Neighbourhood health

A framework to provide assurance of VCFSE involvement in emerging delivery models and services

Introduction

This paper proposes domains and supporting key lines of enquiry (KLOEs) to assess how effectively neighbourhood health (NH) models and services involve the voluntary, community, faith and social enterprise (VCFSE) sector.

These domains and KLOEs are intended to provide an assurance framework for commissioners, system leaders and VCFSEs alike, as to the level of the sector's involvement in this priority area of work.

Proposed domains and KLOEs are informed by local and regional intelligence on VCFSE involvement in neighbourhood health over the past 12 months. This includes learnings from our recent webinar with VCFSE partners from St Helens and Sefton, who are amongst the first 43 pioneers in the national neighbourhood health implementation programme.[1]

Domains to gauge VCFSE involvement

1	Strategic recognition & governance
2	Resourcing and sustainability
3	Embedded in delivery (MDTs and INTs)
4	Co-production and community voice
5	Data, insight and intelligence
6	Prevention, early intervention and continuity
7	System alignment and use of existing assets

These suggested overarching areas of focus are supported by the following supporting draft KLOEs, aimed at testing and measuring VCFSE involvement within those domains.

[1] You can watch the C&M pioneers webinar and read a post-event briefing on the VSNW website.

KLOEs to gauge VCFSE involvement

Domain 1. Strategic recognition & governance

1.1	Is the VCFSE sector formally recognised as a core partner within NH strategies and delivery models?
1.2	Are Local Infrastructure Organisations (LIOs) represented in Place and neighbourhood governance forums with influence over decisions?
1.3	Are roles, responsibilities and decision-making rights of VCFSE partners clearly defined and understood?
1.4	Is there senior system sponsorship for VCFSE involvement in NH?

Domain 2. Resourcing and sustainability

2.1	Is VCFSE participation in NH models adequately resourced, including funding for coordination, infrastructure, engagement time and the real costs of co-design and co-delivery?
2.2	Do commissioning and funding approaches support continuity and sustainability of VCFSE involvement, rather than short-term, fragmented or pilot-only engagement?

Domain 3. Embedded in delivery (MDTs and INTs)

3.1	To what extent are VCFSE partners embedded within place-based multi-disciplinary teams (MDTs) and integrated neighbourhood teams (INTs), beyond acting solely as referral destinations?
3.2	What evidence is there of genuine co-delivery of services with the VCFSE sector?
3.3	Do co-delivery models include shared leadership, co-location, daily huddles, joint case discussions?
3.4	Are the distinct but complementary roles of VCFSE organisations in addressing non-clinical needs and sustaining engagement clearly understood and utilised within NH teams?

Domain 4. Co-production and community voice

4.1	Are NH models and pathways co-designed with VCFSE partners and local communities from the outset, rather than consulted on retrospectively?
4.2	What mechanisms are in place to systematically capture, amplify and act on community voice and lived experience (e.g. alliances, insight tools, hackathons)?
4.3	Is there demonstrable feedback to communities and VCFSE partners showing how their input has influenced NH design and delivery?

Domain 5. Data, insight and intelligence

1.1	Do VCFSE LIOs have equitable access to population health management data to support neighbourhood planning and sector development?
1.2	How effectively is VCFSE local intelligence combined with system data to identify unmet need, target interventions and address health inequalities?
1.3	Are there consistent approaches to capturing and using VCFSE activity and outcomes data alongside health system data at place and neighbourhood level?

Domain 6. Prevention, early intervention and continuity

2.1	To what extent do NH models make purposeful use of VCFSE organisations to deliver prevention and early intervention activity that addresses wider determinants of health?
2.2	Is continuity of support over time built into NH pathways, with VCFSE partners playing a recognised role in maintaining trusted relationships and preventing people from falling through gaps?

Domain 7. System alignment and use of existing assets

3.1	Are existing VCFSE services, networks and social prescribing infrastructure actively mapped, valued and built into NH models?
3.2	Is place-based VCFSE infrastructure used to coordinate engagement across neighbourhoods, reduce duplication and support consistent, scalable NH delivery?
3.3	Are roles, pathways and expectations between statutory services and the VCFSE sector clear, standardised where appropriate, and free from unnecessary bureaucracy?

An assurance framework for VCFSE involvement in NH

Appendix 1 suggests the practical application of these KLOEs as part of an assurance framework (page4).

Appendix 1 – An assurance framework mapping VCFSE neighbourhood health KLOEs against national expectations – identifying example evidence and possible risks

The following table maps our proposed VCFSE NH involvement domains and supporting KLOEs against broad national requirements of the neighbourhood health programme, as well as suggesting risks where the sector is not embedded in NH models and services.

Domain (and supporting KLOEs)		National NH programme expectations	Example evidence	Risk if not met
1	**Strategic recognition & governance**	Neighbourhood Health is place led and partnership based, with the VCFSE sector recognised as a core partner in strategy, governance and delivery, not an adjunct.	• NH strategies and operating models explicitly referencing VCFSE roles • VCFSE/LIO representation on place and NH governance forums • Partnership agreements, compacts or MOUs • Decision records evidencing VCFSE influence	• VCFSE treated as peripheral rather than integral • Weak place accountability for NH delivery • Decisions taken without community insight
2	**Resourcing & sustainability**	Resourcing & sustainability NH models are sustainably resourced, including funding for partnership working, coordination and infrastructure required to enable effective VCFSE involvement.	• Recurrent or multi-year funding for VCFSE infrastructure and coordination • Commissioning / grant agreements covering engagement and delivery costs • Clear investment decisions supporting NH delivery	• Short-term or fragile NH delivery • VCFSE withdrawal due to under resourcing • Over reliance on goodwill and pilots
3	**Embedded in delivery (MDTs and INTs)**	MDTs and INTs are genuinely multi-agency, embedding VCFSE partners as equal contributors to neighbourhood level care and support.	• MDT/INT membership lists including VCFSE partners • Defined VCFSE roles within team models • Evidence of co-location, joint working or shared leadership • Evidence of genuine co-delivery, such as case studies	• Fragmented care and duplication • VCFSE limited to referral routes only • Reduced effectiveness of neighbourhood teams

Domain (and supporting KLOEs)		National NH programme expectations	Example evidence	Risk if not met
4	**Co-production & community voice**	Neighbourhood Health is place led and partnership based, with the VCFSE sector recognised as a core partner in strategy, governance and delivery, not an adjunct.	• NH strategies and operating models explicitly referencing VCFSE roles • VCFSE/LIO representation on place and NH governance forums • Partnership agreements, compacts or MOUs • Decision records evidencing VCFSE influence	• VCFSE treated as peripheral rather than integral • Weak place accountability for NH delivery • Decisions taken without community insight
5	**Data, insight & intelligence**	Resourcing & sustainability NH models are sustainably resourced, including funding for partnership working, coordination and infrastructure required to enable effective VCFSE involvement.	• Recurrent or multi-year funding for VCFSE infrastructure and coordination • Commissioning / grant agreements covering engagement and delivery costs • Clear investment decisions supporting NH delivery	• Short-term or fragile NH delivery • VCFSE withdrawal due to under resourcing • Over reliance on goodwill and pilots
6	**Prevention, early intervention & continuity**	MDTs and INTs are genuinely multi-agency, embedding VCFSE partners as equal contributors to neighbourhood level care and support.	• MDT/INT membership lists including VCFSE partners • Defined VCFSE roles within team models • Evidence of co-location, joint working or shared leadership • Evidence of genuine co-delivery, such as case studies	• Fragmented care and duplication • VCFSE limited to referral routes only • Reduced effectiveness of neighbourhood teams
7	**System alignment & use of existing assets**	NH builds on existing VCFSE services, networks and infrastructure, reducing duplication and ensuring consistent delivery across neighbourhoods.	• Asset mapping of VCFSE services and networks • Alignment with social prescribing and community pathways • Use of place based VCFSE infrastructure to coordinate delivery • Simplified, standardised processes	• Duplication and inefficiency • Inconsistent NH delivery between neighbourhoods • Missed opportunities to scale impact