

TECHNICAL

APPENDIX

APPENDIX A

Impact
on **Urban**
Health



TECHNICAL APPENDIX

THIS APPENDIX TO THE STATE OF URBAN HEALTH REPORT PROVIDES FURTHER DETAIL ON THE RESEARCH METHODOLOGY. IT INCLUDES:

- A.1 Quantitative research methodology**
- A.2 Qualitative research methodology**
- A.3 Facilitators' note for qualitative focus groups**
- A.4 Details on interactive dashboards**
- A.5 Note on how the data shapes the structure of the report**

A.1 Quantitative research methodology

We analysed large-scale publicly available data on demographics, health, and wider determinants to understand the broad patterns shaping urban health across England. This included more than 120 indicators (across several thematic domains: demographics, family structures & experiences, health outcomes, housing, money & resources, education, community & neighbourhood, and environment), and allowed us to see:

- Where the biggest urban–rural differences are.
- Where inequalities show up most clearly – especially by deprivation and ethnicity.
- How outcomes have changed over time.
- How some selected urban areas compare to England.

This gave us a strong view of the context in which urban health is shaped.

Of the 120 indicators, 68 indicators were included in the urban-rural analysis, and 69 indicators were used to compare six selected urban areas to the overall England rate, and to look at trends. Eleven indicators were included in both analyses.

Our analysis of quantitative data focused on:

- A comparison of means, medians, and ranges across all urban areas on the one hand, and all rural areas on the other hand. No testing for statistical significance of differences was carried out.
- A review of inequalities data for included indicators across England.
- A review of trends for included indicators which looked at England overall,

and then for selected urban areas – Lambeth and Southwark, as well as Birmingham, Leicester, Manchester, and Southampton.

- A review of comparisons between selected urban areas and England overall.

Much of the data was accessed via the Urban Health Local Insight platform (Oxford Consultants for Social Inclusion Ltd., 2025), which contains national datasets including those from the Office for National Statistics, the Department for Work and Pensions, the Office for Health Improvement and Disparities, and others. Individual datasets are cited in the reference list. Analysis of deprivation was based on the Index of Multiple Deprivation 2019 (Ministry of Housing, Communities and Local Government, 2019).

Urban-rural classification

We used the England and Wales Official Statistics Rural Urban Classification (RUC) 2021 to categorise each Middle-layer Super Output Areas (MSOAs) in England into rural or urban. This data source provides a classification of geographical areas into urban and rural based on their residential address density and population. Urban and rural categories are then split into six groups based on estimated travel time by road. However, to allow for easier comparison between rural and urban areas, our analyses do not consider the detailed groups, using only the broad urban and rural classification.

Selection of places

To identify the areas for inclusion in our analysis, we applied a set of criteria to ensure relevance and comparability:

- Core areas: Lambeth and Southwark were included as they are the primary focus of work at Impact on Urban Health.
- Deprivation levels: We targeted urban areas with similar or higher levels of deprivation compared to Lambeth and Southwark.
- Ethnic diversity: Selected areas needed to have a similar proportion of population from minoritised ethnic groups
- Geographic distribution: We aimed to include areas across different regions, covering northern, central, and southern England.
- To refine our initial selection, we applied the following exclusion criteria:
 - London and surrounding areas: Other London boroughs and areas in the immediate vicinity were excluded to avoid overrepresentation of the capital.
 - Same region exclusion: We avoided selecting multiple areas from the same region to enhance geographic diversity.

Since many areas with comparable characteristics to Lambeth and Southwark were located in central or northern England, we made a deliberate effort to identify a representative area in the south. Southampton emerged as the most suitable southern counterpart, allowing us to maintain a balanced representation across regions.

A.2 Qualitative research methodology

We also carried out primary qualitative research with people who know urban health best. We spoke with 26 residents and 21 sector partners from Lambeth and Southwark, across seven focus groups:

- Four focus groups involved sector partners including community and voluntary organisations, researchers, and advocates. They shared their perspectives on some of the key drivers of health inequities and what needs to change.
- Three focus groups involved residents, who spoke about their experiences of health, the environments they live in, and how the systems around them affect their wellbeing.

The focus groups were either online or face-to-face sessions. All focus groups were run by two external facilitators with a wealth of experience facilitating focus groups. You can read the facilitators’ methodology note in A.3.

The focus groups were designed around epistemic justice, deep listening, and co-creation. Participants set the agenda, directed the discussion, and highlighted the issues that felt most important to them.

Sampling and recruitment

Impact on Urban Health led on the recruitment of sector partners working in Lambeth and Southwark. An invitation to participate was shared with Impact on Urban Health partners. Partners had an opportunity to fill in a short survey form instead of attending focus groups, which four organisations opted to do.

The facilitators led on the recruitment of residents ensuring participants reflected a broad cross-section of the local population.

21 partners participated in four focus groups, this includes:

- five from our Children’s mental health programme
- four from our Financial foundations for adult health programme
- seven from our Health effects of air pollution programme
- three from our Children’s health and food programme
- two working with our Innovation and Policy and influencing teams.

An additional four partners completed the survey (three Children’s mental health partners; one Children’s health and food partner).

26 residents participated in three focus groups.

Sample characteristics are summarised in **Table 1 (Participant details)** opposite.

The facilitators shared session recordings and transcripts with the Impact on Urban Health team. The team used an iterative process, coding all recorded data, as well as the partners’ survey responses. From this, the data was used to develop the themes that form the structure of this report, see more in A.5.

Table 1: Participant details

| Gender | | | | Disability or long-term health condition | | | | |
|---|--|---------------------------------|-------------------------------|--|---------------|------------|-------|-------|
| Female | Male | Non-binary | Not stated | Yes | No | Not stated | | |
| 18 (69%) | 6 (23%) | 1 (4%) | 1 (4%) | 14 | 10 | 2 | | |
| Age | | | | | | | | |
| 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 65-69 | 70-74 |
| 2 | 1 | 2 | 7 | 7 | 1 | 3 | 2 | 1 |
| Ethnicity | | | | | | | | |
| Asian or Asian British, incl. Asian Caribbean - both Indian and Chinese | Black, Black British, Caribbean or African | Mixed or multiple ethnic groups | Other South American | White British | White other | | | |
| 3 | 9 | 2 | 1 | 5 | 6 | | | |
| Religion | | | | | | | | |
| Atheist/No religion | Buddhist | Christian | Hindu | Muslim | Sikh | | | |
| 7 | 2 | 11 | 1 | 4 | 1 | | | |
| How long lived in Lambeth/Southwark | | | | | | | | |
| Between 1 and 5 years | More than 5 years | More than 10 years | 25 years-40 yrs | Over 40 years | My whole life | | | |
| 3 | 8 | 1 | 2 | 1 | 11 | | | |
| Family status | | | | | | | | |
| Couple | Couple with children | Single | Single parent | Single parent with adult children | | | | |
| 4 | 8 | 9 | 4 | 1 | | | | |
| Tenancy type | | | | | | | | |
| Council or housing association tenancy | Homeowner | Living in temporary housing | Living with friends or family | Private rental | | | | |
| 9 | 10 | 1 | 3 | 3 | | | | |

A.3 Facilitators’ note for qualitative focus groups

State of Urban Health focus groups

Recruitment

We recruited participants through a broad mixture of approaches including word-of-mouth and WhatsApp referrals via local contacts; emailing Parent Panel applicants, local charities and grassroots organisations; a poster on a busy local food-truck, and social media. This outreach resulted in 235 applications for 28 available spaces.

Selection

Participants were selected based on:

- A demographic spread representative of Lambeth and Southwark on the basis of age, gender, ethnicity, religion, family type, tenancy type, and postcode.
- Indications of engagement with the discussion topics, assessed through open-text responses and follow-up phone calls where necessary.
- To guide selection, we used census data for Lambeth and Southwark to establish demographic quotas. This approach was largely successful, though three men did not respond to their selection emails. Due to demographic considerations, these places were reallocated to women.

Facilitation

Our focus group facilitation was centred on epistemic justice, deep listening, and co-creation, ensuring participants had agency in setting the agenda, directing discussions toward what was most meaningful to them regarding health and offering a diversity of modes of expression (visual, written, verbal).

Focus group activities included:

Narrative approach: Storytelling

Participants shared a two-minute story about a health-related experience in Lambeth or Southwark – something they had been involved in, told about, or observed. After sharing, each participant titled their story. We then facilitated a group discussion on which aspects of these stories the group wanted to see more or less of.

Thematic ranking and prioritisation

In the partner focus groups, participants ranked a set of ten health-related themes in order of current importance. This was followed by a group discussion exploring the priorities chosen, potential systemic connections, and the diversity of perspectives within the group.

Visualisation and mapping

In the resident focus groups, participants sketched a map of their local area, highlighting places significant to health for them. They then shared insights from this exercise. We extended this discussion by asking participants what ‘magic wand’ changes they would make and what concrete next steps they would like to see.

Systems edges: What have we missed?

Each session concluded with approximately 15 minutes for participants to specifically name and share edgier or more difficult-to-express thoughts and topics, and take some momentary accountability for areas they wished had been explored further.

Insights and recommendations

- The focus groups highlighted a strong demand for, and consistent appreciation of, being convened around this topic and invited to explore intersections. They also valued being hosted by a third party who didn’t

pretend to be neutral but aimed to invite diversity (in all senses, including diversity of thought) and deepen discussions and awareness.

- Many participants said they experienced moving and meaningful conversations about the health issues affecting themselves, their communities and families.
- Participants, especially partner organisations, expressed a desire for more opportunities to connect and be convened by Impact on Urban Health. There was also appreciation for Impact on Urban Health’s trusting approach to grantees alongside a desire for further transparency, accountability, and power sharing.
- At the same time, there was a noticeable scepticism about whether research findings would translate into real action and an impatience and urgency around these topics, particularly in the current political climate. While participants valued the discussions, they also voiced caution, wanting to see tangible outcomes from the research for their communities and expressing fear given past experiences of being ‘studied’ for third party benefit.
- We approached these focus groups through an epistemic justice lens, in essence to give participants maximum scope to set the agenda and lead the conversation toward what felt most important to them.

A.4 Details on interactive dashboards

As part of this research, we developed a set of interactive dashboards to allow anyone to explore the datasets used in this report in more detail.

This includes three core dashboards:

- Demographics in Major Urban Areas: Demographic patterns across major urban areas in England
- Outcomes in Major Urban Areas: Exploring outcomes across major urban areas in England
- Urban & Rural Differences: Exploring Outcome Disparities Between Urban and Rural Areas in England

In addition, we created five supplementary dashboards with more detail on avoidable mortality, child mortality, damp, mould and decent homes, homelessness prevention and relief duty, and temporary accommodation:

- Avoidable Mortality: Avoidable mortality in England
- Child Mortality: Child mortality in England
- Housing Conditions: Housing conditions in England: Damp & mould and Decent homes
- Homelessness: Homelessness in England and major urban areas
- Temporary Accommodation: Temporary accommodation in England and major urban areas

User guides for navigating these dashboards can be found in Appendix C.

A.5 Note on how the data shapes the structure of the report

This report combines insights from the quantitative and qualitative analysis outlined above, beginning with the findings of urban-rural quantitative analysis, followed by insights on key themes identified in the qualitative analysis.

The qualitative insights represent local voices and priorities and show how the structural conditions that shape health in urban settings are experienced in people's lives. We layered insights from the quantitative analysis, where possible, to show how these experiences align with local, regional, and national patterns of how structural conditions shape health in urban settings.

Understanding who lives in urban and rural areas, and how these places differ.

We begin with population structure and a national picture of key urban-rural differences across health, poverty, employment, housing, and neighbourhoods. These findings set the wider context for the more detailed insights that follow.

The three core insight sections are built directly from what people told us.

From the thematic analysis of the seven focus groups, three major areas emerged:

- Drivers of health equity (deprivation, racism, discrimination)
- Systems that affect health (environments, services, crucial service gaps, workforce)
- What people say would make a difference (the issues people raised most consistently and powerfully when talking about health in Lambeth and Southwark).

