The Case for an Integrated 111 Service in Northern Ireland

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Contents

Introduction	4
The Current State of Play	5
Proof of Concept: Learning from NHS 111	6
Case Study: Greater Manchester	7
The Case for an Integrated System in Northern Ireland	8
Invest to Save	9
Conclusion	10

Introduction

Northern Ireland's health and social care system is under sustained and growing pressure. Nowhere is this more visible than in emergency departments, where rising attendances, extended waiting times, and delays in patient flow have become persistent features of the system. These pressures are often framed as a consequence of increasing demand, but this explanation only tells part of the story. A key issue lies in how that demand is directed through the system.

Patients are required to make complex decisions about where to seek care, often in moments of uncertainty, and frequently without clear or consistent guidance. In the absence of a simple and recognisable access point, many default to emergency departments, even where more appropriate and timely care could be delivered elsewhere. This places unnecessary strain on acute services and undermines the efficiency of the wider system.

The result is a cycle of pressure. Emergency departments become congested with patients whose needs could be met in other settings, while those requiring urgent intervention face longer waits. Staff are left managing the consequences of a system that does not consistently guide patients to the right care, at the right time, in the right place.

There is now broad agreement that this model is unsustainable. The Department of Health has increasingly emphasised the need to "shift left", moving care closer to home, strengthening community provision and focusing on prevention and early intervention. While this direction is both necessary and welcome, it relies on patients being able to access and navigate the system effectively. Without a clear and integrated front door to urgent care, the ambition to rebalance the system will struggle to deliver its full impact.

This report makes the case for the introduction of a single, integrated 111 service for Northern Ireland. Such a service would provide a 24/7 access point to urgent care, supported by clinical triage and direct booking into appropriate services. Properly implemented, it would improve patient experience, support better use of resources, and play a central role in reducing pressure on emergency departments.

It forms part of a series of proposals being brought forward by the SDLP aimed at delivering tangible improvements to our health service and ensuring that people can access care when they need it.

The Current State of Play

Emergency care pressures in Northern Ireland are both acute and worsening. In 2024/25, there were 764,720 emergency department attendances, with only 45.5% of patients seen within four hours and 17.4% waiting more than 12 hours.[1] More recent data shows that performance has continued to deteriorate, with fewer than one-third of patients seen within four hours in late 2025.[2]

While rising demand is often cited as the primary cause, the evidence suggests that the issue is not simply the volume of demand, but how it is distributed. A significant proportion of emergency department attendances could be treated elsewhere. Evidence from England suggests that up to two-fifths of cases may be avoidable or more appropriately managed in alternative settings.[3] Early evidence within Northern Ireland supports this view. Data from the Phone First service shows that in December 2025, 38.5% of callers were not referred to emergency departments,[4] demonstrating that clinical triage can successfully redirect a substantial share of demand.

While Phone First represents a positive step, it has not been established as a universal front door to urgent care. Awareness remains limited and usage inconsistent, meaning that many patients continue to default to emergency departments. As a result, the system is not yet capturing the full benefits of triage-led access.[5]

These pressures are compounded by wider structural challenges, including delayed discharges, workforce shortages, difficulties accessing general practice, and gaps in community provision. The Department of Health's strategy to shift care into community settings is essential, but without a clear and consistent access point, it will not fully address how patients move through the system.[6]

1 https://www.health-ni.gov.uk/news/northern-ireland-hospital-statistics-urgent-and-emergency-care-202425
2 https://www.health-ni.gov.uk/news/emergency-care-waiting-time-statistics-october-december-2025
3 https://www.england.nhs.uk/2024/11/nhs-calls-on-public-to-use-nhs-111-this-winter/
4 To insert
5 https://www.health-ni.gov.uk/news/emergency-care-waiting-time-statistics-october-december-2025
6 https://www.health-ni.gov.uk/publications/neighbourhood-model-health-and-wellbeing

Proof of Concept: Learning from NHS 111

The introduction of NHS 111 in England represented a significant step forward in simplifying access to urgent care. Launched from 2010 onwards, it replaced a more fragmented system of telephone services, including NHS Direct, with a single, easy-to-remember number available to the public 24 hours a day. The aim was to provide a clear front door to urgent care, offering clinical triage and directing patients to the most appropriate service based on their needs.

Since its introduction, NHS 111 has become a well-established and widely used part of the health system. It now handles tens of millions of contacts each year through its telephone and online services, acting as a primary access point for urgent care advice and support. This level of uptake reflects both public demand for a simpler system and the value of having a consistent, recognisable route into care. Over time, the service has evolved beyond its original design, with increasing clinical input, improved digital triage, and greater integration with local health services.

While early evaluations highlighted some limitations, particularly in relation to its impact on overall emergency department demand, the trajectory of the service has been one of steady development and improvement. As it has become more embedded within the wider health system, its role in supporting patient navigation and managing demand has strengthened. In many areas, it now enables direct booking into services and plays an active role in coordinating care rather than simply signposting.

The key lesson from this experience is that the value of a 111 service lies not only in providing triage, but in how it is integrated within the broader system. Where it is supported by strong links to primary, community and emergency care, it can play a significant role in ensuring that patients receive the right care in the right setting, while improving overall system flow.

Case Study: Greater Manchester

A recent SDLP visit to Greater Manchester provided a detailed insight into how a mature and integrated 111 system can operate in practice. Delivered by the North West Ambulance Service, the service handles approximately two million calls each year across a population of around seven million people.

The service combines call handlers with clinical staff, using structured triage systems to assess patients and direct them to the most appropriate care. Crucially, it is fully integrated with a wide range of services, including GP out-of-hours provision, urgent care centres, pharmacy, mental health services, ambulance services and emergency departments.

Outcomes from the service demonstrate its effectiveness. Around a quarter of callers are directed to self-care, while approximately half are referred to primary care services. Only a small proportion require escalation to emergency departments or ambulance services. This reflects a system in which the majority of demand is managed outside hospital settings.

The ability to directly book patients into services is central to the system's success. Rather than simply advising patients, the system actively manages their pathway, ensuring that they receive timely care without defaulting to emergency departments, representing a shift from reactive to planned urgent care.

Initial concerns about increased pressure on general practice have not materialised, with structured allocation of appointments allowing demand to be managed effectively. Over time, the system has become embedded within the wider health service, demonstrating the potential of an integrated approach.

The Case for an Integrated System in Northern Ireland

Northern Ireland is well placed to implement a similar model. Our health service provides a strong foundation for integration, while existing services such as Phone First demonstrate the potential of triage-led access.

However, the current system remains fragmented, with no single entry point and limited ability to direct patients effectively. Similarly, public awareness of initiatives like Phone First is low significantly limiting its effectiveness. As a result, emergency departments continue to act as the default access point.

A well-publicised integrated phone triage service would address this gap, providing a clear and consistent front door to urgent care and enabling the system to function more efficiently. The SDLP proposes the introduction of a Northern Ireland-wide 111 service, operating 24 hours a day and accessible via both telephone and online platforms. The service would provide clinically-led triage and act as a central point of access to urgent care.

At its core, a Northern Ireland 111 service should:

- Provide a single, universally recognised front door to urgent care
- Deliver clinically-led triage to assess patient need
- Enable direct booking into appropriate services
- Integrate with ambulance and emergency care systems
- Connect seamlessly to community and primary care services
- Operate consistently across all Trusts/throughout NI
- Provide real-time visibility of system capacity

Invest to Save

While precise costs will depend on system design, evidence from comparable systems provides a useful benchmark. In Greater Manchester, the 111 service operates at a cost of approximately £23 million for a population of around seven million people, equating to roughly £3-£4 per person.

On this basis, a Northern Ireland-wide service could be expected to cost in the region of £6-£8 million annually, with higher estimates of up to £10-£15 million depending on the level of integration and clinical provision.

It is important to recognise that this should not be viewed as entirely new expenditure. Many of the functions associated with a 111 service already exist within the system, including out-of-hours provision and triage services. A 111 model would rationalise and integrate these functions, improving efficiency and reducing duplication.

By directing patients to the most appropriate form of care, the service has the potential to reduce unnecessary emergency department attendances and ambulance dispatches, generating offsetting savings over time. Even modest reductions in inappropriate ED use could deliver meaningful financial and operational benefits.

A comprehensive communication programme would be required to ensure uptake, supported by strong clinical governance and integration with existing services.

Conclusion

Northern Ireland's health service has reached a tipping point. The pressures facing emergency departments reflect not only rising demand, but a system that does not consistently guide patients to the right care. The end result is a system frequently unable to cope this pressures being placed upon it.

While unable to solve all problems in its entirety, the introduction of a 111 service offers a practical and evidence-based solution, which can help alleviate pressure, while ensuring that more people are able to access appropriate care in an appropriate setting. By providing a clear front door to urgent care, it would improve patient experience, support better use of resources, and enable the wider shift towards community-based care.

The question is not whether we can afford to introduce such a service, but whether we can afford not to.

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