healthwatch Newcastle

Accessible Information & Health Literacy

Addressing Barriers to Accessible Health Information and Improving Health Literacy

About Healthwatch Newcastle

Healthwatch Newcastle is one of 153 local Healthwatch organisations established throughout England on 1 April 2013 under the provisions of the Health and Social Care Act, 2012.

Healthwatch Newcastle is an independent not-for-profit organisation. We are the local champion for everyone using health and social care services in the borough.

• We help people find out about local health and social care services.

• We listen to what people think of services and feed that back to those planning and running services, and the government, to help them understand what people want.

We help children, young people, and adults to have a say about social care and health services in Newcastle. This includes every part of the community, including people who sometimes struggle to be heard. We work to make sure that those who plan and run social care and health services listen to the people using their services and use this information to make services better.

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Contents

Executive Summary

Health literacy and access to clear health information are essential to understanding health information and being able to find clear, easy to use advice that helps people stay healthier and narrows the gaps in health between different groups.

Health literacy is the ability of individuals to find, understand, evaluate, and use health information and services to make informed decisions about their health and healthcare**.** Health Inequalities are unfair differences between people or groups. In health, it refers to some groups having worse health, shorter lives, or less access to care because of factors like income, education, location, disability, or ethnicity.

Key challenges include low literacy levels, with the average reading age in Newcastle between 9 and 11 years, making standard NHS communications difficult to understand. Language barriers further exclude communities in which English isn't the first language. Digital exclusion compounds these issues, as many lack internet access or the skills to use digital tools, and many health websites and documents do not meet the desired accessibility standards. The complexity of health materials, often written in jargon and technical language, remains a significant obstacle. These problems are most pronounced in deprived areas such as Walker, Byker, Elswick, and Benwell, where overlapping disadvantages worsen health inequalities.

Healthwatch Newcastle used a focus group approach to engage participants from existing groups who met the project's targeted communities. The aim of the engagement was to look at what changes could be made to reduce health inequalities in Newcastle by improving health literacy and making health information clearer, more accessible, and inclusive.

The project gathered community feedback to explore barriers to understanding and accessing health information, review existing immunisations and pharmacy materials. Also to work with professionals and stakeholders to co-develop practical recommendations that improve communication, engagement with services, and public health outcomes.

These included adults aged over 65 who experience difficulties accessing and understanding health information at GPs and pharmacies, and new mothers seeking information about childhood immunisations and vaccinations.

A seven-part questionnaire and information leaflets were used to support structured discussions and ensure participants were informed about the topics.

Six focus groups were delivered across Newcastle city by Healthwatch Newcastle with three sessions involving older adults and three involving new mothers. Speaking to 36 people in total from both groups combined. Paper-based materials were used throughout to avoid digital exclusion and enable inclusive, in-person participation.

Our Findings show that written health materials alone do not ensure understanding, particularly for people with low literacy or limited English. Although participants were highly resourceful in overcoming communication barriers, the over 65s group relied on informal networks such as family and friends, indicating that written information alone is insufficient and may shift responsibility onto personal support systems. New mothers expressed clear preferences for communication, especially text messages and post, while GPs and Health Visitors emerged as a key trusted source for questions and reassurance.

Feedback highlighted the importance of combining clear written content with verbal explanation, defined terminology, translation, interpreters, visuals, and short subtitled videos, alongside realistic messaging about service capacity. Overall, accessible, culturally sensitive, and dialogue-supported communication is essential to improve engagement, confidence, and reduce health inequalities.

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Introduction

Health literacy and accessible health information are critical to improving health outcomes and reducing inequalities. Inequalities being unfair differences in the health care some groups have access to due to factors like income, education or where they live.

The region experiences lower literacy rates, poorer health, and higher levels of disability compared to the national average, with more than one third of its population living in the 20 percent most deprived areas of England.[1] These conditions create a setting where health inequalities are more severe and where accessible health communication is especially important.

In Newcastle, several significant barriers limit people's ability to access and understand health information. A key issue is the low average reading age of the population, estimated to be between 9 and 11 years old.[2] This makes standard NHS communications, such as medical letters and guidance documents, difficult for many residents to understand.

Language barriers further complicate the situation, particularly for communities where English is not the first language. While initiatives like "English for Health" exist, they have limited reach, leaving many people without resources in their preferred language.

Digital exclusion adds another layer of difficulty. Research shows that more than 12% of Newcastle residents lack internet access or the skills needed to use digital tools. This prevents them from accessing online booking systems, health apps, and educational materials.

Even where digital resources exist, many local health websites and documents do not meet accessibility standards, with problems such as inaccessible PDFs, missing captions, and lack of alternative text for images. These gaps create further disadvantages for people with disabilities and those reliant on assistive technologies.

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1. Understanding Poverty in Newcastle | Newcastle City Council
2. How we write – NHS digital service manual

The complexity of health information itself is also a major barrier. Many NHS materials continue to use jargon and technical language that go beyond the literacy levels of a large part of the local population. However, sometimes jargon and technical language is used in healthcare settings as there is no other way to rephrase some of the terminology. Therefore, the use of common parlance (easier to understand) terms is required.

Although efforts to simplify communication and promote plain language standards are underway, progress remains slow. For example, community outreach programmes, such as health champions and local literacy initiatives, provide valuable support but are not yet extensive enough to reach all the city's vulnerable groups.

These challenges are not distributed evenly across the city. Areas of deprivation such as Walker, Byker, Elswick and Benwell experience higher levels of poor health, lower life expectancy, and greater communication barriers. In these communities, issues like low literacy, language barriers, and digital exclusion overlap, making it even harder for residents to access and act on health information.

Healthwatch Newcastle has gathered evidence through background research, engagement with local communities, and consultation with health professionals and experts, including GPs, pharmacists, the Integrated Care Board (ICB), and public health teams. The findings highlight that NHS and council materials are often complex, inconsistent, or unavailable in appropriate languages or formats. Communities such as the Bangladeshi population in Elswick, older adults, and people with low literacy levels are especially affected.

Partners spoken to prior to this project, including public health, NGPS and GPs emphasised that accessible information is particularly lacking around pharmacy advice and childhood vaccinations, where misinformation and unclear communication are influencing decisions and outcomes.

Although there are already initiatives tackling health literacy in the region, such as the Health Literacy Programme led by Health Innovation Northeast and North Cumbria, and Newcastle City Council's Community Champions programme, gaps do remain.

To achieve Newcastle's ambitions as a Marmot City in 2025, with a focus on tackling inequalities and improving public health then addressing barriers to accessible health information and health literacy must be a central priority.

Methodology

Healthwatch Newcastle used a focus group approach to recruit participants for the study, attending already established groups of local people meeting the criteria outlines in the project scope. This projects aim was to identify barriers to health literacy and access to health information in Newcastle to develop practical, evidence-based recommendations.

Healthwatch Newcastle gathered community insights through focus groups with key populations, including older adults, new mothers, and non-English speakers, exploring their understanding of health literacy, challenges in accessing information, and preferred communication methods.

The study also reviewed existing NHS and local authority materials for clarity, accessibility, language, and digital inclusion. Findings aim to inform co-developed recommendations with stakeholders and will be shared to advocate for improvements.

The intended outcomes include more accessible and inclusive health communication, increased patient understanding and engagement, improved uptake of services such as vaccinations, and progress toward reducing health inequalities in line with Newcastle's Marmot City goals. We targeted participants that were either over 65 years old or new mothers. For older people finding and understanding health information from GPs and pharmacies was discussed. Whilst for new mothers finding and understanding health information on childhood immunisations and vaccination was discussed.

Healthwatch Newcastle created a 7-part questionnaire which was taken to these groups to discuss key questions on their understanding on health information. These questionnaires were also accompanied by leaflets holding general information about pharmacies and childhood immunisations. These were also printed out as paper-copies. This was to

ensure that all potential participants were well informed about the topic of the questions, and they all could participate within the allocated time of the focus group.

The Healthwatch Newcastle conducted six focus groups in various local venues across Newcastle, three focusing on people over 65 and another three focusing on new mothers. Using paper copies of the questionnaires and printed leaflets we assisted members of the public attending these focused sessions to complete the questionnaire and have discussions.

We used paper copies of these leaflets to actively provide inclusion for anyone included in these groups and to provide less opportunity for anyone to be digitally excluded from this work. This allowed the Healthwatch Newcastle team to record all feedback as and when it came.

The engagement and data collection was undertaken within a 12-week period, extended due to 2 weeks Christmas closure, between the 3rd of November 2025, and 27th January 2026.

In total, 36 members of the public took part in the focus groups; divided into 18 new mothers and 18 people over 65 years of age.

Results and Discussion

Information from GPs and Pharmacy for aged 65+

Demographics;

Demographics being basic information about a group of people, such as their age, gender, ethnicity, income, or where they live.

The Questionnaire were sorted into the following categories:

- General Information & Demographics of the individuals.
- Understanding of Health Information of the leaflets.
- Communication Preferences of the individuals.
- Additional feedback

Demographics *for Over 65's*

18 participants took part in these focus group and 100% of participants (n=18) of these were over 65 years old. 22% (n=4) of participants were from the North of Newcastle 28% (n=5) of participants were from the Outer West, and (n=9) 50% of the participants were from the Inner west.

Geographical data showed that most participants who took part in the questionnaire resided in the Inner-West of Newcastle; post codes NE4 (50% (n=9), NE5/15 (28%, n=5 and NE3 (22%, n=4), were indicated frequently by participants who took part in these focused sessions.

Figure A is a map of all the areas which participants who completed the questionnaire from the focus groups came from:

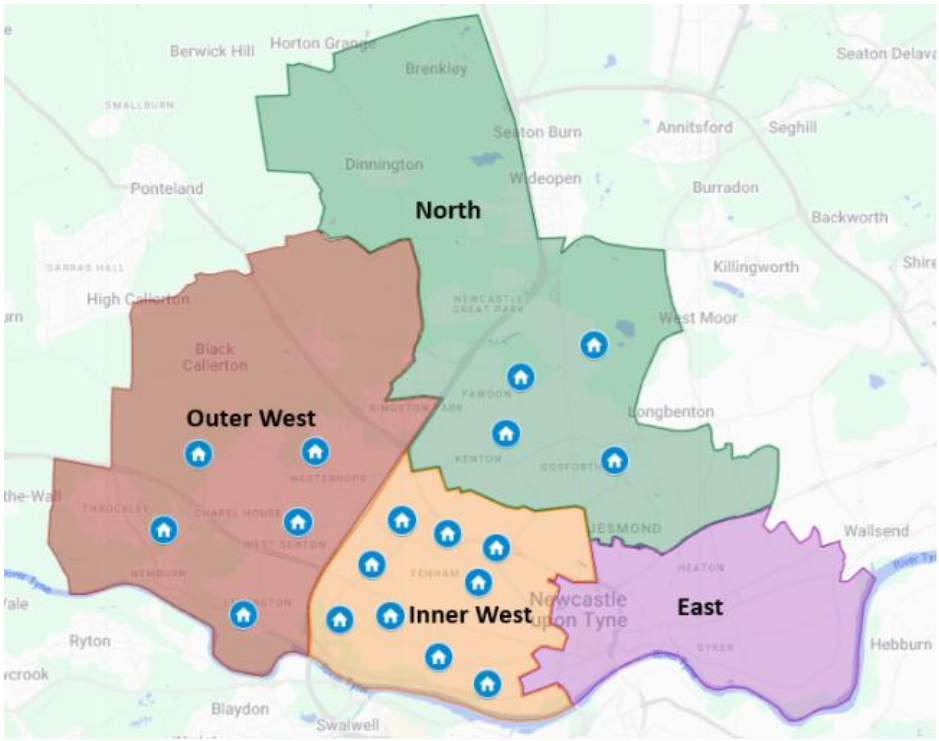


Figure A shows a heavy presence of respondents in the west of the city.

The findings from the remainer of the details about the group of people, section indicate that the majority of respondents have a relatively high-level understanding of English. Most participants reported being able to manage everyday conversations or use English easily in most situations, with over one-third describing themselves as fluent and confident.

Despite this overall strength in English, health literacy levels were more varied. While a substantial proportion of participants reported high or very high health literacy, the largest group rated their health literacy as moderate, indicating that they can manage some health information and services but still require assistance at times.

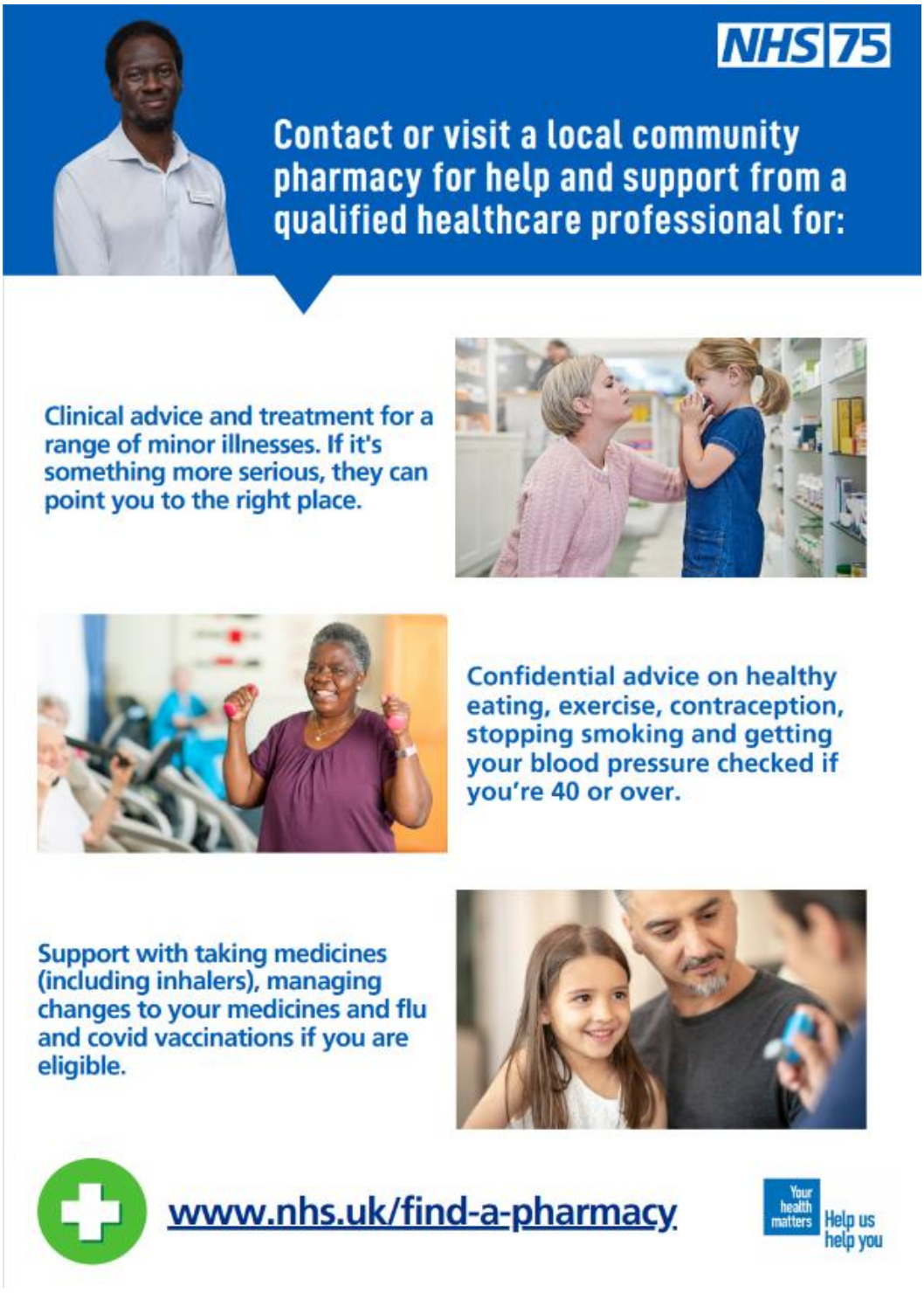
Additionally, a smaller yet noticeable proportion of respondents reported low or very low health literacy, suggesting potential challenges in understanding or using health-related information and services independently.

These findings highlight that proficiency in English does not necessarily equate to high health literacy. Even among individuals who are comfortable using English, navigating health information and communication from services can remain complex due to multiple other factors in a person's individual/unique life. This could be due to the use of technical language, unfamiliar health terms, or the complexity of medical information and how its presented by services.

Overall, the results emphasise the importance of providing health information that is clear, accessible, and supported by plain language with visual or verbal explanations. Interventions aimed at improving health outcomes should not assume high health literacy based solely on English language understanding, and additional support mechanisms may be required to ensure access to health information and services.

Feedback from the leaflet

Feedback from the leaflet for the over 65s group looking at information about pharmacies & GPs.



Overall, the findings indicate that the leaflet was largely understandable, with 16 out of 18 participants reporting that they understood the information presented. The two participants who struggled to understand the leaflet directed this difficulty primarily to low levels of reading and speaking English, highlighting the role of language proficiency in accessing written health information.

Despite the generally positive level of understanding, several important concerns were raised by participants. A key issue was the lack of clarity around the term community pharmacy, with some participants questioning whether all pharmacies fall under this category. Participants also expressed uncertainty about what consists of a minor illness and raised concerns about situations in which minor conditions may worsen into more serious health issues. This led some people to feel that the leaflet oversimplified healthcare decision-making, with one participant commenting that it trivialised the use of medicine.

There were mixed perceptions of pharmacies as healthcare settings. While one participant highlighted pharmacies as being more helpful due to the lack of appointment requirements, others questioned whether the leaflet accurately reflected real-world pharmacy practice. Concerns were raised about the claim that pharmacies offer confidential advice. Participants noted that many pharmacies have issues like small consultation rooms with a lack of privacy, and do not visibly advertise confidential services.

Additionally, time and space constraints were perceived as barriers to providing such advice consistently. The variation in services offered across different pharmacies further contributed to uncertainty, with one participant stating that *"the leaflet and reality are completely different."*

The Additional Feedback provided by participants directly reinforces the underlying logic of the Pharmacy First model. Many of the concerns raised, such as long GP waiting times, uncertainty about whether symptoms require GP or higher-level care, discomfort with navigating multiple access points (services like GPs, Accident & Emergency, NHS 111), and frustration with appointment systems, highlight the very access pressures that Pharmacy First is designed to address.

Pharmacy First is not intended to replace GP services or position pharmacies as an isolated alternative, but rather to function as an accessible first point of contact within primary care, offering timely advice, initial assessment, and appropriate onward referral, when necessary, Importantly, the emphasis should therefore be on Pharmacy First, not Pharmacy Only. This directly responds to participant anxieties about misjudging whether an illness is “minor” or “major”, as responsibility for escalation sits with the professional rather than the patient. In this context, pharmacies act as a gateway and guide within the healthcare system, helping to reduce unnecessary GP appointments while ensuring patients are not dismissed or left unsupported.

Overall, the additional feedback strengthens the case for Pharmacy First as a practical response to access challenges in primary care, provided that public-facing materials clearly explain its role as part of an integrated, patient-centred healthcare system rather than a standalone or limiting alternative to GP services.

In terms of strengths, participants identified the leaflet as a relevant and useful resource. Some felt it increased their confidence to seek advice and improved their awareness of the support pharmacists can provide. The use of colour was viewed positively, as it helped the leaflet stand out visually.

However, several weaknesses were identified. Participants suggested that including a phone number would be more helpful than relying solely on a website link. The images used were recognized by some as tokenistic, and the repeated use of the term minor illness was again criticised for placing responsibility on patients to judge the seriousness of their condition. The absence of translations for non-English speakers was highlighted as a significant limitation, potentially excluding some groups entirely. While most participants found the text size manageable, it was still noted as a minor issue.

When asked how health information could be made easier to understand, participants emphasised the need for clearer signage within pharmacies to advertise confidential advice services. Suggestions also included the availability of interpreters, offering information through alternative formats such as email, and providing an easy-read version of the leaflet with less words. The use of infographics was also recommended to improve

accessibility and engagement making the information a lot easier to understand.

Overall, while the leaflet was generally understood and viewed as relevant, the findings suggest that improvements in clarity, inclusivity, and alignment with pharmacy practices are necessary to enhance its effectiveness and integrity

New Mothers groups looking at childhood immunisations: Demographics:

Demographics being basic information about a group of people, such as their age, gender, ethnicity, income, or where they live.

The Questionnaire were sorted into the following categories:

- General Information & Demographics of the individuals.
- Understanding of Health Information of the leaflets.
- Communication Preferences of the individuals.
- Additional feedback

New mothers being defined (for the purpose of this project) as: Mothers with a child younger than 2 years old. This being the typical time childhood vaccinations are received.

Demographics *for* New Mothers

18 new mothers took part through the series of three focus groups which focused on baby immunisations. Six percent (n=1) of participants were from the North, 50% (n=9) of participants were from the Outer West, and (n=8) 44% of the participants were from the Inner west.

Geographical data showed that most participants who took part in the questionnaire resided in the West of Newcastle; post codes NE4 (44% (n=8), NE5/15 (50%, n=9) were indicated frequently by participants who took part in these focused sessions.

Figure B is an image of all the areas which participants who completed the questionnaire from the focus groups came from:

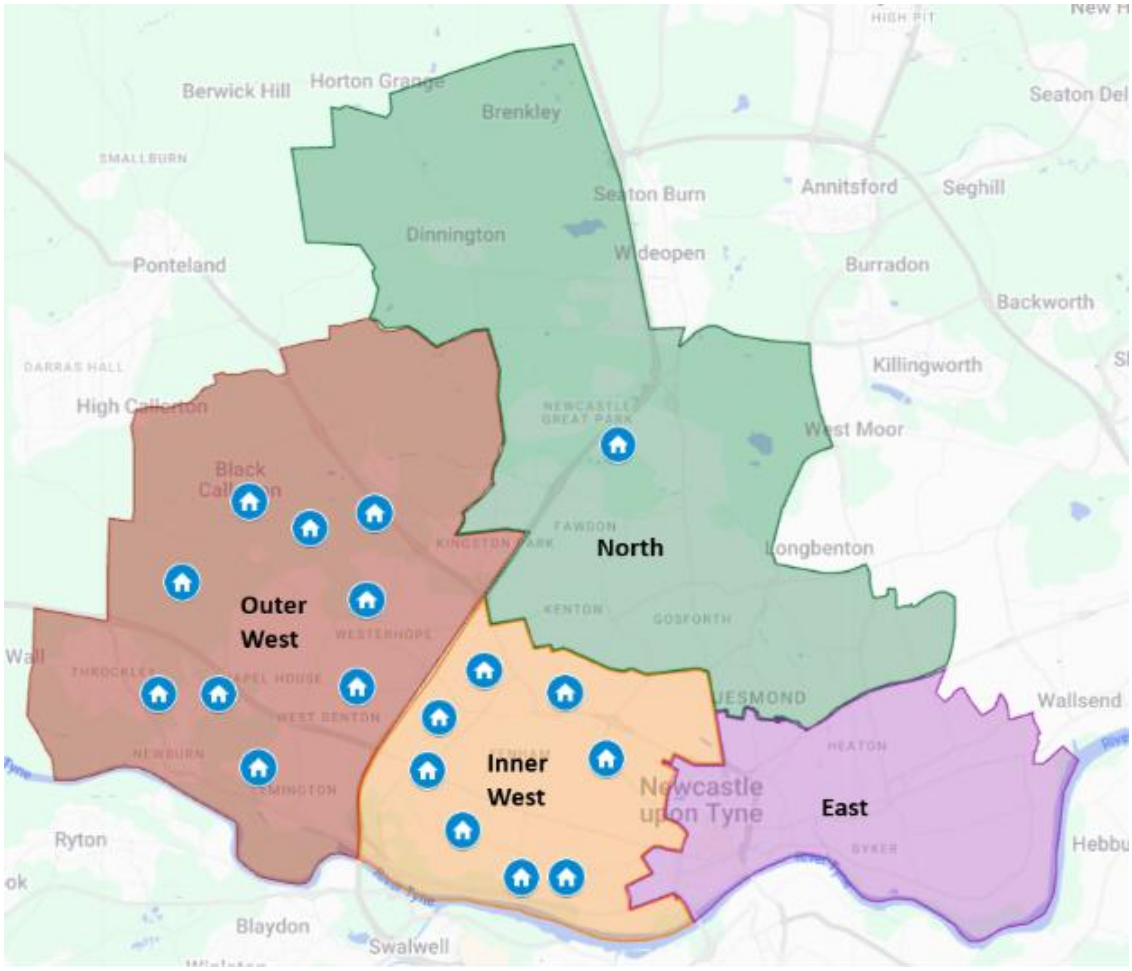


Figure B shows a heavy response from participants in the west end of the city.

Respondents demonstrated a generally high level of English language proficiency. None of the respondents reported being completely unable to understand or communicate in English. A small proportion indicated limited ability, with three respondents stating they can use some English but often require assistance. One respondent reported being able to manage everyday conversations in English. More advanced English speaking was common among the group. Two respondents indicated they can use English easily in most situations, while the majority (11 respondents) reported being fluent and confident in English.

Overall, nearly two-thirds of respondents fall into a high proficiency category, indicating that English is unlikely to be a significant barrier for most participants.

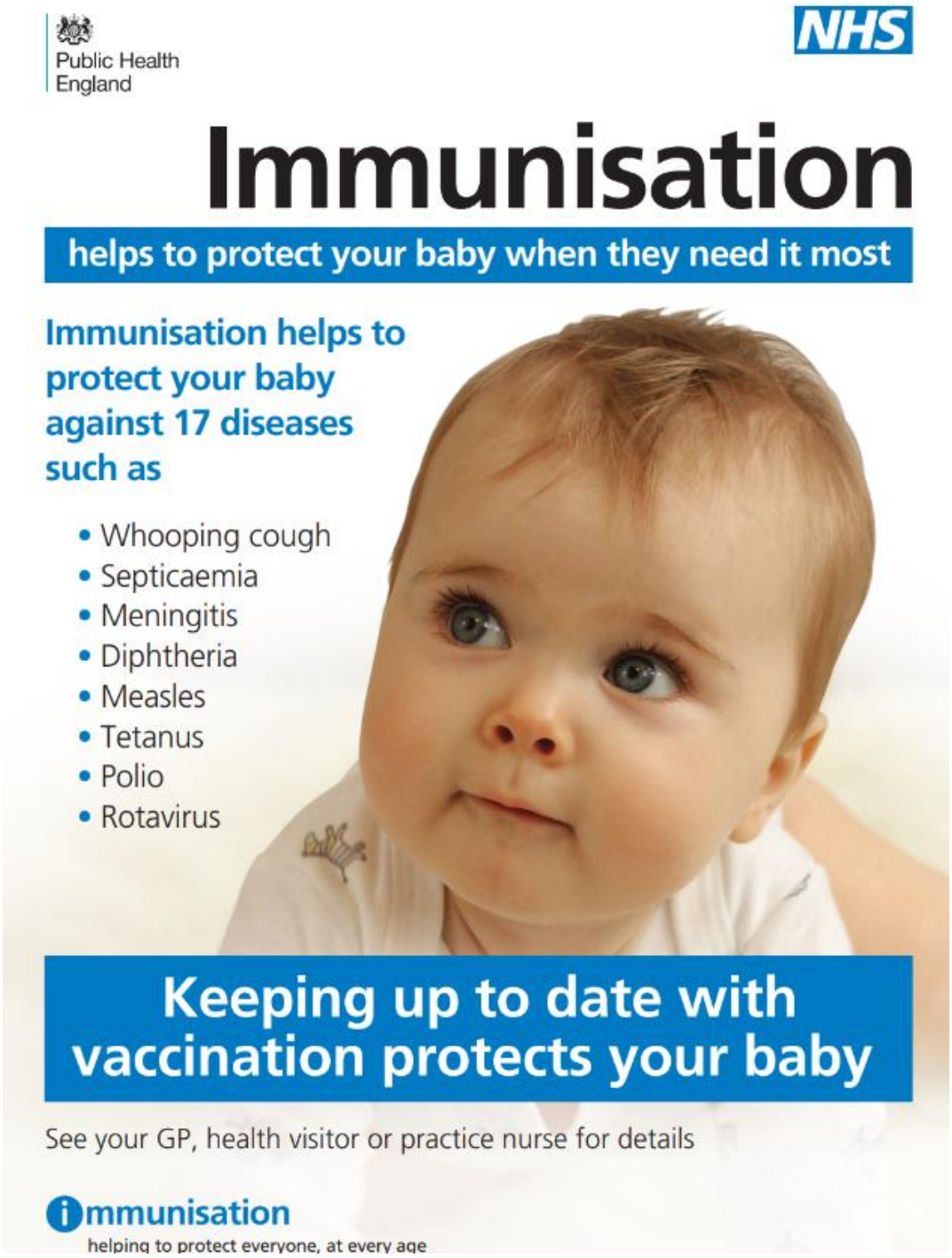
Respondents were asked where they typically obtain information about immunisations for their child. The most cited source was GPs (GP), reported by 11 respondents. Health Visitors were also a key source of information, with six respondents indicating they rely on them. Online sources, including the NHS website, were used by five respondents, highlighting the importance of digital health information. Fewer respondents reported receiving information from informal or less frequently accessed sources, such as family or friends (two respondents), nurses at baby drop-in sessions (one respondent), and midwives (one respondent). Overall, healthcare professionals remain the primary and most trusted source of immunisation information among these respondents.

From understanding health information respondents were also asked to self-assess their level of health literacy. The majority reported high levels of confidence in understanding and using health information. Seven respondents rated their health literacy as very high, indicating they always understand and use health information and services easily. A further six respondents reported a high level of health literacy, stating they usually understand and use health information independently.

A smaller proportion of respondents indicated moderate or lower levels of health literacy. Three respondents reported a moderate level, noting they can manage some health information but still require occasional support. Two respondents reported low or very low health literacy, indicating they often need help or find it very difficult to understand or use health information and services. Overall, the findings suggest that most respondents are confident health information users, though a minority may benefit from additional support.

Feedback from the leaflet

Feedback from the leaflet for the new mothers group looking at information about childhood immunisations and vaccines.



Participants were asked whether they understood the information presented on the immunisation leaflet. The majority of respondents demonstrated good understanding, with 15 out of 18 participants (83%) reporting that they understood the information provided. One participant further commented that the leaflet was *"very easy to understand."* One respondent did not answer this question on whether they understood the information presented.

Among participants who had previously rated their health literacy as very low or low, two indicated that they would prefer translated information. One of these respondents explained that they are unable to read in their native language and would therefore benefit more from having the information explained by a person rather than provided in written form. This highlights the need for alternative, non-written communication methods for some individuals.

Positive Aspects of the leaflet

Several positive features of the leaflet were identified by respondents. The use of images was frequently highlighted, with four respondents stating that the image of a baby was effective in targeting mothers with young children. One respondent noted that the image helped them immediately recognise that the leaflet was relevant to them.

Straightforwardness and ease of understanding were the most mentioned strengths. Eight respondents (44%) reported that the leaflet was easy to follow and simple. Three of these respondents specifically mentioned that the large text size and limited amount of information made it easier to read and prevented information overload.

In addition, three respondents described the leaflet as informative, particularly in explaining which diseases immunisations can prevent. One respondent also highlighted the presence of NHS and Public Health England logos, stating that these increased their confidence in the reliability and trustworthiness of the information. One respondent, who had rated their health literacy as very low, did not provide a response to this question.

Negative Aspects of the leaflet

Despite the generally positive feedback, some negative aspects were identified. Three respondents reported that the colours used on the leaflet made it difficult to read. However, this was attributed to the quality of the printed leaflets rather than the design itself.

Three respondents felt that important information was missing. Specific examples included a lack of information about the BCG (Bacillus Calmette–Guérin) vaccine for mixed-race or travelling children and a lack of content addressing common rumours or misconceptions about immunisations. Another respondent noted that while the leaflet stated immunisations protect against 17 diseases, only eight diseases were listed. They suggested including a link or QR code to access further information online.

However, most respondents (12 participants, 66%) stated that there was nothing negative about the leaflet. However, another respondent commented that while the image attracted their attention, they did not fully understand the leaflet's message without further explanation.

Suggestions to Improve Understanding of Health Information

Participants were asked whether anything else would make health information easier to understand. Three respondents suggested improved use of colours to enhance readability, noting that this may be linked to printing quality.

Four respondents expressed a desire for greater access to information in more accessible formats. Two specifically suggested the inclusion of a QR code linking to additional guidance. Other suggestions included translations into different languages, postal delivery of leaflets, a dedicated Facebook page, and braille versions of information. One respondent noted that new mothers receive a large amount of information and felt it would be helpful to have all relevant information available in one accessible place.

One respondent suggested a change in wording, recommending that the term "immunisation" be replaced with "vaccination," as individuals with limited English proficiency may not understand the term "immunisation." Three respondents did not provide an answer to this question.

The decision-Making Process Regarding Childhood Immunisations

Participants were asked about the factors that support their decision-making in relation to their child's health, particularly regarding immunisations. A key theme identified was the importance of having access to clear and understandable information. Four participants stated that having information about baby immunisations and being able to understand it helped them make informed decisions. One respondent emphasised the need for more positive information about immunisations, noting that negative information can influence parental concerns. Professional knowledge and experience also played a role in decision-making. Three respondents reported that working within the healthcare sector and having relevant education helped them feel more confident about immunisation decisions. One of these respondents additionally suggested that increased availability of helplines and accessible information sources would further support parents.

Many respondents identified multiple sources that influence their decisions. Searching for information online was commonly reported, with four respondents stating that they seek information through online sources. One respondent highlighted the importance of accessing information translated into their native language due to limited English proficiency.

Healthcare professionals were frequently asked, with seven respondents naming their GP as a source of support in decision-making; one respondent described their GP as their main and sole source of information. Other healthcare professionals were also mentioned, including health visitors (two respondents) and midwives (one respondent). In addition, three respondents reported consulting family and friends. One respondent chose not to comment on this question, and two did not provide a response.

Communication preference	Number of respondents
Post	5
Leaflet	4
GP	3
Email	2
Text	7
Online	2
Translated material	1

Concerns About the Safety of Immunisations

When asked about concerns regarding the safety of immunisations, most respondents (11 participants, 61%) reported having no concerns. Two of these respondents explained that their confidence stemmed from the fact that immunisations have been used for many years.

Five respondents indicated that they did have concerns about immunisations. Two reported concerns related to side effects they had heard about from others, while one expressed greater concern about newer immunisations compared with those that have been established for a longer time. Two respondents described having general worries as mothers but stated that discussing immunisations with healthcare professionals helped to reduce these concerns and reinforced their trust in immunisation programmes. One respondent was unable to answer this question due to limited understanding of English and a lack of awareness of immunisations.

Actions Taken When Written Health Information Is Not Understood

Participants were asked what actions they would take if they did not understand written health information provided in immunisation leaflets. The vast majority (16 respondents, 88.8%) reported that they would ask someone for help. Individuals they would consult included GPs, health visitors, nurses, family members, and friends; two respondents did not specify who they would approach.

In addition, five respondents stated that they would carry out their own research. Of these respondents, three specified that they would search for information online, while one did not clarify how they would conduct their research. One respondent reported that they would seek translation of the information into their native language. One participant did not answer this question due to limited English understanding.

Communication Preferences and Opportunities for Discussion

Participants were asked how they prefer to receive information about immunisations for their child. Responses indicated a range of preferred communication methods, highlighting the importance of offering

information through multiple formats. Postal communication was preferred by five respondents. One participant explained that receiving information by post allows them to share materials with family members and ask further questions, particularly due to lower health literacy. Another respondent noted that letters received by post feel more formal, which they prefer.

Text messaging was the most frequently selected communication method, with seven respondents indicating this as a preferred option. Other preferences included receiving information via leaflets (four respondents), through discussions with GPs (three respondents), by email (two respondents), online platforms (two respondents), and through translated materials (one respondent). These findings demonstrate varied communication needs and reinforce the importance of a mixed-method approach when sharing immunisation information.

Many respondents felt they had sufficient opportunities to ask questions and discuss any concerns about immunisations with healthcare professionals. 16 out of 18 participants (88%) responded positively to this question.

Among those who answered yes, five respondents specifically mentioned speaking with their health visitor, with one stating that they feel comfortable discussing concerns and another noting that their health visitor is particularly helpful when contacted by phone. One respondent reported having adequate opportunities to discuss immunisations with their GP, while two respondents said they could speak with a nurse. Two participants did not respond to this question; one non-response was due to limited understanding of English.

Participants were invited to share any further comments following the discussion. Suggestions primarily focused on improving accessibility and inclusivity of immunisation information. Two respondents echoed the need for translated materials in different languages. One participant suggested including a website link in the child health record that provides immunisation information with multiple accessibility options.

Two respondents recommended the development of short online videos about immunisations, with subtitles, to support understanding. One

respondent expressed feeling insecure about their decisions regarding their child's health due to influence from others, although they did not specify whether this influence came from professionals or personal networks. Another respondent reinforced the suggestion to change the terminology used in materials from "immunisation" to "vaccination," noting that this may be easier for individuals with limited English proficiency to understand.

The majority of respondents (11 out of 18) did not provide any additional comments.

Joint data discussion for both groups

Looking at Geographic Distribution

In our project scope we stated that currently we aim to hold Multiple focus groups looking at the two demographics outlined above, including the monitoring of a co-variable – non-English speakers. We propose to present what we mean by health literacy and accessible information, and how ineffective use of them can affect the health and wellbeing of the wider public. Below this was mainly captured in the north and west of the city.

Across both groups, respondents were primarily concentrated in Inner West (NE4) and Outer West (NE5/NE15) areas, with smaller representation from North Newcastle (NE3, NE13).

What each data set shows:	
Over 65s groups:	New mothers' groups:
The people Over 65 spoken to showed a broader spread across NE3 (North), NE4 (Inner West), and NE5/NE15 (Outer West), with the largest group in Inner West (NE4).	The New mothers spoken to had a stronger concentration in Inner West and Outer West, with very limited representation from the North (NE13).

Both samples reflect communities largely based in West Newcastle, suggesting findings are particularly relevant to Inner and Outer West populations.

Looking at the Age Profile (New Mothers only)

The new mothers' groups were from a younger adult population:

- Most respondents were aged 26–35 (12 respondents).
- Smaller numbers were aged 18–25 (2) and 36–45 (4).

This indicates that the second group largely represents parents of young children, which aligns with the focus on childhood immunisation information sources.

Looking at English Language Proficiency

Both groups indicate generally strong English proficiency, though the new mothers' groups suggest a higher proportion of fluent speakers.

English proficiency for both groups:	
Over 65s:	**New Mothers:**
Majority could manage everyday conversations or use English easily. A small group (2 respondents) required frequent help. No respondents reported inability to communicate in English.	A larger proportion identified as fluent and confident in English speaking (11 respondents). Fewer respondents reported needing help with English. Again, no respondents reported inability to communicate.

While English proficiency is generally high across both groups, for over 65s includes more individuals with moderate language needs, which may influence how health information is understood and accessed.

Looking at Health Literacy Levels

- Over 65s:
    - Most respondents reported moderate health literacy.
    - Smaller numbers reported high or very high literacy.
    - A minority experienced low or very low health literacy.
- New Mothers:
    - A movement towards high and very high health literacy.
    - A few respondents required help understanding health information.
    - Low and very low health literacy levels were indicted from only 2 people.

The New Mothers group demonstrates greater confidence and independence in using health services and understanding health information. This may relate to higher English fluency, younger age profile, or increased engagement with health services related to child immunisation.

A look at Overall Comparative Insights to both groups for demographics and literacy understanding.

- Both groups are geographically similar, but for new mothers is more concentrated and younger.
- English proficiency and health literacy are consistently stronger in the New Mothers.
- The over 65s includes more respondents who may require additional support, particularly in understanding health information.

  Healthcare professionals remain the key information providers, highlighting their critical role in immunisation communication.

Looking at the Overall Understanding of the Information

Both leaflets were largely understood by participants, though knowledge varied slightly depending on language ability and health literacy.

The leaflets for Community Pharmacy/Minor Illnesses: from over 65s feedback:	The leaflet for Childhood Immunisations: for the new mother's Feedback:
16 out of 18 participants understood the information.	15 out of 18 participants (83%) reported understanding the leaflet.
Those who did not understand cited low levels of spoken and written English.	One participant stated it was "very easy to understand".
Several participants who understood the leaflet still raised significant concerns about clear health information.	Participants with low or very low health literacy highlighted the need for translation or verbal explanation.
	One participant did not respond, indicating potential disengagement or difficulty. But again, this could be an assumption in understanding the leaflet.

While both leaflets achieved high levels of reported understanding from participants, The leaflet new mothers demonstrated clearer messaging overall, particularly for those with moderate to high health literacy. The leaflet given to Over 65s prompted more critical questioning, suggesting understanding did not necessarily equate to acceptance or confidence.

Looking at Language, Literacy, and Accessibility

Language barriers were a recurring theme in both groups.	
Over 65s Groups	**New mothers' groups**
In the leaflet for over 65s, limited English proficiency directly affected understanding.	In the leaflet for new mothers, participants explicitly requested the below: - Translations into other languages - Human interpreters, particularly for those unable to read even in their native language

The leaflet about childhood immunisations given to the new mother's group had feedback expressed about accessibility needs to be clearer, suggesting greater awareness of their own health literacy limitations. Both sets of participants reinforce that written materials alone are insufficient for some populations.

Looking at Strengths of the Leaflets	
Over 65 groups leaflet for Community Pharmacy:	New mothers leaflet for Childhood Immunisations:
• Relevance to participants' needs • Increased confidence in seeking advice from pharmacists • Improved awareness of pharmacy services • Use of bright colours to attract attention • Personal relevance (e.g. blood pressure concerns)	• Visual targeting: images of babies resonated with mothers • Simplicity and clarity: easy to follow, large text, minimal information overload • Informative content: clear explanation of what immunisations protect against • Trust and credibility: NHS and Public Health England logos enhanced reliability

The leaflet given for the new mother's groups were more successful in combining visual appeal, clarity, and trustworthiness, whereas the leaflet provided to people over 65s, the feedback on strengths were more experiential (confidence, access) rather than informational clarity.

Looking at the Perceived Weaknesses and Concerns of the leaflets	
Over 65 groups leaflet for Community Pharmacy:	New mothers leaflet for Childhood Immunisations:
• Lack of explanation of key terms (e.g. "community pharmacy", "minor illness") • Fear of trivialising medical conditions on the leaflet • Inconsistency between advertised services and real-life pharmacy capacity • Confidentiality concerns due to small, crowded pharmacy layouts	• Colour contrast affecting readability (linked to print quality) • Missing information (addressing vaccine rumours) • Lack of full explanation of all 17 diseases mentioned

• Lack of translation options Quotes such as *"The leaflet and reality are completely different"* highlight a gap between messaging and lived experience.	• No clear signposting (e.g. QR code or link) to further information Notably, two-thirds of respondents reported no negative aspects.

The leaflets given to the over 65s attracted questions on the trust of the information whereas the leaflet given to the new mothers attracted content-based feedback, suggesting refinement rather than fundamental redesign.

Looking at Comparative Themes

Theme	leaflet for Over 65s	Leaflet for New mothers
Overall understanding	High understanding but contested	High understanding and largely accepted
Language accessibility	Limited	Identified need for translation
Visual appeal	Colours attractive	Images highly effective
Trust	Questioned	Strengthened by NHS branding
Main limitation	Communication & realism	Missing detail & ease of access

Conclusion

In Summary:

The key findings show that health information on its own is not enough to make sure people understand it, especially those with low literacy or limited English. Participants emphasised the need for written information to be supported by clear verbal explanations and defined terms. Translated materials, interpreters, clear visuals, and trusted branding were identified as essential for improving comprehension, confidence, and credibility. Materials must also accurately reflect real service capacity to maintain trust, and leaflets should be embedded within broader, dialogue-based community engagement rather than used as standalone tools.

The communication preferences and support needs for older adults described proactive strategies to overcome unclear information, including contacting GPs or pharmacies, consulting trusted individuals, relying on family but also highlighting gaps in accessible communication. New mothers expressed diverse preferences for receiving immunisation information, with text messages and postal communication most favoured. Health Visitors emerged as a key trusted source for asking questions and reassurance. Findings underline the importance of flexible communication tailored to literacy levels and cultural contexts.

The Barriers and Recommendations for Improvement for concerns included difficulty accessing GP appointments, long waits, confusing care pathways, and challenges with telephone-only consultations, particularly for those with limited English or health literacy. Participants recommended expanded translation, interpreter access, inclusive digital resources, short, subtitled videos, clearer terminology (e.g., “vaccination”), and supportive communication. Overall, improving accessibility, clarity, and opportunities for dialogue is critical to strengthening engagement, patient understanding, and health equity.

Together, these findings highlight that effective health communication depends not only on what information is provided, but how, where, and by whom provides it. While many respondents feel confident engaging with immunisation services the broader primary care communication, for basic health information in places like, GPs, pharmacies and community venues,

remains challenging, particularly for individuals with language barriers. A flexible, inclusive, and person-centred communication approach is essential.

Recommendations

Improve clarity and transparency of healthcare access pathways

Healthcare organisations should provide clear, consistent, and easy-to-understand communication explaining who to contact, when, and for what type of care (e.g., GPs, pharmacy, NHS 111, urgent treatment centres, Accident & Emergency). This should include:

- Simple guides outlining appropriate entry points for common health needs
- Clear explanations of appointment types (face-to-face, telephone, digital), including when each is suitable
- Alternative access options for people with limited English, low health literacy, or communication needs

Communications should use plain English, visuals, and multiple formats (text, print, digital, verbal) to reduce confusion, improve trust, and support appropriate service use.

Prioritise infographic-based communication

Public health information should prioritise clear visual images, making greater use of infographics instead of text-heavy materials. Visual formats are often easier to understand for people with lower literacy levels or limited English and enable key messages to be absorbed quickly. They can also improve engagement in busy settings such as GP surgeries and pharmacies. Infographics should present essential information, service pathways, and next steps in a simple and direct way. Information should be provided in multiple formats (visual, written, digital, and verbal), with paper versions available in multiple languages. Distribution methods should include postal delivery and text messaging to maximise reach, accessibility, and inclusivity.

Focus distribution through GP surgeries as trusted access points

Given that GPs are consistently regarded by the participants as the most trusted source of health information. Because of this NHS public health materials, particularly those relating to Pharmacy First, should be distributed and prominently displayed in GP settings. Positioning resources in these trusted locations can strengthen credibility, reassure patients, and help reduce scepticism about accessing care through alternative primary care routes for example: in pharmacies or community venues.

Trusted healthcare professionals to support understanding:

Healthcare services should recognise and strengthen the role of trusted professionals, particularly Health Visitors, in supporting patient understanding of health information. Participants consistently described Health Visitors as approachable, credible, and effective at explaining complex topics in a clear and reassuring way. Services should enable these professionals to provide simplified, verbal explanations alongside written materials also ensure sufficient time for discussion and questions, and integrate them more fully into public health communication, this ultimately lessening a barrier to health care information understanding.

Clear communication of the availability of NHS translation and interpreter services

The NHS system/NHS services should visibly promote the availability of translation and interpreter services, both on its website and in patient-facing materials. Clear signposting helps ensure patients with English as a second language receive accurate information directly from healthcare professionals, rather than relying on informal translation from family or friends.

Healthcare providers must also actively verify the competence of interpreters and not rely solely on interpretation agencies for quality assurance. Interpreters should be demonstrably proficient in both English and the relevant community language, with a solid understanding of healthcare terminology. Robust checks and standards are essential to ensure accurate communication, protect patient safety, and support informed decision-making for individuals with limited English proficiency.

Emphasise ‘Pharmacy First’, not ‘Pharmacy Only’

Communication materials should clearly emphasis that Pharmacy First is an integrated part of the wider healthcare system, not a replacement for GP services. Materials should explicitly state that pharmacists are able to assess conditions, provide advice or treatment, and refer patients to GPs or other services when needed. This messaging is essential for building trust and addressing concerns that patients may be turned away or left to self-manage inappropriately.

Use clear, familiar terminology in public health communication

Healthcare organisations should prioritise the use of plain, widely understood language**,** including favouring the term *“vaccination”* over *“immunisation”* where appropriate. Participants indicated that “vaccination” is more familiar and easier to understand, while “immunisation” may feel technical or unclear, particularly for individuals with lower health literacy or limited English. Using simple, consistent terminology across leaflets, texts, digital platforms, and verbal communication can reduce confusion, support informed decision-making, and improve engagement.

Clarify the distinction between minor and major illnesses

Further work is needed to help the public distinguish between minor conditions and those that may require more urgent care. Information should move away from vague or subjective language and instead use clear, observable, or measurable indicators (e.g. duration of symptoms, severity, fever thresholds, worsening signs of illness/ condition deterioration). This approach reduces uncertainty, self-diagnosis, support informed decision-making, and align with the clinical assessment role of pharmacists within the Pharmacy First model.

Increase transparency of pharmacy services

Each community pharmacy should be encouraged to clearly display the services they provide and those they do not. This information should be easy to find both visible both in-store and online, using clear and accessible language. Transparent information would help manage public expectations, reduce confusion, and build trust enabling patients to understand what support is available locally and when referral to a GP or other service may be required.

Develop multilingual short-form video resources

Short, clear video clips should be developed to communicate key health messages, including the role of Pharmacy First and how to access services. These videos should be available in multiple languages and include subtitles to support different literacy levels. Short-form video content can improve accessibility, reduce reliance on written materials, and provide consistent, easy-to-understand information that can be shared across GP surgeries, pharmacies, NHS websites, and social media platforms.

Expanding engagement beyond healthcare services

Partners across the wider system providing services beyond the NHS, including local authorities and, Voluntary Community & Social Enterprises (VCSE) organisations, could undertake further research and engagement to understand the public's barriers to accessing information. This could include a broader range of communities experiencing inequalities to ensure a more inclusive and system-wide approach to accessible communication.

Target further engagement in underrepresented areas

Additional work could be carried out in underrepresented areas of the city, particularly the east of Newcastle, where engagement was limited in our findings. Future work should consider whether barriers such as location, timing, or running of focus groups affected participation, and adapt approaches to better reach these communities.

Co-produce communication with communities

Partners across the NHS, local authority, and VCSE sector should work more closely with communities to co-design, test, and review written and visual health and service information. This approach will help ensure materials are accessible, relevant, and culturally appropriate, supporting Newcastle's Marmot City commitment to reducing inequalities through community-led action and coproduction.

Strengthen training on health literacy and communication

The wider system could invest in ongoing training and awareness for staff on health literacy, cultural competency, and effective communication. This

could include e-learning for healthcare staff, ensuring professionals are equipped to provide clear, inclusive, and person-centred information to diverse populations.

Training Suggestion: Mandatory staff training on communicating with individuals with limited English proficiency

All Healthcare frontline and support staff should receive internal training on effective communication with individuals whose English is limited. This training should cover the use of plain language, avoidance of medical jargon, appropriate use of interpreters, culturally sensitive communication, and techniques for checking understanding without causing discomfort. Regular training would improve consistency, reduce misunderstandings, and support equitable access to services across all patient-facing settings. See related training below:

English Unlocked training: https://www.englishunlocked.co.uk/
Visit my website

English proficiency training:
https://www.lspm.org.uk/2022/news.aspx?id=12421691&CourseTitle=Communicating+with+Patients+with+Limited+English+Proficiency+in+Health+and+Social+Care+Level+3

Advanced Certificate in Communicating with Patients with Limited English Proficiency through LSBA: https://www.lsba.org.uk/Home/CourseDetail?courseId=744881

Limitations

This project was subject to several limitations that should be considered when interpreting the findings.

A key limitation was the quality and availability of printed materials. Some leaflets were poorly printed, which affected how easy they were to read, colour contrast, and overall visual impact. In addition, it is possible that not all materials were printed or displayed across settings in the same way. This means that participant feedback may have been influenced by how the material looked rather than what the information said. Because of this the

findings cannot be generalised to fully applied to professionally produced materials. This limitation relates only to the print quality and not to the official content of the NHS approved content.

The use of focus groups as the primary method of data collection presented practical challenges. While focus groups allowed for in-depth discussion and rich qualitative insights, they required significant time commitment from participants. This was particularly challenging for new mothers, who may have competing responsibilities, fatigue, or childcare constraints. As a result, participation may have been limited to those who were more available or motivated, introducing potential selection bias.

The project may have benefited from being conducted as a full questionnaire rather than relying heavily on focus groups. A survey-based approach could have reduced time demands on participants, increased response rates, and allowed for broader participation, particularly among parents who were unable to attend group discussions. This may have improved the representativeness of the sample and strengthened the generalisation of the findings

Social desirability bias happens when respondents provide answers, they think are more socially acceptable or favourable rather than saying what they truly think or do. Even in anonymous surveys, people may still feel pressure to show themselves in a good light, particularly when questions are about sensitive topics such as ethics, health behaviours, or workplace conduct. Because of this our findings may make positive behaviours seem more common and make negative behaviours seem less common. This reduces the validity of the data. The bias is especially challenging when people are asked to measure self-reported behaviours, moral attitudes, or performance evaluations.

Extreme response bias happens when someone repeatedly chooses the most extreme option on a rating scale (e.g., “strongly agree” or “strongly disagree”), no matter what the contents and context is. This usually reflects a person’s response style rather than their real opinion. It can happen for several reasons including personality, cultural factors, low attention or misunderstanding of scale gradations. This type of bias introduces inaccurate results as it exaggerates attitudes or perceptions, which can distort the overall results.

Overall, the focus groups gave us useful detail and insight, but the limitations of print quality and participant availability need to be recognised when thinking about how far the findings can be applied elsewhere. Furthermore, both types of bias are risks to the accuracy of the self-report data. They may lead people to give answers based on their answering style rather than their true views or behaviour. Because of this, the results should be interpreted carefully.

Acknowledgements

Healthwatch Newcastle would like to extend our thanks to those who participated in this project and contributed to their time to provide us with their thoughts and valuable insight during research, planning, focus groups and the completion of this project. We would also like to acknowledge the following partners and organisations in the list below for providing us with support and information we needed to complete this piece of work. Without this input we would have not been able to capture such valuable data, that helps amplify the voices of the local people, inform the public and help suggest wider system improvements.

- Newcastle City Council Public Health
- NGPS
- Elswick Practice
- Health literacy team at NENC ICB
- Search Newcastle's Gup Shup Group.
- Well-Baby and Families Group.
- Cornerstone Benwell.
- Search women's group- Asian Ladies West End Friend's.
- Nunsmoor community centre and morning baby clinic.

Partner Feedback

Feedback from Steven Carter, Programme Lead – Public Health Literacy at Newcastle City Council:

- The report reads very well and is easy to understand however in the essence of good health literacy and considering the length of the report I wonder if there is scope over time to think about how to summarise the key data, findings and recommendations as a shorter summary report, accessible slide pack or infographic for a wider audience, perhaps just 1-2 sides of A4 or a poster-style?

- Following that, it would be great to think about how to present or share the high-level findings and recommendations with key groups (we can support with this and happy to discuss) including Health and Wellbeing Board, our wider PH team, health champions/ Marmot network, Age Friendly Newcastle, Family Hubs staff, local pharmaceutical network etc, as I'm sure they will all be really interested particularly with the focus on older people, new mothers and pharmacy-specific materials.

- In terms of next steps/ recommendations:

    - Is it worth including a recommendation for the system around further engagement/ research to look at accessibility of information and services beyond NHS/ healthcare i.e. local authority and VCSE communications/ services and with wider groups facing inequalities beyond older people and new mothers?
    - Recommendation to conduct further insight work in the east of the city, recognising that it was difficult to engage focus groups from this locality? Was this down to the locations of the focus groups maybe?
    - Recommendation for partners/ wider system to better engage and consult with communities/ key groups on the development, design and impact of written and visual service information (including LA and VCSE) to ensure accessibility and understanding (as part of our Marmot City approach?)
    - Recommendation for further system-wide training, awareness and support for staff around health literacy, cultural competency and communication skills via Boost and e-learning for healthcare?

- Finally, is it possible to include examples of the questions/ surveys used with focus group attendees in the appendix i.e. how did people rate their health literacy skills and confidence etc?

Appendices

Questions asked to participants of focus groups:

Health Literacy & Accessible Information for older people at GPs and Pharmacies

1. Background

Healthwatch Newcastle are here to help make local health and care services better for you. We do this by finding out how you are experiencing these services and ultimately feeding this back to the people delivering and commissioning the services, to influence positive change based on what we have been told.

We want to celebrate services that provide outstanding care and find out where improvements might be needed. To do this, we need feedback from YOU. Tell us about your recent experiences and we can help make your voice heard!

All information collected in this survey will be anonymous, treated confidentially, and held securely in accordance with:

- Data Protection Act 2018
- General Data Protection Regulation (GDPR)

Healthwatch Newcastle will use your feedback to generate a report based on your views on how you assess the effectiveness of current service provision.

We will also use this data to ensure we are reaching all parts of the community and to identify good practice and any gaps in services.

You can see how your information will be used by accessing our privacy statement which can be found here:

Healthwatch Newcastle:

https://www.healthwatchnewcastle.org.uk/healthwatch-newcastle

Please complete this survey or if you'd like a paper version or an alternative format please email us at: info@healthwatchnewcastle.org.uk or call Healthwatch Newcastle's Freephone on 0808 178 9282. You can also text us at: Healthwatch Newcastle - 07551 052751.

2. Rationale

Health Literacy & Accessible Information for older people at GPs and Pharmacies:

This survey aims to explore the experiences of **people aged 65 and over** accessing and understanding information about health particularly to research the how they and are affected by misinformation and communications when trying to access reliable GP and Pharmacy information. The findings will help identify areas for improvement, guide decision-making, and track key performance indicators like, service use, accessibility, and outcomes.

3. General Information and Demographics

1) **What is the first part of your postcode? (e.g., NE1)**

2) **How good is your English?**

- I cannot understand or communicate in English
- I can use some English but often need help
- I can manage everyday conversations in English
- I can use English easily in most situations
- I am fluent and confident in English

4. Understanding information

Health literacy means how well a person can find, understand, and use health information to make good choices about their health.

3) **How would you rate your health literacy?**

- Very low – I find it very hard to understand or use health information and services
- Low – I often need help with health information and services
- Moderate – I can manage some health information and services but still need help sometimes
- High – I usually understand and use health and information services on my own
- Very high – I always understand and use health information and services easily

4) [provide leaflet: see Results and Discussion section – page 9]

Do you understand the information in this leaflet?

5) **What is good about this leaflet?**

6) **What is bad about this leaflet?**

7) **Is there anything that would make it easier for you to understand health information?**

5. Communication preferences

8) **If you didn't understand the written health information on leaflets given to you from your GP or Pharmacy, what would you do?**

6. Additional Feedback

9) **Is there anything else that you would like to add after today's discussion?**

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