Health and Social Care

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An Roinn Sláinte
Männystrie O Poustie
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WINTER SURGE PLANNING

2026/27

Strategic Planning and Performance Group

(SPPG)

18/09/2026

Introduction

The Strategic Planning and Performance Group (SPPG) has a number of key regional responsibilities with respect to winter surge planning:

1

Managing the Primary Care Response to Surge Planning

This is particularly relevant during the winter period when there are additional demands on the system due to seasonal illness. Section 1 of this document sets out a high-level summary of the key elements of the plan for 2026/27, alongside a delivery roadmap. The SPPG will monitor surveillance information on seasonal illness and share this with primary care partners, as appropriate. SPPG will also monitor the detailed planning and delivery of additional winter activity by primary care providers.

2

Ongoing Planning and Development of the Neighbourhood Response

It should be noted that these plans represent our ambition for the Integrated Neighbourhood teams. They are indicative at the time of writing, but have been included for completeness and set out within Section 2.

3

Oversight and Monitoring of the HSC System Response

Outline planning guidance for winter was issued by the Department in July. Since then, SPPG and the Public Health Agency (PHA) have worked with all Trusts to ensure that individual operational plans provide assurance that the requirements have been addressed within the resources available. Links to the Trust plans will be available when published by Trusts.

Service Improvements Supporting Winter Planning

A number of important service improvements have been put in place during 2025/26 and 2026/27 to support improved patient experience and outcomes, most relevant to winter surge

planning is “Release to Rescue”, which has significantly improved ambulance efficiency and improved handover times to Emergency Departments and reduced call-out times across all areas. These improvements will continue to be driven forward in support of winter plans.

Monitoring and Evaluation

Monitoring and evaluation of performance will continue across the HSC system, not solely during periods of peak surge, with enhanced arrangements for commissioners (SPPG and PHA) and Trusts to share information and consider actions for escalation and resolution in place for 2026/27.

Section 1 - Primary Care

Primary Care will play a central role in the Health and Social Care system's response to winter pressures. Through coordinated action across General Practice, GP Out of Hours services and Community Pharmacy, Primary Care will provide additional clinical capacity, improve patient access to care, support prevention, deliver vaccination programmes, and help manage demand in community settings. Collectively, these measures are designed to reduce avoidable attendance at Emergency Departments, ease pressure on urgent and unscheduled care services and support overall system resilience during periods of peak demand.

Primary Care's contribution to winter resilience extends beyond General Practice and Community Pharmacy. Established community-based ophthalmic and dental services provide alternative pathways to urgent and unscheduled care throughout the year and continue to support system resilience during periods of winter pressure. The Northern Ireland Primary Eyecare Assessment and Referral Service (NI PEARS) provides community-based assessment and management of acute eye conditions, offering an alternative to General Practice, Emergency Departments and Hospital Eye Services for appropriate patients. The Dental Access Scheme and Out-of-Hours Emergency Dental Clinics provide urgent dental care for registered and unregistered patients, helping to prevent avoidable attendance at Emergency Departments for dental conditions that can be managed safely within primary care. The SPPG team ensures the dissemination of surveillance information to key partners and monitors the delivery of additional services.

General Practice Capacity and Access

Demand for General Medical Services increases significantly during the winter period, driven by seasonal illnesses, respiratory infections, exacerbations of long-term conditions and increased requests for urgent appointments. General Practice remains the foundation of the health system response and will continue to provide comprehensive medical care to registered patients throughout the winter months.

To strengthen capacity, SPPG commissions the Northern Ireland Local Enhanced Service (NILES) Additional Surgeries During the Winter Period. This enhanced service provides additional financial support to GP practices to increase clinical capacity over and above existing contractual provision. Practices will be able to deliver additional GP, Advanced Nurse

Practitioner and Clinical Pharmacist sessions, including provision during evenings and weekends where appropriate to local need.

The service is specifically designed to increase the number of available patient appointments, improve access to planned care, support practices during periods of peak demand and reduce pressure on urgent and unscheduled care pathways. These additional surgeries are above normal service provision and will provide a substantial increase in clinical capacity across Northern Ireland during the winter period.

NILES Additional Surgeries During the Winter Period is a demand led service, with activity determined by the level of additional patient demand experienced by practices over the Winter period. SPPG estimates that approximately in excess of 8,000 additional surgeries will be delivered across Northern Ireland during the Winter period.

SPPG will also provide additional investment to support the increased delivery of NILES GP Proactive Care for Nursing and Residential Homes, ensuring some of the most vulnerable patients in the community receive appropriate, proactive and timely care.

GP Out of Hours Services

GP Out of Hours is a demand led service that provides urgent primary care for patients whose conditions cannot safely wait until their own GP practice reopens. These services represent an important component of the winter response, particularly during periods of increased demand associated with respiratory illness and seasonal surges in urgent care activity.

In 2025/26 demand for GP OOHs services increased by approximately 8% between October and March, compared with demand across the remainder of the year.

Out of Hours providers develop winter pressure plans outlining how available resources of £900k is provided to increase clinical capacity, strengthen demand management arrangements and improve triage processes. These plans build on existing demand and capacity arrangements to ensure patients continue to receive timely access to urgent primary care services during peak periods.

Community Pharmacy Services

Community Pharmacy provides one of the most accessible elements of the health service and will make a significant contribution to managing winter demand. With over 500 pharmacies located across Northern Ireland, the network offers convenient local access to healthcare advice, medicines and clinical services within communities.

Community Pharmacy will support winter preparedness priorities and population health by providing access to safe and reliable supplies of medicines, professional advice and clinical services to prevent and treat illness. The skills of community pharmacy teams will be utilised to increase capacity within the HSC, support acute demand and support people to maintain their wellbeing across the winter period.

Throughout winter, pharmacies will continue to provide core dispensing services, emergency medicine supply arrangements, adherence support and access to pharmacist advice. The Emergency Supply Service enables patients to obtain essential medicines when GP practices are closed, avoiding unnecessary attendance at Out of Hours services or Emergency Departments. Community Pharmacies will also continue to support medicines resilience through Serious Shortage Protocol arrangements where supply disruptions occur. The enhanced Community Pharmacy Palliative Care Network was established as a key part of the 2025/26 winter plan and will continue to operate this winter, expanding to 70 pharmacies, enabling participating pharmacies to provide timely access to essential palliative care medicines and the provision of specialist advice to support continuity of care for palliative patients.

Community Pharmacy also plays a key role in delivering vaccination programmes. In 2025/26 more than 300 Community Pharmacies participated in the seasonal influenza and COVID-19 vaccination programmes, including delivery within care homes and to eligible populations across local communities. We are working with the PHA and Community Pharmacies to expand the scope of vaccinations delivered by Community Pharmacy. This supports both prevention objectives and wider efforts to reduce winter-related demand on health services.

The continued expansion of Pharmacy First services provides an opportunity to manage a greater proportion of lower-acuity conditions within community settings. Community Pharmacies currently provide a range of clinical assessment and treatment services, including

support for everyday health conditions, uncomplicated urinary tract infections, sore throat management, shingles and emergency hormonal contraception. In 2025/26 on average 20,100 patients availed of these services displacing activity from elsewhere in the health service.

These services enable patients to receive timely treatment without requiring a GP appointment and support the appropriate use of healthcare resources. Planned developments, including wider rollout of successful pharmacy initiatives, such as support to care home patients and vaccinations, will further strengthen the ability of community pharmacy to support demand and free GP capacity for more complex and urgent patients. Engagement continues with Community and Voluntary organisations through the Building the Community Pharmacy Partnership Programme (BCPP) to raise awareness of these services.

Prevention, Public Health and Communications

Preventing illness and promoting self-care will remain a critical element of the Primary Care winter response. Community Pharmacies participate in winter health promotion campaigns focused on vaccination uptake, medicines optimisation, self-care and helping people remain well throughout the winter months. Information on available Primary Care services will continue to be integrated within urgent care pathways, ensuring patients receive ongoing information about the range of services available and how to access them.

This preventative approach supports both improved health outcomes and the management of demand across the wider health and social care system.

Expected System Impact

Collectively, these measures provide a comprehensive Primary Care response to winter pressures. The combination of additional General Practice capacity, strengthened GP Out of Hours arrangements, extensive Community Pharmacy provision, vaccination programmes and Pharmacy First services will:

- Increase access to timely clinical care across community settings.
- Deliver additional appointment capacity within General Practice.
- Improve access to urgent primary care services during periods of peak demand.

- Support prevention through vaccination and public health initiatives.
- Manage more patients safely within community settings.
- Reduce avoidable attendance at Emergency Departments and other urgent care services.
- Enhance the resilience of the wider Health and Social Care system during winter 2026/27.

A delivery roadmap is set out below.

Period*	Key Activity	Lead Area	Expected Outcome
September 2026	Finalise winter preparedness arrangements across Primary Care	Primary Care Directorate	Winter plans approved and mobilisation complete
September-October 2026	Commence Flu and COVID vaccination programmes through GP practices and Community Pharmacy	GMS / Community Pharmacy	Increased vaccination uptake and prevention of winter illness
October 2026	OOH Providers submit and activate Winter Pressure Plans	GP Out of Hours	Enhanced urgent care capacity
November 2026	Implement NILES Additional Surgeries Service	GMS	Additional appointment capacity available
November-March 2027	Delivery of additional GP, ANP and Pharmacist sessions	GMS	Improved patient access and demand management

Period*	Key Activity	Lead Area	Expected Outcome
Ongoing	Delivery of Emergency Supply Service	Community Pharmacy	Reduced avoidable OOH and ED attendance
Ongoing	Delivery of Pharmacy First services	Community Pharmacy	More patients managed within community settings
Autumn /Winter 2026/27	Winter public health and self-care campaigns	Community Pharmacy / HSC Communications	Increased public awareness and self-management
Monthly	Monitoring of activity, uptake and system impact	Primary Care Directorate	Ongoing assurance and performance oversight

*Indicative delivery milestones based on current planning assumptions.

Section 2 - Neighbourhood Model of Care

Introduction

This Indicative plan sets out how the Neighbourhood Model of Care, specifically through the work of the Integrated Neighbourhood Teams (INTs), is expected to support delivery of the HSC Winter Surge Plan, by reducing avoidable hospital demand, improving patient flow, strengthening community capacity and delivering more care closer to home during winter 2026/27.

INTs represent the key delivery mechanism for neighbourhood-based health and social care reform. The winter response aligns with the regional focus on reducing emergency department attendance, non-elective admissions, delayed discharge and length of stay while improving patient outcomes and experience.

While the development of INTs is in progress, associated workplans have been developed as set out below. These are wholly dependent on full implementation and therefore this plan is held as draft and will be subject to update.

Supporting the 10,000 Most Vulnerable Patients

Initial winter activity will focus on vulnerable older people, using risk information and local intelligence to identify those at greatest risk and provide earlier, coordinated support closer to home.

Approximately 10,000 of the most vulnerable and frail older people across Northern Ireland have been identified and, through an enhanced care arrangement, GP-led clinical case reviews, proactive care planning, medication review, vaccination support and multidisciplinary intervention will be coordinated through INTs. Patients will be actively monitored throughout winter with the mobilisation of early intervention when risks are identified.

Winter Priorities – Indicative planning assumptions

Alternatives to Hospital Admission

GPs will undertake proactive case reviews of high-risk patients. INTs will coordinate multidisciplinary interventions and maximise access to Hospital at Home, frailty pathways, care home support and community alternatives.

Improving Patient Flow Through and From Hospitals

Trusts and INTs will support early discharge planning, medicines reconciliation, community follow-up and rapid access to support services to prevent readmission.

Keeping People Well at Home and in the Community

Delivery will include vaccination promotion, medication review, proactive care planning, end of life planning, social prescribing and practical Voluntary, Community and Social Enterprise (VCSE) support.

Providing More Care Closer to Home

INTs will support Trust 2% realignment ambitions through identification of services suitable for neighbourhood delivery and expansion of community pathways.

Working Together to Meet Winter Demand

All 17 INTs will bring together General Practice, Community Pharmacy, Trusts and VCSE partners using agreed escalation, coordination and intelligence-sharing arrangements.

What we will do within SPPG

Develop an Enhanced Service to support GP Case Finding & Proactive Care

- Stratification of Vulnerable Older People caseload for each GP Practice
- Target circa 10,000 most vulnerable older people across HSC and all GP Practices
- Support look back for this identified group over past 12 months across ED attendances, unplanned admissions, PEOLC care, broader care packages in place, etc.
- Ensure Proactive Case Review of this caseload at Practice level
- Support a further look back at end March 2027

Participation of other key INT Partners

- Support VCSE partners to develop supportive inputs to this Vulnerable Older People population via seed funding

- Support CPNI partners to develop supportive inputs to this Vulnerable Older People population via Pharmacy First

Additional Support for existing Interventions

- Support the enhancement of the existing NILES for GP support into Care Homes

Winter Delivery Framework

Priority	Named Interventions	Lead Responsibility	Expected Impact
Alternatives to Admission	GP proactive reviews; Hospital at Home; Direct Access Frailty; Care Home Support; Pharmacy First	All INT Partners	Reduced ED attendance and admissions
Patient Flow	Discharge planning; neighbourhood wraparound support; medicines reconciliation	Trust, GP, Pharmacy	Reduced delayed discharges and readmissions
Well at Home	Frailty reviews; vaccination; social prescribing; community support; Pharmacy First	GP, VCSE, Pharmacy	Reduced deterioration and crisis presentations
Care Closer to Home	2% shift schemes; community pathways; MDT interventions	Trust, INTs, SPPG	Increased community-based care
Meeting Demand	Weekly INT meetings; shared intelligence; escalation processes	All INT Partners	Improved system resilience

Action Plan

- *Integrated Neighbourhood Teams*: Coordinate local delivery, monitor high-risk caseloads and identify service gaps.
- *General Practice*: Lead case finding, risk stratification, clinical review and proactive care planning.
- *Community Pharmacy*: Support medicines optimisation with a focus on care homes, expand Pharmacy First service e.g. shingles to further displace activity from other areas of urgent care, enhance palliative care services and consider opportunities to expand the vaccination programme
- *Health and Social Care Trusts*: Provide alternatives to admission, discharge support and service realignment under the 2% agenda.
- *VCSE Sector*: Deliver social prescribing, wellbeing support, community navigation and practical assistance.

Data and Digital Enablers

SAPPHIRE, neighbourhood dashboards, population health management tools, risk stratification and shared performance reporting will support identification of vulnerable patients, monitoring of outcomes and targeting of interventions.

Performance Indicators

- Reduction in ED attendances
- Reduction in non-elective admissions
- Reduction in delayed discharges
- Reduction in average and excess length of stay
- Reduction in readmission rates
- Increase in proactive care plans
- Increase in medication reviews and vaccination uptake
- Improved patient and carer experience