People's Voice in Integrated Neighbourhood Health

West Leeds Final Summary Report

Pudsey Community Project
Fartown, Pudsey, West Yorkshire LS28 8LP

Executive Summary

The Listening Project in West Leeds gathered rich insights from residents—particularly those living with multiple long-term conditions—about how they experience local healthcare and how they want to be heard. Through 50 survey responses, around 25 individual conversations, and two focus groups, participants described a highly localised geography where transport barriers, strong community identities, and historic distrust of institutions shape how and where people engage. A consistent message emerged: meaningful listening requires time, trust, and face-to-face relationships, and community organisations are uniquely placed to facilitate this because they are trusted, embedded, and able to reach people who do not engage digitally or through formal NHS channels. As one participant put it, "Most patients don't want to have to do everything online. We like to speak to real people."

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Across the listening activities, residents shared both positive experiences of individual care and numerous examples of systemic barriers—most notably the difficulty of securing GP appointments, inconsistent communication between services, and gaps in continuity of care. The strongest association with GP access was "8am phonecall," reflecting widespread frustration with same-day-only booking systems. Participants described how these barriers lead to deferred care, self-management of complex conditions, and a sense that the system is not designed around patient needs. Mental health services, particularly Leeds Mental Wellbeing Service, were repeatedly described as inaccessible or ineffective. These experiences shape people's willingness to engage: many felt previous consultation had not led to change, reinforcing the perception that health listening is superficial rather than meaningful.

The project demonstrates that deep listening—embedded, relational, and locally delivered—can counter this narrative. Focus groups produced constructive insights and high engagement, showing that when people feel valued and safe, they are eager to contribute to improving neighbourhood health. The findings point clearly to the need for a mixed-method, multi-neighbourhood listening model led by trusted third sector organisations, with a strong "You said – we did" feedback loop to rebuild confidence. Given West Leeds' dispersed geography, distinct community identities, and transport limitations, neighbourhood health models must be designed around multiple local access points rather than a single hub. Resourcing third sector partners to deliver ongoing listening, outreach, and non-clinical support is essential to creating a patient-centred system that genuinely hears and responds to community voice.

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01 Introduction and engagement mapping

PCP was contracted by Healthwatch/WY ICB to gather insights from local residents and community groups – especially people with multiple health conditions – on the engagement processes that work best in West Leeds LCP area, and how to best gather their views on healthcare in the context of neighbourhood health. This work was intensive and started in April, finishing in July. This was one of three pieces of work – West Leeds communities; neurodiverse patients linked to Leeds Student Practice and The Light; The Reginald Centre.

The first stage of the work involved initial conversations with local partners about their insights, and with residents about what engagement processes worked best for them. The second stage included an online survey with 50 qualifying responses, around 25 individual conversations with people with multiple and/or long term health conditions, and two focus groups with residents living with multiple long-term conditions. Partners included at various levels included MHA, Barca, Pudsey Wellbeing Charity, members of the PCN, and the New Citizen Project.

All participants were West Leeds residents who were patients with West Leeds PCN practices.

50	~25	2	3 wards
survey responses	individual conversations	focus groups	approx. 100,000 people

Key features of West Leeds social and geographical context which must be considered when it comes to both listening and neighbourhood health include:

- Area covers three wards: Pudsey, Farsley, Bramley (approx. 100,000 people)
- Geography matters and is a key challenge: dispersed distinct towns and villages, not a hub-and-spoke model
  - Residents are hyper-local; e.g. typical Pudsey resident avoids going into Leeds city centre; one lifetime Swinnow resident rarely visited Pudsey and could not remember when they last went to Leeds.
  - Services are perceived as far away even when geographically relatively close
  - Transport barriers mean people cannot easily travel between communities unless they have a car, and often prefer not to even if they do
- Psychology and sociology matter too – there is an historic distrust of Leeds City Council persisting in some areas; perception vs reality gaps exist (e.g. youth provision); pride and nostalgia are very important to many West Leeds people and can make engagement (with listening, with health, with some institutions) more complex); pride and nostalgia are key features of many long term West Leeds residents.

02 Insights: Preferred methods of engagement for listening/consultation

Stage 2 – especially the focus groups – worked really well but required significant PCP staff time in building on local trust to get to deep listening. Good listening practice includes deep listening which cannot be done superficially or without staff involvement.

Feedback from participants on ways to listen to them varied enormously in the online survey and individual conversations. In summary, there is no wrong way to engage with people and collect their insights, and a range of methods for different purposes and preferences is important.

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Suggested methods and reflections included (the below are diverse examples provided by participants):

- *Focus groups.*
- *Drop in sessions at the local library might be a good place for people to share their views.*
- *Accessible on- line forums.*
- *Regular Facebook health information, guidance and advice.*
- *Group discussions would be good but they need to be at a variety of times so people who work full-time can join. Also in a variety of places easy to reach by public transport for people who can't drive.*
- *Face to face meetings at an accessible point and also online point of contact where people can share concerns and ideas. For this to be successful obviously regular feedback should be given detailing any changes made.*
- *Via local pharmacists and GP practices.*
- *Dedicated sessions via the PCP Community Pantry or Seniors Lunch Club.*
- *Well advertised public meetings.*
- *Provide an online forum for ideas.*
- *Regular online feedback.*
- *Anonymous feedback forms available across Pudsey which could be dropped off at neutral sites.*
- *Most patients don't want to have to do everything online. We like to speak to real people.*
- *Regular drop in events/meetings.*
- *Easier appointment booking.*
- *Online forums, community groups, gyms, parks etc places where people already are.*
- *Communication hubs where people can voice, or if preferred leave a note with their concerns and suggestions.*
- *Group meetings are so beneficial for mental health to meet people and being able to talk to people going through similar situations.*
- *Surveys at doctors' surgeries and on Facebook.*

- *Method of listening has to be thought through, whilst considering the audience, venues, dates and times. Drop in sessions at local NHS services capturing people face to face is always a positive.*
- *More face to face appointments and actually listen to patients concerns and experiences. They know their own bodies.*
- *An online option would be the most accessible for me.*
- *Questionnaires with the option to have follow up group or 1:1 discussions.*
- *Take phone calls and emails.*

People were asked (if they had previously given feedback/engaged with consultation on health) what didn't work or why they struggled to engage in listening related to health and their responses were consistent:

- *"I can never do to things in work time and I don't drive so often can't reach in person events."*
- *"I didn't get to see or hear about any outputs from this."*
- *"Would share views if it would genuinely make a difference."*
- *"There is a perception, rightly or wrongly than no one really listens, and that everyone is too busy to be able to take on board people's concerns."*
- *"It didn't do any good. Things didn't improve."*

Reasons why people were reluctant to engage with or pessimistic about health listening were largely that they didn't feel it was genuinely making a difference – partly because they assumed that overstretched resources meant that consultation was an exercise rather than core practice, partly because of previous experience where they didn't see any change.

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> **There was a feeling, rightly or wrongly, that health listening was mostly superficial consultation** because of a scepticism about capacity and willingness to change.

Some suggestions from participants about how listening might work well include:

- *Online surveys*
- *Catching people face to face in waiting rooms (pharmacy, GP surgery)*
- *Coming to existing community spaces: lunch clubs, pantry, library, leisure centre, playgroups*
- *Weekend or evening slots essential: standard 9-5 workers and school staff can't attend daytime sessions*
- *Bramley market (monthly, very popular) flagged as a good pop-up venue*
- *NHS health checks hosted at community venues (PCP, library, Pudsey Leisure Centre, Bramley Baths) already well-received*
- *People ignored texts from their surgery but booked easily into familiar local venues*
- *Digital inclusion a real barrier for older residents: community orgs well-placed to bridge this*
- *Community organisations (Pudsey Community Project, MHA/Live at Home, Bramley Elderly Action, Barca) can:*
  - *Host listening conversations through existing services*

- *Reach people who won't engage digitally*
- *Have staff already doing informal health support (blood pressure checks, First Aid training)*

03 Insights: What good local health support looks like

Individual conversations and focus group discussions gave indications as to what they saw ideal neighbourhood health system characteristics might include:

- Access to urgent GP appointments when needed, plus ability to book ahead for non-urgent issues
- A non-GP drop-in for health questions would fill a real gap

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Participants were happy to share their own positive experiences of engaging with healthcare locally (in West Leeds or in hospitals), and those of family members, which included:

- Continuous midwife presence throughout labour
- Childhood absence epilepsy care: GP referral was fast, consultant responsive on medication changes; later, phone appointments with consultant worked well (no examination needed, just conversation)
- Self-referral to physio (via receptionist, no GP needed): appointment within 2 weeks via Sano Health
- Birth experience at hospital: felt cared for, right balance of clinical guidance and patient choice
- Perinatal mental health team: well-joined-up, proactive, spoke to GP and midwife in advance
- Common conditions (skin, infections) relatively easy to manage via GP
- Autism/ADHD diagnosis: positive experience via Right to Choose

04 Insights: What hasn't worked well

Almost every participant in individual conversations or focus groups had specific experiences of their own or of family members of poor experiences of engaging with healthcare. These were memorable to them and connected with or colouring their default stance with regard to healthcare.

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The strongest consistent response was the difficulty in getting an appointment at a surgery – some said it was so much harder than 20 years ago – **especially if the patient is in work**. There was a belief the difficulties securing appointments led to deferred (more expensive) care.

> This feeling of difficulty cannot be underestimated: the strongest word association with "GP" was "8am phonecall"!

Here were some other specific examples given by participants:

- *GP/midwife/receptionist miscommunication was a recurring theme*
- *Pharmacy First only works when:*
  - *Pharmacies are open when patients can make it – hard for people working*
  - *Pharmacy staff are those qualified – but those staff are often not on site when needed especially during work lunch hours*
- *Fit-to-fly note for work trip: midwife said wait until 2 weeks before; GP then said surgery doesn't do them; work trip had to be cancelled; GP later admitted he was wrong*
- *Anti-D injection: blood test lost, chased by patient, then called "urgent" by hospital; arrived to find injection not ordered (only stocked on Fridays)*
- *Several participants expressed bewilderment and frustration that a GP in the middle of a consultation was unable to book a follow up appointment on their own practice computer for three weeks time – this seemed both a significant system deficit but also patients felt it pushed responsibility back to them and square one of the system of difficulty trying to get an appointment*
- *Mounjaro prescribed but no follow up so still on 5mg after 18 months with little weight loss and no face to face support for over a year despite asking twice – such a waste of money.*
- *ADHD shared care: GP and Psychiatry UK didn't communicate clearly; prescription issued as 2x18mg but GP recorded as 36mg, refused to reissue in 18mg capsules so medication inaccessible at correct dosage*
- *Waited 12 months for dermatology referral only to find out GP had been undertreating by not following up and the issue could have been contained with different prescription but instead was inflamed for a year*
- *One patient said they self manage some of multiple conditions because it's too hard to get appointments.*
- *One said they have multiple conditions but their GP only allows two concerns to be brought to an appointment so some go unacted on because appointments are too difficult to get*

- *ADHD diagnosis via Right to Choose (Psychiatry UK): wait under 6 months vs. 3-year local list – not promoted by GPs (presumably because of costs) – but this was raised as an issue by several independent participants.*
- *Patient with Type 2 Diabetes struggling to maintain lifestyle changes several times agreed three months call back rather than 6 months for accountability but never happened over 7 years and now they are seen once a year which they find keeps them above the threshold – they pointed out the cost of blood tests and short nurse appointments must surely be cheaper than years of several medications.*
- *Pregnancy physio: non-specialist dismissed symptoms without treatment; pregnancy-specific physio had long waits and required travel to Leeds*
- *Schizophrenic domestic abuse survivor only offered phone counselling for over a year but couldn't access because it was a shared office they were being called from with voices in the background "which doesn't help when you're alarmed about hearing voices"*
- *Online medical records: chronological only, no summary view; not everything transferred between practices or hospitals*
- *Couldn't get GP appointment for issue as too much 8am competition – tried several times; tried PATCHS twice but each time was in work and by the time read messages, the request had been timed out and closed. Left issue unaddressed.*
- *Travel vaccinations example: records not transferred to university GP, patient nearly re-vaccinated*
- *Age 14 to 16 gap in app access: child too old for parental account access, too young to download NHS apps. Parent must use own account or phone to make appointments for a 14-year-old*
- *Both CAMHS and general mental health services: widely seen as overstretched*
- *Perinatal mental health team difficult to access initially (referral rejected, then midwife resubmitted and accepted)*
- *Lack of continued support post-birth, which participants felt was the most critical window*
- *Travelled to Wharfedale for assessment for concern – fairly quick verbal triage included no visual inspection of area but after 5 hours of waiting a visual inspection of seconds led to discharge – a six and a half hour period out of work for discharge in seconds once a medical professional looked at it – a whole work day wasted: surely not an efficient system.*
- *Postnatal groups (baby massage etc.) only run from The Mount (next to LGI): a real barrier for those further out; one participant travelled an hour by bus from Baildon/Guiseley area*
- *DPDR (dissociation) support: ongoing failure; reapplied to waiting list three separate times, still at stage one over four years later and not felt taken seriously by practice*
- *Leeds Mental Wellbeing Service: disorganized and unresponsive*
  - *One example: Occupational therapist called the referral number; staff member was hostile, said "why are you ringing this number, please stop ringing this number"; follow-up emails sent; no reply; initially referred to counselling for depression, which was the wrong treatment*
- *One patient trying for five years to get referral to LMWS for counselling including several times through several GPs and self referrals. Was offered a 12 hour online lecture series on depression where the presenter did not show and left all the participants' full names visible to one another. Was discharged back to GP without any counselling support with an incorrect medical record of suicidal ideation.*
- *Current system forces same-day-only booking, so non-urgent needs get deferred and sometimes develop rather than being nipped in the bud.*
- *Online triage (Patches) works for some but doesn't show available slots, just collects symptoms so feels like a retrograde step from 10 years ago online booking; patients confused why they can't*

provide an online request for clinical support out of their working hours (say 6pm, to be picked up the next day), as they cannot access while at work.

- *Pharmacy hours a barrier: most close at 6pm, hard for people working 9-5. One pharmacy in Pudsey area known by some to be open past 6; participants unaware of others*
- *Pharmacies useful for some things (blood pressure, some infections, flu) but often just redirect to GP*
- *Participants felt they'd made two trips for no gain*
- *Walk-in option preferred over appointment-only for ad hoc queries but rarely available*
  - *Especially for pregnancy-related queries ("check with your GP before X" is impractical)*
- *Health visitor contact too sparse: assigned at ~4 weeks before birth, then visits at 9 months and 27 months*
- *One patient had had five midwives in their pregnancy and no health visitor visits after leaving hospital*
- *Children's centres closing compounds these problems with resources to attend to new parents: e.g. Postnatal depression risk: nobody checking in regularly enough to catch it.*

05 Assessment of Listening Project

Participants appreciated the listening project and felt able to contribute both generally as well as specifically with regard to ongoing listening engagement as well as community health. There was a clear distinction between consultation (broad, brief, superficial) and listening processes (deep, trusted, long-term, time-intensive). If you want numbers, do an online survey; if you want real opinions and understanding, it takes time and investment.

Social media strongly influences people's perceptions; focus groups and other face to face conversations remain important for balancing views. Social media influences perception in seconds; face to face conversations require time, skills and attention to alter perception in equilibrium.

People's appreciation of and willingness to engage in health discussion is inextricably linked to their personal experiences of health – there are lots of positive experiences of individual care/health care workers, but a greater number of negative experiences of "the system". There is a default position that patients are not a valued part of the health system, and so patient voice will not be listened to or acted upon – with plenty of lived experience examples: this is not an assumption.

A variety of ways of engagement is essential. A variety of places of engagement is essential. People see huge potential value in shifting a neighbourhood health balance but want to be part of discussions about how it works. There is a perception from those who do engage in health that inefficiencies in patient care systems are more important than new initiatives. There is a positive response to non-city-centre health access (e.g. Wharfedale Minor Injuries – however overwhelmed the provision is) and a wish to see more of a spread

There was a desire for embedded health listening – those engaging in focus groups really appreciated the deep listening that happened. There was a widespread assumption that current NHS listening processes felt superficial and tick-box – we spoke to no one, for instance, who would use a QR code on a poster in a surgery as they felt feedback would be lost in noise; there was scepticism about giving feedback by text message responses as no one believed the feedback was analysed and acted on by local health.

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Just as important in terms of health listening to people was the idea that they would be able to communicate well with their GP surgery, or referral service – but there was a lot of negative experience of being listened to about personal health, that added to caution about how valuable the patient voice was in general about neighbourhood health

There was a widespread view that health systems do not communicate well – whether on websites (e.g. surgeries with websites difficult to navigate with out of date information), apps (not user friendly or patient-focused – e.g. no push notification possibility for updated medical records or test results), between hospitals and primary care, and the appointment systems for choice were seen to be better in the past (even 20 years ago) than the present (there was a recognition that might be linked to system overwhelm, but the access possibilities and tech seemed to have not advanced).

In terms of neighbourhood health, there was a clear recognition that, for patients, neighbourhoods in West Leeds do not equate to the 'West Leeds' level but the individual communities within them – i.e.

Pudsey, Calverley, Farsley, Swinnow, Tyersal, Woodhall, Rodley, Bramley, Stanningley – and that there is because of geography, history, traffic, parking and public transport, a reluctance to travel for services too much, so concentration of resource in one or two areas will miss significant proportions of the population – not just those who don't engage with health. The Community Anchor Listening Project this year for the Calverley/Farsley council ward found that the highest priority for local people was insufficient public transport which made it difficult to travel to even adjacent areas. The reduction in Children's Centres has seen not a significant rise in those travelling for support, as much as a reduction in those connecting with support, because parents in Farsley or even Pudsey, for example, are simply very significantly less likely to travel to Swinnow for engagement.

As coordinating agency, PCP found the process to be very helpful in understanding the patient's perspective. People were very much appreciative of the NHS and there were plenty of positive interactions people wanted to share, and even their more difficult experiences did not negate the willingness of those who engaged with the listening process to want to contribute to making things better. The focus groups and individual conversations were hugely valuable as they bypassed the superficial and the social-media-assumptions to deeper reflections. There was a widespread presumption that 'Health' is an institution that does not genuinely want to listen to and respond to patients' experiences (cf the current reports into maternity care) and we encountered lots of specific examples of systems being non-patient-centred.

We would strongly suggest that a third sector embedded listening process would help counter that narrative by providing trusted local organisations with access to people willing to engage with the continuity to show the 'system' has an aspect of listening to patients integrated – that it be multifaceted but incorporate the staff-intensive face to face work of focus groups at its heart. Embedded third sector work would also mean the listening was prioritised as opposed to being a bolt-on from staff's primary focus on health delivery. Deep long-term listening can also help mitigate the effects on health of sociological characteristics such as pride and nostalgia.

'You said – we did' principles are key – there is a reduction of trust/confidence in engagement with health from a patient's perspective due to the perception (with grounds) that health is a system-centred-system rather than a patient-centred-system, so work to concretely demonstrate that patient voice was listened to and action took place as a result is a key idea in winning back trust and confidence.

The only way to beat a permeating negative story is to have and tell a better story.

There was a theme of the psychological consequences of continuity of care – the change in GP working practices has happened without corresponding adaptation by patient groups to lack of continuity of care – not being able to book consistent follow up consultations with the same medical practitioner, for instance. Clearly this is partly due to changing working patterns and partly due to system resourcing, but patients have not been taken along that journey of changing understanding.

To be very clear – the participants were all very positive about the NHS as an institution and many were happy to talk about their positive experience (even lifechanging or lifesaving ones) but their relationship with health was coloured by negative experiences and impressions which meant there was a disjoint between their inclination and their expectation, which affects their attitude to listening, their perception of local health and, especially for those with multiple conditions, their self-management of their health.

Suggestions from participants about what would make engagement feel safe and worthwhile:

- Confidentiality is the top priority
- There was a concern about NHS data sharing, particularly with third-party companies (Palantir named)
- Small focus groups rated as one of the best formats
- Email surveys don't work: people don't respond
- Natural community locations worth targeting:
  - University, shops, train/bus stations (high foot traffic)
  - Gig venues, social spaces
- Any ongoing listening process should be mobile and travel to where people are

Reflections on the roles of Community Organisations and the third sector:

- They often help people navigate entitlements (Universal Credit, prescriptions, treatments)
- Cost of living advice can offer support around prescription costs: some people get initial prescriptions free but can't afford repeats. One participant talked of their frustration trying to find an HC1 form – the surgery staff didn't know what it was, the pharmacy sent them to the surgery (erroneously).
- Particular issues of support for homeless people who can't access Universal Credit
- Promotion of health awareness and messaging
- People often unaware of conditions because they're not actively looking
- Ideal partners for support with broader health communication and medical literacy
- Trusted community anchor organisations are often the most effective engagement route
  - People trust faces and relationships, not institutions
  - e.g. LCP-sponsored blood pressure work cited as a strong example: reached non-engagers cheaply and at scale
- Patient peer support and non-clinical provision support (e.g. bereavement groups cited as an example, but with minimal funding could be much broader) are low-cost, high-impact
  - No medical equipment needed; just trained people and a space
  - Leeds Mental Wellbeing Service received no positive feedback from participants which is damning considering how often mental health features on community's concerns; the third sector often fills this gap formally or informally

06 Key findings

1 Third sector organisations are highly trusted by local communities. They work flexibly and achieve good outcomes despite limited resources. Their existing relationships and local knowledge make them valuable partners for voice-listening work.

2 There was strong engagement and willingness to share experiences with PCP; focus groups produced rich, constructive insights. There were very few external referrals from statutory partners. All 50 survey responses were PCP-generated and the couple of healthcare-referred participants did not attend focus groups.

3 Informal social media strongly influences people's perceptions; focus groups and conversations remain important for balancing views. Online consultation is useful for volume, but not representative – face to face listening works best for depth.

4 The "Trivago effect" shows how a few negative comments can disproportionately shape public opinions (we pay more attention to one negative perspective than we do to 100 positive ones).

5 There are significant geographical concerns to address in West Leeds models of health in order especially to target those who are (a) most in need and (b) least engaging with health. West Leeds is geographically dispersed and isolated, so a single community hub model is unlikely to work completely – very little in terms of services is available in walking distance of the majority and communities are very much spread – plus more significant areas such as Bramley/Farsley/Pudsey/Calverley/Stanningley have distinct and separate identities, not to mention places like Swinnow who are 'in between' and feel neither part of Bramley nor Pudsey. Children's Centre attendance (especially after recent changes reducing from 5 to 2 centres in the area) illustrate the difficulty of moving people from one community to another and many residents want and expect service delivery in each community.

6 There are significant numbers of people without cars, and public transport is inadequate for many to move around the area due to the spoke model of buses, so a spread of service delivery points is essential. Those without cars and dependent on public transport are likely to be more deprived, more prone to multiple conditions, and less confident about self advocating.

7 There are historic concerns about being part of Leeds City Council especially from the former Pudsey borough, which may affect trust and engagement. There can be strong disparities between perception and reality – example: the belief there is nothing for young people to do vs the existence of multiple youth activities with plenty of capacity.

8 There can be a strong disparity between stated desires and actual behaviour – just because feedback is given in consultation does not entail it affecting the individual giving it – deep listening is more likely to result in discovering what would work for the individual but takes time.

9 Conversation with MHA crucial about their being underused for statutory referrals – less than 9% of last year's referrals were from statutory services such as social prescribing. Perception that the third sector is not NHS so sometimes an afterthought. Contribution towards community health of exercise (over 5000 attendances locally in a year) should be more valued as a contribution to reducing impact on health systems.

10 Work is a key problem for engaging with health – there is a widespread perception (with significant reality) that work life and looking after health are incompatible. This effect ranges from inconvenience to reducing people's self-care by avoiding or not being able to access health support outside of work times.

11 People won't engage if they don't feel valued.

07 Recommendations

Recommendations for community voice listening models and neighbourhood health for the area:

1. Resource third sector community organisation to carry out embedded voice-listening work, recognising their trust, reach and local expertise. Recent funded work with blood pressure checks and NHS Health Checks has been a useful demonstration of the effectiveness of genuine collaboration in connecting with people, especially those who do not normally engage with health systems.
2. Develop models that work across multiple neighbourhoods rather than relying on one central hub: no one-size-fits-all. A central hub will work as long as outreach connects with other communities, but it needs to be going to where people are, not expecting them to come to us.
3. Use mixed methods (focus groups and/or digital engagement and/or community outreach) to capture a balanced range of voices of both consultation and listening.
4. Embed a consistent model of community listening within neighbourhood health systems/teams – recognising this ideally should be embedded in the third sector community rather than part of the institution, in order to more effectively and inclusively listen.
5. Close the feedback loop to help participants feel their contributions are listened to (and sometimes acted on) – and consider where listening can be long term rather than one-off
6. Recognise what is Consultation vs Listening – breadth or depth. The strongest learning was that meaningful listening takes time, trust and resource. Short surveys can provide breadth, but deeper conversations are needed to understand context, barriers and what change would feel meaningful to communities.
7. Recognise the main deterrent to both effective community listening and embedded patient voice is the combination of negative previous/current experience and a negative underlying assumption perspective about being listened to
8. Recognise estate and geography issues – lack of community buildings and public transport restrictions affect even basic interaction/engagement
9. Recognise that the West Leeds area is made up of distinct local communities rather than one single neighbourhood. People often identify strongly with their own town and may not travel distance for services.
10. Third sector organisations can be relatively cheap to work with but deserve proper resourcing
    - Key recommendation: resource third sector organizations to do this work properly. Involve early in genuine coproduction not as an afterthought
11. Learn to have & tell a better story e.g. physio self-referral or FB health messaging
12. Neighbourhood health should not assume that one central hub will work for everyone. A satellite, outreach or co-location model may be needed across Pudsey, Bramley, Farsley, Swinnow and other localities.
13. Local access is important, but it is not enough on its own. Communities want services that are both nearby and efficient, with shorter waits and clearer care pathways.
14. There is scepticism about whether listening will lead to change. People are more likely to engage if there is a visible feedback loop showing what has been heard, what can change and what cannot change.

15 Trusted third sector organisations can reach people who may not respond to NHS messaging, especially those less likely to engage with formal health services.

16 Non-clinical community-based support, such as peer support and group-based support while people wait for clinical services, could help reduce pressure and improve wellbeing.

Shared learning:

No one-size-fits-all listening model:	different communities want different ways to take part, from quick digital routes to deeper face-to-face conversations.
Trust is essential:	people are more willing to speak openly through organisations and relationships they already know.
Third sector partnership is central:	community organisations can support outreach, prevention, signposting, advocacy and non-clinical wellbeing support.
Listening must be resourced:	meaningful engagement requires staff time, skilled facilitation and follow-up, not just one-off consultation.
Close the feedback loop:	communities need to know what happened as a result of their input, including honest explanations where change is not possible.
Neighbourhood health needs clear communication:	people need to understand what neighbourhood health means, what services will be available and how it will improve current problems.
Location is only one part of access:	bringing services closer to home will not solve problems if waiting times, capacity, communication and coordination do not improve.



"If I can't manage to be listened to about my current care, how likely is it that my scanning a QR code in a waiting room to give a score out of 10 is going to move the needle on local healthcare plans for the future?"