Belfast Health and Social Care Trust
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Belfast Trust Winter Surge Plan 2026/27

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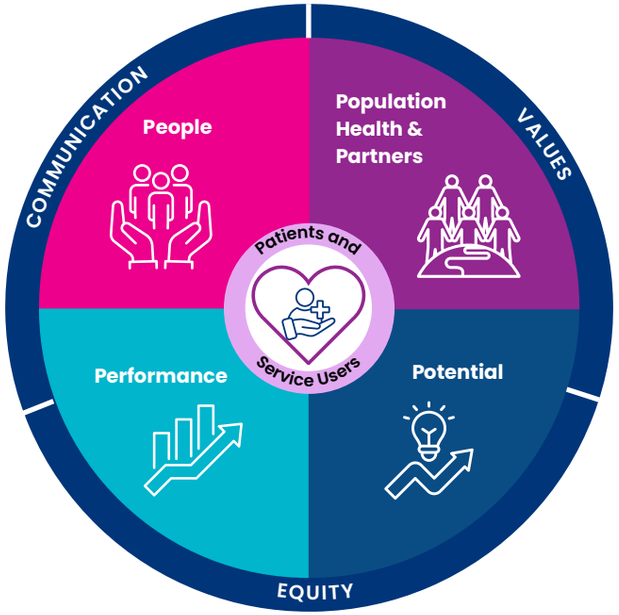
Introduction

Winter is one of the busiest and most challenging periods for health and social care services. Demand increases due to seasonal illnesses such as respiratory infections, flu and norovirus, alongside a rise in urgent care needs resulting from slips, trips and falls. These pressures are experienced across hospitals, community services and social care, placing additional demands on capacity, patient flow and the workforce.



These challenges are further compounded by the significant financial pressures facing the health and social care system. No additional funding has been made available to support winter pressures in 2026/27 and, as a result, the Trust must deliver this plan within existing resources. This makes it more important than ever that we work collaboratively across services and with our partners to maximise capacity, improve patient flow and deliver the best possible care for patients and service users.

Every year, we develop a Winter Plan that sets out how we will manage additional pressures and challenges. At the heart of this plan are our patients and service users. We remain committed to delivering safe, person-centred, high-quality and compassionate care, while ensuring services are resilient and responsive throughout the winter period.

This plan builds on learning from previous winters and our experience of managing increased seasonal demand. We have engaged with our primary care colleagues, patients, service users, carers, staff and trade unions to help shape the plan and ensure it is comprehensive, practical and accessible.

Our Winter Plan 2026/27 outlines how we will prepare for and respond to these challenges while continuing to deliver the priorities set out in our Corporate Plan:
Patients and Service Users, **People**, **Population and Partners**, **Performance**, and **Potential**.

We also recognise that our staff are our greatest asset and are fundamental to the delivery of safe and effective care. We would like to thank colleagues across all services for their continued professionalism, resilience and commitment, particularly during periods of sustained operational pressure.

A guide to terms used in this document is provided at the end.

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Overarching priorities this Winter

A) Working Together Across Services
We will work together across Health and Social Care services to provide joined-up care, ensuring people receive the right care, in the right place, at the right time.

B) Keeping People Healthy and Well
We will support people to stay healthy, well and independent, helping to prevent avoidable illness and reduce pressure on services during the winter period.

C) Being Ready for Winter Pressures
We will ensure services are prepared to respond safely and effectively during periods of increased demand, while maintaining access to emergency care, urgent cancer services and other time-critical treatments.

D) Improving Access to Emergency Care
We will improve access to urgent and emergency care and support people to use the service that best meets their needs.

E) Supporting Our Staff
We will support the health, wellbeing and resilience of our staff so they can continue to provide safe and effective care throughout the winter period.

F) Making Better Use of Technology and Information
We will use technology and real-time information to support better decision-making, improve service performance and enhance patient care.

G) Providing Care Around the Clock
We will ensure services are available and responsive 24 hours a day, 7 days a week, so people can access care when they need it.

H) Measuring Delivery
We will monitor the impact of our actions to understand what is working, learn from experience, and make improvements. This will also help us identify early where changes or additional action may be needed.

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A) Working Together Across Services

Aim: Deliver coordinated care across health and social care services to ensure patients receive the right care, in the right place, at the right time.

Planned Actions:

- Continue to work collaboratively with key partners, including carers and families, Strategic Planning and Performance Group, Public Health Agency (PHA), other Health and Social Care Trusts, and Primary Care.
- Work with Integrated Neighbourhood Teams (INTs) as they are established to identify cohorts of frail older people in Belfast who would benefit from proactive assessment and intervention going into winter.
- Increase alternatives to hospital admission by expanding same-day and home-based care, including Hospital at Home, virtual wards and provision of intravenous antibiotics at home, helping to reduce unnecessary admissions and/or readmissions.
- Work with Care Homes to strengthen their winter preparedness and surge plans, and maximise capacity to support discharge.
- Participate in SPPG-led cross sectoral initiatives to support care homes and home care services in the Independent Sector, to keep communication timely and clear, deal with issues quickly, and make sure key staff are available at weekends and during holiday periods.
- Dedicate 4 Advanced Nurse Practitioners to support people in Residential Care Homes. They will offer proactive care and also be a direct referral pathway to Hospital at Home to avoid calls to NIAS and ED attendances.
- Support ongoing care for people living in Nursing Homes through our Care Home Support Team . This includes support and training for Nursing Home staff, implementation of Restore2, anticipatory care planning and development of each home's own Palliative register and development of a catheter passport for individual residents.
- Improve patient flow by helping people leave hospital safely and promptly, using discharge-to-assess pathways, discharge lounges and early review teams, supported by Trusted Assessors.
- Use site coordination, clear communication and regular safety huddles to support service delivery, having more regular huddles during periods of pressure and in line with Full Capacity Protocols across adult and children's services.
- Promote the Palliative Care Hub and strengthen end-of-life care pathways so that people can access the right care, at the right time, in the setting that best meets their needs and preferences.
- Coordinate service delivery through the HSCNI Regional Coordination Centre (RCC) across the HSC Trusts to manage regional pressures while protecting access to regional and highly specialist services delivered exclusively by Belfast Trust for people across Northern Ireland.
- Support PHA and Primary Care in the provision of flu anti-viral medications in the event of an outbreak in care homes.
- Take part in more enhanced regional meetings with SPPG, PHA and other Trusts to ensure regional communication, performance oversight and coordination - notably when seasonal pressures are high.

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B) Keeping People Healthy and Well

Aim: Help people stay healthy and independent throughout winter, reducing the need for hospital attendance or health and social care services where possible.

Planned Actions:

- Work with partners to support the regional 'This Is Our Health' initiative, which encourages people to take action to maintain and improve their own health.
- Work closely with PHA and other partners for regional health initiatives such as Age Well- which aims to keep those most at risk safe and well at home and support recommendations e.g. promoting use of vitamin D.
- Promote the principles of Sensible Care to support shared decision-making, personalised care, and the reduction of unnecessary testing and interventions.
- Maximise uptake of seasonal vaccination programmes through maternity, community and school settings.
- Strengthen measures to prevent and control infections across all services, working with the Public Health Agency (PHA) when required.
- Provide easy-to-understand information to help people look after their health and use the right service when they need care.
- Promote the Children's Symptom Checker and other digital self-management tools.
- Target early intervention and prevention programmes and support to vulnerable groups using an Inclusion Health approach. The Trust's Inclusion Health Service is a Nurse-Led
- Multi-Disciplinary Team which uses an outreach model to reach those experiencing homelessness within the Belfast Health and Social Care Trust. The team currently use the Welcome Organisation Medical Outreach Bus to access various locations across the city, alongside hostel visits and set clinics to reach some of the most vulnerable in our society. In preparation for Winter, the team will offer both flu and pneumococcal vaccines to those experiencing homelessness .
- NINES provides health assessments and screening for people seeking international protection, helping them access the right health and social care services. It also delivers the Family Help Clinic, a multi-agency service for families with pre-school children that focuses on early intervention, prevention and safeguarding support to help prevent issues from escalating.
- Strengthen support for carers, recognising their vital contribution to health and wellbeing outcomes.
- Continue to expand Patient Initiated Follow Up (PIFU), allowing patients to contact their healthcare team when they need advice, care or support as opposed to having scheduled appointments that they may not need.
- Protect capacity within community-based teams such as the Community Respiratory Team.
- Promote biologic therapies for suitable long-term conditions, including chronic lung disease and rheumatology conditions, to reduce the frequency and severity of flare-ups.
- Identify people at risk of falls and provide early support from the right professionals to help prevent falls, reduce injury, and support people to stay safe, independent and living well at home for longer.
- Establish a Short-Term Assessment Team as the first point of contact for community social work, who focus on prevention, early intervention and helping people return to their usual level of independence wherever possible.

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C) Being Ready for Winter Pressures

Aim: Maintain safe, effective services during periods of peak demand.

Planned Actions:

- Ensure intensive care, emergency departments and other critical services have the capacity needed to respond to increased demand essential for protecting life, health, and wellbeing
- Maintain separation of elective and unscheduled care with delivery of increased volumes of care in dedicated elective units.
- Expand provision of scheduled ‘hot’ clinics for unplanned but non-emergency attendances.
- Implement the Trust’s Full Capacity Protocol at times of severe pressure.
- Start planning for discharge as soon as a patient is admitted to hospital, working with patients, carers and families and using regular multidisciplinary reviews to identify and address need and support timely discharge.
- Make sure hospital pharmacy support is available when needed, to help prevent delays and support safe and timely discharge from hospital.
- Work regionally with all Trusts to co-ordinate and maximise Learning Disability and Mental Health capacity.
- Deliver additional Fracture lists and ensure co-ordination of discharge of patients from other Trust areas to maintain flow.
- Expand Northern Ireland Specialist Transport and Retrieval Service (NISTAR) and support protocols for repatriation of paediatric patients.
- Prioritise staffing resource for continued delivery of PATH (Patient Assessment and Treatment Hub) at the Mater Hospital as an alternative place of safety instead of ED for people who are acutely mentally unwell.
- Continue planned service improvements to enhance patient care and make the best use of available resources, including bringing together Care of the Elderly inpatient services at Belfast City Hospital. Older people will be able to avoid the Emergency Department through a new referral route from GPs and NIAS. A specialist team will carry out a rapid assessment and, where possible, support people through services closer to home. If a hospital stay is needed, they will receive a specialist frailty assessment more quickly.
- Implement recommendations from external reviews and audits.
- Improve patient flow through acute medical services by implementing Getting It Right First Time (GIRFT) best practice guidance, supporting rapid assessment, early senior clinical decision-making, timely treatment and safe discharge.

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D) Improving Access to Emergency Care

Aim: Ensure people can access urgent and emergency care quickly while helping them use alternatives to Emergency Departments (EDs) when appropriate.

Planned Actions:

- Make full use of Rapid Emergency & Acute Care Therapy Team's (REACTT) expertise to support timely assessment and care of patients within the ED.
- Expand Same Day Emergency Care (SDEC) capacity.
- Strengthen the Urgent Care Centre and GP Out of Hours services.
- Develop alternative pathways, including for those in mental health crisis and frail older people, including enhanced support in people's own homes.
- Keep our Trust Directory of Services up-to-date with alternative pathways to ED, available to Primary Care and the Northern Ireland Ambulance Service (NIAS).
- Improve access to specialist assessment and diagnostics including Imaging, Laboratory services, and reporting on these to support rapid assessment and discharge decisions.
- Maintain and strengthen the Royal Belfast Hospital for Sick Children's Direct Access Clinic by increasing pathways to the service.
- Work with the Ambulance Service to reduce ambulance waiting times outside hospitals and avoid unnecessary hospital transfers from care homes.
- Implement a 24/7 thrombectomy service, from September onwards, which will provide equitable and timely access to suitable stroke patients for blood clot removal .

E) Supporting Our Staff

Aim: Maintain a resilient workforce capable of delivering safe care throughout winter.

Planned Actions:

- Plan ahead to maintain safe services during evenings, weekends and holiday periods, including to provide 24-hour care where needed.
- Ensure enough staff with the right skills are available, with clear arrangements in place to respond to any unexpected staffing pressures.
- The staff seasonal flu vaccination campaign will commence 1st October, through a peer vaccinator model and pop up clinics across hospital sites and health and well-being centres.
- Use SafeCare IT system to help place staff where they are most needed and support the management of staff absence.
- Promote staff health and wellbeing through the bWell initiative - a dedicated resource for staff to support resilience and self-care.
- Implement the Trust's People and Culture Strategy.
- Pilot use of Body Worn Cameras within our Adult Emergency Departments to support the management of violence and aggression against staff.
- Continue close working with Trade Union Colleagues.
- Promote the newly established Collaborative Nurse Bank between BHSCT and South Eastern HSC Trust, to reduce agency use, give staff more choice in where and when they work, and strengthen service resilience across Trusts.

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Belfast Trust Winter Surge Plan 2026/27

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F) Making Better Use of Technology and Information

Aim: Use technology and up-to-date information to improve services and patient care.

Planned Actions:

- Implement digital solutions that support capacity and resource management, and patient flow.
- Embed CareLine Live software to improve social care scheduling and deployment.
- Use live information dashboards to monitor pressures, identify issues early and support communication across services.
- Strengthen data-driven decision-making across all services.
- Promote the use of the My Care app to enhance patient access to digital health records and services.
- Promote online and digital tools to support health and wellbeing
  - Health and Social Care Northern Ireland (HSCNI) approved digital apps on all health topics - HSCNI apps
  - HEEADDSSS screening tool and resource website relating to mental health for young people (aged 13-20) it covers Home, Education, Employment, Eating, Activities, Drugs, Sexual Health, and Suicide Prevention/Safety.
  - Dementia support and resources
  - BreathTec for people with Chronic Obstructive Pulmonary Disease (Lung diseases)
  - https://www.mindingyourhead.info/

G) Providing Care Around the Clock

Aim: Optimise service availability and responsiveness to meet patient needs 24 hours a day, 7 days a week.

Planned Actions

- Enhance seven day working models within resources available.
- Maintain 24/7 services
  - District Nursing services
  - Community Discharge hub
- Provide 24/7 help and advice lines
  - Oncology - diagnosis, treatment and care of people with cancer
  - Haematology- diagnosis, treatment and care of people with blood disorders

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Belfast Trust Winter Surge Plan 2026/27

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H) Measuring Delivery and Impact

Aim: Regular monitoring and evaluatation of the impact of our Winter Surge Plan will help us understand what is working, identify areas requiring further action, and support improvement improvements to patient care, service delivery and overall performance.

Planned measures:

- Patient, service user and carer experience.
- Waiting times in the Emergency Department
- Timely ambulance handovers
- Uptake of vaccines
- Staff absence
- Hospital length of stay
- Number of people whose discharge is delayed due to the complexity of their needs
- Activity and access to community care, Patient Initiated Follow Up, Virtual wards, Palliative Care Hub, Care of Elderly and Frailty services, Hospital at Home.
- Monitoring and benchmarking of readmission rates.

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Belfast Trust Winter Surge Plan 2026/27

Glossary- Key Terms Explained

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Age Well A regional programme that supports older people to stay healthy, independent and safe at home for as long as possible.

Ambulatory Care Care and treatment that allows patients to be assessed and treated on the same day without needing an overnight hospital stay.

Biologic Therapies Advanced medicines used to treat certain long-term conditions, such as arthritis or inflammatory bowel disease, by targeting specific parts of the immune system.

CareLine Live A technology-enabled care service that provides support, monitoring and assistance for people living at home, helping them remain safe and independent.

Consumables: Everyday items used in providing care that are intended for single use or need regular replacement, such as gloves, dressings and syringes.

Discharge-to-Assess An approach where patients leave hospital as soon as they are medically ready, with any ongoing assessment and support needs reviewed in their own home or community setting.

Fracture Services Specialist services that assess, treat and support people with broken bones and related injuries.

GIRFT (Getting It Right First Time):A programme that supports hospitals to improve the quality and efficiency of care by sharing proven ways of working and reducing unnecessary delays for patients.

Hospital at Home A service that provides treatment, monitoring and support in a patient's home as an alternative to a hospital stay.

Hot Clinic: A specialty-led outpatient service for rapid review of selected patients with urgent, non-emergency conditions.

Inclusion Health Approach An approach that aims to improve health outcomes for people who are socially excluded, such as those experiencing homelessness, addiction, poverty, vulnerability or barriers to healthcare, by providing accessible, joined-up and person-centred support.

Integrated Neighbourhood Teams (INTs) Local teams of professionals from primary care, community health and social care services, and the voluntary and community sector to work in partnership, providing coordinated, person-centred care and support closer to home.

MyCare App A digital app that helps people manage aspects of their health and care, including accessing information and support.

Northern Ireland Specialist Transport and Retrieval Service (NISTAR) A specialist regional service that safely transfers critically ill adults and children between hospitals when specialist care is required.

Norovirus A highly contagious stomach bug that causes vomiting and diarrhoea.

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Belfast Trust Winter Surge Plan 2026/27

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Patient Initiated Follow Up (PIFU) A follow-up approach that allows patients to contact their healthcare team when they need advice or support, rather than attending routine scheduled follow-up/ review appointments.

Palliative Care Hub A service that coordinates care and support for people with serious or life-limiting illnesses, helping them receive the right care in the most appropriate place.

Primary Care Health services that are usually the first point of contact for patients, including General Practice (GP) and community pharmacy.

Public Health Agency (PHA) The regional organisation responsible for improving health and wellbeing, reducing health inequalities, and helping to protect the public from disease and health risks.

Rapid Emergency & Acute Care Therapy Team's (REACTT) A specialist team in the Emergency Department that helps patients get assessed and treated more quickly so they can receive the right care, in the right place, as soon as possible.

Regional Coordination Centre A regional service that helps coordinate hospital capacity, patient flow and resources across Health and Social Care organisations in Northern Ireland.

Repatriation of Paediatric Patients The transfer of children from specialist hospitals back to their local hospital when they no longer need highly specialised care.

Restore2 A care home tool that helps staff recognise early signs of deterioration, monitor residents' health and escalate concerns promptly to the appropriate healthcare professional. It stands for: **R**ecognise **E**arly **S**oft signs **T**ake **O**bservations **R**espond **E**scalate.

SafeCare A digital system used to help plan staffing, monitor workforce pressures, and support safe patient care across Health and Social Care services.

Sensible Care An approach to healthcare that supports shared decision-making, avoids unnecessary tests or treatments and focuses on providing care that offers the greatest benefit to patients.

Strategic Planning and Performance Group (SPPG) The organisation within Health and Social Care Northern Ireland responsible for planning, commissioning and overseeing health and social care services to ensure they meet the needs of the population. It works with Trusts and other partners to improve services and outcomes for patients and service users.

Thrombectomy A specialist procedure used to remove a blood clot from a blood vessel, most commonly as an emergency treatment for some types of stroke.

Trusted Assessor A trained professional who carries out assessments that can be used by different health and social care services, reducing duplication and helping people access support more quickly.

Virtual Wards A service that allows patients to receive hospital-level monitoring and care in their own home, where it is safe and appropriate to do so.