Paper B

North East Neighbourhood Plan 2023-2028

SHEFFIELD HEALTH AND CARE PARTNERSHIP BOARD

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Author(s)	Lucy Ettridge, Deputy Director for Community Development and Inclusion (ICB)
Sponsor	Emma Latimer, Executive Place Director for Sheffield (ICB)

Purpose of Paper

To set out a plan for a model neighbourhood and for approval.

The plan is the outcome of months of close partnership working in north east with leaders from VCS, VAS, the NHS and the council. Partners have come together via the Community Development and Inclusion Delivery Group (as part of HCP), which is chaired by Dr Leigh Sorsbie, Clinical Director for Health Inequalities.

Key Issues

This paper sets a programme of work to help tackle health inequalities using a ringfenced budget for health inequalities with the priority for the funding being neighbourhood work in the north east of the city. It sets out a new way of working for the NHS, with investment into communities rather than services to effect long-term change in people's lives.

There's strong evidence that the answers to better health lie outside the health care system, with the VCS playing a pivotal role in our communities both delivering services directly but also critically important in developing long term social capital.

We will be ambitious in our approach to support these communities, by embedding a model of community development, which empowers local communities. We know those who are disconnected and disempowered have worse health; conversely, those who are connected and empowered have better health outcomes. This approach is about tackling the wider determinants of health, creating health and wellbeing rather than providing health care.

This plan complements and connects to lots of great work in the city on neighbourhood working and health inequalities. The funding and plan aren't a silver bullet for entrenched inequalities but via thorough evaluation, we hope to present a case for the approach for ongoing investment to scale up the work and deliver in communities citywide.

This isn't a one year programme; it'll be a multi-layered complex piece of work to create health and help improve people's lives -we hope to embed this approach for the long term due to the scale of the challenge. Impacts will only be fully realised over years, if not decades. We want to change Sheffield, one neighbourhood at a time.

Is your report for Approval/Consideration/Noting

Sheffield Health and Care Partnership Board is asked to approve the report.

Recommendations/Action Required by the Sheffield Health and Care Partnership Board

It is recommended that the board:

- Note the report
- Approve the plan

What assurance does this report provide to the Sheffield Health and Care Partnership Board in relations to the ambitions of the Health and Wellbeing Strategy 2019-2024	
	Please ✓
Every child achieves a level of development in their early year for the best start in life	
Every child is included in their education and can access their local school	
Every child and young person has a successful transition to independence	
Everyone has access to a home that supports their health	
Everyone has a fulfilling occupation and the resources to support their needs	
Everyone can safely walk or cycle in their local area regardless of age or ability	
Everyone has equitable access to care and support shaped around them	
Everyone has the level of meaningful social contact that they want	
Everyone lives the end of their life with dignity in the place of their choice	

Are there any Resource Implications (including Financial, Staffing etc)?
Budget of £800k which is from ICB's ringfenced budget for health inequalities.
Have you carried out an Equality Impact Assessment and is it attached?
Please attach if completed. Please explain if not, why not. EIA will be completed during stage four of the plan.
Have you involved patients, carers and the public in the preparation of the report?
Engagement findings, particularly ICB's new health centre consultation helped inform the decisions on where in the NE. specific engagement and co-production are included as part of the plan.

North East Neighbourhood Plan 2023-2028

1. Introduction and background

Sheffield Health and Care Partnership has highlighted the key priority of reducing health inequalities and improving population health, aligning our work with the development of the South Yorkshire Integrated Care Strategy and the Sheffield Joint Health and Wellbeing Strategy. Health Inequalities are differences experienced across the population and between different groups within society. They are a combination of factors that contribute to an individual's experience including where we are born, grow, live, work and age. Targeting interventions based on need is fundamental to tackling health inequalities.

This paper sets a programme of work to help tackle health inequalities using a ringfenced budget for health inequalities with the priority being neighbourhood work in the north east of the city. There's lots of other work going on in the city and HCP on tackling health inequalities and neighbourhood working including a system approach to neighbourhood working, refresh of health and wellbeing strategy, collaborating for Health work, and reforming of public services. This programme complements and connects to the other work.

This isn't a one year programme; it'll be a multi-layered complex piece of work to create health and help improve people's lives -we hope to embed this approach for the long term due to the scale of the challenge. Impacts will only be fully realised over years, if not decades. We want to change Sheffield, one neighbourhood at a time.

The HCP Board is asked to approve the plan.

2. Aims and objectives

Our ambition is to empower communities in north east of Sheffield to live happier and healthier lives.

We have three key aims:

- To connect people to each other in their communities
- To build community capacity of individuals and neighbourhoods to help them address issues that are important to them
- To devolve power to communities.

We'll meet the aims by delivering these objectives:

- Communities will produce their own plans
- Make long term, sustainable investments in communities via the VCS
- Improve opportunities for people to connect and contribute to their local area
- Coordinate work of partners in NE to maximise impact
- People can influence decisions that affect their neighbourhood via participatory budgeting
- Ensure we make the best use of local infrastructure to improve connection to people in the community
- Enhance the skills, knowledge and resources of local people to improve their communities and own lives
- Pilot a new relational model for a small number of families experiencing disadvantage.

3. Case for change

Sheffield has high levels of inequality and deprivation in the city, with disempowered and disconnected communities. The north east of the city has very high levels of deprivation, this is impacting on life expectancy, healthy life expectancy, skill-level and the overall health and wellbeing of our communities. This area also has many people who live in multi-occupation

households, are digitally excluded, experience fuel poverty and food insecurity. The north east also has poor education attainment, high unemployment and high crime rates.

Communities in the north east are big users of public services, many with complex needs and lives, yet have little say, if any, or control over decisions that affect them. Public sector services are designed around the needs of the system, not communities. Very few people would argue this paternalism is working.
The voluntary and community sector is on its knees, suffering huge demands and managing more complex caseloads than before, yet their funding is short-term funding and unsustainable. The health and care system is also overwhelmed and understaffed.

The answers to better health lie outside the health care system with the VCS playing a pivotal role in our communities both delivering services directly but also critically important in developing long term social capital.

While the driver for this work is to improve people's lives, rather than health in the most traditional sense we know that having connected and empowered communities, will over time create health and help the health and care system to cope. Disconnection and loneliness negatively impacts health:

- Loneliness and social isolation have been linked to a 30% increase in the risk of having a stroke or coronary artery disease (British Medical Journal – Heart)
- Loneliness is associated with a 40% increased risk of dementia (Loneliness and the Risk of Dementia Pub: OUP)
- Loneliness, social isolation, and living alone have all been associated with an increased risk of premature death.

The Race Equality Commission on racism and racial inequalities in Sheffield published a report in July 2021. To help become an anti-racist city, one of the many recommendations is for the NHS "reconsider the balance of health funding for prevention and treatment services, disproportionate investment including in community capacity and infrastructure building". This plan aims to address some of the longstanding, historic imbalances in funding where ethnic minority groups have missed out.

Despite the challenges, the north east communities are committed and proud of the area. We have a great, vibrant voluntary and community sector, and innovative PCN. We have hundreds of assets to build on, enabling us to approach an asset based approach to our work.

4. Building a model neighbourhood across north east Sheffield

One of our big five priorities for Sheffield in 2023/24 is to build a model neighbourhood across north east Sheffield, the area with the greatest needs and deprivation. This is our way of focusing on the 'Core20' part of Core20Plus5. Our 'plus' areas will be inclusion health (refugees/asylum seekers, those experiencing homelessness), and people from ethnic minority communities.

We will be ambitious in our approach to support these communities, by embedding a model of community development, which empowers local communities. We know those who are disconnected and disempowered have worse health; conversely, those who are connected and empowered have better health outcomes. This approach is about tackling the wider determinants of health, creating health and wellbeing rather than providing health care.

We won't be setting the priorities or identifying the solutions, we'll be investing in communities and using asset-based community development approaches so local residents can come up with the solutions to their problems. All evidence points to successful

sustainable change happening at a grassroots level and we will facilitate that to happen. Areas that have successfully improved the health and lives of their populations through similar approaches include Wigan (part of the Wigan Deal), Leeds Neighbourhood Networks, and East Ayrshire's 'Vibrant Communities.'

The New Local report, Community Power: The Evidence (2002), sets out three main benefits of our proposed approach to empower communities:

- Enables public services, their workforces and users to operate in a more preventative and less acute response-driven way
- Improves personal health and well-being making ill-health less likely to emerge
- Improves the resilience and collective well-being of local communities directly improving the social determinants of health.

Our focus is to work with the VCS and for them to lead the change alongside their communities and give appropriate funding so they can scale up what they do around health creation and early intervention. We'll help better connect the statutory sector to each other, the statutory sector to VCS, VCS to communities, and people within communities to each other.

5. Where in the north east?

The north east is a big area so we are taking a funnelling approach. Starting with the Northeast we have selected Foundry Primary Care Network (PCN) the network with the largest number of people living in the top 20% of most deprived communities and the largest number of people from an ethnic minority background. Within the PCN, four of the middle super output areas are in the 10% most deprived areas nationally for deprivation and communities experience a range of poor health outcomes.

These are:

Area	Pop size	No. ethnic minority pop
Burngreave and Grimesthorpe (includes Pitsmoor)	12,363	10,187
Firth Park	8,166	4,516
Crabtree and Fir Vale (includes Page Hall)	9,253	7,430
Southey Green East	7,910	1,835
Total	37,692	23,968

All but Southey Green East has the majority of people from an ethnic minority background, it is traditionally a white working-class area. The first three areas have a diverse, younger population with many different ethnicities. Crabtree and Fir Vale and Firth Park have large Roma populations who experience very poor health outcomes and life expectancy, live in very poor standard accommodation which is often multiple occupancy with reports of 20-30 people living a two-up two-down terrace houses and children sharing beds.

They have many refugees and asylum seekers, with many new communities migrating to Sheffield, so there aren't settled groups they can connect to.

Southey Green East has several large council housing estates, with an older population than the other areas. The area has fewer assets and poorer community infrastructure than the other areas.

6. Our principles

Sheffield's principles which will be the framework for our work are:

- Shift power to communities
- Place the public at the heart of the work
- Target resources to where needs are greatest
- Focus on what's strong and local, not what's wrong and external
- Readdress the imbalance in funding for black, minority ethnic communities
- Work alongside communities on identifying needs and solutions
- Plans will be community led and community focused, not system led
- Investment into the VCS promotes partnership working, and is long-term, sustainable, flexible, and accessible
- Non-medical model based on relationships and connections, not services
- Be inclusive and recognise communities of interest alongside neighbourhoods
- All partners will work together to maximise opportunities for extra investment
- Improve coordination of work between local organisations and different parts of the same organisation
- Work will be evidence based
- Share good practice locally and wider
- Monitor long-term impact on the system and communities via stories, not inputs or outputs.

7. What do we mean by empowered communities?

The WHO says, "community empowerment necessarily addresses the social, cultural, political and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions".

Imagine in five years, that we have happier and healthier populations, who are better connected, feel a sense of belonging, and work together to bring about change. Local people have stronger relationships and a network of people who support and look out for each other. We have a robust community infrastructure that will help attract investment into the north east and Sheffield. People employed in meaningful work or volunteering. We have a well-funded VCS that thrives, is self-sufficient and less reliant on public funding. We have the public less reliant on public institutions and services, who actively have a right and say on what matters to them and their community.

The pandemic highlighted the importance of communities. People united to support one another with mutual aid – helping with food and prescriptions. Some people called on elderly neighbours to see if they were ok and others hosted quiz nights on Zoom. This helped people's mental health and their physical health and protected the NHS. We want to build on this, make communities more resilient and form a sense of belonging and solidarity in ordinary times.

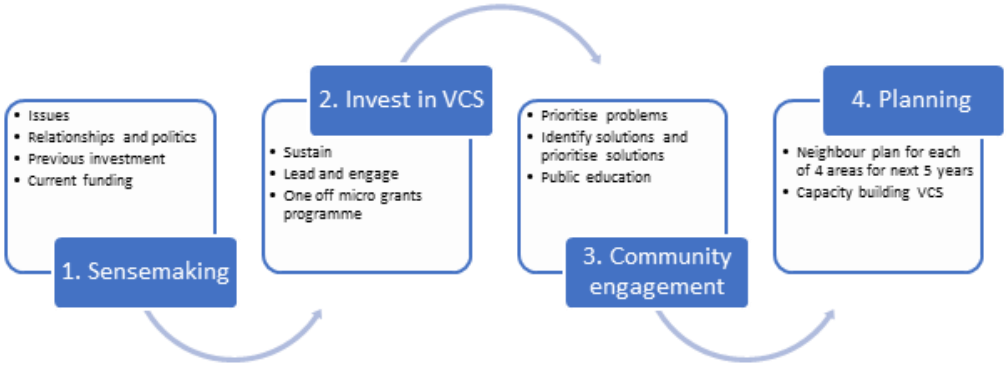
8. Phased plan

In the following section, the different phases of the plan over five years is detailed. Some of the phases will overlap and be continual.

The investment will be to change people's lives in several areas, including:

- Wellbeing
- Voice and participation
- Employment and volunteering
- Environment
- Collaboration
- Community cohesion
- Self-determination

Year one



1. Phase one - Sense making (September to December)

We'll carry out sensemaking in each of the four areas. The challenges facing the areas are complex and before we can make detailed plans on what each area needs, or level of investment, we need a full understanding of the history of the neighbourhoods and their communities, understand key organisations, relationships, demographic changes, current funding and past funding, and learning from past investments and schemes.

This work has already started with interviews, research and asset mapping but as it's a large piece of work, we will commission a third party to support VCS leaders and to facilitate discussions and produce a report.

The sensemaking also includes working with Citizen Network to develop a network map for the whole of Sheffield, identify key people and assets. There are 142 neighbourhoods in the city. We will start with the neighbourhoods in the north east.

2. Phase two - Invest in VCS (October to March)

The north east has a diverse, strong VCS. The sector has expertise and involvement with all communities and are vital system partners in this work. This phase will have the greatest investment.

However, the VCS has been poorly funded or funded unsustainably for over a decade now. This lack of funding is undermining the capacity of VCS organisations to improve the social determinants of health, and the cost of living crisis, exacerbates this. Before the transformation can happen, we need to help build the foundations by helping to sustain key VCS organisations in the north east. We will do this via direct awards and small grants. The funding will be for one year, with a commitment to long-term funding in years 2-5 following the sensemaking and production of area plans.

As well as helping to sustain organisations, we plan to fund at least four place based VCS organisations to lead and steer the model neighbourhood work in their communities, including sensemaking, time for their staff to commit and collaborate, capacity building, and funding the engagement. We will fund other VCS representing communities of interest to engage communities and deliver work on the ground. We will also award dozens of small grants to organisations that can start connecting people such as money for dance classes or gardening tools.

We will co-produce plans with multi-agency partners, examples of how the money will be invested:

- Core funding grants of £30-50k
- Funding for community workers at £27k per worker (includes oncosts)

- Small grants of less than £10k
- Microgrants of less than £2k.

Albeit small, the grants may have a big impact on people's lives. Take, for example, Hani, a Somali woman who lives alone in Burngreave. She's socially isolated which is affecting her mental health. She loves to sew but doesn't have the money for a sewing machine or material. Hani would like to form a sewing group of like minded women, to form friendships and make culturally appropriate clothes for women in Burngreave. Not only could it help improve her loneliness and mental health, but it may also reduce her chances of getting CVD, dementia and early death. The mutual aid may help women who can't afford to buy dresses. Perhaps, with the right support it might build into an enterprise taking Hani and other women out of poverty.

3. Phase three - Community engagement (January to March)

This plan isn't about improving NHS targets or prioritising what's important to the system, it's about improving people's lives - the people know what's important to them, and with the right support and environment, know how to solve their own problems.

The approach will be multifaceted and tailored to audiences to reach as many people as possible in the four areas. The methods will include deliberative workshops and focus groups, interviews, and surveys. All the engagement will be culturally appropriate and help remove barriers to participation.

As mentioned above, we will fund the VCS in the northeast to come together, plan and deliver community engagement covering these themes:

i. Information sharing on problems we're trying to solve – summarising insights i.e., City Goals, public health data, sensemaking.
ii. Discussion and debate on prioritising the problems and issues to solve
iii. Discussion and debate on how best to solve problems helping both individuals and neighbourhoods
iv. Baseline surveys to measure health, happiness, connection, support, etc.

4. Phase 4 - Planning (March)

Following the engagement where we will have a clear idea of the issues people want to solve and possible solutions, the VCS will bring back together the community to turn the insights into four year plans for each neighbourhood.

We will also invest in the capacity building of the VCS. Relationship and trust building within communities is essential but takes time and needs to be an ongoing process throughout this work.
These relationships include those between

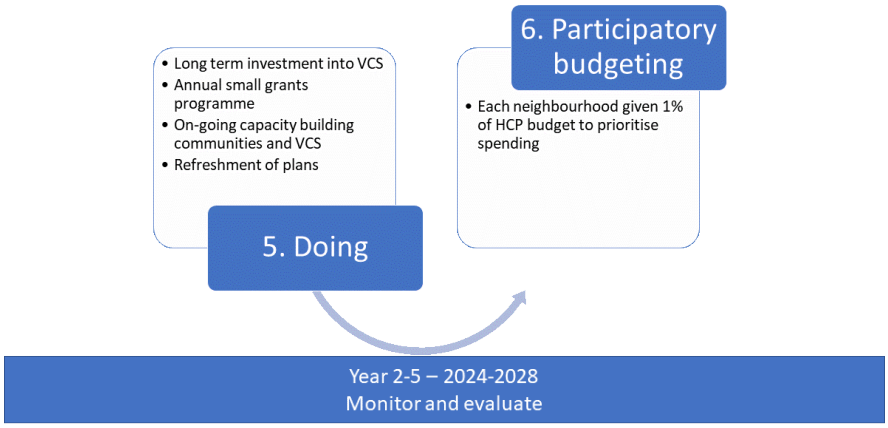
- VCS staff and residents/community members
- Statutory staff and VCS staff
- VCS organisations with each other

We plan to develop an ongoing series of activities that will help facilitate and nurture the above. This will include:

- Listening lunches – held in community venues. Food is provided and local VCS invited to come along and whilst eating, share their thoughts on how things are progressing, the "solutions/ideas" to what is needed, and a chance to take their issues and reframe within what is possible with this fund.
- Grass roots network meetings – for those working at a grass roots level across their patch to meet and share their work, developments, challenges and so on.

Years two - five

5. Doing (Quarter one 2024/25 onwards)



We will give long-term investment to VCS to collaborate, self-govern and deliver the plans in each neighbourhood, and carry out frequent engagement.

We will also continue an annual small grants programme to help fund smaller grassroots organisations or groups of people to connect.

As well as continuing the capacity building started in year one, we will build on this. We will focus on VCS and the community.

We plan to offer an ongoing suite of training and mentoring, and support the VCS involved in this work. This will include:

- Multi-level Community Development and Health (CDH) training for VCS, statutory sector and local citizens to be held in the patch. This would also help address the issues around shifting power and the organisational culture of the statutory organisations.
- Behavioural science and insight to support work around reducing health inequalities. Behavioural science techniques can be used alongside development activities, to better understand how and why individuals and organisations act in certain ways, rather than relying on assumptions of how they should act.
- We'll hold back a percentage of funding "under the radar groups" that are doing good work but are overlooked when it comes to funding and that attached to this is an offer of support in terms of applying for the fund and administering and monitoring the work.
- Mentoring and coaching. Giving VCS the space and think to think and reflect on how to solve their own problems and questions and set goals for their own organisations.
- Mental health support. VCS staff see, hear and experience trauma in their day to day working lives, taking a toll on their own mental health and wellbeing. Look at bringing in peer to peer support to help manage.
- Access to statutory sector training and development such as mentoring and coaching, mental aid training, Thinking Differently.
- Upskill communities. To help people gain employment we will support communities in work. For example, young people in Burngreave could run the social media channels for the community highlighting events, while also being supported with comms and marketing apprenticeships, with opportunities for work experience in partners' comms team.

6. Phase six - participatory budgeting

To shift power to communities, the system needs to give up power. Participatory budgeting (PB) is a democratic process in which community members decide how to spend part of a public budget. It gives people real power over real money.

This will be a huge cultural shift for the HCP and respective partners, so we will start small, and establish processes and best practice. It'll build on the processes and relationships established in year one and moves the co-produced plans to the next level. Here, the HCP will apportion a percentage of its budget to the neighbourhood each year to develop proposals and deliberate the final plans. We aim to include the commissioning and decommissioning of health and care services.

Below is an example of a PB process. VCS leaders will drive this working alongside health and care managers.

PB is a well tried and tested method of devolving power, to great success. It's commonly used in Scotland and is embedded in legislation (whereby the national government and local government committed 1% of their budgets to PB by 2021). It can be used for small budgets or millions of pounds.

It's being proposed that 1% of HCP (estimated to be £10 million) will be part of city wide PB by 2028, with the method being tested in the north east from year two, with year on year increase in the money devolved to communities.

7. Evaluation

A key part of the work will be evaluating the impact of the investment into communities. We will work with a credible, independent organisation, to set a framework for how we monitor the work and establish impact and outcomes. This work will span the lifetime of the work, with annual reports being published.

The evaluation will help us to understand what works and what doesn't, and adapt the work, and look at the wider impact of the work for example social return on investment. We will share the findings locally, regionally and nationally to showcase and leverage money to the north east and the city.

A draft list of outcomes that we will monitor and measure are included in the next section. A lot of the measures are self-reported so we will undertake a baseline survey as part of the community engagement (phase 3) and repeat each year.

9. Outcomes and metrics

The investment isn't a silver bullet for deeply entrenched inequalities in these areas, but it will improve outcomes in several ways. These are shown in the table below.

Aim	Objective	ST Outcomes (First 12 months)	MT Outcomes (1 to 5 years)	LT Outcomes (5 years plus)
1. To connect people to each other in their communities	Ensure we make the best use of local infrastructure to improve	People feel happier and better about themselves	More people have strong and supportive friendships and	Tackled significant inequalities

Aim	Objective	ST Outcomes (First 12 months)	MT Outcomes (1 to 5 years)	LT Outcomes (5 years plus)
	connection to people in the community	People feel more supported by other people More people volunteering	contacts to draw upon People have improved wellbeing and resilience Reduced inappropriate hospital admissions	Live, longer, happier lives
	Improve opportunities for people to connect and contribute to their local area			
	Make long term sustainable investments into VCS			
	To coordinate the work of partners in NE	Better partnership working across sectors		
2. To build community capacity of individuals and neighbourhoods to help them address issues that are important to them	Enhance the skills, knowledge and resources of local people to improve their communities and own lives	People feel happier and better about themselves People feel more supported by other people More people volunteering	People and communities are better able to identify and deliver solutions that meet their needs People are better able to gain the skills, capacity and confidence to play an active role in their communities People and communities are better able to participate in the social, economic and cultural life in Sheffield More people are at work Reduced inappropriate hospital admissions	Tackled significant inequalities Live, longer, happier lives
	Pilot a new relational model for a small number of families experiencing disadvantage	People feel more supported by other people More people volunteering People feel they have more influence over their life circumstances		
3. To devolve power to communities	People can influence decisions that affect their neighbourhood via participatory budgeting	People feel they have more influence over their life circumstances	People and communities are better able to influence and participate in decision making and service development	Tackled significant inequalities Live, longer, happier lives
	Communities will produce			

Aim	Objective	ST Outcomes (First 12 months)	MT Outcomes (1 to 5 years)	LT Outcomes (5 years plus)
	their neighbourhood plans		People and communities are better able to identify and deliver solutions that meet their needs Reduced emergency hosp admissions	

10. Budget
We have an allocated budget for the work in the north east, from the ringfenced health inequalities fund.

Some of the budget has been spent on the north east neighbourhood already or is already committed or reserved for health inclusion work. The budget for the north east work this year will be £800k. This leaves £100k reserves, allowing for underestimation of cost and need, and allowing us to respond differently following the sensemaking conclusions.

2023-24

	Cost
Sensemaking and evaluation	£65k
Invest in VCS	£685k
Community engagement (included above)	
Planning inc capacity building	£50k
Total	£800k

The funding to each of the neighbourhoods will be allocated per head of capita with a 20% weighting for ethnicity, recognising the extra complexity of ethnically diverse neighbourhoods and helping to meet recommendations in the REC.

A detailed plan for 2024 onwards will be published in Q4 of 2023/24.

11. Governance
We have set up a community development and inclusion group who are agents of change – a diverse and multi-sector membership from the community, VCS, health, police, education, and the council – to plan and deliver the work.

Due to the nature of work and the aim to coordinate work in the city, it's anticipated that governance will evolve. A draft governance structure is below. Note the neighbourhood forums haven't been set up and will need local governance to oversee the work in year two.