COMMUNITY WELLBEING CHAMPIONS PROJECT

"HOW ARE YOU, LEICESTER?" REPORT

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1. INTRODUCTION

1.1 The Community Wellbeing Champions (CWC) Project aims to set up a network of organisations and volunteers from across the diverse communities of Leicester to:

- achieve a better understanding of the needs of, and barriers faced by, residents, particularly those most affected by poor health and wellbeing, and
- use these insights and relationships to help address health inequities and reduce avoidable inequalities.

1.2 To help launch the CWC Project to the public and get our community engagement underway, a short, opening engagement survey called "How Are You, Leicester?" was created. This takes the form of a brief survey, asking:

- quantitative questions ranking individuals' physical and mental health before and after the pandemic, and
- qualitative, dialogue-opening questions about perceived health and wellbeing issues faced by individuals and their communities, barriers to better health, and changes they would like to see take place to address these.

1.3 The aim of the consultation was to gain responses from a representative sample of over 16s from across Leicester, with a specific focus on making the survey accessible to groups such as refugees and asylum seekers, the elderly, those with disabilities, the homeless, and those who are digitally excluded. Therefore, local organisations working with the aforementioned groups within Leicester were contacted regarding the possibility of in-person focus groups, facilitating the completion of the survey.

1.4 385 responses were collected as of 5th August 2022 via a variety of both in-person and online methods as outlined in the following chapter.

1.5 The report starts to explore whether changes in health and wellbeing due to the pandemic are experienced differently amongst different community groups (such as cultural, area, age, ability/disability, and sexual orientation), as well as identifying

common health and wellbeing issues and barriers to good health and wellbeing amongst communities to aid future engagement. This allows for the implementation of methods that follow the principle of proportionate universalism, the concept of delivering universal services at a scale and intensity proportionate to the need of the specific population groups.

2. METHODOLOGY

2.1 Recruiting Participants:

2.1.1 The focus of the survey relates to health and wellbeing generally in Leicester, from a broad cross-section of the city and its various demographic groups and communities. Therefore, besides ensuring that respondents lived or worked in the Leicester area, there was little need for exclusions when recruiting participants.

2.1.2 However, there is more control over these factors when recruiting participants via in-person surveying or focus groups, as their location can be gathered through conversation, whereas via online means, respondents of any location can complete the survey. However, to limit the impact of this, social media pages and organisations that operate solely within Leicester were prioritised to promote and facilitate the completion of the survey online.

2.1.3 Whilst generally targeting Leicester residents as a whole, specific emphasis was placed on hearing from a number of different groups who are not often reached by similar surveys, namely Asylum Seekers and Refugees, the Elderly, The Homeless, those with physical disabilities, and traveller communities. After the launch of the consultation and evaluation of the first round of results, those from South Asian ethnic groups, as well as young people in general were added to these target groups due to low initial uptake.

2.2 Ethics:

2.2.1 As the survey contains sensitive subject matter including individual's mental and physical health, disability, ethnicity, and sexual orientation, as well as many of the emotions and feelings associated with inequities and bad health being negative, empathy and respect towards respondents' experiences and views was always given.

2.2.2 Individuals were also given the option to complete the survey themselves or by vocalising their answers to the Public Health team members present. This both provides the option for additional confidentiality, as well as offering extra assistance for those who need or want it.

2.2.3 It was also made clear to participants that their data would remain private and confidential. To ensure this, the data was stored on consultations.leicester.gov, with only those with a password able to access the data reports. Completed paper surveys were also disposed of in a confidential waste bin after data were inputted.

2.3 Survey design:

2.3.1 The survey incorporates both qualitative and quantitative methods throughout. The quantitative methods involve tick boxes, and Likert scale questions to collect measurable data on health and wellbeing in Leicester, while the qualitative methods consist of open box questions aim to delve deeper into the reasons/causes behind the quantitative responses as well as inequities between different areas and communities in the city.

2.3.2 The Qualitative questions were then coded into themes in which they closest related to, and then counted to analyse the most frequent themes for each qualitative question.

3. RESULTS

3.1 Survey Demographics

3.1.1 Ethnicity:

a. 53% of those surveyed identified as White British, followed by 18.7% as Indian. This is somewhat reflective of the population of Leicester; however, this figure is lower than the percentage of Indians in Leicester of around 25%.

b. These two groups formed most respondents, with White European groups being the next highest percentage at 3.9%, somewhat expected given large Polish, Romanian, and other Slavic communities in Leicester, which make up 4.6% of the city's population. The white British majority is slightly higher than the actual percentage of white British in the city (45%).

c. There were 0 respondents from a gypsy/traveller background, making them a possible underrepresented group to target for future engagement. However, reaching out to traveller community groups in Leicester provided a challenge when promoting the survey.

d. There were also fewer Bangladeshi, (1.3%), and Pakistani, (2.3%) respondents than expected.

Option	Total	Percent
Asian or Asian British: Bangladeshi	5	1.30%
Asian or Asian British: Indian	72	18.70%
Asian or Asian British: Pakistani	9	2.34%
Asian or Asian British: Any other Asian background	2	0.52%
Black or Black British: African	7	1.82%
Black or Black British: Caribbean	5	1.30%
Black or Black British: Somali	3	0.78%
Black or Black British: Any other Black background	3	0.78%
Chinese	1	0.26%
Chinese: Any other Chinese background	1	0.26%
Dual/Multiple Heritage: White & Asian	4	1.04%
Dual/Multiple Heritage: White & Black African	1	0.26%
Dual/Multiple Heritage: White & Black Caribbean	1	0.26%
Dual/Multiple Heritage: Any other heritage background	2	0.52%
White: British	204	52.99%
White: European	15	3.90%
White: Irish	8	2.08%
White: Any other White background	4	1.04%
Other ethnic group: Gypsy/Romany/Irish Traveller	0	0.00%
Other ethnic group: Any other ethnic group	7	1.82%
Prefer not to say	16	4.16%
Not Answered	15	3.90%

Fig.1

3.1.2 Age:

a. The most common group surveyed were 46-55, with 21%. Only 4.2% of respondents were under 25 in age, compared to 38% of the population being below 24 in 2015, suggesting more work needs to be done to accurately target the younger population of Leicester.

b. Measures were taken to attempt this, such as trying to arrange in person focus groups at local colleges and Universities, however the time of year of the survey, (late spring-summer), resulted in this having little success.

3.1.3 Sexual Orientation:

a. 79.7% of respondents identified as straight, 3.9% as gay/lesbian, and 4.2% as bisexual.

b. While it is hard to measure the representativeness of this data as the 2011 census does not ask for sexuality, this data does not show a clear disparity between expected and actual percentages with regards to sexual orientation.

3.1.4 Disability:

a. 24.9% of respondents reported having a disability, slightly higher than the national figure of 18%, as well as the Leicester 2017 mid-year estimate where 17% reported that their daily activities were limited either a little or lot by a disability. Therefore, there was no issue with those with disabilities being underrepresented, (NHS Trust 2017).

b. Of those surveyed, 12% reported suffering from a mental health condition.

3.1.5 Religion:

a. In terms of religious beliefs, Christianity was the most common with 32%, with no religion and atheist combined having 28.6%, Hindu 7.8%, Muslim 13.8%, Sikh 2.9%, and 3.9% belonging to other religious groups.

b. In Leicester as a whole, Christians are 33% of the population, Muslims 19%, and Hindus 15%, therefore Hindus and Muslims can be said to be lightly underrepresented. 23% claim no religious affiliation, less than the 28.6% in our survey.

Option	Total	Percent
Atheist	35	9.09%
Bahai	0	0.00%
Buddhist	2	0.52%
Christian	123	31.95%
Hindu	30	7.79%
Jain	0	0.00%
Jewish	0	0.00%
Muslim	53	13.77%
Sikh	11	2.86%
No religion	75	19.48%
Prefer not to say	22	5.71%
Other	15	3.90%
Not Answered	19	4.94%

Fig.2

3.1.6 Gender:

a. 62.1% of those surveyed identified as Female, with 29.9% identifying as male, and the rest either preferring not to say or not answering, suggesting males were underrepresented in the results.

b. In terms of gender identity, 72.2% answered that their gender identity is the same as birth, and 1.6% answering no, and the rest answering neither yes nor no.

3.2 Results

3.2.1 Health and Wellbeing before and after the start of the pandemic:

a. There were 385 responses to the first quantitative question, Question 2, which asks: *"How good would you say your physical health and wellbeing is at the present time (with 1 being very poor and 10 being very good)".* The most common response was 7/10, therefore a favourable view on their current physical health, with 19.7% of respondents, followed by 16.4% selecting 8, and 13.8% selecting 6. The least commonly selected responses were 1, (3.6%), 2, (4.2%) and 3 and 4 respectively, (both 6%). This suggests that most respondents felt more favourably than unfavourably about their current physical health. However, the slightly favourable responses were considerably more common than very favourable, with the 3 modal responses being 7, 8 and 6.

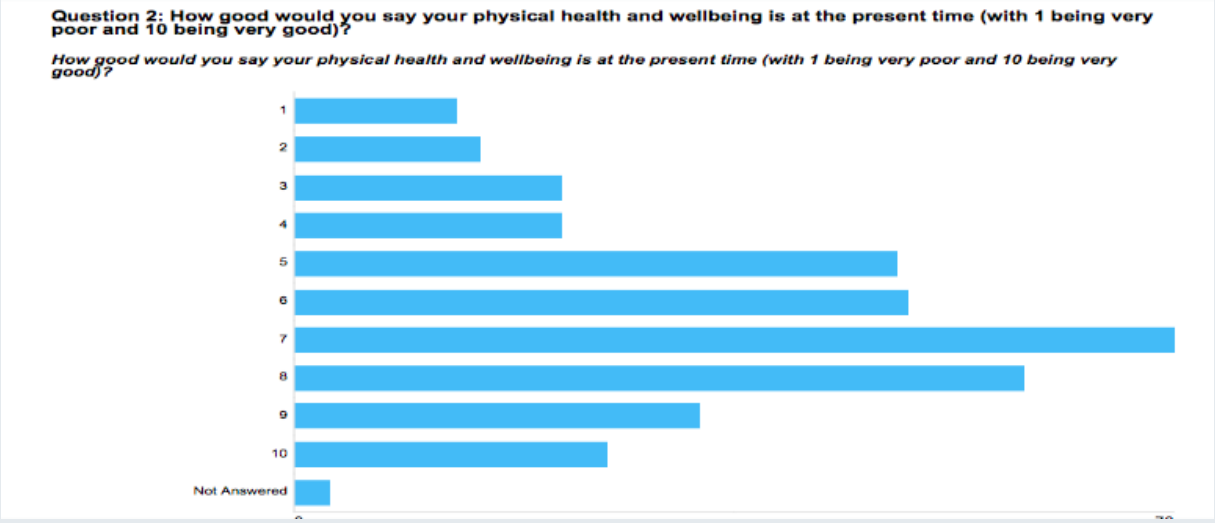

Fig.3

b. There were 385 responses to Question 5, which asks, *"How good would you say your mental health and wellbeing is at the present time (with 1 being very poor and 10 being very good)".* The most common responses were 7, (17.4%), 8, (13.8%), and 5, (12.5%), with the least common responses being 1, (3.4%), 2, (4.2%), and 3, (7.3%). This suggests that the most common feeling amongst those surveyed was to feel 'fairly good' about their current mental health, with a good proportion also feeling neutral. However, there was a wider range of commonly selected responses than question 2 which explores *physical* health at the present time, with all responses ranging from 5-10 receiving at least a 10% share of selection, compared only responses 5-8 in question 2. This suggests respondents' perceptions of their current mental health were more varied than perceptions of their current physical health, with very good options (9-10), receiving a higher share of responses suggesting more people felt very good about their current mental health than physical.

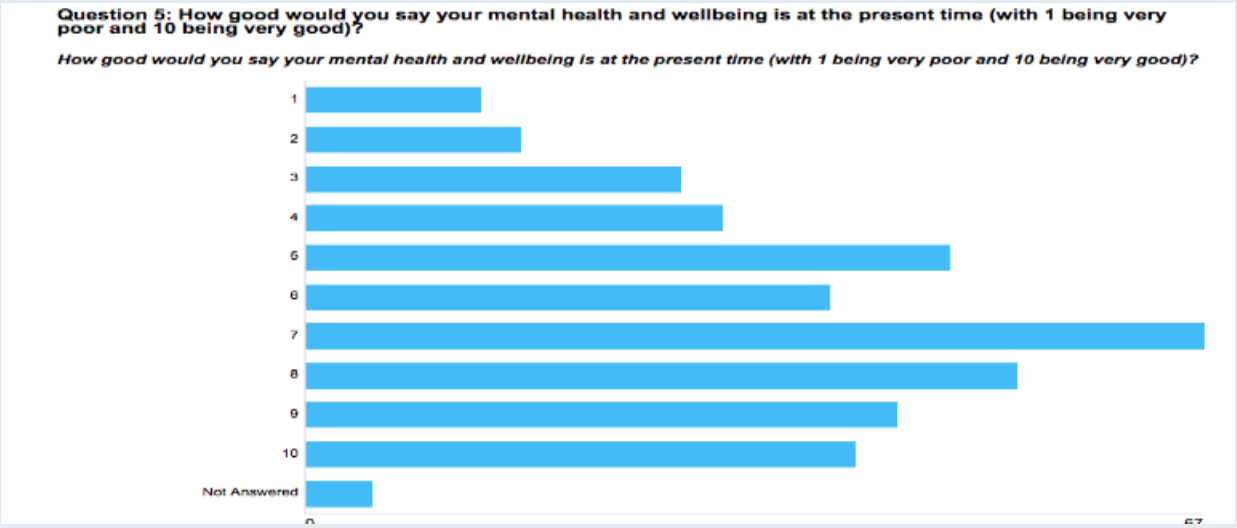

Fig.4

c. There were 385 responses to Question 3, which asks: "*Thinking about your physical health and wellbeing before the pandemic, how good would you say it was at that time (with 1 being very poor and 10 being very good)".* The most common response was 8, (24.7%), followed by 9, (20.5%), and 7, (15%), with the least common responses being 1, (1%), 2, (2.3%), and 3, (3.1%). This suggests a mostly favourable opinion of individuals surveyed perception of their physical health and wellbeing before the pandemic. As the most common responses were further along the scale than question 2, it can be inferred that despite the public's perception of their physical health and wellbeing being favourable, it is less favourable than before the pandemic, making it possible to argue that people's perception of their physical health has declined since the start of the pandemic.

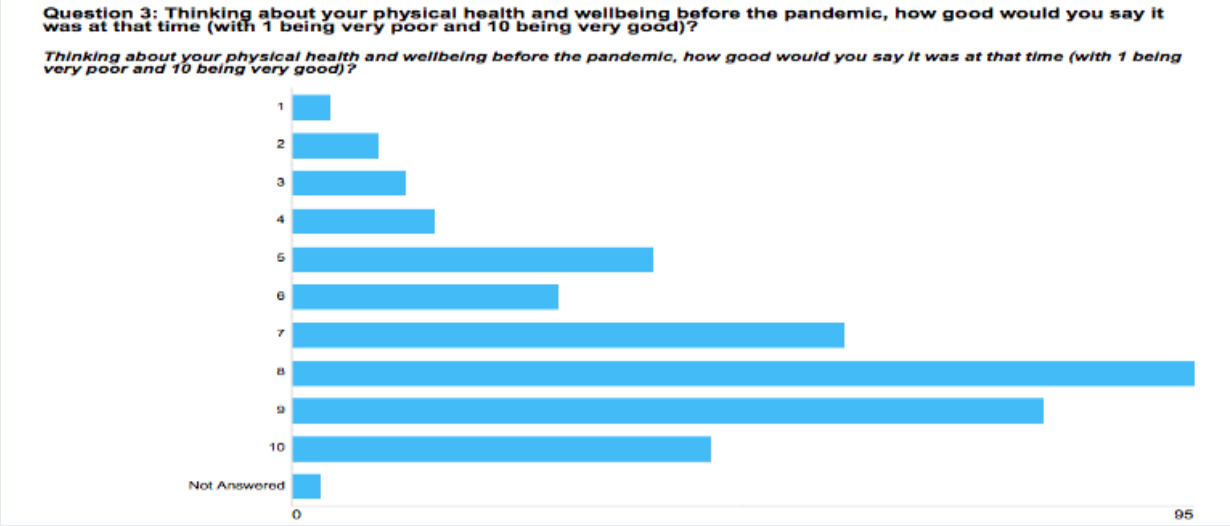

Fig.5

d. Question 6, also with 385 responses, asks, *"Thinking about your mental health and wellbeing before the pandemic, how good would you say it was at that time (with 1 being very poor and 10 being very good)".* The most selected responses were 8, (23.9%), 9, (20.3%), and 10, (15.3%), with the least being 1, (1.6%), 2, (2.3%), and 3, (3.1%). This suggests a trend towards public perception that individuals feel that their mental health was very good before the pandemic, with the 3 most favourable answers being the 3 most selected, and the 3 least favourable answers being the least selected. This also suggests that those surveyed in Leicester found their mental health to be better pre pandemic than post pandemic, despite the post pandemic results still being mostly favourable, just less strongly than the pre pandemic results. These results show a similar trend amongst physical and mental health in Leicester pre and post pandemic, and in another similarity, 8 and 9 were most selected in both mental and physical health levels pre pandemic. However, 10 was the third most common response for mental health, suggesting the trend is stronger in relation to mental health than physical.

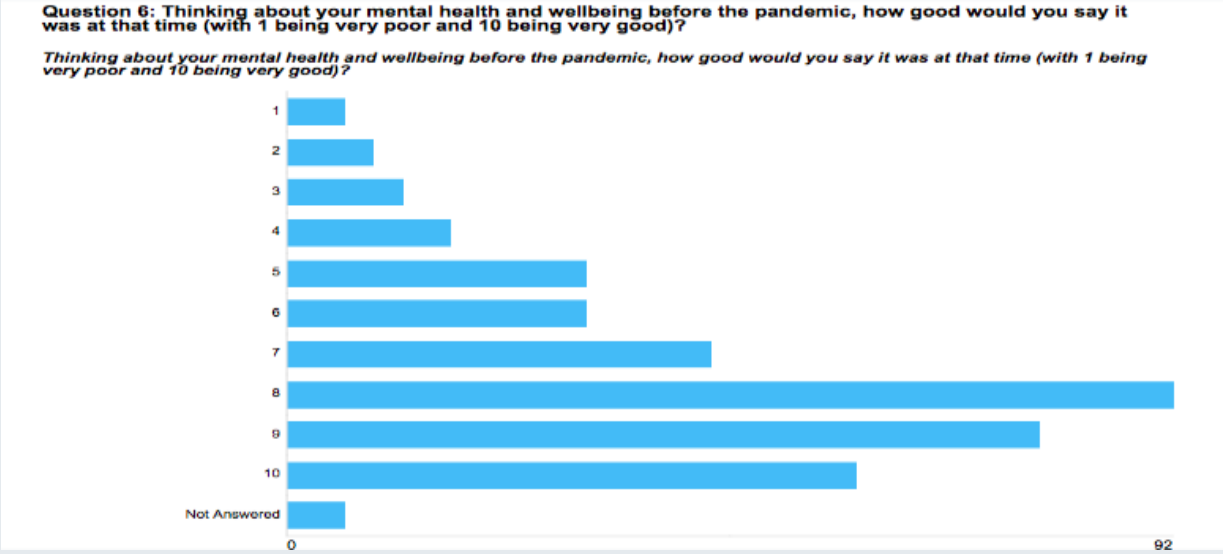

Fig.6

3.2.2 Comparing factors influencing physical and mental health:

a. Question 4 asks: "*Which of the following would you say affects your physical health and wellbeing? Please tick all that apply (with the options being* Environment, Finances, Access to healthcare, Social Isolation, Employment, Education)*".* The most selected responses, therefore the factors the sample size in the city of Leicester felt were most influential on physical health were Environment, (55.8%), Access to Healthcare, (49.7%), and Finances, (49%), with education considerably the least commonly selected option, (10.1%). The open-ended "other, specify" option for this question discovered that the most common "other" factors influencing physical health were Age and Disability (both with 9 responses), and Access to Fitness with 7 responses.

Option	Total	Percent
Environment	215	55.84%
Finances	189	49.09%
Access to healthcare	191	49.61%
Social Isolation	123	31.95%
Employment	130	33.77%
Education	39	10.13%
Not Answered	29	7.53%

Fig.7

b. Question 7 asks "*Which of the following would you say affects your mental health and wellbeing? Please tick all that apply (with the options being* Environment, Finances, Access to healthcare, Social Isolation, Employment, Education)*".* Finances, (54.3%) Environment, (54%) and Access to Healthcare, (47.3%), were the most selected responses, with education again the least selected, (11.2%). The open-ended "other, specify" option, found Both the three most selected responses, and the least commonly selected response was seen to be shared amongst both physical and mental health, however the main factor impacting mental health was instead found to be finances, compared to the environment being perceived as the main

factor impacting respondents' physical health. Education was found to have little perceived impact on neither mental nor physical health, despite the role education may play in spreading awareness on both a healthy diet and exercise regimen, as well as awareness of how to better ones' mental health and/or access help.

Option	Total	Percent
Environment	208	54.03%
Finances	209	54.29%
Access to healthcare	182	47.27%
Social Isolation	163	42.34%
Employment	143	37.14%
Education	44	11.43%
Not Answered	43	11.17%

Fig. 8

3.2.3 Main Health and Wellbeing issues in communities:

a. Respondents were also asked the Qualitative question, "Thinking about your community (or communities), what would you say are the health and wellbeing needs or issues that affect them the most?", to explore in more detail the main issues affecting not just the individuals themselves, but the wider communities to which they belong. These responses were then coded into the following themes: Access to Healthcare, Housing, Finances Access to Education, Access to Employment, Isolation, Access to Services, COVID, Discrimination, Anti-Social Behaviour, Crime, Mental Health, Cultural Barriers, Political Issues, Poverty, Digital Exclusion, Physical Health, Transport, Housing, and Other.

b. The most common issue was disproportionately found to be Access to Healthcare, with 114 responses, followed by Access to Services, (57), Finances, (56), Environment, (47), and Isolation, (45). Responses coded as "Access to healthcare", commonly related to GP access, especially about gaining telephone appointments and the waiting times involved post pandemic. Access to Services relates to both the quality, accessibility, and existence of non-healthcare related services such as gyms, community centres, and voluntary organisations for their communities. Finances relates to financial concerns and issues such as the cost-of-living crisis, but not poverty which was coded separately. Environment relates to the physical environment and issues such as littering as well as wider environmental issues.

3.2.4 Changes to address the main issues in communities:

a. Following up from this, respondents were then asked, "Thinking about the things you've talked about in the previous questions, what changes might help to make things better for you and your community's health and wellbeing?", to give those from within communities themselves the chance to identify possible solutions to mitigate the health and wellbeing issues present currently. The themes are as follows: Access to Healthcare, Housing, Finances Access to Education, Access to Employment, Isolation, Access to Services, COVID,

Discrimination, Anti-Social Behaviour, Crime, Mental Health, Cultural Barriers, Political Issues, Poverty, Digital Exclusion, Physical Health, Transport, Housing, and Other.

b. The most common theme was again relating to Access to Healthcare, (100), followed by Access to Services, (74), and Environment, (46). This suggests that the main solutions to health and wellbeing issues in communities surveyed currently relate to improving Access to Healthcare, Services, and improving the physical environment of the city

3.2.5 Survey Accessibility:

a. Respondents were asked to rank the ease of completing the survey from 1 star to 5 stars. 4.4% rated the survey 1 star, with 2.1% responding 2 stars, 10.4% 3 stars, 17.9% 4 stars, and 61.3% selecting 5 stars. This shows a majority found the survey accessible. However, a sizeable minority (16.9%), rated the survey 3 stars or below.

4.CONCLUSION

4.1 In conclusion, while the results of the survey showed a general trend towards good levels of both physical and mental health in the Leicester, with the most common responses being 7,8 and 6 for physical health, and 7, 8 and 5 for mental health, when ranking their physical and mental health at the present time out of 10, the data also shows that present levels of health and wellbeing are lower than pre-pandemic levels. This is shown as the modal results for perceived individual pre-pandemic physical health were 8,9 and 7, and pre-pandemic mental health 8, 9, and 10. Therefore we can conclude that while individuals' own perceived health and wellbeing levels in Leicester are not low, they are on the decline when compared with pre COVID-19 levels.

4.2 Another interesting finding is that respondents' perceptions of their mental health at the present time were more varied than the perceptions of their physical health at the present time, shown by a wider range of commonly selected responses, with all responses ranging from 5-10 for mental health receiving at least a 10% share of selection, compared to only responses 5-8 in for physical health. The "very good" options (9-10), received a higher share of responses for mental health also, suggesting more people felt very good about their current mental health than physical.

4.3 The main factors influencing individual physical health were found to be Environment, Access to Healthcare, and Finances, with the main factors influencing individual mental health being Finances, Access to Healthcare, and Environment, when respondents were presented with a tick-box list of potential factors. However, when respondents were asked to list the main health and wellbeing issues affecting their wider communities, and these responses were coded into themes, the most frequently appearing theme was disproportionately found to be

Access to Healthcare, with 114 responses, followed by Access to Services, (57), Finances, (56), Environment, (47), and Isolation, (45).

4.4 When asked what changes they would like to see to address these health and wellbeing issues in their communities, the most common theme was again relating to Access to Healthcare, (100), followed by Access to Services, (74), and Environment, (46). This suggests that while the most common physical health issues affecting individuals are environmental (e.g. access to green spaces, transport accessibility, and gym accessibility), and the most common mental health issues affecting individuals being financial factors (e.g. poverty, cost of living crisis, unemployment), the most common issues affecting communities according to respondents was a lack of access to healthcare, with issues such as GP waiting times, the trend towards online appointments replacing face-to-face, and difficulty getting through to GP's on the phone being frequently stated issues.

4.5 Improving communities' access to healthcare was also the modal theme when respondents were asked how the issues could be addressed, (100), followed by Access to Services, (74), and Environment, (46). This suggests that the most immediate issues needing to be addressed in communities should revolve around making access to healthcare services, including mental health services, easier, as well as signposting wider services, events, and support networks.

4.6 However, since the start of the survey, the cost-of-living crisis has worsened, and financial concerns were already a commonly occurring theme, therefore financial support is increasingly relevant.

5.REFERENCES

NHS Trust. 2017. [online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2019/10/University_Hospitals_of_Leicester_NHS_Trust_Annual_Report_and_Accounts_2018-19.pdf> [Accessed 10 August 2022].