South Woodham Ferrers Health & Social Care Group
Caring for the residents of South Woodham Ferrers, Essex

# Maldon Central, Dengie & South Woodham Ferrers: Integrated Neighbourhood Team (INT) Area & Neighbourhood Health Future

## June 2026

**Eileen Wang, Master of Public Health Student,**

**Warwick Medical School**

**Pathways to the Public Health Workplace Module**

**Academic Supervisor:** Dr Bronwyn Harris, University of Warwick

**Organisation Supervisor**: Peter Blackman, South Woodham Ferrers Health & Social Care Group

WARWICK
MEDICAL SCHOOL

# Table of Contents


*Introduction* ..... *3*

**South Woodham Ferrers Health & Social Care Group** ..... **3**

**NHS and Neighbourhood Health** ..... **3**

**South Woodham Ferrers, Dengie, and Maldon** ..... Error! Bookmark not defined.

*Aims and Objectives* ..... *5*

**Aims** ..... **5**

**Objectives** ..... **5**

*Methods* ..... *6*

**Approach** ..... **6**

**Ethical Clearance** ..... **6**

**Survey** ..... **6**

**Focus Group Discussions** ..... **7**

**Data Analysis** ..... **7**

*Results* ..... *8*

**Survey Demographics** ..... **8**

**Survey Findings** ..... **9**

**Focus Group Findings** ..... **10**

*Discussion* ..... *11*

**Recommendations** ..... **15**

*References* ..... *16*

*Appendix 1: Survey (with consent form and information leaflet)* ..... *21*

*Appendix 2: Focus Group Discussion Guides (with consent form and information leaflet)* ..... *72*

*Appendix 3: Survey Results* ..... *82*

**Section 1: Integrated Neighbourhood Teams** ..... **82**

**Section 2: Neighbourhood Health** ..... **82**

**Section 3: Demographics** ..... **91**

*Appendix 4: Focus Group Discussion Results* ..... *94*

# Introduction

## South Woodham Ferrers Health & Social Care Group

South Woodham Ferrers Health & Social Care Group (SWFH&SCG) is an independent, self-governed organisation that was established to look after the health and social care interests of the people of South Woodham Ferrers, recognising the roles of health and social care related professionals, volunteers and the Patient Participation Groups. The Group works to represent local health and social care needs through advocacy, information sharing, and engagement with residents, community organisations, and local system partners.[1] SWFH&SCG maintains links with key local system partners, including the NHS Essex Integrated Care Board, Mid Essex Alliance, the Dengie and South Woodham Ferrers Primary Care Network, and the Central Maldon, the Dengie and South Woodham Ferrers Integrated Neighbourhood Team. This supports its role in sharing local evidence and contributing to discussions about service development. This project was undertaken in collaboration with SWFH&SCG as part of the University of Warwick Master of Public Health Pathways to the Public Health Workplace module.

## NHS and Neighbourhood Health

Poor access and fragmented service coordination are not simply operational problems for the National Health Service (NHS); they are public health issues.[2,3] When people cannot identify the right service, secure timely contact, travel to appointments, or move smoothly between organisations, needs can escalate and inequalities can widen.[2] Difficulty navigating complex health and care systems can result in missed appointments, delayed or forgotten care, deterioration in physical and mental health, and greater need for more intensive treatment or longer hospital stays.[3] Poor coordination can therefore increase both individual harm and wider system pressure. Missed appointments also represent wasted clinical capacity. Recent analysis of General Practitioner (GP) appointment data estimated that 16.3 million GP appointments were missed in England in the 12 months to March 2026; using an assumed cost of £40 per appointment, this equates to an estimated opportunity cost of around £651 million.[4]

These pressures are significant in England, where the NHS continues to face high demand across planned, diagnostic, urgent and community-based care.[2] At the end of April 2026, an estimated 6.1 million patients were waiting to start consultant-led elective treatment; almost 100,000 pathways had waiting times of over 52 weeks.[5] Access pressures at earlier points in the care pathway are also clinically significant. Diagnosis is often the gateway to treatment, monitoring, and disease management, meaning that delays can reduce opportunities for earlier intervention.[6] Evidence from cancer, diabetes, and cardiovascular disease shows that timely diagnosis and early management can affect outcomes: 4-week treatment delays in cancer are associated with increased mortality, diabetes prevention programmes can reduce progression to type 2 diabetes among high-risk groups by 20%, and improved management of blood pressure and blood glucose can reduce cardiovascular complications.[7,8,9]

Poor out-of-hospital capacity also affects hospital flow. Overcrowding and delayed discharge can compromise safe, private and dignified care, while lack of timely community support can prolong hospital stays.[10] Improving flow partly depends on stronger community-based pathways—including timely discharge support, intermediate care, rehabilitation, urgent community response, and proactive management of people with complex needs.[11] An analysis of mental health delayed discharge, for instance, found that patients waiting for supported housing accounted for 109,029 delayed days in 2023/24, costing the NHS about £71 million.[12] This illustrates that poor access and coordination affect not only patient experience and outcomes, but also the efficient use of NHS resources.

Neighbourhood Health has emerged as a policy response to these pressures. The NHS 10-Year Health Plan sets out three major shifts in health and care: from hospital to community, from analogue to digital, and from sickness to prevention.[2,13] These shifts reflect a recognition that a reactive hospital-centred model is

increasingly mismatched to population health need. As more people live with long-term, complex, or multiple conditions, effective care depends not only on treatment, but on earlier support, continuity, self-management, and coordination across services. The World Health Organisation (WHO) proposes integrated, people-centred health services as a response to unequal access, fragmented care, poor quality, and low responsiveness within health systems.[14]

Integrated Neighbourhood Teams (INTs) are one mechanism for translating this policy direction into local delivery. INTs bring together existing providers across primary care, community health, social care, local authority services, and voluntary and community organisations.[2] Their intended value lies in reducing siloed working and creating more proactive, coordinated support around local population needs. In practice, this may include coordinated referral routes, social prescribing, urgent community assessment at home, rehabilitation and equipment support after hospital discharge, virtual wards, and clearer links to wider community support. These functions are especially relevant for groups whose needs cross organisational boundaries, including people with frailty, disability, multiple long-term conditions, palliative care needs, or repeated use of urgent and emergency care.[2,14]

However, integration at system level does not automatically translate into better access for residents. Neighbourhood Health will only improve population health if residents can understand what support is available, navigate between services, and access care through routes that work for them. The 10-Year Health Plan's emphasis on digital transformation, including greater use of the NHS App and improved information sharing, may support easier navigation and coordination. Yet digital-first models also risk excluding residents who are not digitally active, lack confidence online, have disabilities, face language or literacy barriers, or prefer telephone and face-to-face support.[15] The public health significance of Neighbourhood Health therefore lies in both its potential and its implementation risks. Continued barriers to physical access, communication, navigation, and coordination may limit the benefits of neighbourhood models, particularly in communities where rurality, transport, digital exclusion, and service distribution already shape access to care.[16]

## Maldon, the Dengie, and South Woodham Ferrers

The Maldon Central, Dengie, and South Woodham Ferrers INT area covers a mixed rural, semi-rural, and urban locality across Maldon, the Dengie peninsula, and South Woodham Ferrers. South Woodham Ferrers had a Census 2021 population of just over 16,000 and Maldon District had a population of around 66,200.[17,18] In 2022, the Dengie had a population around 28,300.[19,20,21] The INT area includes larger towns, coastal settlements, villages, and areas with low population density. This varied settlement pattern matters because access to health and care is shaped not only by whether services exist, but also by travel time, transport, service distribution, digital access, communication, and residents' knowledge of available support.[22] South Woodham Ferrers has a sizeable town population, while the Dengie includes small, dispersed settlements where transport distance and availability may be more relevant access issues. Neighbourhood Health therefore needs to respond to varied local realities, rather than assuming a single model of access.

Population ageing is a major driver of local health and care need. Maldon's median age increased from 45 to 48 between 2011 and 2021, compared with 41 in the East of England and 40 in England.[17] Around one-quarter of Maldon residents were aged 65 and over in 2021. Maldon also had a higher proportion of one-person older households than England, with 15.1% of households consisting of one person aged 66 and over, compared with 12.8% nationally.[17] South Woodham Ferrers and the approximate Dengie geography also have substantial older populations, with around one-fifth of South Woodham Ferrers residents and around one-quarter of Dengie residents aged 65 and over.[16,19,20,21] These patterns point to growing need for healthy ageing, independence, frailty prevention, rehabilitation, carer support and coordinated community-based care.

Prevention is also relevant across the life course. The INT area includes children, families, working-age adults, commuters and people with long-term conditions. South Woodham Ferrers has a substantial working-age population, with around 62% of residents aged 16 and over in employment, while almost one-quarter are economically inactive due to retirement..[22,23] In Maldon, children aged 0-15 made up around 16.3% of the population in 2021, while 55.4% of usual residents aged 16 and over were in employment and 28.4% were economically inactive.[17] Childhood overweight and obesity remain a local concern, with Year 6 overweight and obesity reported at around one-third of children, similar to the England average.[24] This means that Neighbourhood Health should not be framed only around older adults or complex care; it also has a role in early support, family wellbeing, healthy weight, physical activity, mental wellbeing, and connection to wider community resources.

Long-term conditions are central to the public health case for Neighbourhood Health. Recorded disease burden locally includes cardiometabolic conditions, respiratory disease, musculoskeletal conditions, cancer, mental health need, frailty, and multimorbidity. These conditions often require ongoing monitoring, medicines optimisation, rehabilitation, self-management support, lifestyle advice and coordination across primary care, community services, social care and voluntary sector provision. In a rural and ageing locality, fragmented pathways make this support harder to navigate, particularly for people with multiple conditions, carers, or limited capacity to coordinate their own care[27,28]

Together, these local characteristics create different access risks for different groups. Older adults and people with frailty need coordinated care closer to home; care home residents and people in supported living may depend on proactive multidisciplinary support; people with multiple long-term conditions may need continuity across services; rural residents may face transport and travel barriers; working-age residents and commuters may need flexible contact and appointment routes; and people at risk of digital exclusion may be disadvantaged if access becomes primarily digital. Wider determinants of health, including housing, income, transport, social support, digital access and community resources, are therefore central to how Neighbourhood Health will be experienced locally.[27,28]

## Aims and Objectives

Previous local research undertaken with SWFH&SCG and University of Warwick students identified accessibility as a key concern for residents in the Maldon Central, Dengie, and South Woodham Ferrers INT area.[27,28] Reported issues included limited and costly transport, unclear communication, inconvenient appointment scheduling, and inflexible service models. This study builds on that exploratory local evidence by focusing more specifically on how residents navigate between services, how coordination is experienced, how digital and non-digital routes affect access, and what residents see as priorities for future Neighbourhood Health development.

### Aims

The importance of Neighbourhood Health is a key element of the NHS 10-Year Plan and must include Primary Care Networks (PCNs) and INTs. To respond to immediate challenges in the NHS and to develop an integrated initiative in the next few years, a standardised approach will be required. The aim of the research is to identify how Maldon Central, Dengie, and South Woodham Ferrers INT area might standardise their approach to INTs.

### Objectives

To provide a grounded view from community members of their priorities and understandings of this initiative and to inform service design and implementation locally, the objectives were to:

1. Identify enablers and barriers to accessibility of Neighbourhood Health

2. Explore factors that will improve access to Neighbourhood Health Services for patients and carers, with a particular emphasis on:
    - Digital inclusion and digital health access: What does or does not work for local people? What are the barriers to digital health tools? How could these be overcome?
    - Preventative care and supporting people to manage their own health: What is important to people? What needs to be done differently when developing Neighbourhood Health services to support and empower residents in having control of their own health and wellbeing?
3. Examine what Neighbourhood Health means to local people:
    - How should the NHS App and AI be used?
    - What should be done for people who are not digitally active?
    - Which public health initiatives should be prioritised?

# Methods

## Approach

A mixed-methods design was used, combining an online community survey with online focus group discussions. The survey gathered resident views. Qualitative discussion explored experiences, priorities, and potential solutions in greater depth. Early survey findings were used to inform the focus group prompts.

The exploration of accessibility was guided by Levesque et al.'s framework, which understands access as shaped by the relationship between service characteristics, such as approachability and acceptability, and people's ability to seek, reach, and engage with care.[29] This framework informed the survey and focus group topics by supporting a broader understanding of whether residents know what support is available, can navigate between services, and can access care through digital and non-digital routes.

## Ethical Clearance

The study was granted course-delegated ethical approval on behalf of the Biomedical and Scientific Research Ethics Committee at the University of Warwick (REGO-PATH25-001). The author who designed the research completed the full Epigeum Research Integrity, Second Edition training.

## Survey

The survey, titled *Neighbourhood Health Future in Maldon Central, Dengie & South Woodham Ferrers Integrated Neighbourhood Team Area*, was administered using Qualtrics. It explored residents' experiences of accessing local health, social care, hospital, community, and voluntary services. Questions covered preferences for accessing support, barriers to service coordination and navigation, digital inclusion and exclusion, and perceived local health priorities.

The survey consisted of three sections (Appendix 1). The first section explored residents' experiences of accessing INT services, including service use, preferences for accessing support, barriers to service navigation and coordination, and experiences of communication between services. The second section focused on the future development of Neighbourhood Health services, including questions on digital health access, prevention, self-management support, local health priorities, and views on how Neighbourhood Health services should be organised in the INT area. The third section collected demographic information, including age, gender, ethnicity, area of residence, registered GP surgery, employment status, disability status, veteran status, and caring status. These questions were included to describe the survey sample and explore whether access experiences varied across different groups.

Follow-up questions were used where relevant to explore participants' experiences in more detail. The survey used the term "barriers" broadly to capture both structural issues, such as service availability and coordination, and individual-level factors, such as digital access, confidence, transport, and knowledge of available support.

The survey was open to adults aged 18 and over living in the Maldon Central, Dengie, and South Woodham Ferrers INT area. It remained open for 31 days, from 13 May to 13 June 2026. This timeframe allowed distribution through SWFH&SCG networks, social media, contacts, and community channels, while remaining feasible within the placement timeline.

Survey recruitment was voluntary. A purposive sampling approach was used to ensure that participants were drawn from the defined locality.[30] Snowball sampling was also used, as individuals were encouraged to share the survey link with others in their local networks.[31] This approach was appropriate given the community-based nature of the project, the limited timeframe, and the aim of reaching residents across the INT area. Participants accessed the survey through an anonymous online link or QR code, and consent was indicated by continuing beyond the participant information and consent page.

## Focus Group Discussions

Three synchronous online focus group discussions were conducted using Microsoft Teams (Appendix 2). One discussion was held with members of the public to explore experiences of accessing and navigating Neighbourhood Health services (n=3). Two discussions were held with local stakeholders and service providers to explore perceived reasons for access barriers and possible recommendations for improvement (n=3, n=2).

Participants were selected for the relevance of their local experience rather than to achieve population representativeness. The focus was on gathering perspectives from individuals able to comment on access, navigation, coordination, and communication in the INT area. Focus group prompts were informed by early survey findings and covered experiences of accessing local services, priorities for service organisation, barriers to navigation and coordination, digital and non-digital access, and recommendations for improving Neighbourhood Health locally. To maintain anonymity, explicit demographic screening was outside the scope of the sessions.

In addition to the focus group discussions, a supplementary one-to-one discussion (n=1) was undertaken with a service provider who could not participate in the scheduled group discussions. This discussion followed the same prompts as the focus groups. For reporting purposes, insights from this discussion were analysed alongside the focus group data to support interpretation of survey findings.

## Data Analysis

Survey data was analysed descriptively using Qualtrics and Microsoft Excel. Closed survey responses were summarised using frequencies and percentages to identify patterns in service use, access preferences, barriers to navigation and coordination, digital inclusion, and local health priorities. Free-text responses were reviewed to identify recurring issues and illustrative examples that added context to the quantitative findings.

Qualitative data from the focus group discussions and supplementary one-to-one engagement was analysed using a light-touch thematic approach, guided by Braun and Clarke's thematic analysis process.[32] Transcripts and notes were reviewed to identify recurring patterns across resident and provider perspectives. These were then grouped into broader themes relating to service navigation, coordination, communication, digital and non-digital access, prevention, and recommendations for Neighbourhood Health development.

Survey and qualitative findings (Appendix 3 and Appendix 4) were integrated during interpretation to identify areas of convergence, difference, and practical relevance for local service planning. Desk-based

scoping of relevant policy, local evidence, and academic literature informed both study design and interpretation. Within the evolving NHS policy context, literature and guidance on Neighbourhood Health and INT development were reviewed throughout the project and incorporated in the Discussion and Recommendations.

## Results Summary

A total of 73 participants consented to take part in the survey, although responses varied by question because some respondents only completed earlier sections. The completed non-random sample was skewed toward older residents and people with existing health needs (Table 1). Responses were received from Maldon, the Dengie, and South Woodham Ferrers. Findings are therefore reported descriptively and should not be interpreted as representative estimates of the wider INT population.

The strongest survey findings related to service navigation, communication, coordination, mixed access routes, closer-to-home services, and prevention (Table 2). Qualitative findings from the focus group discussions helped explain these priorities by showing how access was experienced by both patient/public participants and provider/stakeholder participants (Table 3).

"Residents" is used as shorthand for survey respondents and patient/public participants, while "providers" is used as shorthand for provider/stakeholder participants.

### Survey Demographics

| Participant Characteristic | Percentage (n/N) |
|---|---|
| Aged 65 and over | **64.7%** (22/34) |
| Reported a long-term physical or mental health condition | **76.4%** (26/33) |
| Considered themselves to have an impairment or disability | **30.3%** (10/33) |
| Unpaid carer | **15.2%** (5/33) |
| South Woodham Ferrers resident | **38.2%** (13/34) |
| Dengie resident | **32.4%** (11/34) |
| Maldon resident | **26.5%** (9/34) |

*Table 1.* Characteristics of survey respondents included in completed demographic responses. Both percentages and counts (n/N) are reported, where n represents the number of valid responses for each characteristic and N represents total valid responses. Refer to Appendix 1 and Appendix 3.

## Survey Findings

| Theme | Key Survey Findings |
|---|---|
| **Navigation, communication, and coordination** | 85.1% (40/47) respondents prioritised joined-up communication between services, 70.2% (33/47) prioritised one clear contact route or "front door", and 51.1% (24/47) prioritised clear follow-up after making contact.<br><br>80.1% (38/47) identified GP services, NHS 111 and community pharmacy and 78.7% (37/47) identified community diagnostics and testing as the service areas most commonly identified as needing better coordination. |
| **Mixed routes into care** | 80.4% (37/46) of respondents selected a single local phone line as a preferred access route, 54.3% (25/46) selected referral from a healthcare professional, 50.0%, (23/46) selected the NHS App or online request, and 41.3% (19/46) selected a local website or directory. |
| **Access quality and trade-offs** | 66.7% (24/36) of respondents prioritised continuity with a trusted clinician or team, compared with 25.0% (9/36) who prioritised faster access without seeing the same person.<br><br>51.4% (19/37) would accept a longer wait for a nearer location, 24.3% (9/37) would travel further for a sooner appointment, and 24.3% (9/37) were unsure.<br><br>57.1% (20/35) would accept phone or video first followed by in-person care if needed, while 40.0% (14/35) preferred always being seen in person even if this was slower. |
| **Services closer to home** | Tests and diagnostics closer to home (81.6%, 31/38) and same-day urgent assessment outside A&E (73.7%, 28/38) were the most commonly selected services felt to be insufficiently available locally.<br><br>Respondents prioritised community diagnostics and tests closer to home (89.2%, 33/37), specialist follow-up for stable long-term conditions (62.2%, 23/37), and urgent care at home where appropriate (48.6%, 18/37). |
| **Prevention and wider support** | Respondents most often selected long-term condition self-management (51.5%, 17/33), obesity or healthy weight (51.5%, 17/33), physical activity (42.4%, 14/33), mental wellbeing (36.4%, 12/33), and women's health (36.4%, 12/33) as areas for prevention and early support. |

*Table 2.* Key survey findings on access, coordination, closer-to-home care, and prevention priorities. Both percentages and counts (n/N) are reported, where n represents the number of valid responses for each characteristic and N represents total valid responses. Refer to Appendix 1 and Appendix 3.

## Focus Group Findings

Qualitative findings helped explain the survey patterns (Table 3).

| Theme | Resident Quotes | Provider Quotes |
|---|---|---|
| **Navigation, communication, and coordination** | "We have some good services… but I don't think they're integrated into this overall network."<br><br>"The care services around the district are [not] known enough about… people are totally ignorant."<br><br>"We haven't heard too much about integrated neighbourhood services at all."<br><br>"The communication is important… because it will give patients confidence if they know what's happening and how they're going to benefit." | "We've obviously got the ways of working… the handbook, the forums, and the drop-ins."<br><br>""Do we do it regularly? No. And is it kind of systematic? No."<br><br>"I don't know whether it's been implemented or embedded within their day-to-day work."<br><br>"I know of [the INT directory]. I will admit I very rarely use it because I've got my own resources that I've picked up over the years." |
| **Mixed routes into care** | "It's good to have these new satellite places, but the communication about them… is really important."<br><br>"The information about appointments [was] inadequate and causing confusion because it's incomplete."<br><br>"They think they've got to ring [names medical centre], and they don't realise that's a building, not an organisation." | "There is lots of information out there… it takes hours researching things for people… GPs don't have…that time resource."<br><br>"If you don't see emails for a few months, you've then missed that [a provider] has left… [or they have] a different phone number."<br><br>"Having to go through databases and spreadsheets and having to phone and check a service is still running every time you want to signpost somebody to it… it's just not possible." |
| **Access quality and trade-offs** | "There is very good evidence that the practice listens to us… and things that we say matter and they take action to make things better."<br><br>"When somebody is trying to look at you holistically and hasn't got half of the information… until that gets fixed, we won't get anywhere."<br><br>"That blood test never gets onto my GP record so I can see it."<br><br>"Doctors are still getting letters from consultants… rather than putting them on the system so that everybody can see it." | "I am having long conversations with [patients] to find out what their needs are, what they're looking for."<br><br>"There does seem to be something about those relationships, that trusted assessor relationship where you would hand over and people would take your assessment as right and accurate."<br><br>"We need to be doing a lot more with our data around population health management."<br><br>"We assume everyone can engage with written information or will remember everything they're given verbally." |

| | | |
|---|---|---|
| **Services closer to home** | "All the tier 2 services are outside of the [area]… it's very, very difficult for people …to access."<br><br>"Ultrasound is at a location…that isn't served by a bus and it's terribly difficult to get there."<br><br>"It makes it a bit of a nonsense if somebody's trying to optimise their meds, but they've got to wait three weeks for a blood test."<br><br>"They come around in a van now that is equipped for doing those checks." | "We need closer working relationships with GPs so that we can be a bit more responsive in the community."<br><br>"We need to be doing more proactive work… [patients] attend the GP two or three times and… two weeks later, they end up in the acute."<br><br>"There should be better connectivity and support from the acute when we are stepping into that virtual ward space and that urgent response space."<br><br>"We can only do so much and hold so much risk in the community without the acute oversight." |
| **Prevention and wider support** | "They have an outreach place… where they also have a dementia group and also a men's group."<br><br>"Unfortunately, that service has stopped this year and there isn't any funding to replace it." | "It's not just their clinical care that's needed addressing, it's their housing status, their mental health, their safeguarding."<br><br>"How do we bring in voluntary sector? How do we bring in housing? …It's still not holistic enough." |

*Table 3.* For navigation, communication and coordination, residents described limited visibility of INTs and uncertainty about how local services connected; providers described INT infrastructure that existed but was not always consistently embedded. For mixed routes into care, residents highlighted confusion about appointment information and service locations; providers described the continuing importance of direct conversations, signposting, and up-to-date contact routes. For access quality and trade-offs, residents linked good access to being listened to and having complete information promptly available; providers spoke about building trust, avoiding repeated assessments or tests, and maintaining continuity across services. For services closer to home, residents described long waits and physical barriers of access; providers described challenges of GP and acute care connectivity. For prevention and wider support, residents named some services available to them; providers expressed deficiency in integration and support. Refer to Appendix 2 and Appendix 4.

## Discussion

The main implementation challenge for Neighbourhood Health in Maldon Central, Dengie, and South Woodham Ferrers INT area is not simply service availability, but system navigability. Findings showed strong resident preferences for joined-up communication, one clear contact route, clear follow-up, and selected services closer to home. Residents and providers identified the same underlying problem from different positions in the system. Residents described the visible experience of fragmentation: uncertainty about what support exists, which route to use, where responsibility sits, and what happens next. Providers described the mechanisms behind this experience: uneven awareness of INT resources, time-consuming signposting, reliance on local knowledge, and difficulty keeping contact routes current. NHS England's Neighbourhood Health guidance identifies fragmentation, poor communication, and siloed working as causes of delay, duplication, and suboptimal care.[2] Local findings support this policy diagnosis, but expose a

practical weakness: new teams, local sites, and digital tools will not improve access unless they reduce the work residents, carers, and frontline staff must do to make the system function.

This weakness was evident in the identified gap between INTs as an organisational model and an experienced service reality. Residents did not clearly associate INTs with visible changes in day-to-day access. Providers, by contrast, described INT infrastructure such as forums, drop-ins, handbooks, contact lists and asset maps, but also reported uneven engagement and variable usefulness in everyday practice. Providers were more likely to see the connective architecture of INTs, while residents judged integration by whether services felt easier to contact, understand, and move through. This suggests that INTs may currently function more clearly as a professional networking mechanism than as a visible improvement in resident access. This poses a problem when survey priorities, including clearer contact routes, joined-up communication, and reliable follow-up, indicate that residents are asking for better engagement and patient-facing communication as core features of accessible care.

Provider accounts also showed why coordination remains difficult to operationalise. Local integration was often sustained through relational labour: knowing who to contact, attending forums and drop-ins, maintaining informal networks, updating directories, and using local knowledge to identify appropriate support. These relationships were valuable and often made integrated working possible. However, they also made coordination fragile. When navigation depends on individual staff knowledge, personal contacts, or voluntary engagement with forums and directories, access becomes vulnerable to staff turnover, missed emails, changing roles, and organisational restructuring. This challenges explanations that attribute access problems mainly in residents' awareness, confidence, or help-seeking behaviour.[3,33] In this locality, fragmentation was experienced by residents as confusion and by providers as hidden coordination work. This reflects an implementation problem: this new model of integrated care may not be effective if it remains dependent on motivated individuals or informal workarounds.[34] This has important equity implications. Health systems often shift work onto patients and carers through appointments, tests, records, self-management, communication, and coordination tasks.[35] In the local area, workload was mirrored among providers, who described spending hours researching services, signposting residents, and resolving uncertainty where standard directories were insufficient. However, integration cannot depend only on the existence of handbooks, forums, or contact lists. If tools do not operate as a shared working infrastructure across services, Neighbourhood Health risks creating coordination architecture that is not consistently experienced by either frontline staff or residents. Neighbourhood Health should therefore be judged not only by how much provision is moved into the community, but by whether it reduces the workload imposed on people already carrying the greatest health burden. Residents with long-term conditions, disability, frailty, caring responsibilities, limited transport, or lower confidence navigating services are likely to be most affected when access depends on persistence, time, digital confidence, and professional advocacy.[2,13]

Information continuity was one of the clearest examples of how fragmentation operates within the health system, not only between services and residents. Survey and qualitative findings were particularly consistent around diagnostics. In the survey, tests and diagnostics closer to home were the most commonly selected services felt to be insufficiently available locally, and community diagnostics were the strongest priority for more local delivery. Residents in the focus groups explained why this mattered in practice, describing ultrasound appointments in poorly connected locations, long waits for blood tests, and diagnostic results or appointment information not appearing where patients or clinicians could see them. This created uncertainty, delay, and a need to check information between services. Providers described the same issue, emphasising trusted assessments, population health data, and stronger GP-community-acute links. This suggests information flow is not simply a patient communication problem; it is a coordination failure. A resident may obtain an appointment, test, or specialist contact but still experience poor access if results do not appear in the right record, letters do not reach the right clinician, or follow-up responsibility is unclear. Furthermore, when diagnostic results do not move reliably, patients can become the informal

link between disconnected organisations, while clinicians may make decisions with incomplete information. National ambitions for a Single Patient Record and NHS England's expectation that neighbourhood working should be supported by single electronic health and care records are directly relevant.[2,36] However, local findings suggest that digital records will only improve access if they strengthen informational continuity. The value of shared digital records lies in reducing repeated explanations, duplicated tests, delayed medication, and fragmented decision-making to improve continuity of care.[37] This is especially important for residents with multiple long-term conditions, who are most exposed to harm when information breaks down across different services.[2,36,37]

The findings also challenge access policy that focuses primarily on speed, throughput, or appointment volume. National primary care policy has emphasised recovering access through telemedicine, same-day assessment of requests, care navigation, self-referral pathways, and expanded community pharmacy access through Pharmacy First.[38] These reforms can help reduce pressure on general practice. However, local respondents valued not only timely help, but also continuity, proximity, human contact, and being heard. More respondents prioritised continuity with a trusted clinician or team over faster access without continuity. Recent evidence on GP continuity similarly suggests that continuity can improve outcomes and reduce future workload for physicians, especially among older adults, people with multiple chronic illnesses, and people with mental health needs.[39] For higher-need residents, good access is not only rapid entry into the system, but also care that is understandable, relational, and connected to follow-up.

Digital-first access can be interpreted through this same lens. Respondents valued online routes, but the most preferred access route was a single phone number to contact. Residents explained this preference with uncertainty about which organisation to contact, where an appointment was located, and who held responsibility for follow-up. Providers reinforced this by describing the importance of direct conversations and signposting, especially where residents had complex, urgent, emotional, or unclear needs. Providers also described residents who might not reliably read emails, use phones, remember appointments, or fit neatly into online directories. Digital access may therefore improve access for straightforward needs while increasing confusion for others. There are also patient safety concerns around online consultation systems; digital tools need human review, escalation routes, and non-digital alternatives.[40] In this locality, digital transformation needs to reduce uncertainty, not simply make more services physically accessible through an app or online form. Without clear escalation and follow-up, digital exclusion risks relocating confusion from the reception desk to the online form.[41]

The strong support for services closer to home should be interpreted as an equity finding rather than a convenience preference. The present study reinforces previous local findings that transport poverty remains a highly relevant, major access barrier in the INT area.[27,28] Residents, particularly those in the Dengie, continued to link access problems to poor public transport, distance from tier 2 services, and diagnostic locations that were difficult to reach without a car. Some services were formally available but difficult to use, particularly where travel time, parking, poor signage, or limited transport shifted the economic and practical burden of access onto patients. Providers described the service-capacity side of the same issue, emphasising the need for clearer escalation routes when community teams manage urgent response, virtual wards, or complex care at home. Closer-to-home care therefore has two conditions for success: residents must be able to reach and use services, and providers must have the workforce, information, and specialist support needed to deliver care safely.[2] In rural and semi-rural areas, services may be formally available but practically inaccessible. Yet relocating care without capacity risks transferring complexity into under-resourced community settings. Providers highlighted concerns about district nursing capacity despite rising need for frailty care, long-term condition management, post-discharge support, and "home first" care. Recent analysis similarly reports declining district nursing contacts since 2009 despite population growth and increasing needs-weighted demand, alongside a 43% fall in recorded district nurses between 2009 and 2024 and major regional inequities in staffing.[42] Careers also reports a consultant recruitment crisis, with nearly 33,000 consultant job adverts in England and Wales between 2022 and 2025,

including shortages in psychiatry and other specialties needed to support complex community care.[43] These workforce pressures make integration harder when frontline staff lack stable community capacity, senior specialist input, and clear escalation routes. The equity risk is that responsibility moves closer to home without enough capacity moving with it, increasing pressure on residents, carers, and community teams, who already struggle with hidden labour of coordination.

Prevention and wider support need to be interpreted beyond lifestyle intervention. Survey respondents prioritised long-term condition self-management, healthy weight, physical activity, mental wellbeing, and women's health. Providers broadened this further by describing housing, benefits, safeguarding, loneliness, caring responsibilities, mental health, and voluntary sector support as central to health and independence. This reflected a difference in perspective: residents identified areas where earlier support was needed, while providers described the social and practical conditions that determine whether prevention is possible. Both groups pointed to needs that sit across organisational boundaries, but providers were more likely to recognise the wider system work required to respond to them. This raises a wider concern about whether Neighbourhood Health will be implemented as prevention or as more localised reactive care. NHS England's neighbourhood guidance recognises the need to connect people to wider public services and third sector support, but recent analysis by The King's Fund suggests that national neighbourhood priorities remain tightly focused on integrated care teams for "high priority cohorts" such as people with moderate to severe frailty, care home residents, housebound people and those at the end of life, particularly to reduce hospital use.[13,44] This focus is understandable given acute pressure, but it risks narrowing Neighbourhood Health into admission avoidance for the highest-risk groups rather than prevention across the life course. This highlights an implementation risk: Neighbourhood Health may rely on community and voluntary sector support without adequately resourcing or integrating it. If prevention remains clinically framed and dependent on fragile voluntary capacity, it may fail to address service demands. Providers argue that current systems could remain reactive, clinically focused, and shaped by organisational activity measures rather than broader outcomes such as independence, confidence, reduced isolation, improved navigation, or avoided crisis.

## Limitations

This study has several limitations. The survey sample was non-random, small, and non-representative, and valid responses varied between questions. The sample was weighted toward older residents and people with long-term conditions. It was also almost entirely White British (97.1%), which reflects the predominantly White ethnic profile of the INT area; however, the sample was disproportionately female (73.5%), compared to a broadly even gender distribution in the local population.[17-21] The qualitative participants included people with experience of patient participation, service provision, or local community support. As a result, the findings may underrepresent working-age residents, commuters, ethnic minority communities, people with lower trust in services, and residents experiencing more severe digital, financial, or social exclusion.

The focus group discussions were small, limiting the breadth of perspectives captured, and reinforcing that the findings are explanatory rather than representative. However, small or "mini" focus groups can be appropriate where participants have high-level professional expertise, recruitment pools are limited, or a smaller setting may support discussion of sensitive topics.[45,46] In this study, the small focus groups allowed detailed input from participants on access, coordination, and local implementation challenges.

Recruitment and data collection may also have shaped who participated. Survey distribution through GP practices, local networks, and online routes may have been more likely to reach residents already connected to health services or community organisations. Similarly, qualitative participants included residents and providers with experience of patient participation, service provision or local community support. Their accounts may not reflect the experiences of residents who are less engaged, less confident, or more marginalised from formal participation routes. The use of online focus groups may also have

excluded people with limited digital access, confidence, or availability. The study also relied on self-reported experiences and perceptions, rather than direct observation of care pathways or service performance data. It cannot determine whether INTs have objectively improved coordination, reduced duplication, or changed service use. Furthermore, the modest survey response despite repeated local promotion may indicate disconnect between residents and health service engagement; while this study cannot determine reasons for non-participation, possible explanations include engagement barriers, consultation fatigue, or limited public confidence that public feedback can lead to meaningful service change. This is notable given the NHS 10-Year Health Plan's emphasis on public and stakeholder contributions to service reform, and underscores the importance of closing the feedback loop with residents.[13]

Despite these limitations, the skew of the sample is analytically relevant. NHS England's neighbourhood guidance identifies people with complex health and social care needs as an initial priority for neighbourhood working, including people with frailty, disability, multiple long-term conditions, palliative care needs, and high-intensity emergency department use.[2] These are precisely the groups most likely to interact with multiple services and experience the consequences of poor coordination. The findings therefore provide useful insight into how Neighbourhood Health may be experienced by residents with higher access and coordination needs.

Future research should prioritise groups underrepresented in this study. Targeted outreach would help capture perspectives from residents who may be less likely to respond to online surveys or attend virtual focus groups, but who may face the greatest barriers to accessing coordinated care.

## Recommendations

For the INT area, the following recommendations aim to provide more navigable neighbourhood provision (Table 4).

| Recommendation | Rationale |
|---|---|
| **Measure experienced integration:**<br>Build resident feedback into Neighbourhood Health working. This could include short resident experience questions, community feedback sessions, and checking whether residents experience services as joined-up. | Professional coordination does not automatically mean residents experience integrated care. People's experiences of NHS health care are often captured at the level of individual providers; less is known about how people experience coordination across services, or whether these services work together effectively to meet their needs.[47] A systematic review of UK integrated care found that patient experience and person-centred coordinated care are central to evaluating whether integrated services are actually working for service users, supporting the need to measure integration from the resident perspective.[48] |
| **Use women's health as a practical neighbourhood pathway model:**<br>Women's health needs often cross several services, so it is a strong example of where neighbourhood models could reduce fragmentation. | Women's health hubs are integrated community-based models that bring together existing services to improve access, experience, outcomes, and reduce inequalities.[49] A mixed-methods evaluation of Women's Health Hub models in England found that hubs were being used to bring together women's health services and improve implementation, delivery and care, making women's health a useful practical example of integrated neighbourhood-level provision.[50] |

| | |
|---|---|
| **Strengthen links with schools, councils, housing, welfare advice and VCSE organisations:**<br><br>Treat prevention as more than clinical monitoring or behaviour change. Neighbourhood Health risks being too clinically narrow if social determinants of health are not connected to local care pathways. | Many health needs are shaped by social conditions such as hardship, housing, family pressures and access to local support.[2,13,28] Researchers argue integrated health and care systems in England have potential to support disease prevention, but meaningful population health improvement requires action beyond NHS clinical services and stronger attention to wider determinants of health.[51] A study in English primary care describes care navigation as a way to link patients with activities or organisations that can address non-medical needs affecting health and wellbeing.[52] |
| **Reduce navigation burden for residents with complex or long-term needs:**<br><br>Provide clearer points of contact, warm referrals, follow-up after referral or discharge, and proactive navigation for residents who need support across multiple services. Keep telephone, face-to-face and supported access routes available alongside online booking, apps and digital consultation tools. Make sure residents know alternative routes exist. | Poor coordination can shift the burden of navigating care onto patients and carers, especially those with long-term conditions or complex needs. Evidence suggests that system navigation may improve service use and patient experience; team-based navigation was associated with slightly more appropriate health service utilisation, while person-led navigation models appeared to improve patients' experiences of care quality compared with usual care.[53]<br><br>Digital tools may exclude people who lack digital access, confidence, literacy, accessibility support, or who simply prefer non-digital contact. A rapid review found that increased reliance on digital healthcare during COVID-19 risked exacerbating pre-existing health inequalities among disadvantaged groups.[54] |

*Table 4.* These recommendations build on study findings that suggest the success of Neighbourhood Health locally should be judged by whether it produces experienced integration. This means clear contact routes, reliable follow-up, usable information infrastructure, mixed digital and non-digital access, stronger GP-community-acute relationships, and better connection between clinical care, prevention and wider community support. Without these conditions, Neighbourhood Health risks becoming another layer of organisational reform rather than a visible improvement in how residents access care.

## Acknowledgements

With sincere thanks to Peter Blackman and Dr. Bronwyn Harris for their invaluable guidance throughout this project, and to the local residents, service providers, and community partners whose participation and insights made this research possible.

# References


1. South Woodham Ferrers Health & Social Care Group. About Us [Internet]. [date unknown] [cited 2026 Jun 13]. Available from: https://swfhealthsocial.co.uk/about-us/
2. NHS England. Neighbourhood health guidelines 2025/26 [Internet]. London: NHS England; 2025 Jan 30 [updated 2025 Jun 24; cited 2026 Jun 13]. Available from: https://www.england.nhs.uk/publication/neighbourhood-health-guidelines-2025-26/
3. Health Services Safety Investigations Body. Workforce and patient safety: primary and community care co-ordination for people with long-term conditions [Internet]. London: Health Services Safety Investigations Body; 2025 Apr 10 [cited 2026 Jun 13]. Available from: https://www.hssib.org.uk/patient-safety-investigations/workforce-and-patient-safety/fourth-investigation-report/
4. NHS England Digital. Appointments in General Practice [Internet]. Leeds: NHS England; [date unknown] [cited 2026 Jun 13]. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/
5. NHS England. Consultant-led referral to treatment waiting times data 2026-27 [Internet]. London: NHS England; [date unknown] [cited 2026 Jun 13]. Available from: https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2026-27/
6. World Health Organization. The selection and use of essential in vitro diagnostics: report of the third meeting of the WHO Strategic Advisory Group of Experts on In Vitro Diagnostics, 2020, including the third WHO model list of essential in vitro diagnostics. Geneva: World Health Organization; 2021. WHO Technical Report Series, No. 1031. Available from: https://www.who.int/publications/i/item/9789240019102
7. Hanna TP, King WD, Thibodeau S, Jalink M, Paulin GA, Harvey-Jones E, O'Sullivan DE, Booth CM, Sullivan R, Aggarwal A. Mortality due to cancer treatment delay: systematic review and meta-analysis. bmj. 2020 Nov 4;371. doi: 10.1136/bmj.m4087
8. Ravindrarajah R, Sutton M, Reeves D, Cotterill S, Mcmanus E, Meacock R, Whittaker W, Soiland-Reyes C, Heller S, Bower P, Kontopantelis E. Referral to the NHS Diabetes Prevention Programme and conversion from nondiabetic hyperglycaemia to type 2 diabetes mellitus in England: a matched cohort analysis. PLoS medicine. 2023 Feb 27;20(2):e1004177. doi: 10.1371/journal.pmed.1004177
9. SPRINT Research Group. A randomized trial of intensive versus standard blood-pressure control. New England Journal of Medicine. 2015 Nov 26;373(22):2103-16. doi: 10.1056/NEJMoa1511939
10. NHS England. Corridor Care – Urgent and Emergency Care Daily Situation Reports [Internet]. London: NHS England; 2026 Jun 11 [cited 2026 Jun 13]. Available from: https://www.england.nhs.uk/statistics/statistical-work-areas/corridor-care-urgent-and-emergency-care-daily-situation-reports/
11. NHS England. Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge [Internet]. London: NHS England; 2023 Sep 15 [cited 2026 Jun 13]. Available from: https://www.england.nhs.uk/publication/intermediate-care-framework-for-rehabilitation-reablement-and-recovery-following-hospital-discharge/
12. SIG Housing Trust. Addressing the supported mental health housing shortfall [Internet]. London: SIG Housing Trust; [date unknown] [cited 2026 Jun 13]. Available from: https://sighousingtrust.org.uk/addressing-the-supported-mental-health-housing-shortfall/
13. Department of Health and Social Care. Fit for the future: 10 Year Health Plan for England. London: Department of Health and Social Care; 2025 Jul 3. CP 1350. Available from:

https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf
14. World Health Organization. Framework on integrated, people-centred health services: report by the Secretariat. Geneva: World Health Organization; 2016. Report No.: A69/39. Available from: https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf
15. Davies A, Honeyman M, Gann B. Moving from exclusion to inclusion in digital health and care [Internet]. London: The King's Fund; 2023 Mar 8 [cited 2026 Jun 22]. Available from: https://www.kingsfund.org.uk/insight-and-analysis/long-reads/exclusion-inclusion-digital-health-care/
16. Trethewey SP, Clark CE, Honney R, Newlove-Delgado T. Developing a 'neighbourhood health service': ensuring equity of access for rural populations. The British Journal of General Practice. 2026 Mar 1;76(764):102. doi: 10.3399/BJGP.2026.0054
17. Office for National Statistics. How life has changed in Maldon: Census 2021 [Internet]. Newport: Office for National Statistics; 2023 Jan 19 [cited 2026 Jun 13]. Available from: https://www.ons.gov.uk/visualisations/censusareachanges/E07000074/
18. Nomis. Census 2021: usual resident population by sex and five-year age group [Internet]. Durham: Office for National Statistics; 2021 [cited 2026 Jun 13]. Available from: https://www.nomisweb.co.uk/datasets/c2021pp002
19. CensusData.uk. Southminster, Bradwell & Dengie Peninsula: age by grouped years [Internet]. [place unknown]: Good Stuff; 2022 Dec 13 [cited 2026 Jun 23]. Available from: https://censusdata.uk/e02004560-southminster-bradwell--dengie-peninsula/ts007a-age-by-grouped-years
20. CensusData.uk. Mayland, Althorne & Cold Norton: age by grouped years [Internet]. [place unknown]: Good Stuff; 2022 Dec 13 [cited 2026 Jun 23]. Available from: https://censusdata.uk/e02004561-mayland-althorne--cold-norton/ts007a-age-by-grouped-years
21. CensusData.uk. Burnham-on-Crouch: age by grouped years [Internet]. [place unknown]: Good Stuff; 2022 Dec 13 [cited 2026 Jun 23]. Available from: https://censusdata.uk/e02004562-burnham-on-crouch/ts007a-age-by-grouped-years
22. CensusData.uk. South Woodham Ferrers: household composition [Internet]. [place unknown]: Good Stuff; 2022 Dec 13 [cited 2026 Jun 23]. Available from: https://censusdata.uk/e04003972-south-woodham-ferrers/ts003-household-composition
23. CensusData.uk. South Woodham Ferrers: economic activity status [Internet]. [place unknown]: Good Stuff; 2022 Dec 8 [cited 2026 Jun 23]. Available from: https://censusdata.uk/e04003972-south-woodham-ferrers/ts066-economic-activity-status
24. Office for Health Improvement and Disparities. Public health profiles: excess weight [Internet]. London: Department of Health and Social Care; 2026 [cited 2026 Jun 13]. Available from: https://fingertips.phe.org.uk/search/excess%20weight
25. Thomson LJ, Chatterjee HJ. Barriers and enablers of integrated care in the UK: a rapid evidence review of review articles and grey literature 2018-2022. Frontiers in Public Health. 2024 Jan 4;11:1286479. doi: 10.3389/fpubh.2023.1286479
26. NHS England. Quality and Outcomes Framework, 2024-25 [Internet]. Leeds: NHS England; 2025 Aug 28 [cited 2026 Jun 13]. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/2024-25/
27. Philips S. Health, welfare and social care assessment of the Dengie and South Woodham Ferrers PCN. South Woodham Ferrers: South Woodham Ferrers Health & Social Care Group; 2023 Jun.

Available from: https://swfhealthsocial.co.uk/wp-content/uploads/2023/07/health-welfare-social-care-assessment-of-the-dengie-south-woodham-ferrers-pcn-jun23.pdf
28. Cramb E. Accessibility to healthcare services in Maldon Central, Dengie and South Woodham Ferrers. South Woodham Ferrers: South Woodham Ferrers Health & Social Care Group; 2025 Jun. Available from: https://swfhealthsocial.co.uk/wp-content/uploads/2025/06/accessibility-to-healthcare-services-report-swf-hscg-warwick-medical-school-vf.pdf
29. Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. International journal for equity in health. 2013 Mar 11;12(1):18. doi: 10.1186/1475-9276-12-18
30. Palinkas LA, Horwitz SM, Green CA, Wisdom JP, Duan N, Hoagwood K. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and policy in mental health and mental health services research. 2015 Sep;42(5):533-44. doi: 10.1007/s10488-013-0528-y
31. Noy C. Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. International Journal of social research methodology. 2008 Oct 1;11(4):327-44. doi: 10.1080/13645570701401305
32. Clarke V, Braun V. Thematic analysis. The journal of positive psychology. 2017 May 4;12(3):297-8.
33. Gregory A. England's 'complex' health and care system harming patients, report says. The Guardian [Internet]. 2025 Apr 10 [cited 2026 Jun 22]. Available from: https://www.theguardian.com/society/2025/apr/10/englands-complex-health-and-care-system-harming-patients-report-says
34. May C, Finch T. Implementing, embedding, and integrating practices: an outline of normalization process theory. Sociology. 2009 Jun;43(3):535-54. doi: 10.1177/0038038509103208
35. Tran VT, Barnes C, Montori VM, Falissard B, Ravaud P. Taxonomy of the burden of treatment: a multi-country web-based qualitative study of patients with chronic conditions. BMC medicine. 2015 May 14;13(1):115. doi: 10.1186/s12916-015-0356-x
36. NHS England. The Single Patient Record [Internet]. London: NHS England; [date unknown] [cited 2026 Jun 23]. Available from: https://www.england.nhs.uk/digitaltechnology/the-single-patient-record/
37. Haggerty JL, Reid RJ, Freeman GK, Starfield BH, Adair CE, McKendry R. Continuity of care: a multidisciplinary review. Bmj. 2003 Nov 20;327(7425):1219-21. doi: 10.1136/bmj.327.7425.1219
38. NHS England, Department of Health and Social Care. Delivery plan for recovering access to primary care. London: NHS England; 2023 May. Available from: https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00283-delivery-plan-for-recovering-access-to-primary-care-may-2023.pdf
39. Kajaria-Montag H, Freeman M, Scholtes S. Continuity of care increases physician productivity in primary care. Management Science. 2024 Nov;70(11):7943-60. doi: 10.1287/mnsc.2021.02015
40. Health Services Safety Investigations Body. Digital tools for online consultation in general practice [Internet]. Farnborough: Health Services Safety Investigations Body; 2024 Jul 25 [cited 2026 Jun 22]. Available from: https://www.hssib.org.uk/patient-safety-investigations/workforce-and-patient-safety/second-investigation-report/
41. Cream J. Who picks up the phone? Different approaches to NHS admin [Internet]. London: The King's Fund; 2025 Oct 30 [cited 2026 Jun 22]. Available from: https://www.kingsfund.org.uk/insight-and-analysis/blogs/who-picks-up-phone-different-approaches-nhs-admin

42. Palmer B. District nursing: understanding the decline and mapping the future. London: Nuffield Trust; 2025 Oct 31. Available from: https://www.nuffieldtrust.org.uk/research/district-nursing-understanding-the-decline-and-mapping-the-future
43. Wilkinson E, Weinbren E. Medical recruitment crisis: solutions for consultant doctors [Internet]. London: BMJ Careers; 2025 Oct 30 [cited 2026 Jun 22]. Available from: https://www.bmj.com/careers/article/consultant-doctors-solutions-for-a-medical-recruitment-crisis
44. Bottery S, Baird B, Reed S, Wenzel L, Wickens C, Murray R, et al. NHS priorities for 2026/27 to 2028/29: what does it mean for the system, staff and patients? [Internet]. London: The King's Fund; 2025 Oct 27 [cited 2026 Jun 22]. Available from: https://www.kingsfund.org.uk/insight-and-analysis/blogs/nhs-priorities-2026-27-to-2028-29-system-staff-patients
45. O. Nyumba T, Wilson K, Derrick CJ, Mukherjee N. The use of focus group discussion methodology: Insights from two decades of application in conservation. Methods in Ecology and evolution. 2018 Jan;9(1):20-32. doi: 10.1111/2041-210X.12860
46. Guest G, Namey EE, Mitchell ML. Collecting qualitative data: A field manual for applied research. Sage; 2013.
47. Graham C. Understanding integration: how to listen to and learn from people and communities [Internet]. London: The King's Fund; 2021 Jul 20 [cited 2026 Jun 22]. Available from: https://www.kingsfund.org.uk/insight-and-analysis/reports/understanding-integration-listen-people-communities
48. Davidson L, Scott J, Forster N. Patient experiences of integrated care within the United Kingdom: a systematic review. International journal of care coordination. 2021 Jun;24(2):39-56. doi: 10.1177/20534345211004503
49. Department of Health and Social Care. Women's health hubs: core specification [Internet]. London: Department of Health and Social Care; 2024 Mar 21 [updated 2024 Mar 21; cited 2026 Jun 22]. Available from: https://www.gov.uk/government/publications/womens-health-hubs-information-and-guidance/womens-health-hubs-core-specification
50. Daniel K, Bousfield J, Hocking L, Jackson L, Taylor B. Community Women's Health Hub models in England: a mixed methods evaluation. BMC Primary Care. 2025 Dec 16;26(1):398. doi: 10.1186/s12875-025-03037-z
51. Briggs AD, Göpfert A, Thorlby R, Allwood D, Alderwick H. Integrated health and care systems in England: can they help prevent disease?. Integrated Healthcare Journal. 2020 Feb 26;2(1):e000013. doi: 10.1136/ihj-2019-000013
52. Tierney S, Wong G, Roberts N, Boylan AM, Park S, Abrams R, Reeve J, Williams V, Mahtani KR. Supporting social prescribing in primary care by linking people to local assets: a realist review. BMC medicine. 2020 Mar 13;18(1):49. doi: 10.1186/s12916-020-1510-7
53. Teggart K, Neil-Sztramko SE, Nadarajah A, Wang A, Moore C, Carter N, Adams J, Jain K, Petrie P, Alshaikhahmed A, Yugendranag S. Effectiveness of system navigation programs linking primary care with community-based health and social services: a systematic review. BMC Health Services Research. 2023 May 8;23(1):450. doi: 10.1186/s12913-023-09424-5
54. Litchfield I, Shukla D, Greenfield S. Impact of COVID-19 on the digital divide: a rapid review. BMJ open. 2021 Oct 1;11(10):e053440. doi: 10.1136/bmjopen-2021-053440
55. Rolfe G, Freshwater D, Jasper M. Critical reflection for nursing and the helping professions: A user's guide.

## Appendix 1: Survey (with consent form and information leaflet)

The following survey was used to collect resident views:

# Neighbourhood Health Future in Maldon Central, Dengie & South Woodham Ferrers Integrated Neighbourhood Team Area

Start of Block: Introduction

***Study Title:*** **Neighbourhood Health Future in Maldon Central, Dengie & South Woodham Ferrers Integrated Neighbourhood Team Area** ***Investigators:*** Eileen Wang, University of Warwick Peter Blackman, South Woodham Ferrers Health & Social Care Group Bronwyn Harris, University of Warwick Thank you for your interest in partaking in this research study. ***What is the study about?*** This study explores how residents in Maldon Central, the Dengie, and South Woodham Ferrers experience access to local health and care services. It aims to understand what is working well, where access could be improved, and what matters most to local communities when future neighbourhood health services are planned. The findings will help inform local service design and support efforts to make health and care services more accessible and equitable. This research is independent of the NHS, Essex County Council, the GP Patient Survey, and the Friends and Family Test. ***What would my participation involve?*** Taking part involves completing an online survey about your experiences and views of accessing local health and care services. The survey should take approximately 15-25 minutes, depending on your service use. Your participation is completely voluntary. You may skip any question you do not wish to answer. You can withdraw at any time before submitting the survey simply by closing your browser. You will not receive payment for taking part. No identifiable personal data will be collected. Your responses will be collected anonymously through Qualtrics. ***What will happen after completing the survey?*** No identifiable data will be collected from you as part of this study. Once your responses have been submitted to the research team, it will not be possible to withdraw this data, as your individual responses cannot be identified. The data will be accessed only by the research team and used for the purposes of this study. Data will be securely stored on University of Warwick computers. You can read the University of Warwick Research Privacy Notice available here or contact the Legal and Compliance Team at infocompliance@warwick.ac.uk. ***What will happen to the study results?*** The findings will be analysed and written up in a report submitted to the University of Warwick and the South Woodham Ferrers Health & Social Care Group. The report may be published in an online peer reviewed research journal. The results may be used to inform future local health and care planning, or used as secondary data by future students. Any use of the data outside of the project will require additional ethical review and approval. ***Who has reviewed the study ethics?*** The study has been given course-delegated ethical approval on behalf of University of Warwick Biomedical and Scientific Research Ethics Committee (BSREC). ***Who should I contact if I want further information?*** South Woodham Ferrers Health & Social Care Group – Peter Blackman: peter@blackmanservices.co.uk ***Who should I contact if I wish to make a complaint?*** Any complaint can be addressed to the person below, who is a senior University of Warwick official entirely independent of this study: Head of Research Governance Research & Impact Services University House University of Warwick Coventry CV4 8UW Email: researchgovernance@warwick.ac.uk Tel: 02476 575733 If you wish to raise a complaint on how we have

handled your personal data, you can contact our Data Protection Officer who will investigate the matter: DPO@warwick.ac.uk If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO). The survey will be available until May 31, 2026. Thank you for taking the time to read this concise Participant Information Leaflet. Please close the browser if you don't wish to give consent to take part in the study.

Please select below to continue with the study.

- ○ I have read above and **I consent** to take part in this study. (4)

End of Block: Introduction

Start of Block: INT

***Section 1*** 13 questions Integrated Neighbourhood Teams (INTs) bring together local health, social care, and community services to make support easier to access and better coordinated. For this approach to work well, it needs to reflect what matters to local residents. This survey is an opportunity to share how you prefer to find information, connect with existing services, and shape how local services are being redesigned. You will have the option to add any further comments at the end.



**Question 1. Which functions of the INT should be prioritised locally?** Choose up to 3

☐ One clear contact route ("front door") to the right support *A single way to ask for help, so your request is directed to the right service* (1)

☐ Coordinated support for people with complex needs *A named person to help organise care across different service teams* (13)

☐ Joined-up communication between services *Services share relevant information and make handovers, so you do not have to repeat yourself or chase the next step* (15)

☐ Clear follow-up after making contact *Information on what will happen next, who is responsible, when to expect a response, and what to do if things get worse* (17)

☐ More proactive support when needs change *Planned check-ins for ongoing needs, or quicker support at home when appropriate* (19)

☐ Help connecting to practical, non-medical support *Support with issues that affect health and wellbeing, such as benefits, housing, or debt advice* (21)

☐ Other (please specify) (11) _____

**Question 2. Have you used or experienced any of the following INT functions?**

| | Yes (1) | No (2) |
|---|---|---|
| A single contact route (“front door”) (1) | ☐ | ☐ |
| A named coordinator for complex needs (4) | ☐ | ☐ |
| Joined-up communication (handovers between services) (5) | ☐ | ☐ |
| Clear follow-up (next steps, timeframes) (7) | ☐ | ☐ |
| Proactive support (check-ins, support at home) (8) | ☐ | ☐ |
| Links to practical support (benefits, housing, debt, etc.) (10) | ☐ | ☐ |
| Other (please specify) (11) | ☐ | ☐ |



**Question 3. I would value better coordination in the following service areas, so I do not have to repeat my story or manage handovers myself:** Choose up to 3

- ☐ GP services, NHS 111, community pharmacy (1)
- ☐ Community nursing, rehabilitation, and support after hospital discharge *District nursing, physiotherapy/MSK, reablement, equipment, or adaptation* (6)
- ☐ Older adults' support *Falls, frailty, memory, or dementia-related support* (8)
- ☐ Mental health support *Talking therapies or crisis support* (9)
- ☐ Community diagnostics and testing *Blood tests, ECGs, lung tests, or imaging pathways where relevant* (11)
- ☐ Social care advice and support *Social prescribing, benefits, debt, or housing support* (14)
- ☐ Carers support (16)
- ☐ Women's health support (18)
- ☐ Learning disability, autism, neurodevelopmental support (19)
- ☐ Children and family support (20)
- ☐ End of life, palliative care, and bereavement support (21)
- ☐ Other (please specify) (22) _____
- ☐ ⊗Not sure (23)

JS *

**Question 4. If residents need help finding or accessing support, which routes should be available?**
Choose up to 3

- ☐ A single local phone line (1)
- ☐ NHS App or online request (4)
- ☐ Local website or directory with a way to request support (11)
- ☐ Social prescriber or link worker (6)
- ☐ Community venues (library, community centre) (7)
- ☐ Referral from a healthcare professional (hospital discharge, community nursing) (8)
- ☐ Other (please specify) (10) _____

Page Break

**Question 5. How easy is it for you to find clear information (what it is, who it's for, and how to access it) about the following local support?**

| | Very Easy (1) | Easy (2) | Neither Easy / Difficult (3) | Difficult (4) | Very Difficult (5) | I don't need this (6) |
|---|---|---|---|---|---|---|
| Social prescribing or link worker support *(connecting to community or practical help)* (1) | ○ | ○ | ○ | ○ | ○ | ○ |
| Mental health support *(talking therapies or crisis support)* (6) | ○ | ○ | ○ | ○ | ○ | ○ |
| Carers support *(assessments, respite, support groups)* (7) | ○ | ○ | ○ | ○ | ○ | ○ |
| Financial, housing, or homelessness support *(benefits, debt, cost of living, housing issues affecting health)* (8) | ○ | ○ | ○ | ○ | ○ | ○ |
| Alcohol and substance abuse support (10) | ○ | ○ | ○ | ○ | ○ | ○ |
| Domestic abuse support (11) | ○ | ○ | ○ | ○ | ○ | ○ |
| Support after hospital discharge *(rehab, equipment, adaptations)* (12) | ○ | ○ | ○ | ○ | ○ | ○ |
| Older adults' support *(falls, frailty, dementia)* (13) | ○ | ○ | ○ | ○ | ○ | ○ |

*Display this question:*

*If Question 5. How easy is it for you to find clear information (what it is, who it's for, and how t... = Difficult*

*Or Question 5. How easy is it for you to find clear information (what it is, who it's for, and how t... = Very Difficult*

JS

**What would make it easier to find and use information about these services?** Choose up to 3

- [ ] A simple local directory website with clear “how to access” steps (1)
- [ ] GP or practice nurse explains and gives links (4)
- [ ] Social prescriber or link worker explains and helps connect me (5)
- [ ] A local phone line that tells me what exists and how to access it (6)
- [ ] Printed information in plain language (7)
- [ ] Community venues (library, community centre) with staff who can help (8)
- [ ] Other (please specify) (9) _____

Page Break

**Question 6. Have you ever found out about a local service only after you were already struggling (rather than earlier)?**

- ○ Yes (1)
- ○ No (2)
- ○ Not sure (3)

---

*Display this question:*

*If Question 6. Have you ever found out about a local service only after you were already struggling... = Yes*

JS

**What were you struggling with when you found out about the service later than you would have liked?**
Choose up to 3

- [ ] Long-term conditions (e.g., diabetes, heart disease, COPD) (1)
- [ ] Mental health or feeling overwhelmed (4)
- [ ] Caring responsibilities (5)
- [ ] Loneliness or social isolation (6)
- [ ] Mobility, falls risk, and frailty (7)
- [ ] Recovery after hospital stay (8)
- [ ] Money or housing problems (9)
- [ ] Women's health needs (3)
- [ ] Alcohol or substance use (11)
- [ ] Domestic abuse or feeling unsafe (12)
- [ ] Parenting or young person needs (13)
- [ ] Other (please specify) (14) _____
- [ ] ⊗Prefer not to say (15)

Page Break

JS *

**Question 7. Which services and support would you most want clearer information about?** Choose up to 3

- [ ] Long-term conditions (e.g., diabetes, heart disease, COPD) (1)
- [ ] Mental health needs (4)
- [ ] Caring responsibilities (as a carer) (5)
- [ ] Loneliness or social isolation (16)
- [ ] Mobility, falls risk, and frailty (6)
- [ ] Post-hospital recovery or rehabilitation needs (3)
- [ ] Money or housing problems (2)
- [ ] Women's health needs (7)
- [ ] Alcohol or substance use (15)
- [ ] Domestic abuse or safety concerns (10)
- [ ] Parenting or young person needs (14)
- [ ] Other (please specify) (12) _____
- [ ] ⊗Not sure (13)

Page Break

**Question 8. Thinking about a time you were diagnosed with a health condition (or realised you needed ongoing support), how easy was it to find out what services were available to you?**

- ○ Very easy (1)
- ○ Easy (4)
- ○ Neither easy or difficult (5)
- ○ Difficult (6)
- ○ Very difficult (7)
- ○ Not applicable (8)
- ○ Prefer not to say (9)

---

*Display this question:*

*If Question 8. Thinking about a time you were diagnosed with a health condition (or realised you nee... = Easy*

*Or Question 8. Thinking about a time you were diagnosed with a health condition (or realised you nee... = Very easy*

JS

**Where did you find out about the service?** Choose up to 3

- ☐ GP practice (1)
- ☐ Hospital staff (4)
- ☐ Community nurse or therapist (5)
- ☐ Social prescriber or link worker (6)
- ☐ Pharmacist (7)
- ☐ Council or local public services (8)
- ☐ Charity or community group (9)
- ☐ Online search (11)
- ☐ Social media (12)
- ☐ Family or friends (13)
- ☐ Other (please specify) (14) _____

Page Break

JS *

**Question 9. When information is hard to find or use, what are the main reasons?** Choose up to 3

- ☐ Too many different websites or places (1)
- ☐ Don't know which service is right (4)
- ☐ Information is out of date (5)
- ☐ Eligibility rules aren't clear (6)
- ☐ Referral routes aren't clear (7)
- ☐ Contact details are missing or wrong (8)
- ☐ Digital barriers (login, forms, internet) (9)
- ☐ Language, reading, accessibility barriers (10)
- ☐ Worry about stigma and judgement (11)
- ☐ Other (please specify) (13) _____
- ☐ ⊗Not sure (14)

JS *

**Question 10. To make sure there is "no service about me without me", what should be standard?** Choose up to 3

- ☐ Being asked what matters to me (1)
- ☐ Clear options explained (4)
- ☐ Written plan I agree with (5)
- ☐ Choice of communication method (6)
- ☐ Ability to involve carer or family (with consent) (7)
- ☐ Easy way to ask follow-up questions later (8)
- ☐ ⊗Not sure (9)

Page Break

JS *

**Question 11. What are the best ways to reach people who might miss out (for example, people not online)?** Choose up to 3

- ☐ Proactive call when eligible (1)
- ☐ Social prescriber outreach (4)
- ☐ Community venues (libraries, community centres) (5)
- ☐ Community support groups (6)
- ☐ Printed information in key locations (7)
- ☐ Local radio or newsletters (8)
- ☐ Home visiting for those who need it (9)
- ☐ Other (please specify) (12) _____
- ☐ ⊗Not sure (10)

**Question 12. Anything else you want to mention about digital access, including for people not online?** Optional

_____

_____

_____

_____

Page Break

**Question 13. If you could change one thing about local health and care, what would it be?** Optional

_____

_____

_____

_____

End of Block: INT

Start of Block: NH

***Section 2*** 23 questions Neighbourhood Health is the overall approach to making local health and wellbeing support simpler and more local—with clear routes to the right support, and stronger focus on staying well. It's not necessarily a new building; it's about how services are organised and delivered. In this section, we explore which services you would value and use locally.

**Question 14. Which of these local services have you used in the last 12 months?** Select all that apply

- ☐ GP services (1)
- ☐ Pharmacy advice or services (27)
- ☐ NHS 111 (28)
- ☐ Specialist hospital or community services *(respiratory, cardiology, dermatology, audiology, or antenatal care)* (4)
- ☐ Community nursing or care at home (10)
- ☐ Physiotherapy, musculoskeletal, or rehabilitation support (11)
- ☐ Mental health support (12)
- ☐ Learning disability, autism, or neurodevelopmental support (13)
- ☐ Social prescribing or link workers (14)
- ☐ Healthy lifestyle or long-term condition support *(weight management, diabetes support, or smoking cessation)* (15)
- ☐ Falls prevention and frailty support (18)
- ☐ Carers support services (20)
- ☐ Social care advice and support *(care assessments, home care)* (21)
- ☐ Community groups *(loneliness, exercise classes, wellbeing groups)* (22)
- ☐ Diagnostics and scans *(blood tests, ECGs, or breathing tests)* (23)
- ☐ Other (please specify) (25) _____
- ☐ ⊗None of the above (26)

*Carry Forward Selected Choices from "Question 14. Which of these local services have you used in the last 12 months? Select all that apply"*

JS ✱ X→

**Question 15. For the services you've used, which do you want to access better locally?** Choose up to 3

- ☐ GP services (1)
- ☐ Pharmacy advice or services (2)
- ☐ NHS 111 (3)
- ☐ Specialist hospital or community services *(respiratory, cardiology, dermatology, audiology, or antenatal care)* (4)
- ☐ Community nursing or care at home (5)
- ☐ Physiotherapy, musculoskeletal, or rehabilitation support (6)
- ☐ Mental health support (7)
- ☐ Learning disability, autism, or neurodevelopmental support (8)
- ☐ Social prescribing or link workers (9)
- ☐ Healthy lifestyle or long-term condition support *(weight management, diabetes support, or smoking cessation)* (10)
- ☐ Falls prevention and frailty support (11)
- ☐ Carers support services (12)
- ☐ Social care advice and support *(care assessments, home care)* (13)
- ☐ Community groups *(loneliness, exercise classes, wellbeing groups)* (14)
- ☐ Diagnostics and scans *(blood tests, ECGs, or breathing tests)* (15)
- ☐ Other (please specify) (16) _____
- ☐ ⊗None of the above (17)

JS *

**Question 16. What does "better access" mean to you?** Choose up to 3

- [ ] Faster access *(shorter waits, quicker responses)* (1)
- [ ] Clearer next steps *(knowing where to go, what happens next, and who to contact)* (4)
- [ ] More service locations closer to home (5)
- [ ] More convenient opening times *(evenings or weekends)* (6)
- [ ] More continuity *(seeing same clinician or team)* (9)
- [ ] Easier phone or online access (7)
- [ ] More capacity or more appointments (11)
- [ ] More choice in how support is provided *(in person, by phone, or online)* (12)
- [ ] Not having to repeat your story (13)
- [ ] Other (please specify) (14) _____

JS *

**Question 17. Which of these services are hardest to access when you need them?** Choose up to 3

- ☐ Urgent response at home (1)
- ☐ Intermediate care and discharge support (4)
- ☐ Community rehabilitation (5)
- ☐ Prevention of deterioration (6)
- ☐ Specialist long-term condition support (7)
- ☐ Episodic and specialist clinics (8)
- ☐ Palliative and end of life care (9)
- ☐ Learning disability and neurodevelopmental support (10)
- ☐ Other (please specify) (11) _____
- ☐ ⊗Not sure (12)

Page Break

**Question 18. Do you have children under 18 years old in your household, or do you support families?**

- ○ Yes (1)
- ○ No (2)
- ○ Prefer not to say (4)

*Display this question:*

*If Question 18. Do you have children under 18 years old in your household, or do you support families? = Yes*

JS

**Which community health services for children should be reliably available locally?** Choose up to 3

- [ ] Child development, assessment, and therapies *(community paediatrics, neurodevelopmental assessment, OT, physiotherapy, speech and language therapy)* (1)
- [ ] Sensory services *(audiology, paediatric ophthalmology)* (5)
- [ ] Dietetics & nutrition (6)
- [ ] Equipment and mobility services *(wheelchair, orthotics, prosthetics)* (7)
- [ ] Children's specialist long-term condition support *(respiratory, diabetes, epilepsy, continence, continuing care, ventilation support)* (8)
- [ ] SEND and transition-to-adulthood support (10)
- [ ] Support for children in care or with safeguarding needs (11)
- [ ] Community dentistry (12)
- [ ] Other (please specify) (9) _____
- [ ] ⊗Not sure (13)

Page Break

JS *

**Question 19. Given neighbourhood health issues brought up in previous reports, which services do you feel are not available enough locally?** Choose up to 3

- [ ] Same-day urgent assessment (not A&E) (1)
- [ ] Tests and diagnostics closer to home (4)
- [ ] Rehabilitation and support after hospital discharge (5)
- [ ] Falls and frailty support (6)
- [ ] Long-term condition education and support *(diabetes, heart disease, COPD)* (7)
- [ ] Mental health support (8)
- [ ] Pain management or musculoskeletal support (9)
- [ ] Women's health support (10)
- [ ] Social care and practical support navigation *(care advice, benefits, debt, or housing issues linked to health)* (12)
- [ ] Support for carers, including respite (13)
- [ ] End-of-life, palliative support, and bereavement support (14)
- [ ] Loneliness or social connection programmes (16)
- [ ] Other (please specify) (18) _____

*Carry Forward Selected Choices from "Question 19. Given neighbourhood health issues brought up in previous reports, which services do you feel are not available enough locally? Choose up to 3"*

X→

**What is the best way to deliver these services?**

| | Community venue outreach (1) | Home visiting (8) | Digital, with in-person support when needed (9) | Hospital (10) | Mobile health unit (11) | Not sure / Other (13) |
|---|---|---|---|---|---|---|
| Same-day urgent assessment (not A&E) (x1) | ○ | ○ | ○ | ○ | ○ | ○ |
| Tests and diagnostics closer to home (x4) | ○ | ○ | ○ | ○ | ○ | ○ |
| Rehabilitation and support after hospital discharge (x5) | ○ | ○ | ○ | ○ | ○ | ○ |
| Falls and frailty support (x6) | ○ | ○ | ○ | ○ | ○ | ○ |
| Long-term condition education and support *(diabetes, heart disease, COPD)* (x7) | ○ | ○ | ○ | ○ | ○ | ○ |
| Mental health support (x8) | ○ | ○ | ○ | ○ | ○ | ○ |
| Pain management or musculoskeletal support (x9) | ○ | ○ | ○ | ○ | ○ | ○ |
| Women's health support (x10) | ○ | ○ | ○ | ○ | ○ | ○ |
| Social care and practical support navigation *(care advice, benefits, debt, or housing issues linked to health)* (x12) | ○ | ○ | ○ | ○ | ○ | ○ |
| Support for carers, including respite (x13) | ○ | ○ | ○ | ○ | ○ | ○ |
| End-of-life, palliative support, and bereavement support (x14) | ○ | ○ | ○ | ○ | ○ | ○ |

| | | | | | | |
|---|---|---|---|---|---|---|
| Loneliness or social connection programmes (x16) | ○ | ○ | ○ | ○ | ○ | ○ |
| Other (please specify) (x18) | ○ | ○ | ○ | ○ | ○ | ○ |

*Carry Forward Selected Choices from "Question 19. Given neighbourhood health issues brought up in previous reports, which services do you feel are not available enough locally? Choose up to 3"*



**Why are these services not available enough locally?**

| | They do not exist locally (11) | They only exist far away (14) | They exist, but I cannot access them (15) | They exist, but I do not know how to access them (16) | Not sure / Other (13) |
|---|---|---|---|---|---|
| Same-day urgent assessment (not A&E) (x1) | ○ | ○ | ○ | ○ | ○ |
| Tests and diagnostics closer to home (x4) | ○ | ○ | ○ | ○ | ○ |
| Rehabilitation and support after hospital discharge (x5) | ○ | ○ | ○ | ○ | ○ |
| Falls and frailty support (x6) | ○ | ○ | ○ | ○ | ○ |
| Long-term condition education and support *(diabetes, heart disease, COPD)* (x7) | ○ | ○ | ○ | ○ | ○ |
| Mental health support (x8) | ○ | ○ | ○ | ○ | ○ |
| Pain management or musculoskeletal support (x9) | ○ | ○ | ○ | ○ | ○ |
| Women's health support (x10) | ○ | ○ | ○ | ○ | ○ |
| Social care and practical support navigation *(care advice, benefits, debt, or housing issues linked to health)* (x12) | ○ | ○ | ○ | ○ | ○ |
| Support for carers, including respite (x13) | ○ | ○ | ○ | ○ | ○ |
| End-of-life, palliative support, and bereavement support (x14) | ○ | ○ | ○ | ○ | ○ |
| Loneliness or social connection programmes (x16) | ○ | ○ | ○ | ○ | ○ |
| Other (please specify) (x18) | ○ | ○ | ○ | ○ | ○ |

*Display this question:*

*If Why are these services not available enough locally? = They exist, but I cannot access them*

*Or Why are these services not available enough locally? = They exist, but I do not know how to access them*

**For services that exist but are hard to access, what is usually the main barrier?**

- ○ Eligibility criteria are unclear (1)
- ○ Referral pathway is confusing (4)
- ○ Long waits (5)
- ○ Travel distance (6)
- ○ Opening times (7)
- ○ Digital-only route (8)
- ○ Need to call repeatedly (9)
- ○ Cost (10)
- ○ Other (please specify) (11) _____
- ○ Not sure (12)

Page Break

JS *

**Question 20. Over the next 1–3 years, which hospital-based services should be prioritised for more local delivery in the community or at home?** Choose up to 3

- [ ] More community diagnostics and tests closer to home *(blood tests, ECGs, lung function tests, X-ray or ultrasound where feasible)* (1)
- [ ] More specialist follow-up for stable long-term conditions *(cardiology, respiratory care, or diabetes)* (4)
- [ ] Rehabilitation, mobility, and recovery support locally *(musculoskeletal care or recovery after illness or injury)* (5)
- [ ] Urgent care at home when appropriate *(short-term monitoring or treatment for flare-ups that do not require A&E)* (6)
- [ ] Routine antenatal checks locally or partly digital *(for uncomplicated pregnancies, with clear escalation when needed)* (7)
- [ ] Regular treatments at home when appropriate *(e.g. home dialysis)* (8)
- [ ] Other (please specify) (11) _____
- [ ] ⊗Not sure (9)

---

*Display this question:*

*If Question 20. Over the next 1–3 years, which hospital-based services should be prioritised for mor... = More community diagnostics and tests closer to home (blood tests, ECGs, lung function tests, X-ray or ultrasound where feasible)*

JS

**Which diagnostics would you prioritise first?** Choose up to 3

- [ ] More X-rays (1)
- [ ] More ultrasound scans (4)
- [ ] More computed tomography or magnetic resonance imaging access, where feasible (5)
- [ ] More blood tests or phlebotomy (6)
- [ ] More electrocardiograms (7)
- [ ] More lung function tests, including spirometry (8)
- [ ] Other (please specify) (11) _____
- [ ] ⊗Not sure (9)

Page Break

**Question 21. If you had to choose one, which is more important?**

- ○ A trusted relationship with a clinician or team (continuity) (1)
- ○ Faster access, even if you do not see the same person (4)
- ○ Not sure (5)

**Question 22. Which trade-off would you accept?**

- ○ A longer wait for a nearer location (1)
- ○ A further away location for a sooner appointment (12)
- ○ Not sure (13)

**Question 23. Which trade-off would you accept?**

- ○ Phone or video first, then in person if needed (1)
- ○ Always in person, even if slower (4)
- ○ Not sure (5)

**Question 24. When deciding whether to use a service, which one matters most to you?**

- ○ Seeing the same person or team (1)
- ○ Getting help quickly (4)
- ○ Feeling listened to and understood (5)
- ○ Cultural sensitivity (6)
- ○ Clear next steps (7)
- ○ Easy ways to make contact (8)
- ○ Privacy and confidentiality (9)
- ○ Not sure (10)

Page Break

**Question 25. I use the following community services:**

| | I currently use this | | I would use this, or use it more, if it were easier to access | |
|---|---|---|---|---|
| | Yes (1) | No (2) | Yes (1) | No (2) |
| Walking groups or exercise classes (1) | ○ | ○ | ○ | ○ |
| Weight management groups (4) | ○ | ○ | ○ | ○ |
| Stop smoking support groups (5) | ○ | ○ | ○ | ○ |
| Mental wellbeing groups (6) | ○ | ○ | ○ | ○ |
| Befriending or loneliness support (7) | ○ | ○ | ○ | ○ |
| Condition-specific peer support (eg. diabetes, COPD, or cardiac conditions) (8) | ○ | ○ | ○ | ○ |
| Carers groups (9) | ○ | ○ | ○ | ○ |
| Debt, benefits, or housing advice (10) | ○ | ○ | ○ | ○ |

Page Break

**Question 26. In the last 12 months, which have you used?** Select all that apply

- ☐ Online triage form (1)
- ☐ Online booking (4)
- ☐ Prescriptions online (5)
- ☐ Results online (6)
- ☐ Messaging a practice or team (Patchs or other online systems) (7)
- ☐ Phone consult (8)
- ☐ Video consult (9)
- ☐ ⊗None (10)

JS *

**Question 27. What would improve digital access most for an online request?** Choose up to 3

- ☐ Clearer wording (1)
- ☐ Simpler, shorter forms (4)
- ☐ Confirmation of submission and clear response times (5)
- ☐ An easier way to reach a person when needed (6)
- ☐ Two-way messaging after submitting a request (7)
- ☐ Better accessibility and language options (8)
- ☐ Help to complete the form if needed (10)
- ☐ ⊗No improvement needed, digital forms are clear enough already (11)
- ☐ Other (please specify) (12) _____

JS *

Some services could be redesigned with digital components. **Question 28. Which designs would be most useful locally?** Choose up to 3

- ☐ Antenatal check-ins by phone or video, with in-person monitoring when needed (1)
- ☐ Hospital specialist input with local follow-up for stable patients (4)
- ☐ Local diagnostic tests, with hospital review when needed (5)
- ☐ Remote monitoring for long-term conditions, with rapid follow-up if concerns arise (6)
- ☐ Local group education with optional digital support (diabetes, smoking cessation, or weight management) (7)
- ☐ Home-based rehabilitation or falls support, with digital check-ins (8)
- ☐ Other (please specify) (9) _____
- ☒ I would not use digital services (10)

Page Break

JS *

In the past, some services were delivered locally using mobile units (for example, a mobile breast screening unit parked at a health centre). **Question 29. Which mobile diagnostic or treatment services would you value having available locally?** Choose up to 3

- ☐ Breast screening (1)
- ☐ Other screening services *(cervical screening outreach, flu, or COVID vaccination)* (4)
- ☐ Blood tests or routine health checks *(e.g., phlebotomy, blood pressure, or diabetes checks)* (5)
- ☐ Lung health checks or breathing tests (6)
- ☐ Vaccinations (9)
- ☐ X-ray, ultrasound, or other imaging where feasible (10)
- ☐ Other (please specify) (11) _____
- ☐ ⊗I would not use mobile services (13)

Page Break

JS *

**Question 30. Which areas should be prioritised locally to help prevent health problems from getting worse?** Choose up to 3

- [ ] Obesity or healthy weight (1)
- [ ] Smoke-free support (4)
- [ ] Mental wellbeing (5)
- [ ] Physical activity (6)
- [ ] Loneliness (7)
- [ ] Alcohol and substance abuse harms (8)
- [ ] Falls prevention (9)
- [ ] Long-term condition self-management (10)
- [ ] Women's health (11)
- [ ] Other (please specify) (12) _____

JS *

**For the prevention offers you'd most likely use, what format would you choose?** Choose up to 3

- ☐ One-to-one coaching (1)
- ☐ Small group programme (4)
- ☐ Drop-in sessions (5)
- ☐ Digital modules plus reminders (6)
- ☐ Printed guide plus phone support (7)
- ☐ Other (please specify) (9) _____
- ☐ ⊗Not sure (8)

Page Break

JS *

**Question 31. What would help you take more control of health and wellbeing?** Choose up to 3

- [ ] Trusted, clear information (1)
- [ ] One-to-one coaching or goal-setting (4)
- [ ] Local group programmes or classes *(stop smoking, weight management, walking or fitness groups, diabetes education, cardiac or COPD support, and falls prevention classes)* (5)
- [ ] Connection to community activities or support (6)
- [ ] Mental health support (7)
- [ ] Practical support with wider life issues *(benefits, housing, debt support)* (8)
- [ ] Easier check-ins for ongoing health needs (9)
- [ ] Other (please specify) (10) _____

**Question 32. For non-urgent issues, what would be an acceptable response standard?**

- ○ Same day response (1)
- ○ Within 48 hours (4)
- ○ Within 5 working days (5)
- ○ Other (please specify) (6) _____
- ○ Not sure (7)

Page Break

JS *

**Question 33. What should the NHS App do best locally?** Choose up to 3

- ☐ Book or change appointments (1)
- ☐ Manage prescriptions (4)
- ☐ View test results (5)
- ☐ Message your care team (6)
- ☐ Help you find the right service (7)
- ☐ Show local services and support directory (8)
- ☐ Track requests and referrals (9)
- ☐ Self-management plans or reminders (10)
- ☐ Other (please specify) (12) _____
- ☐ ⊗I do not use the NHS App (13)

**Question 34. Which uses of AI in health services would be acceptable to you?** Select all that apply

- ☐ Directing people to the right service (1)
- ☐ Summarising information for clinicians, with human review (4)
- ☐ Sending reminders or self-management prompts (5)
- ☐ Answering general questions about where to find support (6)
- ☐ Other (please specify) (7) _____
- ☐ ⊗None (8)

JS *

**Question 35. Which health issues should our community focus on most over the next few years?** Choose up to 3

- ☐ Heart, blood pressure, or stroke-related problems (1)
- ☐ Respiratory health (4)
- ☐ Diabetes, kidney, or liver health (5)
- ☐ Mental health and suicide prevention (8)
- ☐ Healthy weight and physical activity for children and adults (9)
- ☐ Smoking and tobacco harms (10)
- ☐ Alcohol and substance use harms (11)
- ☐ Falls and frailty in older adults (12)
- ☐ Muscles, joints, and back pain, mobility issues (13)
- ☐ Eye health or vision (14)
- ☐ Disability support and accessible services (15)
- ☐ Other (please specify) (16) _____

Page Break

**Question 36. Is there anything else you want to mention about Neighbourhood Health, INTs, or local needs that we have not asked about?** Optional

_____

_____

_____

_____

_____

End of Block: NH

Start of Block: Demographics

***Section 3*** 12 Questions Please tell us a little about yourself. The survey is anonymous.

**Question 37. What is your age?**

- ○ 18 to 24 (1)
- ○ 25 to 34 (4)
- ○ 35 to 44 (5)
- ○ 45 to 54 (6)
- ○ 55 to 64 (7)
- ○ 65 to 74 (8)
- ○ 75 to 84 (9)
- ○ 85 and over (10)
- ○ Prefer not to say (11)

**Question 38. What is your gender?**

- ○ Man (1)
- ○ Woman (4)
- ○ Non-binary or third gender (5)
- ○ Prefer not to say (6)

**Question 39. What is your ethnicity?**

- ○ English, Welsh, Scottish, Northern Irish or British (1)
- ○ Irish (4)
- ○ Roma (5)
- ○ Any other White background (please specify) (6)

_____

- ○ White and Black Caribbean (7)
- ○ White and Black African (8)
- ○ White and Asian (9)
- ○ Any other Mixed or Multiple ethnic background (please specify) (10)

_____

- ○ Arab (11)
- ○ Indian (19)
- ○ Pakistani (12)
- ○ Bangladeshi (13)
- ○ Chinese (14)
- ○ Any other Asian background (please specify) (15)

_____

- ○ Any other ethnic group (please specify) (17)

_____

- ○ Prefer not to say (18)

**Question 40. What is your area of residence?**

- ○ Maldon (1)
- ○ Dengie (4)
- ○ South Woodham Ferrers (5)
- ○ Other (please specify) (6) _____

**Question 41. Please indicate the name of your GP surgery.**

_____

_____

_____

_____

Page Break

**Question 42. Do you have a long-term health condition, either physical or mental?**

- ○ Yes (1)
- ○ No (4)
- ○ Prefer not to say (5)

---

**Question 43. Do you consider yourself to have an impairment or disability?**

- ○ Yes (1)
- ○ No (4)
- ○ Prefer not to say (5)

---

**Question 44. Are you an unpaid carer for someone with health or care needs?**

- ○ Yes (1)
- ○ No (4)
- ○ Prefer not to say (5)

---

**Question 45. What is your employment status?**

- ○ Employed full-time (1)
- ○ Employed part-time (4)
- ○ Self-employed (5)
- ○ Student (6)
- ○ Unemployed (7)
- ○ Retired (8)
- ○ Unable to work due to health (9)
- ○ Prefer not to say (10)
- ○ Other (please specify) (11) _____

**Question 46. Are you a veteran?**

- ○ Yes (1)
- ○ No (4)
- ○ Prefer not to say (5)

**Question 47. In the last 6 months, have any of the following made it harder to look after your health?** Select all that apply

- ☐ Money worries (1)
- ☐ Work schedule or shift work (4)
- ☐ Caring responsibilities (5)
- ☐ Transport limitations (6)
- ☐ Disability or limited mobility (7)
- ☐ Language or communication needs (8)
- ☐ Mental wellbeing (9)
- ☐ Housing problems (insecurity, poor quality, or overcrowding) (10)
- ☐ ⊗None of these (11)
- ☐ ⊗Prefer not to say (12)
- ☐ Other (please specify) (13) _____

**Question 48. Anything else you want to mention about your circumstances that affects your access or needs?** Optional

_____

_____

_____

_____

Appendix **Additional Context** For your interest Integrated Neighbourhood Teams (INTs) bring together existing local providers across health, social care and community/voluntary services to reduce siloed working, strengthen community resilience, reduce avoidable demand on health and care services, and support workforce satisfaction and retention. In South Woodham Ferrers, Central Maldon, and the Dengie, we cover a registered population of around 69,000 patients. INT partners work together to provide proactive support to make it easier for residents to access the right services. Examples in Essex can include a single point of contact to coordinate referrals, social prescribing to connect people to local groups and practical help, urgent community assessment at home to prevent avoidable hospital visits, home equipment planning and physiotherapy to support recovery after discharge, and virtual wards. However, this integrated approach is only purposeful if it improves the experience for patients, service users, and the public.

**End of Block: Demographics**

# Appendix 2: Focus Group Discussion Guides (with consent form and information leaflet)

## Focus Group Discussion Guide (service users)

**1. Introduction**

- Welcome participants and introduce facilitator, rapporteur and student.
- Explain the purpose of the discussion:
  *To understand experiences in accessing local health and community services and explore potential improvements for INTs.*
- Outline the plan for the session
- Obtain any outstanding consent (written/verbal)
- Highlight confidentiality and maintaining respect for different perspectives
- Re-affirm consent and allowance to withdraw or not answer a question
- Begin the recording

**2. When you think about local health, welfare, and wider support services, what is working well?**

Prompt: Which services feel easy to use? What has helped you have a good experience? Are there examples of services feeling joined-up already?

- Services that are easy to contact
- Staff who communicate clearly
- Good follow-up, services working well together
- Helpful community or voluntary support
- Support being available in the right place or at the right time

**3. When you think about local health, welfare, and wider support services, what is NOT working well?**

Prompts: What improvements would you most like to see in the way health, social care, and welfare services are delivered by the providers as a whole? Are there any concerns or challenges you see with services trying to work more closely together?

- Difficulty finding out what support exists
- Problems moving between hospital, community, and social care

- Poor communication between services, having to repeat the same information
- Long waits or unclear next steps
- Digital exclusion

4. **Integrated Neighbourhood Teams are meant to help services work together more smoothly. Have you noticed any difference in the last few years? What would make services better for you?**

Prompts: How do you think patients, service users, or carers would benefit? What would good joined-up care look like?

- Preliminary survey findings suggest residents would value better coordination across GP services, NHS 111, community nursing, rehabilitation, hospital discharge support, diagnostics, and women's health services.
- Even around one issue such as dementia, residents in South Woodham Ferrers may need to navigate around 5-6 organisations (including GP practices, NHS memory assessment services, Essex County Council adult social care, Essex Library Service, South Woodham Ferrers Library Memory Café, Alzheimer's Society dementia support)

5. **With the development of Neighbourhood Health, which services or types of care would you most want to be provided closer to home?**

Prompts: Are there particular conditions, situations, or types of support that should be more local? Thinking realistically, what do you think is practical to provide locally?

- Outreach and mobile health units
- Diagnostics and tests
- Specialist follow-up for stable conditions
- Rehabilitation and post-discharge support
- Mental health support
- Women's health and men's health
- Social support, prevention, and wellbeing programmes
- Outreach and mobile health units

6. **What would need to change to make these improvements work well in practice?**

Prompts: What changes would you like to see in how services are delivered? Are there any good practices from other areas that could be implemented locally?

7. **Summary**

- Highlight key points made in the discussion.
- Ask participants if they have any final thoughts they would like to add.
- Thank participants for their time and input

## Focus Group Discussion Guide (stakeholders/service providers)

**1. Introduction**

- Welcome participants and introduce facilitator, rapporteur and student.
- Explain the purpose of the discussion:
  *To understand experiences in accessing local health and community services and explore potential improvements for INTs.*
- Outline the plan for the session
- Obtain any outstanding consent (written/verbal)
- Highlight confidentiality and maintaining respect for different perspectives
- Re-affirm consent and allowance to withdraw or not answer a question
- Begin the recording

**2. As providers, when you think about local health, welfare, and wider support services, what do you think is currently working well?**

Prompt: Which pathways or services work smoothly? Where is communication between organisations already working well? Are there examples of INT working that seem to benefit patients, service users, or carers?

- Examples of effective communication or information-sharing between teams
- Good follow-up, handovers, or referral processes
- Where collaboration between health, social care, and voluntary/community services is working well
- Community or voluntary-sector support that is helping to meet local needs
- Services being delivered in the right place, at the right time, or in a way that reduces pressure elsewhere

**3. As providers, when you think about local health, welfare, and wider support services, what do you think is NOT currently working well? What do you think could be better?**

Prompts: What frustrates you about the way services are delivered? What improvements would you most like to see in how services are organised and delivered? Are there any concerns or challenges about services working more closely together?

- Difficulty finding out what support exists
- Problems moving between hospital, community, and social care

- Poor communication or handovers between services
- Long waits or unclear next steps
- Digital exclusion
- Duplication or gaps in provision

4. **Integrated Neighbourhood Teams are meant to help services work together more smoothly. Have you noticed any difference in the last few years? What would make it easier for you to make services more accessible for patients and service users?**

Prompts: How do you think patients, service users, or carers would benefit? What would good coordination look like in practice? What do you think is the effect of not including patients? How could service delivery be improved by including patients?

- Preliminary survey findings suggest residents would value better coordination across GP services, NHS 111, community nursing, rehabilitation, hospital discharge support, diagnostics, and women's health services.
- Even around one issue such as dementia, residents in South Woodham Ferrers may need to navigate around 5-6 organisations (including GP practices, NHS memory assessment services, Essex County Council adult social care, Essex Library Service, South Woodham Ferrers Library Memory Café, Alzheimer's Society dementia support)

5. **With the development of Neighbourhood Health, which services or types of care do you think should be provided closer to home?**

Prompts: Are there particular conditions, situations, or population groups that should be prioritised? Thinking realistically, what is practical to deliver locally?

- Diagnostics and tests
- Specialist follow-up for stable conditions
- Rehabilitation and post-discharge support
- Mental health support
- Women's health and men's health
- Social support, prevention, and wellbeing programmes
- Outreach and mobile health units

6. **What would need to change to make these improvements work well in practice?**

Prompts: Are there any good practices from other areas that could be implemented locally? What would make improvements more sustainable for staff and patients?

7. **Summary**

- Highlight key points made in the discussion.

- Ask participants if they have any final thoughts they would like to add.
- Thank participants for their time and input




## Participation Information Leaflet

| | |
|---|---|
| **Study Title:** | **The Maldon Central, Dengie & South Woodham Ferrers Integrated Neighbourhood Team (INT) area: Neighbourhood Health Future** |
| **Investigator(s):** | **Eileen Wang (University of Warwick), Peter Blackman (South Woodham Ferrers Health & Social Care Group), Bronwyn Harris (University of Warwick)** |

**Version 1. 15.04.26**

### Research team

Researcher: Eileen Wang, University of Warwick

Academic Supervisor: Bronwyn Harris, University of Warwick

Organisational Supervisor and Focus Group Discussion Facilitator: Peter Blackman, South Woodham Ferrers Health and Social Care Group

### Introduction

Thank you for your interest in partaking in this study. Before you decide whether to take part, please take the time to read the following information carefully to understand why the research is being done and what it would involve for you.

Please ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

### Who is organising and funding the study?

The study is organised by South Woodham Ferrers Health & Social Care Group (SWFH&SCG), in partnership with the University of Warwick Master of Public Health course.

### Purpose of the Study

This research is independent of the NHS, Essex County Council, the GP Patient Survey, and the Friends and Family Test. It is designed to gather insights specifically on accessibility needs across different healthcare services.

This study builds upon previous research undertaken in 2023 and 2025 by South Woodham Ferrers Health & Social Group in collaboration with the University of Warwick. These reports highlighted accessibility as a

main health issue for service users in the Maldon Central, Dengie & SWF Integrated Neighbourhood Team (INT)'s area, with transportation and communication as key barriers to physical health access.

Links to the previous reports can be found here:

Health, Welfare & Social Care Assessment of the Dengie & South Woodham Ferrers Primary Care Network (2023)

https://swfhealthsocial.files.wordpress.com/2023/07/health-welfare-social-care-assessment-of-the-dengie-south-woodham-ferrers-pcn-jun23.pdf

Accessibility to Healthcare Services in the Maldon Central, Dengie & South Woodham Ferrers Integrated Neighbourhood Team (INT) Area (2025)

https://swfhealthsocial.co.uk/wp-content/uploads/2025/06/accessibility-to-healthcare-services-report-swf-hscg-warwick-medical-school-vf.pdf

This study focuses on accessibility to Neighbourhood Health services used by residents within the Maldon Central, Dengie, and South Woodham Ferrers Integrated Neighbourhood team (INT) area. INTs represent a collaborative approach in delivering health and social care services in a specific area. These are part of the NHS 10-Year Plan published in 2025 and now exist across the UK. This study observes accessibility within the INT area to provide evidence for enhancing care and equity of service provision.

### Aim of the study:

The aim of this study is to identify how Maldon Central, Dengie, and South Woodham Ferrers INT area might standardise their approach to Integrated Neighbourhood Teams, with a focus on centring community voices on equity and access. The study intends to inform service design improvements locally.

The first stage of the research project was a survey released to the public. This participation leaflet details the second part of the research process that you have been invited to partake in. Focus group discussions (FGDs) will be conducted, aiming to produce insights into experiences, challenges, and potential solutions to service navigation and health needs. The questions used in the FDGs have been formulated based on the aims of the research and preliminary findings from the survey. The project involving both the survey and FDGs will form a minimum 3000-word report for a *Pathways to Public Health Workplace Module,* as part of the student's Master's in Public Health programme at the University of Warwick. This report will also be provided to the South Woodham Ferrers Health & Social Care Group for their use. Potentially, the report may be published in a peer reviewed journal.

### What does participation involve?

You are invited to participate in an FDG. Discussions will last approximately 90 minutes (maximum 2 hours).

- The discussion will be conducted online via Microsoft Teams.
- The discussion will be held in English.
- The session will include 6-10 participants, a facilitator, and a rapporteur.
- The FGD will be recorded and transcribed using Microsoft Teams' inbuilt recording service for accuracy in analysis. The recording will be deleted following transcription. Participants will be anonymised at the point of transcription.
- The discussion will be guided by questions informed by preliminary survey results

If you agree to participate, we would like to hear about your experiences around accessibility barriers to local services and ideas for potential solutions. There will be two FDGs: one with service users and one with as a service provider. You will have been invited to either one of these. The facilitator will have a list of prepared questions to ask the group.

### Do I have to take part?

Your participation is voluntary, and you may withdraw at any time during the FGD without providing a reason. Further details regarding withdrawal will be provided in this leaflet.

### What are the possible benefits of taking part in this study?

There are no direct benefits to individual participants, but taking part in this study will provide wider benefits to the community by identifying the supply and demand of the Maldon Central, Dengie, and South Woodham Ferrers community. The project will provide evidence regarding the accessibility of patients and public in the Central Maldon, Dengie, and South Woodham Ferrers INT area to key services. Results will be used to inform the local health and welfare agenda in future consultations. The report may also be an example of what can be done for other INTs across England.

### What are the possible disadvantages, side effects or risks, of taking part in this study?

There are no direct benefits to participation, but your insights will help improve access to services in the locality. The discussion may cover sensitive topics. If you feel uncomfortable, you may choose not to respond or withdraw at any time.

### Expenses and payments

Participants will not be reimbursed or will not receive any form of payment/token for their time.

### Will my taking part be kept confidential?

Any data we collect from you during this study will be treated as confidential by following legal practices upheld by the University of Warwick. We will not access any record that is not provided by you and will not disclose your participation in this study to anyone outside the research team.

The FGDs will be recorded for transcription and subsequent data analysis using the inbuilt Microsoft Teams function. The recording will be stored on a password protected device of the student researcher. The recording will not be viewable by participants and will be deleted once the transcript is developed. Once transcription is complete the recording will be deleted. The transcripts will contain personal identifiers but are edited using pseudonyms or codes to ensure anonymisation and that your privacy is protected.

All digital records of data will be password-protected and securely stored on University of Warwick secure servers. Only the research team, regulatory authorities and authorised individuals at the University of Warwick with verified needs will have access to the data.

The information you share during the FGD may be quoted or described in the research report and potential publication; however, these will not be identifiable to you.

Participants are asked to respect the confidentiality of fellow participants by not sharing any details discussed outside the session.

### What will happen to the data collected about me?

As a publicly funded organisation, the University of Warwick must ensure that it is in the public interest when we use personally identifiable information from people who have agreed to take part in research. This means that when you agree to take part in a research study, such as this, we will use your data in the ways needed to conduct and analyse the research study.

We will be using information from you to undertake this study and will act as the data controller for this study. We are committed to protecting the rights of individuals in line with data protection legislation.

1) At any point during the discussion, you can choose to withdraw your data from the discussion. However, research data will be anonymised as quickly as possible after data collection. Therefore, once the FDG has finished and it will not be possible to withdraw your data after this point.

2) As data will be pseudonymised as quickly as possible after data collection. This means all direct and indirect identifiers will be removed from the research data and will be replaced with a participant number. The key to identification will be stored separately and securely to the research data to safeguard your identity.

### Data Sharing

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways for the research to be reliable and accurate. The University of Warwick has in place policies and procedures to keep your data safe.

This data may also be used for future research, including impact activities. This will only be granted following additional ethical review and approval by an independent Research Ethics Committee and subject to your consent at the outset of this research project.

For further information, please refer to the University of Warwick Research Privacy Notice which is available here:

https://warwick.ac.uk/services/idc/dataprotection/privacynotices/researchprivacynotice or by contacting the Legal and Compliance Team at infocompliance@warwick.ac.uk.

### What will happen if I don't want to carry on being part of the study?

Please note that if you withdraw from the study, it will not be possible to withdraw your data after the FGD has finished, as the data will have been anonymised. To safeguard your rights, we will use the minimum personally identifiable information possible and keep the data secure in line with the University's Information and Data Compliance policies.

### What will happen to the results of the study?

The results of this study will be collated together in a report that will be submitted to Warwick University and to the South Woodham Ferrers Health & Social Care Group. The report may be published in an online peer reviewed research journal. The results may be used as secondary data by future students. Any use of the data outside of the project will require additional ethical review and approval.

### Who has reviewed the study?

The study has been given course-delegated ethical approval on behalf of BSREC committee at the University of Warwick.

### Who should I contact if I want further information?

South Woodham Ferrers Health & Social Care Group – Peter Blackman (Chair)

Email address: peter@blackmanservices.co.uk

### Who should I contact if I wish to make a complaint?

Any complaint about the way you have been dealt with during the study or any possible harm you might have suffered will be addressed. Please address your complaint to the person below, who is a senior University of Warwick official entirely independent of this study:

Head of Research Governance

Research & Impact Services

University House

University of Warwick

Coventry CV4 8UW

Email: researchgovernance@warwick.ac.uk

Tel: 02476 575733

If you wish to raise a complaint on how we have handled your personal data, you can contact our Data Protection Officer who will investigate the matter: DPO@warwick.ac.uk.

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO).

**Thank you for taking the time to read this Participant Information Leaflet**

## Consent Form

| | |
|---|---|
| **Study Title:** | **The Maldon Central, Dengie & South Woodham Ferrers Integrated Neighbourhood Team (INT) area: Neighourhood Health Future** |
| **Investigator(s):** | **Eileen Wang (University of Warwick), Peter Blackman (South Woodham Ferrers Health & Social Care Group), Bronwyn Harris (University of Warwick)** |

1. I confirm that I have read and understand the participation leaflet (*Version 1, 15/04/26)* for the above study. I have had the opportunity to consider the information, ask questions, and received answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the focus group discussion (FGD) without giving any reason. Once the FGD is complete, I will be unable to withdraw my data.
4. I understand that data collected during the study may be looked at by individuals from University of Warwick and the South Woodham Ferrers Health & Social Care Group where needed, for the purposes of the research. I give permission for these individuals to have access to my data.

5. I agree for the FGD to be recorded through the inbuilt Microsoft Teams system.
6. I consent for anonymised verbatim quotations to be used.
7. I am happy for my data to be used in future research. Any use of the data outside of the project will require additional ethical review and approval.
8. I agree to take part in the above study.

| | | |
|---|---|---|
| Name of Participant | Date | Signature |
| Name of Person | Date | Signature |

# Appendix 3: Survey Results

Survey findings are presented descriptively. Denominators vary between questions because some respondents completed only part of the survey and because not all questions were applicable to all respondents. For multiple-response questions, percentages represent the proportion of valid respondents selecting each option and may sum to more than 100%. These results should therefore be interpreted as descriptive findings from respondents who answered each item, rather than representative estimates of the wider INT population.

## Section 1: Integrated Neighbourhood Teams

Respondents most strongly prioritised joined-up communication between services (40/47, 85.1%), followed by one clear contact route or "front door" to the right support (33/47, 70.2%) and clear follow-up after making contact (24/47, 51.1%). Smaller numbers selected coordinated support for people with complex needs (15/47, 31.9%), proactive support when needs change (10/47, 21.3%) and help connecting to non-medical support such as benefits, housing or debt advice (6/47, 12.8%). This suggests that residents valued coordination and clarity more strongly than any single service function (Figure A1).

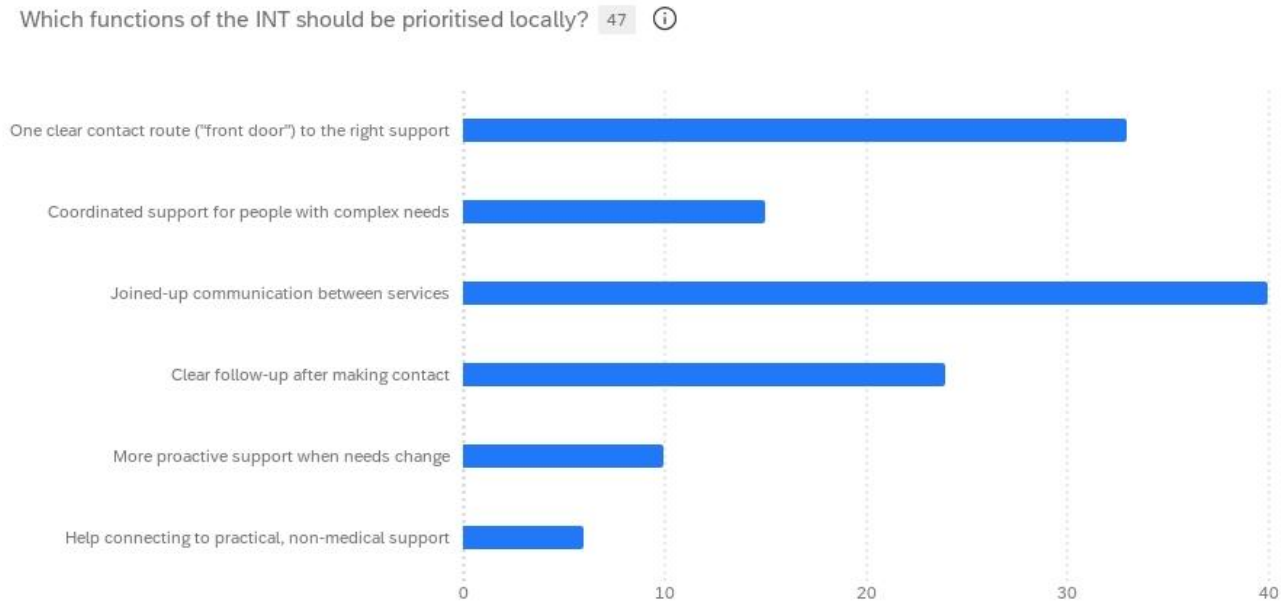



*Figure A1*. INT functions residents would prioritise locally

Reported experience of INT functions was more limited than stated priorities. Only small numbers of respondents reported experiencing a single contact route, joined-up communication, clear follow-up, links to practical support, or a named coordinator for complex needs. No respondents reported experiencing proactive support such as check-ins or support at home. This indicates a gap between the functions residents would value and the functions they had clearly experienced (Figure A2).

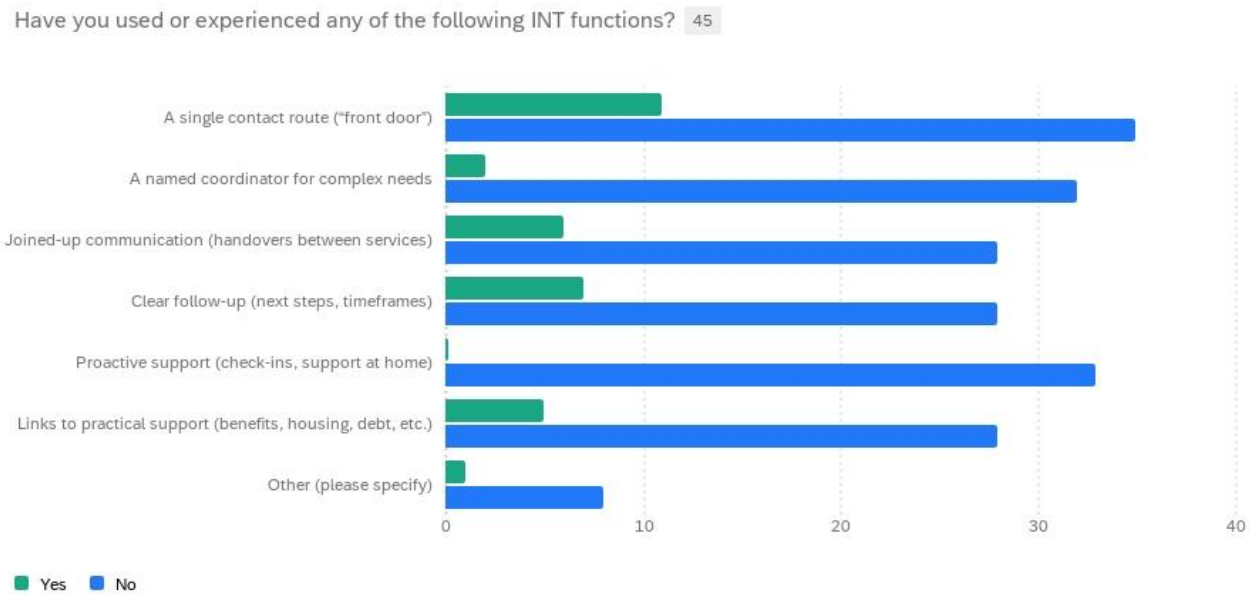



*Figure A2.* INT functions residents had experienced

The service areas most commonly identified as needing better coordination were GP services, NHS 111 and community pharmacy (38/47, 80.9%), and community diagnostics and testing (37/47, 78.7%). Community nursing, rehabilitation and support after hospital discharge was selected by 19 respondents (19/47, 40.4%). Women's health support was selected by 10 respondents (10/47, 21.3%), while mental health support and older adults' support were each selected by eight respondents (8/47, 17.0%). These findings suggest that residents were particularly concerned with coordination around common access points, diagnostics and transitions between services (Figure 3A).

| Service area | n/N | % |
|---|---|---|
| GP services, NHS 111 and community pharmacy | 38/47 | 80.9% |
| Community diagnostics and testing | 37/47 | 78.7% |
| Community nursing, rehabilitation and support after hospital discharge | 19/47 | 40.4% |
| Women's health support | 10/47 | 21.3% |
| Mental health support | 8/47 | 17.0% |
| Older adults' support | 8/47 | 17.0% |
| Carers support | 3/47 | 6.4% |
| Children and family support | 2/47 | 4.3% |
| Social care advice and support | 1/47 | 2.1% |
| Other | 1/47 | 2.1% |
| Learning disability, autism or neurodevelopmental support | 0/47 | 0.0% |
| End-of-life, palliative care or bereavement support | 0/47 | 0.0% |

*Figure A3.* Service areas where residents would value better coordination

Respondents strongly supported mixed access routes. The most preferred access route was a single local phone line (37/46, 80.4%). This was followed by referral from a healthcare professional (25/46, 54.3%), the NHS App or an online request (23/46, 50.0%), and a local website or directory with a way to request support (19/46, 41.3%). Community venues were selected by 11 respondents (11/46, 23.9%), and a social prescriber or link worker by seven respondents (7/46, 15.2%). These results suggest that digital access was valued, but as part of a mixed model that retained phone and professional routes (Figure A4).

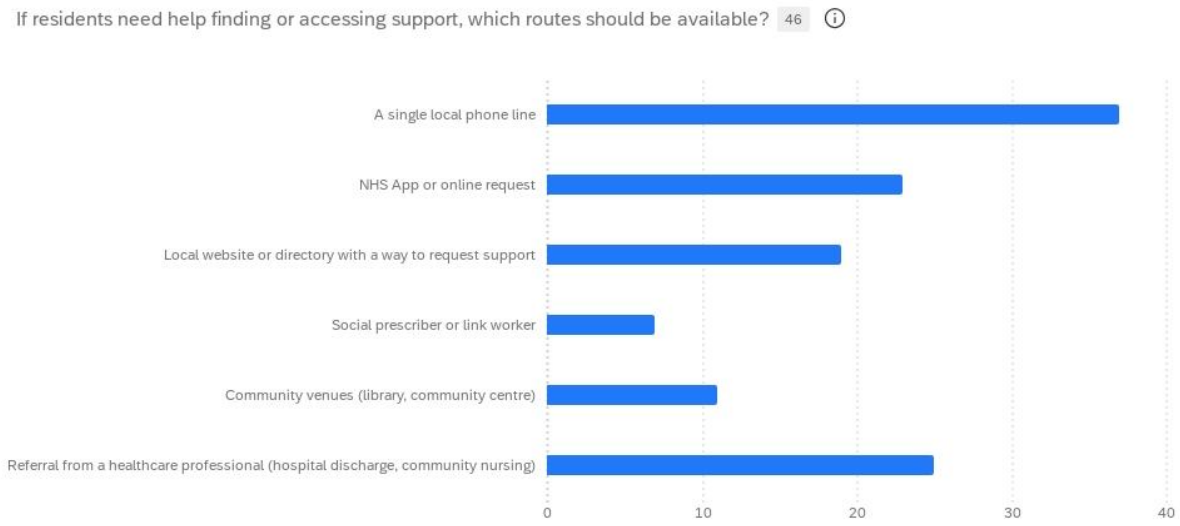



*Figure A4.* Preferred routes into support

The most common information barrier was not knowing which service was right (27/43, 62.8%). This was followed by unclear referral routes (22/43, 51.2%), too many different websites or places to look (19/43, 44.2%), out-of-date information (13/43, 30.2%), unclear eligibility rules (8/43, 18.6%), missing or incorrect contact details (7/43, 16.3%) and digital barriers such as logins, forms or internet access (7/43, 16.3%). When asked what would make information easier, respondents most often selected a local phone line, explanation from a GP or practice nurse, and a simple local directory with clear access steps. This suggests that information barriers were not only about whether information existed, but whether it was current, understandable and linked to clear routes into support (Figure A5).

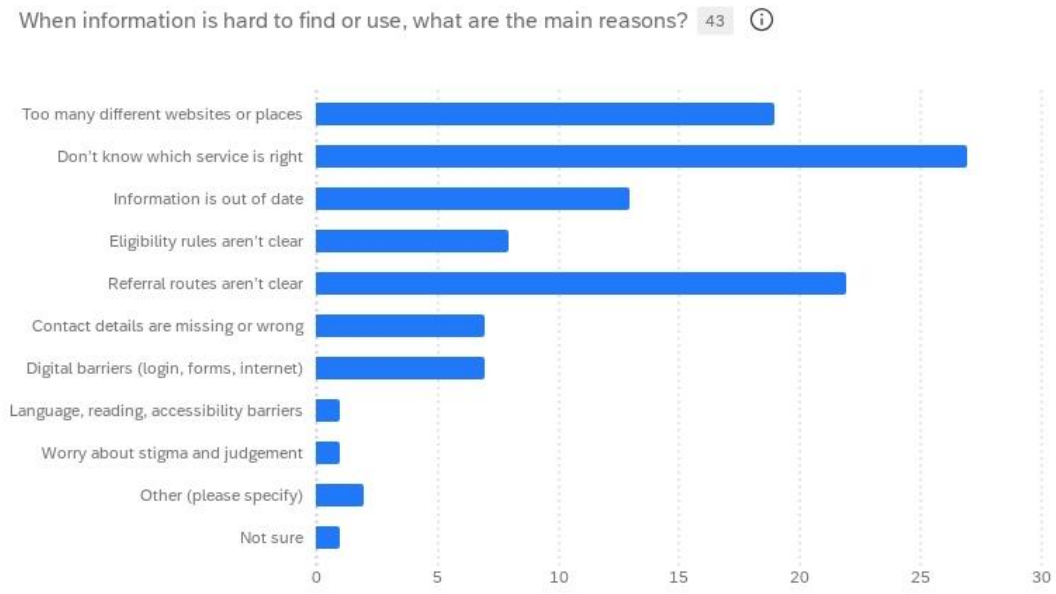



*Figure A5.* Barriers to finding or using information

When asked what should be standard to ensure there is “no service about me without me”, respondents most often selected being asked what matters to me (28/43, 65.1%). This was followed by clear options being explained (24/43, 55.8%), an easy way to ask follow-up questions later (22/43, 51.2%). These findings suggest that person-centred care was associated with being listened to, understanding options and having a reliable route for follow-up (Figure A6).

| Priority | n/N | % |
|---|---|---|
| Being asked what matters to me | 28/43 | 65.1% |
| Clear options being explained | 24/43 | 55.8% |
| An easy way to ask follow-up questions later | 22/43 | 51.2% |
| Choice of communication method | 20/43 | 46.5% |
| A written plan agreed with me | 15/43 | 34.9% |
| Ability to involve a carer or family member, with consent | 7/43 | 16.3% |

*Figure A6.* “No service about me without me” priorities

Home visiting for those who need it was selected most often as a route for reaching people who may miss out (29/40, 72.5%). This was followed by proactive calls when eligible (25/40, 62.5%) and community support groups (22/40, 55.0%). Community venues such as libraries and community centres were selected by 11 respondents (11/40, 27.5%), printed information in key locations by seven respondents (7/40, 17.5%), social prescriber outreach by six respondents (6/40, 15.0%) and local radio or newsletters by two respondents (2/40, 5.0%). These findings indicate that outreach and proactive contact may be important for residents who are less able to navigate services independently (Figure A7).

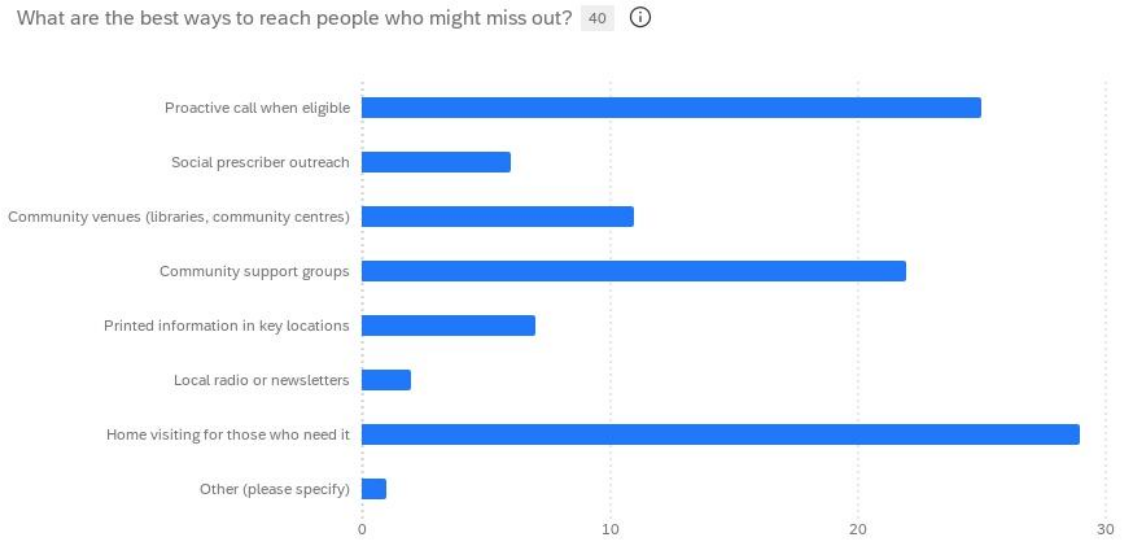



*Figure A7.* Ways to reach people who may miss out

## Section 2: Neighbourhood Health

GP services were the most commonly used local service (34/38, 89.5%), followed by pharmacy advice or services (27/38, 71.1%), diagnostics and scans such as blood tests, ECGs or breathing tests (23/38, 60.5%), specialist hospital or community services (15/38, 39.5%), NHS 111 (10/38, 26.3%) and physiotherapy, musculoskeletal or rehabilitation support (7/38, 18.4%). Smaller numbers reported using healthy lifestyle or long-term condition support, social prescribing, mental health support, community groups, community nursing or falls prevention services.

Among respondents who had used services and wanted better local access, GP services were selected most often (22/33, 66.7%), followed by diagnostics and scans (19/33, 57.6%) and specialist hospital or community services (12/33, 36.4%). Pharmacy advice or services were selected by four respondents (4/33, 12.1%), while NHS 111, physiotherapy/MSK/rehabilitation support and mental health support were each selected by three respondents (3/33, 9.1%). These results indicate that residents wanted better local access both to everyday entry points and to diagnostic or specialist services.

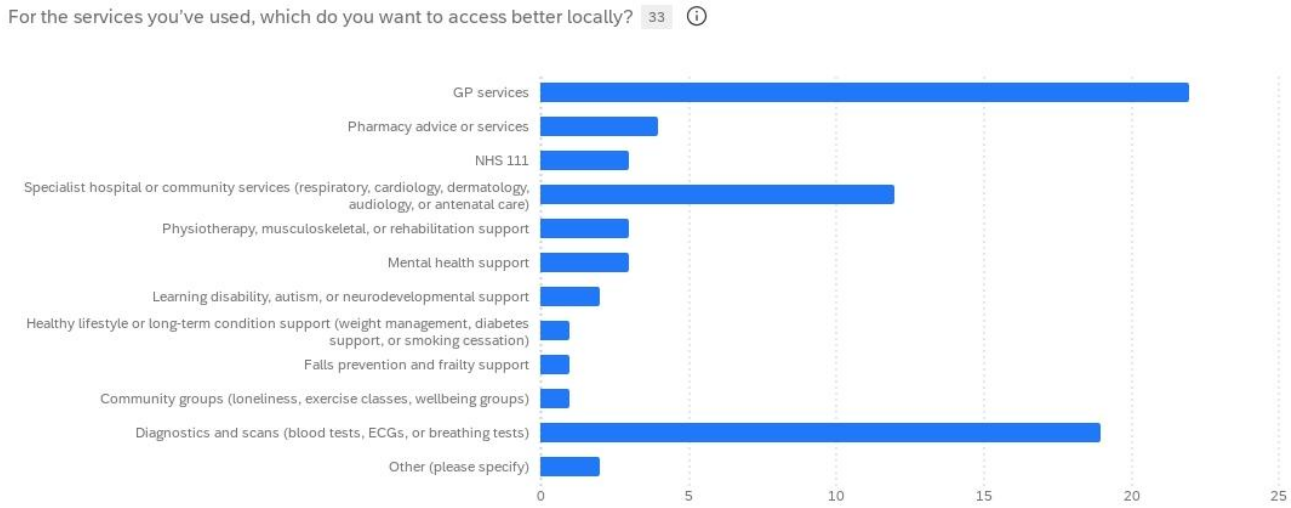



*Figure A8.* Services residents wanted to access better locally

Respondents most often defined better access as faster access, including shorter waits and quicker responses (24/38, 63.2%). More service locations closer to home were selected by 22 respondents (22/38, 57.9%). More continuity, such as seeing the same clinician or team, and more convenient opening times, such as evenings or weekends, were each selected by 15 respondents (15/38, 39.5%). More capacity or more appointments was selected by 13 respondents (13/38, 34.2%), while clearer next steps was selected by seven respondents (7/38, 18.4%). These findings suggest that better access was not understood only as speed, but also as proximity, continuity, convenience and clarity.

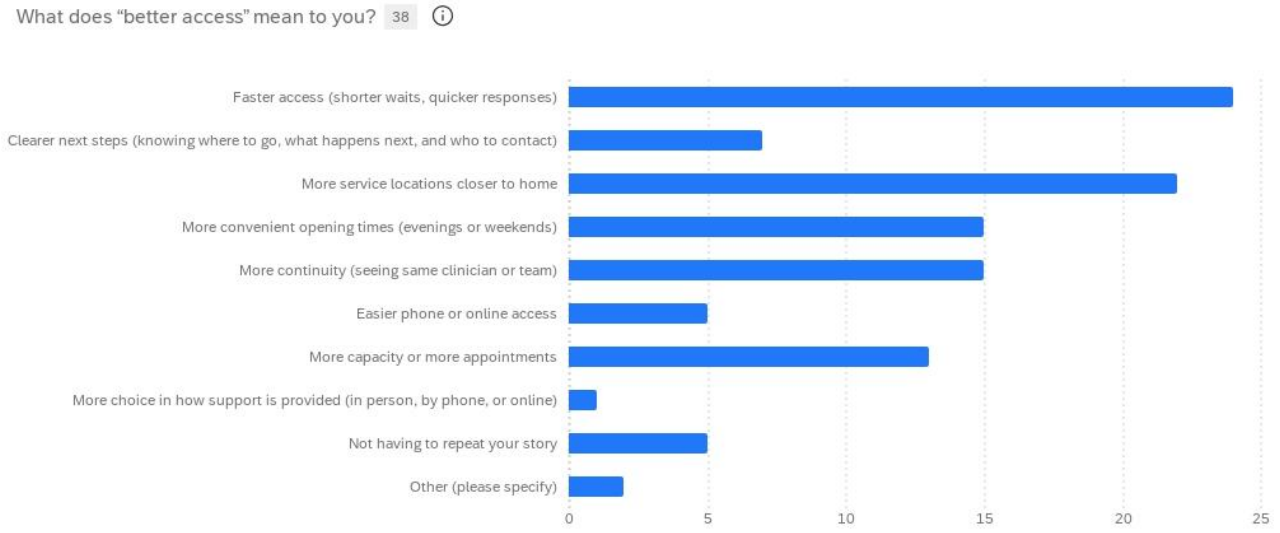



*Figure A9.* What "better access" meant to respondents

Tests and diagnostics closer to home were selected most often as services not available enough locally (31/38, 81.6%). Same-day urgent assessment outside A&E was selected by 28 respondents (28/38, 73.7%). Pain management or musculoskeletal support and women's health support were each selected by seven respondents (7/38, 18.4%), rehabilitation and support after hospital discharge by six respondents (6/38, 15.8%) and mental health support by four respondents (4/38, 10.5%). These findings indicate strong support for diagnostics and urgent assessment outside hospital settings.

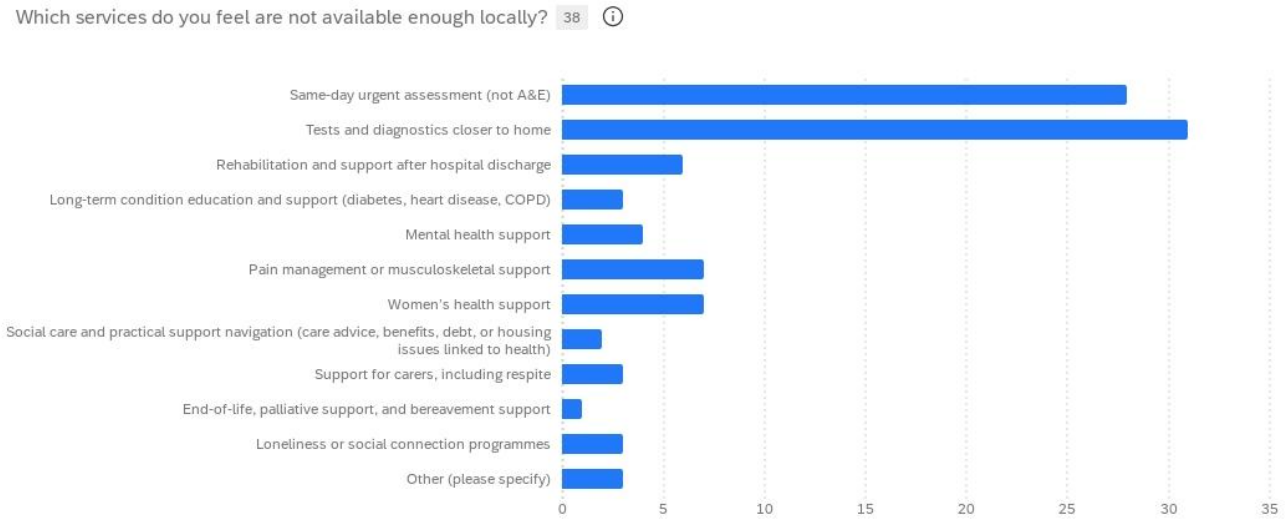



*Figure A10.* Services felt to be insufficiently available locally

The strongest priority was more community diagnostics and tests closer to home, such as blood tests, ECGs, lung function tests, X-ray or ultrasound where feasible (33/37, 89.2%). More specialist follow-up for stable long-term conditions, such as cardiology, respiratory care or diabetes, was selected by 23 respondents (23/37, 62.2%). Urgent care at home where appropriate was selected by 18 respondents (18/37, 48.6%). Rehabilitation, mobility and recovery support locally was selected by nine respondents (9/37, 24.3%), and regular treatments at home where appropriate by eight respondents (8/37, 21.6%).

When asked which diagnostics should be prioritised first, respondents most commonly selected X-rays (26/33, 78.8%), ultrasound scans (19/33, 57.6%), CT or MRI access where feasible (17/33, 51.5%) and blood tests or phlebotomy (16/33, 48.5%). ECGs were selected by seven respondents (7/33, 21.2%). This indicates that respondents prioritised both imaging and routine diagnostic functions (Figure A11).

| Diagnostic service | n/N | % |
|---|---|---|
| X-rays | 26/33 | 78.8% |
| Ultrasound scans | 19/33 | 57.6% |
| CT or MRI access where feasible | 17/33 | 51.5% |
| Blood tests or phlebotomy | 16/33 | 48.5% |
| ECGs | 7/33 | 21.2% |

*Figure A11.* Diagnostics to prioritise first

When asked to choose between speed and continuity, 24 of 36 respondents prioritised a trusted relationship with a clinician or team (24/36, 66.7%), compared with nine who prioritised faster access even if they did not see the same person (9/36, 25.0%). Three were not sure. This suggests that continuity remained important, especially in a sample weighted toward older residents and people with long-term conditions.

When asked about location and speed, 19 of 37 respondents would accept a longer wait for a nearer location (19/37, 51.4%), while nine would accept a further away location for a sooner appointment (9/37, 24.3%). Nine were not sure. This suggests that proximity mattered for many respondents and should not be treated as a minor convenience issue. This reinforces the results of the previous study, which showed that transport poverty is a major issue.

When asked about remote-first care, 20 of 35 respondents would accept phone or video first, followed by in-person care if needed (20/35, 57.1%). However, 14 respondents preferred always being seen in person, even if this was slower (14/35, 40.0%), and one was not sure. These findings suggest that remote access may be acceptable to many respondents, but not as a universal default (Figure A12).

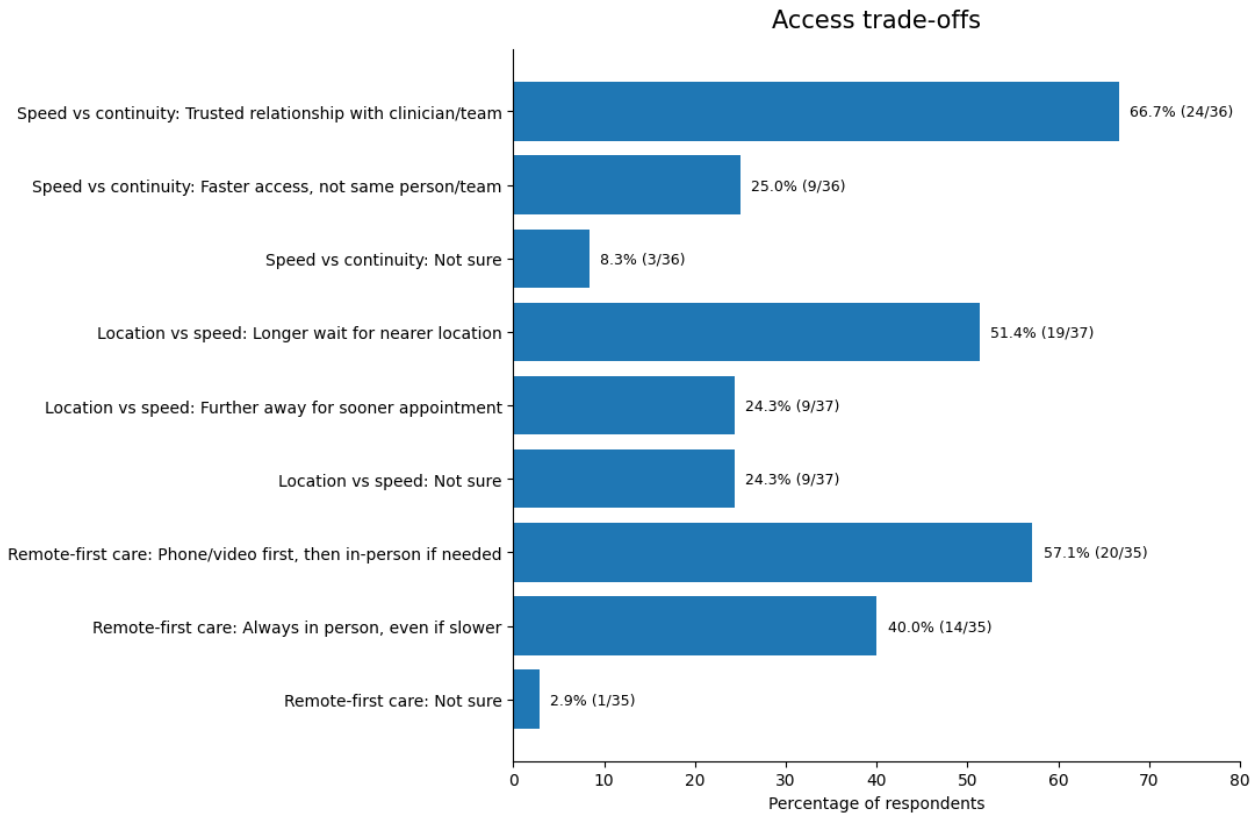



*Figure A12.* Access trade-off

Respondents reported using a range of digital or remote functions. The most common were viewing results online (22/35, 62.9%), phone consultations (21/35, 60.0%), and prescriptions online (20/35, 57.1%) (Figure A13).

| Digital or remote function used | n/N | % |
|---|---|---|
| Viewing results online | 22/35 | 62.9% |
| Phone consultations | 21/35 | 60.0% |
| Prescriptions online | 20/35 | 57.1% |
| Online booking | 19/35 | 54.3% |
| Messaging a practice or team through systems such as Patchs | 17/35 | 48.6% |
| Online triage forms | 7/35 | 20.0% |
| None of these | 1/35 | 2.9% |

*Figure A13.* Digital and remote functions

When asked what would improve online requests most, respondents most often selected an easier way to reach a person when needed (19/34, 55.9%). Two-way messaging after submitting a request was selected by 16 respondents (16/34, 47.1%), simpler and shorter forms by 15 (15/34, 44.1%), and confirmation of submission with clear response times by 13 (13/34, 38.2%). These findings suggest that digital access needs to include confirmation, communication and escalation routes (Figure A14).

Respondents most commonly wanted the NHS App to support booking or changing appointments (26/34, 76.5%). This was followed by viewing test results (19/34, 55.9%), managing prescriptions (14/34, 41.2%), tracking requests and referrals (12/34, 35.3%), helping residents find the right service (8/34, 23.5%), showing a local services and support directory (5/34, 14.7%) and messaging the care team (4/34, 11.8%). Two respondents selected that they did not use the NHS App.

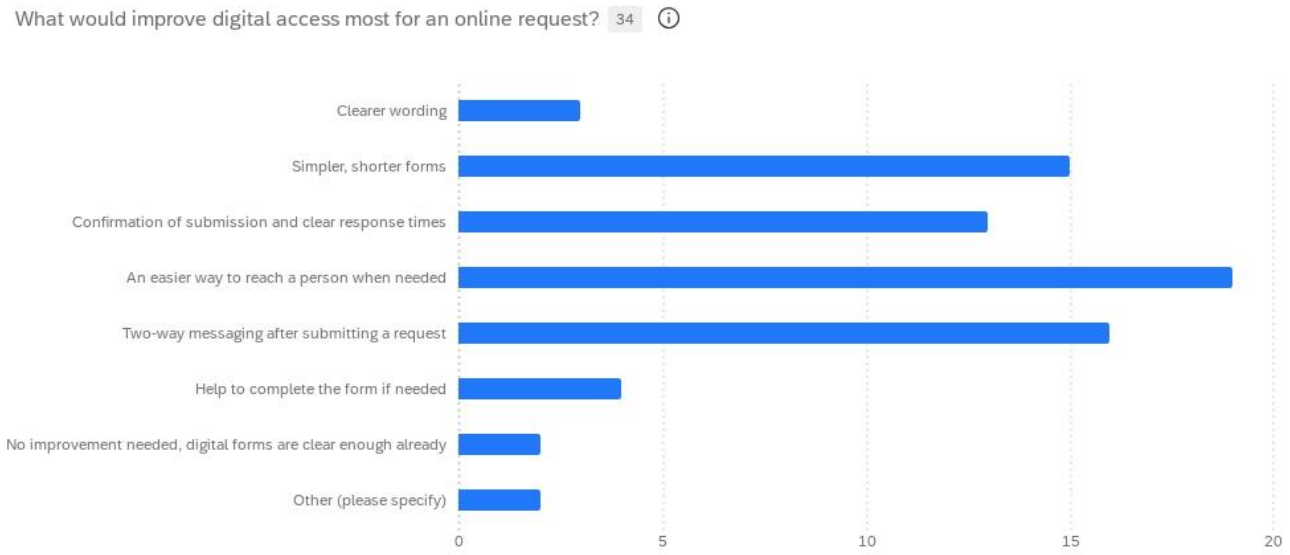



*Figure A14.* Improvements to online requests

Long-term condition self-management and obesity or healthy weight were each selected by 17 respondents (17/33, 51.5%) as areas that should be prioritised locally to prevent health problems getting worse. Physical activity was selected by 14 respondents (14/33, 42.4%). Mental wellbeing and women's health were each selected by 12 respondents (12/33, 36.4%). Loneliness was selected by seven respondents (7/33, 21.2%), alcohol and substance abuse harms by six (6/33, 18.2%), falls prevention by five (5/33, 15.2%) and smoke-free support by two (2/33, 6.1%) (Figure A15).

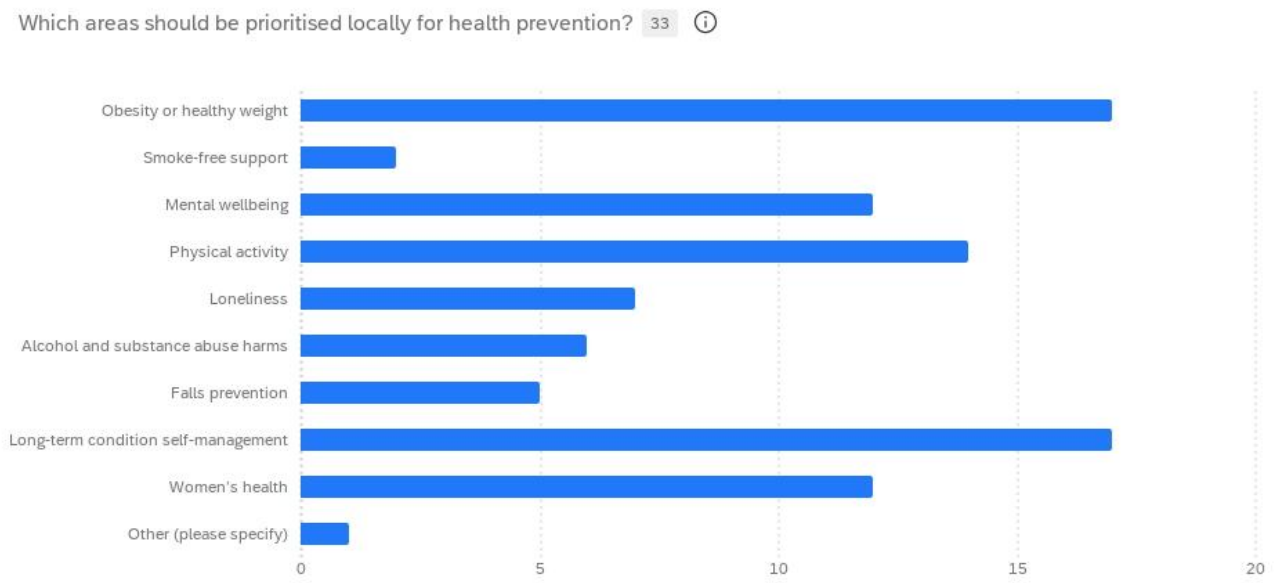



*Figure A15.* Prevention and self-management priorities

Respondents most often preferred one-to-one coaching (22/35, 62.9%) and small group programmes (20/35, 57.1%). Drop-in sessions were selected by 15 respondents (15/35, 42.9%). Printed guides plus phone support were selected by seven respondents (7/35, 20.0%), digital modules plus reminders by six (6/35, 17.1%), and three respondents were not sure. These findings suggest that prevention support should include interpersonal and group-based formats, not only digital information (Figure A16).

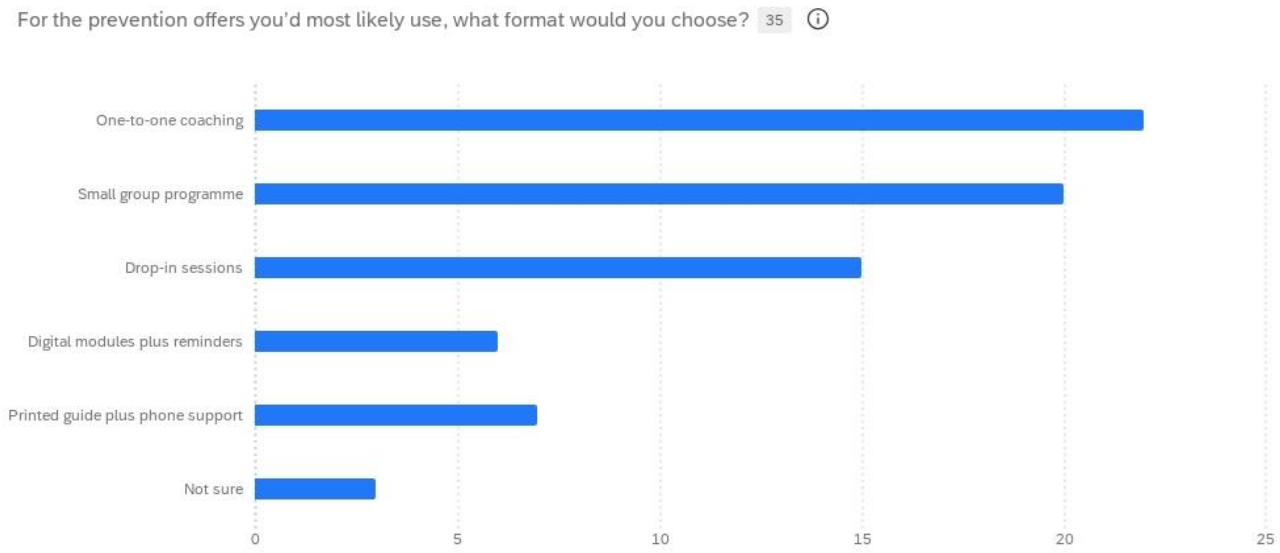



*Figure A16.* Preferred prevention formats

Respondents were also asked which uses of AI in health services would be acceptable. The most commonly selected use was directing people to the right service (18/33, 54.5%), followed by sending reminders or self-management prompts (17/33, 51.5%), answering general questions about where to find support (16/33, 48.5%) and summarising information for clinicians with human review (14/33, 42.4%). However, nine respondents selected “none” (9/33, 27.3%), suggesting some caution about AI use in health services.

Ten respondents said they had children under 18 in their household or supported families (10/38, 26.3%). Among this small subgroup, child development, assessment and therapies were most commonly selected as services that should be reliably available locally (9/10, 90.0%). Children's specialist long-term condition support was selected by five respondents (5/10, 50.0%), SEND and transition-to-adulthood support by four (4/10, 40.0%), sensory services by three (3/10, 30.0%), community dentistry by two (2/10, 20.0%) and dietetics/nutrition by one (1/10, 10.0%). Because the denominator was small, these findings should be interpreted cautiously.

When asked about community priorities, respondents most often selected heart, blood pressure or stroke-related problems as community health priorities (19/34, 55.9%). Healthy weight and physical activity for children and adults was selected by 13 respondents (13/34, 38.2%), diabetes, kidney or liver health by 12 (12/34, 35.3%), mental health and suicide prevention by 11 (11/34, 32.4%), and muscles, joints, back pain and mobility issues by 11 (11/34, 32.4%). Falls and frailty, respiratory health, and disability support and accessible services were each selected by five respondents (5/34, 14.7%).

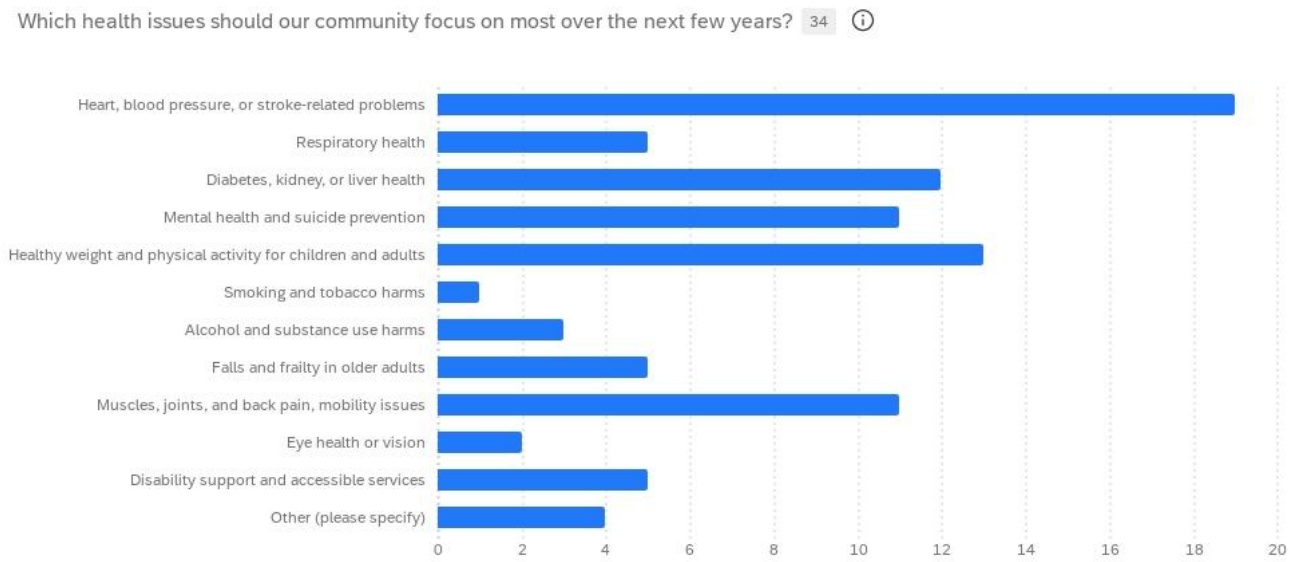



*Figure A20.* Wider community health priorities

## Section 3: Demographics

Among completed demographic responses, the sample was weighted toward older residents. Twenty-two of 34 respondents were aged 65 and over (22/34, 64.7%), including 12 aged 65-74, nine aged 75-84 and one aged 85 or over. Five respondents were aged 55-64, and seven were aged under 55.

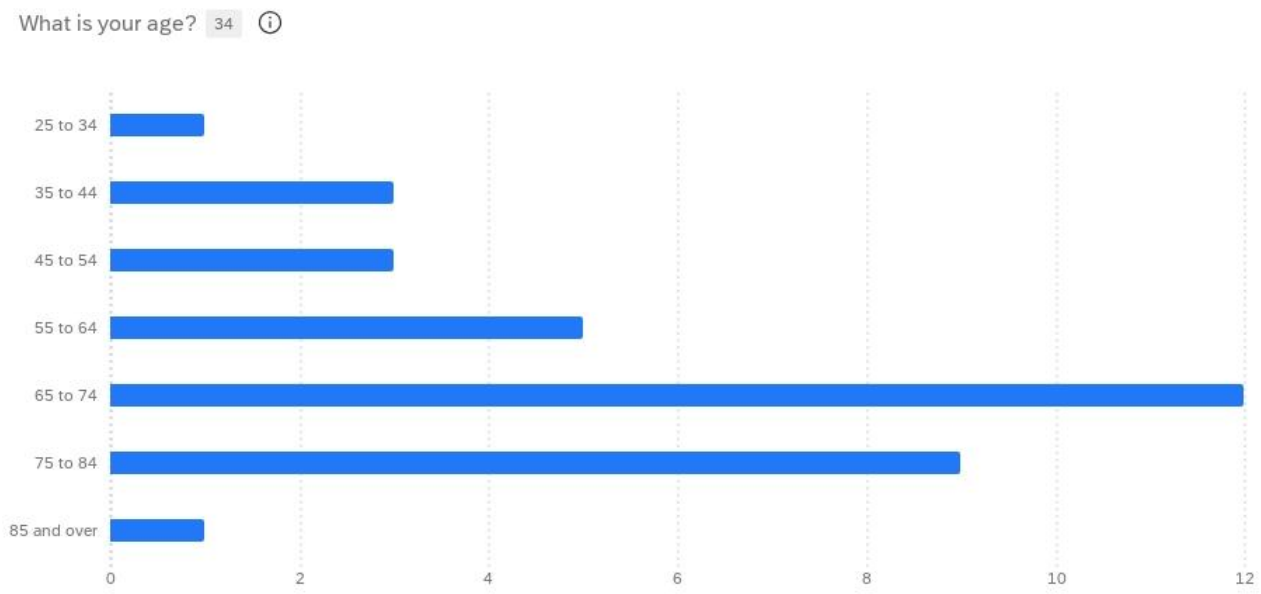



*Figure A21.* Age of respondents

Most respondents were women (25/34, 73.5%), while nine were men (9/34, 26.5%). Most identified as English, Welsh, Scottish, Northern Irish or British (33/34, 97.1%), and one respondent identified as Chinese. Responses were received from South Woodham Ferrers (13/34, 38.2%), the Dengie (11/34, 32.4%), Maldon (9/34, 26.5%) and another area (1/34, 2.9%). Most respondents were retired (22/33, 66.7%), and three identified as veterans (3/32, 9.4%). These demographic characteristics should be considered when interpreting the survey results, as the sample was small and weighted toward older, White British residents with long-term health needs.

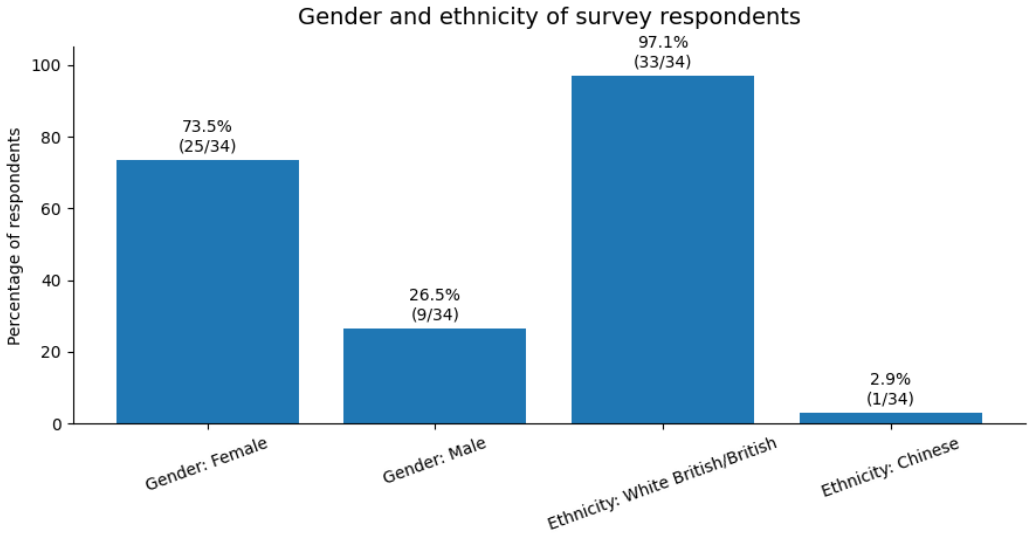



*Figure A22.* Gender and ethnicity

Fourteen respondents selected “none of these” when asked whether circumstances had made it harder to look after their health in the last six months (14/33, 42.4%). Among those who did report barriers, the most common were money worries, transport limitations, and disability or limited mobility, each selected by seven respondents (7/33, 21.2%). Work schedule or shift work, caring responsibilities and mental wellbeing

were each selected by three respondents (3/33, 9.1%). These findings suggest that social, financial, transport and disability-related factors shaped some residents' ability to look after their health.

Long-term health needs were common in the completed sample. Most respondents reported having a long-term physical or mental health condition (26/33, 78.8%). Ten respondents considered themselves to have an impairment or disability (10/33, 30.3%), and five were unpaid carers for someone with health or care needs (5/33, 15.2%).

# Appendix 4: Focus Group Discussion Results

Three online focus group discussions were conducted to explore views on INTs, Neighbourhood Health, local access, coordination and prevention. One discussion involved patient/public participants and two involved provider/stakeholder participants. A supplementary provider/stakeholder discussion was also used to support interpretation. The findings below are presented thematically and should be interpreted as explanatory qualitative evidence rather than representative findings.

Quotes are lightly edited. “Residents” refers to patient/public participants, while “providers” refers to provider/stakeholder participants.

**Theme 1: Navigation, communication and coordination**

The focus group discussions showed that integration was experienced differently depending on participants’ position in the system. Residents tended to describe the visible effects of fragmentation: limited awareness of INTs, uncertainty about how services connected, and difficulty knowing what support existed locally. They did not necessarily suggest that services were absent. Instead, they described a local system where services could be useful but poorly connected, insufficiently publicised or difficult for residents to recognise as part of an integrated model.

Provider accounts were more varied. Some providers described INT infrastructure, including handbooks, forums, drop-ins, newsletters, directories and professional contact routes. However, other provider comments showed that awareness and use of these resources were uneven. Some providers relied on personal knowledge gathered over years, while others were unaware of INT resources or unsure whether they were embedded in day-to-day work. This indicates that coordination was not only a resident-facing issue; it was also a professional implementation issue. This theme therefore highlights a gap between organisational integration and experienced integration (Table A1).

| Resident perspectives | Provider perspectives |
|---|---|
| “We haven’t heard too much about integrated neighbourhood services at all.” | “We’ve obviously got the ways of working… the handbook, the forums, and the drop-ins.” |
| “We have some good services… but I don’t think they’re integrated into this overall network.” | “I know of [the INT directory]. I will admit I very rarely use it because I’ve got my own resources that I’ve picked up over the years.” |
| “The care services around the district are [not] known enough about… people are totally ignorant.” | “I don’t know whether it’s been implemented or embedded within their day-to-day work.” |
| “We seem to be… the one outside of all of that.” | “We’ve got over 800 professionals now within that handbook, which has grown tremendously over the last few years. I would love to see the drop-ins and the forums attended at the same level.” |
| “Nobody’s told anything about them.” | “We’ve definitely got a core group that benefit from the drop-ins and from the forums.” |
| “Even when I ask my GP, he looks at me blankly and says, ‘I know about them, but I don’t know where we are.’” | “There’s a little bit of work to do to try and get the engagement of those that join the handbook.” |
| “It’s no good me knowing about them. It’s the people who want to use the services that need to know about them.” | |
| “The communication is important… because it will give patients confidence if they know what’s happening and how they’re going to benefit.” | |

| | |
|---|---|
| “How do we get these communications out to the various organisations so that they are aware of each other, let alone the public being aware of them?” | “There are some really wonderful green shoots and examples that we can use to think about how we do this better.”<br><br>“We’re very alive to it. I get to hear when things go wrong and when things go very right.”<br><br>“When it works well, it really does work well.”<br><br>“Do we do it regularly? No. And is it kind of systematic? No.” |

*Table A1.* These findings show that INTs cannot be judged only by whether professional infrastructure exists. The more important resident-facing test is whether people experience clearer information, visible routes into support, and smoother coordination between services.

**Theme 2: Mixed routes into care**

The second theme concerned routes into care. Residents described confusion about appointment information, service locations and organisational responsibility. This was especially clear where services operated from shared buildings, satellite sites, or locations associated with another organisation. In these cases, residents could receive an appointment but still be unclear about where to go, who to contact, or which organisation held responsibility.

Provider accounts explained why mixed access routes remained important. Providers described long conversations with residents, signposting work, out-of-date service information, changing contact details and the need to check whether services still existed. This suggests that access routes are not just technical routes into services. They involve human interpretation, local knowledge and ongoing maintenance.

Digital routes and directories were therefore seen as useful but insufficient. Providers described some residents who did not reliably use email, phones or online information, while others had needs too complex for a simple directory search. The qualitative findings therefore support the survey finding that residents wanted a mixed access model, including phone, digital, professional referral and community-based routes.

| Resident perspectives | Provider perspectives |
|---|---|
| “It’s good to have these new satellite places, but the communication about them… is really important.” | “I am having long conversations with them to find out what their needs are, what they’re looking for.”<br><br>“We do need to do quite a lot of signposting.” |
| “The information about appointments [is] inadequate and causing confusion because it’s incomplete.”<br><br>“They think they’ve got to ring [names medical centre], and they don’t realise that’s a building, not an organisation.” | “There is lots of information out there… it takes hours researching things for people.”<br><br>“If you don’t see emails for a few months, you’ve then missed that [a provider] has left… [or they have] a different phone number.” |
| “[She] is not interested in the five bits of the integrated care system have talked to each other. [She] is interested in what can those five bits do for her.” | “Sometimes the information is out of date… services lose their funding, no one tells us they’ve lost their funding.”<br><br>“Having to go through databases and spreadsheets and having to phone and check a service is still running every time you want to signpost somebody to it… it’s just not possible.” |

| | |
|---|---|
| “They ought to consult with local people to make sure that the information they’re sending out is adequate.”<br><br>“There needs to be some sort of communication about this to tell us where we are.” | “How do you remind [a patient] that he’s got that appointment at 10:30? Because he’s not going to look at his phone.”<br><br>“It takes hours researching things for people… GPs don’t have those resources, that time resource.”<br><br>“The people that we support have very complex, complicated lives and the issues… aren’t on many databases. You literally have to scour the internet to try and find something that they want and need.”<br><br>“Sometimes online it doesn’t exist, and [for] most of the things you need money.” |

*Table A2.* These findings show why access routes need to be both clear and plural. A single front door may reduce confusion, but residents and providers still need alternative routes where needs are complex, digital access is limited, or service information changes quickly.

**Theme 3: Access quality and trade-offs**

Residents and providers described access quality as more important than speed (Table A3). Residents valued being listened to, having complete information available, and receiving care that treated them as a whole person rather than as a set of disconnected conditions. Providers similarly described access quality in relational terms, including trust, understanding, continuity and the ability to avoid repeated assessments or tests.

Information continuity was one of the strongest subthemes. Residents described blood tests, consultant letters, hospital appointments, and diagnostic information not always appearing where they expected them to be. These examples show that poor access can occur even after someone has entered the system. If information does not move reliably between organisations, residents may have to check, repeat, or carry information themselves. Provider accounts strengthened this point by describing the importance of trusted assessor relationships and shared data. Where professionals trust each other’s assessments, residents are less likely to repeat their story or undergo repeated tests. Where data is incomplete, proactive care and holistic decision-making become harder.

| Resident perspectives | Provider perspectives |
|---|---|
| “There is very good evidence that the practice listens to us… and things that we say matter and they take action to make things better.” | “We need to be doing a lot more with our data around population health management.” |
| “We will always see the same people. We will build up a relationship with those same people and we will get better care.” | “We know when we look at the data who the likely patients are that will need more regular intervention.” |
| “If you’re treating somebody holistically, you can’t just talk about one condition.” | “If you look back every time that happens… two weeks later, they end up in the acute.” |
| “When somebody is trying to look at you holistically and hasn’t got half of the information… until that gets fixed, we won’t get anywhere.” | “There does seem to be something about those relationships, that trusted assessor relationship where you would hand over and people would take your assessment as right and accurate.” |
| “That blood test never gets onto my GP record so I can see it.” | “Some of that relationship and co-location has been lost.” |
| “I had a blood test [names area] three weeks ago. My results still aren’t in my NHS App.” | “You used to have much more direct relationships with the acute sector.” |
| “Doctors are still getting letters from consultants… rather than putting them on the system so that everybody can see it.” | “We need to be doing more proactive work in that space.” |
| “The NHS App does have access to appointments, hospital appointments and hospital tests, if only the hospital will put the information on.” | “We can start to move back to a space where we’ve got those more shared arrangements and the relationships are built.” |
| “The responsibility for adding things to the patient note seems to be down at a lower level and that’s why it’s so unintegrated.” | “It doesn’t allow providers the space to achieve an outcome the way they feel works best using local assets and the patient voice.” |
| “Any specialist or any group of people need to look at the whole history.” | “We are reactive to that rather than proactively thinking about how to do it best.” |
| “They’re all separate clinics and nobody knows about each other, and they don’t talk to each other.” | “We assume everyone can engage with written information or will remember everything they’re given verbally.” |
| | “There is something about appropriate tailoring of communication and engagement as well.” |

*Table A3.* This theme explains why survey respondents did not treat access as only a matter of faster appointments. For residents with long-term or complex needs, access quality depended on being listened to, having information available, maintaining continuity, and avoiding unnecessary repetition.

**Theme 4: Services closer to home**

The fourth theme concerned local service availability and the practical meaning of distance. Residents, especially those discussing the Dengie, described poor public transport, dispersed services and diagnostic locations that were difficult to reach without a car. These barriers meant that a service could be formally available but practically inaccessible.

Residents also described the value of local or mobile provision where it worked well. Examples such as mobile checks or smaller local sites were seen positively because they reduced travel burden and made access more manageable. However, residents also linked delays in diagnostics to wider care delays, such as medication optimisation being slowed because blood tests were not available quickly enough. Providers supported the principle of care closer to home, but raised concerns about the infrastructure needed to deliver it safely. They emphasised GP-community-acute relationships, proactive work, acute oversight and escalation routes. This suggests that moving services closer to home requires more than relocating activity. Community teams need capacity, data, clinical support, and clear routes back into specialist or acute care when needed.

| Resident perspectives | Provider perspectives |
|---|---|
| "[Our area] was declared as a deprived area… purely because of the access to the tier 2 health services." | "Getting them there is the hardest thing I find." |
| "We…have not got a very good public service transport network." | "Having physical centres where people can coalesce and create something within their community… is really important." |
| "All the tier 2 services are outside [our area]… it's very, very difficult for people [here] to access." | "It should look and feel radically different." |
| "Some of them are in locations that are even not served by a bus service." | "We need closer working relationships with GPs so that we can be a bit more responsive in the community." |
| "Ultrasound is at [names place] that isn't served by a bus and it's terribly difficult to get there." | "There should be better connectivity and support from the acute when we are stepping into that virtual ward space and that urgent response space." |
| "Ultrasound… you can only have ultrasound at [names place] if it's for a specific part of the body." | "We can only do so much and hold so much risk in the community without the acute oversight." |
| "It is difficult to find even if you've got your own car transport. It's not very well signposted." | "We could do more, but we would need better overlap with the acute physician, acute team." |
| "I turn up from my chemo, and I just can't park anywhere. And I've got a disability. I can't walk very far." | "Wherever care can be provided at home, it should be, and services should be reconfigured to facilitate that." |
| "All it does is put the economic burden of transport onto the patient, rather than the service." | "Hospitals are only doing the things that only they can do." |
| "It makes it a bit of a nonsense if somebody's trying to optimise their meds, but they've got to wait three weeks for a blood test." | "Have we got the right workforce? Have we got the right estate to facilitate that?" |
| They come around in a van now that is equipped for doing those checks." | "Have we got the right referral criteria and transport to get people in and out of the acute when that is required?" |
| "These little subsets of places, they're very easy. You go, you park the car, you get in, you get seen on time, you come out." | "There is still a place for community hospital beds, because otherwise… there's too big a gap between what we can do within someone's home." |
| "It doesn't matter where it is in [our] area, as long as whoever chooses the location looks at the transport facilities." | "I'm not allowed to drive them anywhere, which, if I could, would be brilliant because then I know they'd get there." |

| | |
|---|---|
| “We’ve now got easy access to appointments with a physio.” | “What could and should be delivered within a person’s home, within a person’s community, and then within an acute trust?” |

*Table A4.* This theme supports interpreting closer-to-home care as an equity issue rather than simply a convenience preference. For residents affected by rurality, poor transport, disability, frailty or caring responsibilities, distance can determine whether a service is realistically usable.

**Theme 5: Prevention and wider support**

The final theme concerned prevention and wider support (Table A5). Residents identified some valued local services, particularly around dementia, carers, and social connection. However, their accounts also showed that awareness of support was uneven and that useful services could be vulnerable where funding was insecure. Providers described prevention more broadly than clinical monitoring or lifestyle advice. They linked health with housing, mental health, safeguarding, benefit support, voluntary sector provision, and wider wellbeing. Their accounts suggested that local support remained too clinically focused in some areas and that Neighbourhood Health would need stronger links with community, voluntary sector, and practical support services to become genuinely preventative.

This theme therefore shows a difference in perspective rather than a disagreement. Residents described services they knew about or had experienced. Providers described the wider social and practical needs that shape health, independence and service use.

| Resident perspectives | Provider perspectives |
|---|---|
| “We have two really excellent services…[names them].” | “That non-clinical offer, that preventative space…” |
| “They have an outreach place… where they also have a dementia group and also a men’s group.” | “That wider wellbeing offer… supports them to maintain their own health and supports low-level mental health challenges.” |
| “It gives a bit of respite to their carers.” | “It’s not just their clinical care that’s needed addressing, it’s their housing status, their mental health, their safeguarding.” |
| “Unfortunately, that service has stopped this year and there isn’t any funding to replace it.” | “We’re still not joined up in the way that we’re thinking about the impact housing has, or lack of housing, on people’s mental and physical health.” |
| “We haven’t come across any of the other services.” | “We still very much have a clinical response and don’t think about those wider determinants.” |
| “There are a couple of things that are work in progress and not working too well.” | “How do we bring in voluntary sector? How do we bring in housing? How do we bring in DWP with regards to benefit support? It’s still not holistic enough.” |
| “We got more GPs and nursing staff than we’ve ever had… so we’ve improved, but we are not where we would like to be.” | “If the NHS staff can’t find a service in the NHS, then they think that there isn’t anything for a patient.” |
| | “They never seem to be aware of what else there is out there that’s not medical. Clinical.” |

| | |
|---|---|
| “We are a bit deprived in the [names area], unfortunately.”<br><br>“Regarding other services, I really don’t know.”<br><br>“If we could bring [names team] into the INTs, that would give us an opportunity to have a more holistic view.”<br><br>“Nobody will know about you. Nobody will see you unless you’ve got a problem.” | “There’s a lot of work that needs to be done about shifting commissioning to outcomes rather than activities per organisation.”<br><br>“The doctors’ surgeries have become de-skilled… whatever a person’s problem is, it’s ‘social prescriber can help you.’”<br><br>“These people are being left up in the air for… eight weeks at the moment, rather than being given an immediate signpost.”<br><br>“We’re still in competition with each other in the voluntary and wider social enterprise sector… and that’s not always helpful when you’re trying to build relationships and actually put the patient first.”<br><br>“We all depend on volunteers nowadays. We have to, don’t we, because there’s not enough funding for charities like there used to be.”<br><br>“I think a lot of the issues are constrained by finances as well.” |

*Table A5.* These findings suggest that prevention should not be defined only as lifestyle change or hospital avoidance. A more preventative neighbourhood model would need to make social, practical and community support more visible, coordinated and sustainable.

The qualitative findings therefore provide a fuller explanation of the survey results. They show that residents’ priorities for joined-up communication, clear contact routes, continuity, closer-to-home services, and prevention were not abstract preferences. They reflected practical problems in navigating and using care. Provider accounts showed that these problems were also experienced inside the system, where staff had to work around incomplete information, changing contacts, limited capacity, and unevenly embedded integration infrastructure.