The current planning and preparedness of Health and Social Care in Northern Ireland (HSCNI) for the COVID-19 outbreak.

HSC Surge Plan

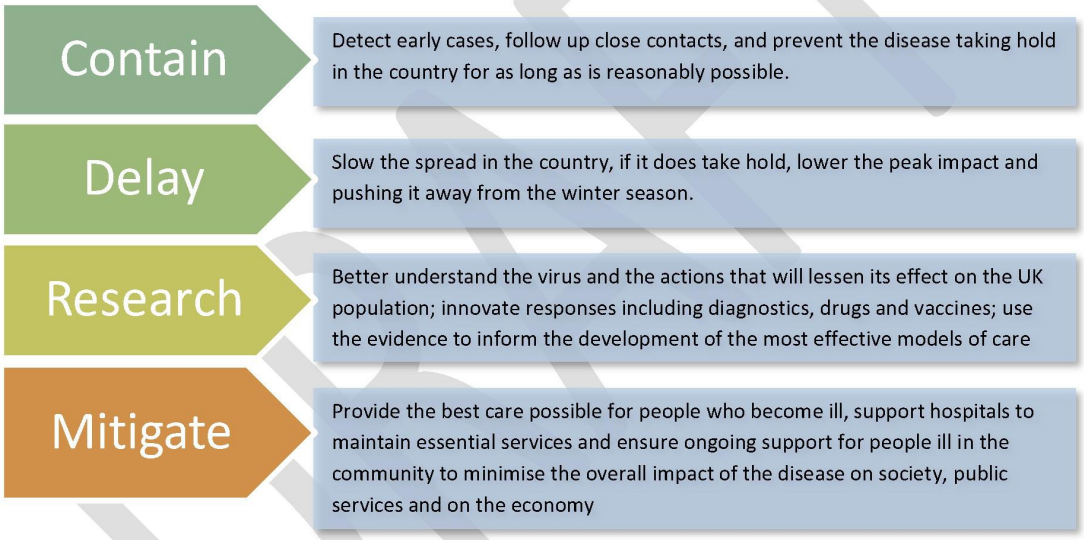
COVID-19

March 2020

Introduction

This report describes the current planning and preparedness of Health and Social Care in Northern Ireland (HSCNI) including HSC Trusts, primary care and community pharmacy. These plans provide an overview of a number of key service areas to provide awareness of available capacity and availability of service during the progressing phases of the response to the COVID-19 outbreak. Further detail can be found with the *Regional Preparedness for COVID-19* document which is available at [Insert Link].

This plan sets out the HSCNI arrangements that will apply from mid-March to mid-April as part of the **Delay phase. This is a dynamic plan and will be constantly refined in light of emerging issues.** The updated plan will be published in the weeks to come as the co-ordinated UK response progresses through the Delay phase and potentially to the remaining phases.



DN – include the most recent assumptions on likely number of cases and hospital admissions (TBC)

Constraints:

There will be a number of constraints in delivering the responses outlined in this document. In particular, the existing pressures in the HSC, especially in regard to the unscheduled care pathway represent a material constraint. Also and importantly the impact of staff absences will compromise the ability for the HSC to respond as planned. **DN expand on this**

The current levels of capacity and preparedness are included for the following service areas: Primary and Community Care; Acute Hospital Care; and Social Care.

Primary and Community Care

Action to improve the service responsiveness:

GP practices will optimise the input of other members of staff such as practice based pharmacists and nurses to assist with increased pressures.
Routine GP work will be adjusted or suspended in the first number of weeks of the epidemic. This will include suspension of non-GMS work e.g. insurance reports, suspension of QOF and suspension of enhanced services as appropriate. This will help GP practices manage the potential significantly increased demand (30% increase) at a time of potential reduced GP workforce.
Requests for consultations will be telephone triaged and an increased proportion of patients will have advice provided by telephone consultation. This will prevent many people needing to attend their GP surgery and hence will help prevent the spread of infection.
Community pharmacies are maintaining effective response in regard to dispensing of prescriptions
Community pharmacies will endeavour to deliver an increased proportion of prescriptions, hence avoiding the need for people to travel to a community pharmacy.

GPs, community pharmacies and community health teams play a key role in the health response to the COVID-19 pandemic. General practitioners are normally the first point of contact for individuals and families experiencing ill health.

At this time planning assumptions have not yet been formally agreed for Northern Ireland. The following is based on planning assumptions agreed by the Scientific Advisory Group for Emergencies (SAGE) and also HSCB Winter Pressures NILES data from November 2019.

From the planning assumptions the majority of symptomatic cases are predicted to present in the first part of the epidemic curve (with 50% of cases occurring within the first 3 weeks of the epidemic). It is predicted there may be 21% health and social care staff absence during the peak week of an unmitigated pandemic.

Winter Pressures NILES data shows that in-hours GPs provide 4.4 sessions per 1000 patients. The data shows that GPs provide on average 96 patient contacts (face to face, telephone,

email correspondence) per 1000 patients per week, this equates to an estimate of 42 patient contacts per GP per day.

Based on 4.4 GP sessions per 1000 patients per week, if there is 21% sickness absence during week 3 of the pandemic would result in a reduction to 3.5 GP sessions per 1000 patients.

The table below is based on the SAGE planning assumptions that in a worst case scenario 80% of the Northern Ireland population will be infected by week 12. It is also based on the assumption that only 50% of the infected population will be symptomatic. It also assumes that only 50% of the symptomatic patients will request GP input (this is an unknown factor and may need to be adjusted based on data as the situation progresses).

Estimated Increased Activity in General Practice

	Infected patients (cumulative figure)	**Newly symptomatic patients/week**	**Patients requesting GP input based on 50% of newly symptomatic per week**	**Additional GP contacts per 1000 patients per week**
Week 3	750,000	125,000	62,500	32
Week 9	1.425m	56,250	28,125	14
Week 12	1.5m	12,500	6,250	3

Community Pharmacy

Community pharmacists will be an important source of advice to people who are concerned about COVID-19 or who are symptomatic and self-isolating. It is anticipated that community pharmacists will experience an increase in attendance at the pharmacy. There is evidence that over the counter medications are in high demand because consumers are purchasing in anticipation of self-isolation.

While there is currently no supply problem with prescription only medicines it will be important that prescribing patterns remain in line with best practice as this will help ensure that supplies are appropriately used.

General Dental Services

There will be a specific group of patients who will require treatment for acute dental pain/ infection/inflammation ordinarily addressed in a dental practice and are assumed to be COVID-19 positive because they are self isolating on the basis of their symptoms.

There needs to be further exploration regarding how these individuals can access the emergency care they require BOX

Community Care

Action to improve the service responsiveness:

Health and social care staff and public health professionals will provide practical information, advice and support to the Northern Ireland Housing Executive (NIHE) as part of the NIHE's assessment of the needs of homeless people potentially affected by coronavirus.

Health and social care staff and public health professionals will support the DoH which is leading on the identification of facilities for the following groups: tourists in Northern Ireland; tourists elsewhere that may need to be repatriated to Northern Ireland for example from cruise ships; those at home who do not have the appropriate facilities to self-isolate at home; people in airports stranded because of flights cancellations and who cannot progress to their next destination or to accommodation in Northern Ireland.

There are a number of key areas to be addressed in regard to vulnerable groups living in the community, not least those who do not have a home and those living in crowded accommodation where the need to quarantine for 7 days id symptomatic can simply not be met. Current measures are underway to ensure that these individuals can meet the current requirement of 7 days quarantine.

Working collaboratively with other jurisdictions:

The Board and PHA will continue to discuss with UK and RoI colleagues the potential for their jurisdictions to provide care for a small number of NI people if needed.

It is important throughout this pandemic that the HSC works closely with colleagues in other jurisdictions including England, Scotland, Wales and ROI.

In this regard there are already strong existing links which are beneficial including NHS specialist commissioning, NHS procurement and existing fora for discussions across the 4 UK health departments. This will include exploring opportunities to utilise scarce capacity particularly in regard to critical care and ventilation facilities.

One particular service that is not currently commissioned in NI is ECMO and arrangements are currently being pursued to establish arrangements for the transfer of patients from NI who require ECMO. At this time discussions are with NHS England and RoI.

Acute Inpatient Care

Action to improve the service responsiveness:

All Trusts have identified additional bed capacity to respond to the needs of people with COVID-19 who need hospital admission

All Trusts will apply appropriate restrictions on the number of visitors that are permitted. This will help minimise the spread of the infection from hospitalised patients to their friends or family.

All Trusts are working to provide care for the increased number of positive COVID-19 patients who may need hospital care in the next few weeks. These arrangements involve identifying wards and prioritising care for the sickest patients. Arrangements will also help ensure that those individuals admitted to hospital for reasons other than coronavirus are cared for in separate areas and their risk of contracting the infection is appropriately managed.

Importantly, to prevent further spread of the infection the number of visitors to hospitals will need to be constrained and this is a matter on which the Trusts have already taken action.

The following sets out the arrangements within Trusts to respond to those who require admission during the second half of March and into early April. Work is ongoing to identify further capacity to caring for people with COVID-19 who require hospital admission.

At this stage there is capacity in Northern Ireland to treat up to 280 inpatients, with all Trusts identifying additional capacity as outlined below. In anticipation of inpatient numbers increasing all Trusts are continuing to assess the steps that may be needed to convert other wards into areas to treat patients diagnosed with COVID-19. This will be a mix of single rooms and ward areas, depending on the most appropriate estate.

Trust	Hospital	Ward	Details
Belfast	Royal Victoria Hospital	7a	This can accommodate 3 COVID-19 patients and has been utilised in the early stages when there have been a very small number of hospital admissions
	Mater Hospital	Ward B	31 people can be accommodated in the identified wards
Northern	Antrim Area Hospital	C7 and A5	48 people can be accommodated in the identified wards

Trust	Hospital	Ward	Details
Southern	Craigavon Area Hospital	Isolation, Acute Medical and Surgical Wards	46 people can be accommodated in the identified wards
South Eastern	Ulster Hospital	Wards 3a, 4a and 5a	51 people can be accommodated in the identified wards
	Downe		24 people can be accommodated in the identified wards
	Lagan Valley		14 people can be accommodated in the identified wards
Western	Altnagelvin Area Hospital	Ward 31	34 people can be accommodated in the identified wards
	South West Acute Hospital	Ward 1 Ward 4	36 people can be accommodated in the identified wards

The above table details the hospital arrangements for adults who require admission. While the proportion of children likely to require admission is expected to be lower than the proportion of adults, Trusts have identified the arrangements that will apply for those children who do require hospital admission. Specifically children with coronavirus will be treated in Belvoir Ward at the Royal Belfast Hospital.

DN will this apply to children across NI

Critical Care for Adults and Children

Critical care, including ventilator support for respiratory complications, is an essential component of a service response to the COVID-19 pandemic

Action to improve the service responsiveness:

Each Trust has a local escalation plan and a *draft* adult regional Critical Care Network Northern Ireland (CCaNNI) plan has been developed.

There are measures within each Trust to increase the capacity to ventilate people who require this during their inpatient stay

The Critical Care Network will explore measures to increase non-invasive ward based ventilation.

There are 88 routinely commissioned adult critical care beds. During normal operation, 56 of these are intensive care (ICU) beds available for patients who require support from a breathing machine (ventilator) and 32 are high dependency (HDU) beds available for patients who are critically ill but do not require the use of a breathing machine. The term critical care applies to both ICU and HDU beds. These beds are used flexibly, so that at any one time more than 56 patients can be receiving care on a ventilator, with less than 32 patients receiving HDU care. Because ICU patients require more intensive nursing, a rule of thumb is that 2 HDU beds are considered equivalent to one ICU bed in terms of nursing requirement.

The breakdown of adult ICU and HDU capacity across Trusts during normal operation, and the projected expanded ICU capacity during surge, is as follows

Trust	**Normal operation**
Northern HSCT	8 ICU + 4 HDU beds, or 10 ICU beds
South Eastern HSCT	6 ICU + 4 HDU beds, or 8 ICU beds
Southern HSCT	6 ICU + 4 HDU beds, or 7 ICU beds
Western HSCT	9 ICU + 7 HDU beds, or 12 ICU beds
Belfast HSCT	27 ICU + 15 HDU beds, or 34 ICU beds
Total	**56 ICU + 32 HDU (88 adult critical care) beds**

The normal capacity of 88 critical care beds could be rapidly increased by a further 38 by the following steps:

- Utilising the facilities in cardiac surgery ICU at the Royal Victoria Hospital;
- Opening additional beds within the critical care footprint; and,
- Opening additional beds in recovery / theatre areas.

It should be noted that the numbers described assume availability of a full complement of specialist staff.

There is recognition that a flexible staffing policy will be required in which (i) current staffing levels will be augmented from areas of reduced activity (e.g. theatres) (ii) some nursing care will be delivered by non-ICU trained staff and (iii) the normal nurse to patient ratios of 1:1 may be reduced.

Caring for patients with coronavirus who require critical care will initially result in a reduction of critical care capacity due to the isolation and PPE requirements, resulting in more staff required per patient. This will mean escalation plans will have to be activated early to maintain capacity. As numbers increase and cohorting arrangements are put in place some of the reduced capacity will be replaced.

The potential to increase critical care capacity above baseline will be dependent on staff. Training of staff who will be redeployed from other areas is ongoing and will increase further as staff released from their elective duties. Redeployed staff will require supervision from trained critical care staff.

While challenging in the face of increased demand it is essential to ensure that patient discharge from critical care is prioritised to maintain patient flow.

Paediatric Critical Care

Action to improve the service responsiveness:

The Critical Care Network for Northern Ireland has an agreed surge plan for paediatric intensive care.

Paediatric critical care capacity can increase from 12 level three beds up to 16 level three.

Information about Covid-19 to date suggests that children experience a very mild disease and many are asymptomatic. There were comparatively few hospitalisations seen in China. However, severe disease requiring respiratory support has been seen. It is possible – although not yet proven – that children with complex chronic medical needs will be more likely to experience severe disease. It should be noted that this relatively small group of children accounts for almost 60% PICU bedday use in usual times. Even a very small number of cases compared to adult numbers in children with complex needs could result in PICU capacity being used up very quickly.

The Critical Care Northern Ireland has an agreed surge plan for paediatric intensive care. This plan involves increasing the number of intensive care beds in RBHSC from 12 level three up to 16 level three. This escalation requires down turning of theatre activity to deliver 16 beds. In normal times children are transferred to critical care units outside NI if no more capacity can be provided in RBHSC. However, in the case of a surge such as a pandemic situation, this option will not be available as all other units will be full. In this situation the plan is for DGHs to provide an agreed amount of critical care. The plan sets out what will be provided in each DGH.

This plan needs reviewed to take account of the clinical picture for coronavirus. It is likely that DGH units will be providing surge capacity for adults and will have difficulty in providing substantial critical care for children.

Further work is required on this. A regional meeting is being held on 18th March to agree the approach.

The PICU escalation plan includes a more flexible staffing policy in which

(i) current staffing levels will be augmented from areas of reduced activity (e.g. theatres)
(ii) some nursing care will be delivered by non-ICU trained staff and
(iii) the normal nurse to patient ratios of 1:1 may be reduced.

The plan for children will complement the other aspects of the overall response.

There is an existing mechanism to establish daily teleconferences between all paediatric units and the tertiary centre in times of surge. The established communication and working links that have been established as part of the Child Health Partnership will assist with ensuring robust and effective working arrangements in the event of a surge within paediatrics.

Equipment

Action to improve the service responsiveness:

Trusts have identified additional equipment to extend capacity to provide care for the maximum number of patients. These are being progressed on a 4 nations basis. Across the region this includes:

- 21 renal dialysis stations
- 30 ventilators for adults and 10 for children across the region. This includes portable ventilators to support the transfer of patients;

Critical Care Transport

DN TO BE ADDED

Critical Care for New-born Infants

Action to improve the service responsiveness:

Keep the matter of critical care for neonate under review

Neonatal critical/intensive care is a separate clinical service from paediatric and adult critical care services, providing care only for new-born critically ill infants, who have not been discharged from hospital. It is provided routinely in 21 intensive care cots in 5 of the 7 neonatal units in N Ireland. Current interventions in critical care for preterm new-born infants are effective, with good clinical outcomes in most cases.

Based on current evidence there is not expected to be an increased demand for new-born critical care as a result of COVID-19. However, this will be kept under review in the coming weeks and months.

Care of Pregnant Women

Action to improve the service responsiveness

Trusts will review and updating their plans for pregnant women in light of emerging evidence and best practice guidance

Trusts are reviewing and updating their plans for pregnant women. Guidance for healthcare professionals on Coronavirus (COVID-19) infection in pregnancy has been published by the RCOG, Royal College of Midwives, Royal College of Paediatrics and Child Health, Public Health England and Health Protection Scotland.

https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/

Home ventilation

Action to improve the service responsiveness

Trusts to confirm that they have identified all home ventilated patients.

There are a small number of patients in NI, both adults and children, who currently receive home ventilation. Trust community services currently provide support alongside the patients' main carers. In some cases this requires high staffing input. In the event that hospital critical care access has to be curtailed because of high population demand, the same admission criteria would apply to these patients as to previously healthy patients who have become critically ill as a result of COVID-19 or other conditions. It follows that home ventilated patients will not necessarily have preferential access to hospital critical care ahead of other very ill patients if their home service should fail due to staffing problems. Trusts have confirmed that they have identified all home ventilated patients.

Single organ support

Action to improve the service responsiveness

This matter is to be kept under review

The greatest numbers of patients who receive single organ support are those who have end-stage renal failure and receive regular haemodialysis. Providing uninterrupted care for this group of patients presents a range of challenges including transport to care, delivery of the optimal three times weekly treatment and increased risk from COVID-19 due to their underlying illness. Advice is being sought from the Regional Nephrology Forum with regard to the optimal way to manage these patients.

Outpatients, day cases, inpatient and diagnostic services

Action to improve the service responsiveness

Trusts to postpone non urgent appointments investigation and procedures consistent with the need to redeploy key staff to support the care of people admitted because of COVID-19

It is inevitable that with the very significant increase in workload that will result from the number of people with COVID-19 who require hospital care that other less urgent services will need to be postponed or provided in a different way. In particular this is likely to apply to non-urgent outpatient, day case and inpatient appointments, investigations or procedures.

It should be emphasised that, at this time, outpatient appointments, day case and elective inpatient services will be maintained for urgent cases.

However, for appointments, tests and procedures that are not urgent Trusts have identified a range of services that may be downturned in order that services can be diverted to care for people with COVID-19. Affected services specifically include non-urgent outpatient appointments, day cases, inpatient and diagnostic work.

Staff who normally work in these areas will be needed to provide support to other inpatient wards where there are likely to be high staff absences. These staff will need additional training to prepare them for this change in role. Trusts have identified elective services that can be reduced during the month of March to allow for the time required to accommodate additional training of staff to help and respond to increased demand.

For example, in Belfast Trust, the Mater Hospital is set to be the main treatment centre for patients affected by the coronavirus in Belfast. Wards in the hospital have been identified and preparations are well underway to admit people affected by COVID-19 and to do so in a cohorted area in which staff will be fully equipped with appropriate protective clothing. Consequently a number of planned and elective services are being postponed or relocated to other hospitals within the Trust. For example, people needing to access the specialist macular service may be seen at the Royal Victoria Hospital and people awaiting specialist liver surgery in the Mater Hospital will have their surgery at the Royal. For people who attend an outpatient clinic at the Mater they may be invited to have their appointment undertaken by video link.

Similarly in all other Trusts, a range of non-urgent inpatient and day case operations will need to be postponed as will diagnostic tests be downturned. This will permit specialist staff including anaesthetists, surgeons, and nurses to be released so that they can undertake additional training if needed and can provide support in other essential service areas.

Surgery for the treatment of cancer and other urgent procedures will continue, although as the pandemic progresses some further measures may be needed to respond to the acutely ill infected with coronovirus.

Venues for services may change as Trusts try to manage and centralise in order to attempt to maintain services.

For patients who need follow up as outpatients, Trusts are planning for greater use of telephone contact and other digital technology, where appropriate.

Patients will be contacted directly by Trusts with regard to any changes to already scheduled appointments.

Discharge Planning

Action to improve the service responsiveness

Staff will be re-deployed to support hospital social work teams to facilitate safe discharges and patient flow.

If patients are deemed, by a consultant, to be medically fit to leave hospital, they and their families will be asked to ensure there are arrangements in place to be collected from hospital promptly on the day of discharge. Ward staff can help you make these arrangements

If patients are deemed, by a consultant, to be medically fit to leave hospital and are waiting on a residential placement, staff will allocate the first place that is available. This may not necessarily be a patient or family's first choice but people can subsequently move to the home of their choice, once it becomes available.

If patients are deemed, by a consultant, to be medically fit to leave hospital and there is a delay in sourcing new or additional home care, they may be discharged to await these elements of their care package. Additional family support may be required until the home care package is finalised.

Additional and alternative community based resources will be identified by each Trust on a local basis

Dedicated care home resource in each Trust area to accept hospital discharges

There are ongoing challenges discharging people from hospital in a timely manner after they have been declared medically fit for discharge. Often this is because of the time required to fully assess their care needs and to respond with an appropriate domiciliary care package or identify a suitable care home to which the individual can be transferred.

The impact of COVID-19 on the unscheduled care pathway and the capacity of hospital staff and facilities mean that it is a priority to improve the timeliness of hospital discharge. It is recognised that to do will require some modification of the existing arrangements, with less patient/ family choice in regard to the type of location of care. The co-operation of patients and their families will be essential in this matter and will help free up beds for ill people requiring admission.

All HSC Trusts will also be focusing sustained attention on ensuring patients who are medically well are promptly discharged from hospital, with appropriate care arrangements, to ensure hospital beds are available for any increase in admissions. This will mean that some patients will need to be discharged sooner than they would normally.

This includes, primarily, a focus on expediting safe but rapid discharges: There is an expectation that hospital discharges of those medically fit for discharge will be expedited immediately. In this context:

- Additional and alternative community based resources will be identified by each Trust on a local basis.
- Staff will be re-deployed to support hospital social work teams to facilitate safe discharges and patient flow.
- Dedicated care home resource in each Trust area to accept hospital discharges.

Social Care and Children's Services

Action to improve the service responsiveness

Services will be prioritised for those most in need i.e. the vulnerable and those at risk of harm

Some social care staff will be redeployed to support those services deemed to be high priority

During the pandemic social care and children's services will be targeted at people in most need and those who are most vulnerable to ensure essential social care and children's services are maintained during periods of significant staff absence and an increased demand for services.

It is anticipated that as the situation escalates, the pressures across the provision of social care will rise significantly, placing heavy and changing demands on our social care services and staff. The plan will be continually reviewed and updated to reflect the wider responses and support required across the system.

This plan is based on the assumptions in terms of the anticipated duration of the surge; the expectation that the pandemic will happen in a series of waves, and that after two waves the community will have developed a level of immunity or a vaccine may have become available; that during that time, staff absences in Trusts will escalate to a peak of 50%; and that the capacity of informal carers in the community will also be reduced.

In light of these assumptions, the plan aims to provide the basis for a co-ordinated response to manage the large numbers of people who will be affected, and to ensure clear and consistent communication and collaboration with internal and external stakeholders.

Anticipating this pressure on resources, the Director of Social Care and Children's services in the Health and Social Care Board has requested Department of Health approval to stand down certain elements of Work across the HSC Board and Trusts. This approval will give the Health and Social Care Board the authority to determine the timing of when to stand down work in response to what is likely to be a fluid and rapidly changing position. On this basis, the Health and Social Care Board will be initiating appropriate deferral processes and organisational arrangements, to ensure effective and timely communication and decisions making across the Children Services and Social Care system.

Children And Young People's Social Work and Social Care Services

Priority will be given to the continuation of services to the following children and young people social work services:

1. Looked after children

2. Fostering and adoption
3. Child protection
4. Early years services
5. Child and adolescent mental health services
6. Children with disabilities
7. Children in need

In particular those where:

- Children and Young People are suffering or likely to suffer significant harm.
- Children requiring an emergency Looked After Child Placement
- Children and Young People at risk of looked after placement breakdown.
- Children with Disabilities including high support needs/complex care packages.
- Young people who are vulnerable and have left care and known to 14 plus service / leaving and aftercare services.

Adult Mental Health & Learning Disability Social Work & Social Care Services

Priority will be given to the continuation of services to the following service user groups:

1. Adults with serious mental illness
2. People with learning disability and complex mental and / or physical health needs

3. Adults with serious mental Illness or learning disability at risk of significant harm

In particular those that require:

- Emergency/crisis response due to serious psychotic episode
- Mental health monitoring / review of medication.
- Care in a 24 hour setting
- Are at risk of placement breakdown.
- Complex care packages.
- Assessment under the Mental Health Order
- Adult protection interventions

Older People and Physical and Sensory Disability Social Work and Social Care Services

Priority will be given to the continuation of the following essential services:

1. Domiciliary Care/Support and Care at Home
2. Care homes and facilities where 24 hour care is provided
3. Day Centres and Day Support services

4. Adult Protection

In particular where:

- People who have critical or substantial levels of care and support in their own home and no one else is available to provide it.
- Adult living in care homes
- Adults at risk who are in need of protection

EMERGENCY SOCIAL WORK SERVICES

The regional emergency social work service (out of hours) will take all available steps to address an increase in demand or high level of staff absence by seeking to increase capacity for example through increased use of locum staff or remote working. Child and adult protection, ASW (Approved Social Worker) assessments and Hospital Discharge will be prioritised.
In addition to the work outlined within this plan the Department of Health is currently investigating the potential to temporarily amend / suspend some of the regulations / standards in relation to care home admissions whilst ensuring that the care delivered is safe and meets needs. This will assist in the facilitation of safe and flexible hospital discharge. The Department has issued Guidance for Social Care, Community Care and residential settings.

Health Care in the Criminal Justice System

Action to improve the service responsiveness

The Trust is working with the Northern Ireland Prison Service to ensure a coordinated response to a potential outbreak of COVID-19 within the prison setting and the implications of having to transfer out acutely unwell prisoners and the associated security implications.

Healthcare in prisons across NI is provided by the South Eastern Trust. The SET provided the Board with its specific prisons contingency/surge plan. The Board has arranged to meet with the Trust on the week commencing 16th March 2020 to consider the plan and the broader issues associated COVID-19 within the prison environment.

Public Health England has provided comprehensive guidance in regard to COVID-19 in the criminal justice system. In addition, a weekly Five Nations tele-conference is now established and the South Eastern Trust and the Board/PHA will be participating in this arrangement.

The Belfast Trust also provide healthcare in police custody suites in Belfast under a transformation project. The Board/PHA has been in contact with the Trust and the PSNI in respect of contingency/surge planning regarding this service.