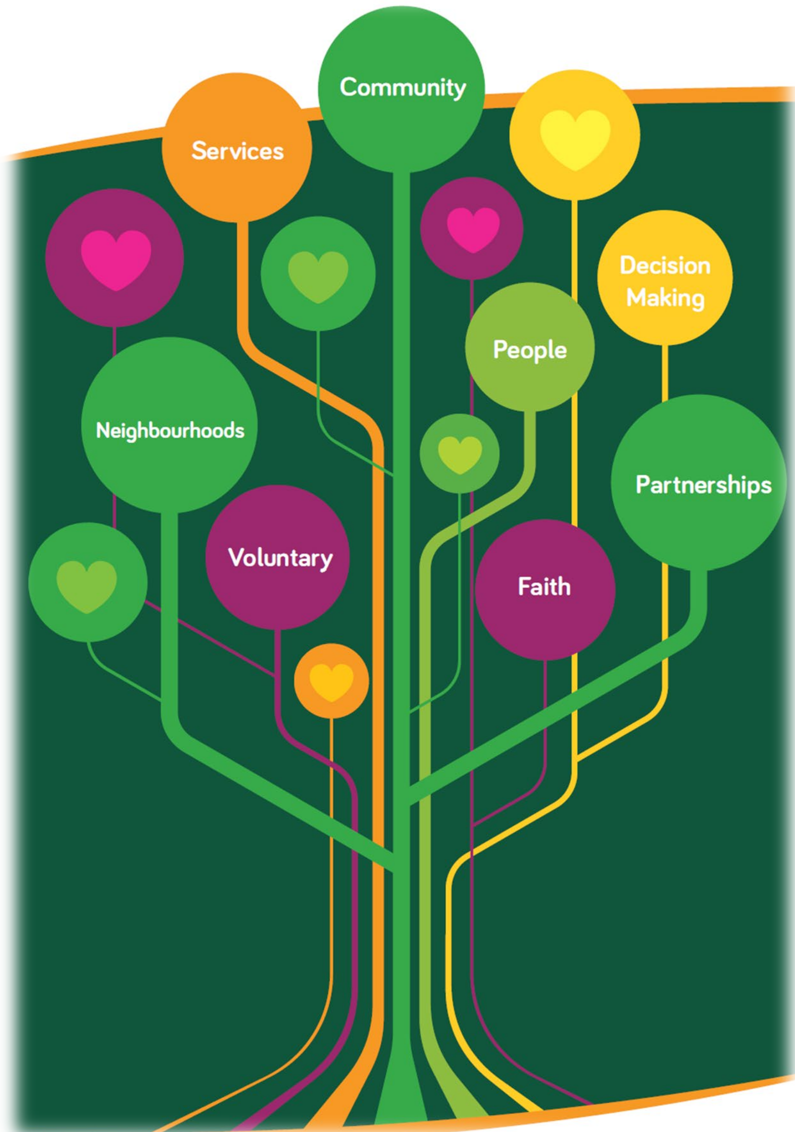
CHAW ONE PLAN for HEALTH

This plan sets out our vision, aims and key delivery areas we want to focus on with our Partners to develop our communities.

This is the place where Chelford, Handforth, Alderley Edge and Wilmslow Care Community (CHAW) and Connected Community partners, working with residents come together, with a shared vision - to identify gaps in services, codesign and co-deliver projects to strengthen our communities.

The **ONE PLAN** is the catalyst for change and improved community wellness.



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Vision **"To build resilience and create a healthy, supportive community for all, across CHAW**

Aims and Objectives

- Develop and oversee an action plan for Community based activity (The ONE Plan) that improves the lives of CHAW residents through a focus on prevention and early intervention
- Support the development and delivery of the One Plan through effective communication and engagement with individuals, families and communities in CHAW
- Develop and deliver effective person centred community-based services to support the delivery of the ONE Plan
- Support local residents, to connect to their community, to empower and promote a positive sense of wellbeing
- Access funding opportunities that improve services and outcomes for all people
- Embed social prescribing in the CHAW Care Community
- Engage with partners and other relevant forums through coproduction, to work through financial challenges by delivering innovation
- Highlight issues and barriers to service development and delivery
- To ensure that equality and inclusion are fundamental in our approach
- To continually drive up quality through working collaboratively

Tools to support delivery – Individuals, families, volunteers, voluntary, faith and community groups, social enterprises, Care Community Partners, Town and Parish Councils, schools, Connected Community Centres, funding providers, research and Intelligence

"The more parent and resident fingerprints that can be found on a project, the more likely it is that project will be meaningful and sustainable"
Cormac Russell

Background context

The ONE PLAN aims to set out a clear understanding of the work being led in communities to enable residents of CHAW to be happy and healthy and live well by connecting to their community.

The priorities of the One Plan are based on our conversations with individuals, families and communities, combined with other research, insight and knowledge from our Partner Organisations in the CHAW Care Community.

Our *5* key priorities are:

- Social Isolation
- Mental Health and well being (including young people)
- Frailty
- Women's Health
- Social Prescribing

Priorities are subject to regular review as we know the needs of our communities are constantly changing.

A wide range of partners are with us on our journey.

The Guild For Lifelong Learning	Cheshire Police	CHAW Care Community
Pathways CIC	Cheshire Fire & Rescue	Chelford Together
Citizens Advice Bureau	Oakmere Extra Care Housing	Time Out Group
Wilmslow High School	Open Arms	CISFA
In Together	Healthwatch	United Reform Church
LOCAL RESIDENTS		

Our partnership membership is all about investing in relationships and building trust and is open for anyone who wants to contribute to delivery of the Plan or simply keep in touch with what we do and support our work and campaigns. (val.burlison@cheshireeast.gov.uk)

There are a number of benefits to both residents and organisations becoming involved in the partnership.

For residents and volunteers

- The opportunity to ensure services are developed on the needs of individuals, families and communities
- The opportunity to work with a range of partners from across all sectors
- Becoming empowered, gaining new leadership skills and knowledge and influencing positive change in your own community
- Gain new ways of thinking and fresh perspectives, new ideas, best practice and tools to take away
- Enhance employability opportunities
- Friendship with like- minded people

For organisations

- Opportunities for partnership working with other VCFSE and health partners
- The opportunity to share good practice and learning opportunities based on an ethos of mutual support
- The opportunity to develop and deliver joined up services at a local level
- The opportunity to influence and develop the priorities for CHAW
- Access to market intelligence (commissioning, procurement, funding opportunities)
- Offers opportunities for you to develop/deliver your organisations CSR where it will have the most impact across communities where it will be valued, and monitored for outcomes, with reports shared
- Networking
- Gain recognition for your organisation and enhance your reputation

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Our Priorities

Social Isolation

Social isolation refers to the inadequate quality and quantity of social relations with other people at the different levels where human interaction takes place (individual, group, community and the larger social environment). The life course of social isolation is highlighted in the following diagram.

<table>
<tr><td>Challenges</td><td>• Inadequate social networks
• Maternal depression</td><td colspan="2">• Adverse childhood experiences
• Being bullied
• Being a young carer
• Being not in employment, education or training (NEET)</td><td>• Being unemployed
• Experiencing relationship breakdown
• Poor social networks
• Being a caregiver</td><td>• Bereavement
• Loss of mobility
• Poor quality living conditions
• Being a carer</td></tr>
<tr><td>Key areas for local action</td><td>• Programmes to provide support during pregnancy</td><td colspan="2">• Parenting programmes
• Programmes to support the home to school transition
• Building children and YP's resilience in schools
• Supporting young carers
• Strategies to reduce NEETs</td><td>• Back to work programmes
• Programmes to support skills development to increase employability
• Support for carers</td><td>• Promote good quality work for older people
• Provision of social activity
• Support for carers
• Support for the bereaved</td></tr>
<tr><td>Life course stages</td><td>Pregnancy</td><td>Early years</td><td>Childhood and adolescence</td><td>Working age</td><td>Retirement and later life</td></tr>
</table>

Our ONE Plan approach to tackling social isolation will:

- Increase opportunities for people to connect by: connecting people into community services; supporting people most at risk (elderly, carers, veterans, disabled, children and young people); embedding social prescribing; providing opportunities to volunteer; Providing opportunities to take part in physical activity
- Develop a community infrastructure that supports connected communities: better transport; digital inclusion; development of community spaces
- Develop cohesive and supportive communities: develop community hubs/partnerships; health and social care work together; support financially disadvantaged
- Build Awareness and Promoting Positive Attitudes: understand the issues in communities; support children and young people; support good mental health and wellbeing

Mental Health

Mental Health is everyone's business individuals, families, employers, educators and communities all need to play their part, good mental health and resilience are fundamental to our physical health and our relationships, education, training, work and to achieving our potential. Challenges of mental health can affect everyone, it is likely that every one of us has experienced mental health issues or knows someone who has. 1 in 4 adults experience at least one diagnosable mental health problem in any given year.

Mental health is the single largest cause of disability in the UK costing the economy an estimated £105 billion a year. The rate of mental health problems in children is 1 in 10, with 50% of all mental health problems established by the age of 14 and 75% by the age of 24. Despite these figures approximately only 25% of people with a mental health problem receive ongoing treatment [2]. Those with mental health issues have disproportionately higher rates of mortality than those without and with the number of people with mental disorders estimated to grow by 15% by the year 2020 [3] mental health should be a key priority across all health and social care sectors

CHAW Care community has been part of a national programme tackling health inequalities with a focus on the mental health support in age 11-17 year olds. Through this work we have identified that far more wide-ranging support to improve physical and mental health of young people is required. This is supported by figures from two of our local VCFSE providers, Just Drop In and Wilmslow Youth who highlight demand for all their services from children, young people and their families.

Our ONE Plan approach to tackling mental health will:

- Develop a cohesive and supportive mental health community in CHAW
- Further develop the strategic role of VCFSE community response partnership model with public services
- Identify gaps in the current service provision and develop new or more services where gaps are identified
- Understand the issues children and young people face in communities and schools and develop community-based support that supports good mental health
- Increase children and young people, adults, families and communities in the design/delivery of holistic, person-centred community-based solutions
- Build awareness by improving and promoting support available
- Promote positive attitudes to mental health

Frailty

The UK population is ageing at an increasing rate and frailty is becoming a more prevalent condition, which is why CHAW Connected Community partners along with other local health providers and patients have identified frailty as a priority which will support the population of CHAW in ageing well by staying well and living independently for longer.

The population of CHAW is expected to continue to grow, with an increase in the number of over 60s living in our community.

But these extra years of life are not always spent in good health, with many people developing conditions that reduce their independence and quality of life. This is why it is so important that people living with frailty have access to well-planned, joined-up support to prevent problems arising in the first place – and a rapid, specialist response should anything go wrong.

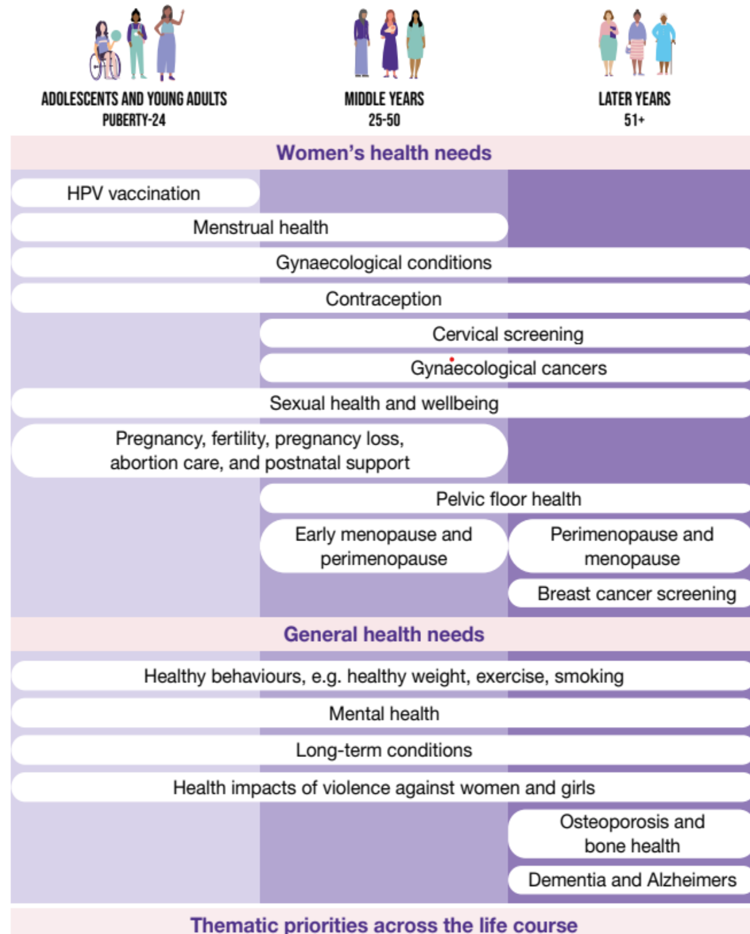
Frailty is generally characterised by issues like reduced muscle strength and fatigue. Around 10% of people aged over 65 live with frailty. This figure rises to between 25% and a 50% for those aged over 85.

Frailty isn't the same as living with multiple long-term health conditions. There's often overlap, but equally someone living with frailty may have no other diagnosed health conditions.

Our ONE Plan approach to tackling frailty will:

- Identify and provide proactive support to old people living with frailty in the community
- Build the capacity of local community support at all levels so that they respond confidently and appropriately to the needs of local people on a day-to-day basis and at times of crisis or uncertainty
- Ensure that information is available and accessible at any and all times that interventions or actions with individuals are being planned, reviewed or delivered
- Support Carers

Women's Health



Although women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men.

Not enough focus is placed on women-specific issues like miscarriage or menopause, and women are under-represented when it comes to important clinical trials. This has meant that not enough is known about conditions that only affect women, or about how conditions that affect both men and women impact them in different ways.

The life course of womwn's health is highlighted in the following diagram.

Our ONE Plan approach to supporting Women's Health will:

- Ensure the development of community services based on the needs of women and girls in CHAW
- Improving access to services that meet the needs of women's health
- Better information and education enabling women (and wider society) to enable women to lead better and healthier lives
- Identify gaps in the current service provision and develop new or more services where gaps are identified

Social Prescribing

Social prescribing seeks to move away from a medical model and towards a holistic person-centred view of well-being, identifying the root causes of the individual’s issues and tackling them head on.

The University of Westminster Social Prescribing Research commissioned by NHS England (2017) defines social prescribing as:

“Enabling healthcare professionals to refer patients to a link worker (connector), to co design a non-clinical social prescription to improve their health and well-being”

In this way social prescribing will offer a personalised offer of support appropriate to the person.

In CHAW Pathways CIC deliver a social prescribing service whereby link workers provide holistic coaching support on what matters to the person and co-produce support plans that connect people into community-based support/prescriptions. This support will include: group activities; peer support; self-management education; health coaching; and other community-based activity to keep people safe and well (e.g. finance and debt advice; housing; domestic abuse).

Our ONE Plan approach to supporting social prescribing will:

- Develop a more integrated VCFSE sector working together to support social prescribing in CHAW
- Develop an up-to -date single Directory of Service that will support the development of social prescribing in CHAW
- Help people to find a new sense of belonging and purpose by enjoying activities they might not have tried before including arts, cultural and sports activities
- Provide people with the necessary support to live well in the CHAW community
- Identify gaps in the current service provision and develop new or more services in the community where gaps are identified
- Support people families and their carers to work with others to set up new groups based on lived experience

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