NI Health Collective: Reflections on AIPB Updates and VCSE Experience

1. Context

VCSE members welcomed the recent update on Area Integrated Partnership Boards (AIPBs). However, concerns remain about representation, awareness, and the ability of AIPBs to deliver meaningful change within a system still heavily weighted toward a medical model. Members also highlighted the need to place services directly in communities most affected by health inequalities.

2. Key Reflections from VCSE Members

Representation & Inclusion

At the CMO & CNO "Big Discussion," 170 participants attended, yet only one was from the VCSE sector.

Over 7,000 VCSE organisations exist in NI, but representation is limited and often dominated by the loudest voices.

Service users and carers are engaged for long periods (up to 18 months) without remuneration, raising equity concerns.

Awareness & Engagement

Low or limited awareness of AIPBs among VCSE organisations, especially new staff.

Engagement often depends on existing networks; those outside these circles remain detached.

Multiple alliances and policy bodies already exist; this can create duplication and confusion – could be streamlined/ further clarification – NIHC can assist with this.

Model & Focus

Concerns that AIPBs operate within a strictly medical model, overlooking wider determinants of health.

80% of health outcomes are shaped by social determinants, yet only 20% are directly healthcare related – need to look at a biopsychosocial model of health

Current focus areas (mental health, CVD, frailty, respiratory, cancer) risk a lack of focus on the causes of causes – social determinants.

Calls to replace "frailty" with a focus on "years lived well."

Trust & Accountability

Trust-building across the sector and across sectors is essential – can NIHC help with this?

Transparency in decision-making and clarity on what is open for discussion is required – in AIPB and other Reset workstreams.

Accountability for delivery remains unclear, particularly across Departments.

Fear that engagement may not lead to tangible outcomes without long-term buy-in.

Outcomes & Impact

Members want clarity on what outcomes will be achieved and what constitutes "reasonable outcomes." Especially for 1-year plans for AIPBs with a remit of prevention and early intervention.

Need for measurable impact, aligned agendas, and evidence-led approaches to reduced health inequalities.

Concerns about resources: time-poor organisations cannot compromise on their delivery commitments which may subsequently impact on their capacity to fully engage in planning processes - is there a role for NIHC here?

3. Opportunities to Strengthen VCSE Influence

Transparency & Accountability

Clear processes for decision-making and accountability mechanisms must be established.

Open dialogue on priorities and legislative implications is critical.

What is the timeline for shadow operations for AIPBs?

Representation & Remuneration

Ensure broad VCSE representation across conditions and communities.

Provide remuneration for VCSE members, service users, and carers contributing to AIPBs.

Communication & Structures

Maximise existing structures such as NI Health Collective, CO3, RSNs, HLCA, and NICON to disseminate information and support communication.

Use multiple communication methods, including online and hybrid formats, to widen participation – communication should be two-way, feedback is critical especially if involving communities. NIHC could act as a conduit to gather feedback from the sector and share information both ways.

Integration & Prevention

Align agendas across alliances and policy bodies to reduce duplication m- function of NIHC to support this collaboration.

Embed VCSE expertise in patient pathways, particularly for long-term conditions (70% of acute hospital beds).

Shift focus towards prevention and social determinants of health, including commercial determinants referenced in IPH All Ireland Conference 2025.

Evidence & Innovation

Define "what good looks like" in terms of outcomes.

Use practice-based evidence across NI to highlight effective models from VCSE sector

Build cross sectoral organisational memory and confidence in what works well.

Explore AI-driven approaches to strengthen collaboration and data-led decision-making.

4. Additional Suggestions from VCSE Members

Place services in communities that need them most.

Hold a focused day on AIPBs to deepen understanding and engagement – NIHC.

Develop a 'community' plan aligned with AIPB priorities

Provide support for VCSE representatives to strengthen their role – NIHC is ideally placed to do this.

HSCNI Reset discussions should ensure a focus on implementation and making progress.

Promote practice-based evidence and case studies to demonstrate impact.

Build confidence in the VCSE and across sectors by showcasing what is working well.

5. Key Questions Raised

Is the Neighbourhood Model of Care consistent with the original AIPB model under ICSNI?

What is the appropriate size of a neighbourhood—should the most disadvantaged areas be prioritised first?

Are GPs fully bought in to the AIPB model?

Can a well-evaluated case study from a geographical postcode be shared to demonstrate successful change?

Recommendations

Formalise VCSE Representation: NIHC is ideally placed to support the collaborative input from VCSE but specifically advocating for strategic partnerships with VCSE members across all HSC NI Reset, AIPB and associated workstreams.

Remuneration Framework: Introduce fair compensation for service users, carers, and VCSE representatives.

Communication Strategy: Develop a coordinated approach for AIPBs but specifically within the VCSE sector using NIHC as a conduit linking with existing networks on a 'Forum of forum' basis to promote awareness and two-way communication.

Outcome Framework: Establish measurable community outcomes, aligned with prevention, health including wellbeing and reducing health inequalities.

Cross-Departmental Commitment: Secure long-term buy-in and accountability across government departments.

Evidence-Led Focus: Prioritise health inequalities and social determinants of health in all AIPB plans.

Neighbourhood Clarity: Define neighbourhood boundaries and prioritise disadvantaged communities.

Case Study Development: Commission and share evaluated examples of change to build confidence and learning.

7. Conclusion

The VCSE sector is a critical partner in delivering health and wellbeing outcomes across Northern Ireland and reducing health inequalities. For AIPBs to succeed, they must move beyond a medical model, embrace prevention, and fully integrate VCSE expertise. Transparency, accountability, and measurable impact are essential to build trust and ensure that engagement translates into meaningful change.

Report prepared by:

Gilllian Lewis

Head of Northern Ireland Health Collective

Appendix 1 – Collated feedback from CO3 Special Interest Group with NI Health Collective (NIHC) focused session on Area Integrated Partnership Boards (AIPB) held on 23rd September 2025.

Reflections on the AIPB updates and experience of VCSE members

- Good to have the update
- But – CMO & CNO 'Big Discussion' 170 people from stats and GP Fed, PC and 1 person from VCSE, 7/8 workstreams – big concerns how realistic this is in a strictly medical model
- Low awareness of the AIPB or limited awareness
- 80% of issues need to be addressed (ie 20% due to healthcare in terms of impact on health)
- If you are in the know in networks VCSE you will be involved many are not, new staff particularly out of the loop.
- Different alliances /groups/policy bodies out there already
- Agenda of AIPBs – CVS over each other – how are communicating areas, some have funding,
- How are we aligning agendas with each other
- Trust building needs to be done in the sector
- Well over 7000 CVS sector in NI how are they represented them all
- Loudest voice always at the front
- Service user and carer - data shows …how are the priorities being set
- Opening dialogue is important – people want to see the process for decision making
- What community outcomes are going to be achieved?
- What are reasonable outcomes
- Any legislative changes as a result?
- Big fear – spend all time with NMC and it doesn't go anywhere, need long term buy in.
- Service user and carers sit for 18 months on groups/engage in process and not compensated remuneration service user /carers for involvement in it
- **Who is held to account for delivery on this?**
- Cross department commitment and decision making?
- How is the 80-20% translating across departments
- How do AIPBs effect change – plans will be costed by AIPBs and SPPG – could be a mix of money
- How did AIPBs arrive at a focus
- Each given 5 areas to chose from based on regional needs assessment By PHA – mental health, CVD, Fraility, respiratory and cancer

- Age profile/ succession
-

How can we best support the VCSE members to maximize the influence of VCSE sector within AIPBs and other existing and emerging structures within HSC?

- **Transparency** – what is open for discussion
- **Accountability**
- **Measurable impact**
- **Communication – use structures we already have such as NIHC, CO3**
- **Renumeration for VCSE and carers**
- What structures are already there – maximise the NI Health Collective
- Representation – are all represented, many different conditions
- AIPBs – how individual charities engage and get their voices heard
- Attending things like this session
- NICON
- RSNs, HLCA, NIHC – multiple methods of spreading the word is needed
- We all have individual responsibility to get involved and find out – join networks
- Patient pathway is key – long term conditions take up 70% acute hospital beds – patient pathways need to be co-ordinated with VCSE to 'shift left' to get into the prevention space
- Joint planning and performance teams covering LTCS etc
- Explore 'what good looks like?'
- Sometimes we know what works but limited linked social capital
- Time poor – don't compromise on delivery
- What can we do online/hybrid
- Who's box am I ticking?
- Think outside the box /get rid of the box
- Led by data and evidence to focus on health inequalities
- Discussion focused on the 'burning platform' especially around access to immediate and urgent care- Where can we make the ultimate difference
- Replace frailty with focus on years lived well.
- No point in considering addressing conditions unless looking at causes of the causes – need to effect change on SDOH – Reference to commercial determinants of health and the role of legislation.
- Need to place services in communities that need them

How can we maximize the current structures to promote collaboration across VCSE?

- Focused day on AIPBs
- Community plan

- Summary into NIHC – use as a conduit to ask for feedback from sector
- Support for VCSE reps
- Reset – change but having the same conversations
- AI Driven
- Conduit to share information both ways
- Organisational memory
- Practice based evidence across NI
- Build the confidence of what is good in the sector

Questions/Suggestions

1. Is Neighbourhood Model of Care the version in the original AIPB model (ICSNI)
2. The size of neighbourhood needs clarity, should it be the most disadvantaged to start with?
3. Are GPs bought in?
4. Well evaluated example of change – case study from geographical postcode.