Collated Feedback from NI Health Collective engagements on NI Neighbourhood Model of Care November-December 2025

NORTHERN IRELAND NEIGHBOURHOOD MODEL OF CARE VCSE WORKSHOP

Wednesday 12th November 2025; 1.30pm – 4.30pm FEEDBACK SHEET

SESSION 1

Q1	**From your perspective, what would help make a NI Neighbourhood Model a success at local level?** • **Building Trust and Relationships** Meaningful community involvement from the start - Not just consultation, but genuine co-design with people affected by cancer, carers, and local volunteers who understand the community's lived reality. This means their voices shape services, not just comment on pre-made plans. • Consistent, familiar faces - Community cancer support thrives on relationships. • Having the same nurses, support workers, and coordinators over time builds trust, especially important given Northern Ireland's close-knit communities where word-of-mouth is powerful. • **Practical Access** • Hyper-local hubs - Services need to be genuinely neighbourhood-based, not just "closer than Belfast." This means utilising existing trusted spaces like GP surgeries, community centres, church halls, or cancer support charity premises that people already know. • Transport solutions - Rural areas and pockets of deprivation need realistic answers to the "how do I get there?" question. Community transport links, volunteer driver schemes, or even virtual options for certain appointments matter enormously. • **Integrated Support** • Holistic, not just clinical - Cancer communities know that benefits advice, mental health support, practical help, and peer connections are as vital as treatment. The model needs to weave together NHS services with voluntary sector expertise. Navigation support - Someone who can guide people through the system, book appointments, explain jargon, and advocate when things go wrong. Many grassroots groups already do this informally • **Community Ownership** • Visible local champions - GPs, consultants, or community leaders who actively promote and believe in the model help overcome scepticism. • Feedback loops that matter - Regular opportunities for community voices to flag what's working and what isn't, with evidence that concerns lead to actual changes.

	• Clear shared Vision communicated – understanding how it links to the other structures and strategies that already exist • Building from the centre, rather from the services down • Leadership • Increased capacity within Primary Care • Community Mobilisation – co-protection • Maximise technology – data warehouse sharing anonymous data for trends to plan response • Availability of data from across sectors and systems integration • Data on Community – need live and real data on children in social care and uptake of services • Feedback from understanding where demand is - Identify Pilot Neighbourhood • Pilot projects – matched with AIPB • Awareness of available resources and core delivery partners • Skills audit – workforce review (in VCSE and Statutory) • Shared workforce training • Effective Commissioning – needs assessment • Explain how it links to resources • Money following the person down into community groups enabling grassroots to grow capacity • Funding stream for V&C provision • Funding models for community preventative care • Areas of high deprivation – no money and no resources for change • Equity of power – equal treatment of V&C sector – need to appreciate and value what the sector offers • Ensuring commitment from the health system • Decision making critical – where does it lie? • Health literacy and agency • 20% of health attributed – education is a microcosm • Not tokenistic – involve local stakeholders • Consideration of minority groups • Consideration of existing services – capacity of partners – harness the assets • Enabling to see right person at right time – and understanding why people access health via different routes • Clear pathways • Consistent messaging – sharing messaging through online forums and helplines • Break GP Federation areas down even more to sub areas and have reps from C&V sector feed up into the Federation. Its still to health service based. If you want prevention you need to involved individuals at community level.

	• Core funding • Mapping exercises • Staff • Consider local stakeholders • Design [xxxx] place based • Sounds similar to previous attempts – wll require big leadership to ensure Trusts don't dictate the terms. • Funding based in need, rural proofing. NI is 37% rural. • Cant? Waste expenditure • Mapping where services are but don't take too long to do it. • Rural proof your model in terms of geographic spread and sparsity? – needs to be equity of access. • Worried about what it driving this – speed of implementation • Start at patient in the home – not GP. target people who don't go to the GP. Meet them in their places. • NM – listen to us – we're already doing it. Lost funding – off the shelf model instead of starting from scratch. • Data sharing – border – with VCSE – us to refer up / encompass • Needs to be more than just navigating – need to look at social determinants – causes of the causes. • Money should follow the patient. • Access to services, signposting and connection with the 3rd sector orgs • Make sure specialist support services are available if reqd eg parkinson's nurse specialist, consultant neurologist. • From personal level – online GP consultation – e-prescriptions, availability of 24hr pharmacy on a rota, more minor ailment schemes and elaborate on more illnesses and prescribing. • GP to be more a community hub – with other services like counselling and minor ops to reduce ED/OOH footfall. • Timeline ambitious. • Need to be brave!! Change needs to be led with purpose and trust. • Technical plus digital poverty??? • Connectivity??? • Need to build trust within HCP Trusts to embrace a new way of working. • Educate public to trust change. • Dull understanding of what services/providers there are in each area, <u>full scoping exercise/review required</u>. • Endure Health Trusts / DoH <u>are not</u> in change, VCS leadership at INT level. • Health Trusts need a major cultural change, to ensure middle managers/Director level and below fully understand the changes required.

	• Ensure local councils are not involved in delivery. • Respect and appreciation for the skills and capacity within V&C sector. • V&C sector involved at strategic level decision making. V&C holding leadership positions, Where does the private sector sit in these neighbourhood models? Within Social care the private sector are controlling the market. • Better investment in micro-organisations that can offer a greater return in investment where does social care sit? Constantly valued only in how well social care can support the health care systems. • Level of respect between all providers and not top down from GPs. • Detail of the funding available to each INT. • Tracking of how many are accessing other than the GP – realising that we can provide care and input – expansion of who could be in the MDT. • Can't be just population based • Shared and agreed understanding of neighbourhood at all levels • Open to change • Understanding and transparency on the decision making, evidence, need. • Language and culture considerations – listen, learn, change. • Consistency of structure, service provision across the 17 N'hood teams so it isn't a postcode lottery. • Clear, consistent information • Clear points of access to services and information of the services being provided by VCS/HSC. • Collation of information – collated in the same way, coordinated and shared • Person centred • Develop incrementally • Money to flow to VCSE too • Place based / issue based development • Respect VCSE • Rurality considerations • Know what is in the V Sector – who will do this? • Whole of govt approach – stronger • Cross departmental strategic alignment for prevention • Minor ops and minor ailments – Pharmacy First • Focus on infrastructure – tech/transport/population. Effective commissioning and role of Trusts in this? • Faster diagnoses – pathways clearer for specialised ????equity and equality in services • Rural proof – transport etc • Local needs assessment for each area

Q2	**How could VCSE Sector support the development of a Neighbourhood Model of Care?**

Bridging Trust and Access

- Trusted intermediaries - VCSE organisations often have relationships with communities that health services are still building, particularly with marginalised groups, those with health literacy challenges, or people distrustful of "the system." They can facilitate honest conversations about what communities actually need. Reaching the underserved - Community groups know where the gaps are - who isn't accessing services, which neighbourhoods have higher needs, and which barriers are invisible to service planners.

Co-Design and Lived Experience

- Bringing authentic voices - VCSE organisations can mobilise people with lived experience of cancer, carers, and community members to genuinely shape the model, not just rubber-stamp it. They can facilitate involvement in ways that feel safe and accessible.
- Testing and prototyping - Smaller VCSE organisations can pilot approaches quickly, learn what works at neighbourhood scale, and iterate before large-scale NHS implementation.

Filling Critical Gaps

- Wraparound support - VCSE sector excels at holistic support - benefits advice, emotional support, practical help, social connection - that complements clinical care but often falls outside NHS remit or capacity.
- Peer support networks - Cancer support charities and community groups can facilitate peer connections, support groups, and mentoring that create the social fabric around clinical pathways.
- Navigation and advocacy - Helping people understand and navigate the system, attend appointments, and have their voices heard when things go wrong.
- Infrastructure and Assets
- Physical spaces - Community centres, charity premises, and trusted local venues can host services, making them feel less clinical and more accessible. Volunteer capacity - Transport schemes, befriending, practical support, and community outreach that extends the reach of paid staff.
- Local knowledge - Understanding community dynamics, seasonal patterns, cultural considerations, and hyperlocal barriers that postcode data alone won't reveal.

Partnership Principles for Success

- For this to work well, the relationship needs to be genuinely collaborative:

	– Early involvement - VCSE at the design table, not just delivery – Equitable funding - Recognising the value VCSE brings with sustainable, not project- by-project, funding – Clear roles - Understanding who does what, avoiding duplication or gaps – Information sharing - Appropriate data sharing protocols so VCSE can identify and support people effectively – Shared outcomes - Measuring what matters to communities, not just clinical metrics – Capacity building-Supporting smaller organisations to engage meaningfully without overwhelming them **Potential Challenges to Navigate** • Capacity constraints - Many VCSE organisations are stretched thin • Competition vs collaboration - Multiple groups may serve similar communities • Sustainability concerns - Short-term NHS contracts don't match the long-term relationship-building VCSE does best • Power dynamics - Ensuring VCSE voice genuinely influences decisions, not just implements them • VCSE already supporting the DoH - want to do more than just support • Already working in a Neighbourhood Model – recognise VCSE expertise and they are trusted sources of information • Co-production • Every contact counts • Representation in development and following • Support needs analysis • Sell it – help mobilise • Language around promoting it – access to comms to share messaging and build trust • Sectors working as equals with AIPBs using VCSE knowledge • Identify MDTs with better efficiency and engagement – operating with data and models of community-based live experiences • Mapping/profiling • Facilitating/convening partnerships • Support implementation • Champion Community input • Community Diagnostics in local community centres • Digital and E-Health for prevention and monitoring • Risk Stratification – communities know who the vulnerable people are (eg. Frail elderly, children in poverty) • Innovate around prevention and inclusion

	• Inequity of care needs addressed – same provisions in each Trust
	• Deliver practical support that keeps people at home
	  – Build local partnerships and integrate
	  – Deliver community-based programmes to strengthen prevention and early detection
	  – Deliver integration and personalised support
	  – Empower communities and their voice
	  – Address wider determinants of health
	  – Pilot new services – collect data – evaluate
	  – Support HSC resilience and workforce capacity by providing volunteers, employing staff to carry out roles
	  – Measure outcomes
	• Short-term pilots have been the norm
	• Can support people and keep them safe whilst on NHS waiting lists
	
	• Having discussions like these is a good start
	• Pilot projects and getting support to adapt and roll out
	• Acknowledge C&V services that are not funded by Health Service
	• Connectivity with the system – acknowledge the role
	• Help with co-production and community development principles
	• Training on Make Every Contact count eg training to C&V sector in supporting the model
	• There is a cost and can't be done without support of funding model – that's invests in community [??] health and inclusion
	• Greater use of community facilities/assets
	• Concordat in each of the 17 n'hoods
	• Space for VCSE at all the decision making levels – including at leadership levels
	• Equal power distribution
	• Challenge inequality
	• Hold the system to account
	• Proper scoping of what is there would help this.
	• Social care only seen as [reliable?] when helping and VCSE can support by providing information on what is available.
	• We are providing N'hood care eg xxxx for chronic lung conditions reducing GP visits / hospital admissions,
	• Mental health CAMHS/adult care – on the ground in schools and groups reducing need to access Tier 3 or 4 services.
	• VCSE sector are skilled at efficiencies, pivoting, shifting direction at pace. We should be involved in planning and our expertise recognised.
	• Engaging in one conversation after the planning phase isn't co-production

	• Provide leadership and experience of working at community level • Share experiences of partnership working • Apply for funding from Indep Trusts & universities to prove models and provide xxxx to prove best practice • VCSE needs to be valued • Needs funding majority rely on community generosity • Cetter communication knowledge what we can provide • My Client and Encompass needs to be trust by HCP. There seems to be reluctance within the trusts and employees. • The public has more access of community support services in their local community like in pharmacies, schools, churches and able to signpost holistic, alternative therapies that are available to improve health and preventative methods. • Signposting • Compiling lists/directories of services that are live and regularly updated • Co-production • Upgrading integrated care "every second counts" • Happy to support if treated as an equal partner – seat at table for decision making. • Fair funding. • Avoid postcode lottery. • Community transport • Allow us to build it from the grass up, not top down. • We have buildings and services and relationships. • We can play a role in helping people understand the model (health education piece) (as trusted partner in our communities) • If resources, we have lots of great projects that are already aligned with the NM. But we need to be resources, money needs to follow the patient. • Take NM to the people – we have physical spaces. • We know "what matters to you" but we can't deliver on it – fed up being asked. • We are a truster source of info/awareness/relationships. • Reach an be wider together. • Expertise – knowledge of this sector can be different but no less important. • Health more than just clinical. • Its still too GP based and the GPs are too powerful. Every local community can be involved in preventative health and already are. This needs harnessed and funded fully. • Good practice in other areas needs to be embraced by others. • Example Health Check Van based in Northern Trust should or could be regional.

Q3	**What might a Neighbourhood Model mean for VCSE Sector and how you work in future?** The Neighbourhood Model could fundamentally reshape how the VCSE sector operates - bringing both significant opportunities and real challenges **Potential Opportunities** • Greater integration and influence - VCSE could move from being seen as "nice to have" add-ons to core partners in health and care delivery. This means a seat at strategic tables, influencing pathways, and being genuinely embedded in how care is designed and delivered locally. • More collaborative working - The neighbourhood approach could break down silos between different VCSE organisations, encouraging partnerships, shared resources, and collective impact rather than competing for the same funding pots • Sustainable funding models - If done well, this could shift from short-term project grants to longer-term commissioning relationships that recognize VCSE as essential infrastructure, allowing you to plan, invest in staff, and build sustainable services. • Clearer referral pathways - Formalised connections between NHS services and VCSE support could mean more people finding your services at the right time, rather than stumbling across you by chance or in crisis. **Potential Challenges and Risks** • Capacity pressures - Increased demand and expectations without corresponding resources could overwhelm organisations, particularly smaller grassroots groups already running on goodwill and tight budgets. • Bureaucracy - More formal NHS partnerships often mean more reporting, • governance requirements, data protection protocols, and monitoring - potentially drowning smaller organisations in admin they're not resourced for. • Competitive tensions - If neighbourhoods become commissioning units, VCSE organisations might find themselves competing for contracts rather than collaborating, potentially fragmenting the sector.

	• Losing flexibility - The magic of VCSE often lies in responding quickly, Innovatively, and personally to individual needs. NHS contracts can be rigid, prescriptive, and target-driven in ways that constrain this flexibility. • Unequal power dynamics - NHS remains the bigger partner with more resources and formal authority VCSE voices could be tokenistic rather than genuinely influential if partnership structures aren't carefully designed. • Equal voice / equal value • Need to be an integrated part of the care pathway with ability to refer to other services/providers • Shift from "support" partner to "system" partner • Formal partnership frameworks • Shared data, Priorities and accountability • Communication of local needs / issues • Lose model of best practice and create more competitive • Better collaboration • Avoid postcode lottery • Duplicated work • Need sustainability to deliver long-term programmes • Programmes based on health inequality data – need better health data to be able to plan services / invest in the right programmes • Need for an ecosystem of intervention within communities of deprivation • Alignment with wider social, commercial, economic determinants of health • Create multiple entry points and safe places for people to engage • More delivery of HLC programmes (Transform you Trolley, Better Days) • Concern about funding model – will V&C organisations only receive funding to do commissioned work? • Focus on place-based, people-led solutions – Coproduce Neighbourhood Wellbeing Plan – Deliver wrap around support to address social determinants of health • Bridging the gap between people in communities and the NHS • Integrated, MDT delivery – treated as equal professional – Workforce development, shadowing, secondments, career pathways • Prevention, early intervention and common connection – Social prescribing – Community-based hubs delivering training • Commission & Funding Reform • More structures to navigate • Another layer and waste of time and resources • Being asked to attend more meetings with no positive outcomes • Build trust again with population

	• Hard to see at the minute how the public will change. Needs a public information campaign. • Every area needs to have had a comprehensive assessment carried out as to whats available – eg an app and you go on and see whats on in your area. • Core funding is very small - CVS lives on project funding • Collaboration and wider reach. Currently can be fractured and postcode lottery. Impacted by staff changeovers as structure and system in place not right. • Involvement in insight/advisory/oversight and leadership could be from any/all. • Sustainable investment to support 360 health system. • Current hard to reach communities could be easier to reach with collaboration. • Equality • Core funding • Accessibility – local and rural – where people live • Hugely beneficial • It won't change what we do but if funded fairly and over multiple year budgets this would take the focus away from that and on the patient/service user. • Integrated system partnership working as we have been working in this style already. • Could be asier to work together and co-produce with patient groups. • Equity in care. • More meetings/conversations/better use of our resources • Less waiting at ED is hospital/less admissions • More support services being used and community are fully information on what is out there to help them, no matter what illness they encounter. • Better online services and full disclosure of the individual medication information. • Infrastrucuture • Accessibility – P Care • Knowledge of whats available in the areas • Sharing of resources • Financial assistance for VCSE • It might have limited impact on how we work in reality • We are accustomed to working in an agile way • Perhaps better links with statutory sector, better communication, better recognition • Could be a great opportunity for music therapists to be utilised at a local level to provide the specialist care - we can deliver it just hasn't been utilised by HSC Trusts to date! • Data collection of what we are providing is not able to access encompass etc. • Would be great if funding moved from HSC to community.

	• Early intervention/public health working occurs here. • It could even the playing field, allow for recognition of the role and value of the VCSE. • Payment for services provided. • Ability to look at gaps and fund accordingly. • Will there really be any impact on VCSE – or more of just the same? • Why not consider using intermediary funding orgs to manage/distribute the funding? • Shortage of GPs – need shared leadership model. • Mental health implementation eg • Role clarity and get all the relationships right • Patient centred services important and communicate what the universal services are for in the community • Record data and make it available to help decision making – community impact not being captured • Training • Communication – bring it down a level • Is this going to be another talking shop? • The frustrations need to be heard in order to work together in future

	Other comments • How does the structure link to regional priorities • How can an already chronic system do more • Experience of Mental Health strategy - Need to rebuild trust • Maximise skills – commissioning on cost/outcomes • Not currently sustainable – stick with one model for tackling health inequality • Too short-term • VCSE need level of decision making • Need clarification on specific management and accountability • Developing health communities based in Derry and Strabane can support community engagement and alignment with the AIPB. • VCSE already work with Neighbourhood Renewal groups (Clear Project etc.) and are part of the DCSDC Strategic Greater Plan re: interagency collaboration to address the wider determinates of health. • Community Planning model in Councils has been underused - could be part of neighbourhood delivery • Use of Council areas rather than GP Federations for neighbourhood geography footprint? • Neighbourhood Health includes infrastructure, locality, isolation, employment, housing and education • How will the money needed to be put in be identified from Trusts? Can't cut from existing money for V&C sector • Neighbourhood model of care must be neighbourhood-led not just neighbourhood based-working in equal partnership with communities is key to building trust and buy-in to what the model is trying to achieve; and to tapping into the knowledge, skills and strengths present within the community. The model will fail to make a lasting impact in local communities if the health and care system has not invested in building deep trusting relationships with the people who live there; and VCSE organisations are of strategic importance in forging and sustaining those relationships. • Focusing investment and action on early interventions to support people who are at risk of worse experiences and outcomes, including people with multiple long-term health conditions, disabled people and people living in the most deprived areas. • VCSE organisations have expertise in delivering wraparound care and support for people, including the assessment of non-medical needs (clinical settings not always most comfortable/appropriate space for this) and providing or signposting to support for mental health, welfare benefits, housing, transport and so on. This

	is a vital ingredient to the success of the neighbourhood model and only the VCSE sector can bring this to the table. • Role of VCSE sector in promoting whole system collaboration / cross sector partnerships • This new NM is already being delivered by a rang eof partnerships/collectively in consortiums, enable the VCS to lead in the views? of partnership building. • The speed of change is concerning – VCS are used to this but Health Trusts are not able to respond rapidly. They must be forced to change – co-leadership at least. • What about cross border care?? Can there be some consideration of those in rural/ border areas? **Example: Macmillan and Boots** Since 2009 we have worked to provide cancer support for people in their community- a long-standing practical example of the power of neighbourhood care for cancer. Boots provide support via their Boots Macmillan Information Pharmacists, Boots Macmillan Beauty Advisors, and Boots Macmillan Optician Professionals. Not only do they provide easily accessible specialist cancer information and support on living with cancer and side effects to thousands of people on the high street, but some-such as our optician professionals - are also trained to spot symptoms of skin cancer on the face, head, eye and brain cancers. How we work in future-the VCSE sector is a very broad and diverse group of organisations, sometimes also fragmented and historically poor at collaborating, but the neighbourhood model will require working more cohesively with each other. In recent years we have seen a lot of progress on this front (e.g. NI Cancer Charities Coalition set up and going from strength to strength) which offers hope and a good example for deeper partnership working. • Spending power? • What is different from previous iterations? • Timing with elections – is this going to be statutory/law of could it change with changing leadership? • How is public awareness happening? • Cross department work is currently NOT working well eg transport/roads/ infrastructure/ funding to community transport/ not linking in with health. From what groups on the ground see. • Is AIPBs still happening? ICBs – what are they doing? • Functionality of encompass at Nhood level • My friend had an infection on holiday in Spain – she accessed online GP – got a telephone consultation within half an hr, got an e-script of an antibiotic and was

	able to get medication at a 24 hr pharmacy and symptoms sorted within an hour of ringing and didn't need to go to a GP/ED. • NMs are transformative when they are implemented as a grass roots movement, from the ground up. The magic can be lost when these strategies are directed at a policy level from the top down. • Speed of implementation concerns. 17 INT a lot. Going to be done to us not with us. • Big change for Trusts etc – are they ready?! • Greater redistribution. • Care pathway scoping to understand what is out there and where the needs is. • As an AHP profession which is not part of HSC who can we as voluntary providers but also freelance providers be involved? • The speed of implementation is a huge concerns and red flag. We welcome process and change but at this scale it is alarming and I fear its doomed to fail. Will it be done to VCSE rather than with us? • The "politics" involved at 17 neighbourhoods will also be a significant challenge. • The starting level is too high. • Start smaller and grow, take into consideration place based investment in the digital infrastructure and way in which services are delivered/ the Trusts need to be agile. • Needs to be built from grassroots up, not top down. • NHSE model – council role – how will this work? • Prioritisation of services – how will that work (decision making) • Many regional strategies not implemented ie mental health /dementia strategy – how will this link to the regional system and the strategies noted above? • How and when will the population/neighbourhood evidence be acted upon and will the C&V groups be involved in the analysis of responses? • The role of the private sector and in social care/tech digital

SESSION 2

Q1	**What do we (VCSE) need to have in place to deliver the neighbourhood model of care?** **Core capacity and sustainability** • Adequate staffing (not just relying on overstretched volunteers or single points of failure) • Financial reserves and diversified funding to weather transitions • Professional development and training for staff/volunteers on partnership working, data protection, safeguarding • Clear governance structures that can handle more formal NHS relationships while maintaining independence **Systems and processes** • Case management/CRM systems that can track referrals, outcomes, and work alongside NHS systems • Data sharing agreements and GDPR-compliant processes for appropriate information exchange • Quality assurance and evaluation frameworks to demonstrate impact • Safeguarding policies, insurance, and risk management robust enough for integrated care environments • Infrastructure support of departments • Technology functionality – encompass – across all areas • Data , weo we know whats needed **VCSE coordination mechanisms** • Formal or informal networks/alliances so the sector speaks with collective voice • Defined representatives for neighbourhood partnership boards who can genuinely represent diverse organisations • Information sharing between VCSE organisations to avoid duplication and identify gaps (eg Communities of Practice) • Collaborative platforms or regular meetings to coordinate activity **Agreed referral pathways** • Clear processes for how people move between NHS, social care, and VCSE services • Single points of contact or navigation functions so referrers know who to connect people with • Feedback loops so you know outcomes and can learn what works **Shared understanding of roles** • Memoranda of Understanding (MOUs) clarifying who does what • Agreement on thresholds - when does someone need clinical intervention vs VCSE support • Protocols for stepping up/down care as needs change • Direction of how re can support this NM

	Relationships and trust Named NHS and social care contacts who understand and value VCSE contribution • Regular joint meetings at operational and strategic levels • Mutual respect for different organisational cultures, timelines, and constraints • Track record of working together, even informally • We need trust **Co-production mechanisms** • VCSE involvement in designing neighbourhood services, not just delivering them • Community voice feeding into continuous improvement Joint problem-solving when things aren't working **Equitable partnership agreements** • Contracts/grants that cover full costs (including overheads, management, evaluation) • Multi-year funding commitments where possible for sustainability • Payment terms that don't put cash flow pressure on smaller organisations • Recognition that VCSE time in meetings, planning, and coordination needs resourcing • Community based grassroots charities need funded – they rely solely on community funding • Core funding **Physical infrastructure** • Accessible, welcoming spaces for delivering services or hosting clinics/meetings • IT equipment and connectivity for staff, including secure systems for any patient data • Transport or creative solutions for reaching people who can't access central hubs **Workforce** • Sufficient paid staff to deliver consistently (volunteers enhance but shouldn't be the whole model) • Volunteers recruited, trained, supervised, and supported properly with sustainability in mind • Specialist skills (benefits advice, counselling, peer support facilitation) where needed • Cultural competency and language skills matching neighbourhood demographics **Communications capacity** • Ability to reach and engage communities through multiple channels • Marketing/awareness-raising so people know you exist and how to access support • Internal communications keeping teams aligned as work evolves **Community insight**

	• Deep understanding of your neighbourhood's demographics, needs, assets, and barriers • Connections with seldom-heard groups who might not access mainstream services • Ability to gather and articulate community voice for service improvement **Evidence of impact** • Evaluation showing your work makes a difference (qualitative and quantitative) • Case studies and stories that illustrate value beyond numbers • Contribution to population health outcomes that neighbourhood partnerships care about • Shared vision and common purpose – Vision and values statement – Agreed comm for staff on how to mainstay and their roles contribute to "neighbourhood wellbeing" – How do our organisation goals connect to regional mission or PfG • Governance structures to bind statutory/community/independent sectors – MOU? – Data sharing agreements • Outcome based planning – Must measure well being outcomes, not activity levels – Regional Outcomes Dashboard (see We Matter) – Capacity to collect and analyse data on health, housing, social participation and carer wellbeing – SROI – skills required • Integrated workforce and shared learning – Cross sector workforce planning – Shared induction and training modules with HSC staff – Career pathways and professional development opportunities – Staff secondments/mentoring/supervisions • Digital and data infrastructure – Compatible digital systems – Secure storage and sharing of SU data – Digital inclusion for SU and carers – Training for staff • Sustainable and flexible funding – Multi year contracts – Pooled budgets b/w HSC/Council/Community partners • Co-production and community engagement mechanisms – Structure for lived experience voice – Staff trained in community development – Shared feedback loops so lived experience influences commissioning • Anchor role in community – Recognition that partner NOT service contractor – Active participation in local regeneration, housing and employment initiatives

	• Leadership, culture and governance must be strong
	  – Board training in strategic collaboration and system leadership
	  – Invest in values-based culture
	  – Transparent governance structures
	• Local intelligence and evaluation capacity – we evolve based on learning and feedback
	  – Mechanism to share feedback with HSC, Council and funders
	  – Dedicated staff/ training for evaluation and reporting
	  – Skills development – needs analysis, community mapping, research
	
	• Reps on AIPB need to have a leadership role and a plan to communicate with VCSE in our area – this is complicated by having 4 Federations in one AIPB (CDRCN)
	• Resources to allow time away form day jobs to help set up INTs
	• VCSE needs to communicate the range of practical programmes and projects which they can deliver over a year and which they can offer Neighbourhood Model
	• Money/core funding
	• Infrastructure (buildings, staff etc.)
	• Information sharing/structure
	• Right people at the table
	• Resource planning time for anything that needs to be delivered
	• Phased approach/clear timescales
	• Longer term investments – non-recurrent funding is hard to plan long term outcomes
	• If we can work positively during covid, we can continue.
	• Mapping exercises
	• Mapping where services are – but don't take long to do it.
	• Rural proof your model in term of geographic spread and sparsity - needs to be equity of access.
	• Worried about what is driving this – speed of implementation.
	• 17 teams creates a lot of "politics" – how can it build upwards.
	• DfC Concordat/partnership agreement could be utilised.
	• We need trust. Infrastructure support of departments technology functionality encompass across all areas. Data so we know what's needed. Direction of how we can support this NM.

Q2	**What existing resources/capacity can be incorporated into this new model?** • There's substantial resource and capacity across Northern Ireland that could be incorporated: **Existing VCSE Infrastructure Cancer-specific organisations**

	• Cancer Focus NI, Macmillan locally, Marie Curie - established services, trained staff, trusted brands • Local cancer support groups with peer networks, volunteers, and community knowledge • Specialist services already running (counselling, benefits advice, complementary therapies, support groups) • Physical spaces - drop-in centres, charity shops that also serve as community touchpoints • Existing helplines, information resources, and navigation support **Generalist community organisations** • Community centres already hosting health activities • Faith-based organisations with trusted community connections • Carers' organisations supporting cancer carers alongside others • Men's sheds, women's groups, older people's forums where health • conversations happen • Advice centres providing benefits, housing, employment support **Volunteer capacity** • Trained befrienders, drivers, practical helpers already active • Peer supporters who've been through cancer themselves • Community connectors and local champions • Board members and trustees with governance experience **GP practices** • Practice nurses already doing cancer care reviews, monitoring, chronic disease management • Community treatment rooms and consultation spaces • Patient lists and established relationships with registered populations • GP federations and clusters that enable coordination • Social prescribing link workers connecting people to community support **Community pharmacies** • Trusted high-street presence with regular customer contact • Medication management expertise • Private consultation spaces • Potential for health checks, signposting, and early conversations **Allied health professionals** • District nurses visiting people at home • Health visitors with community connections • Physiotherapists, occupational therapists working in community settings **Hospital outreach already happening** • Cancer nurse specialists who bridge hospital and community • Specialist palliative care teams doing home visits • Clinical trials units engaging patients

	Existing clinic spaces • Community hospitals and health centres • Outpatient clinics that might have spare capacity at different times • Mobile units or outreach services **Community infrastructure** • Libraries - trusted spaces with IT access, meeting rooms, community links • Leisure centres offering exercise programs (some already cancer-specific) • Community development workers with neighbourhood knowledge • Day centres and social spaces **Transport schemes** • Community transport organisations • Dial-a-ride services • Council-funded transport for medical appointments • Volunteer driver schemes **Quick Wins to Start** 1. Map what exists - start documenting assets in priority neighbourhoods 2. Create simple directories - Make existing services more visible and accessible 3. Fix obvious gaps - Where existing capacity could easily extend with small investment 4. Connect people who should know each other - Bring together those working in same space 5. Celebrate and learn from what works - Identify bright spots and understand why they succeed • Resources/capacity-profound knowledge of needs in local communities as well as needs specific to particular groups such as rural populations, the elderly, ethnic minorities or the LGBTQ+ community, including existing networks and partnerships (e.g. Macmillan and Rainbow Project) • Data-qualitative insights into patient experience/quality of life • Existing VCSE and their resources Models that are already in place Contacts and comms, links, relationships and trust Map existing VCSE by neighbourhood Embed VCSE partners into Neighbourhood Care Teams Commission VCSE delivery through outcome based contracts • Existing HSC infrastructure Joint training, shared care planning and digital referral systems Co-locate VCSE “community connector” or housing support workers along with GP or social care team • Align Neighbourhood Model with existing community plans and wellbeing outcomes Use existing Council and Partnership staff as local coordinators

	• Develop regional workforce plan linking VCSE and HSC staff development (as per We Matter) • Include carer and peer advocates as recognised members of neighbourhood teams • Link VCSE digital systems with Encompass to enable information sharing and joint are planning • Build digital inclusion and assist technology for SU and carers • Share data into regional outcome dashboard • Healthy Living Centres have: – Physical locations/buildings – Ready-made programmes (Transform your Trolley, Better Days Pain Management, PHA Community Health Staff Teams) – Relationships and contacts and trust on the ground which can be brought to the Neighbourhood Model – One-off investments will be available in some places e.g. DoH funded programme in the South-East to tackle "frequent attenders" at GPs. We have an existing member of staff and facility?? available that can take more pressure off our local GP. • The speed & flexibility we respond with versus funding. Very hard to run services when you're fire fighting for funds annually. Respect?? to put V&C on same footing as private sector who have not been mentioned. Keep local councils out of this – bringing up "sexy topics" instead of responding?? to need. Place based consideration, rural access. • Being done to us not with us • Cross border not mentioned – where to they fit? • Can't be population based. Look at demographic. • Workforce, rural framework, transport. • We don't have existing capacity. This demands a fundamental reset. Funding needs to be attached to this. We need to increase training and workforce capacity. Existing resources/capacity of services, or third sector providers, helplines, mental health support, condition specific physical activity.

	Other comments • Pool existing budgets for shared outcomes across health, community wellbeing and housing • Use VCSE social enterprises and delivery vehicles for local employment and inclusion • Repurpose shared spaces (day centres, GP surgeries, libraries as multi-use wellbeing spaces) • Co-locate MDT stat teams and VCSE in community facilities • Policy/strategy – ensure local implementation plans directly reflect strategies and avoid duplication • Embed statutory duties such as equality, safe guarding and coproduction within Neighbourhood governance • Use existing academic partnerships for evidence gathering and evaluation • Share case studies and impact data through regional VCSE forum • Create contracts for local goods and services that deliver both economic and social value. • Existing resources are already allocated – what can be added if this is starting April 2026? • Data should be available and how/why we are doing this. • We need direction and buy-in to understand how we can help and improve services with this model.

VCSE Participant Survey Results following Neighbourhood Model of Care Workshop

8 Responses received in total – survey was sent to all those listed to attend the 12/11/25 workshop)

- 4/8 respondents intended to submit to the call for evidence
- 2 /8 did not intend to respond
- 2/8 had already submitted responses
- 6/8 would like the deadline for submission extended
- 6/8 would like a follow up session
- 6/8 would like the original agenda to be completed

Those who said no to completing the original agenda stated:

Response 1: *Is it too early to ask questions1 and 2 above or are they too broad? Do you have the right sub-regional mix in the room based on the number of regionally based groups on the list? When will/has the work be done on the mapping of VCSE physical and people assets? Who will or who has done it?*

Whilst this session was very useful, and it was clear that thinking on the model and the principles has moved and scale of the change required to move on was communicated well and is taking shape; there is still more work required on the questions and considerations arising from the open discussion session and those noted in your feedback forms. Maybe use the time at the second workshop to focus on these?

What is the Provider Alliance's remit and function within the context of the whole model? Discuss and clarify the role/s of the VCSE sector at the neighbourhood level? What would help build a stronger foundation for collaboration from the VCSE's perspective with provider alliance partners? How the new HSC funding model will shift from Trusts to the new neighbourhood local level Provider Alliance, based on the size, demographics and needs of the population to keep people healthy in all senses of the word, within their area, for longer.The continued role of elected reps on AIPBs, the connection to Community planning, and governance and accountability mechanisms for decisions on funding and resourcing.

Where will responsibility lie for hospitals and waiting list reductions

The connection between the regional level strategies and HSC priorities and how they will be supported and implemented through the new model.

What would help Communications, visualization of the smaller neighbourhood geographies and what ideas do we have for getting the public and politicians from across the spectrum onboard with the vision.

Response 2: *I believe we need to focus on our own core delivery to the people and communities we serve*

Would you like us to share the agenda questions as a survey ? Yes 5/8 No 3/8

Is there anything else that you would like to see covered at a workshop?

2 comments received:

1. Not sure what question above means - are you thinking that an advance agenda with questions would allow participants to discuss the issues in advance with their org or network? That is a good idea - It would be useful for DOH/ HSC leaders further describe the model and the co-design process for building the the model with the NI Health Collective and other key stakeholders thinking about the most open and collaborative way possible within the time chunks you have available - so that this could be shared too.
2. I think there is also a question of what additional resourcing/capacity is needed

The workshop will need to take place before Christmas. Will you have capacity to attend?

- 6/8 yes 2/8 no

Is your preference online or in person?

- 5/8 either
- 3/8 online

Anything else you think we should be aware of?

1. Unlikely that I'll have capacity to attend in before Christmas but it depends on the date. Happy to engage again early in the New Year at the next iteration, when the questions raised at the workshop are addressed and the results of the stakeholder consultation phase are known and can be shared. This will better support communication within organisations and networks on the proposed model and next steps.
2. Whilst I greatly appreciate the opportunity to participate, nobody backfills our sector and I believe we have given enough energy to this topic this year to date
3. Hopefully be able to attend workshop before Christmas

3 further comments received directly -

Belfast Healthy Cities Feedback – Neighbourhood Model of Care via NI Health Collective

Belfast Healthy Cities welcomes the development of a Neighbourhood Model of Care and the planned establishment of 17 Integrated Neighbourhood Teams (INTs) from April 2026. The principle of providing more care closer to home, reducing pressure on emergency and secondary care, and tackling health inequalities aligns strongly with our ongoing work across Belfast and beyond.

We view this as a positive and timely opportunity to embed person-centred, place-based prevention into the structure of health and social care delivery in Northern Ireland. However, there are several considerations we believe should be addressed in the design and implementation phase.

1. Alignment with existing structures and frameworks

It will be important to ensure that the new INTs complement rather than duplicate the work of Area Integrated Partnership Boards (AIPBs), Community Planning Partnerships, and existing Neighbourhood Renewal and Healthy City initiatives. Clarity on how these governance and coordination layers will interlink is critical to maintain efficiency, avoid confusion at local level, and ensure that community and voluntary sector partners can engage effectively without duplication of effort or reporting burdens.

2. Protecting and integrating the VCSE sector

We note with some concern that Trusts are being asked to find funding within existing budgets. Although we understand the necessity for resource to be identified and that the Trusts could potentially make some savings to enable this, It is vital that the Voluntary, Community and Social Enterprise (VCSE) sector is protected when budgets are reallocated and recognised as a key delivery partner, not a discretionary add-on. VCSE organisations provide trusted access to communities, hold local knowledge, and can act as connectors across services, these are all functions that are central to the neighbourhood model's success. Dedicated and ring-fenced investment in VCSE participation within each INT would ensure the sustainability of this partnership approach.

3. Learning from our local practice

Belfast Healthy Cities' work demonstrates how neighbourhood-level collaboration can deliver tangible outcomes aligned with this model, here are a couple of examples:

· The Care Zone (North Belfast) uses a collaborative approach with statutory and community partners to build community resilience, improve access to health and wellbeing services, and

reduce social isolation through initiatives such as Community Champions, Mobile Health Units, and Health Information Days.

· The Primary Pharmacy Schools Programme, co-produced with the Department of Health and Department of Education, builds children's health literacy from an early age, supporting self-care, appropriate use of community pharmacy and reduced GP demand.

These examples show how place-based partnership working and health literacy interventions can reduce inequalities, increase community participation, and contribute directly to preventative health aims.

4. Broader considerations and international learning

International experience demonstrates that neighbourhood models of care can deliver meaningful improvements when the right enabling conditions are in place. For example, New Zealand's locality-based integrated care teams, established under the Pae Ora reforms, embed community

development, Māori health leadership, and prevention at the heart of service design. Other European cities—such as Copenhagen's neighbourhood health hubs—have strengthened outcomes by aligning funding and accountability around collaboration rather than competition and more locally Manchester's Local Care Organisations have shown how devolved decision-making and strong place-based leadership can integrate health, social care, and community services

Across these international models, we can conclude that neighbourhood working succeeds where:

· Local leadership is empowered, consistent, and supported

· Community development and prevention are core components, not add-ons

· Funding and commissioning mechanisms reward partnership, shared outcomes, and early intervention rather than siloed activity

Northern Ireland can draw on these lessons when developing and strengthening Integrated Neighbourhood Teams (INTs). Embedding a public health, community development, and Healthy Cities approach within each INT—with the flexibility to address the social determinants of health—would align NI's reforms with proven international practice.

Conclusions

The neighbourhood model represents a significant opportunity to rebalance the system towards prevention and local care. If delivered with meaningful VCSE involvement, clear

alignment with existing structures, and a focus on improving health outcomes rather than cost-reduction alone, it can be transformative for communities across Northern Ireland.

Submission provided from Community Rehabilitation Framework Community Rehabilitation Alliance.

Briefing: How the Draft Community Rehabilitation Framework supports the DoH HSC Reset Plan and the Neighbourhood Model of Care

Purpose

To outline how the Draft Community Rehabilitation Framework covering rehabilitation, prehabilitation and reablement provides a practical delivery vehicle for the DOH Reset Plan and how it can be embedded as a core component of the proposed Neighbourhood Model of Care.

Key messages

- The Reset Plan sets a clear direction for a neighbourhood centred system of care, with a stronger focus on prevention and early intervention, more care delivered closer to home, and better integration across primary, community and social care.
- The Draft Community Rehabilitation Framework operationalises this direction by establishing a needs based rehabilitation offer that prevents deconditioning, reduces dependency, improves system flow and mobilises a wide range of partners including the community and voluntary sector, local councils, industry and education alongside statutory services.
- A proposed Rehabilitation Lead and Rehabilitation Network would provide the enabling infrastructure to support standardisation, data collection, workforce planning, innovation and consistent commissioning across Northern Ireland, in line with Reset's ambition to strengthen collaboration without structural upheaval.

1) Alignment with the HSC Reset Plan

The Reset Plan identifies seven priority areas for reform. The Draft Framework aligns closely with each of these:

1. Prevention and seeing the citizen as an asset

The framework supports prevention through prehabilitation, early rehabilitation and reablement, shifting the system towards earlier intervention, self-management and independence, including "Waiting Well" approaches.

2. Investment in primary care, community care and social care

The framework applies across all ages and conditions, physical and mental health, and supports delivery in any setting—home, community or digital—by the full multidisciplinary workforce, reinforcing a community-first, integrated model of care.

3. Effective and efficient use of resources

Rehabilitation is positioned as an investment that reduces avoidable deterioration, hospital use, length of stay and escalating packages of care, helping to protect acute capacity through "right place, right time" interventions.

4. Whole-system workforce and estate optimisation
The framework addresses unwarranted variation and fragmented pathways through a needs-based approach, shared pathways and a system wide rehabilitation network, supporting top-of-licence working and workforce development.
5. Digital and data transformation
It commits to the use of standardised datasets, digital delivery options and inclusive access, supporting demand and capacity planning, outcome measurement and service redesign.
6. Research, innovation and early adoption
The framework promotes an innovation-ready environment through partnerships with industry and academia, underpinned by strong governance, evaluation and quality assurance.
7. Enabling collaborative working and decision making
The recommendation to establish a Rehabilitation Lead and Rehabilitation Network directly supports Reset's intent to create structures that enable collaboration and consistency across the system.

2) Fit with the Neighbourhood Model of Care

The Neighbourhood Model of Care is defined as formal partnerships across GPs and federations, community pharmacy, Trust services, the community and voluntary sector, independent providers, local government and other statutory bodies, with the aim of improving outcomes, access, coordination and sustainability.
Rehabilitation is particularly well suited to neighbourhood delivery because it is:

- Place based, enabling care to be delivered at home, in communities or digitally.
- Integrative, naturally bridging health, social care, VCSE and local government.
- Outcomes-focused, prioritising function, independence and participation.

What "good" looks like in practice
Embedding the framework into neighbourhood delivery would mean a clear, needs based rehabilitation offer that includes:

- Prehabilitation and "Waiting Well" support
- Rapid access community rehabilitation
- Home-first reablement
- Community based continuation through VCSE and councils
- Clear escalation and step-down pathways for specialist rehabilitation

This aligns closely with neighbourhood model objectives, including reduced admissions and ED use, improved outcomes, reduced duplication and stronger community resilience.

3) What the framework enables DoH to do next

A. Make neighbourhood delivery measurable
The framework supports the development of neighbourhood-level metrics, including access and waiting times, functional outcomes, reablement outcomes, readmissions and equity indicators.

B. Establish enabling infrastructure
The proposed Northern Ireland Rehabilitation Lead and Rehabilitation Network provide the leadership and governance required to scale neighbourhood rehabilitation consistently.
C. Mobilise formal neighbourhood partnerships
The framework aligns directly with the neighbourhood partnership model and could be used as an early, tangible workstream to support neighbourhood implementation.

Tom Sullivan, Public Affairs & Policy Manager CSPNI
Chartered Society of Physiotherapy NI

Mental Health Services VCSE - Response from participant at VCSE workshop
Thanks for hosting the meeting, it was great to hear from the voices across our sector. I have significant reservations regarding the consultation process given the lack of detail around a model that has been given a go-live date of March. It seems the DoH have decided that the neighbourhoods will be formed around the GP federation structures, concerning given the lack of consistency and infrastructure across the region. The DoH have provided no depth to the approach or explanation of how they plan to link regional strategy, KPI's and approaches within this new model. Is the proposal to put more people into existing structures to work more collaboratively? I would question what they are paying the existing structures for, if they cannot work together in a small region to motivate change, I am unsure how this will add benefit.

As stated, we watched the DoH close wards and beds telling us we needed to move care into the community, only for the community services to be cut or badly resourced!! This has caused significant pressures inside community care with limited to no resources to 'bridge the gap'. I have also watched the train crash that is the Mental Health Strategy unfold, with the plan for regional mental health services, collaborative boards etc fail to deliver much progress / transformation. The fact remains that tough decisions need to be made around Health, with no political will or DoH leadership calling for serious conversations around transformation. If this is the vehicle for some change, I feel we need more than a few slides to fully explain the vision of this plan and detail of how it is going to be implemented to mobilise and maximise community assets.