North East Essex Health and Wellbeing Alliance

Community Assets Mapping

Stay Well
"Right Care, Right Time, Right Place"

January 2023

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Summary

This report looks at the relevant data, literature, services available, views from community and voluntary organisations and perceived gaps in service which relate to the Stay Well Domain. The report provides case studies and spotlights examples of good practice. It has a particular focus on those people who may be waiting for treatment and where the Right Care, Right Place, Right Time approach to care works and where it can be improved. It includes the 'Citizen's Voice' gained from one-to-one discussions, focus groups and interviews with people living in Walton in Tendring and Greenstead in Colchester, in order to help to identify the enablers and barriers to accessing services.

Barriers

- Focus of community assets is often on the 'well elderly', rather than those who have multiple issues and mobility challenges
- Lack of digital literacy, or access to IT equipment
- Communication – there needs to be an understanding by citizens about what assets are, where they are and how they can help
- Language used – whether English is not the first language, plain language or Makaton are needed
- Anxiety about going out – how will I get there? What will it be like? Will I be able to participate? There is still a legacy from Covid-19 where people are fearful of going out.
- Physical access and cost of transport, access to transport in very rural areas, waiting times for transport and poor waiting facilities
- Cost of support to get to activities/groups for carers and those in very rural settings
- Mindset – when waiting for surgery or feeling unwell, people can be resigned to stay at home, hunker down and lack the inner resources to go out. Some of these people will not know about social prescribers or community agents and may find it easier to do nothing
- Out-of-date information available online - some groups are not removed if the organisation closes.

Enablers

- Personalised solutions and supports which afford greater choice and control to people with long-term conditions and their carers
- Word of mouth – talking to people who are 'switched on' and know what's happening and can encourage people to participate
- Awareness of resources available and targeted to those who need them
- Access to digital equipment and skills – or ways around this
- Volunteers to support or volunteering as an activity (giving a sense of purpose)
- Useful information and advice – in accessible formats
- Access to interpreters and translators, a broader understanding of cultural differences and the needs of those with sensory impairment or learning difficulties

- Inclusion of family carers and home care providers in discharge planning or care planning (with the consent of the individual where this is possible), to avoid referrals back to GPs and enable more informed care in the home
- Being enabled to express worries, challenges, problems in a non-judgemental environment
- Access to reliable, timely, affordable transport
- Focus on what can be brought into the home to assist daily living

The recommendations look at the different ways in which the citizen journey may be improved by making changes to the range of care and support available or to the system. They include improved advice and information; improved access to transport and waiting facilities at the hospital; improved information, care and support for carers; support to combat anxiety people have about going out through buddying and befriending; support with digital literacy; building capacity and sustainability of local support groups; more outreach services and activities in remote communities and improved communication support for all who need it.

Introduction

The Stay Well Deep Dive is the fourth in a series of reports published as companions to the Community Assets Mapping refresh of North-East Essex, originally published in Spring 2021. Using the North East Essex Health and Wellbeing Alliance domains as a framework for each report, there will ultimately be a library of six reports:-

- Start Well – completed over the Summer of 2021
- Feel Well – conducted during Autumn 2021
- Be Well
- Age Well – next deep dive
- Stay Well – completed February 2023; this report
- Die Well – completed November 2022

The report has been produced by Healthwatch Essex, CVST (Community Voluntary Services Tendring) and Community360, working in partnership, and collaborating with a Steering Group, which has included the Stay Well domain lead, representatives from District and County Councils, Essex Fire and Rescue, the Local Delivery Pilot, North East Essex ICS, and ESNEFT. The Stay Well Domain has been engaged with this work throughout.

Scope and Methodology

In learning from the completion of the first three deep dive reports for Start Well, Feel Well and Die Well, this document is a continued refinement of a process and evolves as the asset mapping programme delves into new topics. Of primary concern was maintaining an Asset Based Community Development (ABCD) approach in a local context. This involved grounding research in local knowledge whilst using national and regional data sets, where available, for cross reference.

A clear outline for the report was shaped through consultation with the community Assets Mapping Steering Group and the Stay Well domain, as well as topic-specific specialists and relevant organisations.

It was agreed that the work would take into account key drivers and influences on people living with long-term conditions and their carers, using learning from the last 12-18 months and gathering information through a literature search and primary research which accurately reflects: -

- A deeper understanding of what facilitates and what presents barriers to access to services and how to address them
- key challenges facing adults with long-term conditions and their carers, with a focus on physical health and wellbeing
- local cultural factors and limitations, including the impact of diversity on Right Care, Right Time, Right Place and management of long-term conditions while awaiting elective surgery

It was agreed to focus the citizen's voice work in Greenstead and Walton wards as these are areas of specific interest, due to demographics (including a more diverse population in Greenstead), number of care homes, levels of deprivation.
The work will focus on Right Care, Right Time and Right Place and supporting people to manage their long-term conditions while awaiting elective surgery and will be consistent with work being undertaken in North East Essex around the Stay Well Domain.

The work looked at: -

- National vs local assets – pathways to self-access, how are they promoted?
- Networks of care
- Cultural diversity – learning from different ways of practice; overcoming language and understanding barriers

This report is collated from engagement with organisations and individuals across North East Essex. The primary focus is on what is available within local communities and what could help to improve outcomes for this group of people. It is not possible to list every community organisation in North East Essex, so examples of interest are represented in the report. Time does not allow for researching every group, but there are a very many at grassroots level in churches and community halls and venues.

We would like to thank everyone who has contributed towards this report formally or informally, and hope that the content offers further insight into the experiences of local people and organisations working in the voluntary and community sector. Data gathering and consultation was conducted between February 2022 and June 2022.

Acknowledgements

Healthwatch Essex, Community360 and CVST would like to thank the organisations and residents who participated in all sections of the report, and notably as citizens' voices. Their experiences and data help to improve the understanding of this area of work.

Literature Review

This literature review is not extensive but takes some findings and conclusions from papers and reports which are particularly relevant to this report.

The Nuffield Trust[1] in its blog 'Transparent processes with a human touch, the essentials of good waiting list management' takes the findings from the National Voices paper, Patient. Noun. Adjective, which is an analysis of the expectations of those waiting for care. It is based on a detailed literature review and a survey of people waiting for care. It looks at the impact of waiting for care and highlights the detrimental effect on the NHS, worsening physical symptoms for those waiting; anxiety because of lack of control and uncertainty; fears about employment issues and loss of income.

Using the National Voice findings as a basis for analysis, and understanding the huge pressure the NHS and the whole health and wellbeing system is under, the blog identified five ways forward to both respond to the emotional and practical needs of patients and carers and avoid patients being bounced between hospitals and GP, as follows: -

1. Develop a variety of digital tools to support remote review of symptoms and overall quality of life
2. GPs manage the rate of new referrals, adding essential information and results of diagnostic tests before the referral is submitted to the hospital, thereby increasing the appropriateness of referrals and giving specialists the diagnostic information they need
3. GP practices to support patients with alternatives to hospital treatment – lifestyle changes, weight loss, exercises to reduce pain, home aids to enable people to live with their condition and retain independence
4. Adopt the recommendations in Patient. Noun. Adjective. [2] so that patients and carers can check on appointment dates, get self-management advice and report any changes in symptoms without frustration or delay
5. Learn from the experience regarding the role the Third Sector can play in working with NHS services – self-management guides; experts by experience etc. Added investment at community level could be an important source of advice to those on waiting lists.

All this points to the need to look at people more holistically and to treat each patient as an individual. Some will be happy to source support for themselves, others will need more assistance to do so.

The National Voices report Patient, Noun. Adjective. also raises issues of inequality, highlighting issues for patients around phone and video consultations and recommends that 'enabled appointments' for those language challenges, sensory impairment, some long-term conditions, physical or mobility impairment, learning disability, mental health conditions, autism or older age and frailty would help to level this up. People need technological skills, assistive technologies and interpreters to be able to participate fully in consultations and understand the impacts for them as individuals.

[1] https://www.nuffieldtrust.org.uk/news-item/transparent-processes-with-a-human-touch-the-essentials-of-good-waiting-list-management

[2] https://www.nationalvoices.org.uk/publications/our-publications/patient-noun-adjective-understanding-experience-waiting-care

To add context to the Nuffield recommendations above, the National Voices recommendations are as follows: -

- Understand the importance of improving the experience of waiting – and the impact on mental and physical health, mobility, work, employment and finances
- Invest in developing patient-centred information and communication
- Support people while they wait with self-management; routine monitoring with clear pathways to specialist advice; potential for a virtual healthcare offer; partnering with, and signposting to, voluntary, community and peer support.

Just moving people back on waiting lists does not address any needs, except managing workload. If this has to happen, which it clearly does in the present climate, then clear information, regular contact, and access to informed and relevant physical and emotional support is critical for patient wellbeing.

Covid 19 and human resources challenges have had an inevitable impact on waiting lists for treatment. In the Independent Age Report [3], there were more than 5.6 million people in England waiting for hospital treatment. "Worryingly, that number doesn't include the millions who haven't come forward for treatment yet, including those who may have stayed away from health services for fear of catching COVID-19 or because they didn't want to create more work for the already hard-pushed staff in the NHS." Most of those waiting are late in life and many are living in pain every day as they wait for treatment for their hips, knees and other procedures that could significantly improve their quality of life. It states, 'We know that people in later life need good communication, preparation and support to 'wait well' and feel empowered, informed and involved in decisions about their treatment.'

Part of the research included a survey of older people waiting for surgery. Some of the results indicated:

- 31% had considered private healthcare for the operation they were waiting for, but only 20% thought that private healthcare was affordable
- 71% of those waiting for treatment said their health had become worse during the pandemic
- 7 in 10 of those waiting for treatment said their health had become worse during the pandemic
- More than half of those waiting said they were in daily pain, according to our survey of people aged over 50
- Some 47% of those waiting for treatment said that the wait had made their mental wellbeing worse. Women and people living alone were more likely to report a negative impact on their mental wellbeing.
- 84% of people waiting for surgery had not received any additional treatment for their condition

Our evidence showed that currently, people in later life who are waiting for surgery are showing signs of deterioration, frequent pain and a corresponding decline in quality of life.

[3] "'Patiently Waiting', Older People's experiences of waiting for surgery", Independent Age 2021[3]

In their report 'Supporting People with Arthritis waiting for surgery'[4] Versus Arthritis provided a resource guide for health professionals to support those waiting for elective surgery appropriately. The Versus Arthritis, Impossible to Ignore, Joint Replacement Survey of 724 people (October - December 2020) delivered the following headline results:

- 79% reported that their physical health had worsened
- 89% said that their pain levels had deteriorated
- 90% reported reduced mobility
- 79% said they were now less independent
- 72% reported a deterioration in their mental health

All of the above put additional pressure on family carers, paid carers, and the health and wellbeing system as a whole, and people need to be supported and encouraged (lack of motivation is a recurring theme) to be as mobile as they can and to make positive steps to improve their mental health.

The support package has 6 elements:

- Clear communication
- Personalised self-managed support
- Physical activity programmes
- Mental health support
- Signposting to financial support and advice
- Covid 19 recovery plans – with a specific focus on arthritis

Necessarily for documents such as this, the resources pointed to are largely national links as well as giving advice to healthcare providers and GPs, but a similar resource pack could be produced in tandem with local community assets to provide a more personalised, informed support package for anyone awaiting elective surgery in North East Essex.

Context

Extensive work has been undertaken within the Stay Well domain, under the guidance of the Stay Well Steering Group, to establish the context of care in North East Essex.

Through working with members of the Stay Well Steering Group and colleagues within the North East Essex Health and Wellbeing Alliance and gathering data from the Neighbourhoods programme, some key information emerges to accompany the report.

During and following Covid 19, many elective surgery and treatment was postponed or cancelled, awaiting the opportunity to return to normal patient profiles and hospital activity. This inevitably meant that waiting lists grew, and people needed to be able to maintain as much good health as possible while waiting. It also meant that interventions were necessary in the form of 'Right Care, Right Time, Right Place' to prevent unplanned admissions to hospital and avoid crisis for patients.

[4] https://www.versusarthritis.org/media/23694/joint-replacement-support-package-june2021.pdf

To be able to support the NHS as it recovers from the impact of the pandemic, community services – both statutory and voluntary – needed to be mustered to support acute hospitals while they worked on reducing waiting lists

Local data

The Health Profile of Colchester (2019, i.e., pre Covid)[5] stated that the health of people in Colchester is varied compared with the England average. About 14.7% (4,915) children live in low-income families. Life expectancy for men is higher than the England average. Life expectancy is 8.6 years lower for men and 8.0 years lower for women in the most deprived areas of Colchester than in the least deprived areas.

The rate for alcohol-related harm hospital admissions is 654*. This represents 1,179 admissions per year. The rate for self-harm hospital admissions is 206*. This represents 415 admissions per year. Estimated levels of excess weight in adults (aged 18+) are better than the England average. The rates of new sexually transmitted infections and new cases of tuberculosis are better than the England average. The rate of killed and seriously injured on roads is worse than the England average. The rates of statutory homelessness, violent crime (hospital admissions for violence) and under 75 mortality rate from cardiovascular diseases are better than the England average.

The Health Profile of Tendring (2019) stated that the health of people in Tendring is generally worse than the England average. Tendring is one of the 20% most deprived districts/unitary authorities in England, and about 24.1% (5,500) of children live in low-income families. Life expectancy for both men and women is lower than the England average. Life expectancy is 10.6 years lower for men and 7.8 years lower for women in the most deprived areas of Tendring than in the least deprived areas.

The rate for alcohol-related harm hospital admissions is 764*, worse than the average for England. This represents 1,160 admissions per year. The rate for self-harm hospital admissions is 273*[6], worse than the average for England. This represents 330 admissions per year. Estimated levels of excess weight in adults (aged 18+) are worse than the England average. The rates of new sexually transmitted infections and new cases of tuberculosis are better than the England average. The rate of killed and seriously injured on roads is worse than the England average. The under 75 mortality rate from cardiovascular diseases and the under 75 mortality rate from cancer are worse than the England average.

The charts below indicate some of the long-term mortality and health challenges experienced by people living in Tendring and Colchester.

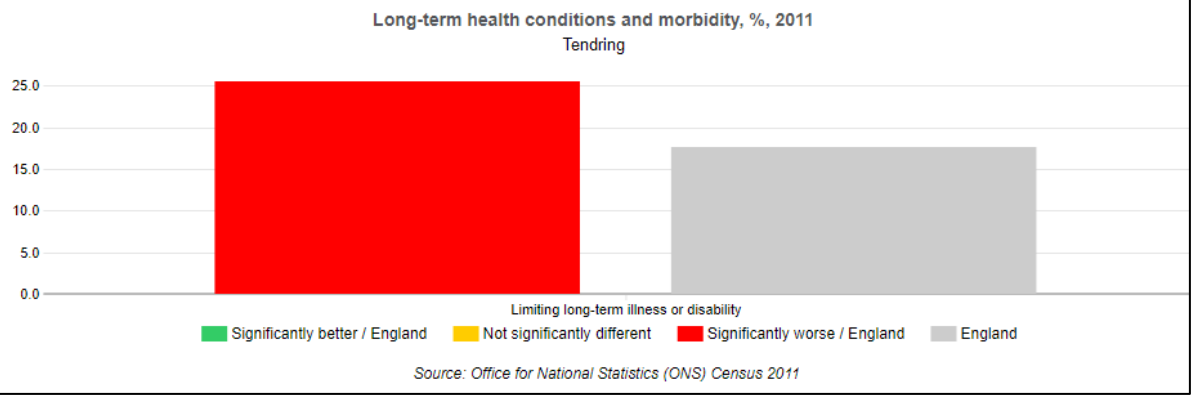
[5] Fingertips.phe.org.uk/static-reports/health-profiles

[6] *rate per 100,000 population

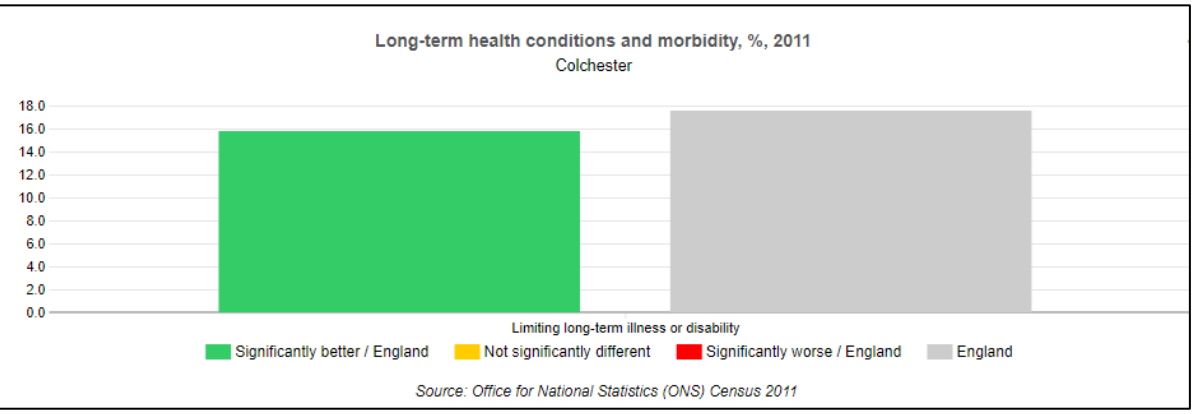
Long-term health conditions and morbidity, %, 2011

Indicators	Tendring	Essex (UTLA 2021)	England
Limiting long-term illness or disability (%)	25.5	17.1	17.6

Source: Office for National Statistics (ONS) Census 2011



Source: Office for National Statistics (ONS) Census 2011



Source: Office for National Statistics (ONS) Census 2011

Tendring

Indicator	Period	Tendring			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Hypertension: QOF prevalence (all ages) (Persons, All ages)	2021/22	–	-	20.0%	-	14.0%	6.9%		20.6%
Depression: QOF prevalence (18+ yrs) (Persons, 18+ yrs)	2021/22	–	-	12.9%	11.7%*	12.7%	3.8%		20.6%
Stroke: QOF prevalence (all ages) (Persons, All ages)	2021/22	↑	-	2.6%	-	1.8%	0.7%		3.1%

Colchester

Indicator	Period	Colchester			Region England	England		England	
		Recent Trend	Count	Value	Value	Value	Lowest	Range	Highest
Hypertension: QOF prevalence (all ages) (Persons, All ages)	2021/22	–	-	13.0%	-	14.0%	6.9%		20.6%
Depression: QOF prevalence (18+ yrs) (Persons, 18+ yrs)	2021/22	–	-	12.9%	11.7%*	12.7%	3.8%		20.6%
Stroke: QOF prevalence (all ages) (Persons, All ages)	2021/22	→	-	1.5%	-	1.8%	0.7%		3.1%

Some analysis was done with the help of the SNEE Business Intelligence Team of the waiting lists from referral to treatment (RTT). This is the time measured between the referral to the first definitive treatment. The table below covers all patients in North East

Essex. The total waits column covers anyone who had been referred for treatment but is now waiting. Historically, the expected RTT timescale for all patients was 18 weeks for consultant-led services. Wait time 92 percentile shows that out of all those waiting, 92% of RTT is within this many weeks. It is important to recognise that, in some areas, there are relatively low numbers, and this can skew the figures due to small numbers of people (for example, elderly medicine). However, this is the best indicator we have. Waiting lists have been falling, but they are now increasing again. With new patients coming in all the time, waits are likely to continue for the foreseeable future.

Elective Recovery Snapshot as at the week-ending 4th Dec 2022

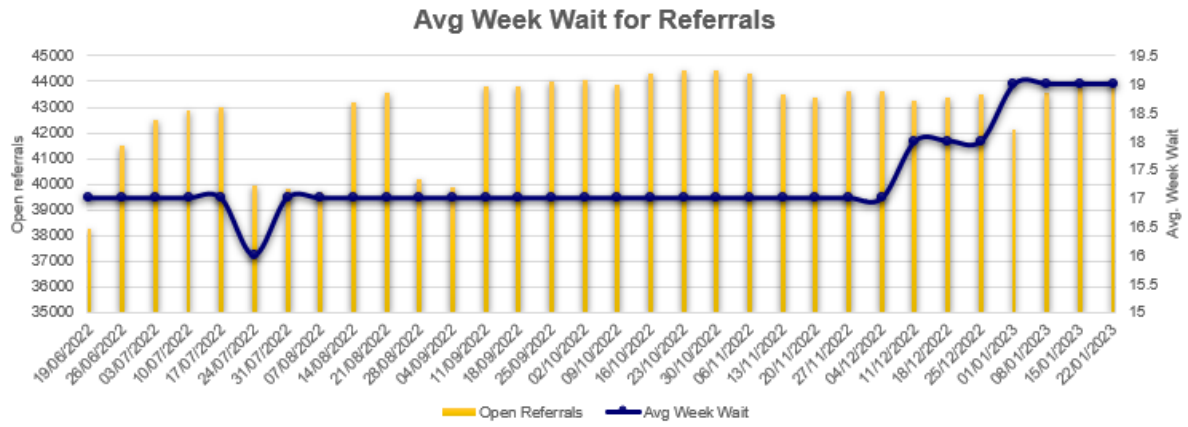
29		Total Waits
Specialty	**Wait time 92%ile**	
Cardiology Service		1,982
Cardiothoracic	53	105
Dermatology Service	45	3,323
Ear Nose and Throat Service	28	2,834
Elderly Medicine Service	10	69
Gastroenterology Service	51	2,692
General Internal Medicine Service	38	387
General Surgery Service	50	5,537
Gynaecology Service	52	3,592
Neurology Service	27	1,218
Ophthalmology Service	33	6,094
Other	35	5,655
Plastic Surgery Service	54	584
Respiratory Medicine Service	30	932
Rheumatology Service	21	494
Trauma and Orthopaedic Service	49	5,894
Urology Service	35	2,228
Total		**43,620**

On a very crude review (taking out the smaller numbers) it appears that the specialities of gastroenterology, general surgery, gynaecology and trauma and orthopaedic services are experiencing the longest waits. Community assets may be able to explore what types of support these patients may benefit from within their local community to keep them well while waiting for treatment.

It is important to note that waiting lists reduced as a result of complex planning and delivery. The focus has to be on the most acutely ill, or those with life-threatening trauma or illness, so, not all waiting list groups will change at the same rate. While work is being done to reduce waiting times, there are new cases emerging every day to be added to the lists.

The graph below (at 22 January 2023) shows how waiting times were being managed down effectively, but there has recently been an upturn. The highest numbers are waits of 1-20 weeks, many of which are new referrals, the number of people waiting longer is declining. Note that small numbers less than 5 have been suppressed to give a more accurate

picture. There are many reasons for some of the longer delays, which include patient delays as well as hospital delays.



The GP patient survey practice report (July 2022 publication) asked, among many other questions, 'Do you have any long-term physical or mental health conditions, disabilities or illnesses?'. Across North-East Essex, over 2,400 weighted responses said that they did, with the distribution across the area as shown below. Percentages are the percentage of people who responded and who answered this question in the affirmative.

Practice Name	%
WEST MERSEA SURGERY	52%
WALTON MEDICAL CENTRE	68%
MAYFLOWER MEDICAL CENTRE	65%
GREAT BENTLEY SURGERY	61%
CARADOC SURGERY	69%
WIVENHOE SURGERY	51%
EAST LYNNE MEDICAL CENTRE	64%
COLCHESTER MEDICAL PRACTICE	62%
THE ARDLEIGH SURGERY	58%
ST. JAMES SURGERY	67%
AMBROSE AVENUE GROUP PRACTICE	57%
WINSTREE MEDICAL PRACTICE	61%
EAST HILL SURGERY	48%
ABBEY FIELD MEDICAL CENTRE	45%
CREFFIELD MEDICAL GROUP	56%
COLNE MEDICAL CENTRE	60%
TIPTREE MEDICAL CENTRE	61%
ROWHEDGE SURGERY	52%
RANWORTH SURGERY	72%
OLD ROAD SURGERY	73%
THORPE SURGERY	53%
FRONKS RD FAMILY SURGERY	62%
HAREWOOD SURGERY	54%
LAWFORD SURGERY	48%
MILL ROAD SURGERY	51%
HIGHWOODS SURGERY	48%
CLACTON COMMUNITY PRACTICES	73%
TOLLGATE HEALTH CENTRE	57%

NORTH CLACTON MEDICAL PRACTICE	53%
BLUEBELL SURGERY	57%
THE RIVERSIDE HEALTH CTR	61%
TURNER ROAD SURGERY	52%

People need to stay well while they are waiting for treatment or while they are living with long-term conditions and need all the tools available to them to support this. A local NHS publicity campaign, 'Waiting Well' aimed to give people the information to help them access support for themselves in leaflet and verbal advice formats. This is a positive move, but the information could be improved if tailored to each patient - with information, advice and contact points relevant to the patient's condition and locality. If these information leaflets are discussed with patients at the point of treatment being delayed, they would be a step forward in signposting people to additional help.

Sense Complex Local Disabilities report[7] highlighted the high number of people all of ages who live with complex disabilities in North East Essex.

Colchester

Our figures estimate that in Colchester there are currently **4,676 people with complex disabilities**. This breaks down as follows:

0-4 years	5-17 years	18-64 years	65+ years
139	867	2,005	1,666

Male	Female
2,570	2,105

Tendring

Our figures estimate that in Tendring there are currently **4,072 people with complex disabilities**. This breaks down as follows:

0-4 years	5-17 years	18-64 years	65+ years
85	587	1,244	2,155

Male	Female
2,140	1,932

[7] Sense: Complex Disabilities Local Report, August 2022: https://www.sense.org.uk/about-us/statistics/complex-disabilities-overview/

These figures come from Sense's Quantifying Complex Disability research project. The estimates have been developed using a modelling approach based on the data collected in the Department for Work and Pensions' Annual Family Resources Survey (FRS) from 2012/13 to 2019/20 as well as historic and future estimates for the UK population.

For the purposes of this research, someone has complex disabilities if they have two or more of the following conditions and they report that their life is impacted by their disabilities: Sight loss, hearing loss, autism, and learning disability.

These people need targeted interventions and support from within the community to be able to live with independence and control over their day-to-day lives – as well as to enable them to have the right care, at the right time and in the right place.

Diabetes

"One in 15 of us is now living with diabetes" is the main line strap of the national charity Diabetes UK[8]. The 2018/19 audit includes information on over 3.5 million people with diabetes, which is 7% of the population of England and Wales. The prevalence of diabetes has generally increased yearly since the first audit, which means that more people than ever have diabetes; the charity predicts that if nothing changes, more than 5 million people will have diabetes in the UK by 2025. Prevalence estimates of diabetes by the Clinical Commissioning Group (now ICS) for Essex of people age 16 and over who will develop diabetes in 2025 is 115,486 or 9.1%, as per the data from the Health Surveys for England. [9]

New figures recently published by the NHS National Diabetes Audit, which tracks how well local areas are performing, show that the North East Essex Diabetes Service (NEEDS) is delivering better service than most other areas in England. [10]

The NHS Long Term Plan makes substantial reference to diabetes by reducing obesity as a significant risk factor in the development of type 2 diabetes and addressing health inequalities, with people from minority ethnic groups are 40% more likely to develop Type 2 Diabetes.

Let's Talk SNEE[11] has highlighted the critical steps that the Board will take to help people living with diabetes and makes a commitment to support people in managing their health by expanding education and self-management, along with access to services, by outlining the main actions:

- People at risk of diabetes are supported to prevent the condition from developing.
- People have access to the best possible care and support they need to live well with diabetes.
- People living with diabetes can monitor and self-manage their condition effectively.
- Reducing health inequalities for patients with diabetes.

The strategy identifies significant stages in the journey for people with diabetes. It stresses a need to reorganise how these services are delivered, from prevention to longer-term management. The entire pathway approach is on providing diabetes services around the quality of life and experience of people living with diabetes.

[8] https://www.diabetes.org.uk/professionals/resources/national-diabetes-audit/nda-reports

[9] Diabetes_prevalence_estimates_for_CCGs_by_ONS_resident_populations.xlsx (live.com)

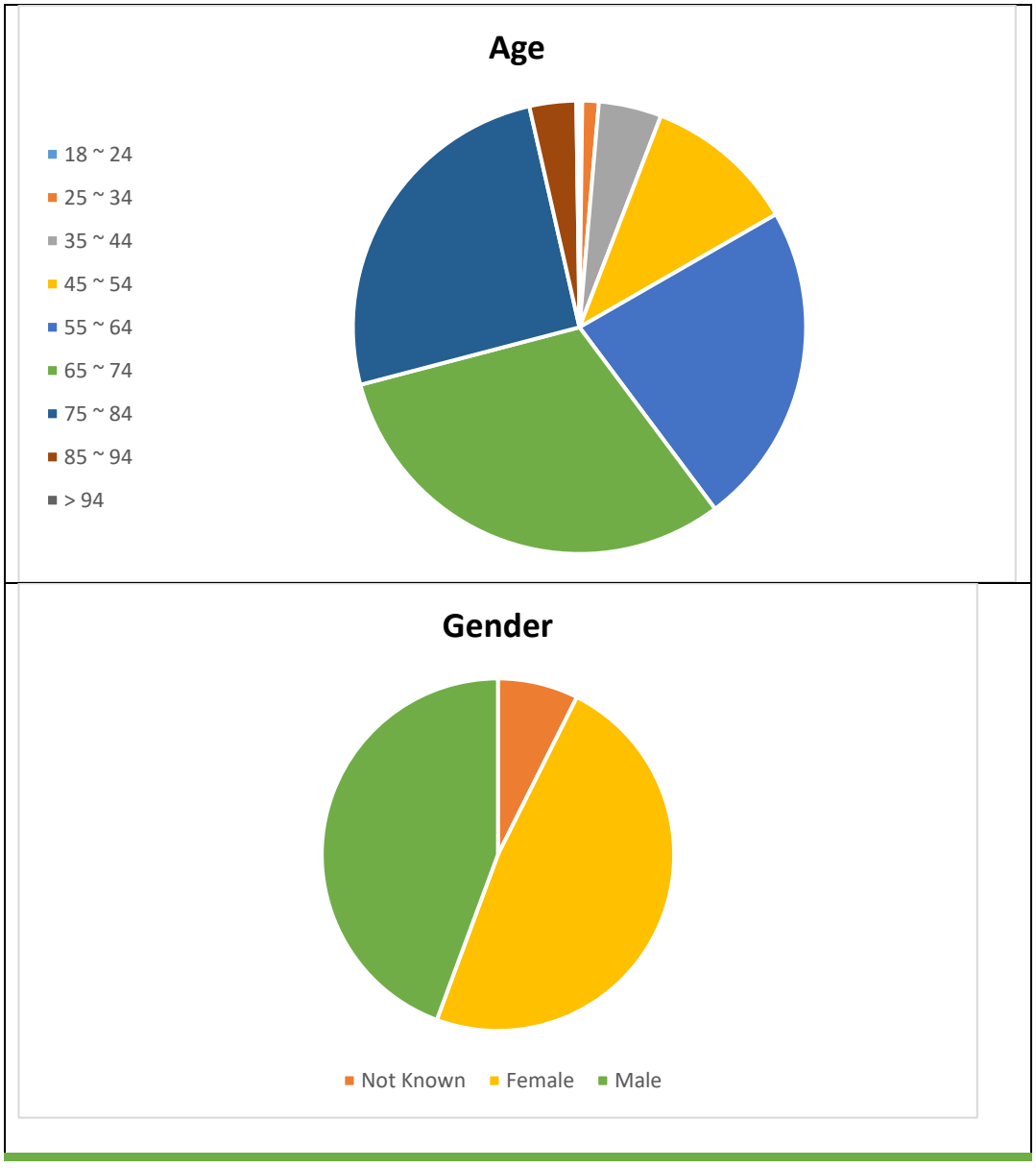
[10] https://suffolkandnortheastessex.icb.nhs.uk/news/diabetes-care-in-north-east-essex-is-among-the-best-in-england/

[11] JFP: Stay Well - Diabetes | Let's Talk SNEE

NHS England, Public Health England and Diabetes UK have committed to improving efforts to prevent diabetes. SNEE strategy highlights the need for ongoing prevention work; as such, Xyla Health & Wellbeing has been selected as one of five providers to deliver the NHS Diabetes Prevention Programme (NHS DPP) across the UK. This programme consists of 1:1 and group sessions and aims to help the 5 million people at risk of developing the disease, focusing on helping people to reduce their weight, increase their physical activity levels and improve their diet, problem-solving, stress reduction and coping skills, thus empowering them to take charge of their health and well-being and learn how to prevent diabetes.

Emma Jones, from the NHS Diabetes Prevention Programme for NEE, commented that Type 2 diabetes represents 90% of all diabetes in patients and is primarily caused by lifestyle factors that can be modified.

The referral dataset for North East Essex for 2022, including ethnicity, recorded by Xyla Health & Wellbeing programme is outlined below (note: 2501 people did not include their ethnicity).



Ethnicity	
Unknown	2501
White British or Mixed British	930
White - Irish	10
White - any other white background	31
Mixed - White or Black Caribbean	3
Mixed-White and Black African	7
Mixed – White and Asian	3
Mixed - Any other	2
Asian or Asian British - Indian	16
Asian or Asian British - Pakistani	2
Asian or Asian British - Bangladeshi	3
Asian or Asian British - any other	9
Black or Black British - African	12
Black or Black British - Caribbean	8
Black or Black British - Any other	2
Other Ethnic Groups: Chinese	12
Other Ethnic Groups: Any Other	18

Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions where it is difficult to breathe air out of the lungs.

In terms of diagnosed cases, COPD is the second most common lung disease in the UK, after asthma. Around 2% of the whole population and 4.5% of all people aged over 40 live with diagnosed COPD. 115,000 people are diagnosed with COPD each year, equivalent to a new diagnosis every 5 minutes. The UK is among the top 20 countries for COPD mortality worldwide, as per the Asthma + Lung UK (formerly British Lung Foundation) statistics. There are thought to be approximately 3 million people in the UK living with COPD, but only around 1.2 million have been diagnosed[12].

There are over 40 different types of lung disease, and one in five people will be affected by lung disease. Some of the other important factors to consider are heart rate, blood pressure, and oxygen levels. Being active and exercising is one way to help to improve breathing and fitness for many people living with COPD.

[12] https://statistics.blf.org.uk/

In addition, the findings of the Asthma + Lung UK highlight that regular exercise not only benefits the heart and blood pressure but also reduces the development of conditions such as diabetes and osteoporosis.

Current data for respiratory diagnosis shows that the waiting times from a GP referral to treatment in Colchester Hospital and in Fryatt Hospital in Harwich are up to 25 weeks for 9/10 patients[13].

We looked into the local asset support around the self-management resources, which can make a big difference to the quality of life of people experiencing breathing difficulties by keeping active in Colchester and Tendring.

Cultural norms and health inequalities:

Health inequalities are exacerbated by inadequate consideration of the importance of differences in cultural practice and how this can hold back both women and men from accessing health and social care. To get a deeper understanding of the cultural practises and access to health and social care services, we reached out to several different cultural groups to find examples of the challenges and experiences of different cultures and to demonstrate the need for culturally sensitive practice and education for minority communities in terms of how the health and care system works. We also reached out to organisations supporting people with Learning Disabilities and Autism to find out what support helps them to Stay Well – it is very common for learning disabilities, long-term health conditions and mental ill health to co-exist.

The Bangladeshi Women's Association Essex (BWAE) was founded in 2001 by Jahanara Loqueman, one of the first Bangladeshi women who moved to Colchester to join her husband in 1965.

Salma Ahmed, Community Ambition Project Coordinator, commented that the BWAE is the only Colchester-based organisation that is fully committed to addressing the needs of Bangladeshi and Muslim families.

BWAE have undertaken a health evaluation in response to feedback from the community, identifying that there are no services tailored to meet the needs of the Bangladeshi Community that take into account the cultural and religious sensitivity or language barriers. The Needs Assessment of the Bangladeshi and wider Muslim Community has been funded by NHS Charities Together, and a full literature review has been undertaken by Dr Farzana Chowdhury, along with the analysis completed by Liesel Park and Sharon Rodie [14]from the Suffolk and North East Essex Integrated Care System's Central Team.

This study aims to identify the barriers, explore potential changes to overcome these barriers and ensure the provision of equal access to health and social healthcare.

[13] https://www.nhs.uk/service-search/other-services/Respiratory-Medicine/CO4-5JL/Results/42/0.899196803569794/51.9101638793945/681/0?distance=25

[14] https://www.bwae.co.uk/_files/ugd/1126ab_05c436ce03e648ebb9087cc043f9fb05.pdf

The main objectives of the study are summarised as:

- Improve access to the NHS for Bangladeshi Asians

A significant proportion of the respondents have highlighted cultural insensitivity, language or communication as barriers in accessing both physical and mental health services. The need for interpreting and translation services has been identified as a major issue, across the evaluation. For instance, relying on family members might not always be the most appropriate way of support, especially if there are confidentiality or sensitive health issues involved.

- Promote information sharing within the community.

Some respondents highlighted how a culturally competent information service signposting to appropriate services would be valuable in increasing people's knowledge of and confidence in services.

- Improve the design of future health and care services for Bangladeshi Asians

This survey and its analysis have provided a depth of data and shared experiences that will be able to inform the coproduction of services for this community. The findings and recommendations can also benefit the wider Muslim community across our local Integrated Care System.

The evaluation has highlighted the need for further work to promote and improve the services for certain diseases and conditions where people of Bangladeshi and South Asian origin have a higher prevalence than other ethnicities, in particular:

Diabetes

The risk of developing diabetes is six times higher in South Asian groups than in white groups, and also has higher mortality from diabetes. About 400,000 people of South Asian ethnicity in the UK have diabetes, which is one-fifth of the UK diabetes population. Some health complications are associated with diabetes, including cardiovascular disease, kidney disease, peripheral arterial disease, and nerve and eye damage. Bangladeshi men display the highest risk among ethnic groups, which is 60% greater than White British men. Type 2 diabetes develops 5 to 10 years earlier in South Asians and at a lower obesity threshold in South Asians compared to White British people.

It is a complex task to understand the high prevalence of diabetes among South Asian groups. Biological and socio-economic disadvantages exacerbate the main risk factors.

The King's Fund analyses the health of people from ethnic minority groups in England and the physiological pathways and impacts of diabetes between the different ethnic groups[15]. For instance, diabetes prevalence in Black groups is up to three times higher than in the white population. However, Black groups have a higher-than-average incidence of and mortality from hypertension and stroke. The prevalence of hypertension, a risk factor for stroke, is high in Africa and the West Indies. Obesity is also higher in Black groups, with NICE guidelines specifying a lower BMI threshold.

[15] The health of people from ethnic minority groups in England | The King's Fund (kingsfund.org.uk)

Although the prevention programme is available in different languages, SNEE ICB and Xyla are still looking at ways to accommodate cultural norms. Their aim is to increase engagement by reflecting on the diversity of demographic, socio-economic, behavioural, cultural and other characteristics between ethnic groups.

Cardiovascular Disease (CVD) and Stroke

CVD is one of the leading causes of mortality in the UK. Diabetes increases the risk of developing CVD two-fold. The prevalence of CVD is higher in South Asian groups, who have higher rates of ischaemic heart disease, hypertension and diabetes compared to the White British population. South Asian groups are significantly younger when diagnosed with heart failure (72 years) compared to the White British population (78 years). British South Asians present with 12% more hypertension (high blood pressure), 24% more diabetes and 11% more anaemia than the White British population. Stroke rates in England and Wales are higher in African-born, Bangladeshi and Pakistani populations.

BWAE and their work to address the stigma around mental health[16]

BWAE has initiated the first-ever mental health workshops with the Muslim community, reaching out to around 70 people to discuss their mental health. The event, which took place in March 2022, helped break the stigma around the issue and improve understanding of what mental health is about and the need for the Muslim community to access appropriate services.

BWAE are passionate about mental health and supporting the needs of their community. Some of the key messages from the two-day workshops are cited as:

- Training for mental healthcare professionals in the 3C's: compassion, curiosity, and cultural nuance – therapists that are professionals who empathise with the community's issues.
- GPs to be more flexible and not rely on arbitrary measures - take time to discuss mental health concerns, rather than just using scales such as "have you had suicidal thoughts in the last 10 days"
- Improve trust with mental health professionals - many community members expressed a lack of faith that their GP would take them seriously
- Tailored Mental Health training for imams

Salma Ahmed commented that the community has a vital role to play, including accessible signposting to the right healthcare professionals, offering community spaces where the Muslim community can provide talks without prejudice, along with workshops to offer information and awareness about mental health. Salma Ahmed explained that Language barriers remain a huge hurdle for the Muslim community to access NHS services, including access to interpreters who are culturally sensitive and understanding.

Furthermore, online self-referrals remain inaccessible, and the peer-support program may be a better alternative for referrals. Salma noted that the attendees at the Mental Health Workshop felt it was okay to talk about mental health. Still, they highlighted that they need to raise awareness of mental health and support people on a localised level because of the stigma. BWAE will be looking to organise more local mental health awareness events and workshops and also offer local activities, both social and educational. In

[16] NHS BWAE 1928 - Digest of The Mental Health Workshop (gs-cdn.co.uk)

addition, they will explore different methods to open the conversation about good mental wellbeing and how to access mental health services.

While some similarities between the different ethnic minority groups exist, issues caused by these communities' outlooks sometimes come from broader cultural norms.

Godwin Dadu, a Community Builder at C360, is offering a new cross-cultural training programme to help ethnic minority groups develop a comprehensive view of a culture and its core values. The training is an in-depth ten-week programme covering different modules.

The goal is to help ethnic minority groups accept and respect the different aspects of diverse cultures and adjust to fit in with them harmoniously. The training also provides tools that can help bridge cultural gaps and adapt to a new environment.

Godwin is also involved in supporting different local groups promoting wider engagement of Black men in mental health awareness. He described this as a complicated process, and it has to be approached from a different angle, for example, a discussion in a less formal environment, such as visits to the barbers.

Godwin commented that the project aims to raise awareness and understanding of mental health and to influence decisions by focusing on the stigma attached. Understanding and recognising the cultural differences with ethnic minority groups is vital to ensure equality when assessing individual needs. Protecting people's mental well-being from these communities is challenging because of personal and societal issues affecting their decision to seek help. Godwin explained that historically, mental health problems do 'not exist' among the British-African communities. In the Black community, mental health problems are attributed to a sign of weakness that should be hidden from the public. The total denial of the existence of mental health is the most significant barrier for many black men to seek help. Providing education and information is the key to reshaping the attitudes towards mental health acceptance.

It is essential to consider that ethnic minority communities may belong to various religious backgrounds, therefore, may experience different challenges in addressing their mental health. Not knowing what help is available and how to access it is another barrier that prevents people from reaching out for help.

The health needs of the refugees from Ukraine

North East Essex collectively welcomed many refugees who fled Ukraine. It is essential to look at the broader landscape and how NHS addresses their needs, especially those with pre-existing chronic conditions.

Chronic illnesses are the most significant contributor to the disease burden among Ukrainian adults. About a third have hypertension, and 7% have diabetes. Ukraine also has one of the highest burdens in Europe of chronic infectious diseases, especially HIV and tuberculosis, as per the British Medical Journal.[17]

Effective management is only possible if those affected have continuous access to medicines and care, both are challenging for refugee populations as most refugees arrive without medical records or adequate medication supplies.

[17] The health needs of refugees from Ukraine | The BMJ

Many refugees stay with host families, who, in many cases, are their primary connections to access health services and support.

Anna Polyak set up the organisation 'Volya Ukraina' in Colchester in June 2022 as a direct response to the needs of the refugees arriving from Ukraine. Anna commented that her idea of creating a Community Interest Company (CIC) was to help out the Ukrainian refugees; more than 100,000 of these people have chosen the UK as their safe place to stay as the war progressively gets worse, destroying most of their homes. 'Volya Ukraina' is working with the Colchester City Council and other volunteering organisations, such as C360, to create new opportunities for further development to provide Ukrainians for their stay. Anna explained that she is half Ukrainian and spent most of her life in Ukraine: "It was heart-breaking to see what has been done to my country and my fellow citizens. My priority is to provide these refugees with fair opportunities and possibilities."

The goal is to create a safe place for the refugees to feel free to come for advice; this would mean creating a Ukrainian hub where they would have access to all necessities. Anna commented that mainly women with children attend the support group she facilitates every Saturday at the One Colchester Hub. These people are all very vulnerable; they have been through the mass trauma of escaping the war and many had to leave their partners in the uncertain environment in Ukraine.

Asked what presents barriers to accessing health services, Anna explained that not only is the complexity of the health system in the UK a barrier for people to navigate through, along with the language, but sometimes the interpreters speak or are Russian, which is another challenge and can be insensitive.

Anna remembered the first meeting when she started the group as very emotionally upsetting; she said these people had been exposed to the traumatic events in Ukraine and the ongoing daily stress of being away from home in a country where many do not speak or understand English. Anna added that many of the women attending her group are affected by the ongoing conflict and continue to experience poor mental health. However, having no knowledge of how to seek help and whom to speak to will lead to further health complications.

In addition, accessing a GP is only possible if you can explain what is wrong with you and understand what the GP is saying. Ukrainian women generally prefer treatment by a female doctor as well. Understanding what support is available might make them feel more included and integrated. Informational events are highly beneficial.

People with Learning Disability and Autism

A residents and tenants group and support staff at Acorn Village, located in Mistley, were asked about the challenges and the things that help them to stay well. Acorn Village has 60 service users across its community and provides support to others from the wider Tendring community and beyond.

Spotlight – the relationship between health and social care

It is reported that there is a lack of consistent joined-up thinking between the local authority and managing the health needs of adults with LD. For Acorn Village, this has resulted in additional hours needing to be 'battled' for in one case of someone having a serious long-term condition. There appeared to be a lack of understanding related to the anxiety that might happen, resulting in behaviour change or other social care needs

but as a result of a new or ongoing health issue. At times there appears to be a battle between health and social care, or even passing responsibility over to health in these cases when for Acorn Village, this is a social care need. The delay in agreement, if it is made, results in pressure on their service to provide the care without sufficient funding This means that scarce resources have to go further and may impact on the whole organisation. Quicker responses will deliver better outcomes for service users.

Referrals to services such as OT are also an issue. There is often conflict between the perceived responsibility of the Local Authority and health.

Acorn Village has good response rates for ambulances and there is a local first responder team that attends. There are excellent links with Lexden hospital and the community teams. There can be difficulties with some of the more able tenants accessing this support if they will not engage. This is not an issue for residential teams as it would usually be deemed in their best interest. The District Nursing team is excellent and the service has a good relationship with them and is very responsive.

The residents group said they often find it hard to understand some health professionals - some of this might be an accent or some might be the content of the information - either way, information needs to be made as clear as possible. On a positive note, generally, they say they are spoken to rather than just the carer. However, one woman said she wasn't always sure what to say as she didn't understand the question.

Hospital support is varied. Generally, Acorn Village's stance is to support someone until they are settled on a ward unless there are specific reasons why this could not happen. The route to the ward appears longer now, and it could be unsafe to leave service users with learning disabilities within this process without someone to advocate for them.

Acorn Village has a positive relationship with the LD liaison teams at ESEFT. Hospital passports are invaluable in ensuring that communication needs, preferences and concerns are understood by all involved in any medical/surgical setting. They are not routinely asked for and many have been lost or misunderstood.

Dentistry for LD residential services is a major issue, and availability for Supported Living tenants is also problematic. There is currently a year delay for the vast majority of Acorn Village's service users, and dentists may not be disabled-friendly in layout.

Voluntary and Community Sector Assets

In order to collect data about current community assets and needs in North-East Essex, many in-depth conversations with local networks and organisations took place to look at how the community supports people with long-term conditions. Through these interactions, the focus was on the community-based asset support which is available to the community. As a result, we aim to help with the development and delivery of meaningful local programmes. This will support our communities and address some of their immediate needs while waiting for treatment, considering the added pressure on the NHS from COVID. Due to timescales and resources, this research cannot cover every asset which exists in the community, but it highlights some areas of innovation, good practice and unmet need.

The responses highlight what is already well established and also expose some of the immediate gaps and barriers to community assets. While Colchester and Tendring are in a very strong position to continue addressing the needs of their communities, we also learned that there needs to be serious attention paid to issues such as well-being, loneliness and carer burden from the angle of the immediate danger of the rising cost of living.

While gathering data on patient experiences, we looked at agencies and government reports, with a focus on a few local groups that support people with long-term health issues, including Breathe Easy Colchester, Warm and Toasty, The Dance Network Association, Tendring Specialist Stroke Services (TSSS), Parkinson's Carers Support/Drop-in, Age Well East, support to carers from various groups and C360 Weight Management support and the CVST My Weight Matters programme provided by Social Prescribers in Tendring, both of which are directly linked with the Finding your Feet Walks and Wellbeing Walks across North East Essex.

Carers

It is widely recognised that the health and social care system could not function without the commitment, support and love given by family and informal carers. Caring for someone who is waiting for treatment can be very challenging. It is deeply distressing to see the decline in the cared for person's physical and mental health and the increase in caring workload often has a negative impact on the carers' physical and mental health too. In terms of admission avoidance, caring for carers goes a long way towards sustaining those with long-term conditions in the community. Without support, carers can find it difficult to continue in their caring role, and this can lead to hospital admission and/or residential or nursing care for their loved one.

Many community organisations, large and small, support carers in different ways – with information and advice, with Carers' Groups, with befriending or giving support with applications for benefits, etc. Some of these are very local, for example, church groups, and some are larger scale. Two larger organisations, Carers First and Essex Carers Support, gave an insight into some of the challenges faced by friend and family carers. Barriers were identified as follows: -

- Ability to navigate the system – even for those working within the system, this can be a challenge. People providing unpaid care are most often the ones dealing with 'the system', arranging appointments, making calls etc. They describe a system which is designed to meet its own needs (*but failing to do so*) rather than the needs of the patient or their carer
- Type and method of communication – people need as much information as possible both to navigate the system and to understand how they can access support or report changes in circumstances
- The number of calls that have to be made to get help – for equipment, for medical intervention, for support – carers are often bounced between personnel or departments
- Carers want the services provided to the person they care for to be improved and be more responsive; they say this would make the biggest difference to them. This is particularly true around hospital-based interventions and treatment. For so many, the period around an elective procedure creates a caring role that they may be totally unprepared for and have no awareness or anticipation of its likely/possible impact. "This is a real gap in the system".
- Lack of internet access – so much contact is now online and for those with no internet access (there are about 6m people in the UK), sourcing appointments,

equipment and information can be problematic. The more that support and information services move online and/or are provided by larger non-local organisations, the poorer the quality of the offer and the less likely carers are to access and trust them

- Lack of face-to-face contact can be a challenge, some people have sensory impairments and telephone or online contact is not appropriate; for some, it is difficult to talk over the telephone, particularly if their loved one is nearby
- Not all carers identify themselves as 'carers' so the language used, particularly by GPs and social care workers, should reflect this, making it easier to ask for help
- Distance – many carers live away from their loved one and good communication about their loved ones' needs and access to local support can support them in their caring role
- Mixed messages from social media – many people now turn to social media for advice and signposting and this can lead carers to groups that no longer exist, false information and sometimes even medication – information needs to come from a trusted source and there needs to be plenty of it
- Support to those who are carers themselves and need elective surgery. There's a need to rethink the support available to them and, in turn, the needs of the person they care for at these times. This is a significant barrier to carers addressing their own health needs as they ought and undergoing procedures they need.

In North East Essex, there is a 'North East Essex Commitment to Carers Network Group', which brings together partners from across the health and social care system (including the community and voluntary sector), led by the ICB. The group has developed a 'Commitment to Carers Pledge', which has been accepted by partners of the North East Essex Health and Wellbeing Alliance. It sets out agreed principles to support the implementation of an integrated approach to the identification and assessment of Carers' health and wellbeing needs across North East Essex.

As well as holding valuable conversations regarding the impact of caring and the importance of self-care, Essex Carers Support's 'Time 4 You' project enables carers to achieve a flexible activity/opportunity which improves their well-being. This can be done to suit their individual circumstances and can be undertaken alongside the cared-for person if this is preferred.

Spotlight: Essex Carers Support, Time 4 You	
	Barbara and Jim had always enjoyed spending time in the garden together, but when Jim's dementia became more advanced, he became a bit unsteady on his feet. Barbara's knees weren't what they used to be either. Barbara used Time4You towards the purchase of a raised garden planter so that they could continue this activity together. They could have something to fill their days and something in common to talk about and plan for in the evenings as they always had done as a couple.

erg

Carers need and want to keep themselves well but often put their loved ones' needs ahead of their own. The State of Caring Survey 2021[18] reported that 25% of carers report bad or very bad physical health and 30% report bad or very bad mental health (over 8,500 existing or former carer completed the survey). Statutory Carers Assessments, access to GP services and those in the local community can support carer wellbeing. It was reported that there are vast differences in Carers Registers across different GP services, clear standards may help to bring in more equality of support.

Small amounts of funding for very tangible things can make a positive difference in preventing hospital admission and speeding up the discharge process – for example, continence support – maybe provision of a tumble dryer to ease stress in the household; smooth and ready access to equipment; help with getting shopping – or maybe vouchers for food delivery firms like Hello Fresh or Gusto.

Peer support is particularly important as it enables sharing of experiences without feeling ashamed or disloyal. Greenstead has a Monthly Wellbeing Group, which offers a place to go to meet other carers and address issues in a safe, informed space, see the Citizen's Voice section of this report.

Crossroads Tendring and Colchester work in the community and cover the whole of Tendring & Colchester District, providing a range of services to support carers who would like a little time to themselves. This can be vital to enable a carer to sustain themselves in a caring role. Trained community support staff go into the home and take care of the cared-for person for a few hours each week to give carers a break. Their support to adults covers the following: -

- Sitting services
- Personal care
- Medication prompting
- Shopping
- Light household duties
- Assisting with correspondence
- Assisting with access to the community
- Promoting Independence

The State of Caring Survey, 2021 found that when carers are asked about barriers they face in accessing support, they reported the following:-

- I don't know about the services that are available in my local area (38%)
- The care and support services available in my area do not meet our needs (28%)
- The cost is too high (24%)
- The quality of the care is not good enough (15%)
- There is no transport available to take the person I care for to services (12%)

When asked about the current support needs carers have in their caring role, they responded with the following

- More support to be able to look after their own health and wellbeing (66%)
- Understanding and recognition of unpaid carers from the public (66%)
- Better recognition from their local council of their needs as a carer (56%)
- Better recognition from the NHS (52%)

[18] Carers UK, State of Caring Survey, 2021

- More breaks or time off from their caring role (50%)
- More support from the social security system (50%) – fear about financial health was very evident throughout the survey

Breathe Easy, Colchester

One example of self-managing COPD conditions is receiving peer-to-peer support. The local Breathe Easy Group is a well-established support Group in Colchester for people living with long COPD in Colchester and Tendring. Breathe Easy Colchester was set up more than 20 years ago and now has in excess of 40 members. There was a Breathe Easy Clacton support group but this is no longer in existence, although the prevalence of COPD and levels of smokers in Tendring are still high.

The group provides additional singing and physical exercise support, which have been rescinded after the long Covid periods of no meetings and a decline in the number of face-to-face attendees. Breathe Easy meetings are informal and service user-led, offering health benefits and mutual support, increasing inclusivity and combatting loneliness. The members are looking to re-establish exercise and singing classes to encourage lung health. Regular exercise participation has been very beneficial for strengthening their muscles and boosting the service users' confidence to engage in community activities.

The group meets every third Friday of the month at St John's and Highwoods Community Centre in Highwoods Square, and it is part of the Asthma + Lung UK support groups.

John Price, the chairman of Breathe Easy Colchester, commented:

"Our group's aim is to support anyone who has just been diagnosed with any lung condition or is living with ongoing lung and breathing problems. Anybody is welcome to attend, participants can bring their spouse or a carer. Bringing awareness to COPD diseases is the main reason why I am still very vocal, and I have been offering many educational talks, including a talk in Parliament.

"Still, much more needs to be done to help people with these diseases live a better quality of life. As a COPD patient, I am very conscious about keeping my immune system strong, so I do not develop any other health issues.

"As a sufferer of Asthma from a child and now living with COPD I know how worrying and isolated you can feel. COPD diagnosis is usually happening in the later part of life, and these people have been very active in their community, so this group offers them the space to talk to like-minded people. In many instances, people have joined the group and become committee members as well because they have seen the positive effect of peer-to-peer support.

"I have found over the years that as a group, we totally understand what each other is going through, and many friendships have been made as well, which helps to reduce the isolation felt when you are suffering from long-term health problems."

Spotlight – reducing social isolation

Evidence of social isolation reduction is given in the following testimonial of one of the service users from Breathe Easy, who has been attending the group for several years:

"I loved the singing exercise, and I am hoping that they will resume. Singing has been an amazing exercise for my lungs and helped me manage breathlessness."

The participant attends the Warm and Toasty Memory Afternoon meetings as an opportunity to sing along at present.

St Helena Hospice Breathlessness Group

St Helena Breathlessness Service runs an educational support group for people who suffer from breathlessness as a result of a life-limiting illness. The group meets for 2 hours a week in a 6-week block either on the St Helena Day Centre site in Colchester or in Imperial House, Clacton.

The service covers goal setting, breathlessness management, fatigue management, anxiety management associated with breathlessness and a session on staying active and engaged for quality of life. Anyone interested can be referred or self-refer through the St Helena website.

SingalongaPen Health and Wellbeing choir[19]

Based in Tendring, this choir is promoted as a 'fun choir for anyone who has been told they can't sing, for those with breathing difficulties or anyone!' The Choir meets every Monday between 11am and 12 noon at St Paul's Church Hall in Clacton.

Harwich Sing Tendring Voices[20]

Harwich Sing Tendring Voices is a very popular singing group for all ages and all abilities. Their Golden Oldies Group meets in Harwich on the first Monday of the month and the third Wednesday of the month and in Mistley on the second Friday of every month.

It is a sing-along session with Golden Oldies as the song choices. It has become very popular with people of all ages and regularly raises the spirits of all those attending, including people living with the experience of dementia and their carers. The session gives an enjoyable time, 'the opportunity to socialise and the 'many wonderful health benefits there are from singing.' To further quote from their website 'This is a great group for the older generation whether you can sing or not – you don't have to have a voice like Doris Day to be part of our HS Golden Oldies gang'. Harwich Sing Tendring Voices provides time to sing, improve wellbeing and happiness and an opportunity to meet new friends and have a laugh and a chat over light refreshments.

There is also a sing-along session for adults with learning difficulties at Acorn Village and if anyone interested (not a resident at Acorn) would like to be part of that monthly session, they can contact Acorn Village and it can be arranged.

[19] (3) SingalongaPen | Facebook
[20] https://www.harwichsingtendringvoices.com/

Warm and Toasty Club

The Warm and Toasty Club is a unique community group working in music, arts and history for people over 50 and supporting young emerging music artists. The founder of the group Johnno Casson started the group 9 years ago in Colchester as a Memory Afternoon with a focus on retired people. However, the group is open to everybody now over 50 years old and from all walks of life.

There are 4 different groups across Colchester: Greenstead Community Centre, Grymes Dyke Court Stanway, Shrub End Social Centre and One Colchester Community Hub. Each venue attracts different age groups with diverse interests, for instance, the group in Greenstead attracted over 55 people at their last meeting.

Johnno Casson commented that the Memory Afternoons are social entertainment events that include memory sharing, quizzes, raffles and live performances. These befriending sessions have been demonstrated to help reduce loneliness and isolation, build self-confidence and friendship circles and to improve social cohesion, particularly around the understanding and engagement of older people. Johnno explained that the activities are designed around having a fun time in good company. We are listening to our participant's wishes, and we have developed the concept into delightful and unique people-centred events. Our Memory Afternoons are engaging and entertaining, we chat, laugh, sing songs, drink tea and eat biscuits and have a really great time. We love celebrating people and the lives they have lived.

We believe that by having a collective laugh, people can strengthen their immune systems and boost their mood, in addition, the group offers friendships and social support networks.

One of the participant's testimonials states: "*Warm and toasty is like a pill a doctor cannot prescribe. It changed my life.*"

Another local asset that has a transformational impact on its service users is:

The Dance Network Association (DNA)

The Dance Network Association is an Essex-based organisation formed in 2015, which provides opportunities for people to improve confidence and physical well-being through a variety of classes across the county, including those for older adults with Parkinson's and dementia and parents with very young children.

Spotlight: The Dance Network Association

Gemma Wright, the founder of DNA, believes that dance is the best form of medicine. Gemma commented: 'Dancing with Dementia' classes offer a chance for participants to experience creative movement and dance with their companions. Classes focus on stimulation of the brain through movement, repetition, props and musical timelines. These factors offer the opportunity to keep the mind alert whilst also unlocking support for general well-being. Approximately 20 people with dementia attend the sessions. Sessions run for 1.5 hours in total, including a 45 - 60-minute dance class and an opportunity for social interactions over tea and coffee. The classes are every fortnight on Thursdays at the Ark in Colchester.

Gemma Wright explained: “Our Dancing with Parkinson's programme offers dance and movement sessions which are appropriate for those living with Parkinson's and anyone living with a neurological condition, heart or circulatory disease. We are proud that this programme not only delivers a high-quality dance experience for the participants but also allows their companions if they wish to experience it alongside them. Approximately 40 people living with Parkinson’s attend the programme in Colchester.”

Classes usually last for 1 hour of dancing and 30 minutes of social time. Classes are mainly seated but we encourage those who would like to stand. A support artist is always in sessions to share the seated version as the lead practitioner develops standing material.

Dancing with Parkinson's class in Colchester, photo DNA

The DNA commissioned the University of Essex to undertake an independent evaluation to look at whether its dance programme is a benefit to people with Parkinson’s and dementia. Some of the headline findings highlight that the level of older participants’ loneliness has reduced, and the sessions have helped many people to socialise with others. In addition, the dance sessions have helped many older participants to stay physically fit and improve their fitness[21].

The older people’s feedback states that ‘the main reason for attending the dance sessions was to improve physical fitness, followed by socialising with others, for pleasure/enjoyment of dance and to stay physically fit. The report also highlights that the participants described the dance sessions as fun and enjoyable, that the teachers are nice and approachable and make them feel welcome, and that the sessions are excellent, thoughtful, well-balanced, and at a good pace.

Some of the main indicators that participants enjoyed the most about the dance sessions were social contact and meeting other people, movement and exercise, the music and learning new routines.

Physical fitness improvement is another indicator that the evaluation has highlighted as a direct result of attending the dancing programmes.

The participants responding to the DNA survey were asked how much the dance sessions have helped them to stay physically fit and how much they have helped to improve their fitness. The average score for staying fit was 5.3 out of 10 (where 1 is not at all good and 10 is excellent), indicating that the sessions have helped people to stay fit. The average

[21] RESOURCES | Dance Network Assoc (dancenetworkassociation.org.uk)

score for improving their fitness was 6.9 out of 10, indicating that the sessions have helped many people to improve their fitness.

Tendring Specialist Stroke Services

In the NHS Suffolk and North East Essex ICB area, 2.20% of the population have experienced a stroke – that equates to 21,143 people.

Tendring Specialist Stroke Services (TSSS) offer supportive services to stroke survivors and their carers. A stroke is effectively a brain injury, with the brain thrown into chaos – TSSS aim to try and help put some order and understanding back. The service offers a Specific Stroke Assessment and has a neuro physiotherapy team and a stroke rehab nurse who, together, can offer a range of bespoke support which helps people to remain independent within the community. TSSS covers Tendring and the organisation receives referrals within six months of discharge. Most people self-refer. Ideally, TSSS believe that people should come to the organisation straight from hospital discharge, but it would need further resources to be able to accommodate this.

In terms of Right Care, Right Time, Right Place, patients need to be talking to the right people, TSSS has a lot of expertise and could have a presence on wards to facilitate discharge, access to community-based service and a clear pathway which is appropriate to each patient.

TSSS has good relationships with GPs and does casework with them, but there are further inroads to be made in some cases and places. They recognise that there is a marketing need there to make sure that GPs know and trust the organisation well.

TSSS would like to see the simple procedure of thrombectomy more widely available (maybe facilitated by dedicated stroke ambulances) within the 'golden hour' to deliver more positive outcomes for patients.

In the past 12 months, TSSS have taken referrals and given support as follows:

- 250 Post discharge reviews
- 215 Counselling referrals
- 500 Physio support and rehab
- 300 Stroke rehab nurse interventions
- Activities and therapies sessions included 700 interventions

The case study below gives a clear picture of the nature of support provided and the way in which it helps people to stay well.

Case Study – Tendring Specialist Stroke Support Service

One gentleman was resigned to life as a wheelchair user. Also, the clawed hand, often experienced by stroke patients, had almost seized up and the nails ingrowing, as well as becoming sore and a site for infection. This gentleman was encouraged to attend the therapy group, he insisted to his wife that he did not want to sit around having cups of tea feeling sorry for himself. Once at the group, the physio and rehab team got to work and spoke with him and carried out an assessment. They listened to his anger and frustration, the gentleman had been a builder and very capable, he referred to himself as a "vegetable." The neurophysiology team persuaded the gentleman that he could start to achieve a lot more with grasp therapy by using manipulation and wax, cleaning up the site and nail care. Working with the rehab nurse, taking the exercises and therapy each week, the gentleman was using his hand, and washing himself instead of

his wife doing it. Sit-to-stand therapy and exercise patterns were established and carried out at home.

Eventually, a walking frame and stick were used. A driving assessment was booked as this gentleman wanted to test his abilities, the team rethought him to get in and out of a car and to walk. Bowling was used to increase his ability to bend and stand upright. The gentleman passed his driving assessment and bought an adapted vehicle, as well as a mobility scooter. The gentleman uses a stick to walk short distances, does some shopping, and deals with his personal care. The best thing for him is, he can make his wife a cup of tea in the morning and take it to her in bed to thank her for looking after him.

Parkinson's Carers Group/Parkinson Drop In

These groups operate in Tendring to support people living with Parkinson's Disease and their carers. Anyone can refer to the clubs and groups, including GP's, CVST and self-referral.

The groups are all drop-in, with no booking required. There is a monthly Carers group at the Kingscliff Hotel, Clacton, with approximately 20 people attending. Two other groups run once a month on Thursday evenings and Tuesday afternoons at Holland Public Hall. There is usually a guest speaker or entertainment, and people can come and chat to share experiences and if any onward referral needs to be made, this can be supported. There is an advisor who attends to help people with more in-depth questions and to give support to attendees. In addition to this, there is a bi-monthly ten-pin bowling group at Clacton Pavilion and a weekly yoga group.

Overall, the groups support approximately 140 people at present. People can attend for as long as they wish. The organiser, Jackie Shield, says that she thinks the attendees feel this is a lifeline and enjoy attending and get a lot out of the groups. The groups help to prevent isolation and connect people to useful information and support within their community.

Harwich Parkinson's Cafe

Harwich Parkinson's Café offers information, friendship and mutual support to local people with Parkinson's, their families and carers in an informal setting. The café is held in The Lounge, Esplanade Hall in Harwich.

St Helena Hospice

St Helena's Compassionate Communities service[22] provides essential care to people and their carers who are experiencing death, dying and loss. This includes a bereavement counselling service for children and adults, management of chronic breathlessness (see above) and person-centred spiritual, mental and emotional support from their Chaplaincy and Complementary therapies teams. A Compassionate Communities approach helps to meet the rising demand for end-of-life and palliative care, built on the ethos of a combined Public Health Approach and Asset Based Community Development (ABCD), supporting the National Palliative and End of Life Care Partnership Framework (2016-2026) Ambition 6: Every Community is prepared to help. Compassionate Communities recognise

[22] St Helena Quality Account, 21-22

that everybody has a role to play in supporting each other during times of health crisis and personal loss and that together we can make a difference. It uses the principles of Asset Based Community Development by working with local people, community groups, businesses, places of worship and other organisations as essential assets that are willing and able to improve the experience of people at the end of their life and increase the resilience of the community to cope with issues related to death and dying and remove some of the taboos around dying and death. More of St Helena's work is covered in the Die Well Asset Map.[23]

There are many organisations across North East Essex working with and for older people. Some are very local (e.g. church groups, U3A, community halls) and some are on a larger scale. Each one plays a part in helping people to remain independent and well.

Age Well East

Age Well East is an example of a larger-scale organisation which has a good reach across NE Essex. It is based in Colchester, with outreach to communities in Colchester City and Tendring District.

Their aim is to provide advice and provide practical information, connecting communities to tackle loneliness and encourage mental and physical wellbeing. They run a befriending service which keeps people in touch with their community and ensures human contact when sometimes there is none.

The organisation offers support to people in later years when they are living with emotional challenges, such as caring for someone at the end of their life or living through bereavement. It supports people and their carers through dementia diagnoses. The objective is to improve people's quality of life, especially during hard or challenging times.

The Information and Advice service deals with a range of topics and issues, including pension or financial queries, housing, or help trusted tradespeople to carry out work in the home. They can provide high quality reliable advice and support that people in later years can trust. This service helps people to access financial support, which they are eligible for and can go a long way to relieving stress from financial pressures.

A quote from their website "Whatever is preventing people from living happy, healthy lives, we are here to help them solve it."

Age Well East case study, August 2022.

D made contact with Age Well East in June 2022 and was referred to the Dementia team for more information on Dementia. Her mother (B) was diagnosed with mixed Dementia of Vascular and Alzheimer's and has moved in with D on a permanent basis. D is a single parent and works part-time, so was worried about her mother. B has started wondering off and getting lost, putting on stress on D and her home life. D's aim is for B to live as well and independently as possible as this is how she has always lived but at the same time, things need to be put in place so B is safe and secure when D is out working.

Since speaking to D in June she has been supported by the Dementia Team and the following has been put in place :

[23] https://healthwatchessex.org.uk/library/community-asset-mapping-die-well/

Carers Assessment – the dementia team have put a successful carer's assessment through to the council and D can now pay her neighbour to come and sit with her mother for a few hours a week whilst she goes to work, removing the worry about her wandering off and giving peace of mind.
Advice – D has been advised about grab rails, adjustments at home, coping mechanisms for carers etc. She feels like she is supported mentally as well as physically. D was advised to go on the Dementia training being offered through our Confident Communities project.
Referrals - Several referrals were made to put in place safety measures at home. Since then, Adult Social Services has put door mats, grab rails and door alarms in place. D booked an appointment with the fire service to get all her alarms up to date etc. Age Well East's Advice team has been in since to do a benefits check and things are being processed.
Training - D attended the Dementia Training we held in Harwich for Carers. She was very grateful for the free service and able to learn a lot about her mum's behaviour. She said our support and the trainer's support have given her invaluable information and a better understanding of how to deal with challenging situations with her mum's Dementia. She has been given tools and coping mechanisms and made aware of items that can help her mum live as independently and safely as possible whilst she is at work, e.g. grab rails, signs and reminders at home, GPS trackers, Herbert protocol etc.
Cafés and Clubs - We have advised D to join our Young Onset group once a month on Tuesdays and the Dementia-friendly group running on Mondays. D was concerned about coming with B as she said B didn't like any groups she has taken her to so far and finds it hard to integrate herself in group settings. B attended both groups so far and has settled in extremely well. D said it has been such a positive change for herself and her child at home, as they now receive support. D uses the Onset group to mingle with other carers and felt relieved that she is no longer alone and is building a network of support. B has settled in well and has left both groups with a smile on her face.
Ongoing Support - D is relieved with the ongoing support and advice during her time at the young-onset group and from the Dementia and Advice team. She didn't know where to start looking for information and felt very overwhelmed with mum's diagnosis. She now feels like she can come to the group to offload and network and be reassured that she isn't in this situation on her own. D said she is happy to see how B has easily integrated herself and enjoys her time at the café. She said mum never engaged with games or activities at home but is happy to do so whilst at the groups. This has given B a new purpose to leave the house.

The HILL (Healthier, Independent, Longer Lives) project in Tendring provides a broad range of activities and support within local communities, with a focus on Clacton, Jaywick, Walton and Harwich, the areas of greatest need within the District. These activities include friendship clubs, bereavement support groups, physical exercise, IT literacy and skills, arts and crafts and walking groups and attract a large number of volunteers. The project is highly valued by residents and is integral to social prescribing (and therefore GP liaison) and signposts to other information, advice and services to support participants. Social prescribers will set up groups to meet unmet needs which they identify through their activities.

Social Prescribing teams managed by CVST and C360 are recognised and valued as key elements of Right Care, Right Time, Right Place – their focus is on linking people up with the resources within their community, building confidence, prevention and early intervention. The teams support hospital discharge, hospice care and GP surgeries, the objective being to connect people to their community and their circles of support. The

challenge is that there are a limited number of social prescribers and a limited number of community-based activities and support to connect people with. The emerging trends identified include demand for information and advice, mobility support, isolation and befriending, mental health, key safes, hoarding advice and deep cleans. Early intervention reduces the likelihood of hospital admission and facilitates discharge while helping to tackle isolation and loneliness. To quote C360 My Social Prescription, *"We give choice and options for people to act on as they can. When people struggle, we work alongside them and do for them if absolutely necessary".*

Clacton & District MS Group

This group has around 60 members. They did have more, but since Covid 19 numbers have not picked up, despite advertising. Members are mainly over 50 years old, and the group would like to attract younger people. A group of volunteers helps to run and fundraise for the group. A coffee morning runs every 2nd Tuesday of the month from 10.45-12pm at St Pauls Church in Clacton on Sea. It is free to attend with free refreshments provided, along with information, advice and support not only for the person living with MS, but also for their carers as well as friendship and understanding. The organisation is able to and does refer people onto the correct services from the group as and when needed.

Weight Management

C360 My Weight Matters Programme and Finding your feet walks

My Weight Matters is an NHS programme which is not designed to be a diet or a quick-fix solution. This programme promotes weight loss in a safe and sustained way. My Weight Matters is a 12-week programme placing a focus on healthy eating, portion management, and keeping active. These evidence-based sessions cover dietary and physical advice whilst supporting you to adopt overall healthier habits. One of the key elements of Staying Well, particularly if the person is unable to be as mobile as they want to be, is keeping weight managed, diet appropriate and maintaining whatever activity levels are possible.

The eligibility criteria for the programme include:

- BMI over 25
- No diagnosed and/or active eating disorder
- No kidney or heart failure
- Not pregnant
- Not have diagnosed dementia
- Over 18 years old
- No diagnosed complex mental health.

The Colchester C360 weight management programme supports around 25 attendees per session, which runs every Tuesday at the One Colchester Hub in partnership with Provide. Many members are signposted to the Finding Your Feet Walks, facilitated by a C360 walk motivator. C360 also offers online walks.

Some of the stories shared by the participants are truly inspirational:

'Before lockdown, I was very active, cycling to work every day and walking everywhere. However, I now work from home, being less active and eating the wrong food, which has led me to put on a lot of weight. Covid has led to me piling on the lbs. I now have high cholesterol and possibly sleep Apnoea because of my weight. I am in my 30's, so this was a cause for concern, so the doctor advised me to join this weight matters programme. I

just want you to know the already big improvements in my lifestyle in the last few weeks because of the weight matters programme. Week by week, you give me hints and tips, which has led me to lose over 11 lbs in the first two weeks because of eating the right foods and motivating me to be more active. I can now play with my two boys without running out of breath, and I no longer feel tired during the day. Thank you for all you have done!'

'I wanted to thank you for the support and help you've given me over the past weeks that I've been on the My Weight Matters programme. As you know, I was referred to the scheme by my GP as I need to get my weight down and improve my health due to having Rheumatoid Arthritis. I'm really pleased with the amount of weight I've lost so far, and continue to lose a little each week, which feels manageable to me. I'm enjoying the 'Online walks' when I'm able to attend and feel they have definitely helped me to be more active than previously.'

'Thanks for weighing me in today. I had an appointment with my APOS Therapy physio yesterday, who reckons that with the progress I have made in using the boots, coupled with my weight loss and increased fitness levels, it is unlikely that I will need knee replacement surgery. I am delighted, I really wasn't looking forward to the procedure or the recovery process. The NHS will have saved a lot of money too. So, thank you for your help, advice and encouragement.'

*'The **Active Motivation walks** have opened up doors for me that I always thought would be shut because of my issues with mobility and walking. As a consequence of my brain injury and surgery, whenever I walk, whether it be 1 step or 10, my vision bounces up and down because of the signal from the brain. This neurological condition is exacerbated by headaches, nausea, double vision, dizziness, balance issues, double vision and loss of vision on the left to right head movement. This means that I'm limited in what I can do for exercise, and government or NHS schemes can't always assist in this situation.*

I've now been to three online walks, and I've adapted how I take part because someone's given me a treadmill, so now I'm walking on that and closing my eyes. The main thing is that by shutting my eyes, it stops that bouncing. Even if I had someone to guide me whilst I was walking normally, it doesn't stop the effect, so I'm really pleased that I've found yourselves and also others who have been referred to the walks.

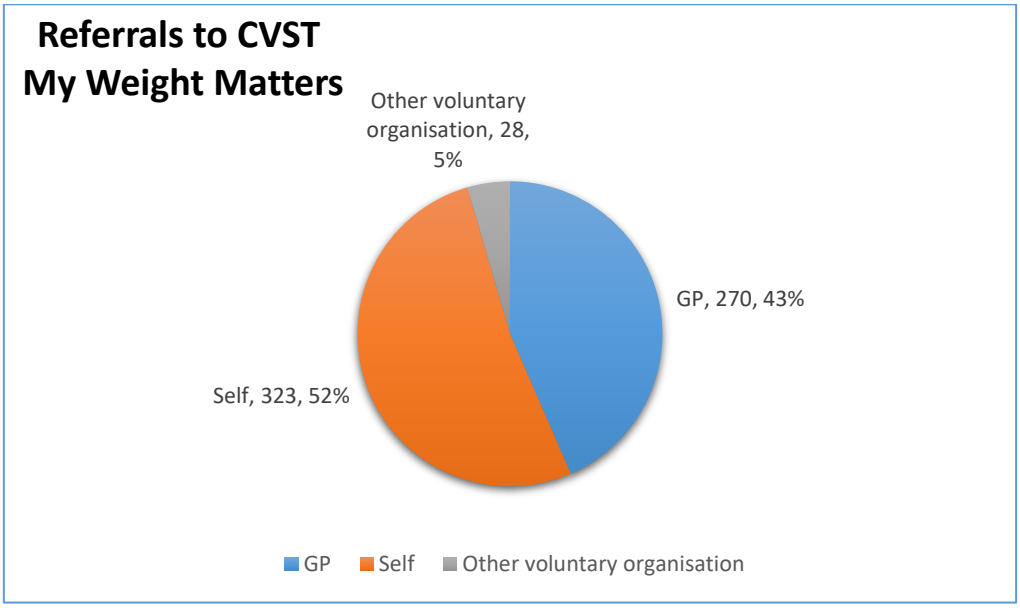
It's given me a form of independence, and from a social point of view, I can go with

C360 walk motivator Jo Bryant (on the right) with one of the participants during the Big Walk in November 2022).

the music and everyone's really supportive of each other. Jo's really passionate about what she does, and I'm certainly planning to continue going to the online walks.'	

CVST My Weight Matters Programme and Wellbeing Walks

The My Weight Matters Programme in Tendring is a free service provided as part of the Essex Wellbeing Service[24], with staff trained by NHS colleagues, which shares the eligibility criteria outlined above. In the financial year to end October 2022, there had been 629 referrals, as indicated in the graph below:



Of these referrals, 268 were referred by their GP and 7 were awaiting surgery; for the remainder, it was a positive lifestyle choice.

[24] https://www.essexwellbeingservice.co.uk/services/weight-management

Many have used this programme, to reduce their BMI in order to have surgery. Demand has been rising sharply. The programme offers help to adults to lose weight, get fitter and enjoy a healthier relationship with food. CVST hosts My Weight Matters sessions around the Tendring district in partnership with Provide, in Harwich, Clacton, and Jaywick on Mondays, Wednesdays and Fridays, respectively. The service is run by social prescribers, who also have direct liaison

My Weight Matters promotes weight loss in a safe, steady and sustained way, with the benefits of:

- Reducing Blood pressure.
- Reducing cholesterol.
- Reducing the risk of obesity-related cancers.
- Reducing the risk of developing type 2 diabetes.
- Improving life expectancy.

Alongside My Weight Matters, **the HILL programme** in Tendring provides other activities to support a healthy, active lifestyle and enable social contact for people who may feel isolated. The groups are friendly and easy to join and include seated dance, seated yoga, tai chi, meditation & relaxation and walking groups. The walks are free of charge, of different lengths and based in different areas of Tendring – currently Clacton, Harwich and Walton. They usually involve fitness and friendship and an opportunity to chat over light refreshments in a local café long the walk.

Case Study: CVST My Weight Matters

A woman had finished her 12 weeks of MWM at Imperial House, but her BMI was still too high for surgery on her knee. I asked her if she wanted to continue with this on a one to one with me at her surgery (Old Road, Clacton), she said she did, as she was quite desperate to lose more weight.

I have seen her there now 4 times, once she told me that she didn't want to go on living due to multiple problems which were getting her down, including the operation delay, having to buy continence pads which she couldn't afford, and pain in her leg not being addressed as the GP wouldn't give her an injection.

I arranged for her height to be correctly measured - the surgery had her at 147cm and not 153cm- she has a stoop which was not taken into account. With losing more weight – 4kg in the time with myself- her BMI is now under 35.

I queried the pain relief and she had her injection last week.

I requested referral to the continence team and she now has her pads via NHS.

I noticed this week that she was much happier and could move better. Although she has reached her BMI goal, she wishes to attend still to keep on track.

She has now been put on the list for a knee replacement.

Personalised Care

Many home care providers are pivotal in keeping people safe and well in their own homes and sustaining their wellbeing - this includes supporting people to stay well while waiting for surgery, to return to their own homes and independence and to prevent hospital admission.

A good example within the Tendring District is Home Instead. The organisation has been running as a franchise for 14 years serving residents in Clacton, Frinton and Walton, providing care and support at home. Clients are mainly older people and some people with physical disability and/or learning disability over the age of 18.

The service provides help with personal tasks like washing and dressing, meal preparation, medication prompting, transporting clients to medical appointments, helping clients to access other services which may help their wellbeing, health promotion, some night care, palliative care and dementia care. The service takes a holistic view of its clients and plans services with the client at the centre.

The key is to support people to stay at home for as long as possible. To achieve this, home care providers should be included in care planning, but this tends not to be the case, with home care being commissioned once a care plan is finalised – inevitably leading to amendments in the care plan. Providers need to know how they can help, what to look out for, warning signs etc. Agencies tend to rely on their own knowledge, experience and training to know when they have to ask for more help or changes to care plans. In setting up services, health or social care professionals should bring in private businesses and not ignore them just because they are not 'medical'. This is particularly the case in discharge planning.

Spotlight – Home Instead

The holistic view taken by the service includes diet, exercise and medication management as well as personal care needs. The service tries to link people with community activities and looks to see what can give clients pleasure. It has a trained activities coordinator who runs "The Fun Programme" delivered in peoples' homes – which includes armchair exercise, social contact and puts the fun back into life. Home Instead offers clients free theatre tickets, afternoon teas and companion calls as well as the Fun Programme. Sometimes they work hard with clients to 'market' these opportunities and integrate them into other things.

To quote their Owner/Director of a local home care service *"There's more to life than putting your knickers on in the morning!"*

Citizen's Voice

To ensure that the citizen's voice could be gathered effectively and productively, the engagement method we used was a qualitative approach, implemented via two different work streams. We would like to extend our gratitude to the participants who kindly gave up their time to take part in the project. We hope you found it empowering to have your voice listened to.

Interviews

In order to gain a more in-depth understanding of barriers, cultural factors and to hear more detail about people's experiences, a number of 1:1 interviews were conducted. These involved reaching out to various organisations and individuals within the intended areas. Participants consented to taking part and having their conversations recorded. These conversations were then transcribed and analysed to produce some key themes for both geographical areas.

Case Studies

Case studies are used frequently throughout this report to spotlight services and understand community response to staying well.

Through our engagement, the following themes were identified:

- Physical health
- Caring for the carer
- Emotional and mental wellbeing
- Advice and guidance

Who have we engaged with?

Greenstead

Though a deprived ward of Colchester, Greenstead has a strong community focus. Several local residents that we engaged with shared their hope that long-term positive change will be made in the area.

> *"I would like the reassurance that investment made in this area will be ongoing, not just for one month, and Greenstead is then forgotten."*

Project participant

Painted mural, Greenstead

At its heart sits the community centre, which offers a 'dynamic and widely accessible facility'.[25] Although offering a selection of support groups, a number of participants noted that groups are predominantly focused on children, the elderly and those with learning disabilities - a large part of the community who fall outside of this bracket.

'A registered charity and not run by any form of council, it is self-sufficient and relies heavily on the income generated through hall hire. All money is put straight back into the Community Centre to enable us to build and improve the lives of our residents and surrounding areas. The Greenstead Community Centre prides itself on a brilliant team of staff and volunteers who ensure that every person is made to feel welcome and that everyone is given a chance.'[22]

Regular support sessions held at the Community Centre include: MS Society weekly Chair Yoga classes; Embracing Neurodiversity Support Group, which takes place twice monthly; IECC Care Ltd, a provider offering domiciliary respite care and supported living services. Sessions are held once monthly via private referral only; The Omnis Centre offers a place for those with learning disabilities, autism and mental health conditions to socialise. Additionally available is a hate crime hub and multiagency referral service. Community 360 are available at the centre every Monday morning for three hours to offer support, provide information, guidance and promote the opportunity to join a monthly one-hour 'Walking for Wellness' session with their Walk Motivator guide. For those unable to access this service, an alternative online walk is available to them.

[25] https://www.greensteadcommunitycentre.org.uk/about

"I joined the Walking for Wellness group because I'm shy, was feeling lonely and started becoming depressed. I was initially hesitant to join but soon began to feel more comfortable as the walks are short, and though everyone talks, though there is no pressure if you'd rather not. I wouldn't have left my house if I hadn't of joined these walks. Now I'm a regular!"

Project participant

Kelly's Kafe based in the community centre, is open six days a week, offering a variety of meals and refreshments, including hot food, and has ample seating offering an opportunity for socialisation.

Weekly Chair Yoga classes for those living with Multiple Sclerosis, facilitated by a Greenstead resident, attracts members from as far as 18 miles away i.e., Dovercourt in Harwich. The sessions are heavily subsidised by MS Society Colchester, which is greatly appreciated by service users. Additionally, the group meets socially once a month in Colchester which provides additional emotional and mental support. The average age of service users is 48.

Transport is a barrier for service users who are unable to drive and the public transport service to Greenstead is limited. A significant number of MS sufferers living in the Stanway area are unable to attend the Chair Yoga session due to the limited bus route.

Social media, via their Facebook page, and a nominal number of posters are used for advertising. This group would appreciate support with advertising their service to support the wider community.

Age Well East offer a weekly two-hour Friendship Club in Greenstead Community Centre and a weekly Armchair Exercise Group class in Colchester. This has been successful and one resident explained she has been able to reduce her respiratory medication by 50%.

"I'm aged 80 and have bad asthma, using a nebulizer four times a day, but since regularly attending these exercise classes, I no longer need the nebulizer. Being able to breathe more easily has given me a new lease of life."

Project participant

For those living with Fibromyalgia, a monthly support group is held in the Greenstead Community Centre. This is a Colchester-wide group, where service users travel from as far away as Clacton and towards Braintree, three-quarters of the service users are Greenstead's local residents.

"It's a lovely group and invaluable."

Project participant

These monthly sessions provide information, support, a space to talk, seek advice and help. Attendance numbers can range from six to twenty service users. To support those unable to attend on a Friday at 1pm, video meetings are available to vary the time of the session during the week. In addition, transport (car lifts) is provided to service users who need collecting. The average age of the service users is 40. A grant has met the cost of the hall hire and as service user numbers are dwindling, the group facilitator has requested support in how to re-engage users with the hope of also encouraging the group to become more ethnically diverse.

"Making us aware to other ethnicities is quite a challenge."

Project participant

Physical health

Essex Pedal Power, the community-based cycling project, will allow eligible residents in Greenstead, over the age of 16, to apply for a new bicycle free of charge. This is due to start in Spring 2023. 'The project will create new community cycling clubs with the ambition to build new cycling facilities, which support the programme and provide more opportunities for residents to take part in cycling.'[26]

Age Space promotes exercise classes for the elderly in Essex to support reducing the risk of disease onset and a great way of staying sociable. Classes include yoga, walking sports and aerobic classes. Age Space signpost to Fun with Fitness classes which are held in St Stephen's Church, 2.1 miles from Greenstead Community Centre.

For those unable to attend classes in person, they are signposted to Mirthy, an online digital platform enjoyed from the comfort of their home. Free exercise classes streamed live include aerobic fitness, Pilates (seated and standing), laughter yoga, regular no-laughing yoga and more.

[26] www.activeessex.org/essex-pedal-power/essex-pedal-power-colchester/

‘ParkPlay started in 2018 with the aim of encouraging everyone to be a little more active, bring communities together and experience the life-changing power of play. With the support of partners, especially Sport England, and despite the pandemic, thirty two ParkPlays have been launched across the country and the number of participants has grown to more than 3,000. Plans are to expand rapidly into new regions and communities. The two-hour long session runs every Saturday morning (https://park-play.com/parks/east-of-england/). ParkPlay breaks down perceptions of what physical activity ‘should’ look like and welcomes people of all ages, backgrounds and abilities. Though the focus isn’t about exercise, people can certainly have a good and active session if they choose. Sessions are available at both Hickory Avenue Playground in Greenstead and at Jubilee Playing Fields in Walton-on-the-Naze.’[27]

Participants agreed on the benefits of these weekly sessions:

“It’s a physical and a wellbeing boost, sure, but I’ve also met so many different people in my community and made some really good friends.”

“I’m glad I trusted my instinct.”

“It’s fun, it’s good for me, and it’s an opportunity to connect with local people.”

“It’s a wonderful way for people of literally all shapes and sizes to be more active.”[28]

In Greenstead, an outdoor gym is located a short walk away at Magnolia Fields, offering free-to-use gym equipment in an outdoor setting.

Enoch House, a Colchester Borough Homes sheltered housing scheme, is located in the heart of Greenstead, offers opportunities for tenants to socialise and encourages mobility with its large garden and communal facilities, including hairdressers/beauty room, pool/snooker room and craft room. Dance Network Association (DNA) offer free weekly Regeneration classes, promoting creative dance and movement for older adults at Enoch House on a Thursday, 2pm – 3.30pm. This session is not exclusive to tenants but to the local community yet given there is no cost implication, uptake from Greenstead residents

[27] Greenstead – ParkPlay (park-play.com)

[28] Our Stories – ParkPlay (park-play.com)

is very limited. DNA would appreciate support to engage and raise awareness of their service with residents.

"It's brilliant for my mental wellbeing because I'm not scared to stand up, sit down, or turn around, although I do it slowly. I've now got more comfortable going out then I did before…I'm enjoying my life!"

Case Study

"This [RE:Generation class] is completely different and it's really entertaining. I mean, I used to dance all my life until I got old, but this has brought it all back to me; doing all these exercises and it's been good. The people have made me laugh; it's been a very enjoyable afternoon. It's a shame it's just once a week, I'd like it three times a week because if you have it one day a week you strain your muscles and then you have got a week and you have to start it all over again. Whereas if you had it three times a week, your muscles would be used to it, a bit like going to the gym.

What made me join RE:Generation classes is Dance. I can't dance like I used to. Any sort of dancing will do me. It's hard to say what I like most about the classes because it's all flipping good. You're using your legs, your arms and stand up when you're able to. It was great to stand up today and do that; first time! All because my blood pressure is alright. The social side is brilliant too. We're all friends here, you know. The only ones that aren't friends don't come, so it doesn't matter [laughter].

Since I've been coming, I've noticed my physical wellbeing was getting good, I wasn't creaking or aching so much."

Project participant

Walton

Walton's Community Centre supports the local community with the following services: Food Bank Community Larder; Warm Hub; Home-Start; Slow Cooker Project, an affordable option for cooking, where service users are provided with six weeks of ingredients and the support on how to make nutritional meals; Preschool, which now opens all day, five days a week; Housing benefits advice; Special needs group; Hearing loss/tinnitus support run by RNLD.

"We would like to offer more services at the centre but due to lack of capacity i.e. physical space and time, it's not possible. Arranging and coordinating our current services are 'ad-ons' to my job - I'm employed by the preschool!"

Project participant

Exercise classes used to be held at the community centre but are no longer due to lack of capacity, so now can be accessed at the nearby Columbine Centre, Walton. This leisure centre is a versatile venue offering indoor bowling facilities, a selection of regular fitness classes, including Zumba, Jazzercise, Walk-It and Gentle Fitness classes.

CVS Tendring offer weekly Wellbeing Walks in Walton, Monday, 9.15am lasting 1.5–2 hours including a refreshment stop at a café. A fun, gentle walking group for all ages and abilities.

Carers

Often considered the hidden voice is the carer, particularly those family related to the person being cared for. Society relies heavily on this voluntary sector. Carers can offer the wraparound care of a loved one, enabling hospital admission avoidance or, similarly, the support when a loved one is discharged from hospital. Their needs are often not met, and their own health implications are frequently put aside or dismissed as this may not be their priority.

"When my husband got COVID, I stopped work to look after him when he returned home from hospital. Sometimes I feel guilty because there's no money, but what if something happened to him when he was home alone."

Project participant

Carers First offers a monthly Frinton and Walton Carers Support Group for carers only, every second Thursday, 1:30pm-3pm at the Homelands Free Church, Walton. This provides an opportunity to meet and connect with other carers who may be experiencing similar caring situations. It allows the chance to enjoy peer support in addition to guest speakers from a variety of organisations on a wide range of subjects, with refreshments provided.

Additional services Carers First offer are ‘Care2Relax’, a once-monthly group session, supporting physical activity and health and wellbeing. ‘Telephone Benefits & Advice’ offer regular telephone appointments, 15 minute slots between
10am–3pm. ‘Side2Side Male Carers Virtual Breakfast’, is an online group for male carers only, 10am-11:30am, online, providing the opportunity to meet other male carers across the North Essex area on Zoom. For many carers, they miss the camaraderie with friends and/or work colleagues that they formerly enjoyed.

Case Study

A project participant shared her experience of being a full-time carer for both her seriously ill daughter who's living with a brain condition and young grandchild, highlighting the challenges that carers face given she has her own medical needs.

"I have got several quite serious things wrong with me at the moment but am in fighting mode supporting my daughter's poor health which is very unstable. I'm not alone with that, family carers completely forget about their own health. It doesn't matter what the disability is that you're supporting, as a carer you're tied, your life stops, you can't make plans and you lose your friends because you regularly say 'no' to their invitations."

"I was in a very low place having had to give up work for my loved one and so there was no income coming in."

Action for Family Carers, AFFC, specifically supports unpaid carers in the Essex area. They offer a telephone befriending service and a counselling service which can be accessed via a GP referral, Social Prescribers, Mental Health trusts, Healthwatch Essex, or self-referral. At a time when feeling low our participant was very grateful for the help of AFFC who sourced her a bereavement counsellor, given her daughter was on a palliative pathway, enabling access to six free one-hour counselling sessions.

Though funding ceased at the end of last year, AFFC's 'Feeling Good Caring Well' project greatly benefited and was thoroughly enjoyed by service users. Those we engaged with agreed that it's very disappointing that this invaluable service offering wellbeing workshops, alpaca walks amongst many other activities has now had to stop.

Headway Essex have also been an incredible support for our participant.
A brain charity relying on voluntary donations to continue to provide vital services to brain injury survivors and their families. They offer a monthly Carers Group but currently no residents from Greenstead access this service. There is one service user from Parsons Heath which is 1.6 miles away.

"Headway Essex has made me whole again really. The carers group has empowered me. They have made me realise I am not the only one going through this."

(Brain injury carer support group in Essex | Headway Essex)

Walton residents have to travel to Clacton to utilise the day centre and costs are incremental, depending on their care need which is individually assessed. A Young Person's Carer Group is available to those aged 18–40.

Emotional and mental wellbeing

The Walton Feel Good Choir is a community choir based in Walton, relying heavily on fundraising. Singing popular music, not choral, it is an all-inclusive group as no music reading ability is required, the focus being on fun and friendship and space offered to support members living with physical and mental health challenges. Members enjoy the additional wellbeing benefits, including organised trips to see shows together as a group, summer BBQs and Christmas parties. The choir leader, also the group founder, is a professional singer, leads several other local groups and is an Occupational Therapist working in the community for the NHS. With an aim of making the Walton Feel Good Choir as accessible as possible, each session costs £4, which includes refreshments.

"Being a carer and with my own experience of ill health has left me feeling socially isolated and anxious. I'm so grateful for the Walton Feel Good Choir"

Project participants

'Also committed to supporting their community, the choir play an active role in upkeeping local flower displays, volunteering, performing and donating to the local foodbank.'[29]

Walton Feel Good Choir

[29] Services | Keep on Dancing (waltonfeelgoodchoir.co.uk)

Case study

Our project participant, aged 54, had a heart attack six years ago and was advised that her life expectancy would be significantly reduced. She was very concerned and found herself feeling very isolated as unable to leave her house due to anxiety and depression which led to suicidal thoughts. She was pleased to hear from a neighbour, the choir leader, about the Walton Feel Good Choir. Though fearful of going outside, her great love of singing gave her the determination to attempt attending.

"It took an awful lot for me to go that first time, and the stairs that you had to go up, it took me about five minutes because I just could hardly walk up the stairs. There's a stair lift but I was determined not to use it for the very first night. I had such a buzz after that first evening, so I kept going. It lifted me out of the depression, because it got me out of the house. I met new people, I've made some really, really good friends I think it inspires me to do something and I've now lost over four stone in weight. My health is so much better albeit I have heart disease. I have angina, obviously because of the heart disease, diabetes and asthma. Most importantly, when I go home I'm in a great mood after choir."

"Now I can sing for the whole performance without getting out of breath, I can now use the stairs, and the support I've had from our choir leader is absolutely phenomenal."

"I take that with me, and it almost carries me throughout the week, the feeling of family within the choir is absolutely wonderful."

And there's laughter, fun and so much love.

"With depression and suicidal thoughts, all my GP offered me was tablets which made me feel like a zombie. The tablets were no good for me. I was relieved to have joined a local choir, now I feel so happy."

An aspect that our participant really enjoys is the opportunity to share this experience [the choir] with the community, allowing other people to see us and even if some of the people know us, what we've been through.

"Wow, look how much they've gone through and they've come out the other side."

"More people deserve help if they feel alone, and life is really hard so I'm very grateful. I find it so helpful. I do hope it carries on for the rest of my life."

Advice and guidance

A new Citizens Advice drop-in service is now available at Greenstead Housing Office, held every Thursday.

Citizens Advice Tendring's outreach office in Walton continues to offer face-to-face appointments once a week.

Many community-based organisations offer advice and information about local resources, as well as signposting to more specific services.

Painted mural, Greenstead

Case study

A 62-year-old with kidney disease and hypertension, was referred by Home from Hospital. She was heard crying out for help by a neighbour who believed she was unkept, malnourished, and the property was uninhabitable, with no lighting (no working bulbs) and an unusable kitchen. She was using a small camping stove in a cluttered lounge where she was also sleeping and cooking meals.

She was unable to be discharged until the property was deep cleaned due to clutter scale. With the help of social prescribers, the deep clean was carried out and she returned home within one week.[30]

Libraries and digital support

Both Greenstead and Walton libraries have computer facilities that need to be booked in advance, either by visiting the library in person, phoning them or booking online. The libraries section of the ECC website has very recently changed due to the software being migrated onto a new platform. A positive change, as the information is now more accessible from different devices, i.e. laptops, tablets, and phones, but possibly an

[30] Personal Health Budget, December 2021 – August 2022, CVST

additional hurdle for those who, to start with, aren't confident in the digital world. Online platforms have a tendency to change frequently as information/software is updated.

In addition to ACL courses available, libraries offer free courses with their Learn My Way program, where you can specifically be guided through how to 'use a touchscreen' on your chosen device.

There has been digital support outreach work during Greenstead's Day of Action, located in Greenstead's Community Centre.

There are various forms of digital support offered in the community for those who demonstrate a need, but for some, it is a bridge too far!

Recommendations

These recommendations are not an exhaustive list of how the whole system can be fixed, but they represent a response to some of the key issues which have arisen during our research within North-East Essex. The Stay Well Domain Steering Group have reviewed the findings and have identified how they may be able to move forward with some of these challenges.

Information and Communication

1. Based on the Waiting Well publicity campaign, to make information, advice and signposting more comprehensive and accessible and relevant to where a person lives. By making more comprehensive links, would enable people or their carers to make contact if their condition or need for support changes markedly. It could also be extended to direct advice about managing finances, employment, physical activity, dietary and nutritional support and mental wellbeing through social prescribing.

   Call to Action:
   Review information pathways, maybe through a task and finish group, including Voluntary and Community organisations and patient/carer representation.

2. Improve communication to support better access to information. Provide access to language and communications support, with a focus which includes people with sensory impairment, people for whom English is not their first language and people with learning disabilities.

   Call to action:
   To consider in full communication needs for each patient at the time of referral and during the treatment pathway to ensure full understanding and the ability to ask questions. *It may be relevant for this to be picked up by the Alliance Communications Group.*

Transport

3. Improving access to and cost of transport, as well as addressing the length of journey and waiting times for transport. It may be a huge improvement for patients waiting for transport to have better waiting facilities or advice about what they should bring with them if a wait is inevitable. More information could be given to community transport schemes (for example, that which operates in Great Bentley) which encourage volunteer drivers as well as well-established community transport schemes and Hopper Buses

   Call to action:
   The Stay Well Domain is already addressing this by proposing changing appointment times for Tendring Residents (to after 10am starts) to allow for ease of travel and promoting Community Transport Schemes more directly. Where people are likely to experience waits, then information and advice can be given to them to enable a more comfortable wait.

Supporting and Including Carers

4. Improve support for carers. In common with every other deep dive undertaken to date, carers often feel ill-informed, find difficulties in navigating the healthcare system and do not feel that their pressures are understood, especially as access to services becomes limited. Ease of access to appointments and support helps carers to feel recognised for the value they add to the system as a whole.

   Call to action:
   Monitor the impact of the 'Commitment to Carers Pledge' and Carers Strategy.
   Encourage carer advocates to link with ESNEFT, GP practices and key partners to help assess how information, pathways and processes may be improved to support them.
   Take this report to the NEE Carers Group led by the ICS.

Facilitating access to community assets and information

5. Accepting that some people do not wish to attend activities within their community, groups could take measures to combat anxiety about going out and lack of motivation by increasing access to and availability of befrienders and buddies to build confidence. For those who would find that inappropriate, the potential demand for other options, for example, online exercise classes and mutual support groups, could be explored.

   Call to action:
   Work with volunteer projects and walking groups and improve awareness of existing projects.

6. Support digital literacy in the home or in local facilities by extending the number of digital support groups available and training befrienders to support the improvement of and confidence in digital skills.

   Call to action:
   Refer this element to the NEE wide Digital Access Support Team

Growing and sustaining Community Assets

7. Fund more outreach support into local facilities for accessible exercise and social interaction, providing training to providers to support people with more complex needs and mobility challenges.

   Call to action:
   Identify key partners to lead this work, link to falls prevention and strength and balance programmes and Active Essex.

8. Build capacity and sustainability of local groups, recognise the need for succession planning to enable groups to continue as group leaders get older or have to deal with their own long-term conditions. Look at models that could be used to support sustainability.

Call to action:
Develop a network of Peer-led Health Groups, including training and tools for their leadership. Ensure that groups are aware of the support available to them from CVST and C360.