Qualitative research on tackling health inequalities in Leeds

For NHS Leeds Clinical Commissioning Group

October 2020

RESEARCH

Merchant House,
11a Piccadilly,
York, YO1 9WB
01904 632039

www.qaresearch.co.uk
Company registration: 3186539

MRS Awards 2016 Highly Commended

MRS Operations Aw Finalist

MARKET RESEARCH SERVICES ISO 20252 Cert No. 0475

UKAS PRODUCT CERTIFICATION 036

Contents

Project number:	HEALT01-8591
Title:	Qualitative research on tackling health inequalities in Leeds
Location:	S:\ProjectFiles\L\Leeds_CCG\HEALT01-8591_Health_Inequality_Delib April 2020\Reports\8591_Report_v5F.docx
Date:	08 October 2020
Report status:	FINAL
Approved by:	Richard Bryan
Authors:	Ben Thatcher
Comments:	to ben.thatcher@qaresearch.co.uk

This research has been carried out in compliance with the International standard ISO 20252, (the International Standard for Market and Social research), The Market Research Society's Code of Conduct and UK Data Protection law

RESEARCH

"At the end of the day we are one community, we're Leeds. That needs to be our focus."

female, 32, Osmondthorpe

RESEARCH

1. Executive Summary

1.1 Introduction, aims and objectives

NHS Leeds Clinical Commissioning Group (CCG) commissioned Qa Research in January 2020 to undertake qualitative research with Leeds residents to seek public opinion on a strategy to address the issue of health inequalities within the city. The research would form a key part of NHS Leeds CCG's approach to involving and engaging with the local population on the proposed health inequalities strategy.

As such, the overall aim of the research was to gauge public reaction to the plan proposed by NHS Leeds CCG. The research also sought to deliver insight on ways of successfully communicating with Leeds citizens about the CCG's planned approach.

Specifically, the research sought to answer the following questions:

- What do Leeds citizens understand about health inequalities?
- How do citizens believe healthcare funding decisions are currently made in relation to health inequalities?
- How do people initially respond to the principles of the proposed health inequalities strategy, and how supportive are they of the NHS working in this way in Leeds?
- What level of context do citizens need to help them understand the rationale for this approach?
- How supportive or unsupportive are people of the proposed strategy?
- How can Leeds CCG best communicate with its citizens about the strategy, how it will be implemented, and what this means for people in practice?

1.2 Methodology

It was originally planned that the research would be undertaken as a large scale face-to-face deliberative event, however, restrictions put in place because of the COVID-19 pandemic made hosting such an event impossible. The research methodology was therefore adjusted to allow the research to be conducted remotely while social distancing measures were still in force.

Qa proposed that this qualitative research be undertaken using a combination of online focus groups and in-depth interviews. 55 Leeds residents were recruited into the research, selected to be demographically representative of the Leeds population.

7 focus group were facilitated, each with 5 participants (35 participants) as well as 20 additional in-depth interviews, conducted both using online video and telephone interviews. Focus groups lasted, on average, for 2 hours. In-depth interviews varied in duration between one hour and 90 minutes, irrespective of mode. Both focus groups and in-depth interviews were structured using pre-agreed discussion guides in order to ensure consistent coverage of the topics of interest and video and written stimuli were used to both introduce participants to the topic under discussion and to prompt further deliberation of NHS Leeds CCG's health inequalities strategy. All fieldwork was undertaken during a 3-week period in August 2020.

Following fieldwork, researchers made extensive notes from the recordings of each focus group and in-depth interview, which included the transcription of quotations. Notes and quotations were then thematically arranged in a framework, and this framework forms the basis of the findings presented herein.

1.3 Findings

1.3.1 Understanding health inequalities

Awareness of health inequalities

Participants in the research had varying levels of understanding coming into the research. Compared with health inequalities per se, participants came to the research with a greater understanding of the areas of relative deprivation and affluence within Leeds. As such, participants could more readily understand how location within Leeds might be a predictor of health and life expectancy than one's membership of specific population groups. In particular, there was a lack of understanding of how members of the Black, Asian and Minority Ethnic (BAME) community might experience health inequalities. However, there was a generalised understanding that being homeless or a member of the traveller community would likely be life-limiting. Although there was generally a feeling of sympathy towards these groups participants frequently questioned how able the NHS would be to either reach or support these groups, particularly in isolation from other agencies and services.

Life expectancy as an indicator of health inequalities

Life expectancy (LE) was the indicator of health inequalities that participants in the research could most readily understand and relate to. Participants were aware that LE might vary across the city, however, many were surprised to learn that LE could vary by as much as nine years in different parts of Leeds. This figure was made even more impactful because data presented pertained only to Leeds as a city, and not a wider geography.

Talking about 'access'

It was found that 'access' is understood in different ways between the health sector and the general public. Whilst health professionals talk about access in terms of an individual's ability and willingness to engage in health and care services, whether related to their living conditions, lifestyle, location, membership to a specific population group or level of education, members of the public tend to define access in terms of geographic location, travel time and transport only. It may be advisable to find alternative language when communicating about the issues of 'access to healthcare' with the general public.

For those defining access more broadly, there was an understanding of how cultural norms or language barriers might prevent access to healthcare. Participants acknowledged that, for immigrant populations, an alien healthcare system might discourage people from seeking medical attention. Equally, people were able to understand how language barriers might result in poorer health circumstances for some.

Lifestyle factors

Lifestyle factors, including diet, levels of physical activity, smoking and alcohol consumption were often mentioned by those taking part in the research as being implicated in health inequalities. Many participants held the view that individuals choose and control how they eat, how much exercise they take, and if they consume alcohol or smoke. Others, however, recognised that these factors were less about 'choice' and more about learned behaviours and social norms from their lived experience. Participants questioned how amenable these factors might be to health interventions. There were thus differences in opinion amongst participants about the merit of the NHS using its limited resources to shape or influence lifestyle factors.

1.3.2 Proportionate universalism

Participants were asked about their prior awareness of the principles of proportionate universalism in lay terms. Whilst many had not considered how NHS funding decisions were taken or how resources were allocated, those who had considered this said they had believed that decisions around healthcare provision were made on the basis of need, rather than the application of a 'per capita' budget, or the allocation of equal funding to all geographic areas within Leeds. A small minority had thought funding to be 'allocated equally' before taking part in the research. These findings provide evidence that there is a good degree of preparedness amongst Leeds residents to hear about the proposed changes to funding, given that this approach represents only a small shift in how many believe resources are being allocated at present.

1.3.3 Views on the proposed plan to tackle health inequalities

Overall level of support
There was a very high level of support for the proposed approach to tackling health inequalities, both for different areas of Leeds and for population groups that experience these inequalities. Support was given by almost all participants, irrespective of their demographics. Given that the plan was presented in high-level terms, individuals' agreement was given for the principles of the proposed approach to tackling health inequalities, rather than the specifics of how it might be operationalised. On this basis, understanding that levels of need differ and thus that levels of investment and support would necessarily need to vary to meet those differing needs, the vast majority of participants believed that Leeds residents should be able to access the healthcare they need, and be supported in so doing, irrespective of where in Leeds they might live, the colour of their skin, or any other sociodemographic factor. Participants saw access to quality healthcare as a basic right for all.

Equality, equity and fairness
Probing on participants' reasons for supporting the proposal for reducing health inequalities revealed that many understood, and subscribed to, the equity principle. People understood that distributing resources equally (as per equality) would not result in the narrowing of the health gap. As well as understanding the need to provide additional resources in deprived geographies and to those population groups adversely impacted by health inequalities, there was an acknowledgement by some that it would be irresponsible to allocate healthcare resources to areas where this was not necessary.

Given the general understanding of the principles of equity, and their application to the provision of public healthcare, most participants were in agreement that the proposed approach was 'fair' or at least the most appropriate course of action societally. When later presenting participants with case studies describing high-intensity users of health and outreach services, some questions were raised about the fairness of these intensive service users drawing on resources when this might result in others being less able to access the care they require.

Participants often told us either that the cartoon depicting baseball spectators (see appendices) helped them to better grasp equity, or that they believed the cartoon would be useful in conveying the principles of equity to others. Some younger participants drew an analogy between equity in healthcare and education that illustrated their understanding.

Reasons for support
Some were supportive of the proposed strategy because they felt that an approach to tackling health inequalities was overdue, and a number of participants noted that the COVID-19 pandemic

had brought the issue into focus, or presented an opportunity and platform to tackle longstanding inequalities.

Other participants recognised that working in the way proposed to reduce health inequalities would bring benefits for people at a societal level, whether they were in receipt of additional levels of health support or not, suggesting that making Leeds a 'happier and healthier place' would drive social cohesion and realise economic benefits.

Some participants rationalised their support for the proposed approach by reiterating the message from the presentation that critical services would not be affected, and that most Leeds residents would not experience any change to the way they receive services as a result of the planned changes to funding.

The final theme to emerge from probing participants on the reasons for support was the potential for the proposed approach to save the health service money. We heard that people believed that some projects, particularly those offering early intervention or support, had the potential to realise long-term cost savings.

Reasons for reservation

Reservations were usually presented as questions and queries, requests for further information about the plan, or anticipated objections on the part of others. Foremost, participants felt there was a general lack of information about the proposed approach. Whilst they could appreciate that the plan was being discussed, and views being sought, in principle, most felt that they would need more information in order to better understand the plan and properly formulate their view on it.

In addition some participants felt that, in order to be fully supportive of the plan, they would need reassurance that working in the way proposed would not greatly impact existing services. Most understood that the impact would be negligible, but having heard about a plan to apportion resources differently, explicit assurances were sought. In particular, participants would be looking for confirmation that any budgetary changes would not affect an individual's ability to access emergency care or medical attention that was required urgently.

In a small number of cases, participants queried the likely impact on them personally of the proposed changes, but many acknowledged that these changes were being made in the interests of the 'greater good'. Infrequent users of health services tended to share more benevolent perspectives. Rather than raising concerns over how they might be personally impacted by any changes, a number of participants acknowledged that some Leeds residents might have concerns about the discontinuation of, or reduction in, services that have always been available. This concern was most often raised in response to the proposal that deprived geographies might enjoy higher levels of funding going forward, with the inference being that relatively affluent areas might see a drop in service provision.

As well as the concerns expressed over where budgets might be reduced in the future, questions were also raised about the services, projects and interventions that might receive additional or new funding under the new strategy. If budgets were to be reapportioned, participants believed that this should be done in a way that could be proven as effective and would be a defensible use of resources. Participants asked whether funding would be allocated to projects that were delivering the desired outcomes, to initiatives that were known to be successful and for health problems that were amenable to intervention, and with clients that would be willing and able to engage with the support offered, or to follow any advice dispensed.

Some of the services identified to potentially receive additional funding might be those offering a high level of long-term support that was resource intensive, potentially to a small number of individuals. Questions were asked about how much support would be offered to any one individual, and what measures of individual level success might be used to ratify continued support for any patient or client. Participants questioned whether this level of support for specific groups would be palatable if large numbers of other service users were then left with difficulties accessing the care they needed.

1.4 Communicating with Leeds residents

The following findings relate specifically to communicating with Leeds citizens about the current situation and the strategy being proposed to tackle the problem of health inequalities.

1.4.1 How to convey the current situation

As the easiest indicator of health and health inequalities to understand and engage with, it is strongly recommended that communications on the current health landscape in Leeds include statistics on life expectancy, and the differences in life expectancy for subgroups of the Leeds population. The differences highlighted in the research were striking and impactful and helped to illustrate the magnitude of the issue of health inequalities in the city. In addition, the use of a map may be useful when trying to identify and convey the areas of deprivation within Leeds.

Tell personal stories and talk about disadvantaged groups
As well as presenting figures and diagrammatic representations of the current health situation, a large number of participants felt that the use of personal stories would bring a human touch to painting the picture, likely eliciting greater feelings of empathy and compassion than the use of statistics alone. Equally, some participants held the view that by talking about groups of individuals experiencing inequalities or health issues the scale of the issue might be better understood compared with telling the story of individuals. By depicting the problem in a collective way, a small number of participants noted that the access issues experienced could be extrapolated and applied to broader population subgroups.

Explain the reasons for inequalities
As well as informing Leeds residents about the statistics and the geography of health inequalities, it was found that people might need to understand more about how health inequalities have come about, and the reasons why some members of society may experience difficulties accessing healthcare. For some groups the barriers to healthcare were instantly evident. For others, including the BAME community, the challenges were less clear and may need to be explicitly presented. This would help residents understand health inequalities and why these are not caused solely by lifestyle factors.

1.4.2 Communicating about the proposed strategy

A picture of inequity
There was a very high level of agreement with the principles of the health inequalities strategy. Most participants subscribed to the application of equity principles to reducing inequalities and narrowing the health gap in Leeds. A number of participants noted that the cartoon depicting baseball spectators quickly and effectively communicated the principles of equity and how the plan proposed would operate in line with them. Some participants told us that they were familiar with the cartoon from other contexts (e.g. human resources). There is good evidence to suggest that this image could be deployed effectively in a communications campaign on the proposed health

inequalities strategy. This would also fulfil another suggestion from participants; that information be represented pictorially where possible.

Personal stories
As per the findings concerning communicating about the current problem, many participants believed that there was great value in using personal case studies to communicate about how some of the initiatives to be funded under the new strategy will support people and increase access for those groups that have experience barriers, thus narrowing the health gap.

More detail
As per the findings above, more information about how the plan would be operationalised, what it would look like on the ground, and the projects and interventions that might receive more funding under the proposed strategy is required. NHS Leeds CCG should therefore consider communicating about the proposal in a less abstract, and more concrete way. This will bring the plan to life, and give citizens tangible information to grasp in order to understand the plan and, in turn, formulate their view on it. A greater depth of information was a clear requirement for most participants. This additional depth of information should include detail on how budgets will be both increased and decreased in different areas and for different services.

Reassurance around existing services and non-deprived geographies
There is a need to reassure the public that important services would remain available, and that the proposed changes would not mean withdrawal of funding entirely for some services. Of particular importance would be communicating this in relation to emergency and urgent care services. Some participants took the view that the proposed changes in funding were unlikely to negatively impact a large number of people, and that the changes would only affect service users in negligible ways and, if true, this should be used in communications. If services are set to change significantly, then this should be communicated at a local level, or with individuals likely to be affected by service changes, where possible.

Some were concerned that increasing spending in deprived areas would lead to significant cuts in non-deprived areas, or at least that residents in those areas might be left with that perception. And so, in the same way that it is important to reassure around the continuity of services, it is also important to provide adequate reassurance to residents in relatively affluent areas that their services will not start to disappear whilst NHS Leeds favours only funding healthcare in deprived geographies.

Evidence
NHS Leeds CCG should consider providing more information about the existing evidence base that investing money in line with proportionate universalism will reduce the health inequalities as anticipated. Where evidence exists for the success of specific interventions then this should be communicated, too. NHS Leeds CCG should also respond to requests that citizens be made aware of how the impact and effectiveness of the roll-out in Leeds will be measured in order to provide ongoing assurance that budgets have been reapportioned successfully.

A multi-agency approach
A number of participants questioned the ability of the NHS to make a significant impact on health inequalities, especially in isolation of other departments and organisations. People questioned the role of schools, charities and other entities and emphasised the need to work in a joined-up way using a multi-agency approach. NHS Leeds CCG should consider describing to the public of Leeds how it intends to collaborate with other agencies in the delivery of its vision that Leeds will be 'a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'.

1.4.3 Gaining support for the proposed strategy

This section presents recommendations on how NHS Leeds CCG might gain support for the strategy being put forward.

Take a human, compassionate approach
The research has shown that a large majority of Leeds residents are likely to be empathetic, compassionate and socialist in their views when it comes to the health of others in their community. There has been a great deal of understanding for those that experience health inequalities, barriers to wellbeing, or difficulties accessing healthcare. This has been observed for different parts of Leeds, and for different population subgroups. NHS Leeds CCG should consider communicating about their health inequalities strategy in a way that is congruent with this socialist perspective, knowing that citizens are ready to receive information in this way. This might include explaining how and why health inequalities might come about, the promotion of personal stories that depict individuals' journeys and health struggles, as well as how future services and interventions will help people to improve their health and increase their wellbeing.

There may be value in promoting the message that by supporting those with the poorest health there are benefits for all because a 'healthy community is a happy community'. Participants were able to see the benefits for society as a whole by supporting those experiencing the poorest levels of health.

Focus on financial long-term benefits
A number of participants saw the potential of the proposed strategy to realise long-term cost savings for the NHS and others. Of particular value here might be providing examples of early intervention services that seek to reduce individuals' risk of developing later disease through good lifestyle choices, for example. These early interventions may overlap with other departments' remits, e.g. education, public health, also speaking to the importance of a multi-agency approach (see 'take a human, compassionate approach', above).

Use COVID-19 as a platform
A number of participants recognised that the COVID-19 pandemic has highlighted the problem of health inequalities, and emphasised the struggles faced by some demographic groups. As well as this, those taking part in the research were able to recognise that this presents a potential springboard for tackling health inequalities, at a time when trust in, and respect for, the NHS may be at its highest in recent times.

Communicate with confidence
Participants believed that the NHS should communicate with confidence and authority about their proposed plan, that they should take ownership of it and speak with conviction about why this approach is the best suited for Leeds and its particular health circumstances. This, in combination with the suggestion that levels of confidence in the health service may be particularly high because of COVID-19, presents an ideally opportunity for the NHS in Leeds to disseminate information on the proposed strategy.

Consider geography and deprivation
The final consideration is that of causing division based on geography and deprivation. The research uncovered potential for concerns amongst both those living in disadvantaged areas and those not. Residents in areas identified as 'deprived' might take offence at such a categorisation. Equally, those living outside of these bounds might be worried that they would see health service

budgets in their local areas diminish. Moreover, talking in these terms might cause a division between residents. NHS Leeds CCG should carefully consider the best way of talking about these geographies within the city so as not to cause offence, unnecessary concern, or division.

2. Introduction

NHS Leeds Clinical Commissioning Group (CCG) commissioned Qa Research in January 2020 to undertake qualitative research with Leeds residents to seek public opinion on a strategy to address the issue of health inequalities within the city.

Health inequalities are those avoidable differences in health across the population, and between different groups within society. Health inequalities arise because of the conditions in which people are born, grow, live, work and age. These conditions influence opportunities for good health, and how one thinks, feels and acts, and this shapes individuals' mental health, physical health and wellbeing [1].

Factors implicated in this social gradient of health include:

- socio-economic status and deprivation: e.g. unemployed, low income, people living in deprived areas (e.g. poor housing, poor education and/or unemployment);
- protected characteristics: e.g. age, sex, race, sexual orientation, disability;
- vulnerable groups within society, or 'inclusion health' groups: e.g. vulnerable migrants; Gypsy, Roma and Traveller communities; rough sleepers and homeless people; sex workers; and
- geography: e.g. urban, rural.

It was originally planned that the research would be undertaken as a large scale face-to-face deliberative event, where some 70 participants from across Leeds would be invited to share their views on the current problem of health inequalities in Leeds and their opinions in response to the plan proposed by NHS Leeds CCG to tackle inequalities.

Restrictions put in place because of the COVID-19 pandemic made hosting such an event impossible. The research methodology was therefore later adjusted to allow the research to be conducted remotely while social distancing measures were still in force.

[1] NHS England, https://www.england.nhs.uk/ltphimenu/definitions-for-health-inequalities/, accessed 07/09/2020.

3. Aims and objectives

The research would form a key part of NHS Leeds CCG's approach to involving and engaging with the local population on the proposed health inequalities strategy. As such, the overall aim of the research was to gauge public reaction to the plan proposed by NHS Leeds CCG to start to address health inequalities. Secondarily, the research sought to deliver insight on ways of successfully communicating with Leeds citizens about the CCG's approach to tackling health inequalities in the city.

Specifically, the research sought to answer the following questions:

- What do Leeds citizens understand about health inequalities?
- How do citizens believe healthcare funding decisions are currently made in relation to health inequalities?
- How do people initially respond to the principles of the proposed health inequalities strategy, and how supportive are they of the NHS working in this way in Leeds?
- What level of context do citizens need to help them understand the rationale for this approach?
- How supportive or unsupportive are people of the proposed strategy?
- How can Leeds CCG best communicate with its citizens about the strategy, how it will be implemented, and what this means for people in practice?

4. Methodology

4.1 Original methodology

Qa has undertaken a number of research projects on behalf of NHS Leeds CCG in the past. These projects have often been run as deliberative events where 70 to 80 Leeds residents attend a half-day workshop with a number of Qa Research moderators, as well as presenters and other representatives from the CCG. The format allows the CCG to introduce the topic under discussion using their knowledge and expertise in an accessible way, and respond to any questions or queries from participants throughout the event. Once the topic has been introduced, Qa's experienced researchers then facilitate discussions with residents, who are spread across multiple tables, with a moderator assigned to each table. The half-day event would usually be split into shorter sessions, with each session focusing on a specific topic or task. Such an approach was planned in order fulfil the research objectives for this project.

Restrictions put in place in response to the COVID-19 pandemic made hosting such an event impossible. The research methodology was therefore adjusted to allow the research to be conducted remotely while social distancing measures were still in force across England.

4.2 Revised methodology

As the planned methodology could not be used because of COVID-19 restrictions, Qa proposed that this qualitative research be undertaken using a combination of online focus groups and in-depth interviews. 7 focus group were facilitated, each with 5 participants (35 participants) as well as 20 additional in-depth interviews. Where participants were recruited for in-depth interviews, they were given the choice of an online video interview or a telephone interview.

The proposed sample size represents only a small reduction in the originally planned number of participants and still constitutes a large sample for qualitative deliberative research of this nature.

The table below indicates how the achieved sample was allocated to the 3 modes of the research.

Research mode	Achieved number
Online video focus group	35
Online video in-depth interview	17
Telephone in-depth interview	3
Total	**55**

Online focus groups and online video interviews were undertaken using the Zoom meeting platform, which allows for the real-time sharing of written and multimedia stimuli, and both audio and video recording for later review and transcription. Telephone interviews were audio recorded using software built into Qa's VOIP telephone system.

Focus groups lasted, on average, for 2 hours. In-depth interviews varied in duration between one hour and 90 minutes, irrespective of mode. Both focus groups and in-depth interviews were structured using pre-agreed discussion guides in order to ensure consistent coverage of the topics of interest. Researchers used these as the basis for their conversations but probed for further detail, as required, in response to participants' experiences and perspectives in order to yield the richest possible data. These discussion guides can be found in the appendices to this report.

4.3 Stimuli

In order to provide adequate context for the discussion all participants, irrespective of mode, were shown a video of a presentation, given by an NHS Leeds CCG colleague, introducing them to:

- the role of NHS Leeds CCG in local healthcare;
- information on the meaning of health inequalities;
- the current situation concerning health inequalities within Leeds, including the implications for residents in different parts of Leeds, and for different population subgroups within the city;
- the principles of equality and equity in healthcare provision; and
- the plan being developed and proposed by NHS Leeds CCG in order to tackle health inequalities in Leeds.

In addition to this introductory video, participants were also shown either video or written stimuli in order to prompt further discussion of their views on the proposed strategy to address health inequalities.

Video stimuli covered the topics of; barriers to healthcare experienced by those with a sensory (hearing) impairment, health amongst homeless people and travelling communities, and how where one lives in Leeds might impact life expectancy and quality of life.

Written stimuli presented case studies of individuals that had been helped by initiatives that might be funded by NHS Leeds CCG as part of its plan to tackle the problem of health inequalities in the future. In addition, these stimuli highlighted hypothetical examples of services that NHS Leeds CCG may not be able to afford to provide, or service levels that would be compromised, if it invested in the initiative that was the main focus of the case study, e.g. reduced waiting times in Accident & Emergency departments, widespread availability of numerous out of hours GP appointments These written case studies can be found in the appendices to this report.

Video participants were shown these stimuli during their online focus group or interview. Where participants took part in a telephone in-depth interview, a weblink containing the stimuli was shared beforehand, and participants were asked to review these ahead of their interview time.

Part way through the fieldwork for this project, video stimuli were replaced with written case studies. This decision was taken following discussions between Qa's researchers and NHS Leeds CCG. It was felt that the video stimuli did not adequately represent the 'opportunity cost' of investing in projects and interventions aimed at reducing health inequalities. That is, these videos did not make explicit that by working in the way proposed to support inclusion health the budgets for existing NHS services would be impacted. Written case studies made clear to participants that allocating additional funding to initiatives seeking to reduce health inequalities would necessarily result in a decrease in the budgets available for other services.

Whilst this change facilitated the research process, there are not grounds for concern that participants presented with video stimuli misunderstood this opportunity cost. Researchers explained clearly to those receiving video stimuli that by providing interventions that further the inclusion health agenda other NHS serviced would be compromised. This change in stimuli, therefore, does not confound the findings of the research.

4.4 Sample and recruitment

55 Leeds residents participated in the research under the revised methodology. Participants were recruited to be demographically representative of the population served by NHS Leeds CCG, and were selected from all across the city. The table below illustrates the quotas imposed on recruitment in order to ensure an appropriate sociodemographic spread.

The goal of most qualitative research is not to generalise findings from a sample to a wider population, but rather to provide a rich, contextualised understanding of opinions, experiences and perspectives, through a process of in-depth discussion and exploration of individuals' views. However, deliberative research often utilises larger sample sizes than traditional qualitative studies and benefits from the depth of understanding gained by group discussion and the challenging, or questioning, of perspectives from numerous participants; deliberation. The data collection methodology used in this research, in combination with the sample size and the factors included in its design, therefore provide a robust framework for public engagement.

Criteria	Suggested target % [2]	Achieved number
Gender		
Male	49%	27
Female	51%	28
Age		
18-29	27%	15
30-44	26%	14
45 -59	22%	12
60+	25%	14
Ethnic group		
White (British, Irish, Gypsy, Traveller, Other)	85%	47
BME (Mixed/multiple, Asian/Asian British, Black/African/ Caribbean/Black British, Other)	15%	8
Household make-up		
One-person household	33%	19
Two+ adult household, with no dependent children	40%	22
Household with dependent children	25%	14
Working Status		
Work full-time, part-time or self-employed	60%	33
Student / in training / Looking for work / unemployed	18%	10
Retired / Looking after home or family / long term sick or disabled / other "at home"	22%	12
Postcodes		
Postcodes throughout the NHS Leeds CCG area	Good spread, with adequate representation from geographies classified as both 'deprived' and 'non-deprived' by NHS Leeds CCG	
Total	100%	55

[2] These proportions have been derived from the demographic profile of the Leeds local authority area population from the 2011 census https://www.nomisweb.co.uk/reports/localarea?compare=1946157127.

Owing to restrictions on face-to-face recruitment, which would have been the preferred method of sourcing participants for this research, participants were drawn from databases of Leeds residents, screened for suitability, and recruited in order to meet the above quotas. All documentation used to support recruitment of research participants is available upon request.

Participants were offered £50, paid by bank transfer, as a thank you for their time and contribution to the research. All fieldwork was completed during a 3-week period in August 2020.

4.5 Analysis

The researchers involved in fieldwork made extensive notes from the recordings of each focus group and in-depth interview, which included the transcription of quotations. Following data collection researchers spent time discussing findings, emerging themes, and divergent perspectives. Notes and quotations were then thematically arranged in a framework, and this framework forms the basis of the findings presented herein.

In the collection and analysis of qualitative data, researchers consider the principle of data saturation. Saturation occurs when no novel information or new themes are observed in the data and is an indicator of both quality and quantity in the research process. Reaching data saturation suggests that the research has been undertaken with the required degree of accuracy and depth (quality) and at an appropriate volume, or with an adequate number of participants (quantity). This research achieved saturation, with little new information emerging towards the end of the data collection period.

5. Findings

This section sets out the main findings from the focus groups and in-depth interviews.

Sub-sections are ordered in line with the discussion guide. Key themes are discussed and, where relevant, supported with quotes taken from focus group and interview recordings.

It was important that this research include the views of residents from all across the NHS Leeds CCG area. Quotes identify the participant's age, gender and the area of Leeds where they live. ***(D)*** and ***(ND)*** following the area indicates whether the contributor lives in a deprived or non-deprived postcode, according to the categorisation provided by NHS Leeds CCG prior to recruitment of participants.

5.1 Understanding of health inequalities

5.1.1 Awareness of health inequalities

The first topic for discussion sought to ascertain people's understanding of health inequalities both before taking part in the research and from having listened to the CCG's introductory presentation. It was clear that participants in the research had varying levels of understanding coming into the research. Those with professional careers had a greater awareness of the issue of health inequalities. Specifically those working in, or retired from, the education sector had good awareness, as did those with socially-oriented roles, including those working with charities or organisations that provide grant funding for social and wellbeing projects. In addition, those participants whose families and friends worked within local authority, healthcare and government roles were better able to relate to the problems of health inequalities and social justice.

Compared with health inequalities per se, participants came to the research with a greater understanding of the areas of relative deprivation and affluence within Leeds. Many were able to name areas within Leeds where one might expect to experience poverty and lower than average access to services. As such, participants could more readily understand how location within Leeds might be a predictor of health and life expectancy than one's membership of specific population groups. In particular, there was a lack of understanding of how members of the Black, Asian and Minority Ethnic (BAME) community might experience health inequalities. However, there was a generalised understanding that being homeless or a member of the traveller community would likely be life-limiting.

> *Why does someone from an ethnic minority struggle with their health? Why do they need some extra help?* ***Female, 52, Gipton (ND)***

> *Otherwise people from those ethnic minorities might think, 'well, why are we being singled out?' They'd be offended because they think of themselves as healthy people. On the flipside, other people will think, 'they're just like me, they live in the same street so why do they need extra help and I don't?'* ***Male, 21, Armley (D)***

> *I realised that they [homeless people, those rough sleeping] would probably die younger but that is quite a big difference.* ***Female, 42, Wetherby (ND)***

As well as participants being able to understand that health outcomes might be poorer amongst homeless and traveller populations, there was a feeling of sympathy, in most part, towards members of these groups as concerns their health. However, participants frequently questioned

how able the NHS would be to either reach or support these groups, particularly in isolation from other agencies and services.

> *Do they not trust medical places? Are they just not accessing healthcare?* ***Female, 33, Kippax (ND)***

> *Travellers exist very much within their own community, so you need to go to them.* ***Male, 37, Pudsey (ND)***

5.1.2 Life expectancy as an indicator of health inequalities

People easily related to life expectancy (LE) as an indicator of health and that differences in LE were indicative of health inequalities. Participants were aware that LE might vary across the city. However, many were surprised to hear that LE could vary by as much as nine years in different parts of Leeds. Some were very much taken aback upon hearing about this disparity in the introductory presentation. This figure was made even more impactful because data presented pertained only to Leeds as a city, and not a wider geography.

> *There's a nine year difference, and that's quite a long time if you think about it; you can do a lot in one year, let alone nine. Nine years is a really long time.* ***Female, 18, Otley (ND)***

> *Well I think that's wrong, especially when it's avoidable. It's powerful. It's not nine days. Nine years is a very long period of time.* ***Male, 21, Armley (D)***

> *I don't think you really appreciate the difference between the poorer and the more affluent areas within a small space and the life expectancy was quite alarming to be honest. It brings it all home when you hear that number.* ***Male, 31, Pudsey (ND)***

5.1.3 Talking about 'access'

It became apparent during data collection that 'access' is understood in different ways between the health sector and the general public. Whilst health professionals talk about access in terms of an individual's ability and willingness to engage in health and care services, whether related to their living conditions, lifestyle, location, membership to a specific population group or level of education, members of the public tend to define access in terms of geographic location, travel time and transport only. When prompting discussion on access, researchers noted that participants would almost always respond with a comment on travel or transport to a hospital, health centre or other medical location. It may be advisable to find alternative language when communicating about the issues of 'access to healthcare' with the general public.

For those defining access more broadly, there was an understanding of how cultural norms or language barriers might prevent access to healthcare. Participants acknowledged that, for immigrant populations, an alien healthcare system might discourage people from seeking medical attention. Equally, people were able to understand how language barriers might result in poorer health circumstances for some.

> *People who have come to England from a different country tend to stick to their own group and they don't always have the knowledge or the access to services that they may need and are entitled to (…) rely on own family and friends that do speak English.* ***Male, 55, Churwell (ND)***

… and I imagine language barriers. If English isn't your first language then I think someone will struggle. ***Female, 42, Wetherby (ND)***

5.1.4 Lifestyle factors

Lifestyle factors, including diet, levels of physical activity, smoking and alcohol consumption were often mentioned by those taking part in the research as being implicated in health inequalities. Viewpoints on whether these lifestyle factors included an element of 'choice' varied. Many participants held the view that individuals choose and control how they eat, how much exercise they take, and if they consume alcohol or smoke. Others, however, recognised that these factors were less about 'choice' and more about learned behaviours and social norms from their lived experience.

She mentioned lifestyle choices (…) there is a certain level of choice, but there are a number of external factors that influence their choices (…) not something they are consciously making a choice about. It's just their lifestyle, it's what they know. ***Female, 29, Burley (ND)***

I think maybe they've [those living in deprived areas with unhealthy lifestyle behaviours] been brought up unhealthy. Mum's too busy to look after herself or cook, or they've maybe left school early, and perhaps that's not their fault. It's about how you're brought up, where you're born, and I don't think you should be penalised for your social situation, that's just unfair. ***Female, 42, Wetherby (ND)***

Participants questioned how amenable these factors might be to health interventions. There were consequently later differences in opinion about the merit of the NHS using its limited resources to shape or influence lifestyle factors.

For some people, some issues won't be resolvable but will get better with the right help, but with others there will be no hope, hours of time spent but no progress. ***Male, 31, Pudsey (ND)***

5.2 Proportionate universalism

Participants were asked about their prior awareness of the principles of proportionate universalism (the resourcing and delivery of universal services at a scale and intensity proportionate to the degree of need) in lay terms.

Whilst many had not considered, before taking part in the research, how NHS funding decisions were taken or how resources were allocated, those who had considered this said they had believed that decisions around healthcare provision were made on the basis of need, rather than the application of a 'per capita' budget, or the allocation of equal funding to all geographic areas within Leeds. More than one participant questioned, in response to the introductory video, whether funding allocations were not 'already being made as outlined in the plan'. A small minority had thought funding to be 'allocated equally' before taking part in the research.

Yeah, I had imagined so, because I think when you think about Leeds and how diverse it is, then Leeds would need more money than, say, Harrogate or Otley. ***Female, 52, Gipton (D)***

She was talking about spending the money differently and distributing resources differently. How was it done before, then? Was it all just an amount per head? ***Female, 34, Horsforth (ND)***

> *I'd expected that funding would be spread equally before today, which has led to the current gap in health.* ***Female, 23, Fearnville (D)***

These findings provide evidence that there is a good degree of preparedness amongst Leeds residents to hear about the proposed changes to funding, given that this approach represents only a small shift in how many believe resources are being allocated at present.

> *I'd be extremely shocked if this [funding being made at a scale and intensity proportionate to need] wasn't the decision process. So it's not surprising and I'm glad that is the approach being put forward.* ***Female, 29, Burley (ND)***

5.3 Views on the proposed plan to tackle health inequalities

5.3.1 Overall level of support

After hearing about the plan proposed to address health inequalities in Leeds, participants were asked to share their views on and, specifically, their level of support for working in the way outlined. There was a very high level of support for the proposed approach, both for different areas of Leeds and for population groups that experience these inequalities. Support was given by almost all participants, irrespective of their demographics.

Given that the plan was presented in high-level terms, individuals' agreement was given for the principles of the proposed approach to tackling health inequalities, rather than the specifics of how things might be operationalised. On this basis, understanding that levels of need differ and thus that levels of investment and support would necessarily need to vary to meet those differing needs, the vast majority of participants believed that Leeds residents should be able to access the healthcare they need, and be supported in so doing, irrespective of where in Leeds they might live, the colour of their skin, or any other sociodemographic factor. Participants saw access to quality healthcare as a basic right for all.

> *I think it is a good idea. I feel like we should all have the same equal opportunities to live as long as possible, regardless of where we live, where we come from. I think everyone should have the same opportunities, yeah.* ***Female, 23, Fearnville (D)***

> *People are people, so if they need healthcare then they need it, regardless of what subgroup they belong to.* ***Female, 34, Horsforth (ND)***

> *Life expectancy is so different across the city, so you're going to have to pump more money somewhere, it just makes sense.* ***Male, 30, Seacroft (D)***

> *There is a definite health inequality and the delegation of resources is the way to try and lessen that inequality.* ***Male, 18, Garforth (ND)***

> *Someone from Alwoodley and someone from Harehills, as humans, they have the same entitlement to life expectancy and good health service.* ***Male, 71, Killingbeck (D)***

5.3.2 Equality, equity and fairness

Probing on participants' reasons for supporting the proposal for reducing health inequalities revealed that many understood, and subscribed to, the equity principle, favouring this approach to the distribution of resources in line with tenets of equality. People understood that distributing

resources equally (as per equality) would not result in the narrowing of the health gap. Participants often told us either that the cartoon depicting baseball spectators (see appendices) helped them to better grasp equity, or that they believed the cartoon would be useful in conveying the principles of equity to others. Others told us they felt their viewpoint on the distribution of resources needed little justification; that the approach was simply 'common sense'.

> *Everyone is in a different position and everyone needs different levels of help.* ***Male, 18, Garforth (ND)***

> *Some people have the ability and the means to do things, but I don't think the people that have desire to do something but physically cannot should be ignored. They should be championed and given the means.* ***Male, 31, Pudsey (ND)***

> *I think everyone deserves equal access to whatever healthcare they need.* ***Female, 29, Burley (ND)***

> *I completely see it. Some people do need that extra support for a variety of different reasons. Just because someone is going to get that extra support it doesn't mean that the care will be different for someone that doesn't need that extra support, so I would be for making sure everyone has the appropriate level of support they need, based on any personal factors.* ***Female, 33, Swarcliffe (D)***

> *… ultimately I know it's the fair and right thing to do and that's why I'm on board. It's completely fair, like the little cartoon illustrated.* ***Female, 34, Horsforth (ND)***

> *It makes sense, especially with the problem of there being nine years in particular for some areas. It just seems like common sense.* ***Male, 21, Armley (D)***

Some younger participants drew an analogy between equity in healthcare and education that illustrated their understanding;

> *It's like at school, you have the really smart kids who don't need as much support off the teachers, whereas the kids that might have a learning difficulty or the people that aren't as smart need a lot more resources and help from the teachers. That's an easier way of understanding it.* ***Male, 18, Ilkley (ND)***

As well as understanding the need to provide additional resources in deprived geographies and to those population groups adversely impacted by health inequalities, there was an acknowledgement by some that it would be irresponsible to allocate healthcare resources to areas where this was not necessary;

> *There's no point giving money to an area just for the sake of equality if it's not going to generate good outcomes (…) so I don't think you should give money for giving money's sake because it's not going to generate a better outcome. It's all about outcomes, isn't it?* ***Male, 21, Armley (D)***

Given the general understanding of the principles of equity, and their application to the provision of public healthcare, most participants were in agreement that the proposed approach was 'fair'. Or, if not fair by their own definition, then the most appropriate course of action societally.

> *Personally I do think it's fair because for me I know that it's a lot easier for people like me to have access and opportunities and by showing areas in Leeds that are more deprived it does make you realise that there are areas that need it more than others.* ***Female, 18, Otley (ND)***

> *For me, that is the approach [as outlined in NHS Leeds CCG's plan] that I would vote for because I see that there are certain groups and areas where they have less privileges and access to services. It's about equity over equality.* ***Female, 29, Burley (ND)***

> *When it's properly explained, it becomes quite apparent that this is the fair thing to do. At face value, without the detail, people could look upon it negatively. But when it is explained it's logical.* ***Male, 31, Pudsey (ND)***

> *It's the best that you can do with the limited resources.* ***Male, 18, Garforth (ND)***

When later presenting participants with case studies describing high-intensity users of health and outreach services, some questions were raised about the fairness of these intensive service users drawing on resources when this might result in others being less able to access the care they require.

5.3.3 Reasons for support

Having established that the majority of participants were supportive of the proposed approach, and that this view was likely mediated by an understanding of the principles of equity and proportionate universalism, the research sought to understand some of the specific reasons why people were in favour of the plan.

Some were supportive because they felt that an approach to tackling health inequalities was overdue, and a number of participants noted that the COVID-19 pandemic had brough the issue into focus, or presented an opportunity and platform to tackle longstanding inequalities.

> *I think it's good that they've acknowledged that now is the time to change, in light of coronavirus. Now has probably shaken the NHS into thinking that they need to support those that are deprived. I do think now is probably a good time. It could have come a little sooner.* ***Female, 23, Fearnville (D)***

> *It surprises me that they've not done something before it's got this bad, that they haven't thought of doing something like this.* ***Male, 18, Ilkley (ND)***

> *I think with the COVID thing it's exaggerated more these inequalities.* ***Female, 24, Shadwell (ND)***

> *I think this is a good time to be putting this sort of thing out there.* ***Female, 33, Kippax (ND)***

Some participants recognised that working in the way proposed to reduce health inequalities would bring benefits for people at a societal level, whether they were in receipt of 'additional levels of health support' or not.

> *What you have to do is to educate the people who feel like they're getting less to be, 'you're actually getting more on a societal level', a stronger world for them to live in.* ***Male, 37, Stanningley (ND)***

> *Having a healthier, happier population of Leeds is going to lead to better social cohesion, better understanding of each other, you know, better economics, it just makes sense on all fronts, really.* ***Female, 29, Burley (ND)***

Some participants rationalised their support for the proposed approach by reiterating the message from the presentation that critical services would not be affected, and that most Leeds residents would not experience any change to the way they receive services as a result of the planned changes to funding. We noted that this view was shared more commonly during the first phase of the research (where video stimuli were used to prompt further discussion, rather than written case studies that explicitly identified potential funding reductions under the proposed plan), during which most participants felt that they would be impacted at most to a very small degree by the changes.

> *The support for everyone is still going to be there, it's just going to hopefully be more readily available for people who aren't seeking the help for whatever reason.* ***Female, 42, Wetherby (ND)***

> *I don't think that a lot of people that have had the resources taken away from them would actually even realise that it had happened.* ***Male, 18, Ilkley (ND)***

> *I think it is a really good idea because they're not only trying to help the groups that are less fortunate, but they're keeping up already what they're doing for everyone and making sure that everything is still in check for those that have always had access.* ***Female, 18, Otley (ND)***

The final theme to emerge from probing participants on the reasons for support was the potential for the proposed approach to save the health service money. We heard that people believed that some projects, particularly those offering early intervention or support, had the potential to realise long-term cost savings.

> *It makes sense to put money into the more deprived areas, and if it works it will save the NHS money, it'll benefit the wider community and sure up the NHS for the future.* ***Male, 70, Shadwell (ND)***

> *There would be an argument that funding can be used smarter, and smarter funding could prevent a lot of issues that are costing a lot of money at the back end. Early interventions, better education.* ***Male, 31, Pudsey (ND)***

> *In the future this will reduce the need for later interventions, so if we can make interventions early, we're not having to fund emergency interventions later when people's health hasn't already deteriorated.* ***Female, 29, Burley (ND)***

In addition, and as mentioned in the above section on proportionate universalism, many participants had assumed the method of allocating healthcare resources proposed was already in use. For this reason the plan presented was only a small departure from what was understood by many to be common practice, leading people to be supportive.

5.3.4 Reasons for reservation

Whilst very little data was collected to suggest that people were unsupportive of the proposed plan as a whole, participants did have some reservations and concerns about the approach they were told about. These usually presented as questions and queries, requests for further information about the plan, or anticipated objections on the part of others.

The primary concern was that participants felt there was a general lack of information about the proposed approach. Whilst they could appreciate that the plan was being discussed, and views being sought, in principle, most felt that they would need more information in order to better

understand the plan and properly formulate their view on it. People told us they felt they required more information on how the plan would be operationalised; what it would look like in practice 'on the ground'.

> *I am [supportive of the plan], it just needs to be clearer…* ***Male, 30, Seacroft (D)***
>
> *The point is there, it's just vague at the minute.* ***Female, 24, Shadwell (ND)***
>
> *Knowing specifically what they're going to put their money into so that people know more about what is going to happen, and how specific people are going to be targeted for help (…) Give examples stating how they are planning to help and what they are putting their money into; that'll help people understand more how it is going to help people.* ***Female, 18, Otley (ND)***
>
> *If you say this would mean, in practice, spending money on, and then naming examples like building a building, something practical to show what steps need to be taken.* ***Male, 21, Armley (D)***
>
> *Name a couple of big examples of what that would mean in practice, so people don't think it's some sort of abstract, theoretical idea, it's something real life that is going to affect people. It's not just a big plan that we've come up with in an office that means nothing in practice, it's a real life thing.* ***Male, 21, Armley (D)***
>
> *What's going to be put in place?* ***Female, 23, Fearnville (D)***

In addition some participants in the research felt that, in order to be fully supportive of the plan, they would need reassurance that working in the way proposed would not greatly impact existing services. Most understood that the impact would be negligible, but having heard about a plan to apportion resources differently, explicit assurances were sought. In particular, participants would be looking for confirmation that any budgetary changes would not affect an individual's ability to access emergency care or medical attention that was required urgently.

> *They did state clearly that everyone is still going to have access... that's a really important thing to put across. Some people would feel like they might be missing out if the NHS puts a lot of funding into areas that need it most (...) they might be thinking that they wont have the access that they had before.* ***Female, 18, Otley (ND)***
>
> *It's important to tell people that resources are going to be reallocated, however, it's unlikely to have an impact on their experiences with the NHS - it's just going to improve others' experiences.* ***Male, 18, Garforth (ND)***
>
> *You need to get across to people that it won't negatively impact one group or one service for the benefit of others. That'll be a vital piece of information to get right.* ***Female, 29, Burley (ND)***
>
> *Showing people that their level of care won't change despite what the funding is, despite where it's distributed.* ***Female, 33, Swarcliffe (D)***
>
> *If it's an emergency thing you will get sorted, wherever you live.* ***Female, 50, Alwoodley (ND)***

In a small number of cases, participants queried the likely impact on them personally of the proposed changes, but many acknowledged that these changes were being made in the interests of the 'greater good'. Infrequent users of health services tended to share more benevolent perspectives.

> *The selfish part of me goes 'what about me when I need a doctor', but I understand why. I have private healthcare through work so if push comes to shove I know I'll be OK.* ***Female, 34, Horsforth (ND)***

> *I would be a little bit annoyed to be honest [if Mr A was getting a great deal of support and the participant was struggling to get out of hours GP appointment]. But that is probably the selfish person in me coming out. The thing for me is when people need urgent help, and making sure that's available.* ***Male, 31, Pudsey (ND)***

Rather than raising concerns over how they might be personally impacted by any changes, or wanting general reassurance about the continuity of existing services, a number of participants acknowledged that some Leeds residents might have concerns about the discontinuation of, or reduction in, services that have always been available. This concern was most often raised in response to the proposal that deprived geographies might enjoy higher levels of funding going forward, with the inference being that relatively affluent areas might see a drop in service provision.

> *Certain people could feel left out with different levels of investment in different areas. They'll think, 'Why am I not getting as much investment as them over there?'* ***Male, 18, Garforth (ND)***

> *People are selfish, aren't they? They're going to want to know how it'll affect them personally, they'll want to know if it will mean they'll have less than they currently do, and if their doctors surgery is going to have less staff. How it's going to affect them personally, not how it'll affect other people.* ***Male, 18, Ilkley (ND)***

Whilst disadvantaged geographies within Leeds stand to gain under the proposed measures, some participants raised the concern that offence might be caused to some residents when identifying areas as 'deprived'. The term has established negative connotations that might cause hurt or frustration to proud residents. Worse still, some were worried that talking about parts of Leeds in this way might cause division between the 'haves and have nots'.

> *I think they need to take the postcode issue away, because it automatically starts debate. It makes some people feel less, it makes some people feel more. At the end of the day we are one community, we're Leeds. That needs to be our focus.* ***Female, 32, Osmondthorpe (D)***

As well as the concerns expressed over where budgets might be reduced in the future, questions were also raised about the services, projects and interventions that might receive additional or new funding under the new strategy. If budgets were to be reapportioned, participants believed that this should be done in a way that could be proven as effective and would be a defensible use of resources. Participants asked whether funding would be allocated to projects that were delivering the desired outcomes, to initiatives that were known to be successful and for health problems that were amenable to intervention, and with clients that would be willing and able to engage with the support offered, or to follow any advice dispensed.

> *I don't think you should give money for giving money's sake because it's not going to generate a better outcome. It's all about outcomes, isn't it?* ***Male, 21, Armley (D)***

> *(…) local information to Leeds on the evidence (…) Areas similar to Leeds in the UK, I'd have more of an interest in that and evidence from somewhere like that.* ***Female, 33, Swarcliffe (D)***

What are other cities doing? Are we following suit? Are we doing something different? Why, if we are? Have we learnt from things that other people have done? What's the evidence? ***Female, 34, Horsforth (ND)***

Some issues won't be resolvable but will get better with the right help but with others there will be no hope, so it's hours of time spent but no progress. ***Male, 31, Pudsey (ND)***

For whatever reason, once they've got themselves in that situation, personally I've got empathy for that person being supported to help themselves through the NHS. What annoys me is when you're putting all this effort in to help the situation and they're still drinking a bottle of gin a day or something. ***Male, 68, Horsforth (ND)***

Stimuli used in the second phase of fieldwork highlighted that some of the services identified to potentially receive additional funding might be those offering a high level of long-term support, that was resource intensive, potentially to a small number of individuals. Questions were asked about how much support would be offered to any one individual, and what measures of individual-level success might be used to ratify continued support for any patient or client. Participants questioned whether this level of support for specific groups would be palatable if large numbers of other service users were then left with difficulties accessing the care they needed.

It's a lot of time to give to one person when there's so many people living in Leeds that also need support. Is there any definitive length of time that is given to a person? Or is it just an endless amount of time until the issue is resolved? ***Male, 31, Pudsey (ND)***

I think it's money well spent, but my concern is can they keep up with whatever they've started to do at the moment? Will the service be able to cope with all those kind of needs? ***Male, 40, Wortley (ND)***

6. Communicating with Leeds residents

The findings presented thus far have implications for communicating with Leeds residents about the proposed strategy to tackle health inequalities within the city. As part of the discussion guide for interviews and focus groups, the research sought to understand participants' views specifically on how NHS Leeds CCG could best communicate with its citizens on the current health landscape, the plan being put forward, and how support for the approach might best be gained by delivering a full understanding of these.

Perspectives and comments in this section may replicate those presented in the sections above. These views have been included here so that this section stands alone in the advice and recommendations it gives.

Please note that ***(D)*** and ***(ND)*** following quotes indicate whether the contributor lives in a deprived or non-deprived postcode, according to the categorisation provided by NHS Leeds CCG prior to recruitment of participants.

6.1 How to convey the current situation

6.1.1 Use statistics on Life Expectancy

Life expectancy (LE; and specifically the difference in LE between parts of Leeds, or population subgroups) was the indicator of health inequalities most readily grasped by participants. Many commented on the stark difference of nine years between parts of Leeds. Participants were also taken aback to hear that LE for homeless people might be as low as 42, and those in travelling communities as low as 50. Participants later confirmed that LE statistics should be used when painting the picture of the health inequalities currently being experienced in Leeds.

> *For me it'd be adding statistics and highlighting the differences between two people's lives (…) Highlighting the different groups that it does affect. Some statistics that really raise awareness of how severe it [difference in LE] can be in some cases and shock people.* ***Female, 18, Otley (ND)***

> *The Statistics and the numbers speak for themselves and that will help people understand the impact of health inequalities. Those numbers jump out at people and illustrate the problem.* ***Female, 29, Burley (ND)***

> *The nine years for Leeds. I particularly like the local statistics so people are going to care a lot more when it's Leeds.* ***Male, 21, Armley (D)***

6.1.2 Present a map

All participants were familiar with the map of Leeds presented in the introductory presentation. Whilst some were familiar with the areas of deprivation highlighted, others were not. Regardless of this, a number of participants suggested that the map would be useful in describing the localised picture. However, this suggestion must be taken in the context of the concerns raised earlier that highlighting small geographies were residents experience deprivation may cause division amongst citizens.

> *When you see the mapping as well, you can really see where the issues are and where they need to address it.* ***Female, 24, Shadwell (ND)***

The map of Leeds, that really demonstrates the problem areas. ***Male, 18, Garforth (ND)***

The map with orange areas, although that may cause offence to some of the people in those areas. ***Male, 31, Pudsey (ND)***

6.1.3 Tell personal stories and talk about disadvantaged groups

As well as presenting figures and diagrammatic representations of the current health situation, a large number of participants felt that the use of personal stories would bring a human touch to painting the picture, likely eliciting greater feelings of empathy and compassion than the use of statistics alone. Equally, some participants held the view that by talking about groups of individuals experiencing inequalities or health issues the scale of the issue might be better understood compared with telling the story of individuals. By depicting the problem in a collective way, a small number of participants noted that the access issues experienced could be extrapolated and applied to broader population subgroups.

You always relate more when there's a story and a person behind it you think, 'fifty two, that could be my auntie'. When there's more information there is more empathy behind it, and I think people would find that really relatable. 'that could have been a neighbour'. ***Female, 23, Fearnville (D)***

It gives them a more personal touch to it. It shows how it really affects people. Giving personal experiences will help people understand it and realise that it can affect anyone and that it needs to be changed. ***Female, 18, Otley (ND)***

If you're using a personal anecdote people have a lot more sympathy towards it and they can relate to it a bit more relative to just facts and figures and general statistics. ***Male, 18, Garforth (ND)***

I think if people can see a real life story it makes it more relatable and believable, it's a real thing… ***Female, 42, Wetherby (ND)***

'So many people died of a heart attack related to obesity. We're spending this much money to try and prevent that.' I think that would be a clear way to show people – ***Male, 30, Seacroft (D)***

6.1.4 Explain the reasons for inequalities

As well as informing Leeds residents about the statistics and the geography of health inequalities, there was a feeling that people might need to understand more about how health inequalities have come about, and the reasons why some members of society may experience difficulties accessing healthcare. For some groups, for example those whose first language is not English, the barriers to healthcare were instantly evident. For others, including the BAME community, the challenges were less clear and may need to be explicitly presented. This would help residents understand health inequalities and why these are not caused solely by lifestyle factors.

Otherwise people from those ethnic minorities might think, 'well, why are we being singled out?' They'd be offended because they think of themselves as healthy people. On the flipside, other people will think 'they're just like me, they live in the same street, so why do they need extra help and I don't? ***Male, 21, Armley (D)***

Once it's explained and you understand it, it makes sense. Understanding the reason behind it is really important. ***Female, 33, Swarcliffe (D)***

6.1.5 Talking about access

The term 'access' tended to be narrowly defined by participants, with people thinking only of physical access considerations like transport and proximity of, and travel time to reach, health services. Whilst it has a broader definition within the lexis of health inequalities, this is not generally understood by the public. NHS Leeds CCG should consider using alternative language when presenting the access issues experienced by some groups.

6.2 Communicating about the proposed strategy

6.2.1 A picture of inequity

There was a very high level of agreement with the principles of the health inequalities strategy that was presented to participants. A majority of participants subscribed to the application of equity principles in order to reduce inequalities and narrow the health gap in Leeds. A number of participants noted that the cartoon depicting baseball spectators quickly and effectively communicated the principles of equity and how the plan proposed would operate in line with them. Some participants told us that they were familiar with the cartoon from other contexts (e.g. human resources). There is good evidence to suggest that this image could be deployed effectively in a communications campaign on the proposed health inequalities strategy. This would also fulfil another suggestion from participants; that information be represented pictorially where possible.

> *I did like the cartoon with the steps - I think that is straight to the point and that everyone would grasp that and understand exactly what it is.* ***Female, 23, Fearnville (D)***

> *Like the idea of what was going on in that cartoon. Different groups of people, different communities have different needs and those needs might be more expensive than others.* ***Male, 21, Farnley (D)***

> *Diagrams are easy to see and understand, language and literacy and all that.* ***Male, 30, Seacroft (D)***

6.2.2 Personal stories

As per the findings concerning communicating about the current problem, many participants believed that there was great value in using personal case studies to communicate about how some of the initiatives to be funded under the new strategy will support people and increase access for those groups that have experience barriers, thus narrowing the health gap.

> *Some examples that (…) turned it from statistics into Mister Joe Bloggs. To make it less of a statistic into, actually, 'these are real life people that do need this service'.* ***Female, 34, Horsforth (ND)***

> *For me it would hit me more to say that this is a human being who has had these struggles, rather than talking as a group because you'll see that person as a human being a bit more.* ***Female, 33, Swarcliffe (D)***

> *I think that case studies are really useful. It's very concise, it's the information, and you can really see that something good has happened there. Those are definitely worth communicating to people.* ***Male, 31, Pudsey (ND)***

6.2.3 More detail

As per the findings presented in section 5, participants felt that more information was required about how the plan would be operationalised, what it would look like on the ground, and the projects and interventions that might receive more funding under the proposed strategy. NHS Leeds CCG should therefore consider communicating about the proposal in a less abstract, and more concrete way. This will bring the plan to life, and give citizens tangible information to grasp in order to understand the plan and, in turn, formulate their view on it. Indeed, when asked about the type of information that NHS Leeds CCG should include in communications with residents, a greater depth of information was a clear requirement for most participants. This additional depth of information should include detail on how budgets will be both increased and decreased in different areas.

> *I don't know that there was very much detail about actually what they were going to do apart from obviously utilising funding and putting that into different areas, but I didn't pick up any specifics of what that might look like. Knowing a little bit more about what initiatives and projects they might be putting that funding into.* ***Female, 29, Burley (ND)***

> *Understanding what that difference means. What that actually changes. Is it as simple as the fact that doctors are open less hours? I don't know. I need to have a list. I guess how it directly affects me. What's being cut.* ***Female, 34, Horsforth (ND)***

> *Knowing a little bit more about what initiatives and projects they might be putting that funding into, what those real on the ground actions and projects are going to look like, what're they going to spend the money on, basically.* ***Female, 29, Burley (ND)***

> *A brief outline of the sort of areas and the proportion of money that would be assigned, is it going to be mental health, social care, actually what?* ***Female, 50, Alwoodley (ND)***

> *There's always a risk that if you take money from one pot and put it in another, where can those costs be saved with the least amount of negative impact on the people that use those services?* ***Female, 29, Burley (ND)***

> *It would be nice to see what exactly they're spending their money on, where exactly they thought it was going to go.* ***Female, 42, Wetherby (ND)***

6.2.4 Reassurance around existing services and non-deprived geographies

Alongside offering more detail to Leeds residents about the changes the health inequalities strategy would bring, many felt that there was a need to reassure the public that important services would remain available, and that the proposed changes would not mean withdrawal of funding entirely for some services. Of particular importance would be communicating this in relation to emergency and urgent care services. Some participants took the view that the proposed changes in funding were unlikely to negatively impact a large number of people, and that the changes would only affect service users in negligible ways and, if true, this should be used in communications.

> *(…) that is something that is on the forefront of people's minds. That reassurance that it's 'there in people's time of need' is what people need, especially in the pandemic.* ***Male, 31, Pudsey (ND)***

> *I think within there there needs to be some kind of reassurance around what kinds of services will be retained.* ***Female, 32, Horsforth (ND)***

If services are set to change significantly, then this should be communicated at a local level, or with individuals likely to be affected by service changes, where possible.

> *People are selfish, aren't they, they're going to want to know how it'll affect them personally, they'll want to know if it will mean they'll have less than they currently do, and if their doctors surgery is going to have less staff. How it's going to affect them personally, not how it'll affect other people.* ***Male 18, Ilkley (ND)***

Some were concerned that increasing spending in deprived areas would lead to significant cuts in non-deprived areas, or at least that residents in those areas might be left with that perception. This finding presented more commonly when using the written case study stimuli as compared to the videos used in the early phase of fieldwork. And so, in the same way that it is important to reassure around the continuity of services, it is also important to provide adequate, clear reassurance to residents in relatively affluent areas that their services will not start to disappear whilst NHS Leeds favours only funding healthcare in deprived geographies.

> *Saying that it's not that they are just prioritising those that are unfortunate (...) if that is excluded, people would get the idea in their heads that they're being left out and they're not as important as other people.* ***Female, 18, Otley (ND)***

> *People need assurance that they are not going to turn up to the hospital and be told they can't get treatment because you're not from this area.* ***Male, 21, Armley (D)***

6.2.5 Evidence

In addition to communicating with more detail on the proposed plan, NHS Leeds CCG should consider providing more information about the existing evidence base that investing money in line with proportionate universalism will indeed reduce the health inequalities as anticipated. Further, where evidence exists for the success of specific interventions or projects that are to receive funding, then this should be communicated, too. Ideally, this evidence should be specific to Leeds or a wider yet still local geography, or be drawn from cities with parallels with Leeds; some participants were concerned that what is successful elsewhere might not necessary 'translate' for Leeds.

> *Once it's explained and you understand it, it makes sense. Understanding the reason behind it is really important.* ***Female, 33, Swarcliffe (D)***

> *What are other cities doing? Are we following suit? Are we doing something different? Why, if we are? Have we learnt from things that other people have done? What's the evidence?* ***Female, 34, Horsforth (ND)***

> *Show people that this way of working does work, and that this is how it needs to be done. It'll make people less argumentative against it.* ***Male, 18, Ilkley (ND)***

> *And I'd also be interested in understanding the rationale behind it and how they've come to the conclusions about what they'd like to do and why this'll work.* ***Female, 29, Burley (ND)***

As well as knowing that the approach, and the interventions that might be part of it, have been successful elsewhere, NHS Leeds CCG should respond to requests that citizens be made aware

of how the impact and effectiveness of the roll-out in Leeds will be measured in order to provide ongoing assurance that budgets have been reapportioned successfully.

> *There's no point giving money to an area just for the sake of equality if it's not going to generate good outcomes. If we spend money in this way it'll help to redress the problem of the gap, so I don't think you should give money for giving money's sake because it's not going to generate a better outcome. It's all about outcomes, isn't it?* ***Male, 21, Armley (D)***

6.2.6 A multi-agency approach

A number of participants questioned the ability of the NHS to make a significant impact on health inequalities, especially in isolation of other departments and organisations. People questioned the role of schools, charities and other entities and emphasised the need to work in a joined-up way using a multi-agency approach. NHS Leeds CCG should consider describing to the public of Leeds how it intends to collaborate with other agencies in the delivery of its vision that Leeds will be 'a healthy and caring city for all ages, where people who are the poorest improve their health the fastest'.

> *Is this really just the NHS's jurisdiction?* ***Female, 50, Alwoodley (ND)***

> *There will surely be very long-term plans, and plans that involve a lot of other people and organisations, and perhaps things that aren't just medical intervention.* ***Female, 29, Burley (ND)***

6.3 Gaining support for the proposed strategy

The sections above have outlined the needs of Leeds citizens when it comes both to understanding the current health picture in Leeds and engaging with the strategy being proposed to address the health inequalities that exist.

This section presents recommendations, based on focus group and interview data generally, but also based on the specific suggestions given by research participants, on how NHS Leeds CCG might gain support for the strategy being put forward.

6.3.1 Take a human, compassionate approach

The research has shown that a large majority of Leeds residents are likely to be empathetic, compassionate and socialist in their views when it comes to the health of others in their community. There has been a great deal of understanding for those that experience health inequalities, barriers to wellbeing, or difficulties accessing healthcare. This has been observed for different parts of Leeds, and for different population subgroups. Many told us they believe that 'people are people', all equally deserving of the best health possible, in order that they can lead the longest and most fulfilling lives. NHS Leeds CCG should consider communicating about their health inequalities strategy in a way that is congruent with this socialist perspective, knowing that citizens are ready to receive information in this way. This might include explaining how and why health inequalities might come about (covering both lifestyle factors and barriers to access), the promotion of personal stories that depict individuals' journeys and struggles with their health, as well as how services and interventions that might enjoy increased support under the new strategy have helped people to improve their health and increase their wellbeing.

6.3.2 Sell the benefits at a societal level

Whilst some might be sceptical of the strategy on hearing that some services will experience reduced funding, or that deprived areas will experience higher levels of support for healthcare, there may be value in promoting the message that by supporting those with the poorest health, whether because of lifestyle factors, access issues or geography, there are benefits for all because a 'healthy community is a happy community'. Participants were able to see the benefits for society as a whole by supporting those experiencing the poorest levels of health.

> *Having a healthier, happier population of Leeds is going to lead to better social cohesion, better understanding of each other, you know, better economics, it just makes sense on all fronts, really.* ***Female, 29, Burley (ND)***

> *We're investing in unwell people to get a bigger return later. Us in well off areas, we're going to get a bit less, I'd be happy about that if down the line I thought I was going to get a bit more.* ***Male, 68, Horsforth (ND)***

6.3.3 Focus on financial long-term benefits

A number of participants saw the potential of the proposed strategy to realise long-term cost savings for the NHS and others. Those that might not be receptive to the planned approach on the human level might be better convinced by painting the financial picture. Of particular value here might be providing examples of early intervention services that seek to reduce individuals' risk of developing later disease through good lifestyle choices, for example. These early interventions may overlap with other departments' remits, e.g. education, public health, also speaking to the importance of a multi-agency approach.

> *There would be an argument that funding can be used smarter, and smarter funding could prevent a lot of issues that are costing a lot of money at the back end. Early interventions, better education.* ***Male, 31, Pudsey (ND)***

> *It makes sense to put money into the more deprived areas, and if it works it will save the NHS money, it'll benefit the wider community and sure up the NHS for the future.* ***Male, 70, Shadwell (ND)***

> *In the future this will reduce the need for later interventions, so if we can make interventions early, we're not having to fund emergency interventions later when people's health hasn't already deteriorated.* ***Female, 29, Burley (ND)***

> *A healthier society will reduce the dependency on emergency services.* ***Male, 18, Harehills (D)***

> *The problem is if you don't do all these things he may end up taking up a hospital bed, so this is a fraction of the cost.* ***Male, 68, Horsforth (ND)***

6.3.4 Use COVID-19 as a platform

A number of participants recognised that the COVID-19 pandemic has highlighted the problem of health inequalities, and emphasised the struggles faced by some demographic groups. As well as this, those taking part in the research were able to recognise that this presents a potential springboard for tackling health inequalities, at a time when trust in, and respect for, the NHS may be at its highest in recent times.

> *I think with the COVID thing it's exaggerated more these inequalities.* ***Female, 24, Shadwell (ND)***

> *They've [the NHS] done a fantastic job during COVID. Levels of confidence in the NHS have gone up recently.* ***Female, 33, Swarcliffe (ND)***

6.3.5 Communicate with confidence

Data collected throughout the research suggests that people should be provided with adequate information on *why* the current situation has come about, *who* is affected or disadvantaged, *how* the proposed strategy will address some of the issues, and *where* evidence will be collected to measure its success. These findings suggest that residents want to be 'shown and not told'. In fact, one participant told us exactly that;

> *I'm a big believer in showing not telling (…) It's a lot more important to get someone on side and get them to understand than just saying 'this is what's happening, this is how we're doing it'.* ***Male, 18, Garforth (ND)***

> *People would say that it wasn't fair if they didn't justify it, you know, why it's fair. They'll need to show people why it needs to be done, instead of just telling people how and that it will be done.* ***Male, 18, Ilkley (ND)***

Participants believed that the NHS should communicate with confidence and authority about their proposed plan, that they should take ownership of it and speak with conviction about why this approach is the best suited for Leeds and its particular health circumstances. This, in combination with the suggestion that levels of confidence in the health service may be particularly high because of COVID-19, presents an ideally opportunity for the NHS in Leeds to disseminate information on the proposed strategy.

> *Most people in this country really value the NHS and I think they would value their opinion on the matter.* ***Male, 31, Pudsey (ND)***

> *Talk with authority and confidence that this* ***is*** *the best plan. Don't open it up for debate.* ***Male, 62, Beeston (D)***

> *The NHS are the experts in that field, they know how to delegate the resources better than anyone. They're most qualified in saying how the resources should be spent (...) but it's a democracy and people want to have their say.* ***Male, 18, Garforth (ND)***

6.3.6 Consider geography and deprivation

The final consideration when communicating about health inequalities in Leeds and the plan to address these is that of causing division based on geography and deprivation. The research uncovered potential for concerns amongst both those living in disadvantaged areas and those not.

Residents in areas identified as 'deprived' might take offence at such a categorisation. Equally, those living outside of these bounds might be worried that they would see health service budgets in their local areas diminish. Moreover, talking in these terms might cause a division between residents. NHS Leeds CCG should carefully consider the best way of talking about these geographies within the city so as not to cause offence, unnecessary concern, or division.

> *The map with orange areas (…) although that may cause offence to some of the people in those areas.* ***Male, 31, Pudsey (ND)***

> *Obviously people are going to take it as, 'if you live in the not orange area on the map they are going to take away money in your area', so you're going to have to be careful about that.* ***Female, 34, Horsforth***

> *What's happened in some of the areas, there are a lot of immigrants and foreign people coming into certain areas and that does cause a big, massive problem because there's so many of them.* ***Male, 75, Alwoodley (ND)***

> *I think they need to take the postcode issue away, because it automatically starts debate. It makes some people feel less, it makes some people feel more. At the end of the day we are one community, we're Leeds. That needs to be our focus.* ***Female, 32, Osmondthorpe (D)***

7. Appendices

7.1 Focus group discussion guide

Session Duration: 1 hour 45 minutes – 2 hours

Section 1: INTRODUCTION

Time allowed: 10 minutes

My name is XX and I work for Qa Research, an independent social research company based in Yorkshire. Thank you for joining us today to talk about health in Leeds, and well done on getting to grips with the complexities of Zoom! We are working with the NHS in Leeds to try and understand how Leeds residents like you feel about the differences that exist in people's health circumstances, as well as the plan being put forward by the NHS in Leeds to tackle these differences. As we will hear about later, these differences apply to people's life expectancy, the number of healthy, illness-free years, and overall quality of life. The discussion today will last just less than 2 hours, so will finish at XX.XX at the latest. You will each be paid £50 by bank transfer in the days after the session as a thank you for your time and input.

I've said that I work for Qa, and that we are independent of the NHS in Leeds. So I've had no involvement in the development of the plans to tackle health inequalities that we'll be discussing. This means that you can be open and honest about your views with me. It also means that I am not an expert on every detail of these plans, so please forgive me if I am unable to answer any specific questions you might have. But sometimes questions, especially those that go unanswered, are really useful, because they indicate to the NHS the kind of information that needs to be made available to Leeds residents when they communicate about plans like these. My role today is to guide the discussion, but as we talk through the topics and I ask questions, feel free to speak to each other as much as to me; we'll be discussing things as a group.

The most important thing to say is that there are no right or wrong answers today; we simply want to hear your views and perspectives. Please be as honest as you can when sharing your thoughts. Bear in mind that not everyone will have the same feelings on some of these topics, and so I ask that we please respect each other's views.

As you'll know from when you were called, we will be recording the focus group so we can write up the conversation accurately afterwards. The recordings stay at Qa, and will not be passed on to the NHS. The NHS will also not be told who has taken part and although we will use some quotes in our report, to illustrate various viewpoints, we don't include anyone's names; you will always remain anonymous.

- Is everyone somewhere quiet, where they can hear clearly, and hopefully won't be disturbed for the next few hours?
- Do any of you have any questions before we begin? Please raise your hand if you wish to ask anything at this stage. You can use the 'raise hand' button in Zoom, or simply put your hand up.
- As we discuss things, please raise your hand if you'd like to make a point and have been unable to get your views across. Also feel free to use the chat window if there's a comment you'd like to make, either to me or the group as a whole.

Ice breaker task

I've had the chance to introduce myself, so now it's your turn. I'd like you to all tell us your first name and one simple fact about yourself. This could be, for example, the name of your dog, the

number of grandchildren you have, or where you last went on holiday, which will likely feel like a very distant memory. So, I'm Ben, I'm speaking to you today from the Cotswolds, despite being based in Yorkshire, and I once played tennis with Tim Henman. XX, would you like to start us off?

<intros, thank Ps>

Section 2: PRESENTATION

Time allowed: 10 minutes

The first thing we need to do is watch a presentation, prepared by Leeds NHS, that gives an overview of what we will be talking about today. It's important we all have an understanding of what health inequalities are, what these differences might mean for different people, and what the NHS is planning to do in order to reduce these inequalities.

The presentation will be played as a pre-recorded video and is given by Becky at Leeds Clinical Commissioning Group – this is the body responsible for planning and coordinating delivery of health care services for the Leeds area. This plan is the result of a large amount of work that Becky has been involved in alongside a number of other colleagues in Leeds.

I'd like to play the presentation without pausing, but feel free to ask me any questions afterwards.

<Clip 1 - Becky Barwick presentation>

Section 3: HEALTH INEQUALITIES

Time allowed: 10 minutes

Initial thoughts – health inequalities (5m)

Thanks for watching that clip. I hope it gave a good introduction to the topic under discussion.

- What are your initial reactions to the problem of health inequalities?
- Were you aware that these differences/inequalities existed?
    - If yes, how much did you understand about them before?
    - If no, can you think of examples of some of these inequalities from your own lives, or people you know?
- What do you think about some of the factors that might contribute to health inequalities?

Understanding the concept of health inequalities (shapes communications; 5m)

Thank you for sharing those initial thoughts and reactions. Let's now assess our understanding of these health inequalities.

- What do we now understand about health inequalities?
- Do you think this presentation gave you a good understanding of the problem? Has it been well explained?
    - If yes, what information was useful in explaining things?
    - If no, what other/additional/different information would be useful in explaining?
- Does anyone have any questions, or is anyone left wondering, about what we have heard?

Section 4: PLAN TO TACKLE HEALTH INEQUALITIES

Time allowed: 30 minutes

Understanding the rationale for the plan and what this might mean (5m)

- What do you understand about why this approach has been chosen?
    - What part of the presentation helped you to gain that understanding?
- What do you understand about what is being proposed by Leeds CCG to tackle these inequalities?
    - Was there enough information?
    - How well was this explained?
    - What additional info might you or others need?
- What information do you think people will need to understand the reasoning behind this plan?

Quick reactions to the plan (5m)

Let's turn our thoughts now to the plan that was spoken about in the presentation.

- What are your initial reactions to what has been described in the plan?
    - Why do you feel that way?

Awareness of 'proportionate universalism' (5m)

- Did you expect that there would be different levels of investment (different levels of support) in different parts of Leeds, or not? *Becky talked about 'deprived areas/deprived Leeds'…*
- Or did you think that funds would be allocated uniformly/evenly across the NHS area?
    - What are your thoughts on this approach?
- Did you know that there might be different levels of support made available for different groups of people? *Think about the cartoon with the men watching baseball and the boxes they stood on…Becky mentioned language barriers, transport difficulties, giving extra support to people with learning disability or those who are homeless…*
    - How do you feel about this?

Positive and negative thoughts (5m)

- What is good about the plan that you've heard about?
- Do you welcome this approach or not?
    - Why?
- What are the negatives, in your view, about what we have heard?
- Is there anything that irks or frustrates you about this approach?
    - What?
    - Why?
- Do you object to this plan, or any of its elements?
    - Talk me through it…

Understanding perspectives (5m)

- Is this approach a good idea or not?
- How fair do you feel this approach is?
- Thinking about the cartoons from the presentation, what do you think about this idea of giving different people in different circumstances different levels of support to put them on a 'level playing field'?
- Can you think of any downsides of working in this way?
    - Are there people/groups/areas that you think would be disadvantaged or worse off?

Who should receive extra support? (5m)

- Are there groups of people, in your opinion, that need that little extra support to give them the 'step up'?
    - Which are these groups? Who are these people?
    - Why are these groups particularly in need?
- What do you think this additional support might look like for some of these groups?
    - What should be done to help those people that need a bit more help?

Section 5: 2 CASE STUDIES (Mr A and Mr B)

Time allowed: 20 minutes for both

We're now going to turn to some specific examples of tackling health inequalities.

I'm going to display on screen a written case study for you all to read. It tells the story of Mr A, a stroke survivor. It talks about his situation and the help that was offered to him through a one-to-one support service funded by the NHS. Once you've read it, I'll ask you about your thoughts on his situation and the help that was offered to him.

<Case Study One – Mr A>

CS 1 Questions (up to 10m)

- What are your thoughts on the difficulties Mr A was facing?
- What do you think about the kind and level of support that was offered to him following his stroke?
    - Do you think the support offered is a good or bad idea?
        - Why?
- Bearing in mind that offering this kind of support might mean reducing funding in other areas, how supportive would you be of services like these?
    - Very supportive? Moderately? Only a little?
    - Why?
- Do you have any concerns about offering services like this?
    - What are they and why?
- Are you left with any questions about how these services would be delivered and the impact on other NHS services?

I have another case study for you to read. It tells the story of Mr B, who has mental health problems and a history of alcohol misuse and associated antisocial behaviour. It talks about his situation and the intensive support that was offered to him through an outreach programme

funded by the NHS. Once you've read it, I'll again ask you about your thoughts on his situation and the help that was offered.

<Case Study Two – Mr B>

CS 2 Questions (up to 10m)

- What are your thoughts on Mr B's circumstances?
- What do you think about the kind and level of support that was offered to him?
    - Do you think the support offered is a good or bad idea?
        - Why?
- Bearing in mind that offering this kind of intensive ongoing support might mean reducing funding in other areas, how supportive would you be of services like these?
    - Very supportive? Moderately? Only a little?
    - Why?
- Do you have any concerns about offering services like this?
    - What are they and why?
- Are you left with any questions about how these services would be delivered and the impact on other NHS services?

Section 6: COMMUNICATING ABOUT THE PLAN

Time allowed: 25 minutes

<moderator briefly summarises the conversation; topics covered, some groups needing additional support, emerging view on level of support for the proposed plan>

(5m)

We've talked about people's health circumstances, the difference between them for certain groups, and some of the approaches that might be taken to reduce some of these 'gaps'. We'd now like to get your input into shaping how Leeds NHS should communicate with residents about the problems and plans to address them.

I'd like to split the group into 2 breakout rooms, where you can approach the next task as a pair/a three. I'd like you to imagine you are Head of the Communications team at Leeds NHS, and that your task is to design a leaflet aimed at Leeds residents that communicates about:

- health inequalities;
- the importance of addressing these; and
- some of the steps that might be taken, and the types of support that might be available.

While doing this, I'd like you to think about the following

- What is the important information to get across?
    - What do people need to know about the problem and what's being done about it?
    - What will answer any questions people might have?
    - What information would you avoid using?
- How would you get support from Leeds residents for this approach to tackling health inequalities?
    - How would you promote the plan as being a good one?

    - What kind of information would you use to get support?
        - Information, data, facts and figures?
        - Personal stories about individuals?
        - Information on groups facing disadvantages and health problems?
- Should the NHS use its authority as a public body to get their message across?
- What sort of language should be used?
    - What sort of language would you avoid?

You'll have **10 minutes** to discus this in the breakout rooms, and then we'll come back together to discuss your ideas as a group. I'll ask you to give a summary of your breakout discussions with the group as a whole when we come back together. Meanwhile, I will move in and out of the 2 rooms so I can provide help and answer any questions.

<Assign breakout rooms, and share the task and considerations (in brown, above) with each room. Moderator will move between the 2 rooms to assist, probe, ensure task is on track and insights being generated>

<Thank Ps for working on the task. Ask the two groups to present their thoughts back and discuss using the following probes **(10m)**>

- How did you choose which types of information to use? And which to avoid?
- What questions did you think people might have? Why?
- How did you decide to win residents' support? Why do you feel that is the best approach?
- What were your thoughts on language use. Explain…
- What questions remain unanswered for you after our discussion today?

Section 7: CLOSING

Time allowed: 5 minutes

We are nearing the end of our time for today. Before we finish, does anyone have anything that they'd like to add?

That brings our discussion today to a close. Thank you all very much for contributing your views, perspectives and thoughts on Leeds' plan. I appreciate that some of the things we've discussed today might be personal for some of you, and that we may have touched on some emotive topics, and so I'm particularly grateful for your input.

Be assured that the things you've shared, including the feedback that you've given, will be used by the NHS in Leeds to understand public opinion on their planned approach, and to inform the roll-out of their plan to tackle health inequalities.

If, after the session today, you wish to share any further thoughts or perspectives, do please feel free to get in touch with us by email - info@qaresearch.co.uk <display on screen if possible>. This is also the address to use if you think of any questions after the event; we'll ensure that any questions get answered by the right person.

<thank and close – pass Ps' details to accounts team for payment>

7.2 Video in-depth interview discussion guide

Session Duration: 1 hour - 1 hour 30 minutes

Notes in green apply to interviews being conducted by telephone.

Section 1: INTRODUCTION

Time allowed: 10 minutes

My name is XX and I work for Qa Research, an independent social research company based in Yorkshire. Thank you for agreeing to speak with me today about health in Leeds, *(and well done on getting to grips with the complexities of Zoom)!* We are working with the NHS in Leeds to try and understand how Leeds residents like you feel about the differences that exist in people's health circumstances, as well as the plan being put forward by the NHS in Leeds to tackle these differences. As we will hear about later (As you will have seen in the videos you've watched), these differences apply to people's life expectancy, the number of healthy, illness-free years, and overall quality of life. The discussion today will last no more than 1 ½ hours, so will finish at XX.XX at the latest. You will be paid £50 by bank transfer in the days after the session as a thank you for your time and input.

I've said that I work for Qa, and that we are independent of the NHS in Leeds. So I've had no involvement in the development of the plans to tackle health inequalities that we'll be discussing. This means that you can be open and honest about your views with me. It also means that I am not an expert on every detail of these plans, so please forgive me if I am unable to answer any specific questions you might have. But sometimes questions, especially those that go unanswered, are really useful, because they indicate to the NHS the kind of information that needs to be made available to Leeds residents when they communicate about plans like these.

The most important thing to say is that there are no right or wrong answers today; all I'm asking is for you to share your views and perspectives. Please be as honest as you can when sharing your thoughts.

As you'll know from when you were called, I will be recording the session so I can write up the conversation accurately afterwards. The recordings stay at Qa, and will not be passed on to the NHS. The NHS will also not be told who has taken part and although we will use some quotes in our report, to illustrate various viewpoints, we don't include anyone's names; you will always remain anonymous.

- Can I just check – are you somewhere quiet, where you can hear clearly, and hopefully won't be disturbed for the next 90 minutes?
- Do you have any questions before we begin?

Ask P to briefly introduce themselves: what they do; where in Leeds they live, living circumstances.

Section 2: PRESENTATION

Time allowed: 10 minutes

For telephone interviews, ensure that P has viewed the 3 videos before the interview. If not, re-share the link (using a new password if needed) by email and ask that they view them during the interview slot. Arrange to call P back after c. 20 mins, giving them time to watch the 3 clips.

The first thing I'd like to do is show you a presentation, prepared by Leeds NHS, that gives an overview of what we will be talking about today. It's important you have an understanding of what health inequalities are, what these differences might mean for different people, and what the NHS is planning to do in order to reduce these inequalities.

The presentation will be played as a pre-recorded video, and is given by Becky at Leeds Clinical Commissioning Group – this is the body responsible for planning and coordinating delivery of health care services for the Leeds area. This plan is the result of a large amount of work that Becky has been involved in alongside a number of other colleagues in Leeds.

I'd like to play the presentation without pausing, but feel free to ask me any questions afterwards.

<Clip 1 - Becky Barwick presentation>

Do you have any questions on the video presentation?

Section 3: HEALTH INEQUALITIES

Time allowed: 5 minutes

Initial thoughts – health inequalities (2m)

Thanks for watching that clip. I hope it gave a good introduction to the topic we're going to talk about.

- What are your initial reactions to the problem of health inequalities? *The diseases at play, differences in life expectancy, different levels of health*
- Were you aware that these differences/inequalities existed?
    - If yes, how much did you understand about them before?
    - If no, can you think of examples of some of these inequalities from your own lives, or people you know? *Becky talked about BAME, homeless, older people, areas of Leeds that are less affluent*
- What do you think about some of the factors that might contribute to health inequalities?

Understanding the concept of health inequalities (shapes communications; 3m)

Thank you for sharing those initial thoughts and reactions. I'd now like to ask you about your understanding of health inequalities…

- What do you now understand about health inequalities?
- Do you think this presentation gave you a good understanding of the problem? Has it been well explained?
    - If yes, what information was useful in explaining things?
    - If no, what other/additional/different information would be useful in explaining?
- Does anyone have any questions, or is anyone left wondering, about what we have heard?

Section 4: PLAN TO TACKLE HEALTH INEQUALITIES

Time allowed: 25 minutes

Understanding the rationale for the plan and what this might mean (3m)

- What do you understand about why this approach has been chosen?

    - What part of the presentation helped you to gain that understanding?
- What do you understand about what is being proposed by Leeds CCG to tackle these inequalities?
    - Was there enough information?
    - How well was this explained?
    - What additional info might you or others need?
- What information do you think people will need to understand the reasoning behind this plan?

Quick reactions to the plan (2m)

Let's turn our thoughts now to the plan that was spoken about in the presentation.

- What are your initial reactions to what has been described in the plan?
    - Why do you feel that way?

Awareness of 'proportionate universalism' (5m)

- Did you expect that there would be different levels of investment (different levels of support) in different parts of Leeds, or not? *Becky talked about 'deprived areas/deprived Leeds'…*
- Or did you think that funds would be allocated uniformly/evenly across the NHS area?
    - What are your thoughts on this approach?
- Did you know that there might be different levels of support made available for different groups of people? *Think about the cartoon with the men watching baseball and the boxes they stood on…Becky mentioned language barriers, transport difficulties, giving extra support to people with learning disability or those who are homeless…*
    - How do you feel about this?

Positive and negative thoughts (5m)

- What is good about the plan that you've heard about?
- Do you welcome this approach or not?
    - Why?
- What are the negatives, in your view, about what we have heard?
- Is there anything that irks or frustrates you about this approach?
    - What?
    - Why?
- Do you object to this plan, or any of its elements?
    - Talk me through it…

Understanding perspectives (5m)

- Is this approach a good idea or not?
- How fair do you feel this approach is?
- Thinking about the cartoons from the presentation, what do you think about this idea of giving different people in different circumstances different levels of support to put them on a 'level playing field'?
- Can you think of any downsides of working in this way?

- Are there people/groups/areas that you think would be disadvantaged or worse off?

Who should receive extra support? (5m)

- Are there groups of people, in your opinion, that need that little extra support to give them the 'step up'?
  - Which are these groups? Who are these people?
  - Why are these groups particularly in need?
- What do you think this additional support might look like for some of these groups?
  - What should be done to help those people that need a bit more help?

Section 5: 2 CASE STUDIES (Mr A and Mr B)

Time allowed: 15 minutes for both

We're now going to turn to some specific examples of tackling health inequalities.

For telephone interviews – Read Case Study One (Mr A) to P over the phone.

I'm going to display on screen a written case study for you to read. It tells the story of Mr A, a stroke survivor. It talks about his situation and the help that was offered to him through a one-to-one support service funded by the NHS. Once you've read it, I'll ask you about your thoughts on his situation and the help that was offered to him.

<Case Study One – Mr A>

CS 1 Questions (up to 5m)

- What are your thoughts on the difficulties Mr A was facing?
- What do you think about the kind and level of support that was offered to him following his stroke?
  - Do you think the support offered is a good or bad idea?
    - Why?
- Bearing in mind that offering this kind of support might mean reducing funding in other areas, how supportive would you be of services like these?
  - Very supportive? Moderately? Only a little?
  - Why?
- Do you have any concerns about offering services like this?
  - What are they and why?
- Are you left with any questions about how these services would be delivered and the impact on other NHS services?

For telephone interviews – Read Case Study Two (Mr B) to P over the phone.

I have another case study for you to read. It tells the story of Mr B, who has mental health problems and a history of alcohol misuse and associated antisocial behaviour. It talks about his situation and the intensive support that was offered to him through an outreach programme funded by the NHS. Once you've read it, I'll again ask you about your thoughts on his situation and the help that was offered.

<Case Study Two – Mr B>

CS 2 Questions (up to 5m)

- What are your thoughts on Mr B's circumstances?
- What do you think about the kind and level of support that was offered to him?
    - Do you think the support offered is a good or bad idea?
        - Why?
- Bearing in mind that offering this kind of intensive ongoing support might mean reducing funding in other areas, how supportive would you be of services like these?
    - Very supportive? Moderately? Only a little?
    - Why?
- Do you have any concerns about offering services like this?
    - What are they and why?
- Are you left with any questions about how these services would be delivered and the impact on other NHS services?

Section 6: COMMUNICATING ABOUT THE PLAN

Time allowed: 15 minutes

We've spoken about people's health circumstances, the difference between them for certain groups, and some of the approaches that might be taken to reduce some of these 'gaps'. I'd now like to get your input into shaping how Leeds NHS should communicate with residents about the problems and plans to address them.

I'd like you to imagine you are Head of the Communications team at Leeds NHS, and that your task is to design a leaflet aimed at Leeds residents that communicates about:

- health inequalities;
- the importance of addressing these; and
- some of the steps that might be taken, and the types of support that might be available.

<clarify the situation, allay concerns, advising that we are just after your ideas about the kind of information that should be communicated, why, and how, and use the following prompts to guide the o2o discussion>

- What is the important information to get across in the leaflet?
    - What do people need to know about the problem and what's being done about it?
    - What will answer any questions people might have?
    - What information would you avoid using?
- How would you get support from Leeds residents for this approach to tackling health inequalities?
    - How would you promote the plan as being a good one?
    - What kind of information would you use to get support?
        - Information, data, facts and figures? Probe
        - Personal stories about individuals? Probe
        - Information on groups facing disadvantages and health problems? Which ones? Why?
- Should the NHS use its authority as a public body to get their message across?

- What sort of language should be used?
    - What sort of language would you avoid?

<Thank P for working on the task.>

- We are coming to the end of our time. I wondered if there are any questions that remain unanswered for you after our discussion today? I can't promise to be able to answer these, but your questions may help us to identify any gaps in information that the NHS in Leeds should be thinking about when rolling out these plans and communicating about them.
- Are there any final thoughts you'd like to feed in?

Section 7: CLOSING

Time allowed: 5 minutes

That brings our discussion today to a close. Thank you for contributing your views, perspectives and thoughts on Leeds' plan. I appreciate that some of the things we've discussed today might be personal for some of you, and that we may have touched on some emotive topics, and so I'm particularly grateful for your input.

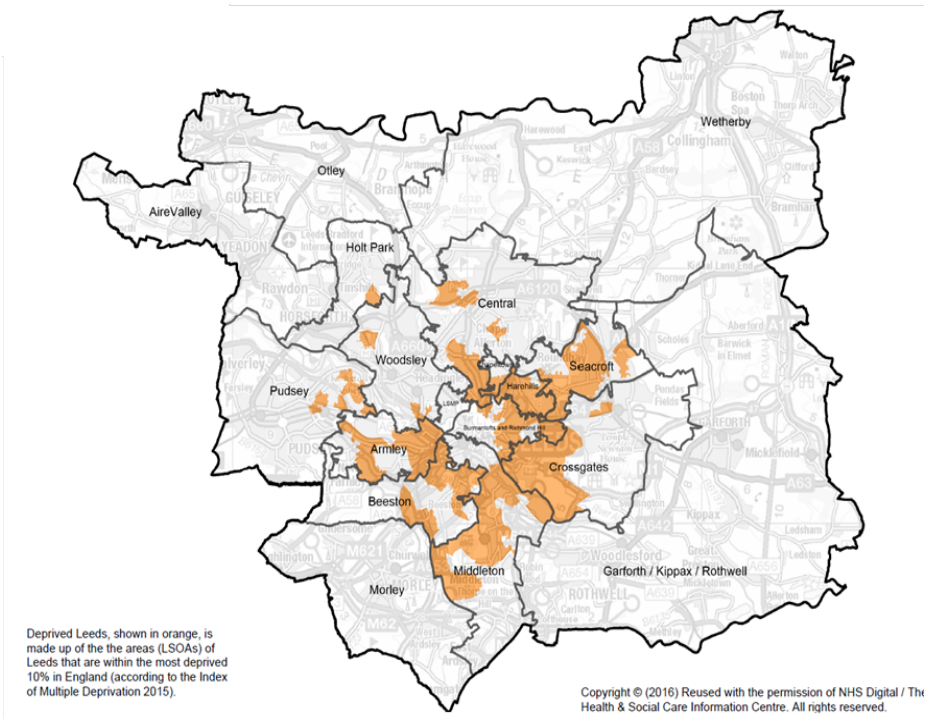
Be assured that the things you've shared, including the feedback that you've given, will be used by the NHS in Leeds to understand public opinion on their planned approach, and to inform the roll-out of their plan to tackle health inequalities.

If, after the session today, you wish to share any further thoughts or perspectives, do please feel free to get in touch with us by email - info@qaresearch.co.uk <display on screen if possible>. This is also the address to use if you think of any questions after the event; we'll ensure that any questions get answered by the right person.

<thank and close – pass P's details to accounts team for payment>

7.3 Cartoon of baseball spectators

7.4 Map of deprived areas in Leeds



Deprived Leeds, shown in orange, is made up of the the areas (LSOAs) of Leeds that are within the most deprived 10% in England (according to the Index of Multiple Deprivation 2015).

Copyright © (2016) Reused with the permission of NHS Digital / The Health & Social Care Information Centre. All rights reserved.

7.5 Case study: Mr. A

Introduction

In recent years the health service has begun to see the value of investing in specialist support services that work with the most challenged and marginalised people in our communities.

This type of work is not new; many charities and voluntary sector organisations have worked in this way for years whereas health funding has typically been reserved to pay for traditional NHS services.

However, we have realised that if the health service is to make a difference on reducing health inequalities it is important for health funding to play its part in this area and work in different ways than in the past. As you will see shortly, there are also other benefits to the health service of working in this way.

It is important to note that the teams who engage with people like those described in the case studies you'll read do not tend to be clinically or medically trained, although they are sometimes specialist 'out-reach' health professionals. Workers tend to have a high level of compassionate interpersonal skills as well as being driven by wanting to help people in the most need. They use coaching-type skills to build trust and, importantly, have the time to spend working intensively with people over a long period of time where needed.

These types of services are sometimes called 'social prescribing' or 'inclusion health' and are still relatively small scale with a tiny proportion of health funding being spent in this way. We envisage that the vast majority of health funding will continue to be spent on the traditional services that diagnose and treat illness.

The benefits to individuals being supported by these services are clear. But what if funding services such as these meant that we weren't able to fund other things such as opening GP practices everywhere on evenings and at weekends? Or free gym passes for everyone, to increase people's physical activity? Or much larger A&E departments where there are no waiting times for anyone?

Case Study 1

Mr. A is a stroke survivor and recovering alcoholic with long standing mental health issues. He had previously spent time in prison. When Mr. A engaged with our service, he had limited mobility, poor motivation, and stated that he wanted to die. His self-care was non-existent. Mr. A had not seen his family since his stroke. His two storey accommodation was inappropriate for a stroke survivor. He was unable to bathe or sleep in his bedroom, was sleeping on the sofa and going to the toilet in a bucket downstairs. Mr. A was not accessing medical support or taking any medication, and has limited thinking capacity since his stroke. He had rent arrears and issues with his benefits.

Through many hours of intensive 1:1 input our service supported Mr. A to:

- regularly access his GP for reviews or other health needs and resume his stroke and mental health medication; and
- be assessed at home by the independent living team – this led to essential modifications being made to his home to make it suitable for him to live in once again.

In supporting Mr. A to work through physical, mental and financial problems following his stroke and prison sentence our service has helped him to re-evaluate his life. He now looks after himself, and has taken on a dog. Where he would have let things deteriorate he now reaches out to his GP or accesses other services when he needs help. He has resumed meaningful relationships with his family, which has improved his emotional wellbeing. His life is no longer centred around drink, and he has a very average lifestyle for a man of his age. He has worked hard to overcome obstacles caused by the stroke, and his mobility has improved in part thanks to walking his dog.

The benefits to Mr. A are clear. But what if funding services such as these meant that we weren't able to fund other things such as opening GP practices everywhere on evenings and at weekends? Or free gym passes for everyone, to increase people's physical activity? Or much larger A&E departments where there are no waiting times for anyone?

7.6 Case study: Mr. B

Mr. B is aged 52 and has a significant history of mental health problems, including emotionally unstable personality disorder and an alcohol dependency issue.

When Mr. B is under the influence of alcohol, he makes offensive calls to the emergency services. This has led to him spending time in prison. Mr. B's tenancy in his rented home was at risk due to alcohol fuelled anti-social behaviour. If Mr. B received a further prison sentence, he would lose his property. Mr. B was banned from the Drug and Alcohol service in Leeds due to offensive and disruptive behaviour.

Mr. B received intensive support in person and by phone thanks to one of our out-reach services. We encouraged a GP appointment, where a referral to the Community Mental Health Team was made. We accompanied him to the mental health assessment; our presence encouraged him to be open and frank during the appointment and he expressed remorse at his past behaviour.

The Community Mental Health Team said that Mr. B's personality disorder was affecting his thinking and alcohol was the catalyst for his behaviour, suggesting he must address his drinking. However, you will recall that he had previously been banned from the Leeds Drug and Alcohol service. We advocated with the Drug and Alcohol service on his behalf and attended an appointment with him and a manager. In time, and with conditions, he was readmitted to this service.

Through intensive support over a long period of time we supported Mr. B in dealing with a further prosecution for inappropriate use of emergency services and eviction from his property. He avoided a prison sentence because of his engagement with services and evidence of progress made. His solicitor appealed his eviction on the grounds of mental health, and the eviction was overturned.

Mr. B's mental health is currently stable, he is engaging with the Leeds Drug and Alcohol service and receives ongoing support from the Community Mental Health Team, too. In addition, he continues to be supported by our out-reach service.

The benefits to Mr. B are clear. But what if funding services such as these meant that we weren't able to fund other things such as opening GP practices everywhere on evenings and at weekends? Or free gym passes for everyone, to increase people's physical activity? Or much larger A&E departments where there are no waiting times for anyone?