the highest impact on reducing mortality/morbidity, and those that could reasonably

be delayed, with the intention of mitigating the impacts of redirecting resources and capacity to respond to a surge and minimise the risk of adverse outcomes for non-COVID related patients in need of time-critical treatment. These secondary care interventions and investigations were assigned priority levels, with services or interventions that preserve life, limb or senses having the highest priority. These guidelines were heavily informed by guidance developed by the Royal Colleges. During a period of surge, these guidelines will continue to provide the basis for clinical judgments to be made, in consultation with patients.

Cancer Services

3.12 Cancer waiting times were challenging pre-COVID, with particular pressures on diagnostic capacity. There has been a significant fall in red flag referrals during the pandemic surge and it is anticipated that the service is likely to experience a surge in referrals over the coming months, with the potential for an increase in late stage presentation. The implications of restarting of cancer screening services are also being considered.

3.13 A bespoke approach was designed for cancer services. The Northern Ireland Cancer Network (NICaN) worked with cancer specialists across the region to develop a regional and equitable approach to the delivery of cancer services during the pandemic. As with the approach to other non-COVID-19 specialities above, this approach involves identifying those interventions within each cancer sub-speciality (tumour site) which have the highest impact on reducing mortality/morbidity, and conversely those interventions that could reasonably be delayed with an acceptable level of risk, following discussion with patients.

3.14 While most cancer diagnostics continued throughout the first surge, measures put in place to ensure patient safety in the context of COVID-19 inevitably impacted capacity and, when compounded with patient reluctance to attend hospital for diagnostic appointments, has led to an increased back log. This is a particular issue for colonoscopy where national guidance meant a total cessation of activity for a period of approximately 6 weeks.

3.15 NICaN produced tumour site / service specific surge plans and regional guidance on the prioritisation of treatment during surge. In terms of surgery, the larger tumour sites report that they have been able to provide surgical treatment to all priority 1 & 2 patients through a combination of in house and independent sector (IS) delivery. However, the impact of the Nightingale hospital within Belfast has resulted in delays to some specialist surgery. With some regionally agreed changes to practice, radiotherapy and systems, anticancer therapy was largely maintained throughout the first surge. Some of these changes to practice, aimed at minimising the need to attend hospital (e.g. telephone consultation; use of alternative regimens / treatment protocols) continue to be used and have the

potential to underpin significant reform which should optimise capacity and enhance patient experience in the future.

Paediatric Services

3.16 While children as a population do not seem to be severely impacted by COVID-19, some do require hospital care. There is a significant risk that the demands of a pandemic could cause disruption to urgent and emergency paediatric services and the associated maternity and neonatal services during a surge period.

3.17 As a result, a paediatric surge plan was developed to ensure the continued delivery of urgent and emergency specialist and local paediatric services and the associated maternity and neonatal services. The plan implements a step-wise temporary reconfiguration of inpatient paediatric services in response to the COVID-19 surge, with a regional approach to triggering, monitoring and communication.

3.18 The paediatric surge plan will be reviewed and updated by the Child Health Partnership by 18th September 2020 in preparation for further COVID-19 surges. The regional approach will be maintained but the steps will be reviewed to take account of the seasonal nature of paediatric inpatient activity which is much higher during autumn and winter months mainly as a result of other respiratory viruses.

*Maternity Serv*ices

3.19 Maternity services cannot be paused and consequently maternity services had to adapt significantly and swiftly throughout the pandemic. As of 16th March 2020 pregnant women have been placed under the 'vulnerable group' which caused concern and anxiety amongst the pregnant population. Although the evidence suggests that pregnant women do not appear more likely to contract COVID-19 than the general population, pregnancy alters the body's immune system and response to viral infections in general, which can occasionally cause more severe symptoms. This may be the same for COVID-19 but there is currently no evidence that pregnant women are more likely to be severely unwell, need admission to intensive care, or die from the illness than non-pregnant adults.

3.20 Most pregnant women with COVID-19 will experience only mild or moderate cold/flu-like symptoms. However, risk factors that appear to be associated with hospital admission with COVID-19 illness include Black, Asian or minority ethnicity (BAME), overweight or obesity, pre-existing comorbidity and maternal age above 35 years. Data from the UK Obstetric Surveillance System study indicate that most women were hospitalised in the third trimester (last 3 months

of pregnancy) or peripartum. Evidence suggests that mother to baby transmission of infection might be possible. However, further investigation around this issue is required and is underway.

3.21 The 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries' report[2] on learning from deaths of pregnant and recently pregnant women in the UK during March – May 2020 related to or associated with COVID-19 made a number of recommendations relating to the clinical management of pregnant women with COVID-19, access to mental health, postnatal and critical care, adult safeguarding and communication with pregnant women and their families. HSC Trusts will be expected to implement these recommendations as an immediate priority.

3.22 In responding to and managing COVID-19, Consultant Obstetrician rotas changed to shift cover, with specialist midwives redeployed, however, it is recognised that women, babies and families continue to need support of their Midwives, especially those women and families with complex vulnerabilities. Home delivery services were impacted with noted increased requests from women for this service. This was reviewed on an individualised basis depending on staffing and ambulance availability in the event of emergency transfer. Intrapartum care was suspended in the three freestanding Midwifery Led units and inpatient maternity services at the Causeway Maternity Unit were paused. Face-to-face visits were reduced and virtual visits introduced with increased use of technology and community hubs. A regional Website '*Northern Ireland Maternity and Parenting'* was developed to provide up to date guidance on COVID-19 and communicate to women changes in service delivery in each HSC Trust throughout Northern Ireland. Innovative ways of working were introduced embracing virtual and online technology.

Care Homes

3.23 COVID-19 has impacted many residents, their relatives and staff working in the care home sector. Based on their age and underlying conditions, many care home residents were at high risk from the effects of COVID-19. A number of interventions were put in place to control transmission in care homes and to mitigate its impact on residents and staff.

3.24 These interventions included the provision of support from specialist infection prevention and control teams; repurposing of Health and Social Care acute care

[2] https://www.hqip.org.uk/resource/maternal-newborn-and-infant-programme-learning-from-sars-cov-2-related-and-associated-maternal-deaths-in-the-uk/

at home teams to provide additional support to homes; additional funding for a bespoke training on using PPE and clinical treatment of COVID-19 including enhanced cleaning and specialist equipment to support regular symptom monitoring among care home residents; the provision of PPE to independent sector care home providers free of charge; and the completion of a programme of testing for all care home residents and staff, including in homes without an outbreak.

3.25 While it is recognised that visiting restrictions were difficult for residents and their loved ones, support was provided to homes to help families keep in contact remotely.

Rapid Learning Initiative

3.26 To ensure that learning from the above interventions inform planning for future COVID-19 waves, the Minister tasked the Chief Nursing Officer with carrying out a Rapid Learning Initiative into care homes. The key findings from this initiative were 24 recommendations, within six themes. These can be used to focus learning from the transmission of COVID-19 into Care Homes during the first surge to mitigate the impact on residents and staff of potential further surges. The six themes are as follows:

1. **Technology**: Leverage technology to keep people, knowledge and learning connected.
2. **Information**: Manage information and guidance to and from Care Homes more efficiently and effectively.
3. **Medical support**: Provide consistent medical support into the Care Homes.
4. **Health and wellbeing**: enhance the health and wellbeing interventions for residents, families and staff.
5. **Safe and effective care**: enhance safe and effective practices including access to training for Care Home staff.
6. **Partnership**; enhance partnership working across all organisations.

3.27 The Rapid Learning Initiative also identified three overarching structures and processes that will need to be established to support the delivery of outcomes and bring about a learning system that works across Heath and Social Care, including the independent sector and Trusts. The three overarching structures are as follows:

- At strategic level, the collaborative partnerships established for the purposes of the Initiative should continue and develop further to support future development of Strategy and Policy;
- A regional learning system should be developed. This should include identifying key quality indicators for Care Homes (led by frontline staff) using real-time data that can for continuous improvement;

- A quality improvement learning system should include building the capability and capacity within Care Home staff to use continuous improvement methodologies to implement operational improvement as a system.

Primary Care

3.28 The general key learning from phase one within wider primary care has been around the speed at which GP practices were able to adopt and adapt to new ways of working and embrace new technologies to ensure key services were maintained for their practice populations. This included the development of widespread remote patient triage prior to attendance and the introduction of virtual consultations, both of which were fundamental changes to how primary care ordinarily operates.

3.29 More specific to the Primary Care COVID-19 centres, the importance of empowering local leaders, providing clarity of purpose and embedding a collegiate approach were all critical to the successful and speedy implementation of centres. Rapid escalation of issues and daily accessibility to senior figures from across primary care, supported by timely support and clear direction from the Department and HSCB, created the environment for prompt delivery, rigorous disease control, maximum use of existing infrastructure and previously unparalleled levels of synergy with the rest of HSC.

3.30 From a peak of around 1,000 referrals per week, Primary Care COVID-19 centres are currently receiving around 500 referrals per week. Staffing of the centres has, therefore, been reduced by half to reflect this reduced demand, with some staff placed on standby, allowing them to carry out other duties whilst remaining available to assist patients in the COVID-19 centres if needed. Rotas are developed by GP Federations a number of weeks in advance of each shift and this will ensure that centres can be staffed to full capacity should the need arise. Escalation plans in the event of a future wave would include, but are not limited to, reopening space not currently in use, reducing number of staff on standby and increasing the numbers of staff on each rota. Consideration could also be given to opening further centres, if it was deemed appropriate.

Mental Health

3.31 Mental Health in-patient services remained operational during COVID-19 and no services were stood down. There was at times the need to close particular wards to new admissions on a temporary basis due to staffing issues or a COVID-19 positive patient. However, these wards became fully operational again when staffing levels increased or when IPC measures were deployed.

3.32 Psychological Therapy Services remained operational during COVID-19 and no services were stood down and services have continued unless deemed clinically inappropriate on a case by case basis. However, in line with COVID-19 best practice guidance to ensure the safety of clients and staff, psychological therapies were delivered via alternative means, e.g. telephone or video calling, wherever possible. Approved digital therapies were also employed as adjuncts to therapy where appropriate. During COVID-19 Psychological Therapy Practitioners also manned helplines and offered Psychological First Aid and support to the workforce as per the HSC Regional Staff Wellbeing Framework, developed in response to the pandemic.

3.33 Mental health day centre services were stood down as a result of COVID-19, and in line with IPC advice. All Trusts are working at resetting MH day centre services as per Stage 2 of the reset and recovery planning. All individuals and families are being involved in the process to agree limited attendance in line with social distancing and IPC advice. Redeployed staff are now being brought back to their substantive posts to support the reset of day centres.

Learning Disability

3.34 The Health & Social Care Board (HSCB) have coordinated the development of operational recovery plans across LD services to restart services in a regionally consistent and phased manner. Decisions to restart, prioritise and scale up services will be informed by factors such as safety, individual need, transmission rates, public health guidance, workforce readiness/re-deployment, risk assessment and estate capacity for social distancing measures within each Trust facility.

3.35 Admission to LD Inpatient Services were stood down in in line with Infection Protection Control advice. In addition, many of the inpatients were identified as in need of 'shielding' and the steps taken to cease admissions were essential for the safety of this cohort. However, were an admission to an inpatient facility was required for a person with LD this was facilitated within a Mental Health ward which had remained open to admissions.

3.36 Day Centre services were stood down in March to reduce community transmission of COVID-19. Facilities re-opened in July 2020 at a reduced level with plans to increase service provision over the coming months, however, social distancing presents a significant challenge to a return to full operational delivery. The HSCB and Trusts are exploring ways to accelerate this process.

3.37 Day opportunities have restarted to a limited degree as a number of community venues and employers are not able to accommodate placements due to infection control requirements. Trusts are working directly with voluntary sector providers to develop recovery plans, although this process is still underway. Short breaks and respite care have been restarted at a reduced capacity.

3.38 A number of actions were taken during the first surge to support people with LD, families and carers. At a regional level, the Public Health Agency developed guidance for service users, families and carers to improve awareness on COVID-19 and better enable families to cope during strict lockdown restrictions. HSC Trusts and voluntary sector providers redeployed staff to provide alternative services, utilising digital platforms to reduce social isolation and improve mental health. In limited cases, exceptional day services were provided to service users at risk of placement breakdown.

3.39 Autism services within the Trusts have continued to provide support to families via telephone or virtual platforms throughout the pandemic. Statutory Assessments continued at a reduced level as clinical and educational settings were unavailable during the first surge. Acknowledging the additional pressure placed on many families as a result of the pandemic a joint Health and Education Oversight Group on Special Educational Needs has been established.

Dental and Ophthalmic Services

3.40 In response to COVID-19, non-urgent care was suspended for both General Dental and Ophthalmic services with alternative arrangements put in place for those patients requiring emergency treatment. While this worked effectively in general, a key lesson is the importance of ensuring that sufficient alternative arrangements are in place for emergency care as part of any plans to restrict routine services. There is also a need to balance the risk from transmission of the COVID-19 virus against the impact on patients of a delay in dental care or eye care.

3.41 One of the greatest challenges in respect of dental services has been in respect of the resumption of non-urgent care given the need for enhanced infection control measures due to the greater risk of virus transmission from Aerosol Generating Procedures (AGPs). Early planning is required to ensure that Dental Practices and Ophthalmic Practitioners are made aware of the necessary changes in operating procedures and are able to source sufficient levels of Personal Protective Equipment to be in a position to resume services as early as possible.

PPE

3.42 The global COVID-19 pandemic resulted in a significant and intensified global demand for PPE at a time when the global supply chain was experiencing extreme pressure due to the huge uncertainties associated with a ban on the export of PPE by China, a leading global provider.

3.43 This had the potential to significantly impact the availability of PPE in Northern Ireland and as a result every feasible route was pursued locally, nationally and internationally to enhance supplies. DoH Pandemic Influenza Preparedness Programme (PIPP) stocks were released to provide support whilst additional stock was being sourced. Procurement activity was significantly ramped up from early February 2020 with use made of the emergency legislative easement to speed the end to end procurement process.

3.44 The Department's strategic approach has been to focus, alongside the Department of Finance, on ensuring all supply lines were maximised to their full potential. Orders were placed with existing and new suppliers and, working with Invest NI, a call was put out to local manufacturing seeking support in repurposing their manufacturing processes to produce suitable PPE. A coordinated approach across the UK has been adopted and the Department has worked alongside the other nations to ensure continuity of supply.

3.45 A PPE Plan covering the 4 Nations was published on 10 April 2020. The three-strand plan provides clear guidance on who needs PPE and when they need it, ensures those who need it can get it at the right time and sets out action to secure enough PPE to last through the crisis. The Department has worked closely with England, Scotland and Wales on all aspects of that plan including the receipt and provision of mutual aid and has developed its own plan to underpin the key actions.

3.46 The Business Support Organisation distribute PPE Supplies to the 5 Health Trusts who in turn provide to their frontline staff in Hospitals as well as Domiciliary Care, Community Care and Social Workers. Whilst there were some challenges with distribution at the outset of the pandemic, particularly to the independent sector, steps were quickly taken to address this. The Department worked with the Trusts to put in place the necessary processes to support independent providers running care homes and providing domiciliary care where they were unable to secure their own PPE.

3.47 As an indicator of the scale of the distribution during the first wave, in 2019 the average weekly supply of PPE to the 5 Trust was 1.4 million items per week. In week ending 21 June 2020, BSO distributed over 6.24 million items of PPE to

the 5 Health Trusts who in turn provided approximately 2.94 million items of PPE to Domiciliary Care and Care Homes for week ending 21 June 2020.

3.48 A new demand management process was also put in place supported by management information on stock levels and usage rates to enhance transparency in terms of potential PPE pressures and overall management control of PPE stock.

3.49 The key priority has been to ensure the safety of those working in a health and social care setting. It has therefore been of paramount importance that those staff have been fully aware of and have had confidence in the appropriate use and application of PPE. In addition to ensuring the provision of all updated guidance, a dedicated email contact point was established through which staff were able to raise any concerns with regards to distribution and quality.

Medicines

3.50 Medicines are the most commonly used medical intervention and pharmacy teams lead on optimising their use across all sectors of the HSC, including community pharmacies, general practices and hospitals.

3.51 COVID-19 presented a number of significant challenges related to access to medicines and the pharmaceutical care provided by pharmacy teams. This required a wide range of interventions to be made during the initial surge. A Pharmacy Surge Planning Group was convened to lead the operational response needed.

3.52 Pressures on the global medicines supply chain and a risk of shortages of critical treatments required rapid action to ensure essential supplies of medicines and related products were available in Northern Ireland for the increasing number of patients requiring intensive care and palliative care, and a new modelling methodology was developed to inform the procurement, supply and distribution of critical care medicines across Trusts.

3.53 Enhanced local manufacturing of high risk drugs and near patient production of batch intravenous drugs by all Trusts ensured access in critical care units, while Pharmacists and pharmacy technicians were re-trained and re-deployed to critical care and other essential services to maximise the use of the available workforce as staff absences rose.

3.54 New arrangements were established to ensure that patients on specialist treatments, including cancer, received home deliveries of their medication. Pharmacist led virtual clinics supported patients receiving specialist treatments and technology was used to provide education and learning for staff.

Arrangements were established to improve access to essential medicines in care homes, including palliative care and oxygen.

3.55 Pharmacy teams supported the rapid establishment of the Nightingale Hospital, COVID-19 centres and step down facilities, while community pharmacies quickly adapted practice and opening hours, prioritised services and worked with community and voluntary organisations to successfully maintain supplies of prescriptions and over the counter medicines for the public.

Conclusion

3.56 The planning for the initial surge was carried out at a time when there was limited data available on the pandemic trajectory. In this context, plans were put in place to deal with an extreme level of surge. As a result of this planning, every patient requiring treatment for COVID-19 was able to receive it. However, it is also clear that the creation of so much additional capacity had a significant impact on other HSC services. The scale of this impact is outlined in the *Rebuilding HSC Services Strategic Framework*.

3.57 It is also important to recognise the impact on staff during this first wave. While the levels of demand did not reach the scenarios set out in the Department's reasonable worst case scenario, they still represented a significant increase in critical care demand compared to normal commissioned capacity. Staff across acute care and social care have had to learn new skills, adapt to rapid redeployment and work in challenging environments in uncomfortable PPE for long periods.

4. REGIONAL PLANNING ASSUMPTIONS

4.1 A number of planning assumptions have been made in the development of this Framework. These are outlined below:

- There is a risk of further waves of COVID-19. These must be considered alongside recurrent winter pressures.
- With the increased capacity to test and trace, there will be early warning of any rise in infection rates.
- Critical Care will need to be ready to flex up at short notice according to the regional critical care escalation plan.
- The Department will continue to monitor the spread of COVID-19. 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 level of surge planning must be based on sustainable staff rotas.
- Appropriate PPE must be available to staff in different clinical settings.
- The impact on non-COVID-19 secondary and tertiary services should be minimised.
- Changes to service configuration may be required to meet specific challenges and protect services and patients.
- Flow must be maintained through hospitals. This will require strict protocols to ensure timely and safe transfer of patients from hospital to community settings, including step-down into care homes.

5. SURVEILLANCE & MODELLING

Demand and Supply Modelling

5.1 Modelling has been carried out to assess the impact of any increase in transmission of the virus on the expected demand for COVID-19 services in the context of existing HSC capacity. This has been used to inform the approach to the delivery of additional capacity as set out in Section 7 (second Nightingale facility).

COVID-19 Modelling

5.2 The modelling group established by the Chief Medical Officer and chaired by the Chief Scientific Advisor has made it possible to track and monitor the trajectory of the pandemic much more effectively. As a result of this, decisions on de-escalation of surge capacity were taken rapidly in the light of emerging information on declining numbers of hospital admissions. This allowed staff and equipment to be freed up to return to providing mainstream health and social care services, although with ongoing constraints imposed by issues such as a need to adhere to social distancing and the use of PPE.

5.3 Northern Ireland specific data and modelling will continue to be used to enable more effective planning and ensure that there is early warning of any impact on health and social care services. The existence of this modelling will also enable a different approach to surge planning. In any further waves, while plans to expand capacity for COVID-19 patients will be in place, there will also be increased emphasis on maintaining non COVID-19 services.

5.4 Using the available data, combined with surveillance of influenza and other winter diseases, it is intended that Chief Medical Officer and Chief Scientific Advisor will provide advice to the Minister and Northern Ireland Executive who will make decisions on the need to re-introduce measures to reduce the R number in the event of any significant and sustained increase in the epidemic.

5.5 With this approach, the intention is to ensure that the system is equipped to deal with a significant increase in demand, but also to keep that level of demand manageable in order to prevent the health and care service becoming overwhelmed. Since demand is widely defined in a health and social care context, it is not practicable to be definitive about a certain trigger point. Instead, the Chief Scientific Advisor and the Chief Medical Officer will continue to monitor a wide range of surveillance data and will advise the Executive if they judge that action is required to contain the spread of the virus.

6. MINIMISING TRANSMISSION AND IMPACT

6.1 In the absence of a vaccine or effective prophylactic treatments it has been deemed important from the outset to minimise transmission of the virus. At a global level this has largely been through rigorously applying public health measures such as social distancing, hand hygiene and the use of face coverings.

6.1 The Northern Ireland Executive announced measures restricting the movements of the population and encouraging working from home for all but essential functions on March 28th. This was underpinned by the The Health Protection (Coronavirus, Restrictions) (Northern Ireland) Regulations 2020.

6.3 On May 12th the Northern Ireland Executive published a phased five-stage coronavirus recovery plan. The document set out the approach the Executive would take when deciding how to ease coronavirus restrictions. Since its publication most restrictions have largely eased and large sectors of the public and commercial sector are now operating, albeit with the appropriate measures in place to minimise transmission of the virus. Any easing of restrictions has been decided by the Northern Ireland executive, with due consideration of advice from the Chief Medical Officer and Chief Scientific Adviser.

6.4 Transmission eased considerably in Northern Ireland throughout the summer. However, current trends strongly indicate that virus activity has started to accelerate, which is in line with the rest of the UK and Ireland. Therefore current restrictions and any proposed relaxations are kept under continual review. The Test Trace and Protect service as described in section 14 is also vital in controlling the transmission of the virus through contact tracing; advice to isolate; and investigation of outbreaks and clusters in conjunction with the Public Health Agency.

6.5 Further control of importation and onward transmission of the virus has been achieved by the imposition of the 'The Health Protection (Coronavirus, International Travel) Regulations (Northern Ireland) 2020' where those arriving from "non exempt" countries are mandatorily required to self-isolate for two weeks. The list of exempt countries is reviewed and updated in line with regular epidemiological assessments.

6.6 Work is ongoing regarding the development of a safe and effective Covid-19 vaccine for use in the UK. The results so far on human trials have been very encouraging. The best case scenario is that a vaccine can be in use before Christmas and planning is proceeding on that basis. However, there is still much uncertainty around the timing and availability of an effective vaccine. Even if an effective vaccine is developed before Christmas, it is likely that it may well be next

year before sufficient doses are available to vaccinate on a large scale. Work is ongoing to ensure that a vaccination programme in Northern Ireland is ready to commence, once an effective vaccine is available in sufficient numbers.

7. REGIONAL INITIATIVES

Introduction

7.1 In order to manage future COVID-19 surges, HSC must be organised and ready to respond. To ensure that services are delivered most effectively in the COVID-19 context, the Department has taken a number of initiatives adopting regional approaches to service delivery. A number of these key initiatives are outlined below.

Critical Care

7.2 The CCANNI critical care surge plan has been updated and will remain in place for this winter and future waves of the pandemic. The CCANNI plan is attached at Appendix A.

7.3 The Northern Ireland Nightingale at the Belfast City Hospital will continue to retain 3 floors that can be used to treat 75 critically ill patients in the event of a high surge in demand. This will remain the region's critical care contingency in the event of any adverse events this winter period.

7.4 As in the first wave, any additional bed capacity will also require additional staff resources. CCANNI has identified the staffing needs to maintain beds at each hospital site. From September, Trusts will need plans in place to redeploy staff into these roles and ensure that they are fully trained coming into the winter.

7.5 Throughout the winter and for potential further COVID-19 waves, CCANNI will have a formal role in operational management of critical care capacity regionally. The network will report directly to the Department on bed occupancy, staffing levels, length of stay and regional performance. Any emerging issues will be escalated rapidly to the Department for resolution.

Acute medical beds

7.6 Trusts will continue to develop their existing surge plans to ensure sufficient capacity on hospital sites for COVID and non-COVID patients. These will take into account the capacity impact of infection prevention measures and the need to minimise the impact of surge plans on non-COVID services.

7.7 In addition, the South Eastern Trust is commissioning the Acute Services Block on the Ulster Hospital site. The Trust received handover of Levels 0-5 and 7 in the building in May 2020 and began the commissioning of the inpatient

accommodation to enable it to be ready for use. The Trust anticipates the building will be ready for use by the region towards the end of 2020, with a comprehensive training and orientation programme to be developed prior to operation. This facility would require regional support to provide the necessary workforce to become operational.

7.8 The Acute Services Block has been designed to reflect the latest guidance in relation to Infection, Prevention Control and the commissioned beds will provide 112 single ensuite bedrooms and 12 x 4 bed bays. The generic design ensures that the facility can be used for either COVID-19 positive patients or as a general medical facility. The commissioned facility will thus provide the 160 Inpatient beds across 7 wards for the region.

Intermediate Care

7.9 Trusts will continue to develop their surge plans to ensure maximum use of their existing capacity for step down and step up beds in the community. This will include the further development and expansion of the *Acute Care at Home* programme that allows patients to receive the care they need in their own homes. Trusts will also seek to maximise the use of their existing care home capacity in a way that ensures safe transfer of care for patients from hospitals into care homes.

Second Nightingale Facility

7.10 Nightingale facilities were developed across the UK to deal with the first wave of the pandemic. While the overriding purpose was to increase bed capacity and provide a layout that allowed a higher number of patients to be looked after by a smaller group of staff, the specification and purpose of these facilities varied significantly.

7.11 The Belfast City Hospital Tower Block was designated as Northern Ireland's critical care Nightingale facility during the first wave and will revert to this function for future surges should it be necessary.

7.12 Additionally, in advance of further COVID-19 waves, the Chief Nursing Officer has been leading a project to explore the best function and configuration for a further Nightingale facility, with a view to having it operational by winter. On the back of this work, the Minister has approved plans to commission a new Nightingale facility at Whiteabbey hospital to increase bed capacity and relieve wider pressures. This facility will provide an additional 100 regional intermediate care beds to help aid the flow of patients from ICU and acute care. This facility will facilitate robust pathways for patients being discharged from hospitals into care homes or community settings.

Elective care

7.13 Day-case Elective Care Centres (DECCs) are designed to provide a dedicated resource for less complex planned day surgery and procedures. Crucially, they operate separately from urgent and emergency hospital care – meaning they will not be competing for operating rooms, staff and other resources, leading to fewer cancellations of operations.

7.14 The COVID-19 pandemic has further demonstrated the vulnerability of having scheduled and unscheduled care co-located on multiple sites. For infection control purposes there are clear benefits in separating elective care, where service delivery can be tightly controlled, from the more unpredictable unscheduled care. The focus on day-case will also become increasingly important in rebuilding services by: reducing the length of time in hospital; freeing up bed days; and reducing the risk of nosocomial infection.

7.15 Work has now commenced on rebuilding of daycase elective services through the establishment of a dedicated 'hub' day procedure centre at the Lagan Valley Hospital in the South Eastern Trust. South Eastern Trust has been tasked with taking forward the establishment and management of the regional Day Procedure Centre model in the first instance, and plans are also in place to establish a regional clinically-led network to oversee the development of the regional Day Procedure Centre hub and spoke model. This Regional Network will be tasked with driving forward a whole system, integrated approach to the delivery of Day Procedure Centres to achieve benefits for patients in terms of reduced waiting times and improved quality and outcomes.

7.16 It is anticipated that through this work, the establishment of dedicated elective care centres will 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.

Orthopaedic Surgery

7.17 Waiting times in Northern Ireland for orthopaedic surgery are among the worst in the UK, with patients waiting up to four or five years for operations such as hip replacements. As a result of the COVID-19 crisis, the vast majority of elective orthopaedic surgery was halted and as a result these services have been significantly adversely affected with increased and growing waiting lists.

7.18 It is within that context that work is currently underway to establish dedicated ring fenced centres for the delivery of orthopaedic services. Initially, the focus for elective orthopaedics will be from two dedicated 'hub' sites located at Musgrave Park Hospital (Belfast Trust) and Altnagelvin Area Hospital (Western Trust),

however the longer term aim is that orthopaedic services will be delivered from all existing units across Northern Ireland.

7.19 Plans are also in place to establish a regional clinically-led network which will have responsibility for the regional planning and commissioning of the service across Northern Ireland. The network will be facilitated by the Belfast Trust which will have responsibility for providing governance and oversight of the administrative management of the service on behalf of the region.

7.20 Similar to the model for Day Procedure Centres as outlined above, it is anticipated that the development of these dedicated orthopaedic centres would have the benefit of tighter control over service delivery through the separation of elective care from unscheduled care, and would also potentially facilitate the continuation of elective orthopaedic services in the event of a second COVID-19 wave.

Cancer Services

7.21 Requirements for use of PPE and enhanced decontamination measures will continue to impact on both diagnostic and treatment capacity going forward in respect of cancer services. A particular concern remains about the impact on surgical provision where existing constraints relating to the availability of theatre nurses have been exacerbated due to the redeployment of nurses to support ICU. Going forward then a key focus for cancer services will be on the optimisation of diagnostic and surgical capacity and the equalisation of waiting lists.

7.22 In terms of diagnostic capacity, Northern Ireland has benefited from a share of NHS England COVID-19 supplies including a mobile CT unit and additional ultrasound machines. Work is also underway to secure a number of existing mobile scanners funded 'at risk' within Trusts where contracts are due to expire and which will need to be secured to continue to provide service continuity as well as resilience. The requirement for additional MRI and CT mobile capacity from the IS is also being considered.

7.23 Recognising ongoing capacity constraints for the provision of colonoscopy, contracts have been agreed across the three IS providers for an additional 50 scopes lists per month. The option of securing a mobile unit for regional use is also being explored. NICaN has also introduced FIT testing within secondary care to enable risk-stratification of patients so that those at highest risk can be prioritised against the available capacity.

7.24 Recognising the ongoing challenges in terms of theatre access, a contract has been agreed across the three IS providers for an additional 30 theatre sessions

per week and 25 day procedure lists per month. It is proposed that this capacity is prioritised for cancer with a particular focus on breast and urology in the first instance. A surgical oversight group has been established within NICaN with the aim of optimising capacity now and through any potential surge and will provide ongoing clinical advice to the Cancer Reset Cell.

7.25 Finally, oncology and haematology services were experiencing significant pressures pre-COVID. In the context of a potential surge in referrals and an increase in late presentation and the risks that a second surge would pose in terms of its impact on staffing, there is an urgent requirement to invest in the stabilisation of these services. A stabilisation plan has been developed and is with the Minister for consideration.

7.26 In summary, there are ongoing capacity challenges across the cancer pathway which the service is actively managing. As during the first surge, all possible steps will be taken to maintain services in the event of a second surge. However, it is likely that redeployment of staff, staff absences, reduced access to theatres and patient reluctance to attend hospital will all contribute to delays in pathways. Experience during the first surge suggests that the greatest impact is likely to be on invasive diagnostics and surgical treatment so, dependent on the scale of the surge, there may be a requirement to increase IS capacity beyond the current contracted level.

Urgent and emergency care

7.27 Prior to the pandemic, there was clear evidence that our urgent and emergency care services were under increasing pressure. Growing numbers of people were experiencing long waits to be seen in overcrowded emergency departments. The impact of the pandemic, and the accompanying focus on infection prevention and social distancing measures, has driven home the urgency of ensuring that we do not allow emergency departments or hospitals to reach these levels of overcrowding.

7.28 A review of urgent and emergency care is currently being finalised and recommendations will be submitted for consideration by the Minister. This will inform actions to address overcrowding in emergency departments during the coming winter.

Personal Protective Equipment (PPE)

7.29 As the focus moves to planning for potential further COVID-19 waves, it is essential to forecast PPE requirements, which underpin the procurement strategy. Whilst initial modelling did form the basis of the approach in the first wave, a new health resource model has now been developed with dynamic

forecasting ability. The refinement and maintenance of a dynamic resource model facilitates the provision of a more robust evidence basis to inform procurement decisions and mitigate the risk of insufficient supply.

7.30 The unprecedented demand for PPE along with the supply chain issues experienced during the first wave rendered the previously reliable Global supply chain untenable in mitigating against disruption. In recognition of this the Business Services Organisation has developed a supply chain strategy based on creating a PPE stock holding equivalent to usage over a 12 week period and maintaining this for a period of 24 months. This creates a "just in case" stock holding and is in addition to any PIPP stock held by the Department.

7.31 The "just in case" stock holding will be complimented by a "just in time" approach to weekly PPE supply requirements to the HSC with the stock holding accessed at critical points in time where supply cannot meet demand. The stock holding required and associated procurement activity can be increased and decreased in line with modelled estimates of ongoing PPE requirements.

7.32 A new dynamic purchasing system (DPS) has been developed for the procurement of PPE. The DPS creates a compliant vehicle through which to procure which enables competitions to be conducted in an agile manner; increases market capacity during a time of unprecedented demand and works responsively to support SME sectors and enhance business development and employment opportunities.

7.33 The Department continues to work collaboratively with DoF and Invest NI in supporting local businesses in repurposing their manufacturing output to meet the PPE needs identified by the Department. The UK Chief Medical Officer/Chief Nursing Officer group will continue to keep best practice guidance on appropriate use of PPE under review and any change to this factored into supply modelling or alternative guidance provided should shortages emerge.

Children's Services

7.34 During the first wave of the pandemic, a small number of children's services were suspended in full, including the inspection of early years services. Most services were either delivered in slower time or in different ways, for example, by maximizing the use of technology. Legislation was introduced to enable HSC Trusts and some voluntary providers of fostering and adoption services to alter their service delivery models. A Regional Action Card was deployed across all HSC Trusts to guide service delivery and to ensure, as far as possible,

consistency of provision. The Department issued service-specific guidance, which was updated as public health advice developed.

7.35 A system of weekly data collection was implemented to monitor developments in critical service areas, including child protection and looked after children services. That data is indicating a significant increase in the number of referrals to children's services and in the number of looked after children, for example. Services are already under pressure as a result. There is the potential for that pressure to grow in the event of a second surge. Decision-making in connection with schools will undoubtedly have an impact, particularly if it leads to further schools closure. Decision-making relating to children's health services, for example, to restrict access, also has the potential to impact adversely on children's services.

7.36 In preparation for a second wave of the pandemic, the Regional Action Card is being reviewed by the Health and Social Care Board and the Department's guidance is being plotted against the pathway of the pandemic. This will determine what guidance will issue and in what circumstances in the event of a second wave. The legislation required during the first wave is being kept under review and a decision to revoke the legislation in early Autumn may need to be revised.

8. GENERAL PRACTICE SURGE PLANNING

8.1 COVID Centres continue to be operational across 10 sites, in each Trust area. These Centres operate under reduced rotas and teams to maintain the minimum required capacity to sustain a service that is accessible 14 hours per day over most sites, 7 days per week. Some of the COVID Centre locations may change but 10 Centres will be maintained. Planning for a second Surge will include increasing rotas to ensure that the COVID Centre capacity meets patient demand.

8.2 The HSCB is currently developing Patient Flow and Infection Control Guidelines for General Practice, who may be able to manage COVID patients within their premises. This will provide the required best practice and governance to support this where it can be implemented.

8.3 General Practice continues to engage with the PHA in preparation for Flu planning in Autumn/Winter 2020. This will include Federation level plans in how best to deliver this year's Flu programme to practice patients and acknowledges plans to increase the volume of the programme later in the year to a wider patient cohort. This will continue to be a challenging programme to deliver for all General Practices.

8.4 General Practice continues to actively engage with local leaders to ensure that practice core activity is increased via the use of technology, flu planning and delivery in the context of a potential second surge.

9. DENTAL /OPTHALMIC / ALLIED PROFESSIONS COMMUNITY CARE

Dental & Ophthalmic Services

9.1 The need for ongoing infection control measures means that dental services have yet to recover from the first surge in COVID-19 cases. For example, the need for a 1 hour fallow time between treatments involving aerosol generating procedures means that activity is currently less than 20% of normal levels.

9.2 In preparation for a further surge, the arrangements to ensure emergency treatment can continue and financial support provided to independent contractors remain in place from the first surge. These can be ramped up in response to a tightening of restrictions on normal activity. At the same time, there is ongoing engagement in respect of the scientific evidence and risk of virus transmission for both dental and ophthalmic care. This will allow a proportionate response to be adopted in terms of restricting routine services, in the context of the enhanced infection control measures.

9.3 Service planning engagement and established groups have been maintained to deal with further waves. It is likely that the approach adopted with first wave will be repeated, depending on the nature of the increase in number of cases. Consideration is being given to the possibility of localised restrictions on dental / ophthalmic services with the corollary that the impact on practices could be quite variable.

Health Visiting and School Nursing Services

9.4 Lockdown and the need for social distancing and self-isolation have reduced the visibility of children and young people and has limited many of the social support structures available to children and families. This means that neglect, abuse, and escalating needs and challenges have gone undetected and children and families have not been receiving the support they need. Also, during the lockdown period, similar to other areas both nationally and internationally, Northern Ireland has seen a dramatic rise in the number of domestic abuse referrals.

9.6 In responding to and managing COVID-19, some health visitors were redeployed and some aspects of the service were stood down. It was recognised that families continued to need support of their Health Visitors, especially those families with complex vulnerabilities. New ways of working were introduced with virtual and online technology.

9.7 Health Visitors are in the process of implementing the recovery plan to deliver Healthy Child Healthy Future and address the needs of children and young people. This has been a challenging time for Health Visitors and school nurses.

9.8 The School Health Service was reduced during COVID-19, as schools were closed. Currently School nurses are actively working with schools, teachers and children in preparation for the flu vaccination to all primary school children and year 8 post primary schools. This has included plans for how to deliver the flu vaccine to school children while maintaining social distancing and increasing the target to 95%. Plans are underway to address the backlog in other immunisation programme.

District Nursing Service

9.9 District Nurses have been at the forefront of dealing with COVID-19. District Nursing have continued to deliver a patient facing front line community nursing service throughout the COVID-19 pandemic. District Nurses have responded quickly to the changing demand on their service, influenced by other services who have moved to a more virtual service delivery model. District Nursing have implemented their surge plan to create capacity, they facilitated more patients to self-manage their condition independently at home. It is expected that these service models will continue during future potential COVID-19 waves.

10. MENTAL HEALTH AND LEARNING DISABILITY NEEDS

Mental Health

10.1 The HSCB/PHA have developed a regional Service Recovery Plan for Adult Mental Health Services. Furthermore, each HSC Trust has developed detailed local recovery plans for mental health services.

10.2 A number of actions were taken during the first surge and period of lockdown to support individuals to maintain good mental health and emotional wellbeing. These continue to be used and developed further.

10.3 For example, the PHA published revised 'Take 5' advice to help people stay well during lockdown, and revamped the 'Mindingyourhead.info' website to ensure support, guidance and information was accessible. Psychological First Aid training was rolled out across sectors, and a bespoke 'Apps Library' was developed to provide a home for safe and approved apps to assist individuals in managing issues such as stress and anxiety. Online Stress Control classes have also been provided free of charge to the public and this service will continue until March 2021. Information on the mental health support available was included in food boxes issued by the Department for Communities and shielding letters, and the PHA worked with DfC and a consortium of voluntary and community organisations to develop the 'COVID Wellbeing NI hub', which provides a broad range of information, help and support on emotional wellbeing.

10.4 It is understood that referrals to some services dropped over the period of the lockdown. This may be due to a number of factors, including the availability of new therapy options such as Stress Control classes. Nonetheless, in the medium to longer term the Department expects there to be higher waiting lists in key areas such as access to psychological therapies, despite investment in new ways of working.

10.5 The Department is currently gathering further information and data on the impact that COVID and the lockdown have had on waiting lists and on ongoing capacity. This will be used to inform future service planning by the HSCB and Trusts to address the likely increased demand on mental health services, and prepare for a potential second surge. It is expected that even without a second COVID-19 surge, there will be an increase in demand on mental health services.

10.6 In the longer term, the experience and work during the pandemic will also be used to inform the development of the new Mental Health Strategy.

Learning Disability (LD)

10.7 The Department is collating further information and data on the impact of COVID-19 and lockdown on people with LD, families and carers. This will be used to inform future surge planning and decisions on service recovery. The Department is acutely aware that the closure of day centres have had impact on the mental health and wellbeing of service users, families and carers.

10.8 Trusts continues to explore alternative ways to support service users by reconfiguring physical space, using digital platforms and repurposing voluntary sector contracts. The HSCB is coordinating a lessons learned exercise to identify innovative approaches that could be replicated across Trusts and inform how core services are delivered in the future. Learning gathered will also be used to inform the development and implementation of the Learning Disability Service Model.

11. CARE HOMES

Care Home Capacity/Enhanced support for care homes

11.1 In April, the Health Minister asked the Chief Nursing Officer to lead a rapid learning initiative to understand the impact of the range of policy and practice interventions implemented within care homes during the first surge of COVID-19 to prevent or mitigate the impact of the transmission of COVID-19 into care homes during future potential surges. That initiative has been taken forward in partnership with a range of key stakeholders including residents and their families; care home staff and managers; independent care home sector providers; the Royal College of Nursing; relevant policy leads within the Department of Health; the Public Health Agency; the Health and Social Care Board; and Health and Social Care Trusts. This will enable collaborative action across the statutory and independent sector to implement best practice and plan for any future COVID-19 surge. Unison also provided written input to the report.

11.2 A final report on the outcomes of the rapid learning initiative has now been completed. The report will inform plans to mitigate the transmission of the virus during any future waves in care homes and is currently being considered by the Chief Nursing Officer prior to seeking Ministerial approval.

11.3 The learning over the past few months has highlighted the high level of frailty and clinical acuity of residents in our nursing homes and the need for much greater resilience. The 'Acute Care at Home and at Care Homes' is an initiative comprised of a multi-disciplinary team that reach into care homes to support sick residents, and prevent residents going to hospital unless absolutely necessary. This key priority initiative will develop a regional and common approach to the expansion, redirection and repurposing of acute care at home models to provide the necessary care and support into care homes across Northern Ireland and the community.

11.4 On 17 June 2020, the Minister announced plans for a new framework for nursing, medical and multidisciplinary in-reach into care homes. A new care homes nursing project will develop the new framework in partnership with care home providers, HSC Trusts, voluntary and community sector, clients and their families and the staff who provide the care. The project aim is to ensure that people who live in care homes are supported to lead the best life possible. This includes ensuring that they have access to the right clinical care, ensuring that future surges can be dealt with effectively taking the learning from the first COVID-19 surge.

Testing and isolation of patients being discharged from hospital

11.5 It remains the case that Trusts must ensure all individuals discharged to a care home have been subject to a COVID-19 test, 48 hours before discharge. Ideally, patients who are COVID positive or symptomatic, should not be discharged to a care home that has no symptomatic or COVID positive residents unless that home is the patient's previous residence. However, where the care home has the resources to isolate an individual, it should accept new or returning residents discharged from hospital while test results are awaited. In addition, all new residents in care homes should be subject to isolation for 14 days. Where care homes are unable to isolate individuals effectively, Trusts will make arrangements for the isolation of patients in a suitable setting until they can be admitted to the care home. Further detail is set out in guidance for care homes[3].

Cohorting staff

11.6 Consideration will continue to be given to cohorting residents and staff in care homes to help limit any risks of infection spreading. However, this in itself may present unintended consequences, such as changes in behaviour, distress from being in an unfamiliar environment or increased levels of anxiety. Where cohorting, isolation or relocation are under consideration, a discussion between the resident, and/or their relative/representative, the care home, the Trust and any other relevant persons should include holistic consideration of the benefits and risks of the proposed protective measure. Trusts should also consider how to cohort staff who need to visit care homes to help limit any risks of infection being carried between homes. Further detail is set out in guidance for care homes.

[3] https://www.health-ni.gov.uk/publications/COVID-19-guidance-nursing-and-residential-care-homes-northern-ireland

12. WINTER PRESSURES

Winter Pressure Issues

12.1 The winter pressures planning process usually commences over the summer with regional planning arrangements involving all key stakeholders to consider the likely pressure area in the context of seasonal flu intelligence, current strategic direction, lessons learnt from previous years, the potential opportunities from system change and the consideration of the known constraints within the system. Timelines for implementation of winter pressure responses are also mapped out.

12.2 Trusts have forwarded proportionate winter pressures plans to the HSCB. Trusts will work closely with primary care to maximise capacity with an emphasis on timely and comprehensive seasonal flu vaccination programme. Discussions with community pharmacy provides an opportunity to maximise capacity with this contractor group. This approach has been supported by early and targeted public media and communication campaigns.

12.3 In recent years, with the maturing of Community Planning Partnerships, there have been opportunities to involve the broader statutory sector and the community and voluntary sector in targeting vulnerable groups such as the frail elderly and isolated, those living in cold homes and those with mental health problems or who are homeless.

12.4 There has been a particular focus on trying to address the regional pressures in the GP out of hours services. These services have moved to change their skill mix arrangements, but challenges continue in filling rotas particular in overnight slots and over holiday periods like Christmas and the New Year. Enhanced payments have gone some way to addressing this.

12.5 Managing admissions into the hospitals has in recent years led to the expansion of ambulatory care models or hubs with the ability to turn patients round and into community services such as acute or enhanced care at home.

12.6 Trusts continue to maximize bed capacity and to ensure that all funded beds are available, particularly were they have been stood down due to staffing shortages. During the winter period there will always be a need to ensure good flow through fracture surgery and ensuring access to theatres and rehab capacity. The coordination of timely discharge remains a challenge. The Department is considering a model that builds more on intermediate care at home rather than bed based care. This offers more flexibility, potentially better outcomes and a better experience for the person.

12.7 There are a range of workforce issues under consideration during the winter period particular to ensure that vacancy levels are managed down, ensuring that staff vaccination programmes are effective.

12.8 Trusts have also been asked to ensure that escalation plans are in place and that these align with the regional arrangements for coordinating an escalation response. Work has also developed to ensure that there is good data analytics in place to support the assessment of emerging system pressures at Trust and at regional level.

12.9 NIAS, with its regional oversight of emerging unscheduled pressures has been well placed to respond to system pressures by working within guidelines to redirect ambulance patients to the most appropriate Emergency Department.

Winter Flu Vaccination

12.10 The flu vaccination programme in Northern Ireland is being expanded this year to help protect vulnerable people and to relieve winter pressures on the Health and Social Care system during the ongoing COVID-19 pandemic. The current groups eligible for a free flu vaccination are everyone aged 65 and over, pregnant women, those aged under 65 years of age in clinical "at risk" groups, all children aged 2 to 4, all primary school pupils, and frontline health and social care workers. Additional vaccine has been secured which will allow for the following groups to receive a free flu vaccination during the 2020/21 flu vaccination programme:

- Household contacts of those who received shielding letters during the COVID-19 pandemic can request vaccination via their GP;
- Staff in independent care homes; and
- School children in year 8 i.e. those who will be in the 1st year of secondary school from September 2020.
- Subject to vaccine availability, the programme may be extended by December to include those in the 50-64 year old age group, starting with the oldest first. This extension will be phased to allow GP practices to prioritise those in a clinical at risk group.

13. WORKFORCE

13.1 The success of any response to COVID-19 can only succeed if the appropriate staff are in place in appropriate numbers to deal with the challenges to the system. This was achieved through a number of intervention during the first wave and these will need to be maintained for future surges.

Internal redeployment

13.2 The process across Trusts was largely efficient and safe. Trusts did internal workforce appeals to which there was a positive response, although there could have been a more strategic, corporate approach. Junior doctor rotations stayed in place which contributed to cover and there was excellent HR and Professional lead collaboration for safe staffing deployment decisions. Quicker redeployment decisions, will be needed during future waves, particularly where this is on a cross-sector basis, such as into Nursing Homes.

HSC Workforce Appeal

13.3 This workforce appeal garnered a very encouraging response, with an easy to use IT system coupled with processes that allowed the recruitment of additional staff that provided control and visibility for those involved. The processes also allowed for customer engagement via instant communications with those who expressed an interest, meaning people were job ready as demands were received. For future surges, there should be a better understanding of the likely demand against other sources of staffing supply, including agency and bank staff. That said, staffing continues to be challenging despite this initiative.

Deployment of students

13.4 There was a largely regional approach to the appointment of students and high numbers were processed through the efficient appointment method that was put in place. This was helped by the agility and flexibility shown by regulators (in bringing people on to registers on a temporary/provisional basis) and employing Trusts. The students, across all professions, who entered the health service played an invaluable role in providing services during the first COVID-19 wave and they did so in an incredibly challenging environment. This willingness to step up significantly increased the flexibility of the workforce. For example, in nursing, midwifery and Allied Health Professions alone more than 900 final year students were successfully deployed following careful and regular communication between the Department, Directors of Nursing, Higher Education Institutions and Trusts.

13.5 Early and regular engagement with Trusts to discuss system response to COVID-19 and trainee redeployment meant that minimum requirements for redeployment were agreed in advance. Medical trainees were quick to respond to request to return to clinical practice and there was a rapid response of redeploying trainees to meet anticipated service needs. A more strategic oversight of the student workforce will be beneficial in future waves, including to ensure that the education and training needs of students are not overlooked or side-lined.

Resilience

13.6 The role HSC staff played across the entire service has been recognised and acknowledged across the political spectrum and by the general public, with the approach and commitment of HSC staff widely praised. It is important that appropriate support, both physically and psychologically, is provided for staff to maintain resilience and morale throughout future waves.

International

13.7 The UK government has acknowledged the role played by overseas professionals within the HSC by moving to waive the immigration health surcharge, providing simplified visa extensions and introducing the NHS visa for new applications to come and work within the HSC. However, direct international recruitment to the HSC of nurses has currently been paused due to COVID-19, although consideration is currently being given to reinstating recruitment, if feasible within the current COVID-19 restrictions. The changes to immigration policy to coincide with the end of EU exit transition, may put additional pressure on the recruitment of professionals and will reduce the recruitment pool for supporting roles most specifically in social care.

Indemnity for Independent Hospitals

13.8 In support of the workforce appeal the Department proficiently considered a wide range of indemnity arrangements required to facilitate returning and redeployed staff in support of the COVID – 19 response. Departmental staff engaged widely considering and responding to requests for indemnity support or interpretation of current arrangements for returning staff, Independent Sector staff and facilities. This was in addition to arranging building and contents cover for hotels and other 'step down' facilities outside the health estate, in addition to arranging indemnity for adopted facility staff, ensuring continuity of protection. New and evolving services were also considered and provided with indemnity coverage to facilitate patient support, where appropriate. Indemnity coverage was also provided to the Trust boundary, where private testing facilities was utilised in support of the significant increase in demand for HSC laboratory testing services.

13.9 Indemnity arrangements have been enacted and reviewed using a risk based framework to allow periodic reviews to manage the financial exposure risk. This has allowed the Department to consult and evolve the process ensuring an agile response in support of the HSC sector. Throughout the current outbreak colleagues have been supported in the performance of their duties providing quality healthcare to patients. In managing subsequent and future surges or outbreaks, there should be a better understanding of indemnity services required to support public health provisioning.

14. MEDICINES

14.1 A rapid review of pharmacy services has been completed to ensure that lessons are learnt and actions taken to prepare for a potential future COVID-19 waves. The review highlighted good practices from over eighty different pharmacy teams across all HSC sectors. It identified a number of areas of work that are ready for reactivation if needed and others that require a degree of agreement to implement consistently across the region.

Seven day working - optimising the skills and expertise of pharmacy staff

14.2 Pharmacy and pharmacy technicians are a valued part of the multi-disciplinary teams working in critical care and it will be important that sufficient staff are available and trained for seven day working in advance of a second surge. Trusts will also seek to build on experience from the first surge relating to the successful re-deployment of pharmacy staff to ensure the safe prescribing and supply of medicines in COVID wards and in specialist services including cancer.

Ensuring access to critical care medicines and medical consumables

14.3 As demand increases for critical care medicines and medical consumables used in intensive and palliative care, regional systems developed during the first surge will be re-activated to manage the procurement, supply, storage and distribution of critical care medicines, oxygen and related consumables in Trusts, care homes and the community. In addition extra supplies of high demand COVID-19 medicines will be held in Northern Ireland for use within the HSC if needed. Also to ensure access to short life intravenous drugs, a regional approach to manufacturing will incorporate licensed and unlicensed manufacturing units, batch and near patient production units.

Virtual clinics, training and communication

14.4 Virtual communication methods have become part of business as usual for many pharmacy teams in recent months. Video and telephone consultations will play an important role during future surges in enabling patients and the public to safely access the advice of pharmacists in specialist outpatient clinics, general practices and community pharmacies. Virtual learning systems will also be widely utilised to provide under/post graduate pharmacy education as well as supporting professional networking and helping to maintain contact between remote teams.

Community pharmacy

14.5 Community pharmacies will provide essential access to prescribed medicines and professional advice during future waves and provide medicines deliveries for high risk patients. In addition a new 'Pharmacy First' service will be available to provide access to advice and treatment for common conditions from a community pharmacist, without needing to visit the doctor. Work is also underway to scope the feasibility of a community pharmacy flu vaccination service to support an enhanced seasonal flu campaign.

EU Exit

14.6 The UK is scheduled to leave the EU at the end of the transition period on 31st December 2020 and a range of measure have been taken nationally to protect medicines' supply chains. A multi-layered approach is being adopted, with suppliers asked to put in place flexible mitigation and readiness plans which include re-routing away from the Channel short straits, supporting trader readiness for new customs and border arrangements, and ensuring that additional buffer stocks are available within the UK where possible. Medicines shortages can and do sometimes occur for a variety of reasons unrelated to exiting the EU, and there are already well-established procedures to deal with medicine shortages if they do occur to mitigate and minimise risk to patients.

15. TESTING

15.1 Testing in line with emerging scientific evidence continues to be a vital tool in the response to the COVID-19 pandemic. Testing is overseen by the Department's Expert Advisory Group on Testing (EAGT) and is delivered in close collaboration with expert virology and public health teams.

Testing Approach & Capacity

15.2 The NI Testing Strategy aligns with the UK's strategic approach to scale-up of testing for COVID-19 (the Five Pillar Approach). Through work with a number of key stakeholders and delivery partners across the Health and Social Care Sector, local universities and industry, testing capacity has increased significantly. Current capacity is approximately 2,200 tests per day. This is referred to as 'Pillar 1' testing. Anticipated capacity under Pillar 1 is subject to the availability of reagents, global supply chains and for some laboratories, the allocation of ROCHE testing kits which are currently on a national allocation.

15.3 Testing capacity in Northern Ireland has been increased through participation in the UK Coronavirus National Testing Programme (Pillar 2). Testing capacity under Pillar 2 is flexible and is informed by the number of bookings made on the digital platform in the preceding 48hours. If demand for testing increases, testing capacity can be extended to meet the demand. All members of the general public that have symptoms are now eligible for a test including, from 16 July, those aged under 5. Groups eligible for testing are kept under constant review and updated as required in line with emerging scientific and medical evidence. There are four approaches to testing as part of the National Testing Programme.

i. Fixed sites: There are 4 operational at present – SSE arena, Derry / Londonderry, Craigavon and Enniskillen (St Angelo Airfield).
ii. Mobile Testing Units: 6 are currently available in Northern Ireland; five of which are currently operational. The other unit is kept in reserve for rapid deployment for a cluster or an outbreak. A further 2 units will be available during September.
iii. Postal option: where people requiring tests can book on-line and have a testing kit delivered to their homes.
iv. Satellite testing: This is where tests are couriered to and from fixed test sites e.g. care homes.

Care Home Testing Programme

15.4 Testing in Care Home settings has been a key priority in Northern Ireland since the beginning of this pandemic. A significant programme of testing in Care

Homes was undertaken throughout June to test all residents and staff in all care homes in Northern Ireland. A regular programme of COVID-19 testing for all staff and all residents in care homes across Northern Ireland will commence on Monday 3 August 2020.

15.5 There are two components to the COVID-19 care home testing programme in Northern Ireland; those care homes which do not have a COVID-19 outbreak, and care homes with a suspected or confirmed COVID-19 outbreak. In care homes which do not have a COVID-19 outbreak (clean homes), all staff are to be tested for COVID-19 every 14 days, and all residents are to be tested for COVID-19 every 28 days. This aspect of the care home testing programme will be undertaken through the National Testing Programme.

15.6 It is important to identify both single cases and potential clusters of COVID-19 cases, as early identification will allow immediate steps to be taken to prevent spread. Therefore, the current testing protocol implemented across the PHA and HSC Trusts will be further enhanced to effectively support testing arrangements in care homes with a new suspected or confirmed COVID-19 outbreak. This aspect of the care home testing programme will be undertaken through the HSC/Consortium laboratory system.

15.7 The number of testing rounds to be undertaken in a care home with a suspected or confirmed COVID-19 outbreak will be determined taking into account the specific circumstances of that care home. This could mean that three rounds of testing are undertaken: all staff and residents tested at the risk assessment stage; a second round of COVID-19 testing undertaken 4 to 7 days following the first round of testing; and a further (third) round of testing carried out 28 days following the symptom onset in the last known case (either among staff and residents) in the home.

15.8 Once any care home experiencing a COVID-19 outbreak has fully met the specified criteria for an outbreak to be successfully concluded, the care home will return to participate in the regular programme of care home testing supported by the National Testing Programme.

15.9 The position on frequency of testing for staff and residents in care homes with no COVID-19 outbreak and in care homes with a suspected or confirmed COVID-19 outbreak will be kept under active review.

Testing in schools

15.10 In order to support planning for Education Restart, discussions are ongoing with the Department of Education (DE) to better understand some of the challenges faced by the sector and to assist in developing solutions. This includes

consideration of a range of issues, including: requirements of the region-wide contact tracing programme '*Test, Trace and Protect'*; the management of any future cluster/outbreaks; how testing resources, including Mobile Testing Units and supplies of home testing kits, can be managed/deployed going forward; and potential options for testing of asymptomatic teachers and other school staff.

Antibody Testing

15.11 The introduction of antibody testing may help with efforts to create effective treatments against the pandemic as well as supporting future risk assessment and management of clusters and outbreaks. However, it is important to note that there remains considerable uncertainty about the significance of a positive test result for antibodies. While it means that an individual has had COVID-19 at some time in the past it does not indicate that the individual cannot be re-infected with the virus, or would not pass it on to others, or have protective immunity. People should not alter behaviours based on a positive test result for antibodies.

Test, trace, protect

15.12 Contact tracing is an established method of identifying and breaking chains of infection and clusters of communicable disease. This will help to understand the transmission of COVID-19 in Northern Ireland and reduce further transmission. There is a strong international consensus that this work is a critical measure for preventing or minimising further waves, whilst allowing restrictions to be lifted.

15.13 The Public Health requirements for contact tracing are as set out in the *'Test, Trace, Protect' (TTP)* strategy which was launched in May 2020. The Northern Ireland Contact Tracing Service, operated by the Public Health Agency, began contact tracing all confirmed cases of COVID-19 on 18 May 2020. The contact tracing services are likely to be required for the next two years to effectively deal with any future COVID-19 waves, or until a vaccine is available and a mass vaccination programme in place.

16. PRIORITISING HOSPITAL SERVICES

16.1 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.

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

16.3 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. In addition, the Royal College of Surgeons has published two COVID-19 toolkits: 'Safety considerations and risk assessment for patients and surgical teams' and 'Checklist for restarting elective surgical services'. Clinical teams should also consider these toolkits in their decision making.

16.4 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'. Paediatric clinical teams should consider the principles set out in the RCPCH guidance.

16.5 Recent guidance issued by NICE[4] on arranging planned care in hospitals should also be taken account by clinical teams. Furthermore, clinical teams should consider further guidance from professional bodies as it becomes available.

[4] https://www.nice.org.uk/guidance/ng179

17. PRINCIPLES – TRUST PLANS

17.1 Each Health and Social Care Trust will in October publish individual Surge Plans covering the period to May 2021, consistent with this overarching Framework. The Trusts should adopt the following principles in preparing their individual surge plans:

- Patient safety remains the overriding priority.

- Safe staffing remains a key priority and Trusts will engage with Trade Union side on safe staffing matters in relation to relevant surge plans. It is recognised that staffing will remain a key constraint in managing COVID-19 and winter pressures, whilst also delivering other services.

- 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. It will be important to fully address COVID-19 and winter pressures and it is recognised that this may impact on elective care services. However, the regional approaches announced, such as day case elective care centres and orthopaedic hubs, will help to 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 this document.

- Trusts should as far as possible manage COVID-19 pressures within their own capacity first. Should this not be possible, Trusts are required to make use of the regional Emergency Care facility at Belfast City Hospital or the regional 'step down' facility provided at Whiteabbey hospital, as appropriate. Trusts will also consider collectively how they will contribute staff resources to support Nightingale hospitals when necessary.

- 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.

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APPENDIX A – CCANNI CRITICAL CARE SURGE PLAN

CCaNNI Critical Care Services Surge Plan (COVID and non-COVID) Draft V3 27_08_20

CCaNNI ESCALATION

	ALT	ANT	BCH	CWY	CAH	MIH	RICU	SWAH	ULSTER	CSICU	BEDS
STEADY	8.5	6	10.5	3	7	0	24	4	8	0 (14)	70.5

	ALT	ANT	BCH	CWY	CAH	MIH	RICU	SWAH	ULSTER	CSICU	TOTAL
PRE	10	6	4	3	8	10	28	6	10	0 (14)	85

	ALT	ANT	BCH	CWY	CAH	MIH	RICU	SWAH	ULSTER	CSICU	TOTAL
LOW	13	7	14	3	12	12	28	7	13	0 (14)	109

	ALT	ANT	BCH	CWY	CAH	MIH	RICU	SWAH	ULSTER	CSICU	TOTAL
MED	15	9	56	3	14	0	30	9	15	0	151

	ALT	ANT	BCH	CWY	CAH	MIH	RICU	SWAH	ULSTER	CSICU	TOTAL
HIGH	18	10	78	3	20	0	30	10	20	0	189

APPENDIX B – SUMMARY OF KEY ACTIONS

Introduction

The key actions included in this Surge Planning Strategic Framework are summarised in this Appendix. Steps have already been taken in many areas to prepare for further COVID-19 surges and these actions have been included first, with actions still to be taken next.

Key Actions

- A COVID-19 modelling Group has been established to track and monitor the trajectory of the pandemic.
- The Critical Care Network for Northern Ireland escalation framework has been updated and will remain in place for future COVID-19 waves.
- The Critical Care Nightingale facility at Belfast City Hospital providing additional capacity to treat 75 critically ill patients remains available should it be needed.
- A second Nightingale facility providing 100 step down beds at Whiteabbey hospital to be available as soon as possible.
- A new day case elective care centre at Lagan Valley Hospital has been announced.
- Two new dedicated orthopaedic surgery hubs at Musgrave Park Hospital and Altnagelvin Area Hospital have been announced.
- Urgent and emergency care review is currently being finalised with recommendations on the way forward to be submitted to the Minister.
- A new health resource model has been developed with dynamic PPE forecasting capacity.
- The Business Services Organisation has developed a supply chain strategy based on creating a PPE stock holding equivalent to 12 weeks usage.
- 10 COVID-19 Centres have been maintained, currently operating under reduced rotas. This can be scaled up in a surge situation.
- The Chief Nursing Officer has completed a Rapid Learning Initiative in relation to care homes.

- Plans have been announced for a new framework for nursing, medical and multidisciplinary in-reach into care homes.

- A rapid review of pharmacy services in the first COVID-19 wave has been completed and learning will inform preparation for future surges.

- A Testing Strategy has been published and testing capacity has been increased to approximately 2,200 tests per day.

- A COVID-19 testing programme has been rolled out for care homes.

- A contact tracing strategy 'Test, Trace, Protect' has been published and the Public Health Agency led contract tracing service commenced on 18 May 2020.

- 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.

- Recommendations resulting from the Care Home Rapid Learning Initiative will be implemented, once the presented to and agreed by the Minister.

- The UK Chief Medical Officer/Chief Nursing Officer group will continue to keep best practice guidance on appropriate use of PPE under review and any change to this factored into supply modelling or alternative guidance provided should shortages emerge.