Northern Health
and Social Care Trust

Rural Needs Impact Assessment Template

Section 1: Define activity subject to Section 1(1) of Rural Needs Act (NI) 2016

1A. Short title describing activity being undertaken that is subject to Section 1(1) of the Rural Needs Act (NI) 2016:

Northern Health and Social Care Trust (NHSCT) COVID-19 Response: Rebuilding Services Plan, Phase 3 (1st April – 30th June 2021)

1B. Are you Developing, Adopting, Implementing or Revising a Policy a Strategy or a Plan? (Underline or Circle)
Or are you delivering or designing a public service? (Underline or Circle)

The COVID-19 emergency has prompted the need to adopt new ways of working to balance the challenges of protecting the health of the population and safeguarding the health and wellbeing of the most vulnerable people in the community, whilst continuing to delivery high quality, safe patient/client services and a safe working environment for staff and all those who come into contact with our services. The Rebuilding Services Plan details how we will begin to rebuild our health and social care services in a phased and incremental way.

The Trust has, and is continuing to, work closely with the Department of Health (DoH), the Health and Social Care Board, the Public Health Agency and with General Practitioners in Primary Care to deliver a robust and cohesive partnership approach to tackling the pressures of COVID-19. The Department of Health (DoH) have, following Ministerial approval introduced a new "Strategic Framework for Rebuilding HSC Services" and has taken the lead on planning and preparation of a "Phase 3 plan" covering the period from 1 April 2021 to 30 June 2021.It is recognised that Coronavirus will be with us for some time and this will change the way we provide many of our services.

Phase 3, Rebuilding Services Plan for the period April 2021 to June 2021 is detailed within this rural needs impact assessment aligned to services provided by the Trust.

What is official title of this Policy, Strategy, Plan or Public service (if any)?

Northern Health and Social Care Trust (NHSCT) COVID-19 Response: Rebuilding Services Plan, Phase 3 (1st April – 30th June 2021)

1C. Give details of the aims and/or objectives of the Policy, Strategy, Plan or Public Service:

The Phase 3 Plan for April, May and June 2021 outlines how NHSCT will continue the journey of rebuilding health and social care across all services, following the third COVID surge. This is the fourth published plan following on from the Phase 1 (June 2020) published on 9th June, Phase 2 (July 2020) published on 10th July 2020 and the Trust Resilience Plan to address Winter Pressures and COVID-19 surge 2021/22, published on 10th October 2020.

Since declaration of pandemic on 11th March 2020, COVID-19 has had a detrimental impact on services across all areas of the wider health and social care system. Within the NHSCT, the focus has been to ensure the safety of our patients, service users and staff. Many services have had to

be suspended or reduced, including many elective procedures, allows protection of emergency and urgent services. There are many examples of how services within the NHSCT have adapted to meet the challenge of the pandemic, providing innovative ways to ensure service users continued to receive care throughout this period.

In July 2020 the NHSCT, in line with the DOH's Strategic Framework for Rebuilding HSC Services, commenced planning for the restart of normal services, detailed in the rebuild plans agreed with the Health and Social Care Board (HSCB), aimed at achieving a stepped approach to the resetting of services over the rest of the year. The Trust was able to the maintain progress of rebuilding services during the second surge of COVID-19, which began in September 2020. However, due to the scale and pace of the third surge in late December 2020, the Trust had to take action based on the Trust Resilience plan. Regional surge planning arrangements were put in place in relation to critical care, respiratory care and elective care, in order to ensure capacity was maximised to treat COVID-19 patients on a system-wide basis, regardless of place of residence. This saw Antrim Area Hospital ICU scale up from a baseline of seven beds to 14 beds in line with the regional Critical Care Network Northern Ireland (CCaNNI) Surge Plan. A regional group was also established to prioritise urgent elective treatments, again to ensure access based on need, against a set of agreed criteria regardless of place of residence. Throughout the pandemic, Trust staff went to great lengths to ensure that, where possible, services were sustained during the COVID-19 surge. This was particularly notable in this latest and most challenging surge. We are grateful for the resilience and dedication that our staff and those across the region have shown during this period. We are cognisant of the significant demands that have been placed on staff both physically and emotionally and we remain committed to working in partnership with staff and Trades Unions to support our staff recovery from the pandemic.

The Trust is committed to providing a carefully considered, balanced and evidence-based response to rebuilding services, taking into account what we have learnt from experience and engagement with staff and services users over the last year. We have to acknowledge that we will continue to live with COVID-19 for some time and this will continue to impact on how we can deliver our services, including social distancing and infection prevention control measures.

The Trust recognises that there are a number of policy leads/decision makers across HSC who likewise must comply with the S75 Equality Duties, the Human Rights Act and the Disability Duties in the development, implementation and review of the Minister for Health's "Strategic Framework for Rebuilding HSC Services" in NI and in the development and implementation of HSC Trusts Rebuild Plans. The Trust therefore commits to collaborate, as necessary, with all relevant HSC organisations in seeking to ensure the fulfilment of these statutory duties. This may entail, in some instances, the Trust feeding upward into regional EQIAs led by other HSC Policy Leads e.g. DoH, HSCB et al, contributing to equality screenings by other policy leads where there are for example regional themes, undertaking further individual equality screenings on Trust proposals and where necessary and appropriate conducting EQIAs and associated consultation in line with the commitments in approved Equality Schemes and in the fulfilment of the requirement of the DoH Circular Guidance 'Change of Withdrawal of Services – Guidance on Roles and Responsibilities' – September 2019 especially where temporary changes are being proposed as permanent.

Key Principles Adopted when Developing the Rebuild Plan

The Trust has set out in this document, a high-level overview of the services that we plan to maintain and rebuild during April to June 2021. The Trust remains committed to delivering safe and effective care for our clients and patients and the focus will be on treating the most urgent cases first.

As a result, some patients may continue to wait longer than we would like. In accordance with the Regional Rebuilding Management Board, chaired by the Permanent Secretary of Health, the process of rebuild will be guided by the following five principles:

- Principle 1: We de-escalate ICU as a region, informed by demand modelling and staffing availability
- Principle 2: Staff are afforded an opportunity to take annual leave before assuming 'normal' duties
- Principle 3: Elective Care rebuild must reflect regional prioritisation to ensure that those most in clinical need, regardless of place of residence, are prioritised (short notice cancellations may result in the scheduling of routine patients to avoid the loss of theatre capacity)
- Principle 4: All Trusts should seek to develop green pathways and schedule theatre lists 2-3 weeks in advance. The aim, for any given staffing availability, will be to maximise theatre throughput
- Principle 5: The Nightingale facilities should be prioritised for de-escalation to increase regional complex surgery capacity as quickly as possible.

As well as these principles the Trust will continue to work together with our partners across Northern Ireland to implement the recovery of Health and Social Care Services. Staff are contributing to regional work streams / areas of focus to support the HSC in delivering for our population based on our agreed regional approach:

- To ensure Equity of Access for the treatment of patients across Northern Ireland
- To minimise transmission of COVID-19
- To protect access to the most urgent services for our population

As we develop and progress our rebuild plans, we will be informed and guided by the work of a range of regional rebuild cells covering Critical Care De-escalation, Cancer Services, Regional Waiting List, Orthopaedic Hubs, Day Case Elective Care, No More Silos, Vaccine Programme, Mental Health and Adult Social Care. Further information on these groups, provided by the regional rebuild cells, is set out below.

Regional Position on Rebuild Plans - April 2021 to June 2021

Critical Care De-escalation

1. Critical Care Units continue to operate above their baseline bed numbers and this position is currently expected to continue into April and May. The critical care system has been operating at a higher level of beds from the spring last year. This additional pressure for such a prolonged period has been challenging for intensive care staff and the re-deployed staff from other areas in Trusts who have been helping to keep the critical care beds open.
2. It is acknowledged that it will be some time before critical care is able to reduce beds to its baseline funded bed complement of 72 Level 3 equivalents. Although there has been a reduction in COVID-19 patients within critical care, from a high of 69% of the patients being cared for to 39%, it is anticipated that there will continue to be between 20-25 COVID-19 patients in critical care into April and May. Coupled with this, non-COVID-19 demand will increase as elective work resumes.
3. The critical care system will continue to work together across the region to ensure that where and when beds can be de-escalated and

staffing allowed to return to their normal positions, after rest and recovery, this is achieved in a managed way, at the local and regional level. Plans are in place to do this safely while supporting mutual aid and ensuring equity across the system.

Cancer Services

4. Cancer waiting times were unacceptable before the COVID-19 pandemic. Cancer referrals, and screening, diagnostic and treatment services have all been significantly impacted by the pandemic resulting in immeasurable distress for patients. The service needs to act now, not just to build services back but to build them back better. The Health and Social Care Board is currently working with the Department of Health to produce a Cancer Recovery Plan. The 3-year plan builds on the work already commenced through the Cancer Reset Cell and pulls forward a number of early actions associated with recommendations included in the draft Cancer Strategy, which is being co-produced with patients, the wider service and the voluntary sector. The plan will aim to improve cancer waiting times, by addressing backlogs that have arisen as a consequence of the COVID-19 pandemic, as well as seeking to address capacity gaps that existed pre-COVID. It will do this through an expansion in capacity (both staffing and equipment), the modernisation of care pathways and the adoption of new tests and technologies. All of this will be underpinned by a focus on skills mix and multi-professional education and training.
5. The plan does not specifically address cancer surgery which is being looked at as part of the wider elective plan. It covers the following key areas:
    - Supporting patients
    - Screening
    - Awareness & early detection
    - Safety netting & patient flow
    - Diagnostics to include imaging, endoscopy, colposcopy and pathology
    - Prehabilitation & Rehabilitation
    - Oncology & Haematology
    - Palliative care

Regional Waiting List

6. As we emerge from the latest wave of the pandemic, the focus of the HSC will be on resetting all elective services in an environment that is safe for both staff and patients. It is expected that theatre capacity will continue to be constrained during this period and that theatre access will vary across Northern Ireland, potentially resulting in differential waiting times. It is therefore essential that capacity is protected for the highest priority patients and that access to this capacity is provided equitably across Northern Ireland. The Regional Prioritisation Oversight Group (RPOG) will continue to play a key role in ensuring that the clinical prioritisation of cancer and time critical/urgent cases across surgical specialities and Trust boundaries is consistent and transparent and to ensure the utilisation of all available capacity (in-house and in the Independent Sector) is fully and appropriately maximised.
7. Trusts, as part of their rebuild plans April to June 2021, will also need to designate 'green' sites by ensuring complete separation of elective and unscheduled services. At the same time, Trusts will need to put in place 'green' pathways at major acute hospitals to ensure that cancer and complex elective surgery (that can only be provided on these sites) can be kept separate from complex unscheduled surgery. While accepting that there are still risks in the system, all organisations will need to be agile and manage this risk proportionally, giving the best

opportunity to maximise theatre throughput and patient care.

Orthopaedic Hubs

8. In July 2020, the Minister announced plans for the regional rebuilding of elective orthopaedic services with the publication of the blueprint document 'Rebuilding, Transition and Transformation of Elective Orthopaedic Care delivered by Health and Social Care in Northern Ireland' and the establishment of a regional Orthopaedic Network to take this forward. The blueprint document set out a plan to focus service delivery from two hub sites initially (Musgrave Park Hospital and Altnagelvin Area Hospital), with the longer term aim to utilise all orthopaedic units in Northern Ireland. Despite the successful resumption of activity across the region at that time, elective orthopaedic services were subsequently suspended in October as resources were redeployed to address the immediate pressures arising as a result of the COVID-19 surge. Services remain suspended, however throughout this period the Orthopaedic Network has continued to explore and develop opportunities for regional transformational change for the service.

9. Entering the next phase of service rebuilding, the blueprint will be re-established through the regional Orthopaedic Network. The key aim is to restart regional elective orthopaedic services in a safe and sustainable manner on a dedicated site with a 'COVID light' pathway. This will be taken forward on a phased basis, addressing as a priority those patients with the greatest clinical need, whilst at the same time working to deliver long-term transformational change to the service.

Day Case Elective Care

10. In July 2020, the Minister announced that Lagan Valley Hospital in the South Eastern Trust would become a dedicated day procedure centre for the region. While the nature of the site means that it is most suitable for day case surgery and procedures rather than more complex work, the complete separation of elective and unscheduled services at the site has enabled services to continue to be delivered throughout the pandemic on a 'COVID-light' pathway. In recent months, the site has delivered red flag and other high priority lists on behalf of the region where these could not be accommodated at the hospital of origin due to pandemic pressures. Work is underway with clinicians across the HSC to identify the types of procedure that will be suitable for the regional day procedure centre at Lagan Valley Hospital as elective activity resumes.
11. Prior to the pandemic, there were also similar initiatives for cataracts and varicose veins in the Downe, Omagh, South Tyrone and Mid-Ulster Hospitals. Over time and as more elective capacity becomes available, as pressures at hospitals decrease, it is expected that options for other regional day procedure facilities will be explored by the Day Procedure Network.

No More Silos

12. The Department's COVID-19 Urgent and Emergency Care Action Plan, which seeks to implement 10 key actions to maintain and improve services, is currently being implemented in all Trusts. Local Implementation Groups have been established in all Trust areas and significant progress has been made over the last quarter.
13. Key developments during the period April to June will include: the roll out of the Phone First telephone triage and assessment service to all Trusts, using a single regional number; establishment of urgent care centres attached to EDs across the region, and development of new direct referral pathways to services in primary, secondary and community settings.

Vaccine Programme

14. The vaccination programme is following the prioritisation list recommended by the Joint Committee on Vaccination and Immunisation (JCVI). While the vaccination programme is dependent on the supply of vaccine, rapid progress has been made and by April it is hoped that the first nine priority groups will be close to being vaccinated. This will allow the programme to proceed to priority groups 10, 11 and 12 which will cover the remaining adult population aged 18 to 49 years of age. A large portion of these groups is likely to be vaccinated during the period of April to June using a combination of the Trust regional vaccination centres, including the large centre located at the SSE Arena in Belfast, GP Practices and Community Pharmacies.
15. The vaccination programme is still in its early stages and to be sure of its success, we will continue to closely monitor its impact on serious illness and hospitalisations. On a positive note, there is emerging evidence of fewer outbreaks in care homes. The long-term success of the programme depends on achieving high uptake rates in all sections of the adult community and therefore every effort will be made to ensure the programme continues to be rolled out rapidly.

Mental Health

16. Mental health services continue to face considerable pressures as a result of the COVID-19 pandemic. Adult in-patient services regularly see bed occupancy rates over 100% and heightened acuity levels, including a threefold increase in special observations and doubling of the proportion of detained patients. Community mental health services are also reporting increasing levels of low level anxiety and depression. A similar positon is reflected in our younger population with referrals to CAMHS continuing to increase. It is expected that these pressures will continue.
17. Work has progressed to help and support people’s mental health and wellbeing. A reformed Mental Health and Emotional Wellbeing Strategic Working Group will provide strategic direction in the recovery work. Additional funding has also been invested in mental health services, with commitments for a new specialist perinatal mental health service and managed care networks for CAMHS and forensic mental health. DOH will also allocate £1.5m recurrent funding from 2021/22 to support the implementation of the new Emotional Health and Wellbeing in Education Framework. The new Mental Health Strategy is the subject of a public consultation, which closed on 26 March. This will help ensure a cohesive strategic direction for development of mental health services over the next 10 years.

Adult Social Care

18. Significant financial and in-kind support has been provided to independent sector providers of adult social care, helping to keep our care homes safe and ensure essential services such as domiciliary care (homecare) continue. This has included up to £45m in direct financial support for care homes, as well as income guarantees. Careful consideration is being given to what on-going financial support is provided into 2021/22, while also assessing the longer term impact the pandemic has had on the sector. The ongoing provision of PPE without charge, where providers cannot access their own supplies, will continue into 2021/22, as will the use of routine asymptomatic testing, and testing in situations where there is a suspected or confirmed COVID-19 outbreak, to help protect care homes and supported living settings. The Department will continue to actively review the frequency of testing in these settings in the coming months; any requirement to vary testing frequency will be appropriately informed by emerging scientific evidence and other contributory factors, including local community transmission rates and the deployment of the COVID-19 vaccination programme.

19. The Department will continue to work with Trusts to ensure all options are explored to ensure day centre services, day opportunities and short breaks capacity is maximised – and that we build on new ways of working, such as greater use of direct payments to support the care of individuals. Support to carers will continue to be a priority, recognising the increased burdens that have been placed on those who care throughout the pandemic. The pandemic has reinforced the need to secure long term change and reform of adult social care, in line with the priorities set out in Power to the People.

As with previous rebuild plans we will also continue to engage with key partners, including Primary Care, Voluntary and Community Care, Independent Sector and Trade Unions, to ensure it is representative of and includes the valuable input of those who use our services. The Trust is committed to its legal duties under Section 75 of the Northern Ireland Act 1998 as detailed in its approved Equality Scheme, and the Rural Needs Act 2016. In terms of assessment of the Northern HSC Trust Rebuild plan, the Trust will screen for both equality and rurality to identify potential adverse impact.

<u>Assumptions in the Development of this Rebuild Plan (April to June 2021)</u>
In order to develop this rebuild plan within the required timescales the following assumptions have been made:

- There is no further surge prior to or during the delivery of this plan
- The vaccination programme continues to roll out in line with regional requirements and there is no further demand on Trust staff to support the mass vaccination centres
- There is no change to the current PHA guidance on PPE provision and there are adequate supplies of such
- The plans are acceptable to, and accepted by, key stakeholders including our Trade Union Colleagues
- Any additional revenue and capital required to deliver this plan is available
- Staff will be supported to take planned annual leave over this period.

<u>Our Staff</u>
Throughout the pandemic and in developing our rebuild plans, the Trust has been keen to promote the health and wellbeing of our staff. Staff across a range of service areas, including human resources, occupational health, psychology, infection control and health improvement, have worked collaboratively to pool their expertise and resources to draw together a comprehensive package of practical support for our staff which include:

- The development of a Colleague Support Pack entitled “Are You Well?”. This is a digital resource which highlights a range of options that are available, including information on support helplines, downloadable resources, wellbeing webinars and links to drop-in mindfulness sessions etc.
- The establishment of a dedicated psychological support helpline and staff support in-reach service, with particular emphasis on high-intensity COVID-impacted settings, to support staff through the COVID-19 pandemic and beyond. NHS Charities funding was secured to supplement the existing Occupational Health & Wellbeing Consultant Clinical Psychologist, to enable staff to continue to be supported through on-going surge episodes and during resumption of normal business.
- A comprehensive support package for teams, developed and supported by the Organisation Development team

- Regular Health & Safety Committee meetings took place and provided a platform to support staff to develop safe working arrangements and practices, to ensure we can continue to work safely during COVID-19. This includes the development of guidance to provide the framework to assess and support the safety and wellbeing of our staff, visitors and service users.
- A range of staff health and wellbeing resources on the i-matter hub, including on-line nutrition and exercise programmes, stress management sessions and advice and support on a range of issues such as managing anxiety, building resilience and coping mechanisms, sleep well resources and mental health support for adults and young people.
- The Trust provides a testing and track and trace service for staff which has helped to contain any outbreaks and minimise risk to our staff, patients and service users.
- Occupational Health services have been significantly stretched to provide support to staff during this period and a review of the resources to support this area will be required.

The Trust recognises the importance of continuing to support its staff going forward and these measures will be maintained as we progress the rebuild plans outlined below.

NHSCT Rebuild Plan by Service area

The table below outlines, for the period April to June 2021, those NHSCT services that experienced a significant impact as a result of the pandemic and explains the actions being proposed to further increase capacity and/or access from April 2021.

NHSCT REBUILD PLAN APRIL– JUNE 2021

Our services	What we plan to do to rebuild services during April-June 2021
Urgent and Emergency Care	❖ Embed No More Silos workstreams to include same day urgent care streams and associated pathways in partnership with Primary Care and key stakeholders - to include exploring CCG referral pathways ❖ Develop NMS pathway increased capacity for NIAS turnaround target improvements ❖ Continue in line with NMS to address development of admission and discharge pathways ❖ Review and expand on ambulatory medicine pathways on both acute sites ❖ Continue to develop enablers to promote capacity and flow within Urgent Care ❖ Increase outpatient activity including virtual opportunities.
Critical Care	❖ Due to the very limited space in Antrim Hospital's ICU and the inability to care for COVID-19 and non-COVID-19 patients in the same unit, Antrim ICU is being reprovided temporarily in ward A1 which provides access to 14 beds. As the COVID-19 surge has de-escalated, it has now been agreed regionally that the ICU will support 10 beds throughout March 2021. This will further de-escalate as agreed, through the regional CCaNNi Network, depending on the surge level throughout the region. The current ICU footprint within A1 is a combination of three side rooms and two bays, each of which can accommodate four patients. This arrangement allows

	for three segregated areas for the provision of supporting COVID-19 patients, non-COVID-19 patients and patients with unknown COVID-19 status, or who may require a sideroom for other infectious conditions. This identified area in A1 will remain ICU and will support the agreed service provision until another ward area is re-purposed to accommodate ICU. The design of the new area is required so that it has more access to single rooms and more space for the commissioned ICU service. The re-purposing work is expected to begin in April 2021. The current funded establishment for ICU is six Level 3 beds and two Level 2 beds, which is equivalent to seven Level 3 beds. The Trust will continue to provide the pre-COVID-19 bed numbers going forward (i.e. seven Level 3 beds equivalent), however to be COVID-19 compliant the Trust will require additional nursing staff which the Trust is progressing at financial risk. Causeway ICU is commissioned for two Level 2 and two Level 3 beds, which is equivalent to three Level 3 beds. COVID-19 presents issues regarding the ICU physical environment, in that Causeway ICU has only one sideroom and a main open ward area. This allows for two segregated spaces, therefore when a third zone is required, for example, to care for a COVID-19 patient, it means that non-COVID-19 patients and infection status unknown patients, must be nursed in either recovery or theatre ❖ The AAH unit will be staffed for a baseline of six Level 3 ICU patients at the end of March 2021. Beds will open and close within COVID-19 and non-COVID-19 areas, depending on the COVID-19 status of the patients to be admitted. The opening of additional beds for surge, will be dependent on demand and on the availability of staff with ICU training to transfer from other areas, or the additional recruitment/training of nursing staff ❖ The CH unit will be staffed for a maximum of four patients. The number of patients which can be accommodated will depend on the level of the patient and the COVID-19 status of the patients in the unit.
Diagnostics (X-Ray, MRI, CT, cardiac investigations)	For Phase 3 it is anticipated that capacity will increase as follows; ❖ CT will be at 90% of pre-COVID-19 capacity, delivering approx. 2,750 scans per month ❖ MRI will be at 90% of pre-COVID-19 capacity, delivering approx. 970 scans per month ❖ NOUS will be at 80% of pre-COVID-19 capacity, delivering approx. 3,560 scans per month ❖ Plain film will be at 90% of pre-COVID-19 capacity, delivering approx. 16,600 exams per month ❖ Activity will be continually reviewed, however it should be acknowledged that the above projections are dependent on anticipated staffing levels allowing all equipment to be utilised
Cancer Treatment Services	❖ Continue with Oncology, CNS NMP and Haematology clinics as per Phase 2. ❖ Oral medication home-delivery ceased on 1st September. New systems have been put in place by Pharmacy from 1st September to enable patients to collect their medications from a hospital pharmacy closer to home, e.g. AAH Main Pharmacy Dept., Causeway Pharmacy

Northern Health and Social Care Trust

	Dept. or Mid Ulster Pharmacy Dept.
Day Surgery & Endoscopy Services	❖ The Trust's Day Surgery provision should increase. Nursing staff are continuing to support ICU and the number of lists will be kept under review and increased, as staff are released from ICU. The provision of day surgery should be: ➢ Causeway Day Surgery unit increasing to 13 sessions per week; Urology, Pain, Gen Surgery, Dental (Learning Dis & Children) ENT and Gynaecology. ➢ Mid Ulster - The Cataract Elective Care Centre was stepped down due to the COVID-19 Surge 3, when all staff had to redeploy into ICU or inpatient theatres. The sessions will be stepped up once the ICU de-escalates and staff can return to their base. It would be envisaged that four to six sessions / week will be delivered. ➢ Whiteabbey Hospital was stepped down due to staff being redeployed to support ICU and inpatient theatre services in response to COVID-19 Surge 3. This will be reviewed following confirmation of ICU de-escalating to normal funded bed capacity. ➢ Antrim Hospital's Day Surgery capacity also ceased as a result of COVID-19 Surge 3. There are plans to implement a low risk surgical pathway for patients who will be admitted via DSU ward
	➢ The Trust's Endoscopy capacity will be increased to 27.5 Endoscopy lists, three Bronchoscopy lists, three ERCP and four Bowel Cancer screening lists delivered across the four Endoscopy sites
Outpatient Services	❖ Continue with a mix of face-to-face and virtual outpatient assessments, increasing the number of patient assessments during the next two quarters ❖ The phlebotomy service will continue into Phase 3 across all OPD sites as an enabler for virtual clinics, with patients being booked pre or post-clinic depending on demand.
Integrated Maternity and Women's Health	❖ Maternity services continue in both AAH and Causeway Hospitals. Maternity OP clinics have been relocated to Level B OPD to accommodate ICU location until end August 2021 in AAH site. ❖ The Gynae outpatient service reset will begin 12 Apr 2021 and will be relocated on AAH site to Level C OPD, to accommodate ICU location until end Aug 2021. The team has begun to work towards the re-establishment of the majority of gynae OP sessions across the Trust from April 2021. However these will all have reduced templates in order to accommodate social distancing requirements ❖ The gynae team is working in partnership with acute colleagues, to utilise available sessions when the elective green pathway is re-established from 22 Mar 21 on AAH site, for priority 2A & 2B red flag cases. The Gynae team has continued to utilise one session per week in Causeway Hospital for red flag surgery. ❖ Outpatient with procedures appointments continue in The Meadows in Causeway Hospital and

Northern Health and Social Care Trust

	will be re-established in AAH in relocated Level C OPD from 12 Apr 2021.
Inpatient Elective and Emergency Surgery for Adults and Paediatrics	❖ Inpatient surgery on Causeway site is currently at eight lists per week; shared amongst Gynae, ENT, Breast and Colorectal surgery. Surgery is currently being allocated using the regional FSSA priority coding – this will continue until such times as more capacity can come into the system, allowing for lower priority patients to be reintroduced to the process. ❖ Lists will increase in tandem with the de-escalation of ICU and the associated staffing impacts ❖ A Low-risk Pathway in Day of Surgery Unit (DoSU) will begin on 22nd March – initially six lists per week to be shared amongst Gynae, ENT, Breast and Colorectal – lists will be allocated via the Trust's internal FSSA Group – which feeds in to a regional FSSA group. ❖ No paediatric elective surgery is being performed currently
Pharmacy	❖ Continue to support Mass Vaccination Centre and vaccine distribution for the community programme ❖ Re-establish pharmacist role in surgical pre-admission medication review ❖ Discharge Follow-up Team fully re-established ❖ Home-working facilitated to assist with social distancing ❖ Project commenced with HSCB to scope requirements for a regional medicines delivery service ❖ Clinical Pharmacy input will be provided six days per week ❖ Continue with enhanced stock management in EDs and critical care ❖ Management and distribution of PPE to continue
Screening Programmes	❖ The Trust will deliver across all population screening programmes in line with Public Health Agency recommendations. ❖ Each screening programme will seek to restore screening capacity to enable the timely offer of screening to all eligible individuals. ❖ The Trust will work with the Public Health Agency to develop plans to recover screening intervals/round lengths to recommended timescales. ❖ The Trust will seek to ensure that timely diagnostic and treatment services are available to those with a positive screening test result.

Service area: MENTAL HEALTH AND LEARNING DISABILITY

Our services	What we plan to do to rebuild services during April-June 2021
Community Health & Well being	❖ All services delivering virtually and with social distancing with improved outcomes ❖ Farm Families Health Checks, Smoking Cessation and Diabetic Prevention Programme move to

	mixed model of virtual, socially distanced and direct client contact delivery ❖ Build self-efficacy to reduce pressure on Trust services through the development of Access Hub for single point of access, triaged and co-ordinated signposting, navigation and social prescribing ❖ Explore option of extending effective Health Coaching model beyond Diabetic Prevention to other long-term conditions such as CVD ❖ Strengthen partnership planning with partners and Community & Voluntary Sector
Mental Health Inpatient facilities	❖ Mental Health Acute Inpatient Services continue to experience a significant increase in acute admissions, and this is reflected across the region. Patients are presenting with more significant needs and there is an increased number of Mental Health Order presentations. The current level of daily admissions does not match the daily level of discharges. A significant proportion of patients in hospital have lengths of stay less than 30 days and are in active treatment. We will focus on our discharge pathways and will maximise the use of Facilitated Early Discharge through the Home Treatment Team. We will continue to work with CMHTs to ensure timely discharge from hospital. We will also put plans in place to take forward the further introduction of the Purposeful Inpatient Admission Pathway (PiPA) within our acute inpatient wards. This will further support timely discharge from inpatient services. ❖ Recruitment will continue, to recruit additional Band 6 nursing posts to support the delivery of safe and effective mental health inpatient services that deliver evidenced-based care and nurse-led therapeutic interventions. Through a Management of Change process, the investment and workforce development of Band 6 nurses in line with regional recommendations will allow wards to move their Band 7 nurses to supernumerary positions allowing for 5-day working and an increase in senior leadership availability on the wards. ❖ The Mental Health Liaison Service has experienced resourcing challenges due to a number of vacant posts. We will progress filling of posts as quickly as possible to ensure the service can meet the level of demand. ❖ Inpatient Addiction Services will recommence and admission will be offered to those next on the waiting list. All efforts will be made to ensure this service is not further impacted.
Community Addictions	❖ The service will continue to reinitiate and re-induct service users on OST. ❖ The Service will continue to utilise new ways of working and service delivery will incorporate both face-to-face contacts and the use of virtual options. The service has resolved accommodation issues in all localities. ❖ Having secured new accommodation for service base, plans for required works will be initiated. ❖ In collaboration with stakeholders, the service will seek to develop a pathway for Community Alcohol Detox, providing a pathway to divert such presentations from ED. ❖ The service has completed a pilot of their group on line and will reinstate the ‘Changing it Together’ group work through virtual solutions such as Zoom.

Community Mental Health Teams	❖ Partnership working with the GP Federation will embed an integrated care service that supports people whose complex mental health needs require care over and above what can be provided in primary care. ❖ The Service will recommence the Brief Intervention and Intensive Intervention Pilot for service users with Severe and Enduring Mental Illness to inform service development. ❖ As teams return to business as usual, an organisational training and development plan will be developed and taken forward in conjunction with HR. ❖ Community Mental Health Services will develop a Community Rehabilitation Service which was delayed due to COVID-19. The Team will offer clinical intervention to individuals transitioning to supported living in the community from a variety of inpatient and community settings as well as those currently residing in Supported Living accommodation.
Learning Disability (Day Care Services)	❖ Buildings-based facilities, including adult centres, satellites and hubs, will continue to offer day care to the maximum number of service users, as per the reduced daily allocations, based on completed facility assessments in line with COVID-19 restrictions. This will be reviewed on an on-going basis and increased where possible according to re-assessment of environment. Service users transitioning from schools will be allocated day care, albeit on a reduced scale, according to assessment of need ❖ Maximum attendance at facilities, in line with COVID-19 regulations, will be increased throughout April, May and June. ❖ Direct payments to continue to provide financial support during day care hours for those service users who live in supported living. ❖ Review of staffing establishment required to meet assessed need of service users based on allocated days of attendance is currently underway ❖ Continue to review the day services management structure at senior management level ❖ The service continues to engage with current community outreach opportunities across localities, such as Mid-Ulster Sanctuary, Ashes to Gold, Jubilee Farm, for an alternative means to provide a service, as well as scoping/sourcing non-Trust local community facilities in which to provide day care activities ❖ The service will continue to scope and source community activities or volunteers that could provide alternative activities. ❖ Support service users who are at home by remote access e.g. zoom, telephone calls and by activity packs. ❖ Alternative ways of making effective use of current buildings based facilities e.g. flexible service during day, evenings and weekends, will continue to be scoped, in conjunction with Human Resources, staff side, support services and community teams and with collaborative working with service users and carers.

	❖ We are currently looking into additional estate to widen the scope of being able to increase offers of attendance ❖ It is anticipated that service users who previously attended and continue to require buildings-based day care and those who have transitioned from school, will be provided with a limited service albeit in a reduced and/or alternative way ❖ Collaboration with service users who represent day care at the User Forum will continue and this will include their input re the rebuild of services ❖ Options to provide alternative supports to people with LD will be developed in collaboration with service users, their families and carers, staff groups and partner organisations
Learning Disability (Day Opportunity Services)	❖ Community and public transport will meet transport need, to enable access for community based opportunities, subject to DfI risk mitigation strategies ❖ Regionally agreed criteria for critical care need will continue to be monitored and applied and service users transitioning from education will be considered and progressed for September intake along with this RAG classification ❖ It is anticipated that all those who previously attended these facility-based day opportunities will continue to be provided with a service, albeit in a reduced and/or alternative way, subject to any PHA changes to current risk mitigation measures ❖ We will continue to engage with the Reset Plans for buildings-based day care and meet with Partnership providers, where required, to progress on identified actions.
Learning Disability Short Breaks	❖ Provide vaccination rollout to Social Care Staff and to Adult Placement Providers ❖ Continue to facilitate weekly COVID-19 swab tests for Short Break staff and facilitate swab test for all Service Users 72 hours prior to using short break bed. ❖ Following consultation with Service Users/Carers, increase from the current three-night short breaks offered to four- night allocation. ❖ Continue with the current number of bed-based short breaks and review monthly to consider increasing the number of beds available. ❖ Continue with the introduction of Service Users who are new to the service. ❖ Revisit the gradual reintroduction of Share The Care short breaks ❖ Revisit Regional Operational Policy for assessment and allocation of bed-based short break services and plan for implementation of this Policy ❖ Maintain the RAG rating, updating accordingly to changing needs and circumstances.
Community Learning Disability Teams	❖ Rebuild our Learning Disability community services following the COVID-19 pandemic ❖ Hold and lead on workstreams across Learning Disability teams ❖ Work in partnership with day services and short breaks to rebuild Learning Disability services ❖ Review the RAG rating assessment tool to determine the allocation of Services ❖ Increase face-to-face contacts with service users and families

	❖ Complete legacy and all new applications for Deprivations of Liberty Safeguards in accordance with the Mental Capacity Act ❖ Progress transitions from Children's Services to Adult Services following the individual pathway of care ❖ Continue to offer Carers Assessments ❖ To utilise an informal model of review to record need. ❖ Work in partnership with service users, carers and stakeholders to support the rebuild of all of our services and support systems ❖ Enhance the use of Direct Payments. ❖ Health facilitators to link with Primary Care to review the health needs of Service Users ❖ Continuation of resettlement programme of patients from Muckamore Abbey Hospital ❖ Provide opportunities for staff to work in office space and to continue use of Remote Working ❖ Support recovery of the Community Learning Disability teams and promote health and wellbeing options available to employees and promote a safe and healthy working culture
Adult Safeguarding	❖ The Trust continues to provide an Adult Safeguarding response to all referrals, in relation to those in need of protection or at risk of harm
Condition Management Programme	❖ The CMP service has resumed business as usual. The service will secure new premises that allow the service to function in an area that meets social distancing requirements. Work continues with C&V Partners to create additional estate capacity lost during the pandemic, for example within Leisure Centres and Jobs & Benefits Offices
Psychology (including Adult Autism and Psychological Therapies)	❖ Psychological services will continue to deliver a blended approach of face-to-face and virtual therapeutic contacts based on on-going dynamic risk assessment of individual engagement and progress. Face-to-face appointments will be increased during April – June 2021, in line with infection prevention guidance. ❖ Virtual group work programmes will remain in place for all previous face-to-face groups. Planning will commence to re-instate face-to-face groups when safe to do so. ❖ On-going engagement with professional bodies and review of best practice guidance, will inform decisions regarding those services currently limited due to social distancing and concerns of validity of process if PPE is worn i.e. psychometric assessment of ability; ASD diagnostic assessment
Dementia Outpatients	❖ As GP referrals continue to increase, the reset plan is to increase critical face-to-face for Initial Assessments (New) and review appointments based on service users' clinical mental health presentation i.e. Seriously Mentally Ill and Mental Health Risk Assessment. The service will continue with telephone contacts for routine assessments and review using virtual and digital solutions where suitable ❖ Deliver critical face-to-face for assessments (new) and review casework based on service users'

Mental Health Service for Older People. (for Dementia OT see AHP/ OT)	clinical mental health presentation and risk assessment ❖ We will consult with families and service users on approaches to service delivery ❖ Dementia Reform - The Service will take forward a waiting list initiative to reduce the number of service users awaiting the assessment of a dementia diagnosis. In addition, the service will develop a sustainable model to provide an efficient and effective response to the projected increase in referrals for memory assessment. This model will require expansion of the Psychiatry of Old Age service within the multi-disciplinary team. ❖ Dementia Home Support Team (DHST) will continue to deliver a blended approach to service delivery, with face-to- face, virtual and telephone contacts as appropriate. ❖ Delirium Support Service – All essential direct assessment and interventions will be undertaken with service users. ❖ The service will continue to review the therapeutic interventions which cannot be carried out due to social distancing and requirements of Infection Prevention Control (for example, some group activities and activities that use items which cannot be appropriately decontaminated between use).

Service area: PRIMARY CARE

Our services	What we plan to do to rebuild services during April-June 2021
GP Out of Hours / Primary Care COVID-19 Assessment Centres	❖ COVID centres have consolidated on two sites and remain as such for now, while we explore the potential demand for additional capacity beyond this and the appropriate sustainable staffing model.

Service area: ALLIED HEALTH SERVICES

Our services	What we plan to do to rebuild services during April-June 2021
Physiotherapy	❖ The service will continue to use a combination of telephone triage/reviews, Zoom calls and face-to-face activity across all areas. All areas will continue to ramp up urgent face-to-face activity as footfall through depts., social distancing and PPE allows ❖ Musculo-skeletal will review all urgent patients face-to-face, as required and continue to manage routine patients by telephone/zoom. The service will slowly ramp up some routine F/F activity as capacity allows ❖ Domiciliary appointments will continue to be used for urgent patients as required, across Neuro OPs., Paediatrics, ALD and Lymphoedema in combination with telephone/zoom

	❖ Community Physio will return to full service with a combination of face-to-face and remote interventions as appropriate ❖ Recovery Physio (generic & stroke) will return to full service provision with a combination of face-to-face and tele-rehabilitation interventions ❖ Special schools are open - F/F activity has been reinstated ❖ In the Mental Health service, the gym sessions will be increased and input resumed to the re-opened Addictions ward ❖ In the Adult Learning Disability service physio will review patients face-to-face when patients arrive
Occupational Therapy	❖ Acute OT The service will continue to assess all referrals, including routine referrals. ❖ Community OT The service will continue to assess all referrals, including routine referrals. During the current COVID-19 wave, from March onwards all referrals will be assessed by telephone in the first instance. Domiciliary visits will progress after the appropriate COVID screening. Throughput of activity depending on other agencies such as NIHE or suppliers, may be reduced, dependent on their individual risk assessment. A virtual clinic pilot will commence during this period, to ascertain effectiveness of this approach. Cross-locality working will be required to focus on waiting list management during this period, to mitigate the impact of previous redeployments and reduced service provision. ❖ Recovery OT Service The service will continue to assess all referrals, including routine referrals. During the COVID-19 first wave, the service could only see those referrals deemed to be critical. ❖ Outpatient OT The service will continue to assess all referrals, including routine referrals. During the COVID-19 first wave, the service could only see those referrals deemed to be critical. Splinting clinics will be re-established as and when suitable clinic space becomes available. The service will explore and pilot the further use of video/teleconference individual and group assessments and interventions. This will require on-going monitoring of clinical outcomes and engagement with service users to ascertain the viability of delivering new service models in the longer term. ❖ Dementia OT The service will continue to assess all referrals, including routine referrals. During the COVID-19 first wave, the service could only see those referrals deemed to be critical. ❖ Paediatric OT The service will continue to assess all referrals, including routine referrals. During the current COVID-19 wave, the service could only see those referrals deemed to be critical. Routine paediatric domiciliary appointments are being gradually re-established for all appropriate specialist equipment

	and housing needs. The service continues to explore and pilot the further use of video/teleconference for parent training and individual and group assessments and interventions. This will require ongoing monitoring of clinical outcomes and engagement with service users to ascertain the viability of delivering new service models in the longer term.
Orthoptics	❖ Service provision will be at 50%, due to the reduced numbers of face-to-face scheduled appointments which will be possible as a result of social distancing and cleaning between patients Numbers may be increased if there is further relaxation of social distancing requirements ❖ New service for SEN children will begin to be implemented, some patients will transfer to school setting from acute ❖ Continue with Orthoptic Telephone Triage to manage patients appropriately and prioritise face-to-face appointments effectively
Speech & Language Therapy	❖ Introduce a blended virtual and face-to-face service model for all aspects of the service - Children, CWD and Adult ❖ Involve service users in the design of this model ❖ Re-establish Joint Voice Clinic ❖ Re-establish outpatient video fluoroscopy clinic ❖ RISE NI: Embed new ways of working with schools moving towards a more 'blended' approach to service delivery and offer and evaluate the online delivery of training to education staff.
Podiatry	❖ Continue virtual triage/treatment planning for MSK and a blended virtual and face-to-face service model for all interventions.
Community Stroke Service	❖ Full service delivery with a combination of face-to-face and tele-rehabilitation interventions. ❖
Nutrition and Dietetics	❖ Continue to develop processes and procedures to support new methods of virtual delivery for elective services ❖ Determine the ratio of elective services that may be required to be delivered in the traditional face-to-face method – through monitoring and reflection of practice since March 2020 ❖ Continue to facilitate remote/flexible working arrangements until accommodation meets all the necessary risk assessment requirements to ensure safety of patients and colleagues ❖ Re-establish the regional prescribing support Dietetic service.

Service area: community services

Our services	What we plan to do to rebuild services during April-June 2021
Community Hospitals	❖ The current position will be maintained and evaluated in line with infection rates ❖ In three out of the Trust's four community hospitals (Inver, Dalriada and Mid Ulster), rehabilitation services have been re-established ❖ The fourth (Robinson) remains the Trust's COVID-19 Unit and decisions around it will be driven by

Northern Health and Social Care Trust

	infection rates and demands from the Independent Sector in the community
District Nursing	❖ Continue to deliver critical and essential care ❖ Continue to monitor evidenced increase in activity across all teams, from previous year and mitigate risks as they arise. Prioritisation of referrals will continue to ensure that priority interventions are facilitated.
Treatment Rooms	❖ Continue with new ways of working as a result of COVID-19 IPC arrangements, which reflect extended appointment slots to permit donning and doffing of PPE and sanitation of clinical areas between patients ❖ Treatment Rooms will continue to operate at their new full capacity which has been reduced by one third due to the increase in allotted appointment time, which is 15 mins as opposed to 10 mins.
Social Work	• All services have been reinstated. Community Social Work interventions are now being delivered through a combination of virtual reviews and face-to-face assessments. As vaccination uptake increases amongst the social work/social care workforce, there is an expectation that social work reviews will be reinstated and that all domiciliary care packages, temporarily reduced due to COVID-19, will be reinstated. • CSW teams are currently reviewing the number of carers' cases open within each caseload and making active plans to complete face-to-face reassessment of care need.
Community Equipment Services	❖ Continue to deliver full service, including deliveries and collections of routine work.
Wheelchairs & Continence	❖ Wheelchairs and Continence services will continue to assess all referrals, including routine referrals. Services will be delivered through a combination of face-to-face and remote interventions.
Residential Homes	❖ Continue to work with multi-disciplinary colleagues to ensure provision of bed-based rehabilitation and recovery ❖ Continue to enable visiting within the statutory Residential Homes in line with DoH visiting principles. This includes working with care partners.
Day Care	❖ Day Care services will continue to be delivered Trust wide. While there will be a reduction in attendees each day due to existing COVID-19 guidelines, it is planned that we will continue to increase the number of attendees on a phased approach and reintroduce programme-based services.
Macmillan Unit	❖ The Macmillan Unit returned to its substantive base on the Antrim Area Hospital site on 1st September. However the service will continue to share facilities with a reduced service alongside the haematology service. This will be reviewed in June 2021.
Sensory Support	❖ The service will endeavour to provide a full service, triaging first before visiting, to maintain

minimum footfall into service users' homes.

Service area: COMMUNITY DENTAL

Our services	What we plan to do to rebuild services during April-June 2021
Community Dental	❖ The surgical element of the service is addressed in the Day Surgery section above. ❖ Continue to deliver AGP services on three sites, up to an average of four days per site, per week ❖ Deliver non-AGP dental services on up to five sites, for an average of three days per site, per week ❖ Review treatment appointments will continue to be delivered in line with clinical need, however routine surveillance appointments have not yet been fully re-established ❖ Re-establish on-site oral surgery clinics – delivered by SET in-reach service ❖ Continue to deliver a reduced orthodontic service in line with clinical priority.

Service area: SEXUAL HEALTH

Our services	What we plan to do to rebuild services during April-June 2021
The Rowan	❖ Continue to deliver 24/7 access
CASH	❖ Continue with triage telemedicine and postal medications. Urgent face-to-face appointments will be arranged ❖ Capacity will remain restricted due to the location of some clinics and reduction of footfall ❖ Awaiting regional direction regarding funding for this service

Service area: COMMUNITY CHILDREN'S SERVICES

Our services	What we plan to do to rebuild services during April-June 2021
Looked After Children	❖ As per phase 2, the service continues to increase face-to-face visits and reviews through use of Zoom technology, alongside physical attendance in adherence to social distancing guidelines. Contact has begun again, facilitated by Zoom technology and face-to-face contact, again in line with social distancing guidelines.
Child Protection (to include Children's Disability)	❖ Service continues to visit all Child Protection cases and the majority of Family Support cases in Gateway. ❖ Child Protection conferences continue as was, all taking place remotely with some attendees socially distanced. ❖ All CP cases in FSIT being visited at least monthly.
Gateway services	❖ Service continues to visit all Child Protection cases

Northern Health and Social Care Trust

	❖ The family support service has increased face-to-face contacts and will endeavour to visit all Family Support Cases monthly and in line with risk assessment.
Child, Adolescent Mental Health Services	❖ The volume of face-to-face contacts delivered in July 2020 was greater than anticipated, due to the step-down of lockdown measures and a concerted effort to increase face-to-face contact where these had not been possible previously. ❖ The service will aim to continue to deliver 40% of clinical time as face-to-face contacts and utilise teleconferencing facilities for the remaining 60% of clinical time. ❖ The ability to maximise the volume of face-to-face contacts is predicated largely upon the availability of clinical space and infection control measures. ❖ Waiting list targets of nine weeks continue to be met.
CEIS	❖ The volume of face-to-face contacts delivered by CEIS in July 2020 was greater than anticipated, due to the step-down of lockdown measures and a concerted effort to increase face-to-face contact where it was not possible previously. ❖ The anticipated re-introduction of group work, employing virtual media progressed as planned, with positive feedback being received. ❖ The service's efforts to maximise the volume of face-to-face contacts are predicated largely upon the availability of appropriate space and the necessary infection control measures. ❖ It is the service's aspiration to continue to devote 40% of contact time within the CAPA model, to face-to-face contact, with the remaining 60% of contact time being invested in teleconferencing facilities. ❖ Waiting list targets of nine weeks continues to be met.
Paediatric ASD	❖ The service will not hold face to face appointments while PPE requirements are in place, telephone and video calls will be delivered. ❖ Continue to offer intervention support across Diagnostic and Intervention Services through telephone consultation. ❖ Intervention service will offer an additional 80-100 new planned appointments and increase review appointments to 250 appointments across the service. ❖ A pilot for pre-school non-verbal children and secondary school children has been completed and virtual assessments are now in place ❖ BOSA approach is currently being piloted and staff are undergoing training for other children with a plan for implementation in May 2021. This approach will require more time to complete, resulting in reduction in assessments from 85 to 40 per month.
Public Health Nursing (Health Visiting, School Nursing, School Immunisation Programme)	❖ Planning is in place to issue consent forms for the outstanding HPV and School Leaver boosters (10,000) and in-year immunisations in school and to extend the 'flu vaccination programme to Year 8 pupils (44,000). However there are concerns regarding the handling of large volumes of consent forms within school environments.

	❖ The service is awaiting confirmation of the additional funding allocation. ❖ Recruitment to a high number of vacant health visiting posts is in progress ❖ BAS has reinstated clinics and they are currently holding 12 sessions per month. This is due to the accommodation constraints which have prevented the return to 18 sessions/month. A new model of home assessment for QB testing is currently being piloted and, if successful, will reduce the demand on accommodation and may increase the number of new contacts. ❖ Continence sessions have been reinstated at five sessions/month in line with phase 2. This level of activity will continue to be supported.
Health Protection Programme, Specialist Roles	❖ Clinics have been centralised and will continue to be delivered at the Phase 2 level of 50% capacity i.e. 12 sessions/month. However, the management of new tuberculosis cases will continue to impact on this level of activity.
CPMS	❖ As per Phase 2, CPMS are almost at full capacity, the service intends to increase new face-to-face contacts as part of Phase 3. This will depend on access to suitable 'COVID-19 safe' clinic space. The number of review contacts has increased as they have been delivered through teleconferencing facilities, this was an appropriate contact in the short-term, during COVID-19 surges, however this may reduce slightly due to the requirement to support face-to- face appointments.

Service area: CORPORATE

Our services	What we plan to do to rebuild services during April-June 2021
Corporate Nursing NH In-Reach Team	❖ Continue with delivery of REaCH Masterclasses to Care Homes as clinical training needs are identified. Methods of delivery include face-to-face, zoom and video ❖ In addition REaCH will support pilots for Wellness Checklists into PRH ❖ Begin education programmes for the deteriorating resident via Zoom technology for all 68 PNHS and 69 PRHs ❖ Support GPs in Anticipatory Care pilots as funding permits ❖ Continue to act as link workers for 34 PNHs
Tissue Viability Nursing Team	❖ Continue telephone triage of all referrals - referrals are triaged based on date of referral and not locality ❖ Continue to offer a telephone advice service to staff for all new referrals - written TVN plans are saved on our shared drive and shared with referring professional. ❖ Face-to-face visits will continue where this is deemed essential to patient care ❖ Complex wound care clinic running to meet the demand - currently one full day clinic per week. ❖ All referrals are being triaged for the complex wound care clinic - utilising the doppler skills of treatment room nurses when possible

	❖ The Senior IQI Facilitator, is leading the TVN wound photography project for secondary care ❖ TVNs and some district nurses are trialling the PANDO app for photography in primary care ❖ Post-incident reviews of pressure ulcer incidents are being managed remotely where possible. District nursing sisters and ward managers are being asked to commence the post-incident review form which is then reviewed by the TVN along with the relevant patient records. The post-incident review process is planned for evaluation as soon as possible.
Visitors	❖ The Trust will continue to implement the revised regional policy
Support Services	❖ Domestic Services - additional cleaning services required as a result of COVID-19 will continue on all sites, including the Seven Towers Mass Vaccination Centre and Trust Test Centre. ❖ Catering extension of the marquee on the AAH site to provide additional seating for meals/breaks to support social distancing. Additional staff resource will continue to provide breakfast and lunch. ❖ Transport continues to provide vehicles and staff for the transportation of vaccines to the community ❖ Portering, Car Parking and Security - additional portering duties required to support lockdown and duties in the Seven Towers Mass Vaccination Centre. ❖ Community Extension of Workplace Safety Champions on AAH and CWH sites to support safer workplace compliance.
Falls	❖ Restart face-to-face falls screenings for all NIAS referrals from the end of June (subject to COVID-19 telephone screening prior to visit) ❖ Restart face-to-face screening for ED referrals from the end of June, for patients who have been referred to the Falls Screening service twice within six months (subject to COVID-19 telephone screening prior to visit) ❖ Continue with falls screening for ED referrals by telephone, and as staff return to substantive posts work through waiting list. ❖ Restart face-to-face post-falls investigation meetings with wards at the beginning of April ❖ As staff return to substantive posts restart falls awareness training sessions – this will be via Zoom initially ❖ Continue with “Post-falls Clinical Pathway” pilot with identified Care Homes

1D. What definition of ‘rural’ is the Trust using in respect of the Policy, Strategy, Plan or Public Service:

Rural areas have been classified by whether they are within a 20 or 30 minute drive-time from the centre of a settlement containing at least 10,000 usual residents.

Section 2 - Understanding impact of Policy, Strategy, Plan or Public Service

2A. Is the Policy, Strategy, Plan or Public Service likely to impact on people in rural areas?

Northern Ireland is a region that is composed of a range of settlement structures. As can be demonstrated by the table below, which is based on the results of the most recent population census taken in 2011 as available on NISRA website, these range from cities such as Belfast and Londonderry through to much smaller settlements of less than 5,000 people, the level that is relevant for consideration under rural needs impact assessment. (Band F, intermediate settlements, Band G, villages and Band H, open countryside). As at 2011 these categories of settlements of less than 5,000 people equated to a total of 678,939 people in a total population for the region of 1,810,863. It can be seen that, based on 2011 census information available from NISRA website, 37.5% of the population of NI therefore live in settlements that would require the application of rural needs assessment therefore some of the actions taken in the Phase 3 Plan are likely to have an impact on people in rural areas in the Trust - see section 2B.

Classification	Settlement Development Limit (SDL)	2011 Census Population	20 Minute Drive-time	30 Minute Drive-time
BAND A - BELFAST	BELFAST CITY	280,211	-	-
BAND B - DERRY CITY	DERRY CITY	83,125	-	-
BAND C - LARGE TOWN (POPULATION 18,000+)	METROPOLITAN NEWTOWNABBEY	65,555	-	-
	CRAIGAVON URBAN AREA including AGHACOMMON	64,193	-	-
	BANGOR	61,401	-	-
	METROPOLITAN CASTLEREAGH	55,783	-	-
	LISBURN CITY	45,410	-	-
	METROPOLITAN LISBURN	31,203	-	-
	BALLYMENA	29,467	-	-
	NEWTOWNARDS	28,039	-	-
	CARRICKFERGUS	27,903	-	-
	NEWRY	26,893	-	-
	COLERAINE	24,630	-	-
	ANTRIM	23,353	-	-
	OMAGH TOWN	19,682	-	-
	LARNE	18,705	-	-
Band Total	14	522,217	-	-

BAND D - MEDIUM TOWN (POPULATION 10,000 - 17,999)	BANBRIDGE		16,653	-	-	
	ARMAGH		14,749	-	-	
	DUNGANNON		14,332	-	-	
	ENNISKILLEN		13,790	-	-	
	STRABANE		13,147	-	-	
	LIMAVADY		12,047	-	-	
	COOKSTOWN		11,620	-	-	
	HOLYWOOD		11,332	-	-	
	DOWNPATRICK		10,874	-	-	
	BALLYMONEY*		10,393	-	-	
Band Total		10	128,937	-	-	
BAND E - SMALL TOWN (POPULATION 5,000 - 9,999)	BALLYCLARE		9,919	Y	Y	
	COMBER		9,078	Y	Y	
	MAGHERAFELT		8,819	Y	Y	
	WARRENPOINT / BURREN		8,721	Y	Y	
	PORTSTEWART		8,029	Y	Y	
	NEWCASTLE		7,743	N	Y	
	CARRYDUFF		6,947	Y	Y	
	DONAGHADEE		6,869	Y	Y	
	KILKEEL		6,521	N	Y	
	PORTRUSH		6,442	Y	Y	
	DROMORE_BANBRIDGE		6,011	Y	Y	
	BALLYNAHINCH		5,715	N	Y	
	COALISLAND		5,700	Y	Y	
	GREENISLAND		5,484	Y	Y	
	BALLYCASTLE		5,238	N	N	
	CRUMLIN*		5,099	N	Y	
	RANDALSTOWN		5,099	Y	Y	
Band Total		17	117,434	12	16	
DEFAULT URBAN/RURAL SPLIT						

BAND F - INTERMEDIATE SETTLEMENT (POPULATION 2,500 - 4,999)	MOIRA	4,584	Y	Y
	MAGHERA	4,217	N	Y
	HILLSBOROUGH AND CULCAVY	3,953	Y	Y
	WHITEHEAD	3,786	Y	Y
	EGLINTON	3,650	Y	Y
	WARINGSTOWN	3,647	Y	Y
	TANDRAGEE	3,486	Y	Y
	CULMORE	3,466	Y	Y
	SAINTFIELD	3,406	Y	Y
	AHOGHILL	3,403	Y	Y
	DUNGIVEN	3,286	N	Y
	KEADY	3,036	Y	Y
	CASTLEDERG	2,985	N	Y
	LISNASKEA	2,960	N	Y
	BALLYGOWAN	2,957	N	Y
	KILLYLEAGH	2,928	Y	Y
	BROUGHSHANE	2,851	Y	Y
	RICHHILL	2,821	Y	Y
	CASTLEWELLAN	2,792	N	Y
	ROSTREVOR	2,788	Y	Y
	BESSBROOK*	2,739	Y	Y
	NEWBUILDINGS	2,599	Y	Y
	CULLYBACKEY	2,569	Y	Y
	PORTAFERRY	2,514	N	Y
Band Total	24	77,423	17	24
BAND G - VILLAGE (POPULATION 1,000 - 2,499)	RATHFRILAND	2,472	N	Y
	MAGHABERRY	2,468	Y	Y
	STRATHFOYLE	2,412	Y	Y
	MILLISLE	2,318	Y	Y
	CASTLEDAWSON	2,292	N	Y
	IRVINESTOWN	2,264	Y	Y

	DOLLINGSTOWN	2,126	Y	Y	
	PORTAVOGIE	2,122	N	N	
	BALLYKELLY	2,103	Y	Y	
	KELLS / CONNOR	2,053	Y	Y	
	BALLYWALTER	2,027	N	Y	
	GILFORD	1,927	Y	Y	
	SION MILLS	1,903	Y	Y	
	MONEYMORE	1,897	Y	Y	
	CROSSGAR	1,892	Y	Y	
	ANNALONG	1,796	N	N	
	GLENAVY	1,791	N	Y	
	DRAPERSTOWN	1,772	N	Y	
	DONAGHCLONEY*	1,701	Y	Y	
	HILLTOWN*	1,698	N	Y	
	KILREA	1,679	N	Y	
	MARKETHILL	1,652	Y	Y	
	ARDGLASS	1,643	Y	Y	
	CROSSMAGLEN	1,608	N	N	
	MOY	1,603	Y	Y	
	DUNDRUM	1,551	Y	Y	
	NEWTOWNSTEWART	1,547	Y	Y	
	CARNLOUGH	1,512	N	Y	
	MILLTOWN	1,499	Y	Y	
	GREYSTEEL	1,454	Y	Y	
	TEMPLEPATRICK	1,437	Y	Y	
	BALLINAMALLARD	1,432	Y	Y	
	DOAGH	1,390	Y	Y	
	HELEN'S BAY	1,390	Y	Y	
	MONEYREAGH*	1,379	Y	Y	
	BALLYCARRY*	1,371	Y	Y	
	DRUMANESS	1,344	Y	Y	
	MAGHERALIN	1,337	Y	Y	

Northern Health
and Social Care Trust

	CLAUDY	1,336	N	Y	
	CLOGH MILLS	1,309	Y	Y	
	BUSHMILLS	1,292	N	Y	
	CASTLEROCK	1,287	Y	Y	
	LAURELVALE / MULLAVILLY*	1,284	Y	Y	
	CUSHENDALL	1,276	N	N	
	GARVAGH	1,274	N	Y	
	COGRY / KILBRIDE	1,246	N	Y	
	FIVEMILETOWN	1,243	N	N	
	GROOMSPORT	1,233	Y	Y	
	DUNLOY	1,215	Y	Y	
	DROMORE_OMAGH	1,202	Y	Y	
	PORTGLENONE	1,174	N	Y	
	FINTONA	1,160	Y	Y	
	KIRCUBBIN	1,153	N	Y	
	DONAGHMORE*	1,122	Y	Y	
	BELLAGHY	1,115	N	Y	
	RASHARKIN*	1,114	Y	Y	
	LISBELLAW	1,102	Y	Y	
	CAMLOUGH*	1,081	Y	Y	
	CLOUGHEY*	1,075	N	N	
	MAYOBRIDGE*	1,068	Y	Y	
	AGHAGALLON*	1,056	Y	Y	
	ANNAHILT	1,045	Y	Y	
	AUGHNACLOY*	1,041	N	Y	
	MAGUIRESBRIDGE*	1,038	Y	Y	
	KESH*	1,036	N	Y	
	BALLYHALBERT*	1,026	N	N	
	SEAHILL	1,018	Y	Y	
	BLEARY*	1,011	Y	Y	
	DROMARA*	1,006	N	Y	
Band Total	69	103,500	44	62	

Bands A – D Total (Population 10,000+)	26	1,014,490	26	26
Bands E – G Total (Population 1,000 to 9,999)	110	298,357	73	102
TOTAL A – G	136	1,312,847	99	128
Band H	-	498,016	-	-

* Settlements whose Band classification has changed (from the 2005 report); including 17 additions to Band G, reflecting the overall increase in population since 2001.

Source: NISRA Urban-rural classification, drive times by size of settlement

Please note that the table above also usefully indicates travel time distances attributed to each of the settlements detailed for Northern Ireland in the categories Band A to Band G, travel time exceeding 20 minutes or 30 minutes from the centre of a settlement containing at least 10,000 residents; this is the way that this Phase 3 plan identifies areas in NHSCT geography that has been applied to this RNIA.

2B. How is it likely to impact on people in rural areas?

The Trust's Phase 3 Plan includes actions that relate to reinstating services in an incremental way while ensuring the delivery of high quality and safe patient/client services. It is acknowledged that COVID-19 is still infecting people in our community. This will continue to impact on people living in both rural and urban areas. This assessment for rural needs concentrates on services being created, services being delivered remotely or virtually to accommodate social distancing by use of broadband or mobile technology or existing services still being provided but where the location of these services continues to be changed.

Below are the actions in the Phase 3 Plan that are likely to be relevant for rural needs as a result of ongoing or planned changes. Continued consideration of the impact on service users and carers who reside in rural areas in respect of access to services and access to broadband and mobile connection.

- Acute Services –breast surgery and some colorectal and gynaecological surgery continues to be provided at Causeway Hospital after move from Antrim Area Hospital
- Cancer Treatment Services - activity has been gradually increasing with an increase in phone/video assessments. Medications must be collected from a hospital pharmacy close to patients home; AAH, Mid Ulster, Causeway – travel required to collect those
- Outpatient Services - in Phase 3 outpatient activity will be increased including virtual opportunities through continued use of telephone and video assessments.
- Day Surgery – being re-established at acute hospitals but not as yet at AAH, Mid Ulster or Whiteabbey– possible change of service location for service users
- Pharmacy- scoping of regional medicines delivery service with HSCB
- Community Health and Well-being – virtual delivery of all services. Mixed model used for farm families health checks, smoking cessation and diabetic prevention
- Community Addictions – mix of face to face and virtual clinics

- MHOP – mix of face to face and virtual clinics for memory assessments, dementia home support team
- Learning Disability day services – virtual contact for those service users not able to access day centres due to regional criteria
- Community Mental Health Teams – some work delivered by virtual clinics
- Community Learning Disability Teams – some care management reviews delivered virtually, transition planning by Zoom technology
- Psychology services – mixed delivery of face to face and virtual including virtual group work programmes
- Dementia outpatients – telephone contacts for routine assessments, review using virtual and digital solutions
- GP OOH service has been consolidated onto 2 sites only – probable change of location for access
- Physiotherapy - services being delivered with a combination of telephone triage/reviews, Zoom technology calls and face to face
- Occupational Therapy – use of tele-rehabilitation techniques and remote contact including videoconferencing for completion of paediatric developmental history questionnaires, group assessment and interventions
- Orthoptics – use of telephone triage
- Speech and Language therapy – blended virtual and face to face service model across all client groups
- Podiatry – use of virtual triage and technology for virtual clinics
- Community Stroke team – some tele-rehabilitation interventions
- Nutrition and dietetics – virtual delivery for elective services
- Community hospitals – allocation of Robinson hospital to COVID-19 unit status – probable change of locations for access to service
- Social Work – new remote working model to be implemented in this service. Social Work interventions delivered through a combination of virtual reviews and face to face assessments
- Wheelchair service – telephone triage and combination of face to face and use of remote interventions
- Continence Service – use of telephone contact for reviews of existing caseload
- The Rowan - an on line testing pilot continues with services delivered by telemedicine while model for re-establishing service is examined
- CASH- triage by telemedicine and postal medications.
- Looked After Children (LAC) - reviews either by phone/ZOOM or face to face where social distancing is possible
- Child Protection (to include Children's Disability) - Case conferences to continue face to face or remotely using Zoom as risk assessment dictates
- Child Adolescent Mental Health Services – use of teleconferencing for remote delivery (approx. 60% of the time)
- CEIS – service relocation to limit footfall to family centres plus remote delivery of service including group work
- Paediatric autistic spectrum disorder service (ASD) - Phase 3 plans include the maintenance of the Telephone Consult/Support service as an element of remote delivery Structured assessment model via video link from October 2020, develop online training for self-help
- Public Health Nursing – testing of new model of home assessment for QB testing
- Health Protection Programme – centralisation of clinics – probable change of service location
- CPMS- assessment and review by remote means eg telephone and Zoom
- Corporate Nursing – Continued delivery of REaCH Masterclasses to Care Homes as clinical training needs is identified via face to face and on line platforms such as Zoom. Education programmes for the management of the deteriorating resident deliverd via ZOOM

- Tissue Viability Nursing Team – Telephone triage of referrals, This service will continue to provide telephone support with increased use of technology to view remotely images of tissue viability conditions
- Visitors - new regional guidance document for Trust inpatient services, Maternity Services, Care Homes, Mental Health Services and Children's Hospital Services, for the duration for the COVID-19 pandemic will be followed by NHSCT as part of their Phase 3 Plan.
- Falls – falls awareness training via ZOOM remotely

In order to protect public health and ensure capacity in the service to protect life and respond to the potential impact of COVID-19 these measures were put in place as a matter of urgency. Mindful of its obligations under Section 1(1) of the Rural Needs Act (NI) 2016 the Trust has completed and published this rural needs impact assessment template. The Trust's Phase 3 Plan is under constant review and further measures may have to be taken at any stage to protect public health. The Trust is also committed to carrying out further rural needs impact assessments and public consultation on any actions that it proposes to take forward on a permanent basis.

2C. If the Policy, Strategy, Plan or Public Service is likely to impact on people in rural areas _differently**_ from people in urban areas, please explain how it is likely to impact on people in rural areas differently?**

- Economic cost of travel and travel time to services which are centrally based in urban areas or in one centralised location in the Trust area
- Ability of individuals in rural areas to travel to clinics which are centrally based in urban areas – availability of public or community transportation.
- For staff redeployments – availability of public or community transportation (travel costs will be reimbursed)
- Access to adequate Broadband or mobile communication in rural areas for remote access to services.

2D. Please indicate which of the following rural policy areas the Policy, Strategy, Plan or Public Service is likely to primarily impact on.

Jobs or Employment in Rural Areas		Community Safety or Rural Crime		Agriculture-Environment	
Education or Training in Rural Areas		Health or Social Care Services in Rural Areas	**X**	Other, please state below;	
Rural Development		Broadband/Mobile Communications in Rural Areas	**X**		
Poverty or Deprivation in Rural Areas		Rural Business, Tourism or Housing			

2E. Please explain why the Policy, Strategy, Plan or Public Service is NOT likely to impact on people in rural areas.

N/A

If you completed 2E above GO TO Section 6

SECTION 3 - Identifying Social and Economic Needs of Persons in Rural Areas

3A. Has the Trust taken steps to identify the social and economic needs of people in rural areas, relevant to the Policy, Strategy, Plan or Public Service? **Yes ☒** **No ☐** **if the response is NO, GO TO Section 3D**

3B. Which of following methods or information sources were used by the Trust to identify these needs?

Consultation with relevant stakeholders / Survey or Questionnaire / Research / Statistics / Publications / Other methods.
Please provide details:

During Phase 3 it is planned to identify specific projects on-going in each division and undertake engagement with stakeholders and utilise feedback to inform the direction of the project and the final shape of service delivery.

Use of Research and Statistics at regional level for NI:

NI geography specific anticipated rural needs:

- High level information about extent of potential impact based on 2011 census information available from NISRA – Northern Ireland Neighbourhood Information Service (NINIS)
- NISRA – NI multiple deprivation measure 2017 as a combination of the aggregate results of the 7 domains plus specifically the domains of health deprivation and disability and access to services
- NISRA – dataset on Home Internet and Broadband Access
- OFCOM – Connected Nations Report

3C. What social and economic needs of the people in rural areas have been identified?

The aggregated Northern Ireland Multiple Deprivation Measure (2017) indicates that, of the top 100 most deprived super output areas (SOAs) none are related to rural areas in NHSCT. Deprivation at high levels appears to exist primarily in urban areas.

Two domains were identified as sub sets relevant to rural needs impact assessment for the COVID-19 pandemic Programme; health deprivation and disability and access to services.

Specifically examining the 2017 results in the domain of health deprivation and disability it was found that none of the top 100 most deprived areas were rural in nature.

In the other domain identified as relevant to rural needs impact assessment for health and social care service change, that of access to services, it was identified that, in 2017, 95 out of the top 100 most deprived areas across NI were rural in nature. This is in line with anticipated findings as it is

the issue of transport availability and cost of transport that can make access to services difficult for those who reside in rural areas. Alongside this access to adequate Broadband or mobile communication is required for people living in rural areas when accessing services remotely.

The table below fully analyses the top 100 most deprived wards (at SOA level) in respect of access to services and aligns to the relevant Health Trust area. NHSCT has the highest number of areas in the top 100 (39). This information will be relevant for any further analysis or assessment carried on any measures proposed to be taken forward on a permanent basis.

SOA	Access to Services Domain Rank	Trust in which this area sits
Plumbridge	1	Western Trust
Belcoo and Garrison	2	Western Trust
Glenarm	3	Northern Trust
Ballyward	4	Southern Trust
Rosslea	5	Western Trust
Dunnamore	6	Northern Trust
Trillick	7	Western Trust
Sixmilecross	8	Western Trust
Owenkillew	9	Western Trust
Lissan	10	Southern Trust
Florence Court and Kinawley	11	Western Trust
Glack	12	Northern Trust
Ballyhoe and Corkey	13	Northern Trust
Belleek and Boa	14	Western Trust
Fairy Water	15	Western Trust
Donagh	16	Western Trust
Aldergrove 1	17	Northern Trust
Bannside	18	Northern Trust
Shilvodan	19	Northern Trust
Clanabogan	20	Western Trust
Dunnamanagh	21	Western Trust
Newtownsaville	22	Western Trust
Glenderg	23	Western Trust
Swatragh 2	24	Northern Trust

Magilligan	25	Northern Trust
Donaghmore 1	26	Southern Trust
Brookeborough	27	Western Trust
Lisnacree	28	Southern Trust
Mayobridge 2	29	Southern Trust
Lower Glenshane 1	30	Northern Trust
Strangford	31	Southern Trust
Claudy 2	32	Western Trust
Katesbridge	33	South Eastern Trust
Slemish	34	Northern Trust
Killinchy 1	35	South Eastern Trust
Augher	36	Northern Trust
Newtownhamilton	37	Southern Trust
Carnmoon and Dunseverick	38	Northern Trust
Newtownbutler	39	Western Trust
Clogher	40	Northern Trust
Banagher	41	Western Trust
Derrylin	42	Western Trust
Drumquin	43	Western Trust
The Loop	44	Northern Trust
Ballinderry 1	45	South Eastern Trust
Termon	46	Western Trust
Kesh Ederney and Lack 1	47	Western Trust
Boho Cleenish and Letterbreen	48	Western Trust
Grange	49	Northern Trust
Derrygonnelly	50	Western Trust
Ringsend	51	Northern Trust
Slievekirk	52	Western Trust
Altmore	53	Northern Trust
Derrynoose	54	Southern Trust

Armoy and Moss-Side and Moyarget	55	Northern Trust
Ballymacbrennan 2	56	South Eastern Trust
Caledon	57	Northern Trust
The Vow	58	Northern Trust
Oaklands	59	Northern Trust
Clare	60	Western Trust
Creggan	61	Southern Trust
Lower Glenshane 2	62	Northern Trust
The Highlands	63	Northern Trust
Gransha	64	Western Trust
Lecumpher	65	Northern Trust
Seaforde	66	Southern Trust
Silver Bridge 2	67	Southern Trust
Dunloy	68	Northern Trust
Island Magee	69	Northern Trust
Knockaholet	70	Northern Trust
Glenwhirry	71	Northern Trust
Killough 2	72	Southern Trust
Derrytrasna 2	73	Southern Trust
Ballynure 1	74	Northern Trust
Drumnakilly	75	Western Trust
Tollymore 1	76	Southern Trust
Aghanloo 2	77	Northern Trust
Silver Bridge 1	78	Southern Trust
Ardboe	79	Northern Trust
Killycolpy	80	Northern Trust
Tempo	81	Western Trust
Clady	82	Northern Trust
Lisnarrick	83	Western Trust
Parkgate	84	Northern Trust
Glenaan and Glendun	85	Northern Trust

Ballymacbrennan 1	86	South Eastern Trust
Glenavy 2	87	South Eastern Trust
Dromore	88	Western Trust
Killylea	89	Southern Trust
Burren and Kilbroney 1	90	Southern Trust
Pomeroy	91	Northern Trust
Glenravel	92	Northern Trust
Binnian	93	Southern Trust
Forkhill 2	94	Southern Trust
Derryboy 1	95	Southern Trust
The Birches 2	96	Southern Trust
Tullyhappy	97	Southern Trust
Quilly	98	South Eastern Trust
Kilwaughter 2	99	Northern Trust
Carrigatuke	100	Southern Trust

In Northern Ireland, for the latest dataset available on NISRA (2018), 16% of households had no home broadband and 15% had no home internet access. These households will not be able to avail of services being delivered remotely using this technology with remote delivery being a focus of the Phase 3 Plan. In addition. the OFCOM Connected Nations report (2019) acknowledges that more work is needed to improve services in rural areas where some customers who do have access to broadband experience slower speeds that in towns or cities and, further, that 19% of rural dwellers are unable to receive decent broadband.

3D Please explain why no steps were taken by the Trust to identify the social and economic needs of people in rural areas?

N/A

SECTION 4 - Considering Social and Economic Needs of Persons in Rural Areas

4A. What issues were considered in relation to the social and economic needs of people in rural areas?

Access to services in terms of economic cost , availability of public transport and broadband/internet/mobile communication access

Northern Health
and Social Care Trust

SECTION 5 - Influencing the Policy, Strategy, Plan or Public Service
5A. Has the policy, strategy, plan or public service been changed by consideration of the rural needs identified? **Yes ☐ No ☒ if the response is NO, GO TO Section 5C**
5B. If yes, how have rural needs influenced the policy, strategy plan or public service?
5C. If no, why have the rural needs identified not influenced the policy, strategy, plan or public service? Mindful of its obligations under the Rural Needs Act 2016, the Trust has completed and published this rural needs impact assessment template. The Trust's Phase 3 Plan is under constant review and further measures may have to be taken at any stage to protect public health. The Trust is also committed to carrying out a full RNIA and public consultation on any actions that may be taken forward on a permanent basis. The Trust recognises that there are a number of policy leads/decision makers across HSC who likewise must comply with Section 1(1) of the Rural Needs Act (NI) 2016 in the development, implementation and review of the Minister for Health's "Strategic Framework for Rebuilding HSC Services" in NI and in the development and implementation of HSC Trusts Rebuild Plans. The Trust therefore commits to collaborate, as necessary, with all relevant HSC organisations in seeking to ensure the fulfilment of these statutory duties. This may entail, in some instances, the Trust feeding upward into regional RNIAs led by other HSC Policy Leads e.g. DoH, HSCB et al, contributing to RNIAs by other policy leads where there are for example regional themes, undertaking further individual RNIAs on Trust proposals and, where necessary and appropriate, conducting RNIAs and associated consultation in line with the Rural Needs Act (NI) 2016 and in fulfilment of the requirement of the DoH Circular Guidance 'Change of Withdrawal of Services – Guidance on Roles and Responsibilities' - September 2019 especially where temporary changes are being proposed as permanent.
Section 6: Documentation: **6A.** Please tick below to confirm that the RNIA Template will be retained by the Trust and relevant information on the Section 1 activity compiled in accordance with paragraph 6.7 of the guidance.
I confirm that the RNIA Template will be retained and relevant information compiled ☒

Approved by:	Senior Management Team
Date:	20 April 2021