North East Essex Community Asset Mapping

Frailty Report

North East Essex Health & Wellbeing Alliance

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Contributors

Healthwatch Essex are an independent voice for the people of Essex, helping to shape and improve health and social care services in the county. We believe that people's views and lived experience of health and care matter, so we're here to make sure your voice is heard and responded to. Healthwatch Essex collects data and lived experience from the public of Essex relating to health and social care services, and uses that information to inform the way services are designed and delivered. It is important to us that the work that we do creates meaningful change.

Community Voluntary Services Tendring (CVST) is the local infrastructure organisation for Tendring. A registered local charity run by local people for local people we support local communities by empowering individuals and groups. CVST provides a range of services including volunteer recruitment, training, assistance with project development, funding advice, and organisational guidance and support for local charities and community groups. We work to promote community wellbeing, social inclusion, and collaboration among local residents. By fostering volunteer-ism and enhancing community connections, CVST plays a crucial role in strengthening the social fabric and improving the quality of life in Tendring.

Community360 is a registered charity and company limited by guarantee. Originally formed in 1968, the charity is an established anchor organisation working to achieve positive outcomes for local people across Essex, but with important bases in Colchester and Braintree. The charity's purpose is "Through partnership working we will foster resilient, thriving, and inclusive environments so everyone can live their best lives." Our activities and the effects of what we do are diverse. We endeavour to provide voluntary organisations with passionate, intelligent leadership, investing in bringing people together to co-develop and deliver impactful programmes of work that address local priorities.

1. Introduction

1.1 Context of this report:

This report is part of an ongoing series of community asset mapping within the voluntary and community sector in North East Essex (NEE) to support local health and social care. Since 2019, these reports have aimed to improve understanding of communities by drawing on the knowledge of local groups and leaders.

This report focuses on community and clinical assets related to frailty and falls care in North East Essex, aligned with the NHS Long Term Plan (2025). Frailty is defined as a loss of resilience in older adults or those with long-term conditions, reducing recovery from illness and increasing fall risk. Both frailty and falls worsen during winter, with hospital admissions rising due to poor mobility. These seasonal challenges highlight the need for proactive, integrated care rather than reactive treatment.

Policy makers advocate early intervention and community-based support within Integrated Care Systems to prevent deterioration and reduce hospitalisations. In response, this report examines current clinical and community service provision for frailty and falls in North East Essex. Its purpose is to inform winter planning for the Suffolk and North East Essex Integrated Care Board (SNEE ICB), aiming to improve health outcomes and reduce falls during the winter period.

1.2 Target Areas

1.2.2 Colchester

Population Health Management and ambulance call-out data identify CO4 and CO3 as priority areas in Colchester. CO4 includes Greenstead and St Anne's & St John's wards. Greenstead is the most deprived and densely populated ward in Colchester, with poorer health outcomes; 32.6% of residents aged 65+ live alone, above Colchester's 29.9% average. St Anne's & St John's has 24% of its population at pension age, compared to 17.2% locally. CO3 covers Stanway and Lexden, where over-65 populations are 22.1% and 23% respectively. These demographics correlate with high fall-related ambulance calls.

1.2.3 CO15

CO15, is a coastal urban area in Tendring which includes Clacton-on-Sea and Jaywick Sands. It offers green spaces and beaches with moderate population density and mixed suburban and semi-rural surroundings.

The area has a notably older population, with many residents aged 65+. Housing tenure is varied: 10,682 homes owned outright, 5,096 privately rented, and 1,487 in social housing. While many homes are owner-occupied, private rentals often suffer poor conditions, especially in deprived areas. Tendring ranks among England's most deprived areas, driven by low income, unemployment, poor health, and low educational attainment, contributing to health inequalities and high preventable disease rates.

2. Methodology

2.1 Asset Mapping Research

For this research, we adopted the definition of community assets from ARU's Overcoming Barriers to Health and Wellbeing report by Oonagh Corrigan:

• A community asset is defined as any factor or resource which enhances the ability of individuals, groups, communities, populations and/or institutions to maintain and sustain health and wellbeing and to help reduce health inequities.
• Community assets can take a variety of forms including activities, support groups, social networks and community spaces/places. A defining feature is that they have their roots in the community with the aim of benefiting community members.

Using Asset-Based Community Development principles, Community360 and CVST mapped assets by reviewing SNEE ICB materials and NICE guidelines to identify key elements of frailty prevention and intervention. This framework guided the categorisation of community and clinical assets linked to frailty pathways in NEE. Researchers then conducted semi-structured interviews with local service providers to explore roles, challenges, and support offered to frail patients.

2.2 Lived Experience Summary

For the Lived Experience element, Healthwatch Essex researchers conducted 30–60 minute semi-structured interviews with frontline workers and individuals connected to frailty and falls prevention. Recruitment was supported by GP surgeries, local groups, and surveys. In total, 30 participants were interviewed across Colchester (Greenstead, St Anne's & St John's, Stanway, Lexden) and Tendring (Clacton-on-Sea, Jaywick Sands).

10 people frontline workers were also interviewed including Frailty Nurses, Occupational Therapists, Primary Care Networks, Exercise Programme Leaders. All participants were fully informed of their rights within this research and consented fully.

A common theme cited from participants was loneliness and isolation, sharing that when mobility declines, they see fewer friends, lose social connections, and can feel "forgotten". This sense of isolation is often as hard to cope with as the physical challenges.

"Since I stopped going out, I feel cut off."

- Colchester participant

"It's the loneliness that gets you as much as the falling."

- Tendring participant

The support of the community and the assets therein is essential to enable people to live independently for as long as possible and to prevent increased frailty and need.

3. Winter Resilience in NEE: Access to Assets which Alleviate Winter Pressures

3.1 Fuel Poverty & Winter Warmth

Keeping warm in winter is challenging for those with frailty, as cold temperatures and reduced activity worsen health and mobility, increasing fall risk. Fuel poverty intensifies this problem. A household is fuel poor if on a low income and facing high energy costs, making heating unaffordable and raising health risks. Nationally, 13% of households (3.17 million) are fuel poor (Annual Fuel Poverty Statistics, 2024). In North East Essex, 4,950 households in Colchester and 6,578 in Clacton-on-Sea (15.2% of households, above the East of England average of 13.2%) face fuel poverty, driving winter health inequalities.

In Colchester, Community360 assessed, compiled, and distributed winter packs to support those facing fuel poverty and cold weather pressures. Residents could visit the Town Centre for assessment and collection, ensuring tailored support. While the scheme provided vital help, two challenges emerged. First, packs were not delivered, creating barriers for those with limited mobility or frailty who cannot easily access transport. Second, the £50 utility payment, though helpful, was often insufficient for sustained heating, leaving some with ongoing discomfort, such as arthritis pain. Despite these challenges, the initiative offered essential resources and highlighted opportunities to improve accessibility and impact.

Tendring adopted a different model to boost resilience by helping residents stay healthy, warm, and connected during winter while reducing reliance on statutory services. Funded by SNEEICB, the Winter Warmer initiative was delivered by CVST's Resilience team with Social Prescribers and partner organisations. Activities included supporting warm hubs across the district, promoted via CVST's website, and door-to-door deliveries in areas such as Clacton, Jaywick, Harwich, and Brightlingsea. Outreach included GP flu days, SOS Bus events, and community gatherings.
In 2024/25, 400 people used collection points, 1,352 attended pop-ups, and 8,144 winter items were distributed, including 438 coats. Forty-three people joined budgeting workshops. CVST also received £7,947 Household Support Fund, aiding 157 households with food and fuel vouchers. Residents needing extra help were referred to Social Prescribers. The Resilience project is funded until March 2026.

Financial support in North East Essex to improve warmth within the home is at a high level, as shown below in Fig.1:

Scheme	Purpose	Eligibility	Amount
Local Authority Disabled Facilities Grants	Heating Upgrades and Installation	Referred through ECC after recommendations from OTs	Up to £30,000 Grant per application
Local Authority Energy Efficiency Grants	Boiler Upgrade Scheme ECO4 Flex Home Upgrade Grant Insulation Scheme	Subject to Earnings Threshold and Home Assessment.	Varied
Macmillan Cold Weather Payments	Utility payment	Benefit Recipients Conditional based on temperature of the home across a week.	£25 per day per 7-day period
UK Gov. Winter Fuel Payment	Utility Payment	Pension Age People Means Tested	£200 if under 80 £300 if over 80

Fuel Vouchers CCC Citizens Advice Colchester Food Bank Signpost CVST	Emergency vouchers to top up fuel meters.	Anyone	Various
The Fuel Poverty Office at Tendring District Council	Energy saving advice Fuel debt counselling Grants for energy efficiency improvements Benefit checks and income maximisation Referrals to food banks and wellbeing services	Available to all Tendring residents Support via phone, email, or in-person	

Fig.1: Energy and Fuel Poverty Grants in North East Essex

Tendring District Council also maintains a Cost of Living Support Hub on their website, which includes:
·Links to:
oFood banks
oWarm spaces
oHousehold support funds
oLocal and national financial aid
·Regularly updated with new schemes and emergency support
·Visit: Cost of Living Support – Tendring DC

The Jaywick & District Energy Hub helps residents of Jaywick Sands and nearby areas manage energy needs. In partnership with Tendring District Council and Citizens Advice Tendring, it offers free services like home energy visits, grant applications, benefit checks, fuel/food vouchers, and advice on cutting bills. Support also covers fuel poverty, damp, mould, and ventilation issues. Open Wednesdays and Thursdays, 1 - 4 pm, at the Enterprise Centre on Lotus Way, Jaywick on a drop in basis.

Local authorities receive Essex County Council funding to run warm spaces in winter, heated areas for those unable to afford regular heating or needing a warm place while out. These spaces often include social activities to reduce isolation. CVST maintains and updates the full list of Tendring warm spaces annually on its website, alongside Colchester's map on Colchester City Council's site. Two major Colchester spaces, One Colchester Hub and Age Well East have closed since last winter, reducing provision and social activity. New warm space options are needed despite other sites remaining.

3.2 Damp and Mould Prevention

Winter increases condensation and mould, creating extra challenges for those in fuel poverty who struggle to heat homes. Mould in homes is common in older or poorly ventilated properties, often caused by excess moisture, poor heating, or insulation. It can lead to respiratory issues, especially for children, the elderly, and those with frailty which is worse in winter when windows stay shut to retain heat.

In Colchester, Eastlight Community Homes and Colchester Borough Homes offer free mould removal and repairs for tenants. Tendring District Council also prioritises damp and mould control through its Housing Damp and Mould policy.

Colchester and Tendring have Private Sector Housing teams responsible for regulatory enforcement. Using the Housing Health and Safety Rating System (HHSRS), they inspect properties, advise landlords, and can issue improvement notices to address serious damp and mould problems.

Anti-Mould Initiatives in Essex Healthy Homes Project, which operates in parts of Essex including Colchester and Tendring, aims to improve living conditions for vulnerable residents. The project focuses on addressing damp and mould issues by offering home visits to assess housing conditions, provide advice, and help households access funding for home improvements, such as better ventilation and insulation. Energy Efficiency Grants and Schemes Several government-funded schemes and grants are available to help residents improve their homes' energy efficiency, which in turn can reduce mould caused by condensation and inadequate heating. These include:

·Energy Company Obligation (ECO): A government initiative that provides funding for energy efficiency improvements like insulation and heating upgrades, which can reduce moisture build up in homes.

·Local Authority Delivery (LAD) Scheme: This helps local authorities, including Tendring District Council, fund energy-efficient upgrades for low-income and fuel-poor households.

·Warm Homes Essex: An initiative that provides advice and support on reducing heating costs and improving home insulation, which can help combat dampness and mould.

Community Support and Advice Local organisations, such as Citizens Advice Tendring and others, provide guidance and support for tenants and homeowners dealing with damp and mould issues. They offer advice on tenants' rights, how to deal with landlords, and how to access grants or funding for home improvements. Landlords in Colchester and Tendring are legally required to ensure that their properties are free from serious damp and mould issues. Tenants who experience mould growth can report the problem to the Environmental Health Department, and the council can intervene if the property is deemed a health hazard.

3.3 Social Isolation and Mental Health Pathway Integration
A major concern during winter is the heightened risk of social isolation and its impact on mental health. Cold temperatures, shorter daylight hours, and adverse weather make people less likely to leave home. This isolation can worsen if someone experiences a fall or has advanced frailty. After a fall, fear of falling again often reduces mobility and confidence, leading to fewer social interactions, increased loneliness, and faster physical decline. Loneliness itself can weaken individuals, raising the risk of further falls. Breaking this cycle is key to prevention. To tackle these possible adverse health conditions, there are a good range of assets available within the community to connect people:

Befriending Services	
Independent Age	Independent age offer financial advice, wellbeing support, help with health and care and technology, and end of life support, their current focus is tackling loneliness.
Age UK Essex	Age UK offer weekly telephone calls. This service is free of charge.
Age Well East	Age Well East Colchester provides support including befriending, care in the community, bereavement befriending and dedicated dementia support.

The Silver Line	The Silver Line is a confidential, free helpline for older people across the UK, open every day and night of the year.
Essex Befriends	Essex Befriends offers befriending services to people over 18 and who are carers, older people, those experiencing mental ill health or who have a learning disability. They are currently making most of their contacts by phone, video call, email or text.

Fig.2: Social Isolation and Befriending Services in NEE

Despite the wealth of social isolation and befriending assets across NEE, there is a challenge of integration into mental health services. Given that there is no dedicated older people's mental health pathway in NEE, older adults must access normal mental health pathways if they are experiencing challenges, with low intensity interventions, such as NHS talking therapies, having large waiting lists, meaning that for someone who has advanced frailty or has just suffered a fall (or indeed any older person during winter) social isolation assets are essential to maintaining good mental health. However, these assets mostly reside within community settings, primarily being run by voluntary and community sector organisations. As a result of this, there is often a lack of knowledge or will to refer to these organisations by clinical staff, meaning that social prescribers must bridge the gap. Ensuring that people are swiftly signposted or referred onto these organisations, through integration within the pathways, would help maintain good mental health of those experiencing reduced mobility or advanced frailty.

3.3.1 CASE STUDY Warm and Toasty Club

The Warm and Toasty Club is a community arts and history group based in Colchester. It delivers Memory Afternoons and related events specifically designed for people aged over 50. Its mission is to reduce loneliness, strengthen self-esteem, preserve personal and collective memory and contribute to older people's wellbeing. Their Memory Afternoons include regular face to face gatherings (and alternative online sessions) in community spaces or retirement homes. People share personal stories and memories, enjoy socialising, live entertainment, and reminiscence activities. The Memory Afternoons sessions take place on Mondays at the Greenstead Community Centre, and Shrub End Social Centre, in the CO4 and CO3 areas of Colchester.

Feedback and observations from the club's attendees can be seen below:

"I really look forward to the social contact I get from going to the Warm and Toasty Club, it really stops me getting lonely."

"My family have noticed I'm a lot happier and more confident now."

"I've suffered from depression for a long time but coming to this club regularly has helped me so much. I now don't need to go to see my GP as much."

"My partner is living with dementia, so this club has been such a great help for us both. It's warm and welcoming."

"I struggle to leave my house, so I'm glad there is an online option for me to be part of this club."

3.3.2 Community Transport

Transport is another key challenge facing our communities who are most in need, particularly those communities located around the coastal fringe often with poor interconnection. Similarly, there are large rural areas which are not served by strong support or road and transport links.
Community transport plays a vital role in supporting older people across north east Essex, particularly those living with frailty or limited mobility, providing a lifeline for those who may otherwise struggle to access essential medical appointments, social activities, and community groups. This service is invaluable as promotes independence and ensures that older residents remain connected to the services and support they need to maintain their health and wellbeing.

Tendring Dial-A-Ride is a wheelchair accessible, door-to-door transport service tailored to meet the needs of Tendring District's residents enabling people to access vital health and social activities, education, training, volunteering opportunities, shopping and visiting friends.
Service users are able to book their pickup and return times to fit around appointment times. This community transport service operates Monday to Friday 9am 5pm and is free to those with a valid bus pass.

Tendring Community Transport Hospital Hopper Service is available for people to access hospital and medical centres. This daily service picks up from both Jaywick and Holland on-Sea and is free to those with a valid bus pass.

In Harwich and Dovercourt this service is offered through Harwich Connexions who work closely in partnership with Tendring Community Transport. Community360 also run a community transport service within Colchester, whereby members can request rides to assets they may need to access for a lower cost than public transport.

Many participants expressed frustration at the lack of availability of community transport.

"It's a shame really. I'd go if I could, but without a way to get there, I just stay home."
- Colchester participant

"I'd love to go to the class—it sounds just what I need - but getting there's the problem. There's no bus that fits the time, and I can't afford a taxi every week."
- Tendring participant

4. Fall Prevention

4.1 Enhancing Physical Qualities in the Community

4.1.1 Demand and Assessment in Low Intensity Exercise Services

There are many benefits of maintaining physical activity throughout life; regular exercise, of at least moderate intensity, five times per week can prevent a number of non-communicable diseases including diabetes (type 2), various forms of cancer, mental health problems and musculoskeletal conditions. Mitigating the negative health outcomes that come as a result of the winter period, physical activity can:

• reduce the risk of cardiac death by 25% amongst people with diagnosed heart disease
• strengthen and reinvigorate age-related muscle tissue weakness
• impact on depression and in helping to maintain mental health and wellbeing in later life

Likewise, a planned and appropriate programme of physical activity has been demonstrated to reduce the risk of falls by nearly 30% amongst a population of older people at risk of falling. Two important risks of falls which may be present in those experiencing frailty come from muscle weakness (and deconditioning) and balance problems.

The North East Essex Strength and Balance Service, run by East Suffolk and North East Essex Foundation Trust, look to address exactly these issues. Commissioned by Essex County Council, the Strength and Balance Service uses a therapy-led approach with education on falls. Users complete a 12-week class-based program (with limited home options for poor mobility), offering 4 classes in Clacton, 3 in Colchester, and 1 in Harwich weekly. Exercises focus on postural stability, floor recovery, and Otago-informed routines, alongside advice on footwear, nutrition, environment, and medication to improve fitness and reduce fall risk.

The University of Essex's Move and Meet takes a similar approach, using placement students to assess participants and lead at least five tailored sessions, adding a social element to reduce isolation.
Demand and capacity are major challenges. Strength and Balance referrals rose from 55 to 70 per month (2023/24–2024/25), creating waits of 15 weeks in Clacton and up to 22 weeks in Colchester - above NHS targets. Extra winter funding briefly reduced waits by 3 weeks, but lists grew again. Referral quality also worsened since multifactorial risk assessments ended; inappropriate referrals (e.g., high dependency or medical fall risks) now delay access.
Move and Meet faces summer capacity issues as student-led sessions drop when students leave, with no structured volunteering scheme to sustain delivery. Ad-hoc volunteering occurs but is inconsistent; formal roles coordinated with Student Union volunteering teams could help maintain reduced service outside term time.
Despite these barriers, community alternatives exist. WHO recommends older adults do multicomponent activity emphasizing balance and strength at moderate intensity 3+ days weekly to prevent falls. Moderate exercise improves strength and balance, while low-intensity options suit frail individuals. Activities like aerobic exercise, resistance training, dance, yoga, and tai chi all support fall prevention.

4.1.2 CASE STUDY Senior U's

The Senior U's programme, run by the Colchester United Community Foundation is a free initiative designed to support older adults in Colchester, Tendring, and surrounding areas. Aimed at individuals aged 60 and over, the programme promotes physical activity, social connection with peers and their community, and supports mental wellbeing through weekly sessions held at multiple venues including Shrub End Community Sports Centre in Colchester. Sessions were formerly run in Clacton Leisure Centre.

Each session includes both social time and a range of low-impact physical activities, such as: walking football and walking cricket; boccia; table tennis; darts; and indoor curling.

Dementia-friendly and fall-prevention exercises are also offered in addition to refreshments for socialising. Currently the sponsorship from Provide Community allows the programme to remain free of charge to attendees which removes financial barriers and ensuring accessibility for all participants. Feedback and observations from the programme's attendees can be seen below:

"My partner and I love being part of Senior U's, not just for the varied (and not too strenuous!) fun activities…but, importantly, for the good friends we have made. We hope to see more people join us as they are missing out!"

- In response to the question of improved social connectedness since joining Senior U's, 92% of participants said they now feel closer to those around them; and 81% of participants said they are less isolated.
- In response to the question of improved physical activity levels since joining Senior U's, 92% of participants have been more active; 88% of participants have encouraged others to be more active; and 88% of participants wanted to take part in more physical activity.
- In response to the question of reduced incidence of falls / improved strength and balance since joining Senior U's, 92% of participant felt that their balance had improved.
- In response to the question of improved mental health and wellbeing since joining Senior U's, 92% of participants said they were feeling more relaxed; 73% of participants said they were feeling less anxious; 85% of participants said they were thinking more clearly; 85% of participants said they were feeling more confident; 88% of participants said they were feeling good about themselves; 92% of participants said they were feeling cheerful.

"It's very enjoyable, I always like to try something new…since I joined Senior U's shortly after Covid, it's been a joy to come and socialise with the other guys and gals and we have a laugh and it's all free, so even better!"
- Colchester participant

4.1.3 Physical Activity Assets

Tendring is well served by community assets which support a more active lifestyle that can contribute to living a longer, more active life. From maintaining mobility through regular visits outside the home to Tai Chi, Yoga and Seated Exercise classes there is a wide variety of assets to engage in. These moderate-low intensity exercise schemes that can be found across North East Essex, are not often utilised by those within clinical pathways. Whilst a completely up to date list of community activities is difficult to maintain, a list of the activities that were identified as part of this work is listed in Appendix 4.

Without proper evaluation procedures such as multi-factorial risk assessments and the coordinating service conducting those assessments which had previously been instated in North East Essex and the consequences shown within the strength and balance service, it may be difficult for health practitioners to effectively recommend appropriate low-intensity exercise classes in absence of capacity for the aforementioned services.

Some assets listed here require a higher order of physical qualities meaning that a misevaluation of the general physical capacities of someone at risk of falls may, in fact, put them at higher risk of falls.

4.1.4 CASE STUDY Sport for Confidence

The Strength & Balance programme at Clacton Leisure Centre and Leisure World Colchester helps those at risk of frailty and falls maintain mobility, confidence, and independence.

“I’m now finding it a lot easier standing up from a chair, my walking has improved, I’m now a lot steadier on my feet.”

“Now I’m feeling more confidence, I’m less reliant on other people. Am enjoying my independence again!”

Weekly classes include seated and standing exercises tailored to individual ability, improving strength, balance, coordination, and reaction time. Beyond physical benefits, the programme supports wellbeing, social connection, and independence. Home-based classes are available for those unable to attend in person.

“The best part about me getting more active is that I’m now less fearful that I’ll fall.”

“I’m a lot less anxious now. The exercises give me strength and hope.”

4.1.5 Care Homes Team

The Care Homes Team works across Suffolk and North East Essex, supporting homes with advice, training, projects, innovations, and workforce development. Activity Coordinators are in all homes and share good practice through a network. The team promotes resources like Golden Carers packs, strength and balance programs, Talking Therapies, and celebrates success via Prosper Awards.

Practice varies, with some coordinators needing more training, but the network enables sharing solutions. Notable successes include the ‘raise a chair’ project, which reduced ambulance call-outs. However, without evaluation tools health practitioners cannot confidently recommend appropriate exercise for those at risk of falls, limiting use of community assets to reduce falls and waiting list pressures.

4.1.6 CASE STUDY Right At Home Colchester

Right at Home Colchester, founded in 2015, helps people live independently at home and offers craft days and exercise classes. Its “Love to Move” program uses bilaterally asymmetrical movements shown to benefit older adults and those with dementia or mild cognitive impairment. These exercises also improve coordination, balance, core strength, and flexibility.
Love to Move classes take place in Stanway and other areas within Colchester. Feedback and observations from the programme’s attendees can be seen below:
“My husband and I attend sessions together. The sessions are great fun and uplifting. We are always happy when we leave”.

“I feel more alert, and the activities here keep my brain going.”

Right At Home Colchester have focused on fall prevention this year and have a ferrule (rubber stopper) replacement service where walking aids are checked for safety.
Regular social contact was highlighted as a crucial factor in helping older people cope with living with frailty or recovering from a fall. Participants who had close family and friends nearby reported being better able to cope with their recovery.

“I’ve got family around me, so I’m not like a lot of people who might be isolated and struggle because they haven’t got that support.”
- Colchester Participant

4.2 Addressing other Risk Factors for Falls

4.2.1 Hearing Tests

RNID Hearing Aid Support service includes maintenance and re-tubing of NHS hearing aids, replacement batteries, free hearing checks and signposting to other services that can provide support. Support is offered monthly at the following drop in venues:

• St John Church, Colchester • Walton Community Centre • West Mersea Town Council	• St Mary's Church Frinton • CVST Imperial House, Clacton • CVST Dovercourt and Harwich Hub, Harwich	• Tiptree Community Centre, • Kingsland Church, Colchester • Brightlingsea Town Council Offices

Hearing Help Essex, based in Chelmsford provide advice and support to help find solutions to difficulties associated with hearing loss. Their information, advice and guidance service includes:

- 1-2-1 appointments in person, via FaceTime/Skype, or over the telephone.
- Telephone and Email advice service
- Assistive equipment demonstration and loan from our Resource Centre in Chelmsford.
- Home visits are available upon request for those that are unable to visit our Resource Centre.
- Community Outreach stands across the county.

4.2.2 Nutrition, Hydration and Decaffeination

In 2015, Essex NHS areas launched 100-Day Challenges to cut unplanned admissions, including a hydration campaign with initiatives like the "50 Shades of Pee" campaign, awareness events, and UTI test strip training. Together, good nutrition and hydration form a core strategy for fall prevention and independence.

Older adults switching to decaffeinated drinks can significantly lower fall risk, especially those linked to toileting urgency. A six-month trial in eight care homes by Stow Healthcare, Care England, and University Hospitals of Leicester NHS Trust showed a 35% fall reduction and improved sleep among residents who switched.

This simple, cost-neutral change demonstrates how small routine adjustments can greatly improve safety and wellbeing.

"I didn't think switching to decaf would matter, but if it means I don't rush to the toilet as much - and that means fewer chances of falling, I'm happy to give it a go."

- Project participant

4.2.3 Dementia

Dementia greatly increases frailty and fall risk among older adults, creating major challenges for NHS services. Cognitive decline combined with poor balance, reduced mobility, and sensory deficits heightens this risk. NICE guidance notes people aged 65+ with dementia and comorbidities face serious outcomes from falls, including injury, loss of independence, and higher mortality.

Frailty is further compounded by polypharmacy, poor nutrition, and environmental hazards, requiring person-centred interventions. NHS case studies show targeted falls prevention using multidisciplinary assessments, personalised care plans, and home adaptations reduces falls and improves outcomes.

There are a number of voluntary and community organisations also provide information and support for people with dementia and their carers. However information about these is patchy and not held in one place.

- **Essex Community Dementia Support Service**, delivered by the Alzheimer's Society, offers tailored advice, signposting, and ongoing support for individuals and families affected by dementia.
- **CVST and Community360**, are key voluntary sector organisations who lead Dementia Friendly Community initiatives. These programmes bring together local assets such as businesses, schools, and places of worship to create a supportive environment where people with dementia can live well and participate fully in community life. They also run dementia cafés and awareness sessions
- **Age Well East**, based in Tendring, provides befriending services, community care, bereavement support, and dedicated dementia assistance. Their work helps reduce isolation and improve wellbeing among older adults
- **Healthwatch Essex**, provide a free information and guidance service

These organisations play a role in complementing statutory health and social care services, ensuring that people living with dementia in Colchester and Tendring have access to compassionate, community-based support.

4.2.4 Oral health and balance

A study conducted in 2018 found that poor oral health may affect your vestibular system (the part of your body which is responsible for balance). Your vestibular system contains sensory organs in your ear which detect information about your body’s position. (Source: A study conducted in 2018)

Dental health problems may lead to falls as gum inflammation can affect the complex network of nerves in the jaw which may also affect balance. The health of the jaw plays a large part in keeping a person upright, so anything that causes it to be out of place or working unevenly can be an issue. Poor oral health can also impact a person eating a healthy and nutritional diet - a lack of necessary vitamins and nutrients impacts blood pressure and in turn can contribute to a person feeling dizzy.

“It’s so expensive to go to the dentist so I don’t go. I wished I’d been told sooner about the support I’d get from the NHS with my dentist checks and maybe my teeth wouldn’t be in such a bad state. I live in Jaywick.”
- Tendring participant

4.2.5 Hoarding behaviours

Hoarding behaviours can significantly increase the risk of falls for older adults living at home. Cluttered environments often lead to obstructed walkways, unstable stacks of items, and limited access to essential areas like an exit in the case of a fire, bathrooms and kitchens all of which heighten the likelihood of tripping or falling. Hoarding behaviour also can lead to disorganisation or an increased likelihood of losing medications or important medical information/appointment letters.

There has been no attempt within the academic literature, nor the wider VCSE and health sectors, to explore the interdependencies between frailty, hoarding and falls, however, with mobility issues possibly compounding risk of falls, especially if they struggle to declutter. Thus, a further body of work is required to understand the way these conditions intersect, as well as the resulting care plans to further prevent falls amongst the population of frail people.

It is important to recognise that hoarding behaviour is not simply a matter of untidiness; it is often linked to complex mental health conditions such as anxiety, depression, or trauma. Effective falls prevention should include a compassionate understanding of the psychological factors behind hoarding. A significant number of participants spoke of their issues around their hoarding behaviour.

"I know my home isn’t safe the way it is. There are piles of things everywhere - magazines, clothes, boxes - and I’ve tripped more than once. I worry about falling, but I also feel sad and overwhelmed at the thought of letting go of anything. Each item has a memory. I feel ashamed when people visit, so I avoid having anyone over. It’s lonely, and sometimes I feel trapped. I need help but don’t want to be judged."
- Project Participant

5. Supporting People to Continue to Live Independently

5.1 Independence within the Community

If a person has suffered a fall, it may become difficult for a person to continue to live independently, leading them to need to access support. Fortunately, there is support available to help them retain some independence outside of acute settings.

5.1.1 Unpaid Family Carers

Unpaid family carers in Colchester and Tendring play an important role in helping frail individuals remain safely at home, reducing reliance on formal care and preventing falls. Carers assist with mobility, medication, and home safety all key factors in fall prevention.

The number of unpaid carers has grown significantly. Tendring saw one of the largest increases in the East of England for those providing 20 - 49 hours of care weekly, rising from 1.7% in 2011 to 2.4% in 2021. Additionally, 3.8% provide 50+ hours weekly. With Tendring's ageing population and one of the region's highest median ages, demand for informal care, especially for frail individuals at high fall risk continues to rise

The overarching concern fed back from carers was the constant worry that their cared for person may fall, and so great efforts were made to adapt their homes and routines to reduce risks. All agreed that this vigilance is emotionally taxing, especially when combined with limited access to respite or support services.

Their desire is to be included in any conversations about frailty and fall prevention and to be included in any decision making with their cared for. Participants agreed that they benefit from support networks and practical resources and requested that the dual impact of frailty on the individual and their carer be recognised.

"Caring for my mum, who lives with frailty and is at high risk of falling, is both a privilege and a constant worry. Every day starts with a mental checklist - has she slept well, is she steady on her feet, are there any new bruises or signs of dizziness? We've had to adapt our home completely: grab rails; non-slip mats; and a fall alarm that she wears around her neck. But even with all that, I never truly relax. A simple trip to the bathroom can turn into an emergency."

- Colchester participant

“Emotionally, it’s draining. I’m always on alert, and the fear of mum falling again never leaves me. What helps most is knowing we’re not alone. Support from local services, other carers, and health professionals makes a huge difference."
- Tendring participant

A full case study is available in Appendix 1
Since 2022, there is a legal duty to involve carers in discharge planning, and the system must ensure this happens meaningfully. Carers should be aware of this duty and know how to act if it’s unmet. Advocacy, empowerment, and information enable them to play a proactive role. Essex Carers Support has trained Colchester Hospital staff on carer identification and the importance of involvement.

5.1.2 Essex Wellbeing Service Community Agents
Community Agents, part of the Essex Wellbeing Service, support frail and elderly residents in Colchester and Tendring to live safely and independently at home. This free home-visiting service helps older people, those with disabilities, and informal carers overcome daily challenges through tailored one-on-one support.
Agents assist with mobility aids, minor home adaptations to prevent falls, benefits guidance, paperwork, and connecting people to social groups to reduce isolation. They also provide trusted information on care and wellbeing. Current waiting time for the service is two weeks in Colchester and Tendring.

5.1.3 Helpline 24/7 Services
Helpline, run by Colchester City Council, supports people of all ages living independently in Colchester and Tendring, including those who are elderly, disabled, chronically ill, or recently discharged from hospital. Available 24/7 year-round, it offers reassurance and emergency assistance, reaching 99% of fall cases within an hour. An in-house team of first-aid trained staff responds via personal alarms and pendant technology, helping users maintain independence. Once installed, pressing the Helpline button connects directly to an operator anywhere in the home. Products include pendants and falls detectors.

In 2022 Helpline surveyed their customers, 590 of the 599 customers reported being very satisfied with their Helpline service. Feedback from their customers included:

"Helpline staff are extremely attentive, pleasant and efficient; they always introduce themselves when arriving.

I recommended the service to my parents who use it all the time – which gives all the daughters' peace of mind." - Helpline customer family member

"The team were quick to respond when I pushed the button and staff are very friendly. I couldn't live without Helpline, knowing that when I push the button someone responds straight away."
- Helpline customer

"Over many years Helpline 24/7 has demonstrated its capability to deliver an excellent falls pick-up service. Our contract with them is helping to ease the pressure on emergency ambulance teams across north Essex."
Mark Shorter, Head of Transformation, Suffolk and North East Essex Integrated Care Board

5.1.4 Proactive NHS Care
As our population ages, the need for tailored healthcare becomes increasingly vital. The **Proactive Frailty Clinic** at Clacton Hospital plays a crucial role in supporting older adults living with frailty across the Tendring district by identify frailty early, providing geriatric assessments, and delivering care plans that help older individuals maintain independence and avoid unnecessary hospital admissions.
Services such as the **Frailty Rapid Assessment Service (FRAS)** and **Frailty Virtual Ward** enable specialist care and remote monitoring, ensuring patients receive support in the comfort of their own homes. An example of proactive care can be seen in the case study in Appendix 2.

5.2 Preventing Hospital Readmission through Reablement
After being hospitalised for a fall or other conditions, those experiencing frailty access support in order to be able to return to independent living and also prevent the likelihood of readmission. For those who have especially impaired mobility, home adaptations and equipment can be accessed to assist their mobility and also reduce the likelihood of them suffering another fall.

5.2.1 Reablement Pressures
Reablement services face similar referral issues as Strength and Balance classes, often receiving inappropriate referrals such as end-of-life patients, which fall outside their scope. Providers also report requests beyond their remit, highlighting limited awareness of what the team offers.
Pathway One, the main reablement provider in NEE, includes over 100 support workers, 17 trusted assessors, 2 physiotherapists, and 1 occupational therapist to help people leaving hospital remain independent and avoid re-hospitalization, particularly for frailty or falls.

They supply equipment like beds, handrails, key safes, and commodes, and create six-week care plans after assessment. Devir acts as a secondary provider, offering overflow support and the Home to Assess scheme.

5.2.2 Financial Support

Outside of the reablement team's immediate provision, there is some strong financial support available for people to access assistance recommended through Pathway One across NEE, with a number of grants available to those who need services, shown in Fig.X below:

Organisation	Type of Support	Details
Local Authority Disabled Facilities Grant	Home Adaptations	To keep people independent in their homes, DFG can offer up to £30,000 grants for the following: - Extensions - Stair Lifts - Level Access Showers - Wash and Dry Toilets Ramp Access
NEST	Mobility Equipment and Clearing/Installation Service	Clearing and installation service to ensure equipment can be properly installed within a person's home.
Community Agents	Mobility Equipment	Mobility equipment can be sourced through personalised care plans to help individuals retain independence
Colchester Catalyst Grants	Mobility Equipment	Will make grants to individuals for equipment who live in in the CO postcode area

ECC Care Technology	Assistive Technology	Monitoring and alert technology to enable people to be safe and carers to be responsive in case of emergencies. • Alarm systems • Medication Dispensers • GPS location trackers
Helpline 24/7	Community Alarm Service	Alarm service to alert carers or emergency services when an individual has had a fall.

Fig.3: Reablement Assistance in North East Essex

5.2.3 Fear of Falling

Many participants agreed that they've become hesitant to leave their home following falls, resulting in limiting their activity and independence as illustrated by their responses below.

"I feel safer knowing there's a dedicated frailty team at Clacton Hospital who can assess me quickly."

"Those fall detection sensors have made a huge difference - I know someone will help me, even if I can't call out."

"After my fall, I didn't want to go out. But when I figured out what caused it (a lack of confidence), I made small changes and I'm walking more again."

"It's scary to admit my confidence is gone. I worry about losing my independence, so I try not to mention it."

- Clacton participants

6. Recommendations

6.1 Improving Access and Assessment Processes

6.1.1 Strengthen Referral Pathways into Strength and Balance Classes

- Objective: Ensure service users are directed to the most appropriate support.
- Actions:
  - o Review referral processes into Strength and Balance services, especially in light of the removal of multi-factorial risk assessments.
  - o Implement clearer criteria and guidance for referrers to reduce inappropriate referrals and waiting lists.

6.1.2 Expand Capacity of Strength and Balance Classes

- Objective: Reduce waiting times and improve access
- Actions:
  - o Assess current class capacity and demand across North East Essex (NEE) and explore options for adding new classes or restructuring existing ones.
  - o Continue Winter Resilience funding and extend it to Colchester to manage seasonal spikes in demand.

6.1.3 Enhance Understanding of Reablement Services

- Objective: Improve referral quality and service alignment.
- Actions:
  - o Deliver targeted training to professionals across NEE on the scope and role of reablement services so they are clear which individuals are suitable for referral and what interventions are available.

6.2 Strengthening Community Infrastructure and Integration

6.2.1 Integrate Mental Health Support and Social Isolation Services

- Objective: Improve access to community-based support through social prescribers.
- Actions:
  - o Review current mental health commissioning models to identify opportunities to integrate befriending and social isolation services into formal pathways, especially during winter months.

6.2.2 Expand and Promote Warm Spaces

- Objective: Promote safe, accessible environments during colder months.
- Actions:
  - o Map and promote existing warm spaces and develop partnerships with community venues to reopen or repurpose spaces particularly in Colchester City Centre.

6.2.3 Raise Awareness and Improve Accessibility

- Objective: Ensure residents understand and can access available services.
- Actions:
  - o Launch targeted education campaigns through GP surgeries, libraries, and local media.
  - o Simplify referral pathways and promote walk-in options at Urgent Treatment Centres.
  - o Address digital exclusion issues in GP booking systems, such as email limitations.

6.2.4 Promote Environmental and Home Safety

- Objective: Reduce fall risks and support safer living conditions.
- Actions:
  - o Increase awareness of home adaptations (e.g., grab rails, stair lifts, lighting) and support handyperson schemes that undertake minor repairs and energy efficiency.
  - o Advocate for timely repairs to hazardous pavements in Clacton and Colchester (e.g., Culver Street West, Pier Avenue).

6.2.5 Raizer Chair Training

- Objective: Reduce unnecessary ambulance callouts.
- Actions:
  - o Provide training for NHS and Partner colleagues that emphasises the benefits and use of the Raizer Lifting Chair. Training to focus on confidence-building and decision-making, not just technical use.

6.2.6 Student Volunteering for Move and Meet

- Objective: Sustain and expand student community-based activity programs in Colchester.
- Actions:
  - o Partner with local university to develop a summer volunteering scheme that aligns with existing university volunteering infrastructures to facilitate this community engagement.

6.3 Enhancing Lived Experience and Holistic Support

6.3.1 Community-Based Health Services

- Objective: Bring healthcare closer to residents and reduce hospital dependency.
- Actions:
  - o Encourage partnerships between private and charity sectors to support vulnerable groups.
  - o Host rotating “Healthcare Days” in community venues with mobile screening services (e.g., cholesterol, breast cancer) and use community buses to reach remote areas and offer bundled services (e.g., slipper swap, health checks).
  - o Consider how to support the delivery of more affordable chiropody services, including toenail cutting and foot health checks.

6.3.2 Expand Home-Based Preventative Care

- Objective: Support independence and reduce fall risks.
- Actions:
  - o Commission tailored physiotherapy programs for falls prevention.
  - o Strengthen the Frailty Virtual Ward for remote monitoring and care.
  - o Promote the Frailty Rapid Assessment Service (FRAS) to support paramedics and reduce hospital admissions.
  - o Ensure regular medication reviews to identify drugs that may increase fall risk.

6.3.3 Address Emotional and Social Impacts

- Objective: Build resilience and reduce isolation.
- Actions:
  - o Develop confidence-building programs within services for people who have fallen that also include mental resilience support.
  - o Facilitate peer support networks for older adults to share experiences. Support social prescribing services to tackle loneliness and increase wellbeing and befriending.

7. Appendices

Appendix 1 Case Study: a story from the perspective of a family carer – a daughter caring for her father.
A 93-year-old man living independently in Clacton has faced multiple falls following his third hip replacement, despite initial recovery and determination. His family, particularly his daughter who lives nearby, has had to navigate complex healthcare systems, emergency services, and limited community support to ensure his safety and well-being. Challenges include delays in accessing A&E, lack of minor injury centres, and barriers to booking GP appointments due to new online digital booking systems. Though his home is well-equipped with mobility aids and he's connected to services like AgeWell East and Livity Life, gaps in frailty support and transport access persist. The story highlights the emotional and logistical strain on carers and the need for clearer, more accessible support pathways for older adults.

To access the audio recording, please use this URL or scan the accompanying QR code. https://youtu.be/hapmE_E3nx4

Appendix 2 Case Study: Proactive Frailty Clinic, Clacton Hospital
An 88-year-old gentleman known to have Lewy-body dementia was seen within the Frailty Clinic in Clacton Hospital. He was referred via the Practice Paramedic in the GP surgery in view of progressive decreased mobility.
He was taking 14+ medications, with an anticholinergic burden score of 3 (this placed him at high risk of falls, confusion and functional decline).
The clinic reviewed his medications and rationalised them. This reduced his anticholinergic burden score down to 1.
The gentleman was reviewed again within the Frailty Clinic after 4 weeks. His wife has reported that the difference has been "night and day". He is now much more interactive, mobile and has increased appetite. His blood pressure has also improved. The patient and wife left feeling impressed and satisfied.

Appendix 3 Case Study: Proactive Care Case Study
A 77-year-old lady, scored 5 on the Clinical Frailty Scale, she lived alone and had become progressively socially isolated since the bereavement of her husband several years ago.
She had decreased static and dynamic balance, likely secondary to her sedentary lifestyle. She was at high risk of falling but had not experienced any falls within the previous 12 months. She was fearful of falling due to her reduced balance.

Her EuroQOL (a standardised measure of health assessing health status across five dimensions: mobility; self-care; usual activities; pain/discomfort; anxiety/depression) visual analogue score was recorded as 52/100.
As a result of the appointment, this lady was referred to the community Strength and Balance classes, to the befriending services, also referred her to the Essex therapy dogs charity as she was a keen dog lover.
Following the above, her EuroQOL visual analogue score had increased to 60/100 (recorded by the Strength and Balance classes). Her confidence has improved alongside her general strength and balance.

Appendix 4 Table of Low Intensity Exercise Activities Available in CO3, CO4 and CO15

Type of Exercise	Organisation	Location
Walking Football	Phoenix FC Stanway Rovers FC	St Helena School, CO3 Stanway, CO3
Walking Netball	England Netball	University of Essex, CO4
Seated Yoga	COLTE Partnership Happy Yoga Life Changing Lives	Referral Based Stanway, CO3 City Centre, CO1
Zumba (Standing and Seated)	Independent	Colchester Central, CO1
Various/Accessible Sport	Disability4Sport Making Fitness Accessible	Various
Seated Dance	Dance Network Association	Greenstead, CO4
CBH Physical Activity Coordinator	CBH	Sheltered Accommodation (various)
Love to Move Class (general exercise)	Right at Home	Stanway, CO3
Yoga	Albert Edward Hall Community Centre	Clacton

Mish Mash Fitness	Albert Edward Hall Community Centre	Clacton
Weekly Over 50s Walking Group	Bishops Park College	Clacton
Weekly Tai Chi	Brotherhood Community Hall	Clacton
Weekly Lets Get Moving		
Weekly Yoga		
Carpet Bowls Club, 2x weekly	Clacton Carpet Bowls Club	Clacton
Clinically led Strength and Balance (12 week course referral)	Clacton Leisure Centre / Harwich Hospital / Weeley Village Hall	Clacton / Harwich / Weeley
Various Fitness sessions, inc. Yoga / Spinning / Zumba, Legs, Bums and Tums / Pilates, High Intensity Training / Aquacise / Netball, Walking Netball / Tea Dance / Active4Life 50yrs+, check timetable to confirm current	Clacton Leisure Centre	
Lifestyles Gym, variety of weights and exercise equipment		
Walking Football for over 50s, 2x weekly		
Sport for Confidence: INCLUSIVE DANCE, MULTI-SPORT SKILLS , BOCCIA SKILLS , FUN FITNESS, Inclusive Swimming		

Petanque, weather permitting throughout Spring and Summer months. All welcome - new, experience and disabled players. Boules available	Clacton Leisure Centre	Clacton
Swimming - 50s + & inclusive		
Seated Yoga, Ladies only Seated Yoga, Supported Swimming, Swimming lessons	Community Voluntary Services Tendring	Clacton
Weekly Seated Yoga	Tendring Time Bank	Clacton
Weekly Ten Pin Bowling	U3A Tendring District	Clacton
Heal in Motion, based on the principles of Tai Chi, 2x weekly	Jaywick Community Resource Centre	Jaywick
Weekly Seated Yoga		