Impact on Urban Health

Health & Wellbeing in Lambeth & Southwark: Insights from Local Communities

July 2024

Contents

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We work best with organisations who give a damn and want to make a genuine impact.

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Impact on Urban Health

At **Impact on Urban Health,** we collaborate with partners and share what we learn to build health equity for people in Lambeth& Southwark and beyond.

Poor health, poverty and racism are deeply connected. Poverty causes bad health and bad health worsens poverty. Racism means minoritised communities are more likely to be living in poverty and have poor health as a result. We see these connections most starkly in urban areas where poverty and affluence sit side by side. People living just streets apart can be worlds apart in their health.

This is why we focus on urban health. We believe cities are the best places to find ways to break these links.

To increase our understanding and offer solutions with long-term potential, we focus on a specific set of urban health issues as routes into the challenge. These are: children's health and food, children's mental health, health effects of air pollution, financial foundations for adult health.

https://urbanhealth.org.uk/

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We would like to thank Michael Rigby, Claire Diamond, Nikola Duncanova, Jenny Steele, Ben Whitman and Robin Minchom from Impact on Urban Health for their support throughout this research project.

We would also like to thank representatives of Southwark and Lambeth Councils who fed into the workshop content during phase one.

Most of all, we extend our appreciation and thanks to the community researchers who have been instrumental in shaping this project, and who have shared their valuable lived experiences to co-create this research into health inequalities in Lambeth and Southwark.

1. Project background

Background

Health inequality can be defined as "avoidable, unfair and systematic differences in health between different groups of people"[1]. Health inequality is often researched to understand how health outcomes and care varies across society. To make health inequalities more comprehensible, they are often broken down into four categories:

- Socio-economic
- Geographic
- Protected characteristics, e.g. gender and ethnicity
- Socially excluded groups, e.g. those who experience homelessness, refugees and asylum seekers, those who have been through the criminal justice system etc

These factors are often linked to wider health determinants. NHS England refers to these as the conditions within which an individual lives, grows, works and ages. They are non-medical factors that have the power to impact health and wellbeing[2]. Also known as social determinants of health (SDH), research shows that these can be more important than healthcare or lifestyle choices in influencing health. For example, numerous studies suggest that SDH accounts for between 30-55% of health outcomes.

Our Approach

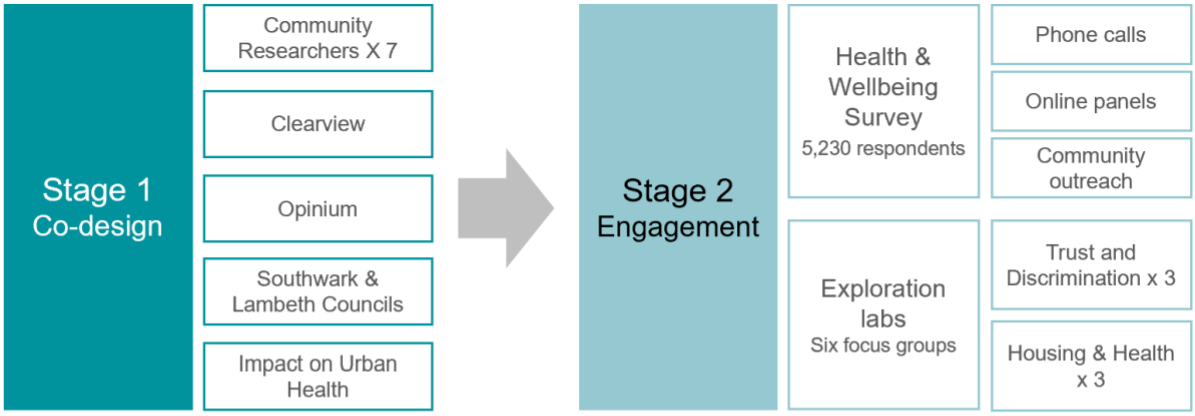
This project was delivered in partnership with Opinium who were responsible for the quantitative aspect of this study, whilst ClearView Research (CVR) were responsible for the qualitative research. Impact on Urban Health, as funders for this project, were involved throughout. This research study to learn more about health inequalities and their link to wider determinants of health consisted of two phases:

- The first phase focused on recruiting and training a co-creation group of seven residents of Southwark and Lambeth in co-designing the priority areas in relation to learn more about health inequalities. The co-creation group was recruited from Lambeth and Southwark with a focus on membership that reflected different protected characteristics in order to ensure a wider representation of voices and experiences. In this phase the group, along with representatives from Southwark and Lambeth Councils, fed into the quantitative survey design and the qualitative themes for exploration
- The second phase focused on the two themes: lack of trust and discrimination in healthcare, and poor-quality housing and its impact on health. These themes were chosen after exploring various SDH related to health inequalities, based on the experiences of the co-creation group. Amongst the many SDH mentioned, we focused on those areas where the group had more collective experiences, where the research from the desk review aligned with these themes, and finally where the priorities of Impact on Urban Health were also taken into consideration, given previous research themes that had already been explored. We undertook six exploration labs with residents, to qualitatively explore lived experiences around the two themes. In this phase, the co-creation group helped to design the structure of the discussion guides that were used in the labs. The co-created quantitative survey was

[1] https://www.kingsfund.org.uk/publications/what-are-health-inequalities

[2] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/what-are-healthcare-inequalities/

conducted in parallel, between June and October 2023. The methods used included telephone and online surveys, and others completed through face-to-face community outreach.



A co-creation group made up of **local partners** and seven trained **community researchers** led on both the **survey design** and the **selection of themes** to be explored in more detail

A mixed methods approach to understand health & wellbeing was undertaken within Lambeth & Southwark:

Quant: A detailed Health & Wellbeing Survey was completed by over 5,000 residents via a mixture of channels to widen engagement
Qual: Six exploration labs were held to explore local experiences of 'Trust and Discrimination' and 'Housing & Health'

Population size and sampling

The survey sample was designed to represent the 16+ adult population of Lambeth and Southwark with sampling and weighting targets set at a borough level. While age group, gender, working status and ethnicity were the criteria used in weighting, this solution produced outcomes for other variables, such as education, that were in line with census results.

To qualify, participants simply had to be aged 16+ and living in one of the two boroughs. The sample size was based on an ideal target of 100 participants per ward which multiplied by 25 Lambeth wards plus 23 Southwark wards gave an overall target of 4,800. As the estimated maximum feasibility via survey panels was approximately 600 between the two boroughs, the fieldwork plan was for 2,000 interviews to take place via telephone and approx. 2,000 to be achieved via community outreach methods, with the option of increasing the telephone quota to 4,000 if community outreach failed. In the end, online survey panels overperformed, and community outreach achieved most of its target. The overall breakdown of sources therefore was:

Online panel	1,503
Telephone	2,001
Community outreach	1,726
TOTAL	5,230

Full details of the qualitative and quantitative methodology can be found in the Appendices.

A note on the quantitative data used for analysis

At completion of fieldwork and once online responses had been cleaned to remove spam or poor-quality responses, completed surveys had been received from 5,230 people.

As the online panel sample was on a "whatever is accessible" basis, there were no quotas employed here. Similarly, for the non-incentivised community outreach sample (and particularly the council mailing lists that form the bulk of these responses), there was no upper limit to the number of responses within the scope of the project, so no quotas were employed here either. Targeting in community outreach was done on the basis of reaching out to organisations that work with specific demographics that were falling short (e.g. the OCA Community Kitchen for Spanish-speakers). The only quotas that were formally implemented to help ensure a balanced sample at the total level were in the telephone element. Even here, there were the issues mentioned above regarding likelihood of different demographics to take part in a telephone survey.

While some surveys in their sampling approach aim to give the population an equal chance of taking part, this was not the approach taken for this research. This was by design as 'snowball' sampling techniques, such as reaching out through community groups, are a good way to broaden participation to groups that are not usually reached through mainstream survey sampling, although this approach can also introduce other types of biases.

This mixture of fieldwork methods, each with its own strengths and weaknesses, meant that the overall sample still skews towards slightly older people than the population as a whole, and there were also shortfalls in various other subgroups. The weighting scheme applied used the following factors:

- Age group combined with gender and borough
- Working status combined with borough
- Age combined with ethnicity and borough
- Housing tenure combined with borough

Applying this weighting to the full 5,230 sample risked overweighting some key subgroups and a low overall efficiency (62%) and therefore a process of refinement took place. The weighting scheme above was applied using targets from the 2021 Census. Participants who were significantly down-weighted and the 20-25% who were being down-weighted the most were removed from the sample before the weighting was re-applied. This gave us a final working sample of 4,000 people with significantly higher weighting efficiency of 80%[3]. This is the dataset that has been used for analysis unless otherwise stated but for some ward or neighbourhood analysis the full sample has been used.

[3] Weighting efficiency aims to correct for any biases in the sample and ensure the final results accurately represent the broader population by giving appropriate importance to each subgroup. A higher weighting efficiency indicates that the assigned weights are more effective in correcting for any imbalances in the sample, leading to more accurate and representative results.

Note: the telephone survey took approximately twice as long to complete as the online survey, therefore some questions were removed. Due to this, the bases for some questions will be approximately 2,200 rather than the full 4,000.

A note on approach to analysis

The quantitative analysis in this report uses a mixture of crosstab analysis and regression analysis.

Crosstab analysis involves comparing the results in aggregate for one subgroup with those of another, for example those aged 16-24 compared to those aged 25-34. The majority of the quantitative analysis is done this way as it is a quick and intuitive way of making comparisons and looking at notable differences between individual subgroups and between subgroups and the total level. Significance testing was applied to the crosstabs at a 95 per confidence interval to give an indication of notable differences (n.b. significance testing is only fully accurate for data obtained by random sampling, which was not feasible for this study).

Each section also looks at regression analysis, which is used to understand further the role of social and economic characteristics on health and wellbeing among residents.

A regression analysis here is useful to disentangle the effects of various factors. For example, the crosstab analysis showed us that in our sample, 30% of participants with a graduate level education reported being in very good health compared to only 17% of those without a degree. However, the differences between these two groups could be for other reasons, such as younger people generally having higher education and being in better health. By running a model where we include both age and education, we can measure the effect of having a degree, holding age constant.

When looking at regression analysis, terms such as ‘significant’ are used to help with understanding the data. A significant difference means that the result is unlikely to have occurred by chance alone and indicates that there are meaningful distinctions between groups being studied.

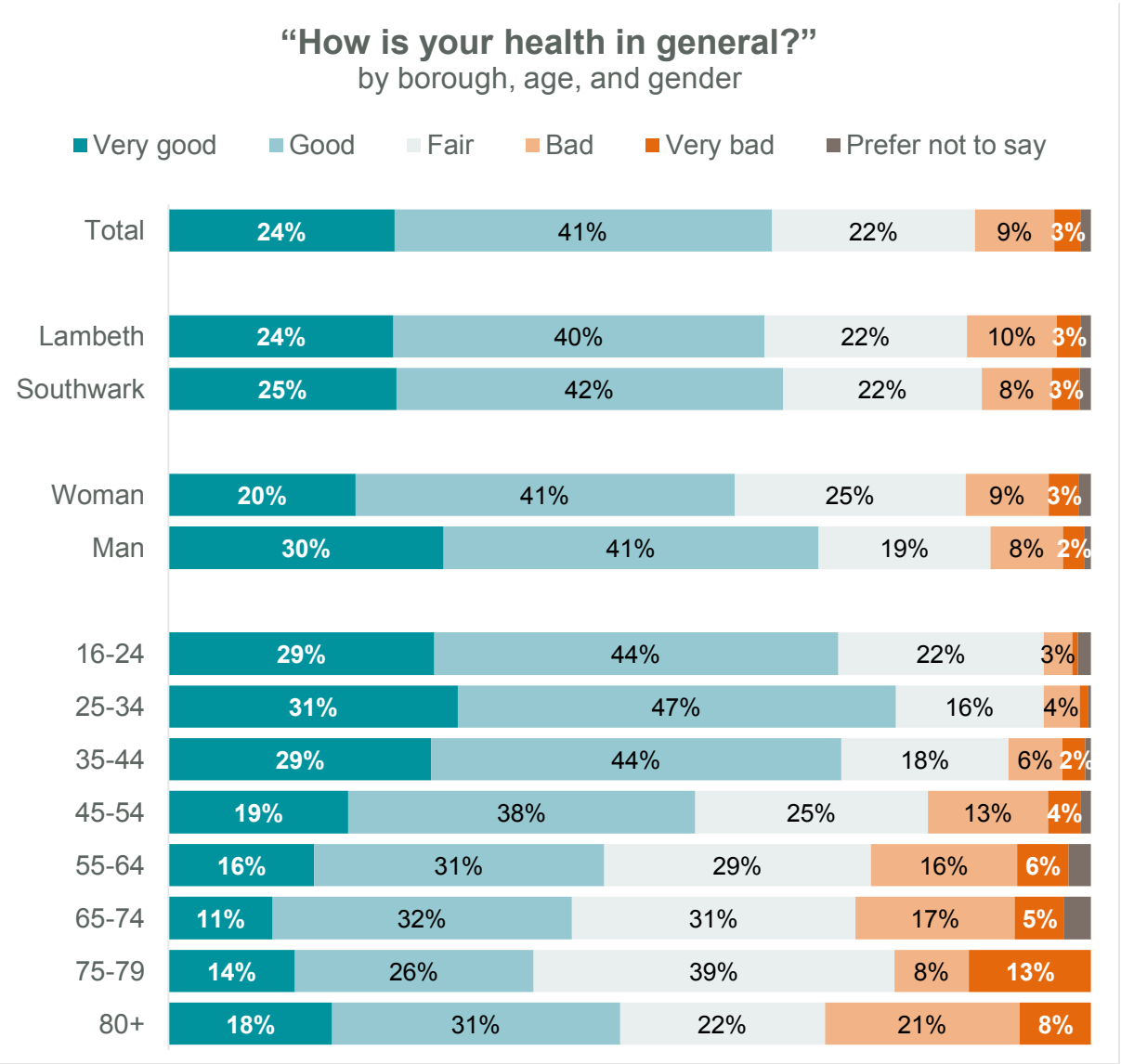
A note on sample sizes of sub-groups and impact on analysis

How big a sub-group is impacts confidence in the robustness of data analysis. A larger sample size tends to provide more reliable results in statistical analysis, while smaller sample sizes may lead to increased variability. Analysis in the report has tended to focus on sub-groups with sample sizes of at least 100 people. Any sample sizes of sub-groups below 50 are to be treated as indicative and are less robust.

2. Health and Wellbeing Survey – the overall picture

Self-reported health

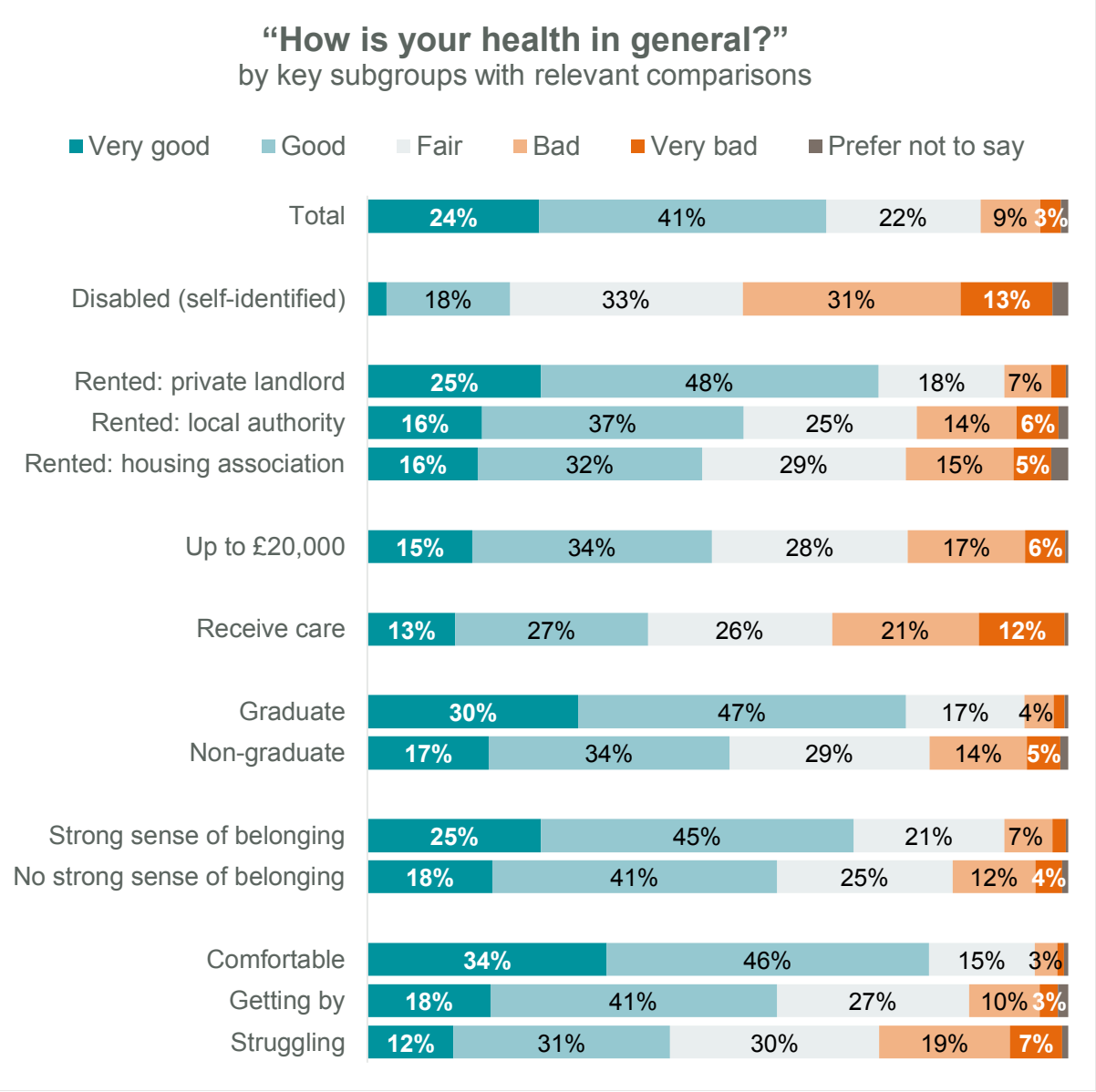
At a total level (i.e. among all survey participants), 65% of Lambeth and Southwark residents report their health as either very good (24%) or good (41%) with no notable difference between boroughs. The difference in age groups is largely as expected but there is a notable gender gap, with 30% of men reporting their health as "very good" compared to just 20% of women.



Question: H1. How is your health in general?
Base: all adults (4,000), Lambeth (1,951), Southwark (1,884), Woman (2,221), Man (1,634), 16-24 (371), 25-34 (934), 35-44 (877), 45-54 (807), 55-64 (625), 65-74 (265), 75-79 (73), 80+ (46)

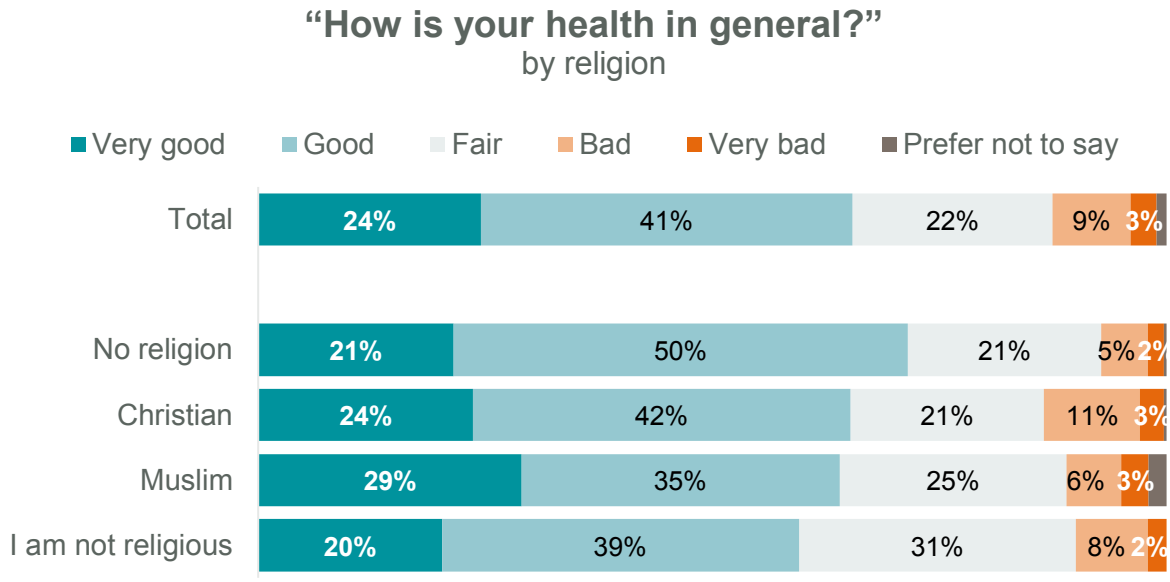
If we look at the key subgroups within the data, there are notable differences in people reporting poor health. Those who self-describe as disabled are notably more likely to report being in poor health, as are those who receive care for a mental or physical health condition or due to old age.

Our analysis showed that those renting from a local authority or housing association are more likely to have poor health compared to those who own their own home. Around a fifth (22%) of those on less than £20,000 per year personal income described their health as 'bad' compared to 5% or fewer of those in higher income bands. Similarly, those who describe their financial situation as "struggling" are notably less likely to describe themselves as healthy than those describing their financial situation as "comfortable". Those renting privately are notably less likely to report being in poor health but, as we shall see in later sections, this is largely a function of age and the demographics of the privately renting population.



Question: H1. How is your health in general?
Base: all adults (4,000), Disabled (565), rented from private landlord (840), rented from local authority (951), rented from housing association (531), up to £20,000 personal income (913), receiving care (573), graduate (2,252), non-graduate (1,566), strong sense of belonging to local area (1,817), no strong sense of belonging (649), comfortable (1,958), getting by (1,093), struggling (842)

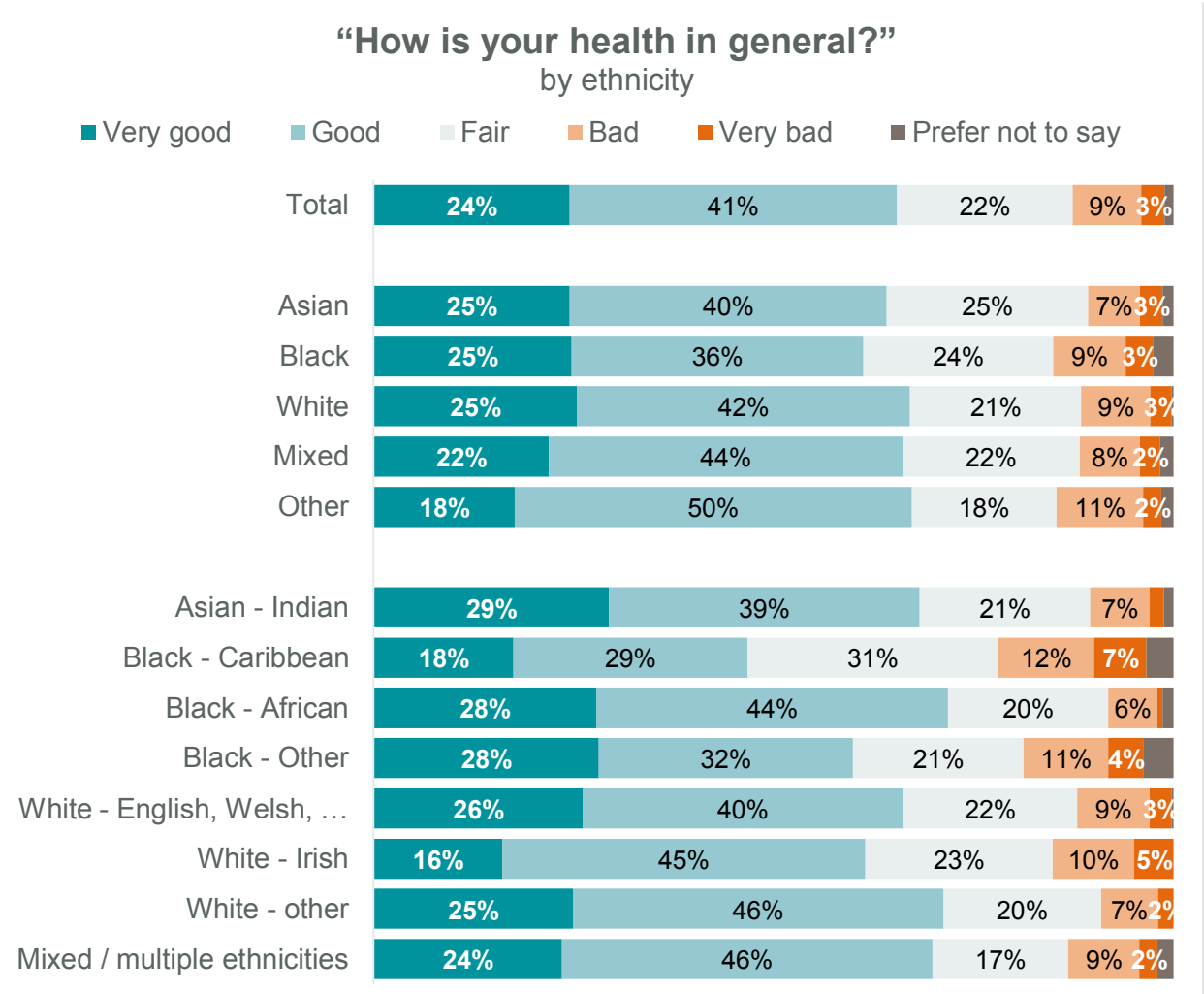
Variation by religion is limited to a slightly higher "bad" proportion among Christian residents and a higher "very good" proportion among Muslims[4].



Question: H1. How is your health in general?
Base: all adults (4,000), No Religion (831), Christian (994), Muslim (205), I am not Religious (291)

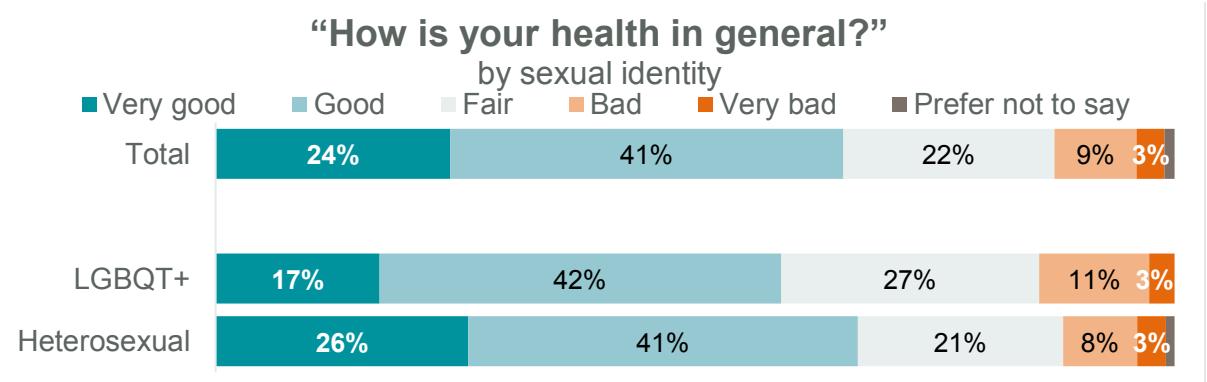
While there is little variation in ethnicity at the broad category level, this masks greater variation among subgroups within each category. Those of a Black Caribbean ethnicity are much less likely to report good health than those of a Black African ethnicity.

[4] Figures for Muslim residents are based on non-White Muslim residents only. As quotas were not interlocked to this level, the proportion of Muslim respondents who are White is significantly higher than is the case in the actual population and the answers given by these respondents tend to be different to a degree that distorts the findings for the Muslim subsample as a whole.



Question: H1. How is your health in general?
Base: all adults (4,000), Asian (340), Black (907), White (2,202), Mixed (241), Other Ethnic Group (242), Asian – India (110), Black – Caribbean (275), Black – African (404), Black – Other (228), White – English, Welsh, Scottish, Northern Ireland or British (1,616), White – Irish (81), White – other (492), Mixed or multiple ethnicities (134)

There is also a stark difference between LGBTQ+ residents and heterosexual residents:

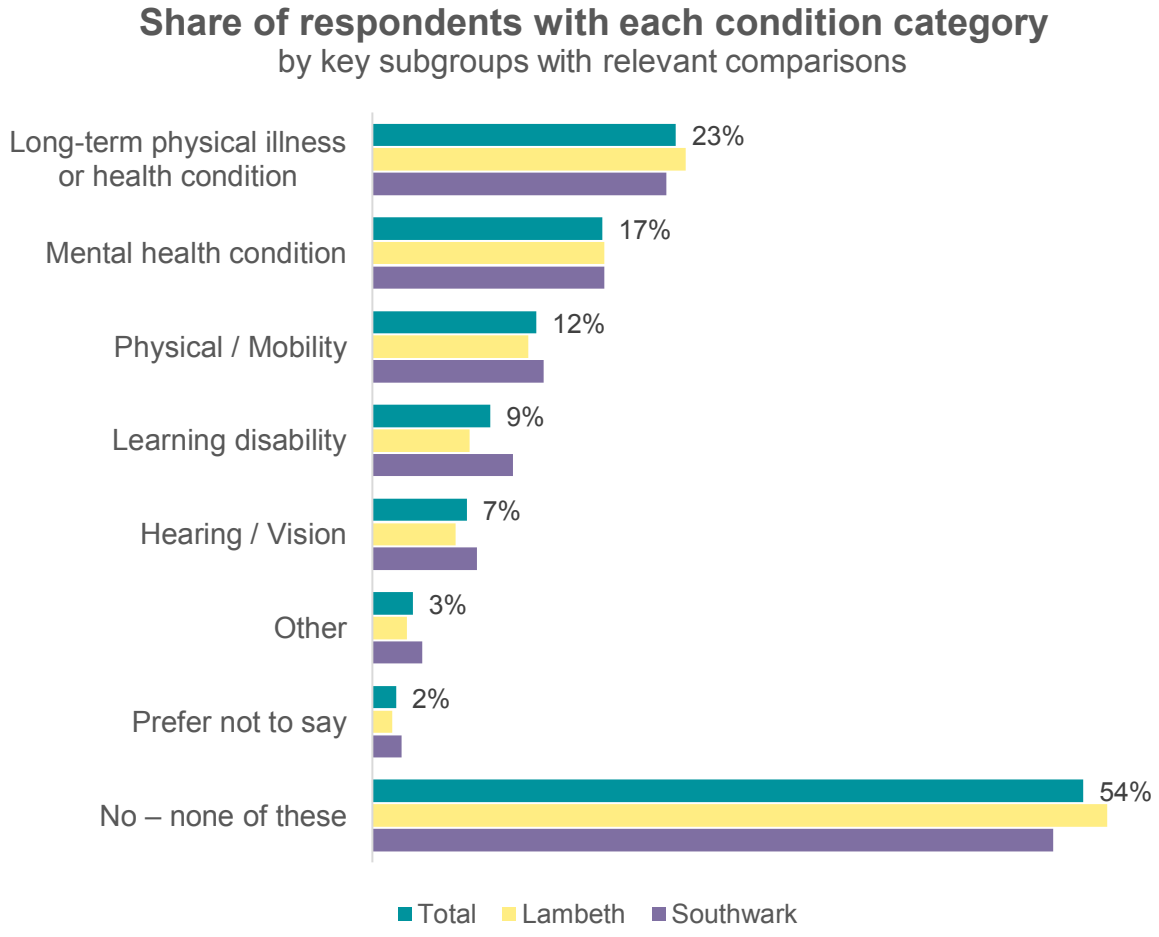


Question: H1. How is your health in general?
Base: all adults (4,000), LGBTQ+ (523), Heterosexual (3,223)

Regression analysis shows that a person is more likely to report poor health if they have higher financial insecurity, if they do not have a degree, are in poor housing conditions, are renting privately and socially (i.e. from a local authority or housing association), are a woman or LGBTQ+. Once socio-economic conditions are controlled for, the impact of ethnicity in determining self-reported health is not significant for most groups, showing that the ethnicity gaps in results for this question are largely determined by ethnic minorities being disproportionately hit by socio-economic disadvantages. This relationship between poverty, ethnicity and health inequity reflects findings within the latest Marmot Review[5] and a review into this topic by The Kings Fund[6].

Prevalence of long-term conditions

At a total level, 44% of participants have at least one of the long-term health conditions when selecting from a list of key categories with few differences between boroughs.



Question: H2. Do you have any of the following long-term health conditions, impairments or disabilities? By long-term we mean lasting 12 months or more.
Base: all adults (4,000), Lambeth (1,951), Southwark (1,884)

[5] https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf
[6] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/health-people-ethnic-minority-groups-england

The full detail shown/read to participants for each option was:

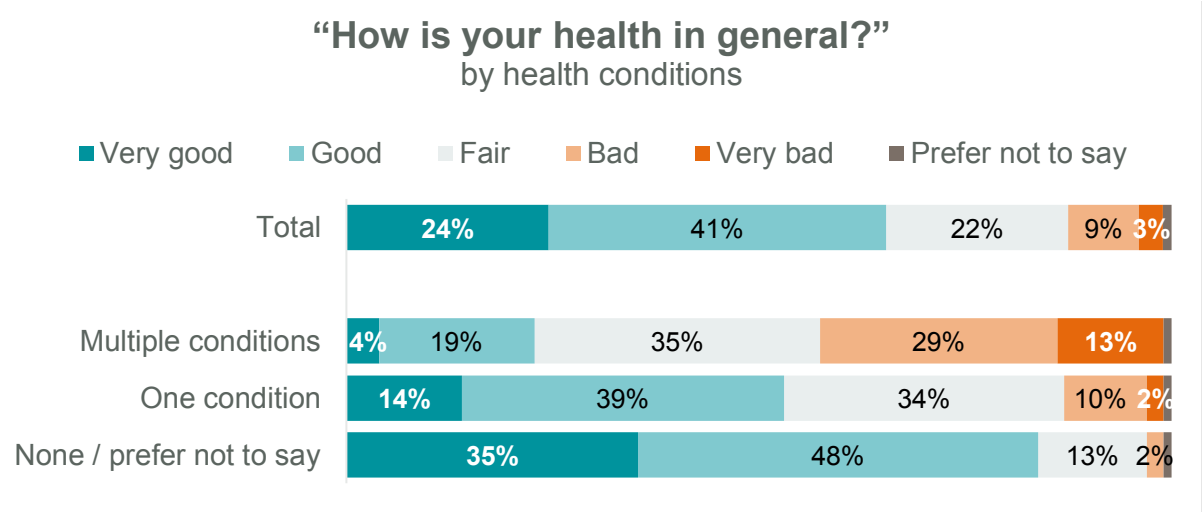
- Hearing/Vision (e.g. deaf, partially deaf or hard of hearing; blind or partial sight)
- Physical/Mobility (e.g. wheelchair user, arthritis, multiple sclerosis etc.)
- Mental health condition (lasting more than a year. e.g. major depression, schizophrenia etc.)
- Learning disability (e.g. dyslexia, dyspraxia etc.)
- Long-term physical illness or health condition (e.g. Cancer, HIV, Diabetes, Chronic Heart disease, Rheumatoid Arthritis, Chronic Asthma, Long Covid)
- Other

One in six residents (17%) selected two or more conditions (including 'other') and, while it is possible to have more than one of the same type of condition, we have used this as a proxy for multiple conditions. However, 24% of residents selected one condition.

The table below shows the overlap of answers selected at this question with percentages showing the share of each column selecting each row. For example, 34% of those with a hearing or vision condition also have a physical or mobility condition.

	Total	Hearing / Vision	Physical / Mobility	Mental health condition	Learning disability	Long-term physical illness or health condition	Other
Hearing / Vision	7%	100%	20%	11%	13%	15%	11%
Physical / Mobility	12%	34%	100%	27%	17%	31%	13%
Mental health condition	17%	27%	37%	100%	42%	31%	34%
Learning disability	9%	17%	12%	22%	100%	12%	22%
Long-term physical illness or health condition	23%	48%	57%	41%	30%	100%	18%
Other	3%	5%	3%	6%	8%	2%	100%

As would be expected, those with multiple conditions are more likely to describe their health as bad:



Question: H1. How is your health in general?
Base: all adults (4,000), multiple conditions (642), one condition (976), none / PNTS (2,382)

Regression analysis shows that those reporting more financial insecurity and not having graduate level education have higher odds of having at least one long-term health condition, impairment, or disability. In addition to those who socially rent, private renters also have increased odds of having a long-term condition when compared to those who own outright or with a mortgage. However, odds are lower for private renters than social renters, private renters are 30% more likely to have a long-term condition than homeowners while social renters are 82% more likely.

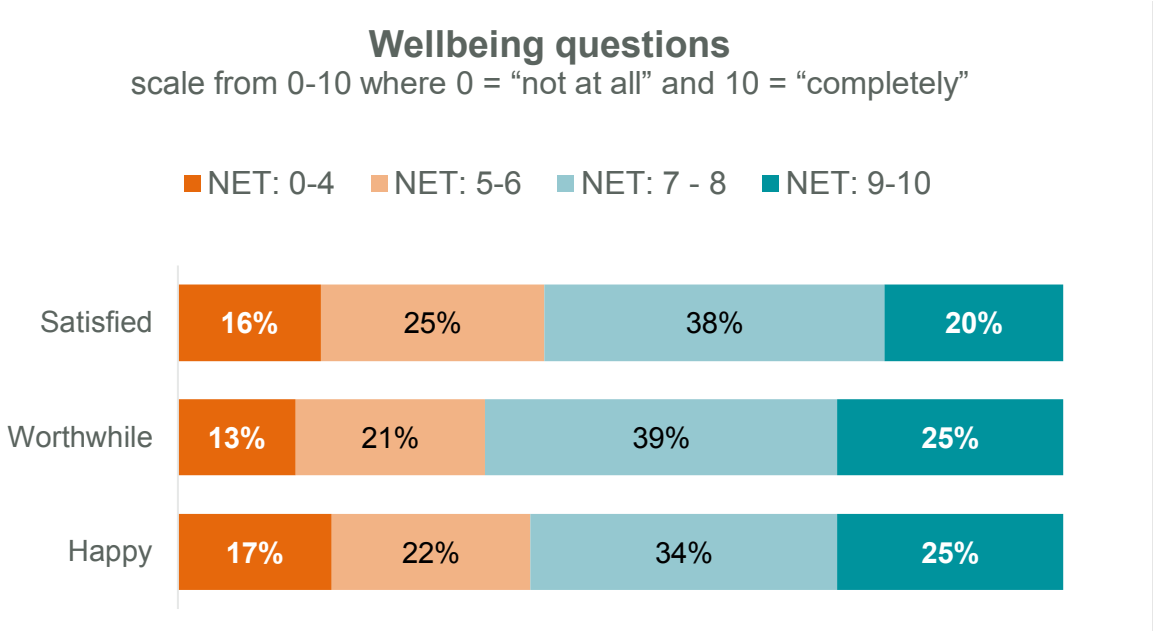
Living in poor housing conditions is also a significant key driver of having a long-term health condition, impairment or disability. Women also have higher odds of having at least one long-term condition than men and those identifying as LGBTQ+ have higher odds than those who do not. Respondents from a Black African background have lower odds of having a long-term condition than those of a White British background (56% less likely compared to those from a White British background). Respondents from Asian backgrounds are also less likely to have a long-term condition, being 29% less likely to have this compared to those of a White British background.

Social health and wellbeing

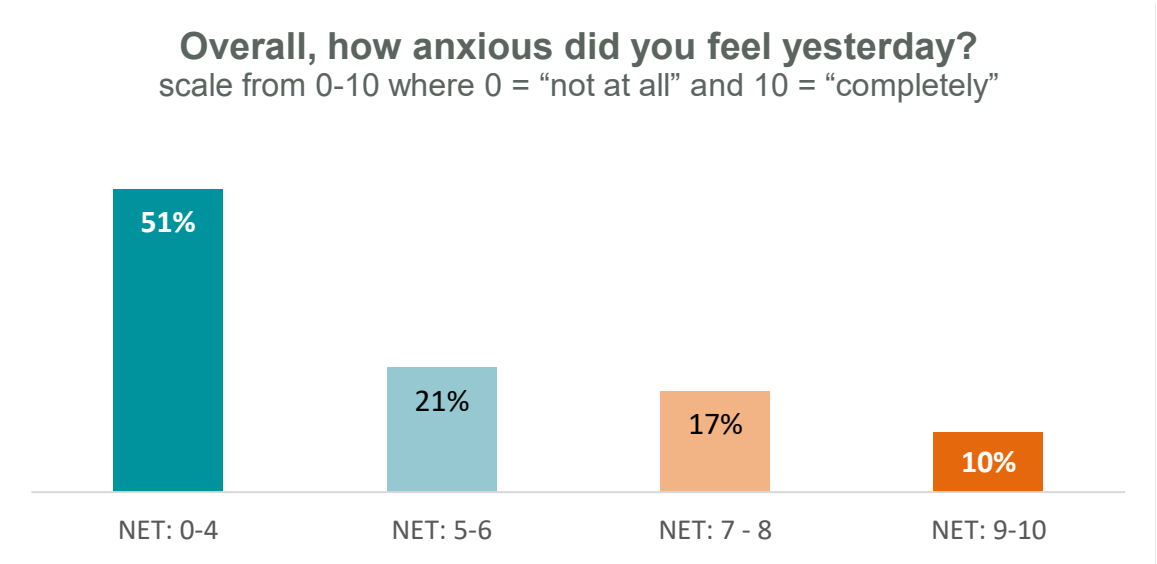
We asked six core social health and wellbeing questions. The first four were shown as part of a single choice grid where participants were asked to answer each question on a scale from "0 – not at all" to "10 – completely":

- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel that the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

Net in the chart below indicates the combination of the scale. For instance, net 0-4 combines the number of people who selected 0-4 on the scale.



Question: H3. We're now going to ask you about your feelings on aspects of your life. There are no right or wrong answers. For each one, please give an answer on a scale from 0-10 where 0 = "not at all" and 10 = "completely". Overall, how satisfied are you with your life nowadays? Overall, to what extent do you feel that the things you do in your life are worthwhile? Overall, how happy did you feel yesterday? Base: all adults (4,000)

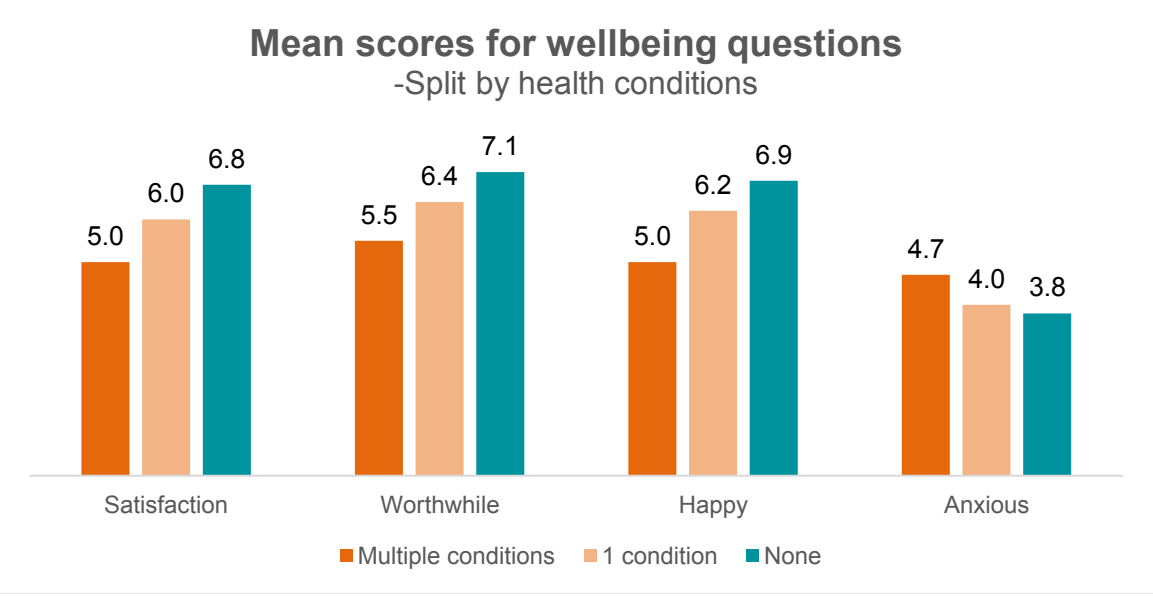


Question: H3. We're now going to ask you about your feelings on aspects of your life. There are no right or wrong answers. For each one, please give an answer on a scale from 0-10 where 0 = "not at all" and 10 = "completely". Overall, how anxious did you feel yesterday?
Base: all adults (4,000)

The similarity in responses to these questions is reflected in the mean scores of 6.4, 6.7, 6.5 and 4.1 respectively. The three positive measures (where a higher mean score indicates a better outcome) all have similar mean scores while the one negative measure (where a higher mean score indicates a worse outcome) has a much lower score.

As with overall self-reported health, the scores for these questions generally track other demographic or lifestyle factors.

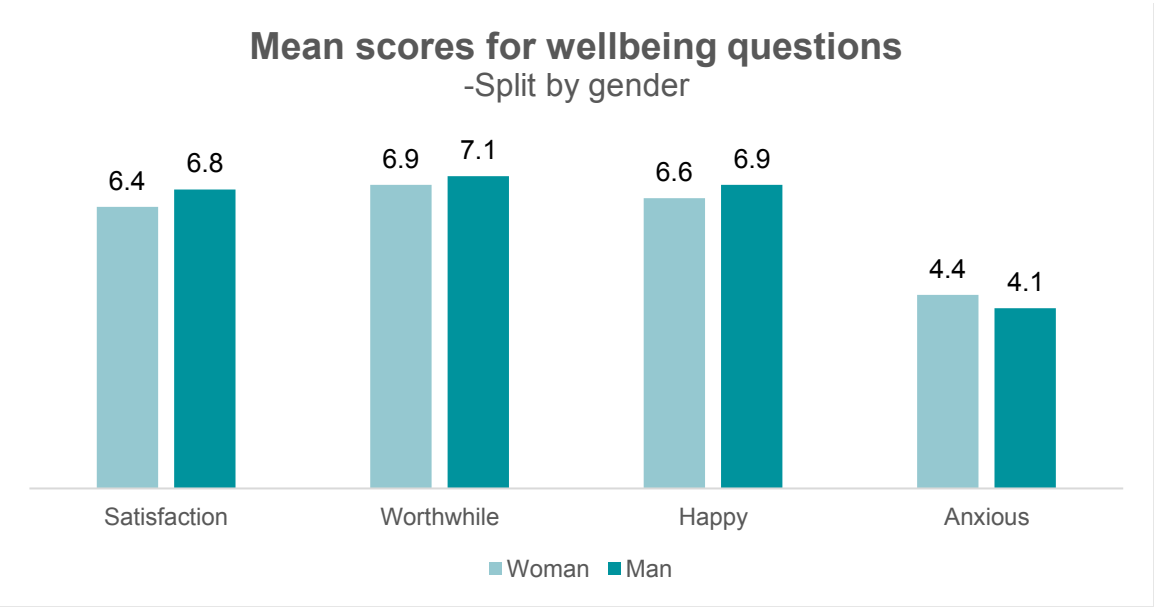
When we split by presence of multiple conditions, we see notably poorer results on all measures compared to those with one or no conditions:



Question: H3. We're now going to ask you about your feelings on aspects of your life. There are no right or wrong answers. For each one, please give an answer on a scale from 0-10 where 0 = "not at all" and 10 = "completely".
Base: all adults (4,000), multiple conditions (642), one condition (976), none / PNTS (2,382)

Unlike self-reported health, however, the only correlation with age relates to the likelihood of feeling anxious, where there is a slight decline with increasing age when the other measures are controlled for.

Gender differences are generally small, with men marginally more likely to have higher averages for satisfaction, worthwhileness and happiness and slightly lower for feeling anxious:

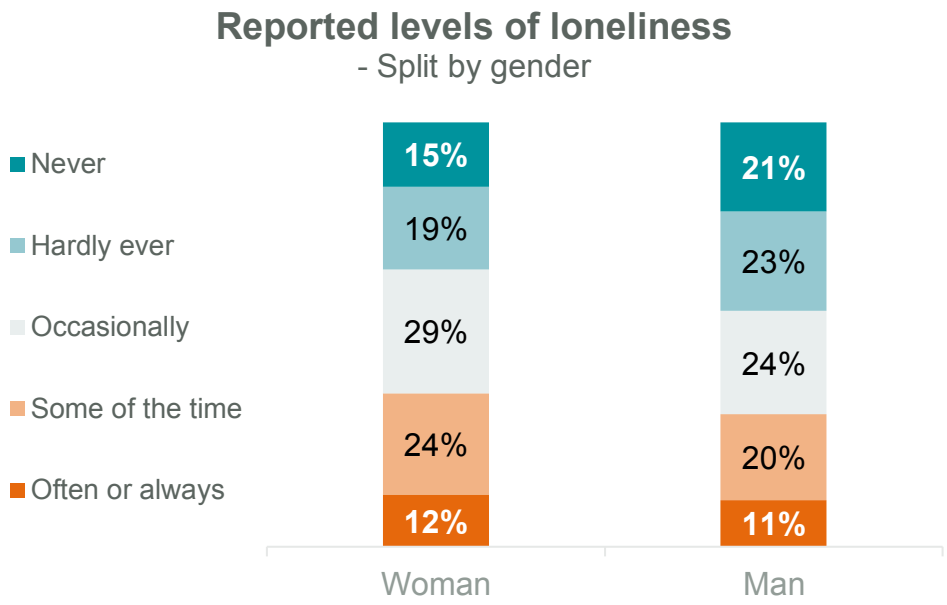


Question: H3. We're now going to ask you about your feelings on aspects of your life. There are no right or wrong answers. For each one, please give an answer on a scale from 0-10 where 0 = "not at all" and 10 = "completely".
Base: Woman (2,221), Man (1,634)

Loneliness

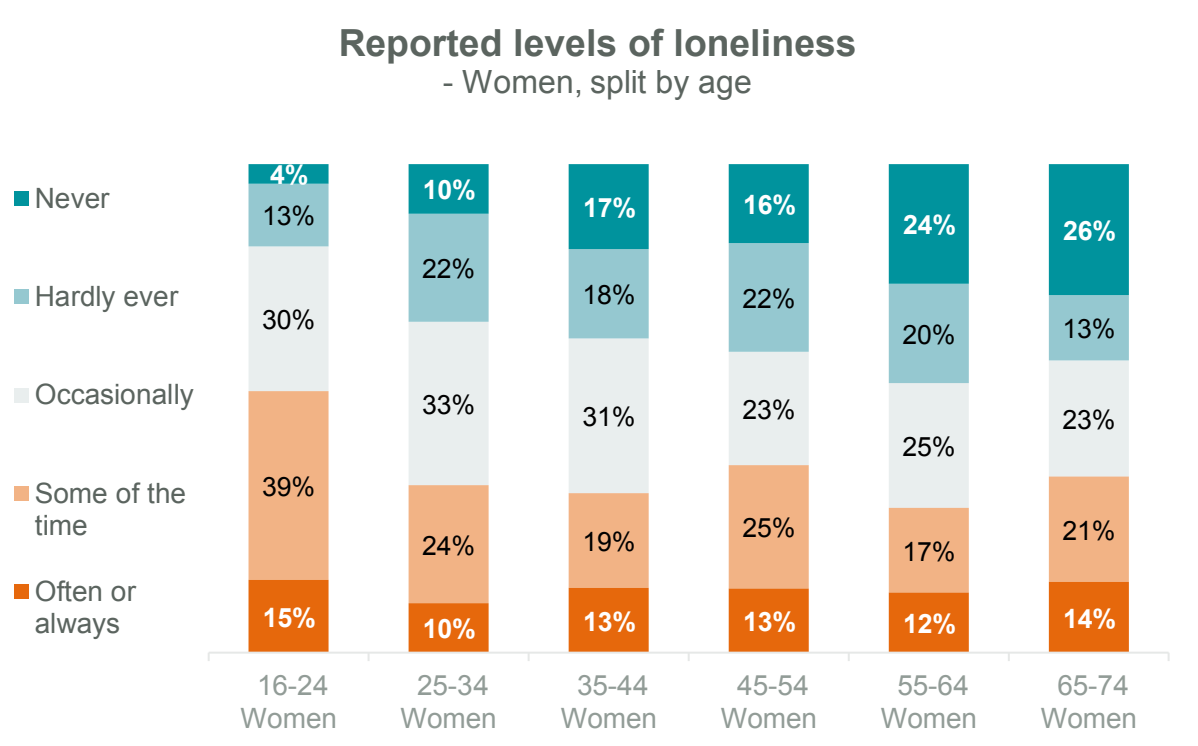
A third (33%) of adults in Lambeth and Southwark said that they felt lonely often/always or some of the time, compared to 39% who hardly ever or never feel this way. There were no notable differences at a borough level.

There is a notable difference by gender, with 36% of women saying "often or always/ some of the time" compared to 31% of men and 34% of women saying "hardly ever/never" compared to 44% of men.

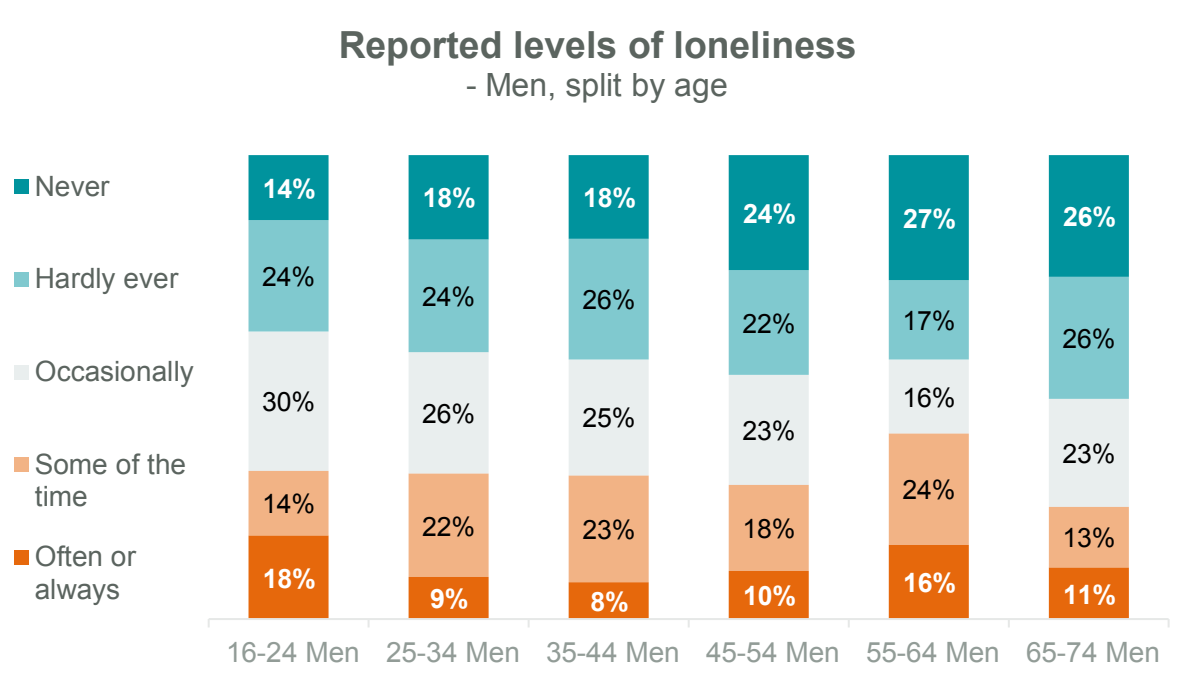


Question: S1. How often do you feel lonely?
Base: all adults (4,000), Woman (2,221), Man (1,634)

When we look more closely and split gender by age group, we see than 16–24-year-old women are the most likely to report feeling lonely “some of the time” or “often or always” (53%) compared to an average of 30% among women of other ages, and 31% for 16–24-year-old men.

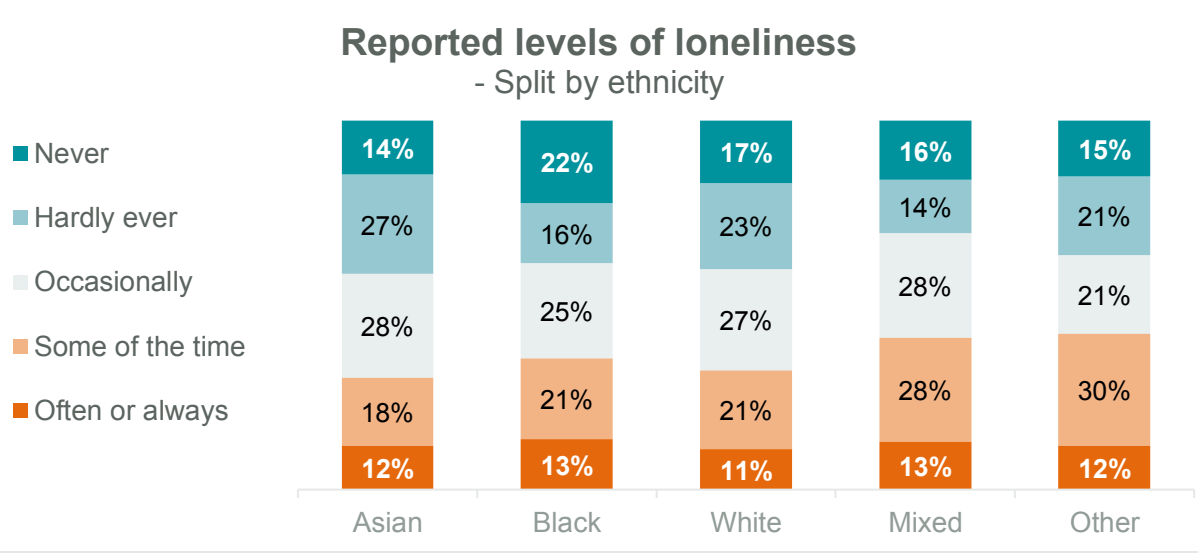


Question: S1. How often do you feel lonely?
Base: Woman 16-24 (225), Woman 25-34 (589), Woman 35-44 (487), Woman 45-54 (429), Woman 55-64 (350), Woman 65-74 (99)



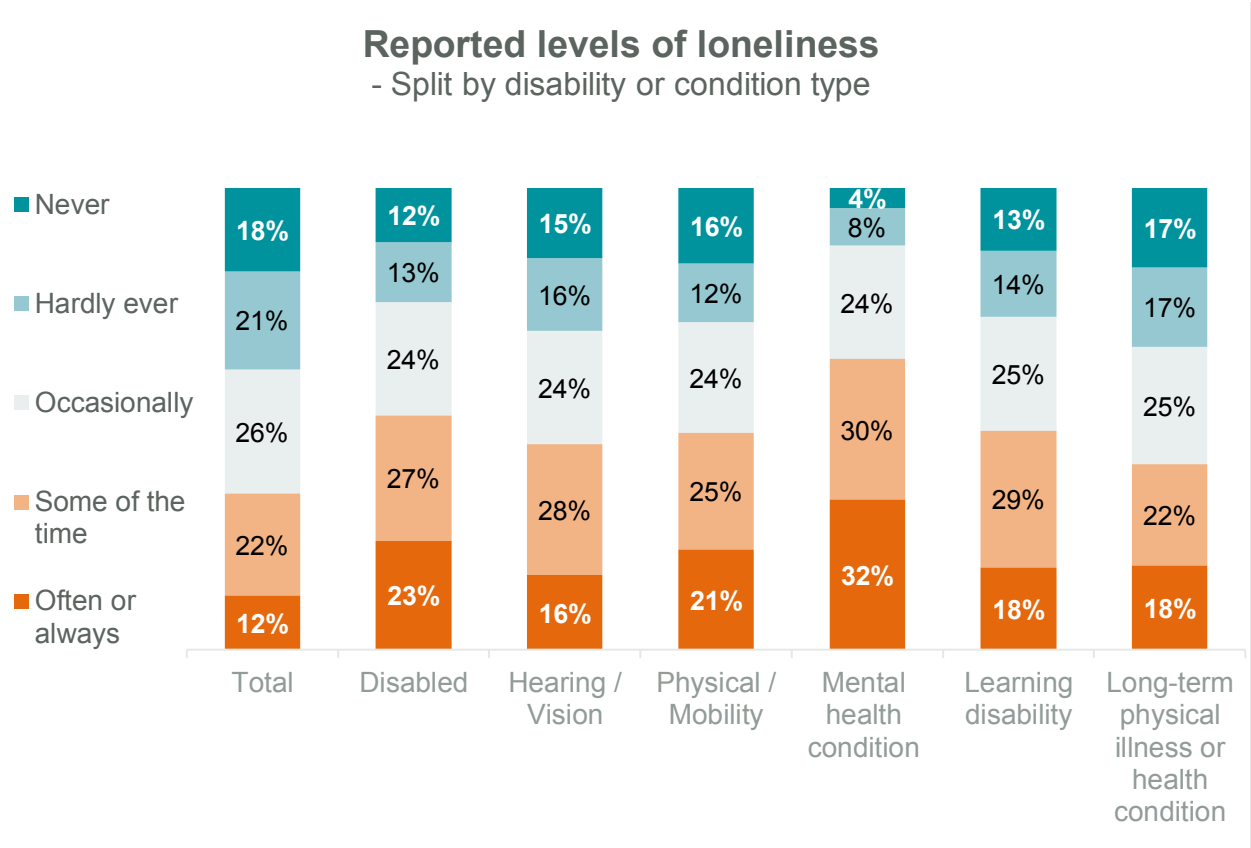
Question: S1. How often do you feel lonely?
Base: Man 16-24 (140), Man 25-34 (327), Man 35-44 (369), Man 45-54 (343), Man 55-64 (250), Man 65-74 (143)

Splitting by ethnicity, Black respondents are more likely to say that they "never" feel lonely.



Question: S1. How often do you feel lonely?
Base: Asian (290), Black (1,077), White (2,102), Mixed (223), Other Ethnic Groups (223)

Residents who identify as disabled are much more likely to frequently feel lonely compared to the average resident. Levels of loneliness are particularly high among those that have mental health conditions as well as those that have a physical or mobility condition.

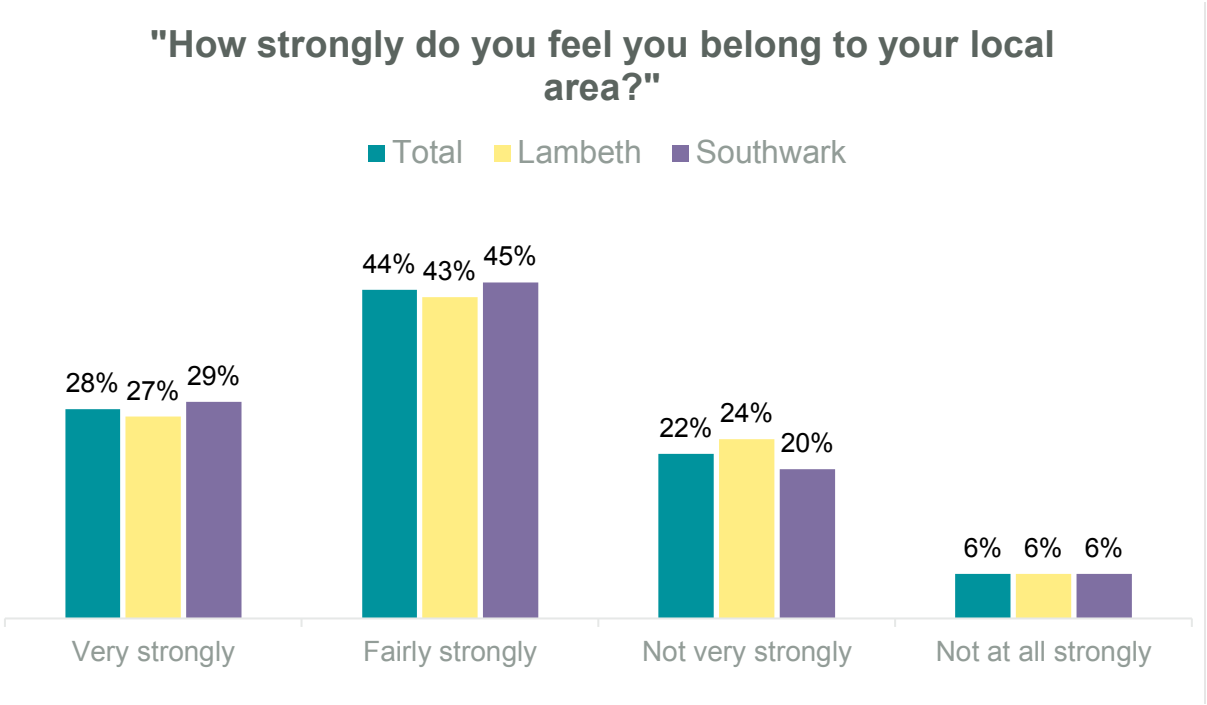


Question: S1. How often do you feel lonely?
Base: Disabled (565), Hearing/vision (249), Physical/mobility (438), Mental health condition (592), Learning disability (308), Long term physical illness or health condition (865)

Sense of belonging

Surprisingly, how often someone feels lonely does not correlate very strongly with the extent to which they feel a sense of belonging to their local area.

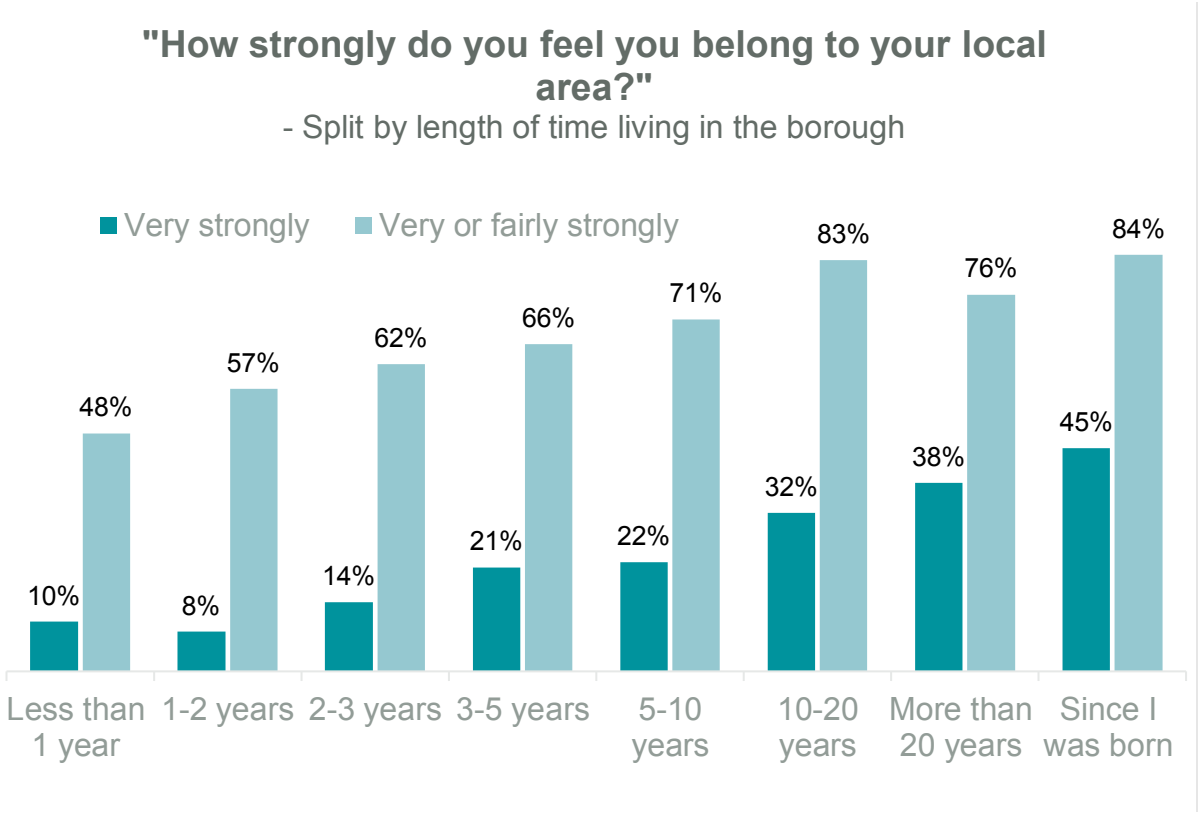
At a total level, 72% of residents feel strongly that they belong to their local area with this being marginally higher in Southwark (74%) than Lambeth (70%).



Question: S2. How strongly do you feel you belong to your local area?
Base: all online (2,466), Lambeth (1,257), Southwark (1,069)

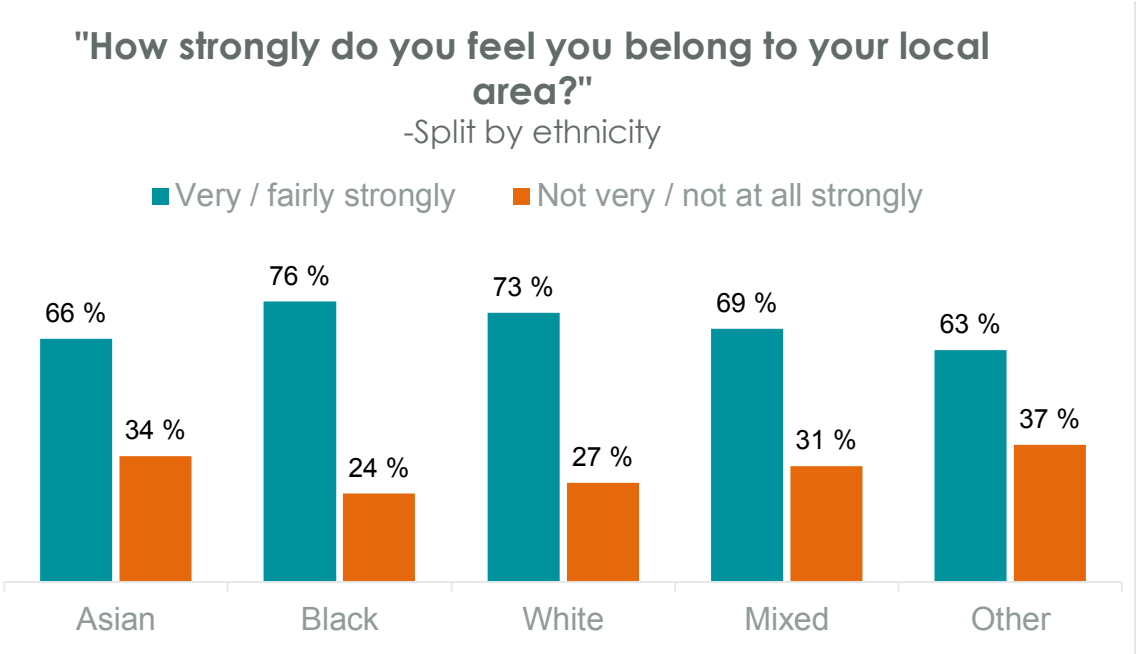
There was a minimal gender divide, while the age divide mainly takes the form of those who are 16-24 feeling less of a sense of belonging (64% compared to 70% of those aged 25-34 and an average of 75% of those aged 35+).

As one might expect, the longer someone lives in each borough, the more likely they are to feel a sense of belonging to the area. This effect is clearer when we look at people selecting “very strongly” than those ticking “very” or “fairly” strongly.



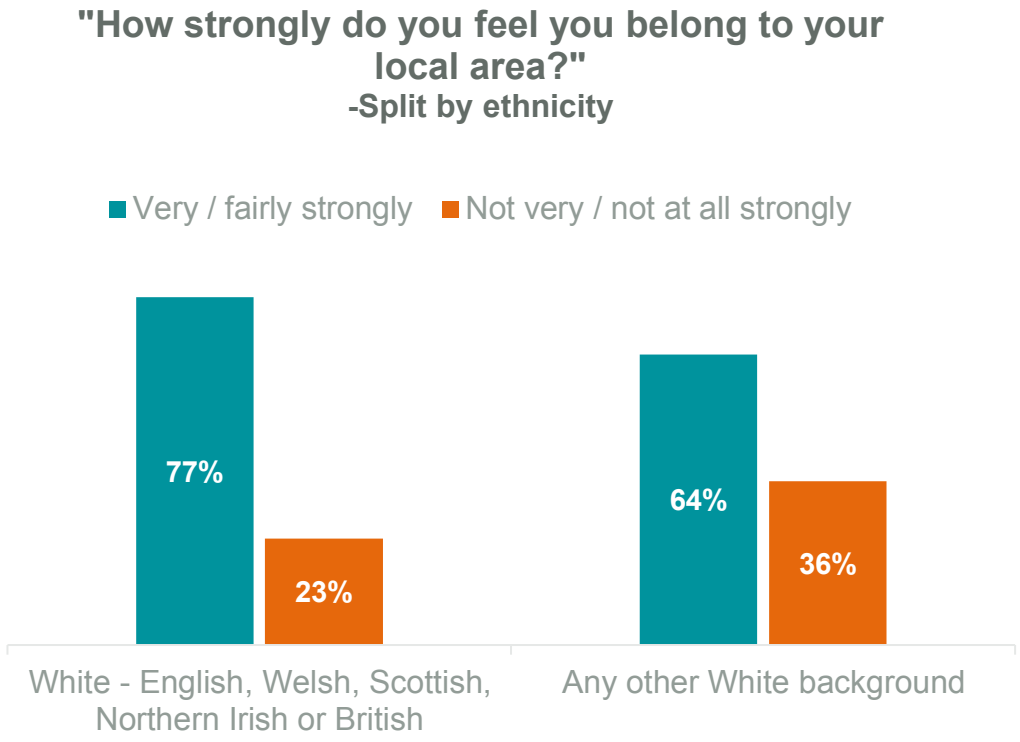
Question: S2. How strongly do you feel you belong to your local area?
Base: Less than 1 year (143), 1-2 years (146), 2-3 years (142), 3-5 years (224), 5-10 years (438), 10-20 years (726), 20+ years (1,262), since I was born (568)

Splitting the data by ethnicity, those of a Black ethnicity are the most likely to feel that they strongly belong to their area (76%) while that drops to 63% of those that selected 'Other' ethnicity.



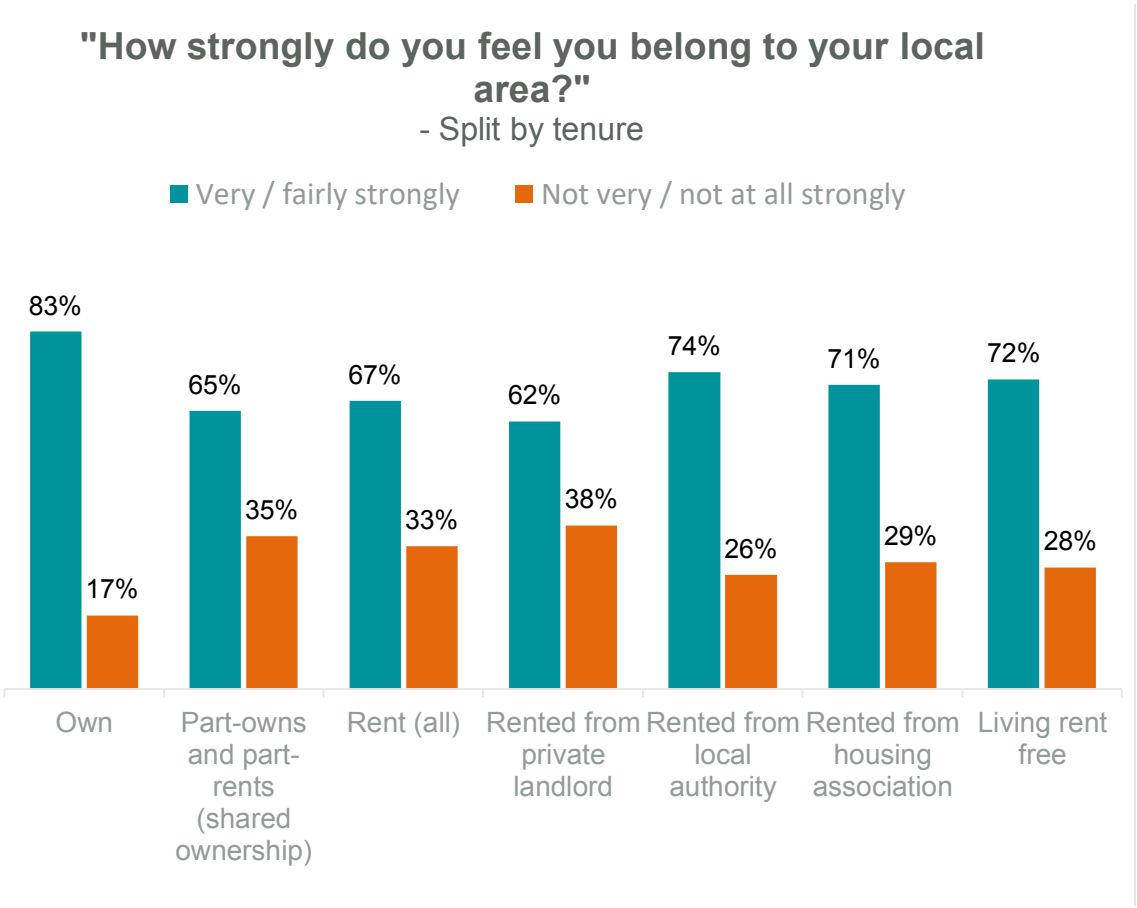
Question: S2. How strongly do you feel you belong to your local area?
Base: Asian (181), Black (466), White (1,501), Mixed (153), Other Ethnic Group (128)

Sense of belonging is notably higher among those who are White English, Welsh, Scottish, Northern Irish (77%) than those from an “other White background” (64%). This is likely to be linked to the amount of time that people have lived in the borough.



Question: S2. How strongly do you feel you belong to your local area?
Base: White – English, Welsh, Scottish, Northern Irish or British (1,084), Any other White background (348)

There is a stronger impact on feelings of belonging when we split the data by tenure type. Here those who own their own homes are the most likely to feel they belong to their local area, while those who privately rent are the least likely to. The difference in rental types is clear too, with those renting from a local authority being more likely to feel a sense of belonging:



Question: S2. How strongly do you feel you belong to your local area?
Base: Own (865), part-owns and part-rents (61), rent all (1,345), rented from a private landlord (634), rented from local authority (464), rented from housing association (247), living rent free (129)

3. Key Theme 1 | Discrimination and lack of trust within healthcare

The structure of each of the three exploration labs first explored the different experiences surrounding discrimination within healthcare, and then potential solutions that could reduce such discrimination. Similarly, the second half of each exploration lab explored the reasons why there is a lack of trust within healthcare, and potential solutions that could reduce this. Below are the findings:

Discrimination within healthcare

1. Discrimination due to skin colour or ethnicity

Discrimination due to skin colour or ethnicity was by far the most commonly cited cause of discrimination in healthcare. Most 'Black Caribbean' or 'Black African' participants spoke about their lived experiences of being treated differently, specifically due to their ethnic background. Their experiences ranged from not being taken seriously when they speak to a doctor, to having very different levels of treatment in comparison to White patients:

> You walk into a hospital, they tend to pay more attention to people of (their) same skin colour...even if your case is very serious, they might not take you seriously.

> Black women [are seen as] having this higher pain threshold and that's why there's high mortality rates for Black women who are having babies and all of that kind of stuff because no one takes the symptoms of Black women seriously.

One participant described his experiences when his wife got ill and was taken into hospital, he was not allowed to accompany her into the ward, so he repeatedly asked at the reception about his wife's condition. He was then escorted out of the building:

> [She] called security and said to them, you need to get him out. I wasn't shouting. I wasn't doing anything. And then you see White people, British people actually going in with whoever they came with and I'm not even trying to go in, I just want to know what's going on with my wife.

2. Discrimination due to language barriers

The next most commonly cited reason for being discriminated against was where English was not patients' first language. Similarly to being discriminated against because of ethnicity, participants felt that they were not listened to, their symptoms were not taken seriously, and that they did not feel cared for:

> When we don't speak the language very good, they don't care (about) us that much.

> I used to have really strong pain when I was going to the GP, the doctor never sent me to the hospital. I was not able to speak good English, I wasn't British too. My pain was 24 hours, 7 days non-stop. I wasn't able to go to work. One day I went to the GP when I had the pain. I told him if you don't send me to the hospital, it would be your responsibility - my family and friends know you're doing (it) on purpose. Finally, he sent me to the hospital.

3. Discrimination due to disabilities or mental health issues

Some participants felt discriminated against due to their hidden disabilities or their mental health conditions. They mentioned that their levels of pain were not taken seriously, and they felt that some healthcare professionals treated them as if they were not capable of understanding information properly:

> There was a time when I was in so much pain because of a hidden illness, they (ambulance crew) were thinking 'Oh you can walk, you don't need a wheelchair, you're fine.' But I was discriminated against. When I'm telling you I'm in pain, I'm in so much pain…I did complain but...you don't really get any feedback after a complaint.

> So, in 2015, I was diagnosed with bipolar affective disorder. And I find that… when I'm speaking to healthcare professionals, they sort of talk to me as if I'm spinning or . I don't understand what's going on. And I have a very full understanding of what I'm saying. … it's almost as if … you've lost your senses, which isn't the case. You know, like I said, I'm fully aware of what's going on and fully aware of what I need to do. And I just find that they sort of talk down to you.

> Anyone with mental health needs critical care and I feel like there was not much of this attention, rather I was being discriminated (against). Trying to access the mental health facilities, I found myself falling into depression because of how I was being … treated.

4. Discrimination based on levels of influence (or lack of)

Some participants mentioned that the level and quality of treatment that they receive often depends on where they work, who they know, or who they take with them to the appointment. One participant worked in a healthcare trust and noted how her treatment would differ depending on whether she mentioned this or not:

> If I mentioned that I worked in HR there (the same NHS Trust), they would quickly look after me which I feel is not right. But on the flip side if I don't mention that... (I will be treated worse). As an example, I had major surgery in 2018...but the

> following day I was asked to come home and I could not even stand...had I mentioned that I worked there I would have been in a private room.

Another participant whose mother was a doctor in another country, felt that her treatment changed if she took her mother to appointments with her. However, this could also subsequently result in different responses, depending upon what her mother disclosed about whether or not she was currently a practising doctor:

> My mum went to most of these appointments with me, and the treatment does change as soon as she says she's in that profession as well...So I always bring her for, like, moral support, just everything, but like, the treatment changes. But then sometimes they look down on her because if she says she's not practising, they'll talk down to her. But if she says that she is, then they'll, like, respect her a bit more.

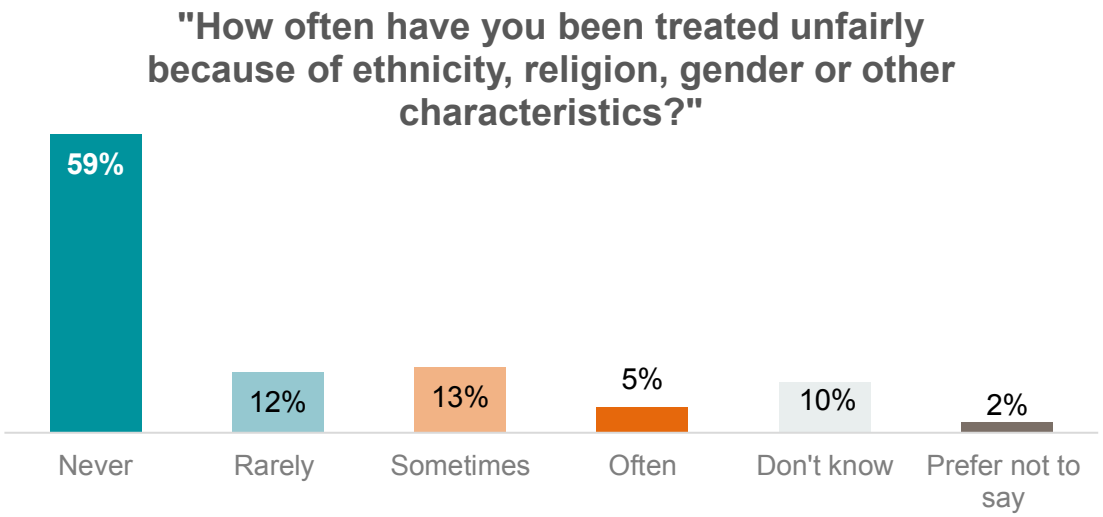
A participant mentioned that not having any special contacts (therefore being less influential) impacted upon the treatment they received:

> I have faced a lot of discrimination recently in the hospital. I was trying to access some senior doctors, but I have found that you should have a relationship or (some sort of) influence. If you don't have that influence, you don't have access to the big doctors.

Survey findings about discrimination in healthcare

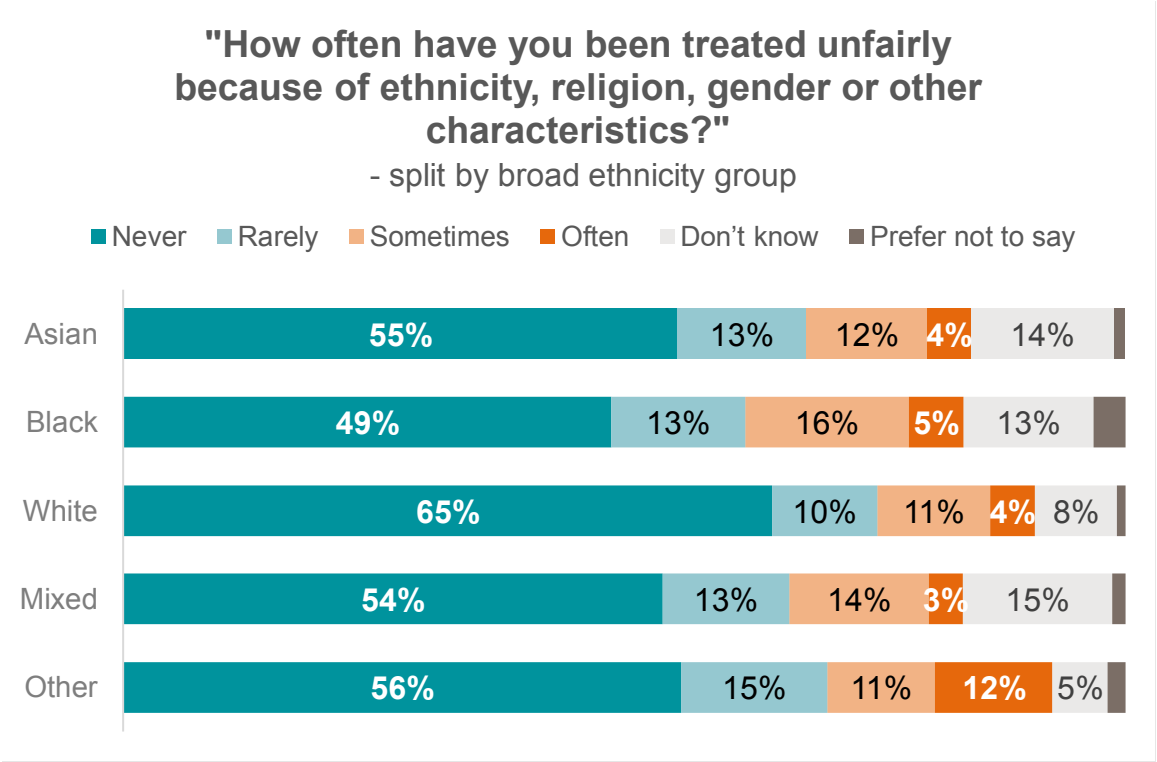
In order to gather quantitative information about discrimination, participants were asked how often, within the last two years, they had been treated unfairly when getting medical care because of their ethnicity, religion, gender or other characteristics. It is important to note that the questions related to perceived experiences of discrimination.

The majority of residents reported no experiences of unfair treatment (59%) but 18% reported sometimes or often facing discrimination.



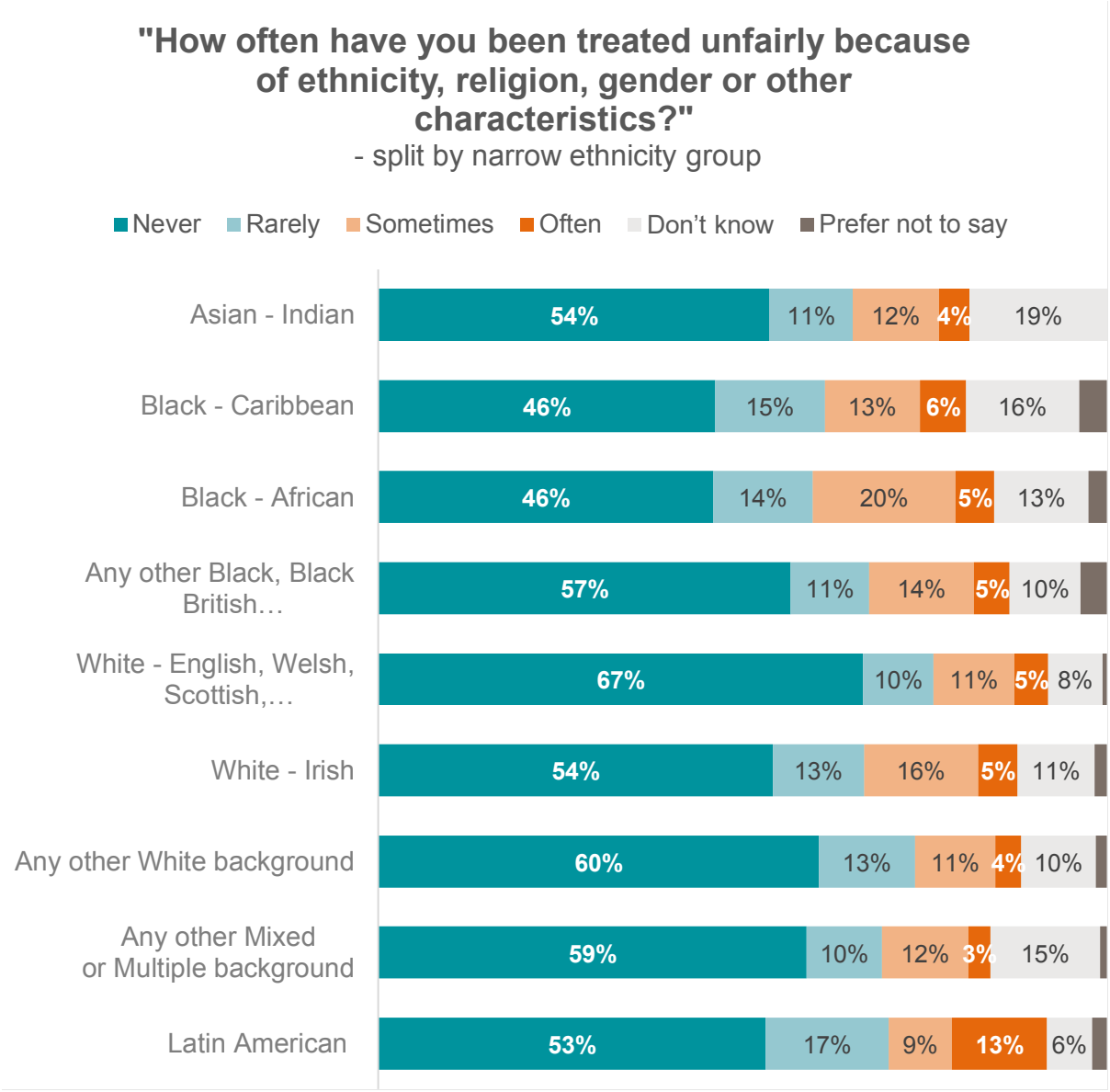
Question: C6. Within the past 2 years, how often have you been treated unfairly when getting medical care because of your ethnicity, religion, gender or other characteristics?
Base: all adults (4,000)

As one might expect, this is higher among ethnic minority residents with the total for sometimes and often being 22% for Black participants.



Question: C6. Within the past 2 years, how often have you been treated unfairly when getting medical care because of your ethnicity, religion, gender or other characteristics?
Base: Asian (290), Black (1,077), White (2,102), Mixed (223), Other Ethnic Groups (223)

Breaking ethnicity down further, we can see that the high “never” figure among White participants is mainly among White English, Welsh, Scottish, Northern Irish or British participants with significant proportions of White Irish and White other experiencing discrimination.

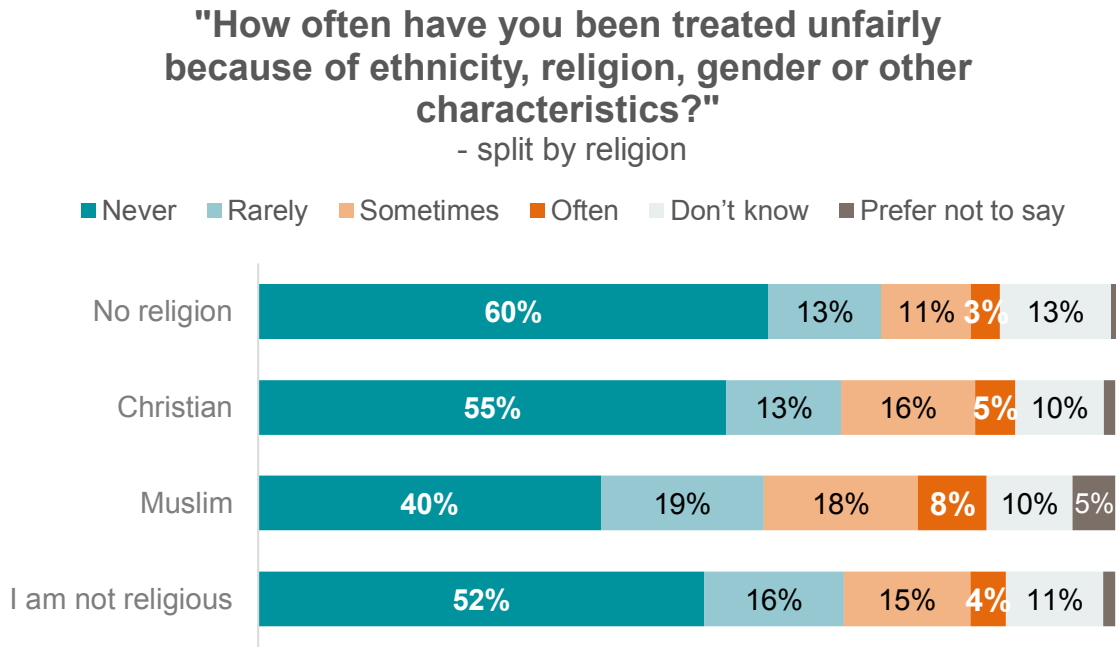


Question: C6. Within the past 2 years, how often have you been treated unfairly when getting medical care because of your ethnicity, religion, gender or other characteristics?
Base: Asian – Indian (93), Black Caribbean (331), Black African (482), Any other Black, Black British or Caribbean background (264), White – English, Welsh, Scottish, Northern Irish or British (1,535), White – Irish (81), Any other White background (476), Any other Mixed or Multiple background (120), Latin American (124)

Within the Black community, 25% of Black African participants reported experiencing discrimination sometimes or often compared to 19% of Black Caribbean participants.

There are no notable differences in responses to this question between those with English as their main language spoken at home and those for whom English is not their first language. However, there are stark differences in relation to religion.

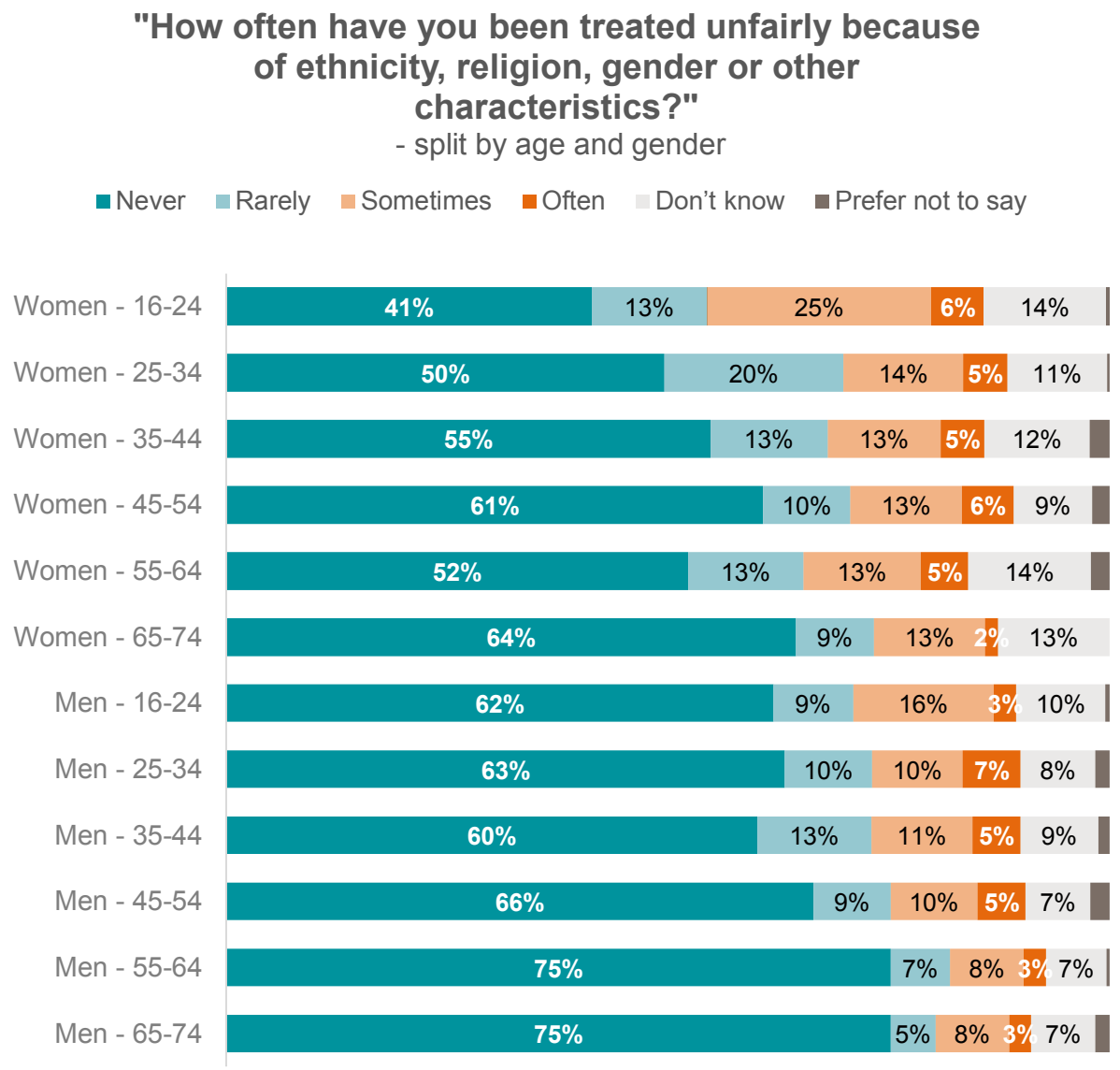
A quarter (26%) of Muslim respondents said that they have experienced unfair treatment “sometimes" or "often”. While this is only marginally higher than the share for Christians, the “never” percentage for Muslims is notably lower than for Christians or other groups.



*Note: Muslim data refers to predominantly non-White Muslim respondents only owing to imbalances in the sample distorting results

Question: C6. Within the past 2 years, how often have you been treated unfairly when getting medical care because of your ethnicity, religion, gender or other characteristics?
Base: No religion (790), Christian (980), Muslim (133), I am not religious (276)

There is also a notable gender divide. Two thirds (66%) of men say they have never experienced discrimination compared to 53% of women. As with other issues discussed earlier, the experience of young women in particular stands out here:



Question: C6. Within the past 2 years, how often have you been treated unfairly when getting medical care because of your ethnicity, religion, gender or other characteristics?
Base: Woman 16-24 (225), Woman 25-34 (589), Woman 35-44 (487), Woman 45-54 (429), Woman 55-64 (350), Woman 65-74 (99), Man 16-24 (140), Man 25-34 (327), Man 35-44 (369), Man 45-54 (343), Man 55-64 (250), Man 65-74 (143)

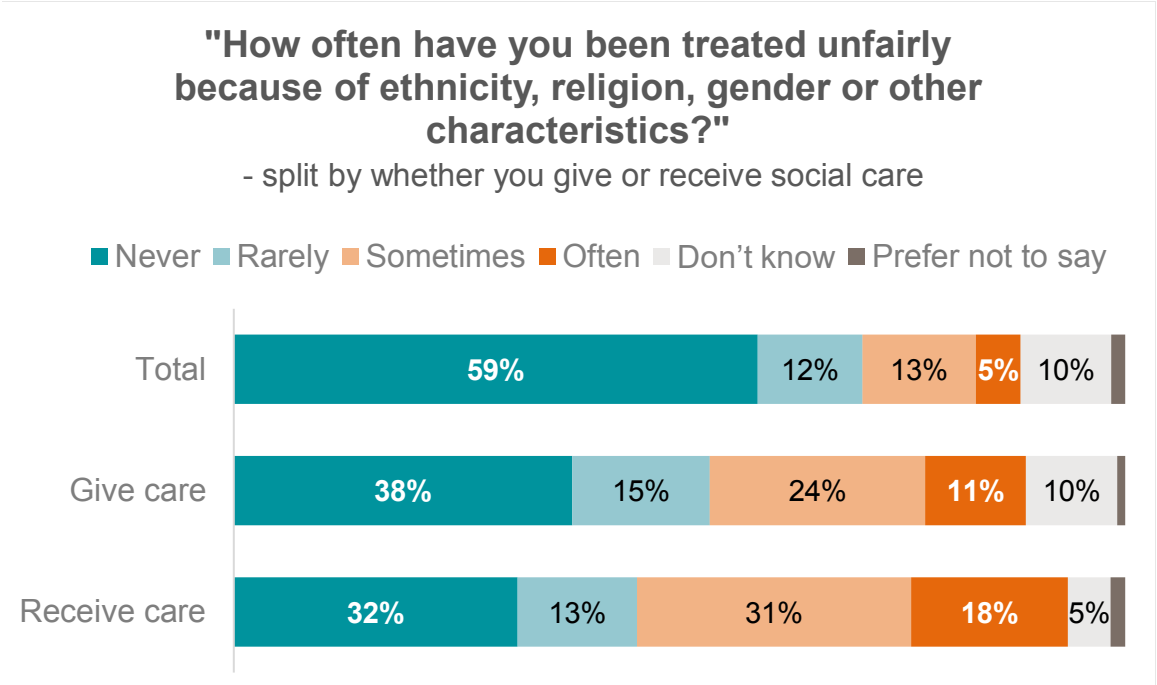
The final two groups to look at in this section are those who give or receive a form of social care. This is based on two questions:

- Do you look after or give any help or support to anyone because they have long term physical or mental health conditions or illnesses, or problems related to old age?
- And do you currently RECEIVE any help or support from anyone because of your long term physical or mental health conditions or illnesses, or problems related to old age?

Those selecting yes to either question (either paid, unpaid, or in receipt of carers allowance) were deemed to be giving or receiving social care. Among those who give a form of social care to

someone else, and among those who receive a form of social care, experiences of unfair treatment are notably higher than average.

“Sometimes” or “often” experiencing unfair treatment was reported by 35% of caregivers and a more substantial 48% of care receivers. Given how these two groups map onto other socio-economic categories, this way of splitting the data can function in a similar way to financial situation in that it highlights the experience of more vulnerable groups:



Question: C6. Within the past 2 years, how often have you been treated unfairly when getting medical care because of your ethnicity, religion, gender or other characteristics?
Base: all adults (4,000), give care (573), receive care (202)

Regression analysis: factors influencing likelihood to have experienced unfair treatment

Residents’ likelihood of having experienced unfair treatment because of their ethnicity, gender, religion or other characteristics is significantly impacted by all characteristics apart from sexual identity. One possible reason for this may be that sexual identity is not mentioned as an example in the question, though it was intended to be covered by “other characteristics”.

- The chance of experiencing unfair treatment decreases with age and is 49% more likely among women than men.
- Those experiencing financial insecurity are more likely to have experienced unfair treatment. However, those who were socially or privately renting were less likely to have experienced this, as were those without a degree compared to those who do have one.
- Residents from all Black ethnic backgrounds have higher odds of experiencing unfair treatment, particularly Black African residents relative to White British residents (117% more likely). Those who were ‘other ethnicity’ also have higher odds but those of an Asian or Mixed / Multiple ethnic background were not more likely to have experienced unfair treatment in this model.
- Respondents with a long-term condition were also more likely to report these experiences that those who do not have one.

Lack of trust within healthcare

Before beginning the discussion about lack of trust within healthcare, the exploration lab participants were asked to rate (out of ten) their current level of trust, with 0 being 'do not trust at all' to 10 being 'fully trust'. The average score was just under half, at 4.6 out of 10. This shows that currently some residents from Lambeth and Southwark are not very trusting of the healthcare sector based on their lived experiences.

Participants expressed a few different reasons for this lack of trust:

1. Lack of confidence in doctors

Participants mentioned that they do not get enough information from doctors, and they are not confident with what they are being told at appointments. They therefore purposely find out information online before visiting the doctor so that they can question what they are being told.

> Because I know myself and my body, what I do is I go in with a list of symptoms, when they started, what have you. And then when they say, this is what we think you have, I'll ask them, what made you get this conclusion? Because to me, I feel that's the only way I actually get any information... if I'm not well, I feel I have to do the work... I feel more comfortable if I'm literally armed with that information. I trust anything my mum says before a doctor or anything like that.

Quantitative survey findings confirm this (see Key Theme 2 below), where the highest rate of 'non-confidence' in healthcare services was that in relation to GPs (as opposed to a pharmacy or dentist for example).

2. Racism and discrimination lead to a lack of trust

The lived experiences of discrimination and racism which participants spoke about in the first half of the sessions, played their part in causing a lack of trust in the healthcare sector. Participants mentioned that their White friends and colleagues have very different experiences to them.

> What's interesting, (when) speaking to my White friends and colleagues, it seems particularly (with) the female ones. They don't experience the same issues as us, or their trust level is very high. But the number of times they go to a doctor, they get an appointment pretty quickly or they're getting referred. (I ask them) how have you managed to do that? You had a cough yesterday. Now you're seeing (someone).

3. Lack of understanding of the needs of Black people

Other participants mentioned that doctors do not understand the specific needs of Black people, alluding to the fact that medical knowledge and research should not be based upon the average white male or female.

> I believe that some doctors are not familiar with how to care for Black people's skin.... (I went and got my own herbal treatment from an African school), and the doctor said just keep doing whatever you are doing. (If) anybody gives me some kind of diagnosis, I go to 'Dr Google.'

4. Lack of confidence in systems

Some participants struggled to get GP appointments and felt frustrated that the appointment system was lengthy and tedious. The quantitative survey data confirmed this finding in terms of access to GPs, where Asian and disabled people were most likely to state that access to GPs as being 'not easy'. Additionally, from all the healthcare services, survey respondents stated that getting access to a GP was the most difficult (see graphs in Key Theme 2)

> The appointment system (is) terrible. Sometimes you don't get any… You call them on the phone. Most of the times when you start to call them from 8:00am, you may still (have to queue). When you finally get someone on the phone. They tell you, 'oh, we're fully booked' but then they encourage you to ring at 8:00am... We don't trust them when it comes to appointments.

5. Other issues that cause a lack of trust

A couple of participants mentioned that their lack of trust is caused by a belief that issues (of wrongdoing) within the healthcare system are covered up and not addressed sufficiently, and that there are a lot of inconsistencies in the level and type of care that is given.

Survey findings about lack of trust within healthcare

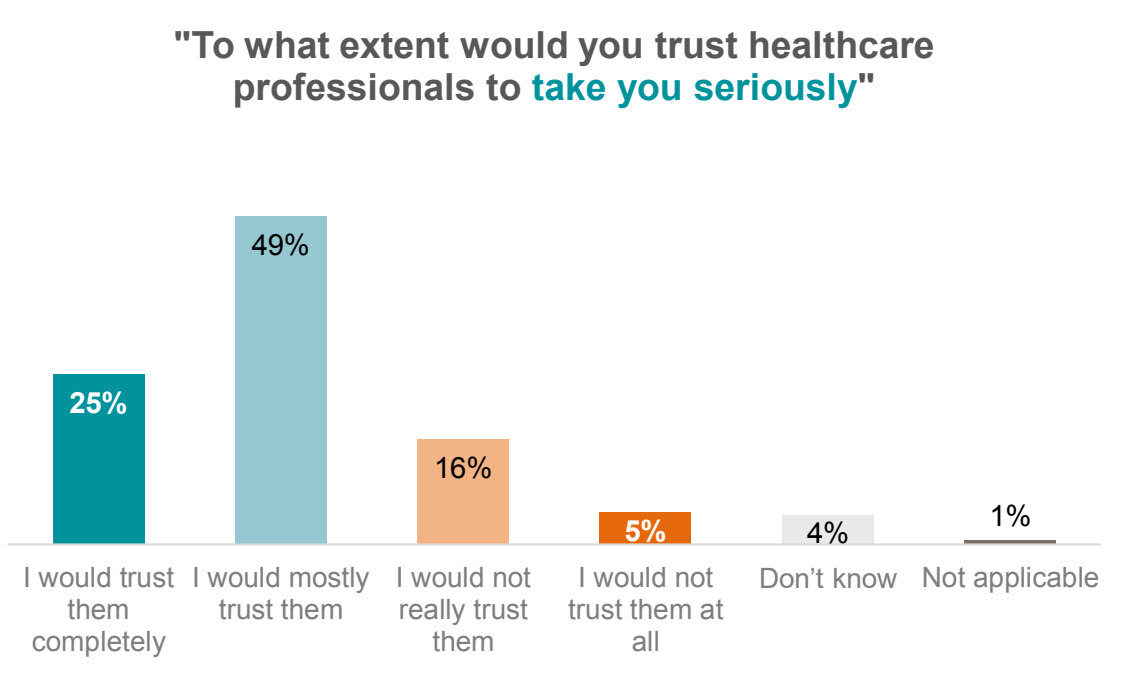
To understand trust (or lack of it) in more detail, we relied on one main question from the survey. This was a grid asking participants to imagine that they were talking to a healthcare professional (such as a GP, nurse, pharmacist) about a health problem and asked the extent to which they would trust that healthcare professional to do each of the following:

- …take me seriously
- …take my problem seriously
- …believe what I was telling them
- …be aware of issues affecting people from my background
- …be able to help with my problem

The goal of this was to tease out differing experiences by different population groups.

Taking you and your problem seriously

In Lambeth and Southwark, the level of trust in healthcare professionals is generally high, but with notable variations across different demographic groups. Overall, 74% of respondents expressed trust in healthcare professionals to take them seriously, compared to 21% who say they would not trust healthcare workers to take them seriously.



Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: all adults (4,000)

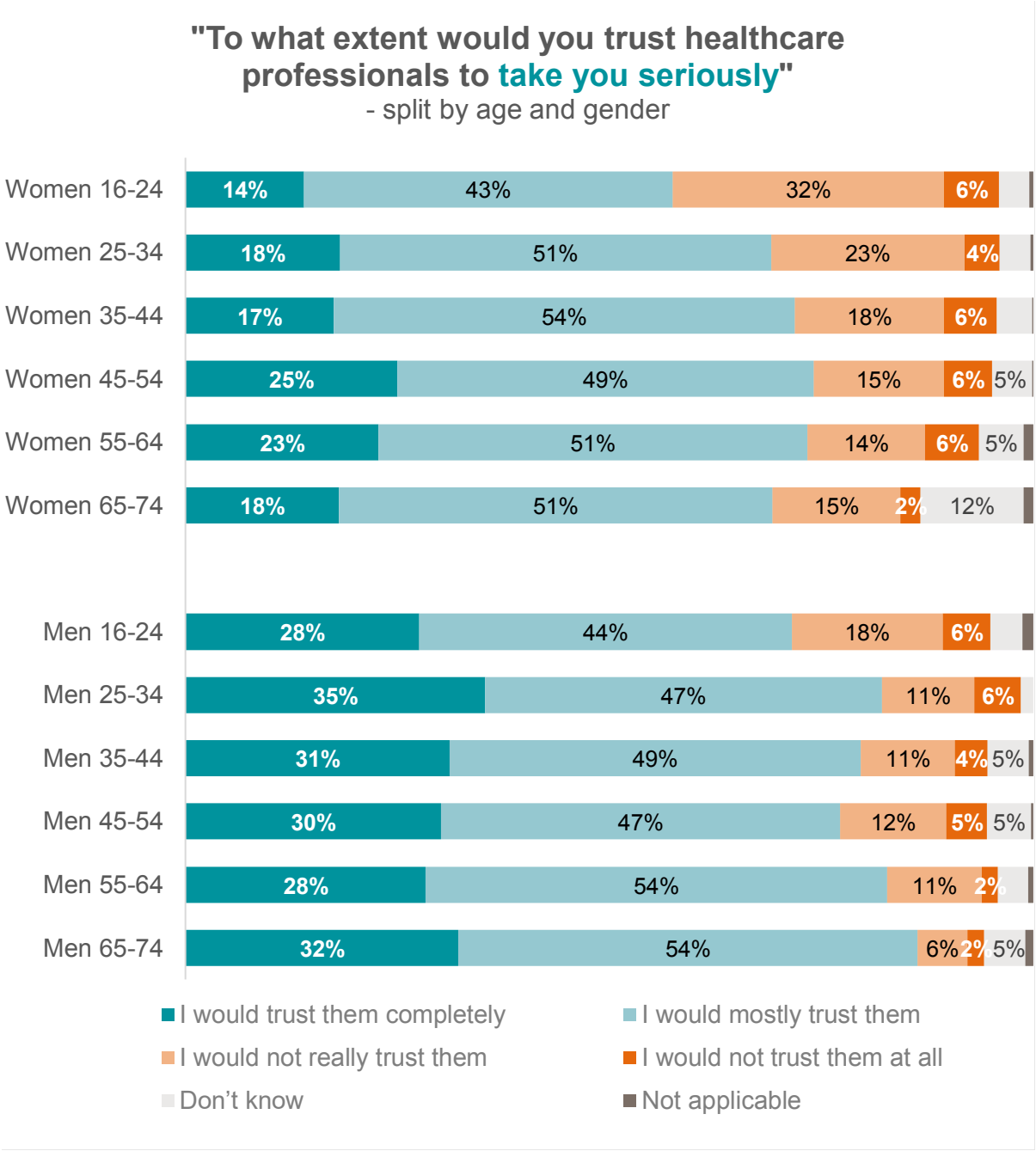
If we define "net trust" as those who would trust completely or mostly minus those who would not really trust them or not trust them at all, men have far higher net trust (64%) than women (45%).

Among age groups, net trust increases with age after a long plateau between 25 and 64:

- 16-24: 33%
- 25-34: 53%
- 35-44: 55%
- 45-54: 56%
- 55-64: 58%
- 65-74: 64%
- 75-79: 82%
- 80+: 71%

However, base sizes for those over 75 are smaller and less representative than younger groups.

When we combine age and gender though, we see that distrust is particularly high among younger women. Net trust among 16–24-year-old women is 19% (57% trusting minus 38% distrusting) compared to 48% among 16–24-year-old men (72% trusting minus 24% distrusting). However, differences continue between genders at each age band:

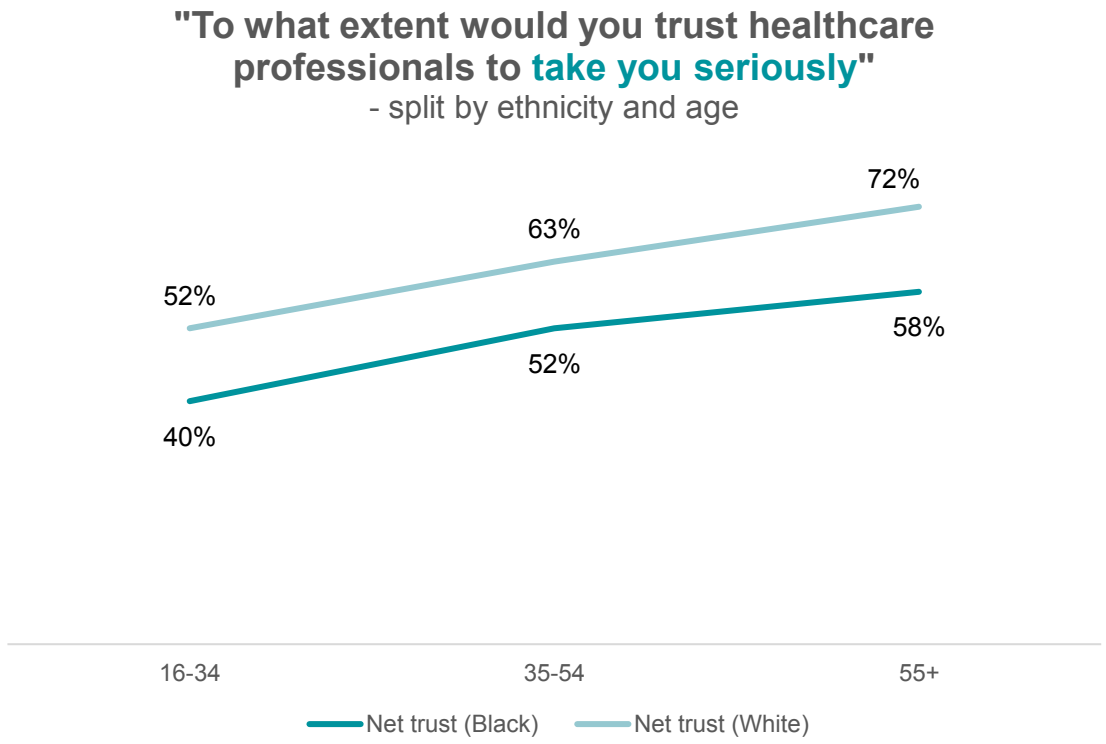


Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: Woman 16-24 (225), Woman 25-34 (589), Woman 35-44 (487), Woman 45-54 (429), Woman 55-64 (350), Woman 65-74 (99), Man 16-24 (140), Man 25-34 (327), Man 35-44 (369), Man 45-54 (343), Man 55-64 (250), Man 65-74 (143)

Net trust among women rises from 19% among the youngest age group to 42% among those aged 25-34 and levels off at around 50% for older age groups. There is a slightly similar age effect among men but at a higher absolute level.

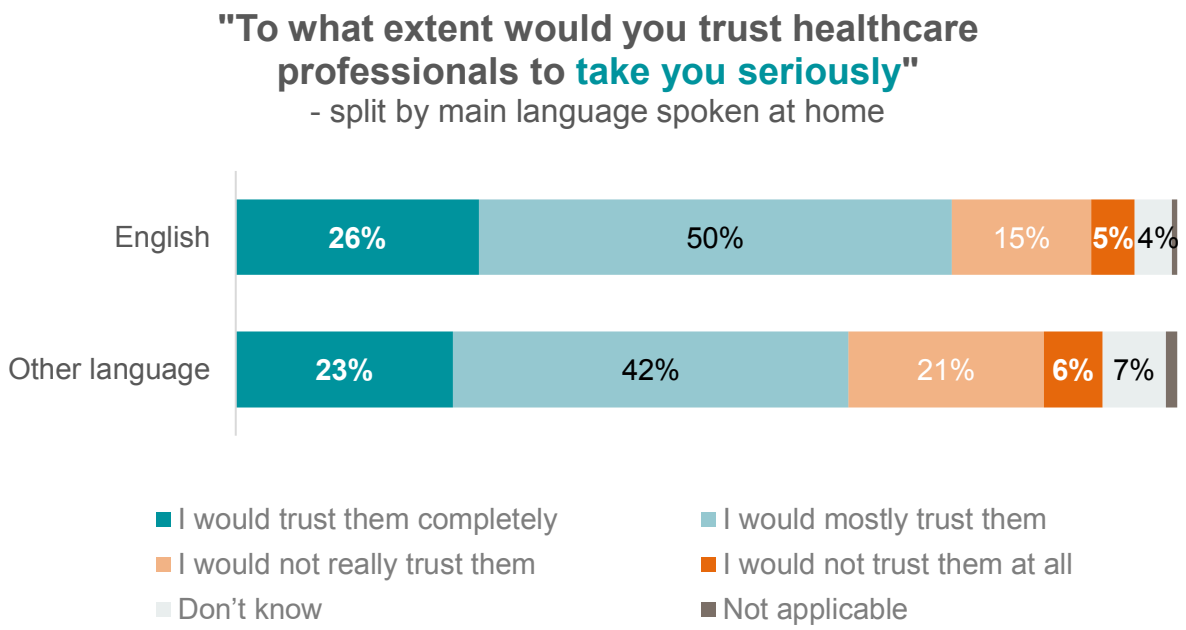
When we ask about taking “your problem” seriously, there is less of an age gap at total level but a similar overall pattern and this holds true when we break things down by subgroups as well.

Ethnicity also shows a wide range of different trust levels with White residents having high levels of net trust (58%) vs. 50% for Black residents and 49% for Asian residents. This is particularly true when combining ethnicity and age. Amongst younger Black and younger White residents of Lambeth and Southwark, the trust divide is high with net trust of 40% amongst young Black participants and 52% amongst young White participants. This trust gap further increases amongst older Black respondents (58%) and older White respondents (72%).



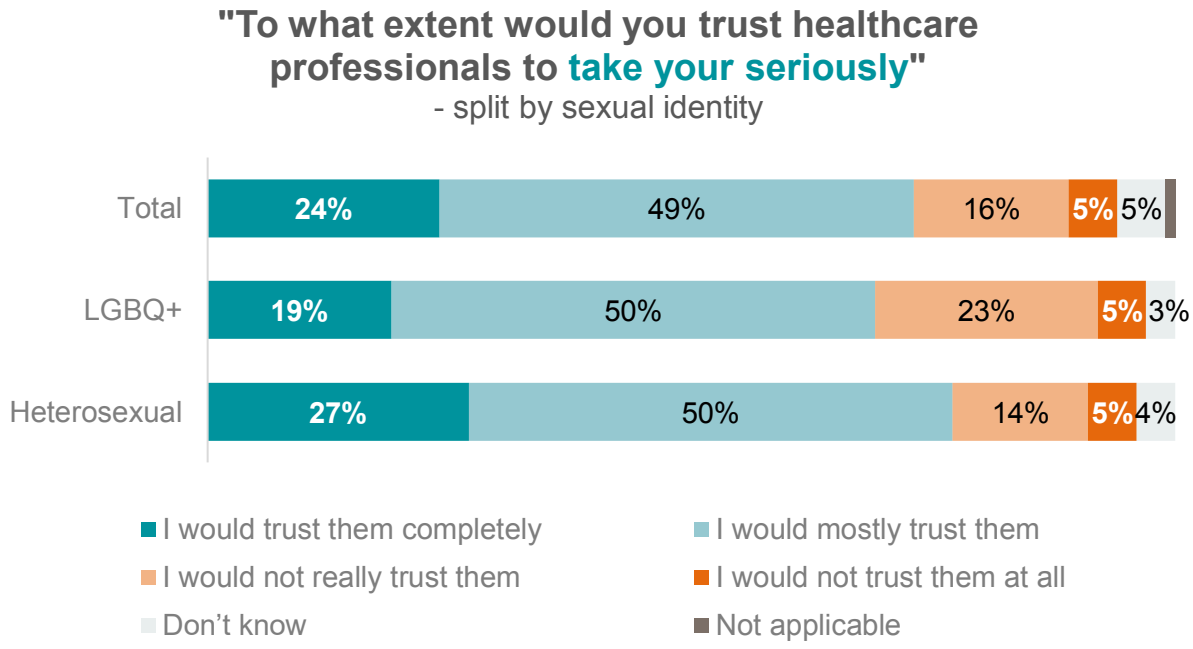
Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: Black 16-34 (352), Black 35-54 (420), Black 55+ (305), White 16-34 (631), White 35-54 (906), White 55+ (563)

Another key difference is between those who have English as their main language spoken at home and those who do not. Among those whose main language is English, net trust in healthcare professionals to take them seriously is 57% compared to 38% for those whose main language at home is not English:



Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: English (3,398), other language (602)

There is also a notable gap between LGBTQ+ participants and those who are heterosexual, with net trust to take you seriously among those who are LGBTQ+ is 41% compared to 57% among heterosexual residents:



Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: LGBTQ+ (522), Heterosexual (3,223)

Regression analysis was undertaken in relation to people's perceptions of whether healthcare professionals take them seriously:

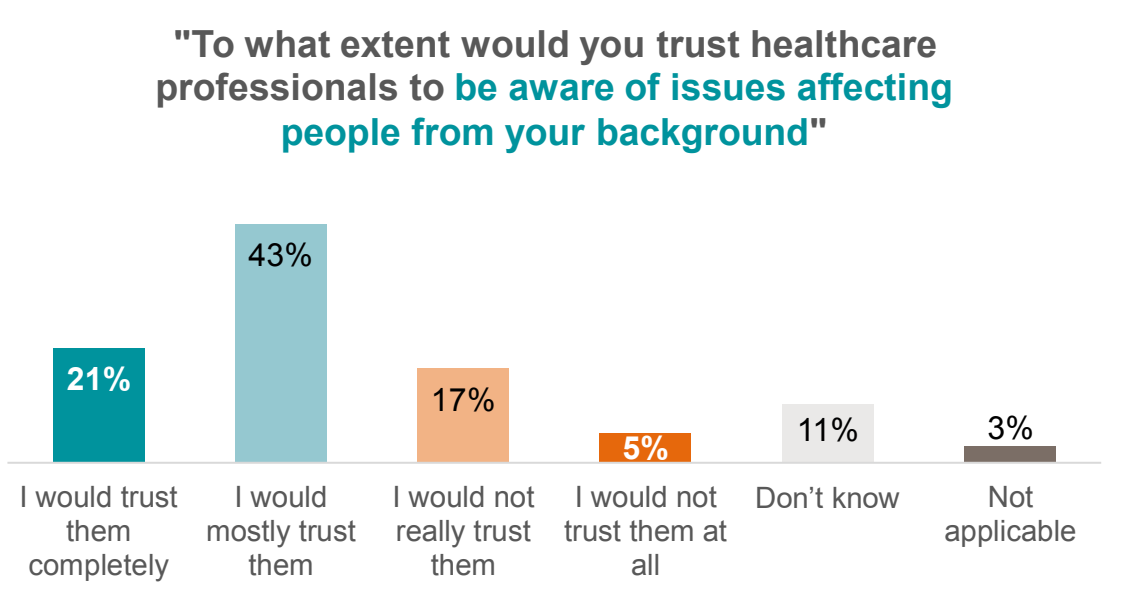
- Age was significant here, as a resident's increasing age also decreases their likelihood to say that they would not trust a healthcare professional to take them seriously.
- A higher level of financial insecurity increases residents' likelihood to distrust health professionals (for each higher level of financial security, residents were 80% more likely to feel distrust).
- Social and private renters are also more likely to not trust health professionals, compared to those who own outright or with a mortgage (23% and 29% more likely respectively).
- Women are also more likely (70%) than men to not trust health professionals, as are LGBTQ+ residents (56%).
- Some ethnic minority groups also had higher odds of not trusting health professionals; compared to those from a White British background, those in the 'other' category, Mixed / Multiple ethnicities, and Asian residents were more likely to distrust health professionals by 84%, 57% and 29% respectively.
- Those with one or more long-term health conditions, impairments or disabilities were also more likely than those without (19% higher compared to those without).

Regression analysis was also undertaken in relation to perceptions of whether healthcare professionals take people's problems seriously. For this item, age, financial security, house tenure, sexual identity, gender, ethnicity, and having a long-term condition were statistically significant.

- As with "taking you seriously", as age increases the odds of someone not trusting a healthcare professional to take problems seriously decrease, while an increase in the level of financial insecurity increases the odds by 90%.
- Private and social renters are also more likely to not trust their healthcare professional by 40% and 19% respectively when compared to those who own outright or with a mortgage.
- Women and those identifying as LGBTQ+ also have increased odds (56%, 48% respectively compared to men and heterosexual/straight respondents).
- Residents of an Asian, Mixed / Multiple, 'other' and 'Other White' background also had higher odds against White British residents of not trusting health professionals.

Awareness of background

About two thirds (64%) of Lambeth and Southwark adults trust that healthcare professionals are aware of issues affecting people of their background, compared to around one in five (22%) who do not trust healthcare professionals to do this.



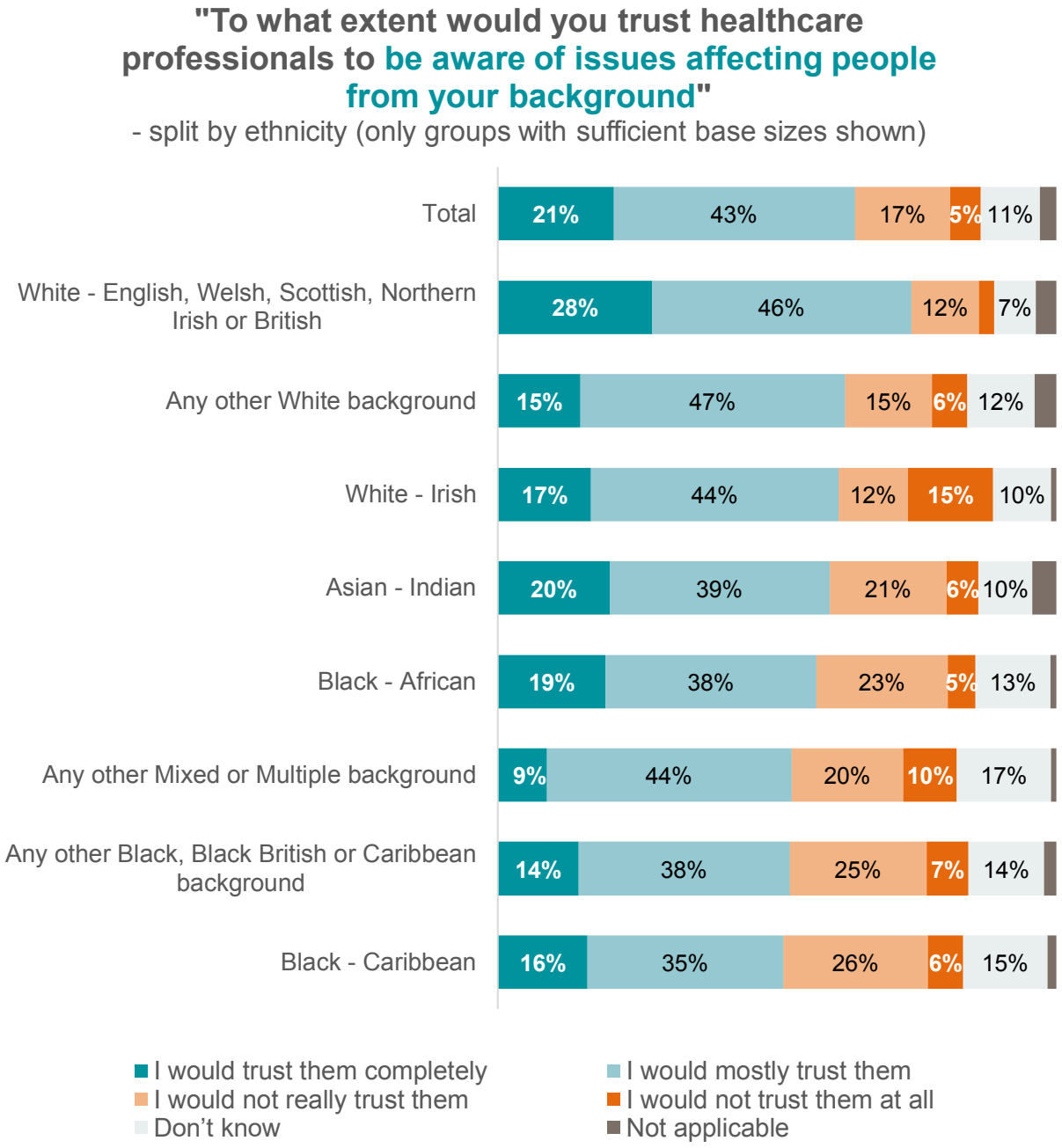
Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: all adults (4,000)

Looking at key population breakdowns several key insights emerge. Splitting by age, those who are 16-24 are less likely to have trust on this measure than older age groups, with 28% saying they would not trust a healthcare professional to be aware of this vs. 22% across all age groups.

However, the focus of this question was on the experiences of ethnic minorities and here we do see distinctly varying trust levels.

Looking at the broader census groups, 60% of Asian participants expressed trust in healthcare professionals being aware of issues affecting people from their background vs. 54% for Black participants and 59% of Latin American participants.

Moreover, when looking at the sub-categories within "Black", there is variation in trust levels: Black African respondents showed 57% trust, whereas Black Caribbean respondents showed slightly lower trust at 51%.



Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...

Base: Asian – Indian (93), Black Caribbean (331), Black African (482), Any other Black, Black British or Caribbean background (264), White – English, Welsh, Scottish, Northern Irish or British (1,535), White – Irish (81), Any other White background (476), Any other Mixed or Multiple background (120), Latin American (124)

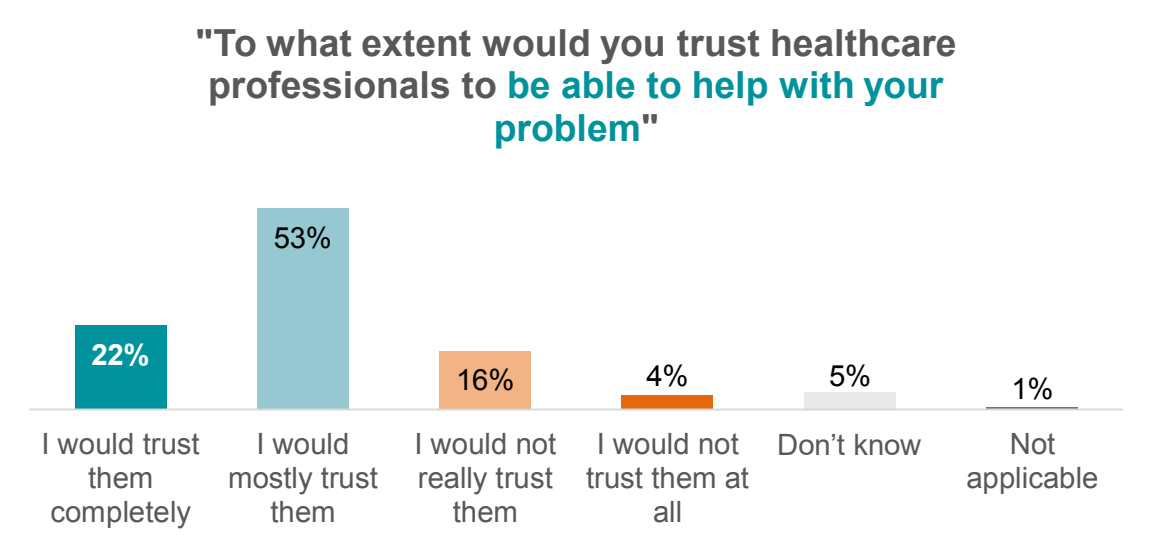
The regression analysis for this question highlights the following key drivers.

- Age and financial insecurity have the same directional relationship here as with other questions in this section, namely age reducing residents' likelihood to distrust healthcare professionals on this issue and greater financial insecurity increasing it.
- Since this question relates most to ethnicity, it is not surprising that all ethnic minority groups were more likely than White British residents to say that they distrusted healthcare professionals here.

- Women also had a 45% higher chance than men of not trusting healthcare professionals, as do those with a long-term health condition.

Trust in outcomes

Three quarters (75%) of residents trust healthcare professionals to be able to help them with their problem, compared to 19% who would not trust them (difference due to rounding).



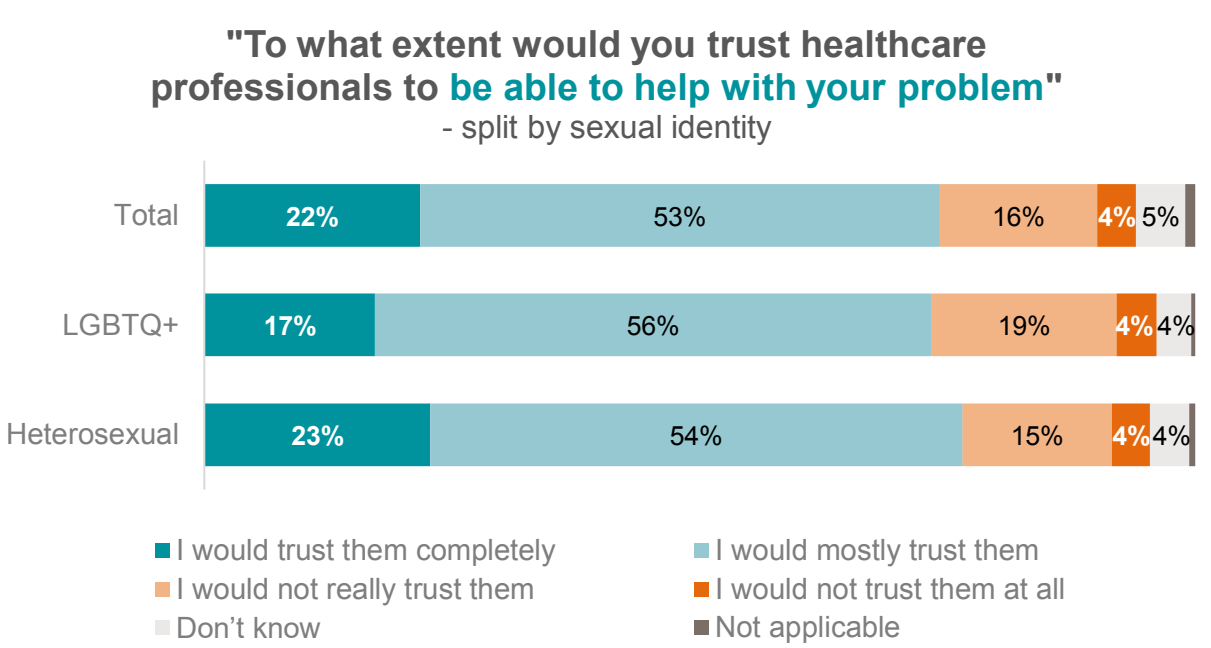
Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: all adults (4,000)

Ethnic background appears to influence trust levels here; White residents report higher levels of complete trust (23%) than those with Mixed ethnicity (14%).

The highest level of distrust is among those with "other" ethnicity, particularly those with a Latin American background who make up a significant proportion of this group. Among Latin American participants, 62% would and 32% would not trust healthcare professionals to be able to help with their problem.

Another disparity is found in the trust levels between different educational backgrounds. Graduates express a slightly higher degree of trust (78%) compared to non-graduates (73%).

A final notable variation appears in the responses based on sexual identity. LGBTQ+ residents demonstrate a lower level of complete trust in healthcare professionals (17%) compared to heterosexual residents (23%).

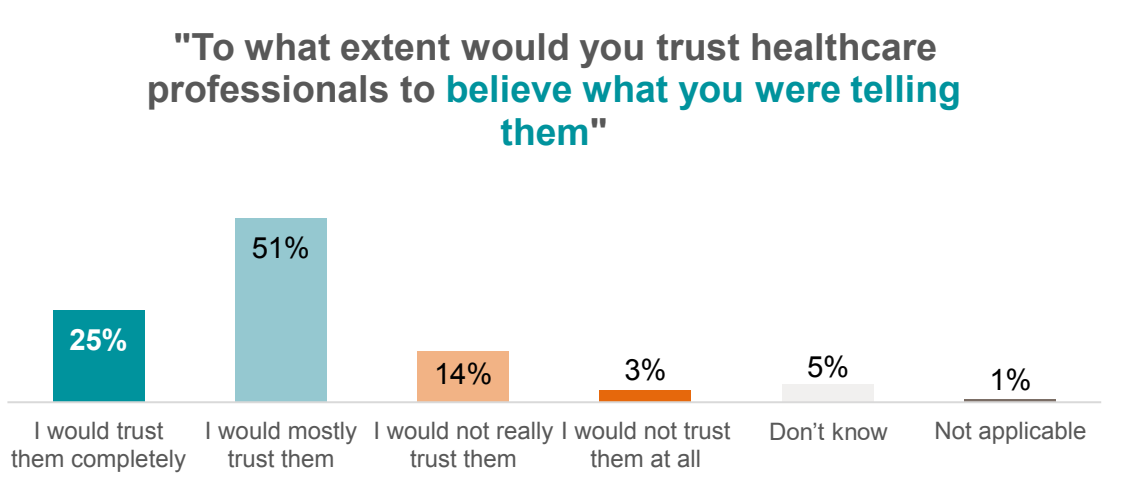


Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: LGBTQ+ (522), Heterosexual (577)

The regression analysis for this question finds that the likelihood of saying "do not trust" decreases with age but increases with financial insecurity. Private renters, women and LGBTQ+ residents are more likely to distrust here, as are those with a long-term health condition. All ethnicity groups were more likely to say 'distrust' than White British residents.

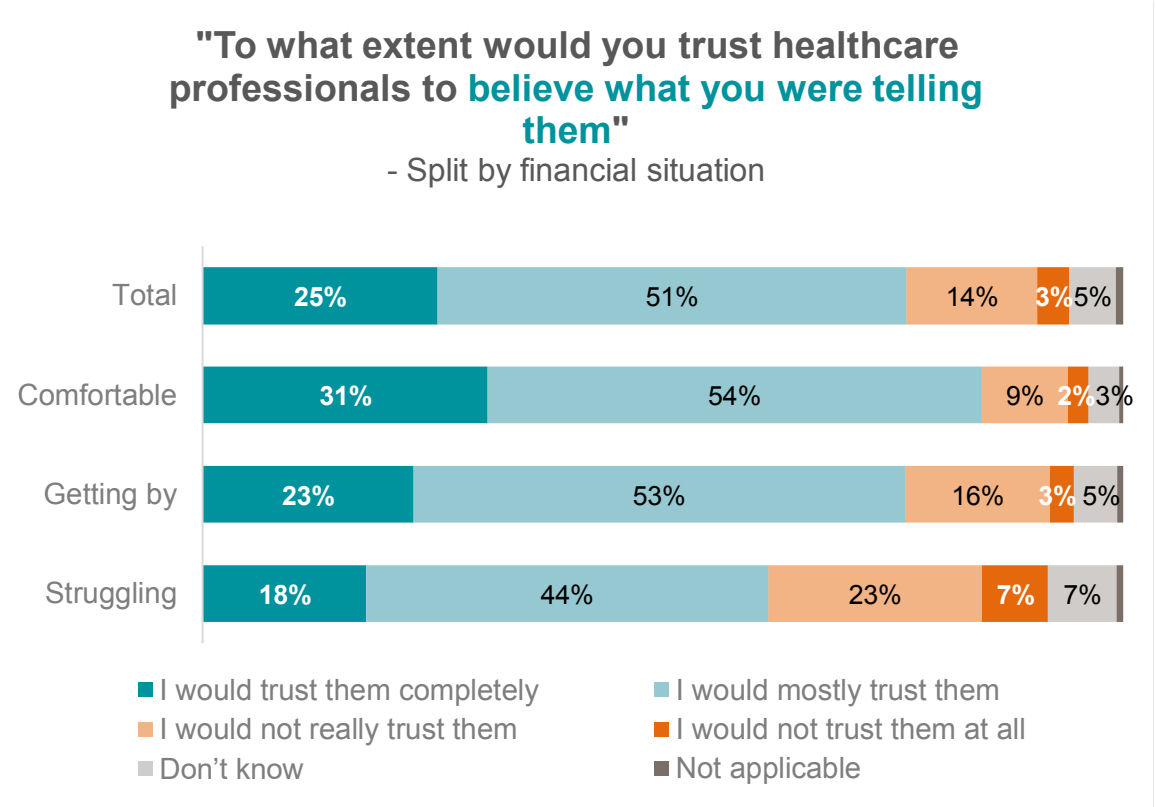
Believing patients

Three quarters (76%) would trust healthcare professionals to believe them compared to 18% who would not (difference due to decimals and rounding).



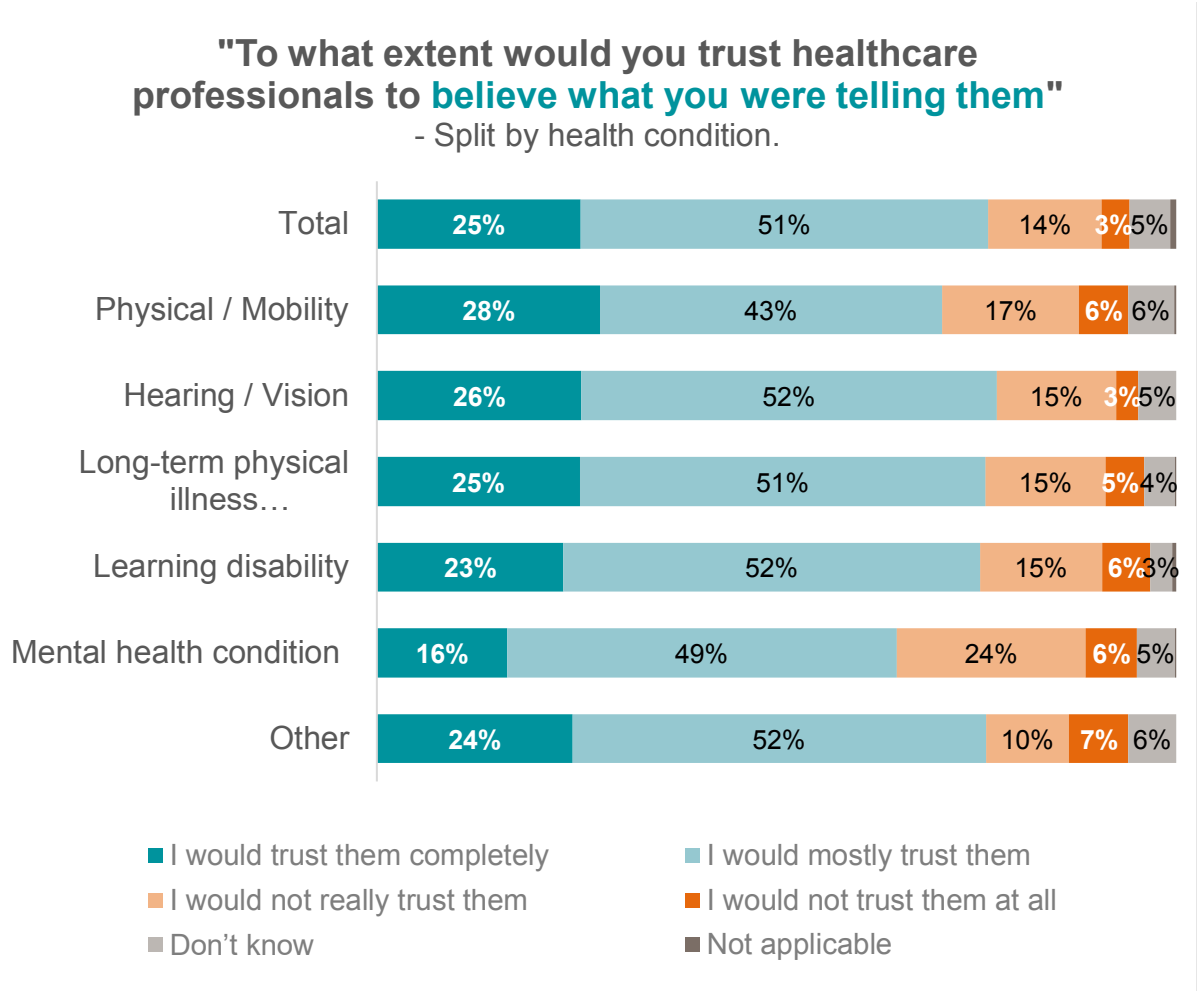
Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: all adults (4,000)

There is a significant split by financial situation with those who are financially “comfortable” having a high level of trust (85%) vs. those who are “struggling” financially (61%).



Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: all adults (4,000), comfortable (1,958), getting by (1,093), struggling (841)

Those with long-term mental health conditions report lower levels of trust compared to the average resident (65% compared to 76% respectively).



Question: C5. Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...
Base: all adults (4,000), physical / mobility (438), hearing / vision (249), long-term physical illness or health condition (864), learning disability (308), mental health condition (592), other (100)

Exploring the regression analysis for this measure, age, financial security, sexual identity, housing tenure and whether or not someone has a long-term condition all have the same directional effect on a person's likelihood to trust a healthcare professional to believe them.
Similarly, on ethnicity, Black African, Black Caribbean, Mixed/Multiple ethnicities, 'other ethnicity' and 'Other White' residents all had increased likelihood of saying they do not trust healthcare professionals to believe them.

Suggested ways to reduce discrimination and increase trust within healthcare

Participants suggested ways that discrimination within healthcare could be reduced, and ways to increase levels of trust. These suggestions included increasing the diversity and cultural training provision amongst healthcare staff, providing easy mechanisms for patients to give feedback, recruiting more diverse workforces in different healthcare settings, and reducing the pressure on healthcare staff. Some of these initiatives may have already been undertaken in the healthcare settings experienced by participants, but participants were either not aware of this, or felt that the service they received was lacking, therefore called for improvements regardless.

1. Training for staff in health-related services

Participants suggested that training should be embedded within career progression structures and start from university level. This training should cover topics such as unconscious bias or cultural sensitivity:

> …… cultural sensitivity training, I think is really important because there's so many people, like there might be a Muslim woman who doesn't want to be seen by a male doctor and …. provisions need to be made for that.

Another element of training flagged was the need for healthcare staff to learn how to actively 'listen' to patients and learn how to show more empathy. A common theme throughout the exploration labs was participants feeling unheard:

> There's something about empathy because it seems to have left the building. I think that will make a huge difference… listening to what they're saying and hearing them, but also asking clarifying questions…You know, to investigate what's happening.

Along with providing culture and diversity training for healthcare staff and having clear anti-discrimination policies, one participant suggested that medical students could take part in internship opportunities in order to reduce the gap between staff and patients when they come into contact with diverse communities at the very start of their careers.

> I think there can be some form of internships for the medical students just to bridge the gap between the staff and patients… that will (give) exposure to the students. Also, they can earn some form of experience, or some form of certifications and they will gain experience, exposure and that will reduce the gap and it will increase the credibility.

2. Better mechanisms to provide feedback to healthcare staff, and to know how feedback has been addressed

Participants stated that there should be improved mechanisms for them to provide feedback to healthcare staff, even though some acknowledged that in some healthcare settings this is available. They also felt unsure whether the feedback is actioned.

> GPs and hospitals (should) ask for feedback and reviews.
> my GP or the hospital normally sends a text, a request for feedback...what we don't know is what they do with the feedback that we give.

3. More medical research to be carried out with diverse audiences

Linked to the training, participants felt it was important to provide alternative examples of medical cases, and not just those causes and symptoms that would be prevalent in White men. This highlighted the need for more research into medicine, and health and wellbeing, from the perspective of those from underserved communities. For this to happen, more research needs to be done into the different characteristics of different ethnicities:

> I feel like we need to start expanding research, things like, the average height or weight. Especially with Black people we have a higher weight mass, BMI. The average height and weight of someone who is White, raised in the UK and (their) whole ancestry is White, (would be lower) in comparison to a Black person whose (BMI) would be much higher. There's a lot of Black women and men who are being diagnosed with obesity which (is) to a White person's standards, we're quite obese but we're actually quite healthy.

4. Reduce pressure on healthcare staff, invest more resources into health services

Participants expressed a level of empathy and understanding about the amount of pressure that healthcare staff - particularly doctors and nurses- are facing, and this could play a part in the way that they interact with or treat patients. They proposed that more resources should therefore be invested in healthcare services to ease this pressure.

> I think it needs to go like this… more resources need to be put into the healthcare system, but not just in…predominantly White middle-class areas (but those) actual areas that need it, because the less resources there are, the more people, the marginalised, the minorities that will be affected by it. And then because there's less resources, doctors also have less time. So, they need to like have more time, more resources.

5. Increase diversity within healthcare staff

Having diversity within the workforce was a common suggestion for improvement. Participants felt that a diverse workforce would not only represent diverse communities that visit healthcare settings, but there would be better understanding of diverse needs. Participants also felt that some of the current workforce within healthcare settings is there due to 'need,' as opposed to 'want,' therefore they lack the passion that is required in this sector.

> I think culture change is important. Like that means commitment from the very top levels to the bottom. [Meaning] that people in the top level and those who are funding or anything [similar] should represent a diverse group of people. And then the people who are working in hospitals and managing hospitals like every level [should] have different people.

6. Consistency and continuity with doctors (GPs)

Participants felt that there is now a lack of consistency or continuity with the same doctor when going to a surgery, and this has led to a reduction in trust. They appreciated being able to see the same doctor who knew about their medical conditions and history, so they did not need to repeat it all whenever they had a new appointment.

> Seeing the same doctor, because a lot of the time you're getting different doctors… like the amount of time that I repeat myself for something that is fairly standard and simple and … (there are) no records (which is) terrible as well.

7. Sanctions imposed for discriminatory behaviour

In order to address the discrimination that does take place, some participants felt that healthcare staff should face consequences if they are found to have behaved in a discriminatory way with the aim of reducing this kind of behaviour through a zero-tolerance policy:

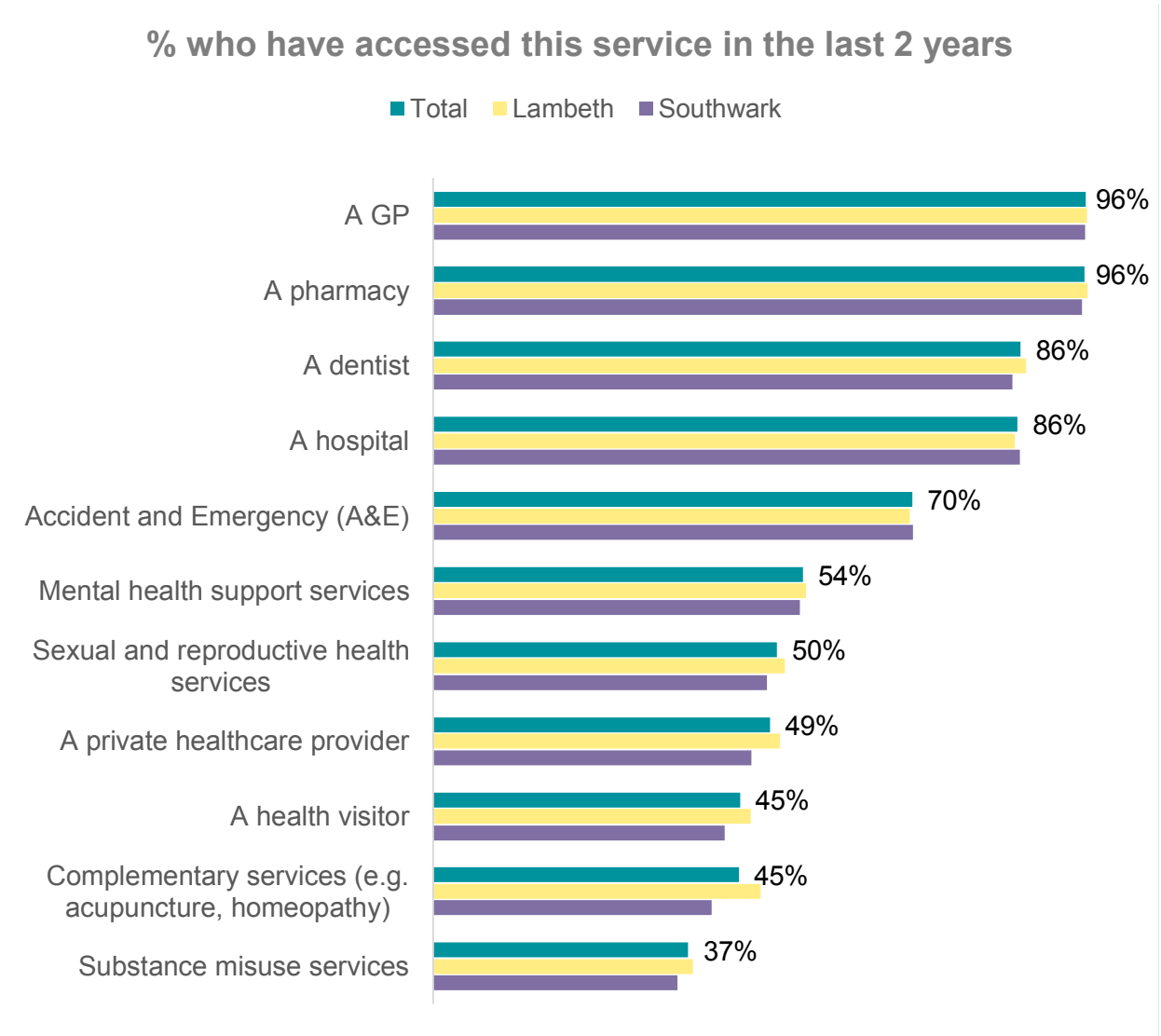
> People shouldn't be made to feel like they're walking on ice...I think they need to bear the responsibility of the fact that any form of discrimination is not tolerable. And it can lead to some sort of, you know, action.

8. Other ways to improve levels of trust within healthcare

Other suggestions that participants made to improve levels of trust within healthcare included relatively straightforward changes such as using accessible language, especially with those for whom English is not their first language. This would enable them to have a better understanding of their health-related queries. And for those who are comfortable with technology, apps like 'Dr IQ' have proven to be helpful sources of information, especially when they provide an online GP consultation service.

Access to services

We asked residents in Lambeth and Southwark how easy it was for them to access various health services they had needed over the past two years. Residents were also able to say whether they had accessed these health services or not. Almost all residents had needed to access a GP (96%) or pharmacist (96%) while the majority had also needed to access a dentist, a hospital and an A&E. Over half of residents had needed to access mental health support services. Across almost all services, there is little difference in levels of need across Lambeth and Southwark as a whole, although residents in Southwark are slightly more likely to have needed to access a complimentary service, such as acupuncture.



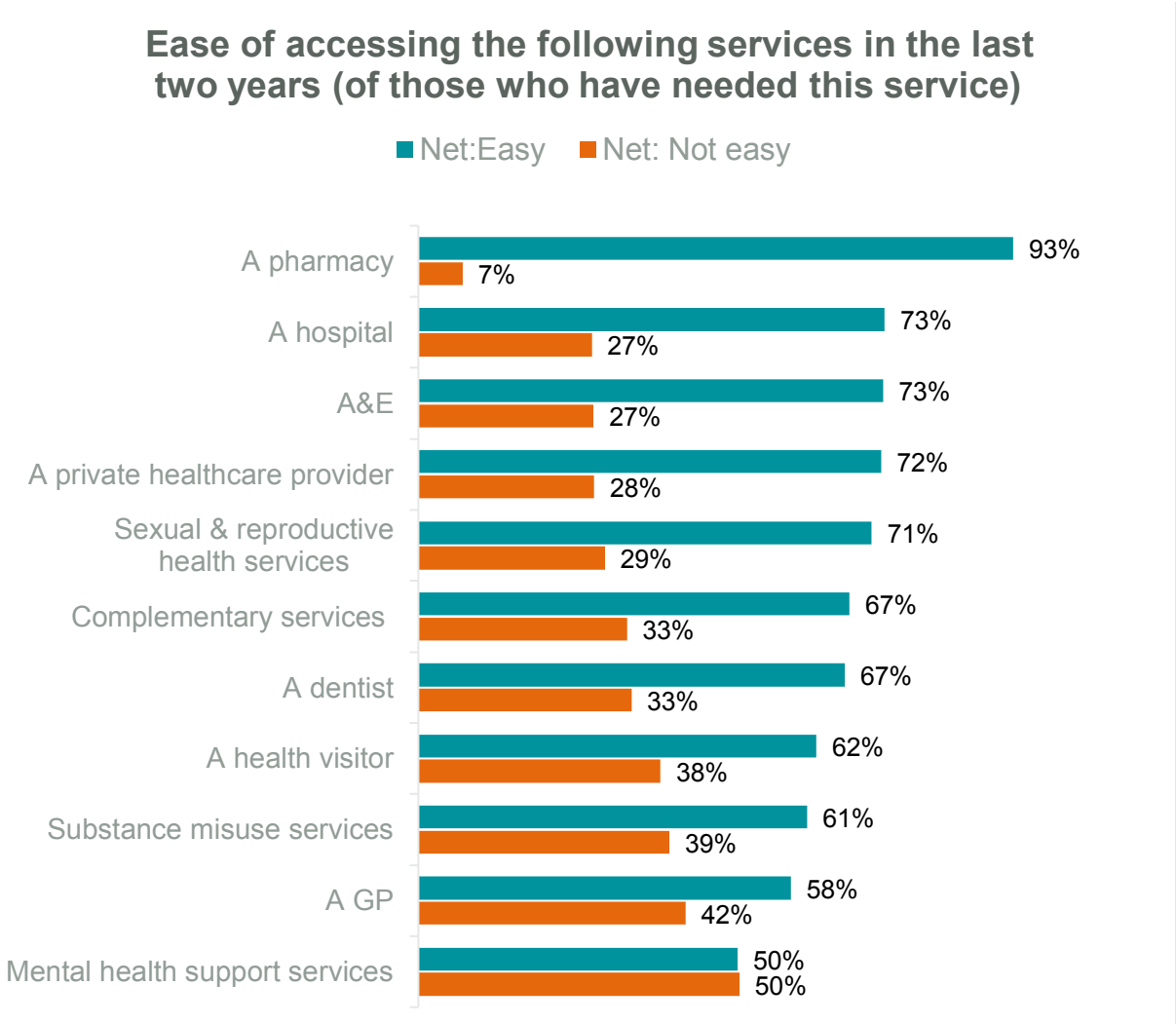
C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for. (% shown is those not selecting "N/A – have not needed this service in the last two years)

Base: all online and community outreach respondents. CATI respondents saw two randomly allocated services (base size varies for each service), services (767), mental health support services (1,299)

NOTE: for telephone respondents, all were asked about GP, hospital, A&E, pharmacy and dentist but otherwise only asked about a randomly assigned 2 services. Bases are therefore lower for these services.

Residents in Lambeth and Southwark struggle to access mental health support services. Among those who have needed mental health support services in the last two years who answered the question on ease of accessing services, half said it was not easy to access the mental health services they needed. GP services are also a struggle for many to access, with 42% of those who have needed to speak to a GP over the last 2 years stating that access was not easy, compared to 58% who found it easy. This is of particular concern, as after pharmacists, GPs are the most accessed health service (96%), while half (54%) have accessed mental health support services. So, although mental health services perform worst in terms of access, more people are affected by difficult access to GP services.

It should be noted that due to questionnaire space limitations, whether or not someone has accessed each service was determined by whether or not they ticked N/A in the question on ease of access. It is possible therefore that there is some overclaim on some of the less used services.



C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" for each service, and excluding those that ticked don't know or prefer not to say: pharmacy (3,644), hospital (3,227), A&E (2,617), dentist (3,215), sexual & reproductive health services (1,311), private healthcare provider (1,120), GP (3,631), health visitor (1,149), complementary services (988), substance misuse services (767), mental health support services (1,299)

NOTE: for telephone respondents, all were asked about GP, hospital, A&E, pharmacy and dentist but otherwise only asked about a randomly assigned 2 services. Bases are therefore lower for these services.

Pharmacies in Lambeth and Southwark are doing well; 96% of residents have needed a pharmacy service in the last 2 years, and of these, almost all (93%) have found access easy, with just 7% saying it was not easy.

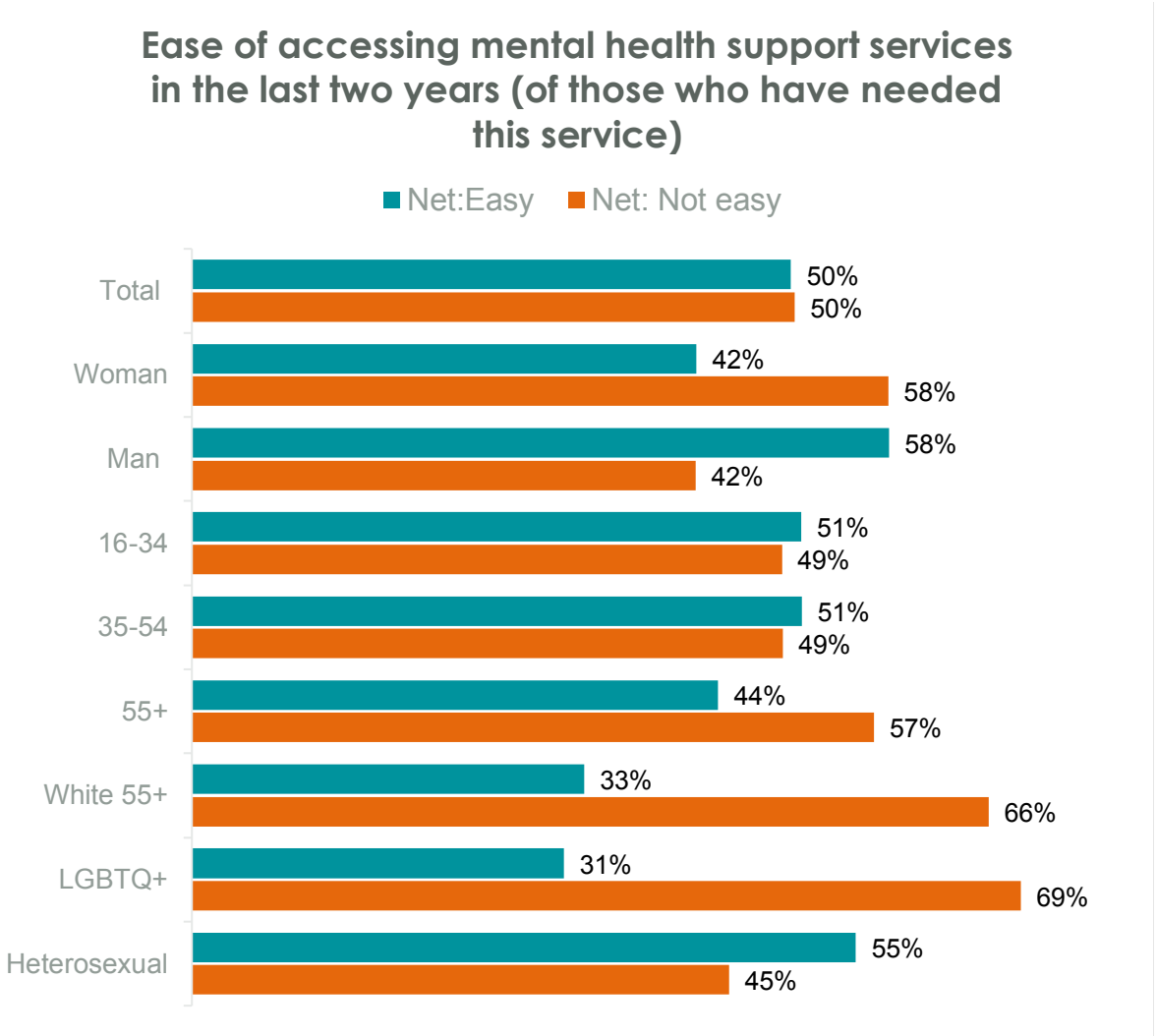
Seven in ten of those who have needed a hospital or A&E service in the last two years have found access easy while around a quarter have not.

After mental health services and GPs, dentists and substance misuse services have the highest proportions of residents who have needed their services saying it was not easy to access them.

Variations in access to mental health services

While 54% of residents indicated that they have had to access mental health support services (based on 46% selecting "N/A - I have not needed this service"), this is higher among younger people, compared to older residents (63% of 16–34-year-olds, 55% of 35–54-year-olds and 38% of 55+). Other groups who are also more likely to have needed to access mental health services are:

- Disabled residents (63%)
- Residents with mental health conditions (85%) and learning disabilities (74%)
- Those that give care (72%)
- LGBTQ+ residents (64%)
- Religious residents are more likely to than those that are not religious (e.g. 62% of Christian residents, 65% of Muslims).
- Residents from a White background (56%) are more likely to than residents from an ethnic minority background (52%)
- Residents on the lowest and highest ends of the income scale (61% of residents with a personal income of under £20,000, 62% of residents on personal income above £60,000)
- Those that are struggling financially (67%)



C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at mental health support services and excluding those that ticked don't know or prefer not to say, total (1,299), Woman (652), Man (603), 16-34 (690), 35-54 (447), 55+ (162), White 55+ (101), LGBTQ+ (271), Heterosexual (975)

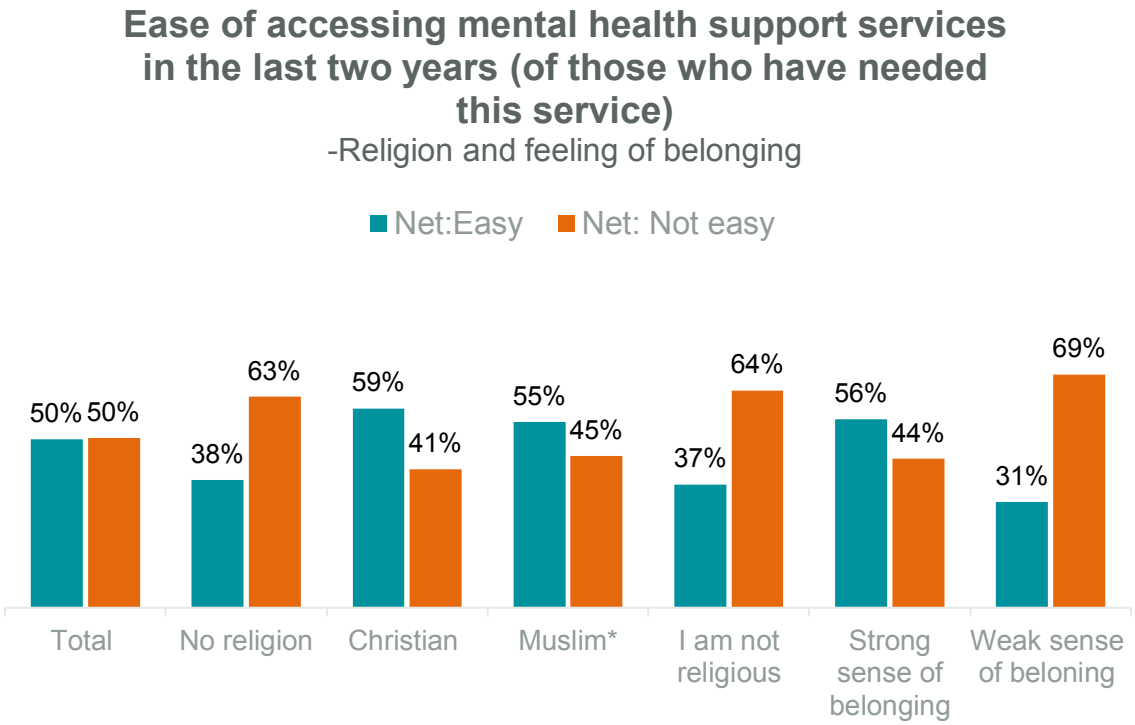
Women who have needed access to mental health services over the past 2 years and gave a response on whether this was easy or not, are more likely to have found that difficult than men, with 58% saying access was not easy compared to 42% of men.

Older residents were more than twice as likely in our survey to respond with 'don't know' or 'prefer not to say' about ease of access to mental health support services they have needed in the past 2 years compared to other age groups, resulting in differences between the number of younger people saying access was easy compared to older residents. Accounting for this by removing the don't know and prefer not to say responses from calculations reveals that older people are actually more likely to find it harder to access mental health services, with 57% of those aged 55 or over saying this has not been easy for them compared to half of those under the age of 55.

Those of a White ethnicity are slightly more likely than other ethnic groups to say access was not easy, and this is being driven in particular by older age groups of a White ethnicity.

LGBTQ+ residents who have needed mental health support services in the last two years are much more likely to say access is not easy compared to heterosexual residents (69% and 45% respectively).

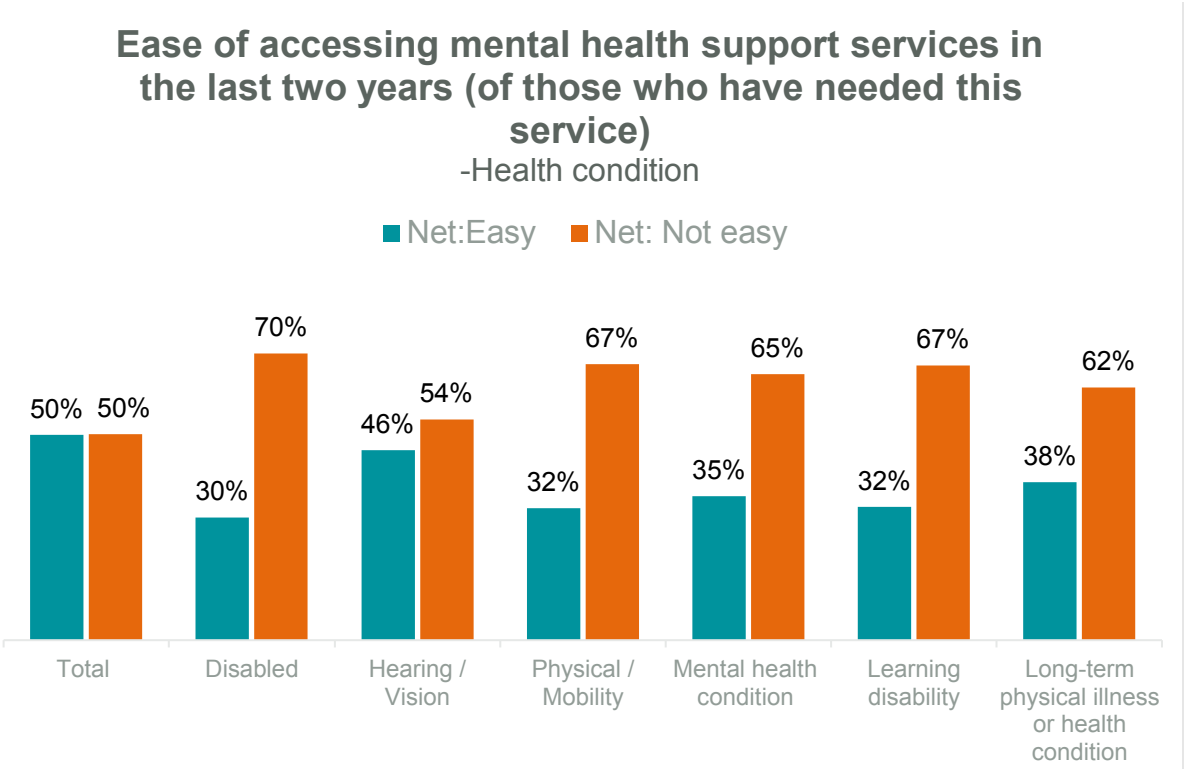
Residents who said they have no religion or that they are not religious are some of the most likely to say they have found it difficult to access the mental health services they have needed in the last two years. Those with a weak sense of belonging to their local area are also more likely to find it difficult to access mental health services than those with a strong sense of belonging.



*Note: Muslim data refers to predominantly non-White Muslim respondents only owing to imbalances in the sample distorting results

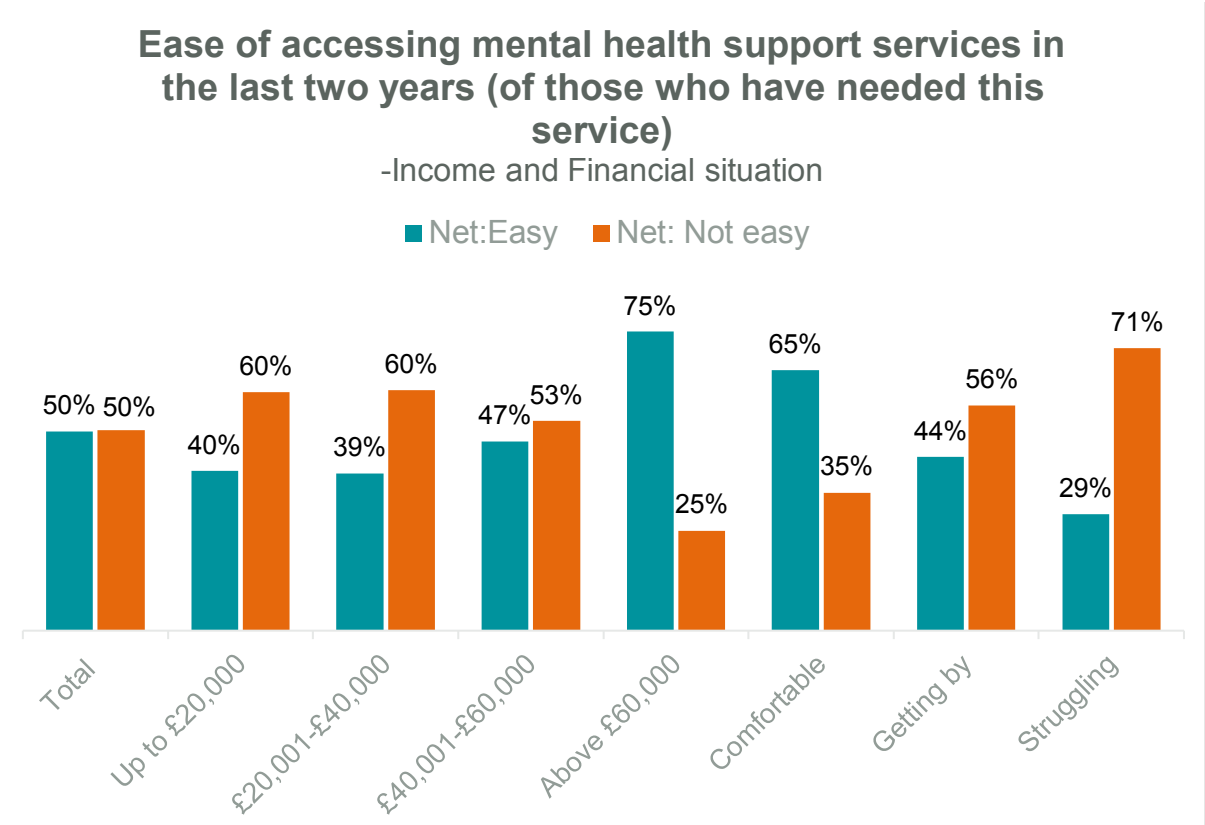
C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at mental health support services and excluding those that ticked don't know or prefer not to say, total (1,299), no religion (352), Christian (468), Muslim (76), not religious (115), strong sense of belonging (895), weak sense of belonging (285)

Residents who identify as disabled have more difficulty accessing the mental health support that they need with 70% of those who needed support finding access difficult in the last two years. This is particularly more difficult for those that have mental health conditions, learning disabilities or physical disabilities.



C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at mental health support services and excluding those that ticked don't know or prefer not to say, total (1,299), disabled (238), hearing/vision (67), physical/mobility (143), mental health condition (394), learning disability (151), long-term physical illness or health condition (278)

Finances also impact ease of access to mental health services. Three fifths (60%) of residents on the lowest end of the income scale who have needed mental health support have found that difficult to access, while three in four (75%) of those on £60,000 or above have found it easy:



C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at mental health support services and excluding those that ticked don't know or prefer not to say, total (1,299), up to £20,000 (360), £20-40,000 (315), £40-60,000 (177), Above £60,000 (275), comfortable (598), getting by (347), struggling (329)

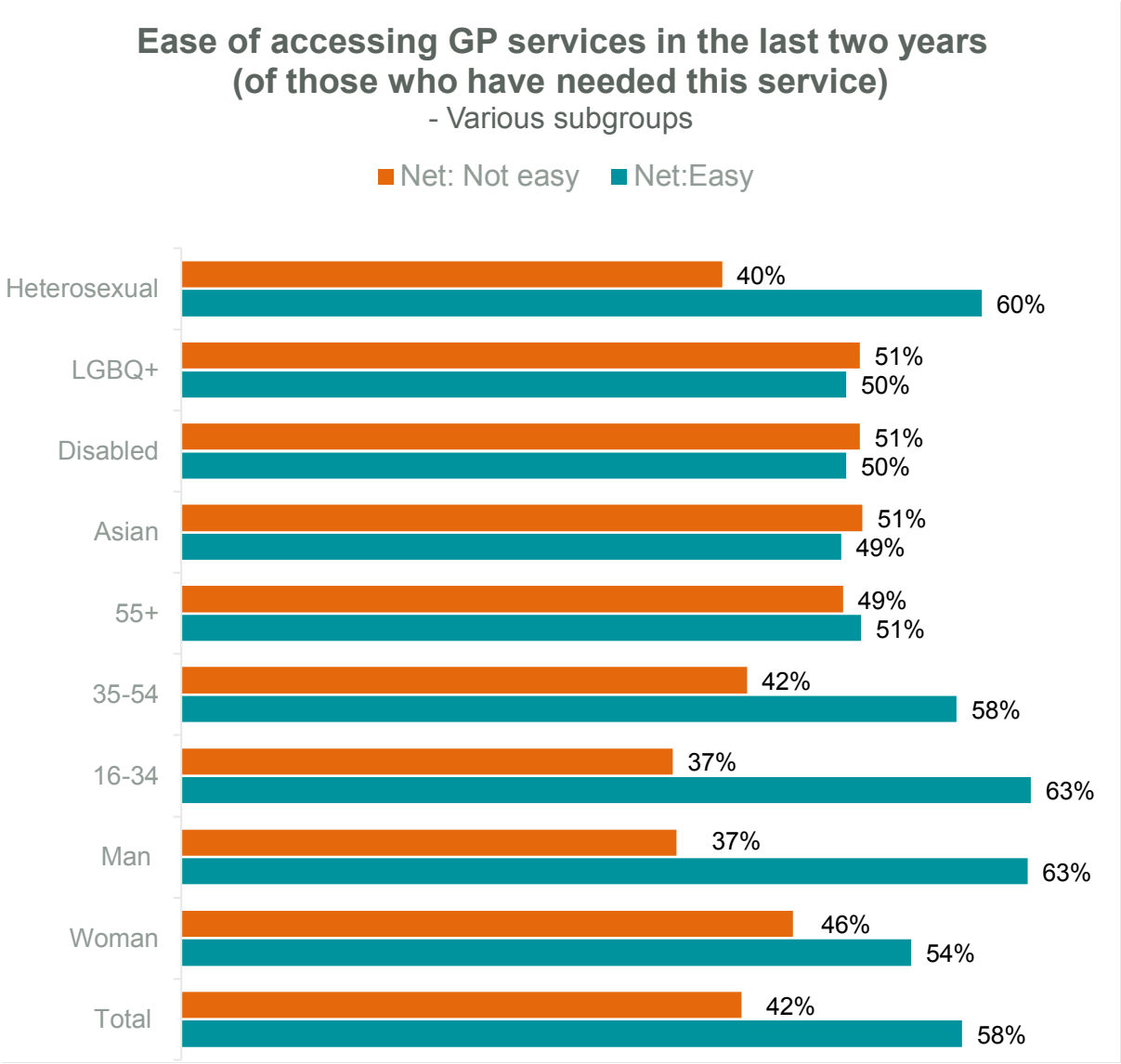
There is little variation in ease of access at a total borough level between residents in Lambeth and Southwark.

Variations in access to GP services

Men who have needed to access a GP in the last 2 years and gave a response on whether this has been easy or not, have found it easier to get that access than women. Three fifths (63%) of these men say accessing a GP has been easy for them compared to half (54%) of women. 46% of women have not found access easy.

Younger people that have needed to access a GP have found that easier than those aged 55+.

Disabled adults who need GP access struggle more than the rest of the population to access a GP, with 51% saying they have not found it easy in the last two years.

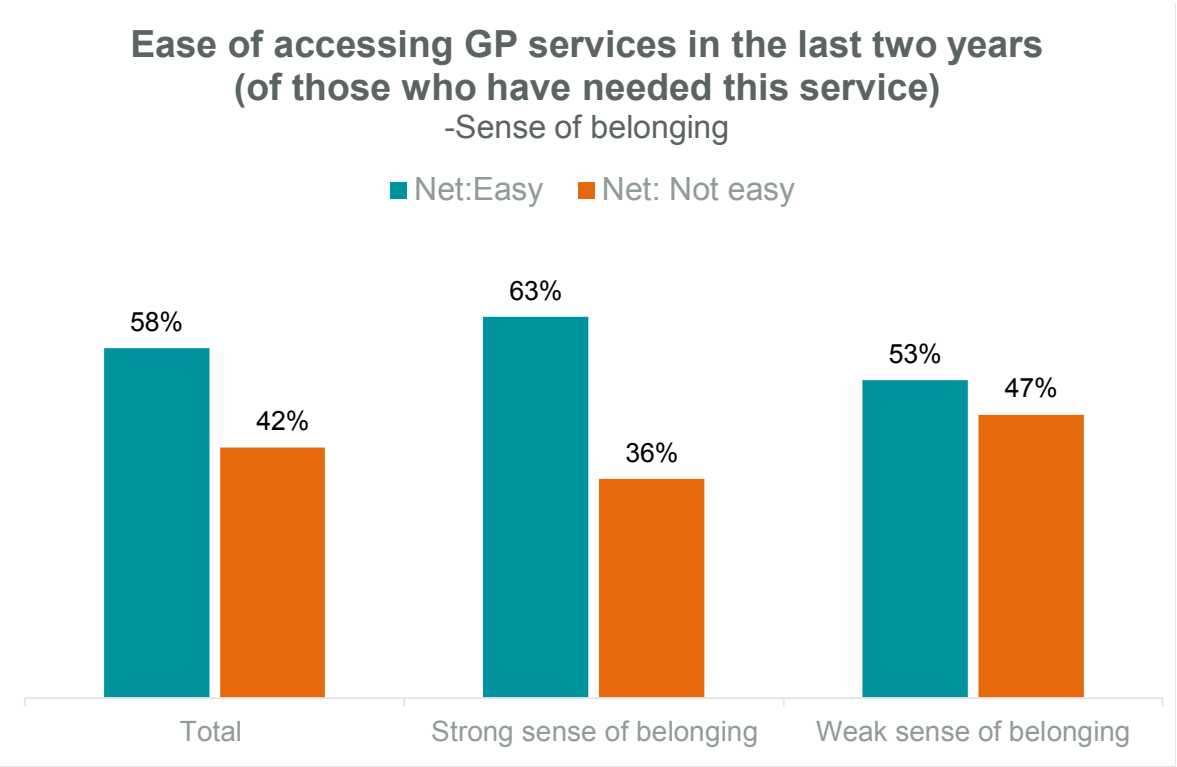


C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at GP services and excluding those that ticked don't know or prefer not to say, total (3,631), Woman (1,871), Man (1,620), 16-34 (1,438), 35-54 (1,292), 55+ (898), Asian (313), Disabled (591), LGBTQ+ (527), Heterosexual (2,897)

Asian residents are more likely than residents of other ethnic groups to have found it difficult to access a GP when needed. Half (51%) of Asian residents who have needed to access a GP in the past 2 years have found that difficult.

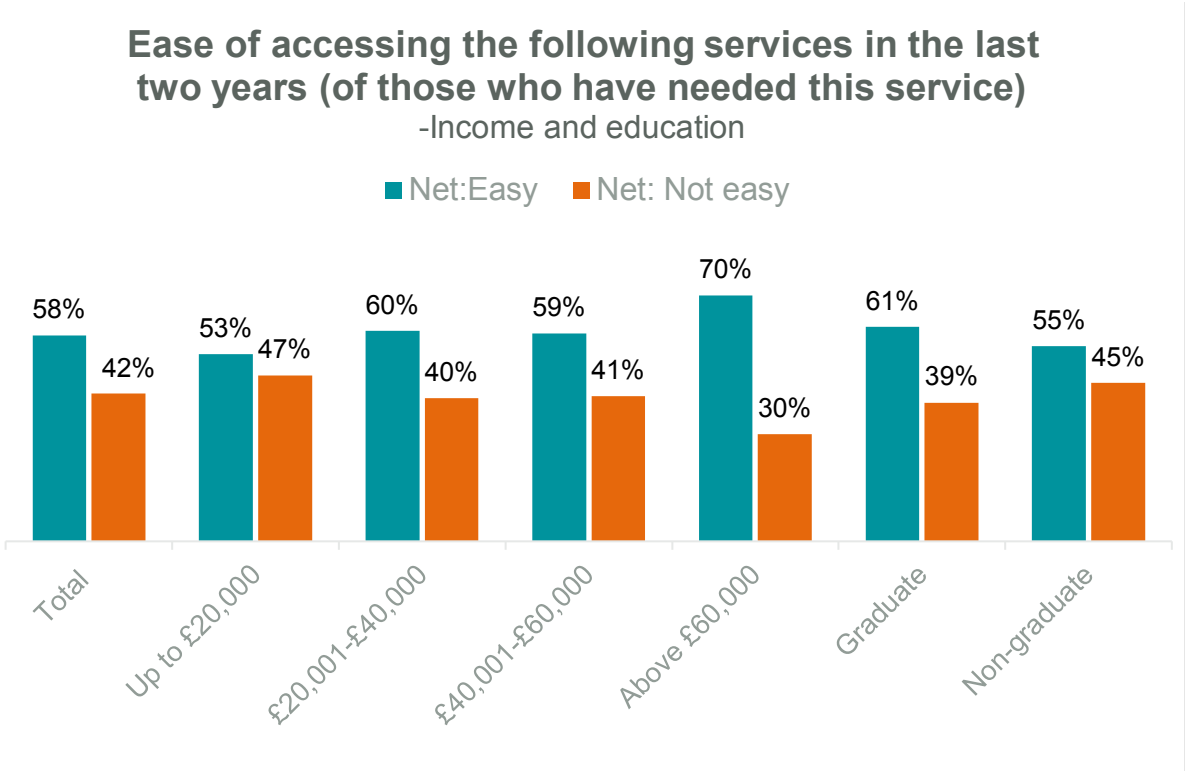
There are also variations depending on sexuality. LGBTQ+ residents who have needed to see a GP in the last two year are more likely to report that this has not been easy for them to access than heterosexual residents.

Those with a strong sense of belonging are more likely to access the GP service that they have needed than those with a weak sense of belonging. This might be linked to the longer length of time in the borough for those with a stronger sense of belonging and the associated likelihood of being registered with a GP.



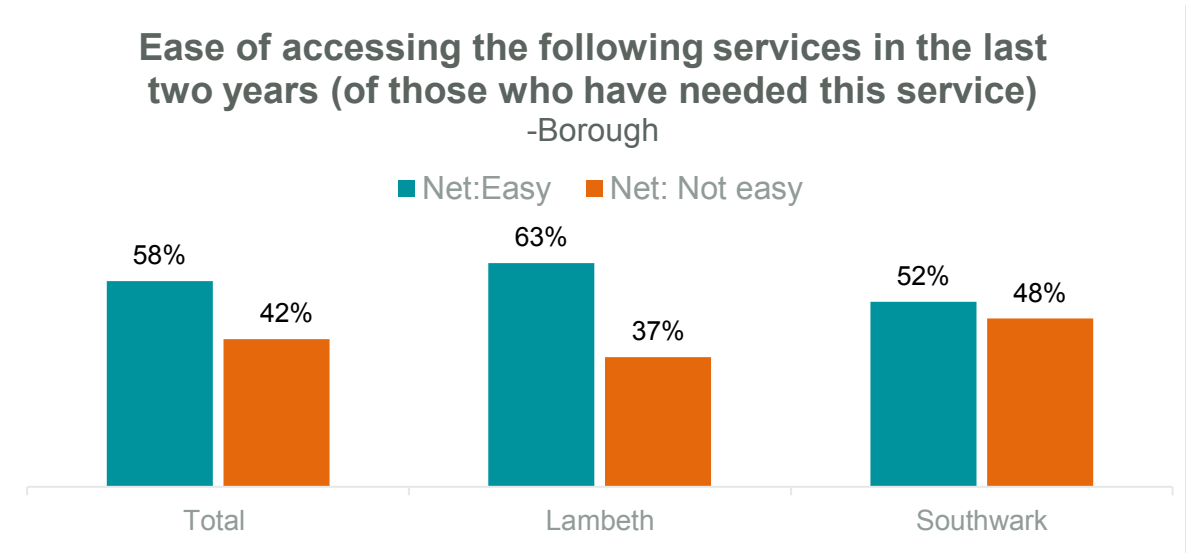
C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at GP services and excluding those that ticked don't know or prefer not to say, total (3,631), strong sense of belonging (1,695), weak sense of belonging (591)

Income also has an influence on ease of access. Those on the lower end of the income scale who have needed GP services are more likely to report this has not been easy for them to access compared to those on the higher end of the income scale. In line with this, non-graduates are also more likely to report GPs have not been easy for them to access compared to graduates.



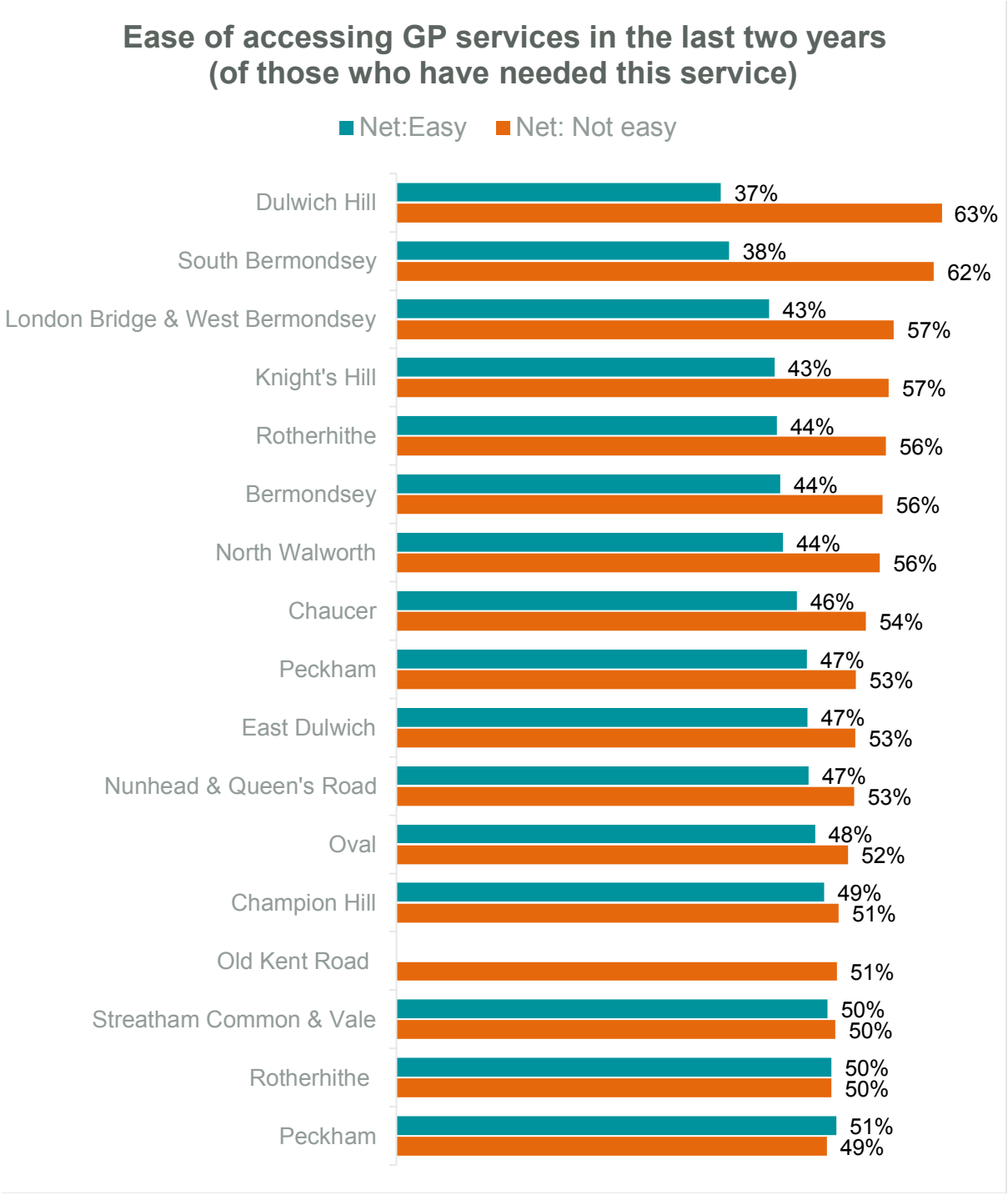
C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at GP services and excluding those that ticked don't know or prefer not to say, total (3,631), up to £20,000 (872), £20-40,000 (914), £40-60,000 (486), Above £60,000 (501), graduate (2,059), non-graduate (1,413)

Residents in Southwark who have needed a GP service have found it more difficult to access this than Lambeth residents, with almost half (48%) saying it has not been easy compared to a third (37%) of Lambeth residents.



C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at GP services and excluding those that ticked don't know or prefer not to say, total (3,631), Lambeth (1,778), Southwark (1,701)

Looking deeper into neighbourhood areas, residents in Dulwich Hill and South Bermondsey who have needed a GP service in the last two years were more likely to say access was not easy for them than easy.



C1. How easy was it for you to access any of the following services in the last two years if you have used them? This could be for yourself or for someone that you care for.
Base: those not ticking "N/A" at GP services and excluding those that ticked don't know or prefer not to say,

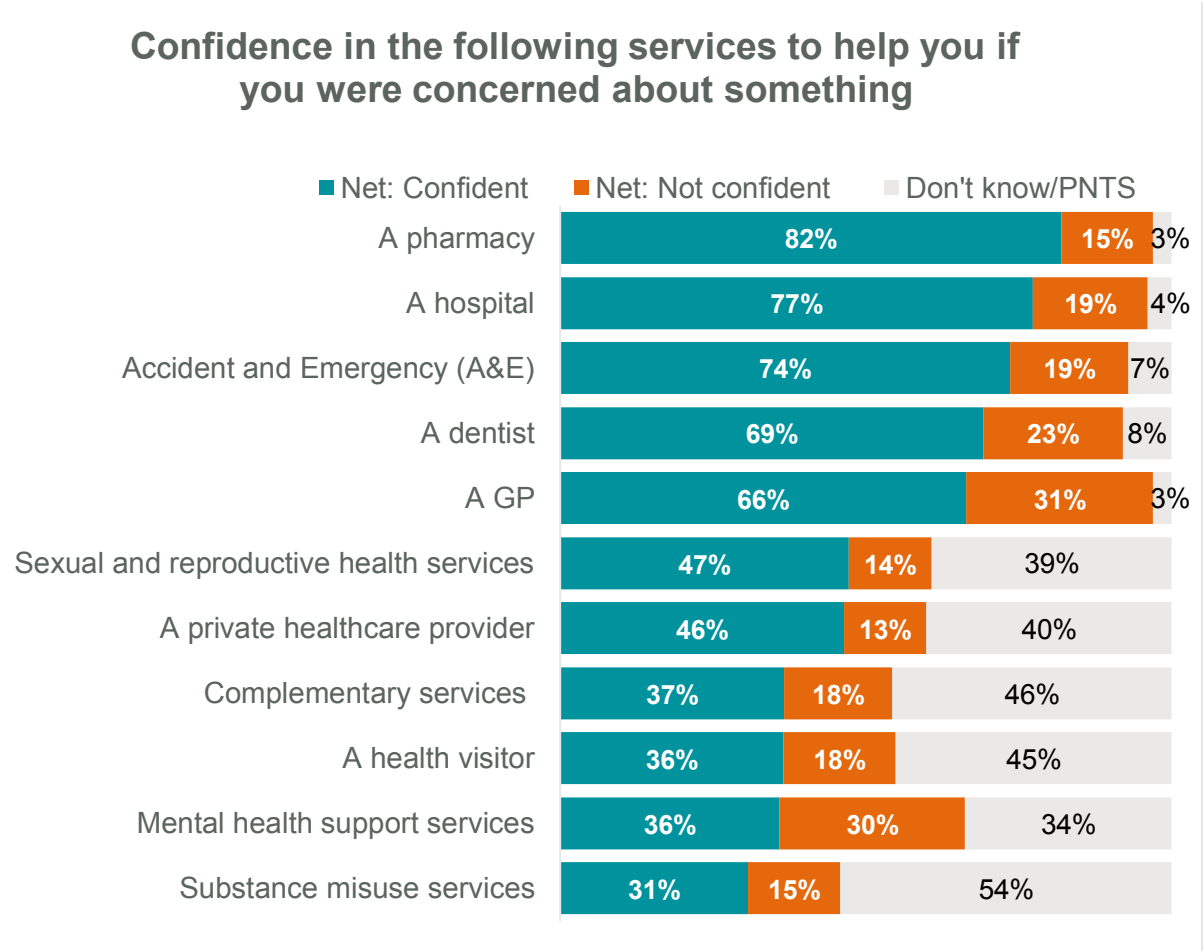
Residents living in higher deprivation areas who have needed to access a GP in the last two years are more likely to say that access has not been easy for them (44% in highest deprivation IMD Quintile vs 39% in lowest deprivation IMD Quintile).

Confidence in services

We asked residents whether they would be confident in a health service to help them if they were concerned about something to do with their health. Residents were most confident that a pharmacy could help them with their concern with 85% saying they would feel confident. More than three quarters of residents have confidence in hospitals and A&E departments.

Only two thirds (66%) feel confident that a GP could help them with their concern, with almost one in three (31%) not being confident.

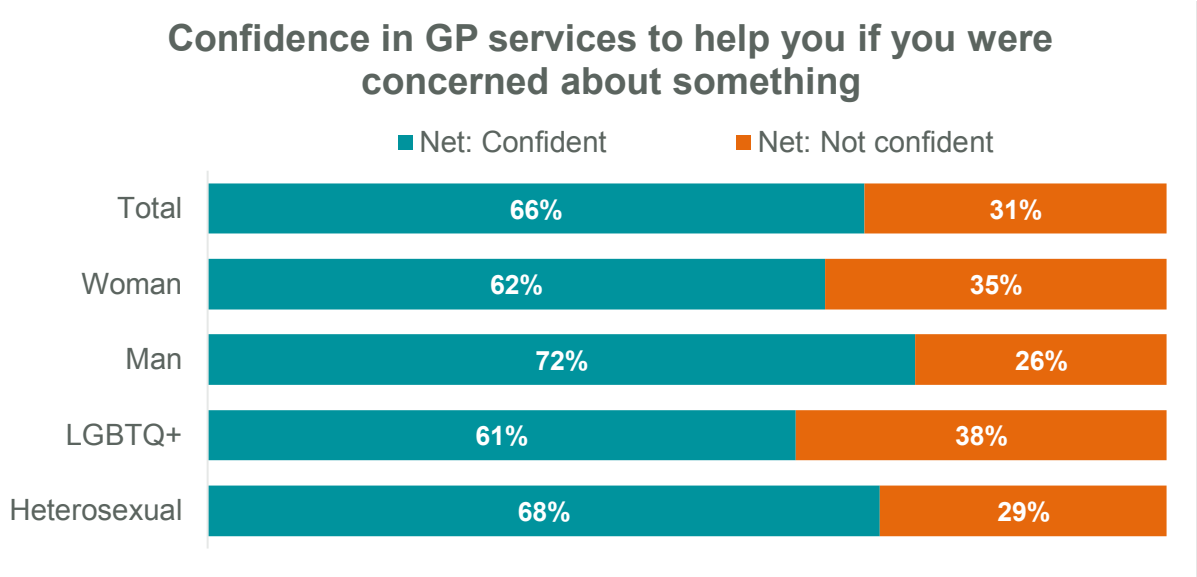
Views of mental health support services were mixed. While 36% said they would be confident that they would be able to help them, 34% were not sure and 30% were not confident, the second highest "not confident" figure for any service.



Question: C3. And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?
Base: all adults (3,881 for GP, hospital, A&E, pharmacy, dentist, 2,789-2,996 for others)

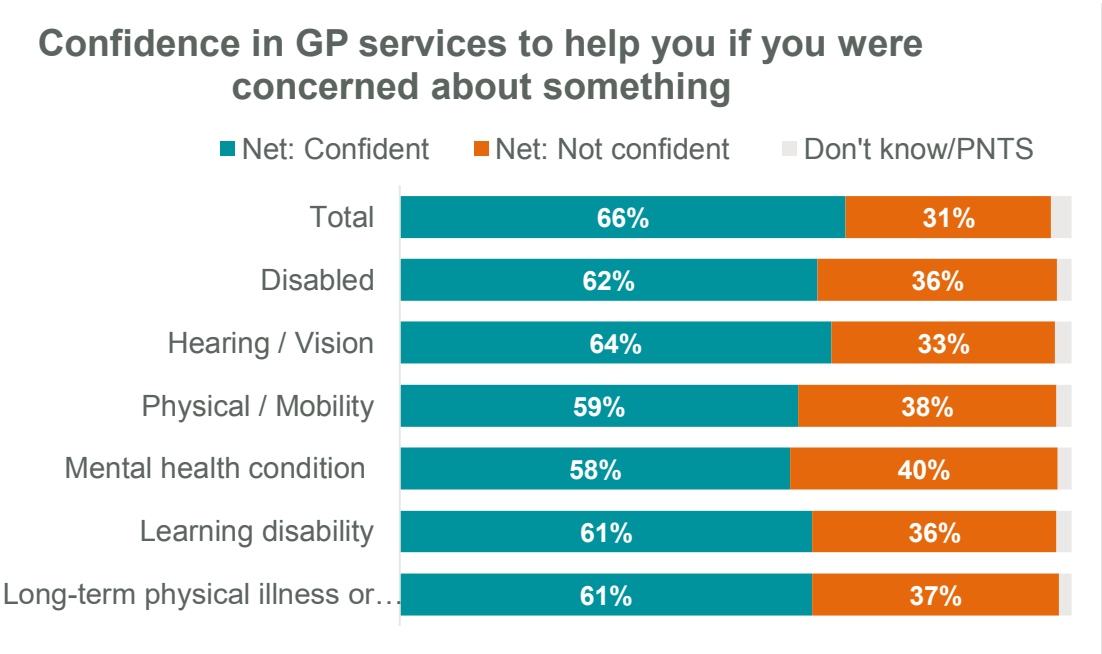
Women are less likely to have confidence in a GP to be able to help them if they had a problem than men, with over a third (35%) saying they would not feel confident compared to over a quarter (26%) of men.

Confidence is also lower among LGBTQ+ residents, with 38% saying they would not feel confident a GP could help them compared to 29% of heterosexual residents.



Question: C3. And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?
Base: all adults (3,881), Woman (2,171), Man (1,567), LGBTQ+ (505), Heterosexual (3,130)

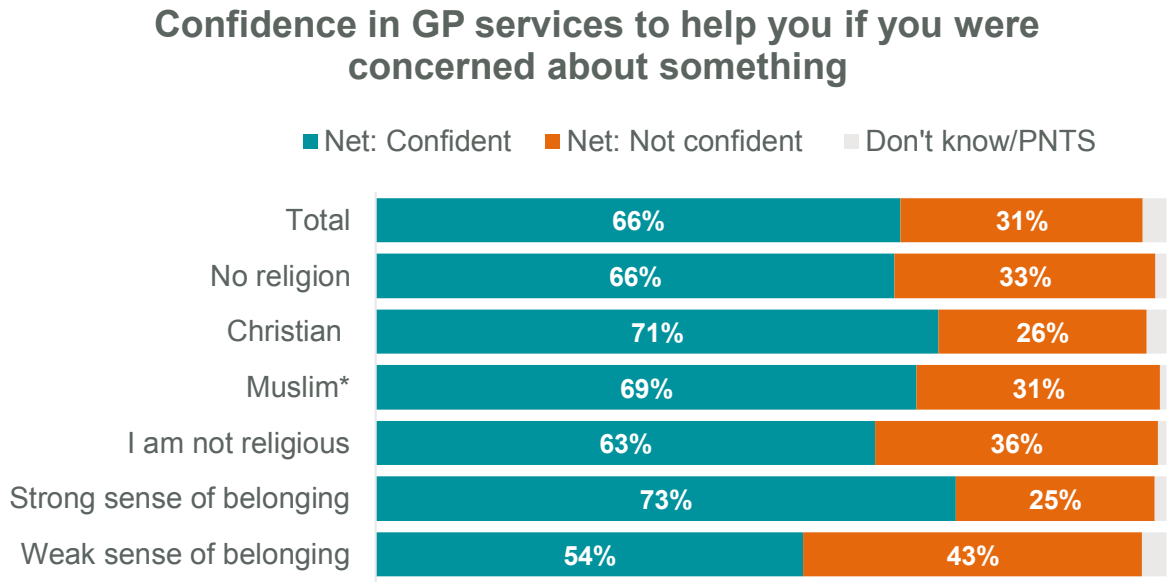
Residents that identify as disabled also feel less confident in GPs to help them compared to the general population across the two boroughs. Lack of confidence is highest among those with a mental health condition and a physical or mobility condition.



Question: C3. And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?
Base: all adults (3,881), Disabled (556), hearing / vision (249), physical / mobility (438), mental health condition (592), learning disability (308), long-term physical illness or health condition (865)

Residents that do not have a religion or are not religious are more likely to not feel confident that a GP can help them than Muslim or Christian residents.

Residents from a White background (68%) are more likely to feel confident that a GP can help them compared to residents from an ethnic minority background (64%), and particularly more likely than residents that identify as 'Any other ethnic group' (48%) and Latin American residents (51%). Residents with a weaker sense of belonging are notably more likely to lack confidence in a GP being able to help them with a health problem than residents with a strong sense of belonging.

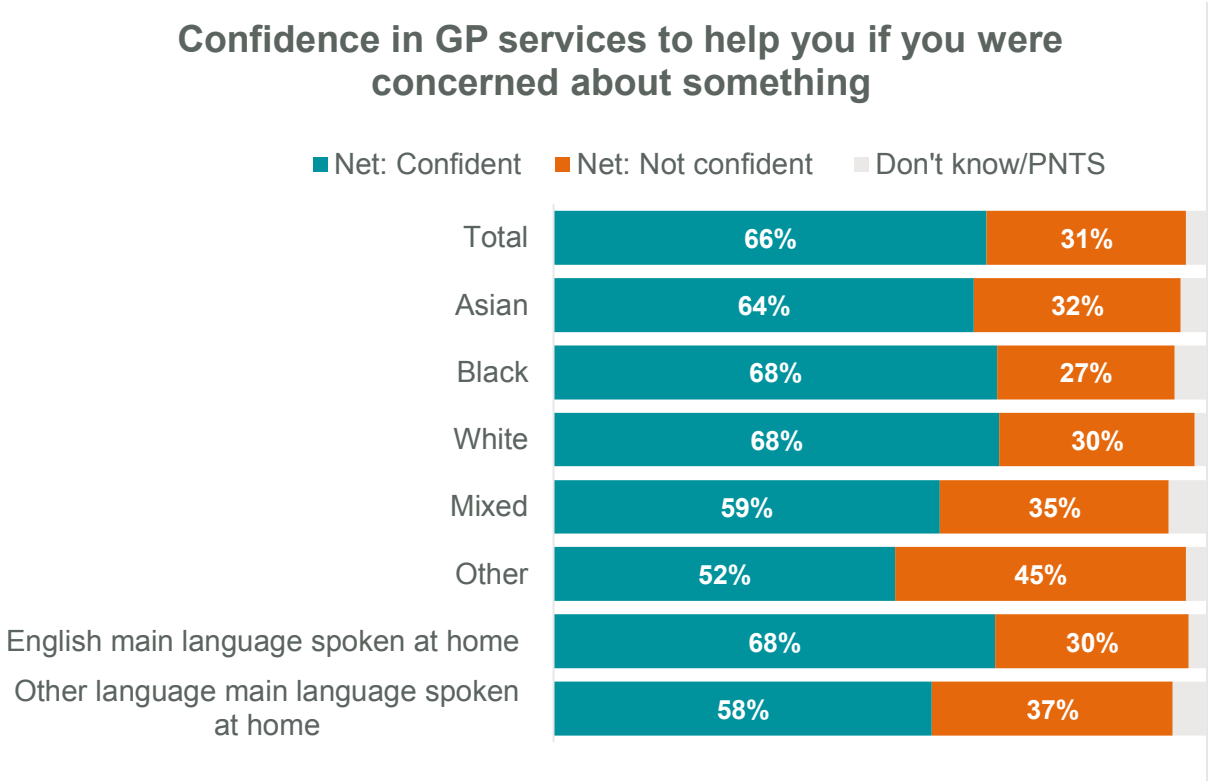


*Note: Muslim data refers to predominantly non-White Muslim respondents only owing to imbalances in the sample distorting results

Question: C3. And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?
Base: all adults (3,881), no religion (766), Christian (923), Muslim (125), not religious (264), strong sense of belonging (1,751), weak sense of belonging (596)

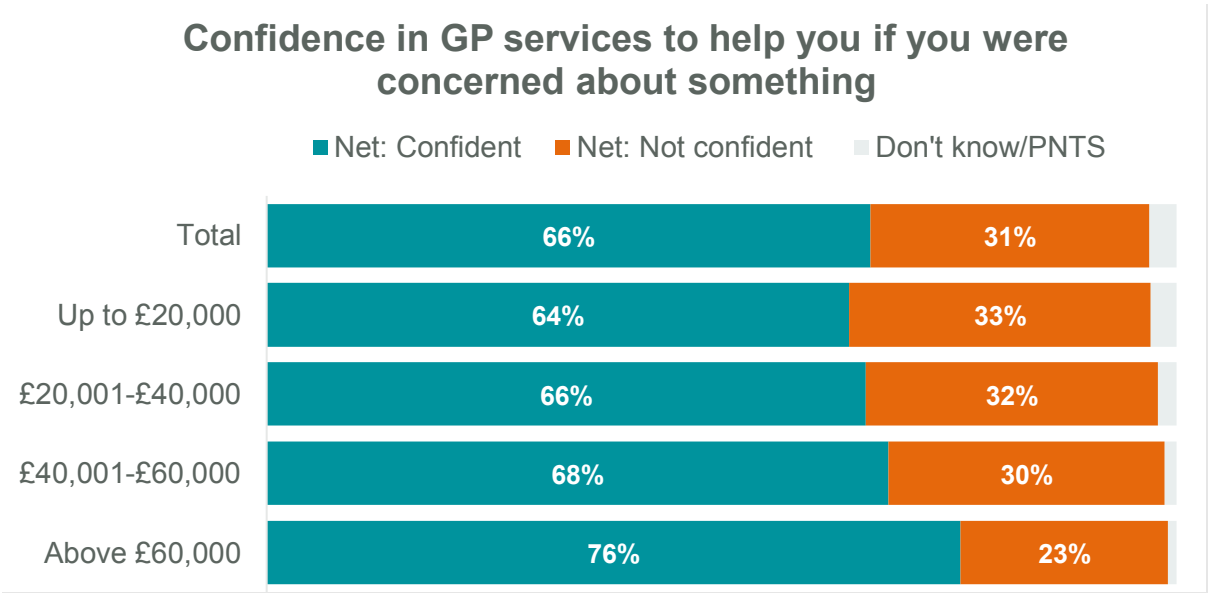
Residents that identified as 'Another ethnic group' were also less likely to feel confident, with 52% saying they are confident, compared to 45% not feeling confident. Confidence levels were also lower among those with a mixed ethnicity with only 59% feeling confident.

Confidence of GPs being able to help is also lower among residents where the main language spoken at home is not English. 37% of those who main language spoken at home is another language do not feel confident that a GP can help them compared to 30% of residents where English is the main language spoken at home.



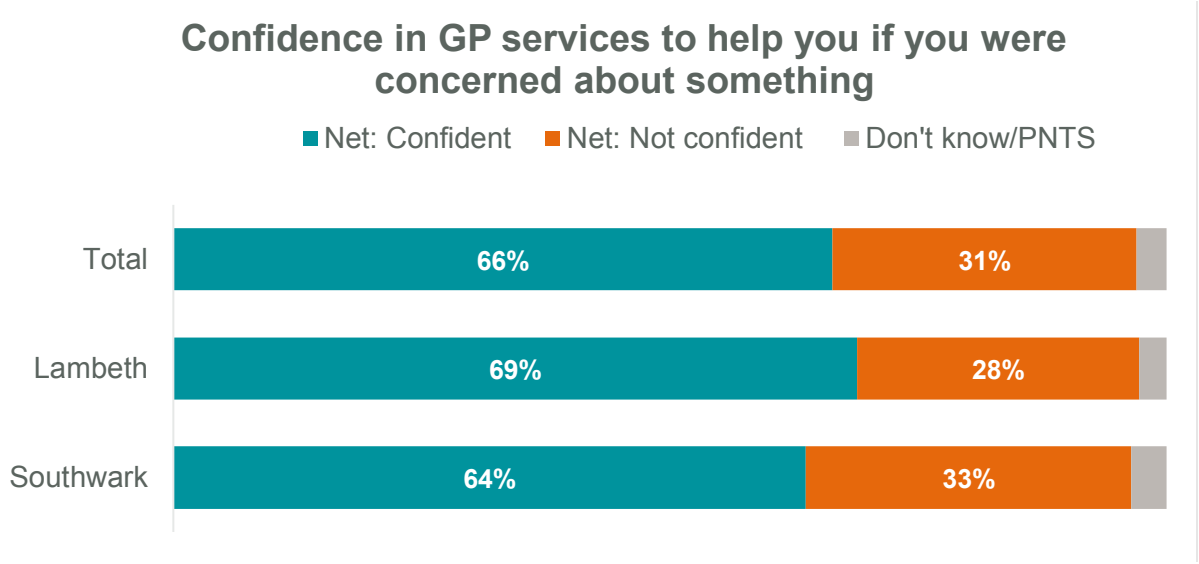
Question: C3. And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?
Base: all using service (3,881), Asian (286), Black (1,049), White (2,079), Mixed (213), Other (144), English (3,348), other language (534)

Residents on the higher end of the income scale are more confident that a GP could help them with a health problem than those on the lower end of the income scale.



Question: C3. And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?
Base: all adults (3,881), Up to £20,000 (854), £20-40,000 (1,014), £40-60,000 (536), above £60,000 (558)

Residents in Lambeth are more confident that a GP could help them with a health problem than Southwark residents, with 69% of Lambeth residents feeling confident compared to 64% of Southwark residents. Looking further into neighbourhood area, residents in Brixton (73%) and Stockwell (73%) are most confident that a GP could help them, with this dropping to 60% for residents in Old Kent Road and Rotherhithe.



Question: C3. And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?
Base: all adults (3,881), Lambeth (1,890), Southwark (1,827)

Factors influencing confidence in health services

In the regression analysis, results show similar trends to those found in crosstab analysis. Residents are more likely to have lower confidence in health services if they are financially insecure, if they are women, LGBTQ+, or have a long-term health condition but other factors that can have an impact are age, housing tenure, education level and ethnicity.

For all services, confidence decreases as financial insecurity increases, is lower for women than men, and for LGBTQ+ residents than heterosexual residents. However, for other services the picture is more mixed.

Having a long-term condition means a resident is likely to have lower confidence in GPs (13%), hospitals (18%) and dentists (20%).

Ethnicity is less straight forward in its effect on confidence. Residents of an ethnic minority background were generally more likely than White British residents to have lower confidence in health services. The exception was for Black African and Black Caribbean residents in the case of GPs where their level of confidence was not significantly lower than White British residents. Being of a Black African background was not significant in affecting confidence in the other health services asked about.

Age was significant in affecting confidence in GPs, A&E and pharmacies. However, this relationship is not linear; confidence does not simply increase with age and is generally lower among middle aged adults.

5. Key theme 3 | Housing and health

What is poor quality housing?

Participants of all three labs explored various issues related to housing that can have an impact on health:

1. Lack of maintenance in homes

This was by far the most common problem that tenants had and included a variety of issues ranging from mould and damp to leaks (both water and gas), and the breakdown of appliances within homes that had an impact on health. Participants mentioned that mould and damp were the cause of some respiratory problems, and these also made other illnesses worse (see next section). Gas and water leaks were widely mentioned in each exploration lab, and these had a significant impact on health. The breakdown of appliances such as a fridge had a serious impact on a diabetic participant's health, particularly as they needed to keep medicine and food stored:

> I had my toilet flooded during the night and 3 people came to fix it and it wasn't resolved. They told us to wait an hour and it'll be fine. It took 36 (hours).
>
> There was a leakage in our area, so they stopped our heating and hot water. So, for one year I didn't have any heating and hot water…
>
> I had a leak for 14 years, on and off, it was coming through my roof which is dangerous because it could be an electrical fault and hazards. They would come, put scaffolding up for about a week and claim the job is done. But the [leaks would continue].

2. Lack of heating or hot water

Related to lack of maintenance in the home, experiencing problems with lack of access to hot water and heating was another common issue within poor quality housing. Participants said that in the winter this is especially difficult to deal with, and heavily impacts on both physical and mental health. There were some examples where the hot water and heating was connected to a common boiler system, so that if one residence in the building is affected, it is likely that all will be. Participants mentioned that this lack of heating or hot water can also indirectly lead to dangerous situations, such as having to boil water in a kettle and transport this upstairs and downstairs (to a bathroom), as experienced by one participant

> Hot water not working, we have that issue a lot of the time. If your hot water is not working, especially in the winter …… Some people can't bathe with cold water.

We have a communal boiler so that's an issue as well, so it's everybody in the building, basically (if) one person doesn't have . hot water in most cases, we all don't have hot water.

For example, if your bathroom is upstairs, like my situation now, when my boiler breaks, I have to boil water. My bathroom is upstairs … so, I have to come up, down, up, down. And there's also people that . because of their health issues (they) may be really shaky - they can potentially pour the water on themselves.

3. Infestations

Participants said that infestations of bugs or mice are a problem within rental housing, and these are very difficult to handle, especially if people have phobias as this impacts their daily life significantly.

Some people when they see mice in their kitchen, they won't go in their kitchen. Two weeks, then they are eating rubbish, this affects the health of the family.

They could have phobias of it. Some people live with it. Some people are not getting enough help in the house. I believe that sometimes the council must help more. They give help but not enough sometimes.

I was depressed, I wasn't eating right (due to infestation).

4. Noise and pollution

One participant was sensitive to noise and had been severely affected by neighbours' dogs, which had affected his sleep, and then led to other health issues. He said he felt helpless to do anything about this. Similarly, another participant mentioned that living next to a busy road could also be noisy, as well as being the cause of emissions and air pollution:

My neighbour has two big pets (dogs), and they make a big noise, and I'm a little bit more sensitive to the noise. We can't do anything; you need a calming and peaceful environment for a good sleep.

If you are by a busy road and there are a lot of cars etc, there [may be] a lot of noise pollution or emission coming from cars.

5. Perception that council homes are mismanaged.

Some participants felt that council homes are mismanaged, especially in instances where tenants say they are living there but they are actually away. These homes could be allocated to others who are

in more urgent need. Another issue related to mismanagement, was where participants felt that (council) homes are not maintained properly, which is a cause of stress:

> We have two council properties (near me) that should have been let to others, one has been empty for 5 years, another chap says he's lived in it for 30 years, but he's never lived there. So (there's) all this mismanagement, and people are desperate for houses.

> For other neighbours, they have problems with overgrown gardens because the council are not managing them properly, that can cause stress to people. Southwark Council in particular need to do something about this, and they won't. Years ago, we would go to the media...but it shouldn't come to that.

6. Short-term renting

Linked to mismanaged homes, one participant mentioned that there were instances where tenants let out their homes through Airbnb, which caused a lot of disruption to neighbours. He stated that these homes are not well looked after when they are under very short-term rental arrangements:

> People are leasing these properties as Airbnb, and maybe that's something the council should get on top of and look at. This can affect health because the (short-term) tenants that come are going to leave the place in a state, the bins are going to be left out, foxes will be ripping open the bins etc. If you lived there permanently, you are going to respect your place much more.

How does poor quality housing affect health?

Due to the above issues with poor quality housing, participants talked about many different type of health effects caused. These ranged from respiratory problems, mental health issues such as stress, anxiety and depression, sleep deprivation, and having existing health conditions worsen due to poor quality housing.

1. Respiratory problems

Leaks, damp and mould are having significant physical and mental impact on tenants. Physical health issues related to breathing, and asthma were common:

> Then these leakages leads to damp then this causes problems for the family in terms of respiratory problems [as] the house is never quite dry so the children in the home are having problems with breathing

If they have asthma, the smell of the leaks can affect their breathing.

If problems in your flat, for example leaks are not repaired properly by the council when they come, it can cause problems like asthma and chronic obstructive pulmonary disease.

One participant stated that some medical conditions may not be visible now and may only become apparent many years later. In this case he was referring particularly to mould:

If you have a child sleeping with mould now, (they could be) affected ten years later. You won't see it now

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2. Mental health effects

The effect of poor-quality housing on mental health cannot be underestimated, participants spoke of the continuous levels of stress and anxiety caused, and how this also brought about unrecognisable change in their personalities. They felt consumed by the housing issues and frustrated that these issues would take so long to be addressed. Once the housing issue had been resolved or they moved homes, one participant in particular, felt like her old self again:

It does massively impact your mental health, having to deal with the constant back and forth with your landlords and playing with incompetent employees. As tenants communicating with landlords, you do see some levels of progress, only for there to be a standstill then you find out you have to do it all over again... People have other [personal issues] that they're going through, so this does take a mental toll.

Mental health - …for you as a person, an individual, it [housing problems] can shape you. It can change who you are. You could become unrecognisable. And that's what happened to me but when I moved… I laugh again, I have friends. My life just changed.

It impacted my health; in the morning I didn't want to come out because it was so cold… It affected me mentally because if I was in the office at work, it would cause me stress and that made me really ill.

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3. Worsening of existing health conditions

Participants stated that although some health conditions can arise solely due to poor housing, other conditions are worsened. They particularly mentioned asthma again, and eczema:

I also have a friend…. her son suffers from asthma and this asthma has gone really, really worse since he's been dealing with all these mould issues.

> My son has breathing problems too. His room has so much mould and this is an old issue that has been (re-) occurring. At night, he can't sleep because of the smell. On one occasion, when he woke up to go to school [he said] 'Mum I can't breathe' and before I knew it, he collapsed. This has been an issue that keeps occurring. Anytime it is cold, it keeps happening...He has problems with his sinus, and I know it has made it worse.

> My daughter has eczema, when we were referred to specialist, they would ask about the state of the house. When I tell them about the problems [mould, damp and condensation] they gave me a letter to take to the council [urging] them to come and review if the house is fit to live in. [The cold, damp and condensation] is causing her eczema to get worse.

4. Sleep deprivation

Sleep deprivation was mentioned as another symptom of housing problems, and this occurred either due to noise pollution, or other housing issues such as mice infestations. For one participant, the detrimental impact of noise pollution, which led to sleep deprivation, then went on to cause more severe, long-term health problems:

> I'm very much sensitive to sound and it causes me sleep deprivation for more than two years now. So (this has led) to insomnia and now there is inflammation in my brain. So that is causing me tremors in my legs because of just not getting proper sleep. These medical conditions I have suffered (are) just because of noise pollution and my sensitivity to sound.
> I'm not sleeping at night because I can hear the scratching [of the mice]. The pest control people come every other week but ignore the photos that we show them …. I'm just losing a lot of sleep.

The experiences of social and private tenants

'Non-decent homes' are defined as those that are not in a reasonable state of repair, pose a hazard of immediate threat to a person's health, or cannot be effectively heated or insulated.' National research[7] suggests that the private rental sector has the highest proportion of poor-quality housing, with 23% of homes in this sector being categorised as non-decent according to the Decent Homes Standard. This compares with 10% of socially rented homes.

Similarly, according to the Housing Health and Safety Rating[8] system, 14% of privately rented homes had at least one Category 1 hazard, compared with 4% of those in the social rented sector. This

[7] English Housing Survey 2021-2022: https://www.gov.uk/government/statistics/english-housing-survey-2021-to-2022-headline-report/english-housing-survey-2021-to-2022-headline-report

[8] Ibid

extreme poor state of privately rented accommodation would suggest that levels of self-reported ill health would then be higher in the privately rented sector.

In Lambeth and Southwark, Census 2021 data shows that the proportion of residents living in social housing is double that of the rest of England, where 34% of households in Lambeth, and 40% in Southwark live in social rented accommodation, compared to 17% in England as a whole. There are a higher proportion (22%) of residents in socially rented accommodation who say they are not in good health, compared to those in private rented accommodation (7%). This is confirmed in the quantitative survey findings below.

Residents in Southwark and Lambeth, and those in England and Wales who self-report that they are not in good health[9]

	Southwark and Lambeth	England and Wales
Socially rented	22%	30%
Own outright	17%	25%
Privately rented	7%	13%
Own with mortgage or shared ownership	6%	9%

Although nationally, socially rented accommodation is of a better standard than privately rented accommodation, social renters in England/Wales and in Southwark/Lambeth have worse self-reported health. Although there can be many reasons for this, one such reason could be that there are more people living in socially rented accommodation (than privately rented) in both boroughs, therefore this was explored further with the exploration lab participants to hear of their experiences and thoughts. There were some mixed views about which group of renters were in a better overall position with regards to their housing, and therefore how much impact this had on their health:

1. People who are older, or those with more health needs, are more likely to live in socially rented accommodation

Qualitative feedback from participants of the exploration labs indicated that one of the reasons for higher rates of self-reported ill health amongst social renters could be because those with health needs are prioritised for social housing, over those without. Additionally, participants stated that it might be more difficult for younger people to acquire social housing so there is a likelihood that more private renters are younger whilst more social renters are older. This finding is confirmed by the quantitative survey data below. Additionally, the English Housing Survey reported that the average age for private renters was 40 years in 2017-18, and 53 years for social renters.

If you have more health needs, you are more likely to be in social housing because then you have priority, and you are top of the list.

[9] Census 2021

Differences in statistics could be because of age. Because where I live, I rent privately and most of my neighbours are a similar age to me, probably 30 and under but there is a big social block next to where I live where there tends to be a lot of older people or people with families.

For a younger person, it is harder to get onto the social renting ladder, so the demographics would most likely show that those in social housing are most likely to older people and the private renters are most likely younger.

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2. Private renters have better quality accommodation (due to landlord's personal motivations), or they address their own housing issues.

Some participants were of the view that private renters are likely to live in better quality housing because there is a personal incentive for the landlord to keep their own property maintained (and therefore rentable in the future). This, coupled with the view that there are long delays in socially rented accommodation to get property maintained, indicate that private renters may live in better conditions.

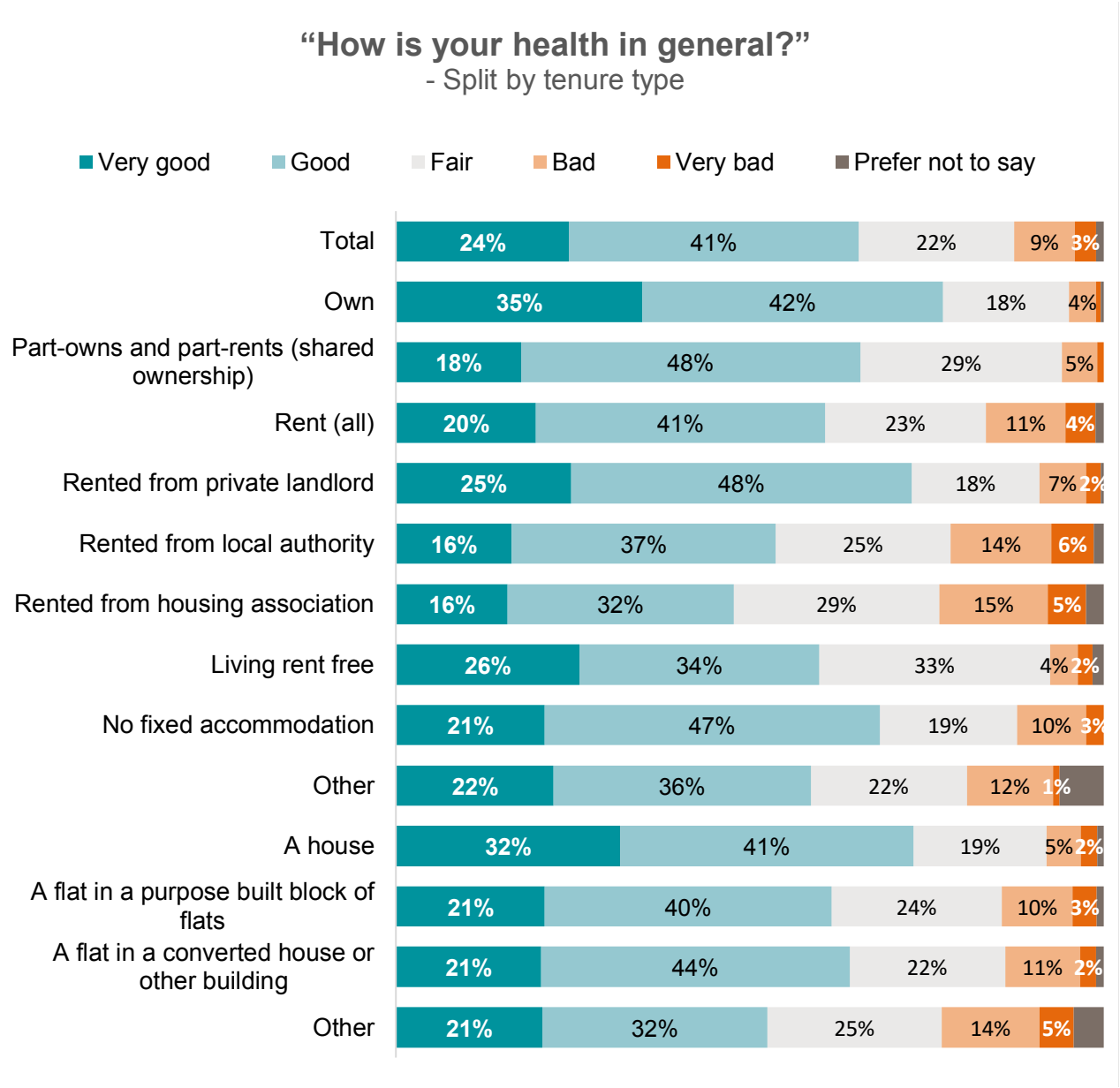
So as a private renter, I guess if you have any issues or any worries about your property, you would get a quicker response than the council because obviously the council will take their time. They will say they haven't got appointments or there was a point where I was trying to get a window fixed in my kitchen or something and they'll say: 'Oh, it's not important.' Whereas if it was in private, they would come and sort out your property as soon as. So, I think that they're more reactive in private, whereas in social they're just like, oh you have to wait until it's more and more important, basically more of an emergency.

Survey findings related to poor quality housing and its impact on health

To understand the impact of housing situation on health, our key questions were those from the previous section around overall health as well as those relating to conditions affecting respondents, and a question on their living situation which asked how often they worry about each of the following:

- The possibility of being evicted from my home
- Being able to afford my accommodation costs (e.g. rent / mortgage / bills)
- Damp or mould in my home
- Being able to afford to keep my home warm
- My home not being in a good state of repair
- Heating / electrics / plumbing not being in good working order
- Being able to keep my home cool enough on hot days

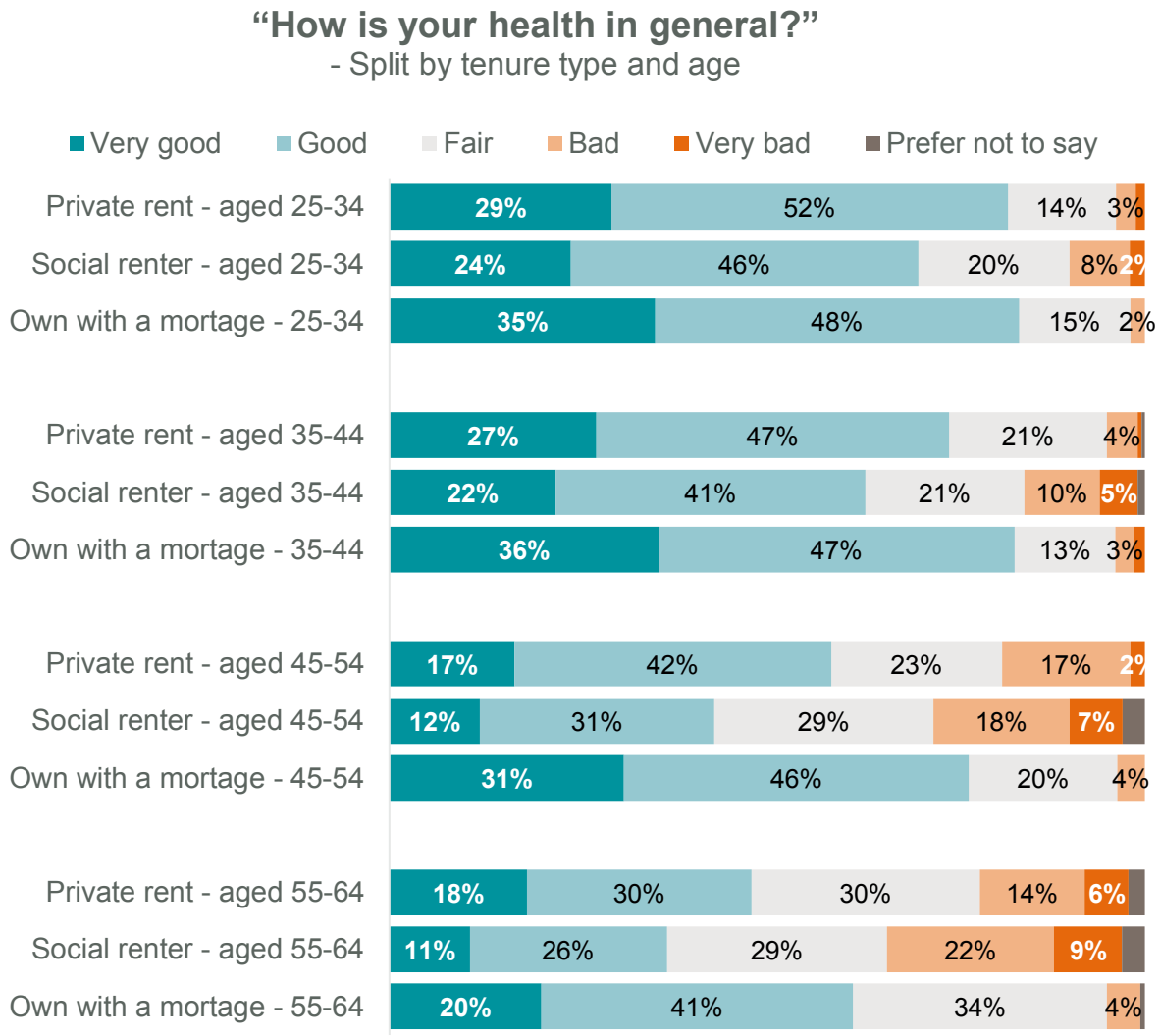
Around three-quarters of those who owned (either with a mortgage or outright) and privately rented reported being in good health (78% and 77% respectively) with this figure falling among those renting from either a local authority or housing association (54% and 48% respectively).



0.Question: H1. How is your health in general?
Base: all adults (4,000), own (1,213), part-own and part-rent / shared ownership (87), rented from private landlord (840), rented from local authority (951), rented from housing association (531), living rent free (239), other (107)

Those who own their home are the most likely to report good health followed by those renting from a private landlord and those in shared ownership.

As mentioned previously, the younger age profile of private renters skews the overall figure for this group. If we break housing tenure by age group, then what we find is that older age groups among private and social renters are notably more likely to report poor health than homeowners of the same age:

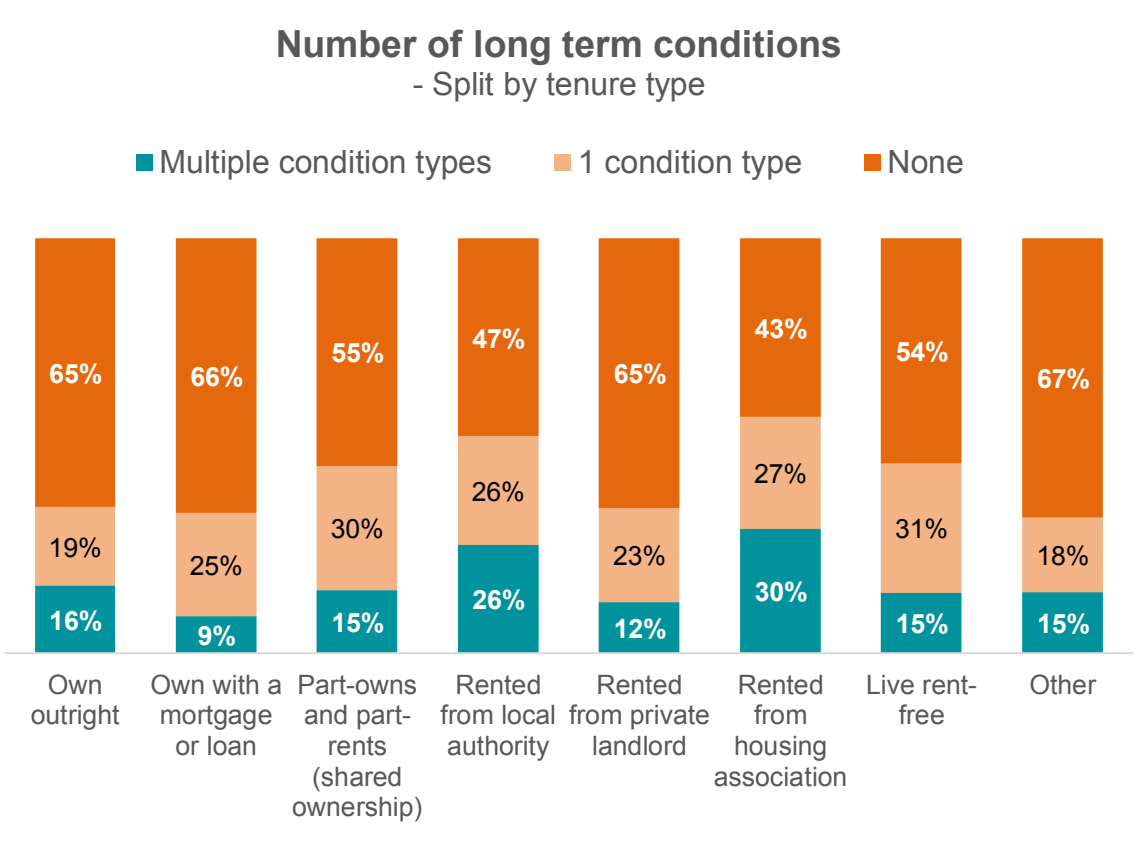


Question: H1. How is your health in general?
Base: all adults (4,000), private rent aged 25-34 (326), Social renter aged 25-34 (262), own with a mortgage aged 25-34 (138), private rent aged 35-44 (193), Social renter aged 35-44 (283), own with a mortgage aged 35-44 (271), private rent aged 45-54 (130), Social renter aged 45-54 (321), own with a mortgage aged 45-54 (252), private rent aged 55-64 (70), Social renter aged 55-64 (314), own with a mortgage aged 55-64 (154)

NOTE: renting from a local authority includes housing associations

Looking specifically at private renting vs. social renting and owning with a mortgage (owing to the lack of outright owners in younger age groups to allow for comparison), we can see that those aged 25-34 have relatively minimal variation between each tenure type. Mortgage holders aged 35-44 have almost the same good health as their younger counterparts but among private renters and particularly social renters we see a decline and this pattern continues as we go further up the age spectrum.

As one might expect, propensity to have multiple health conditions increases with age, rising from 10% among 16–24-year-olds to 21% of 45–54-year-olds and 31% of those aged 65-74.

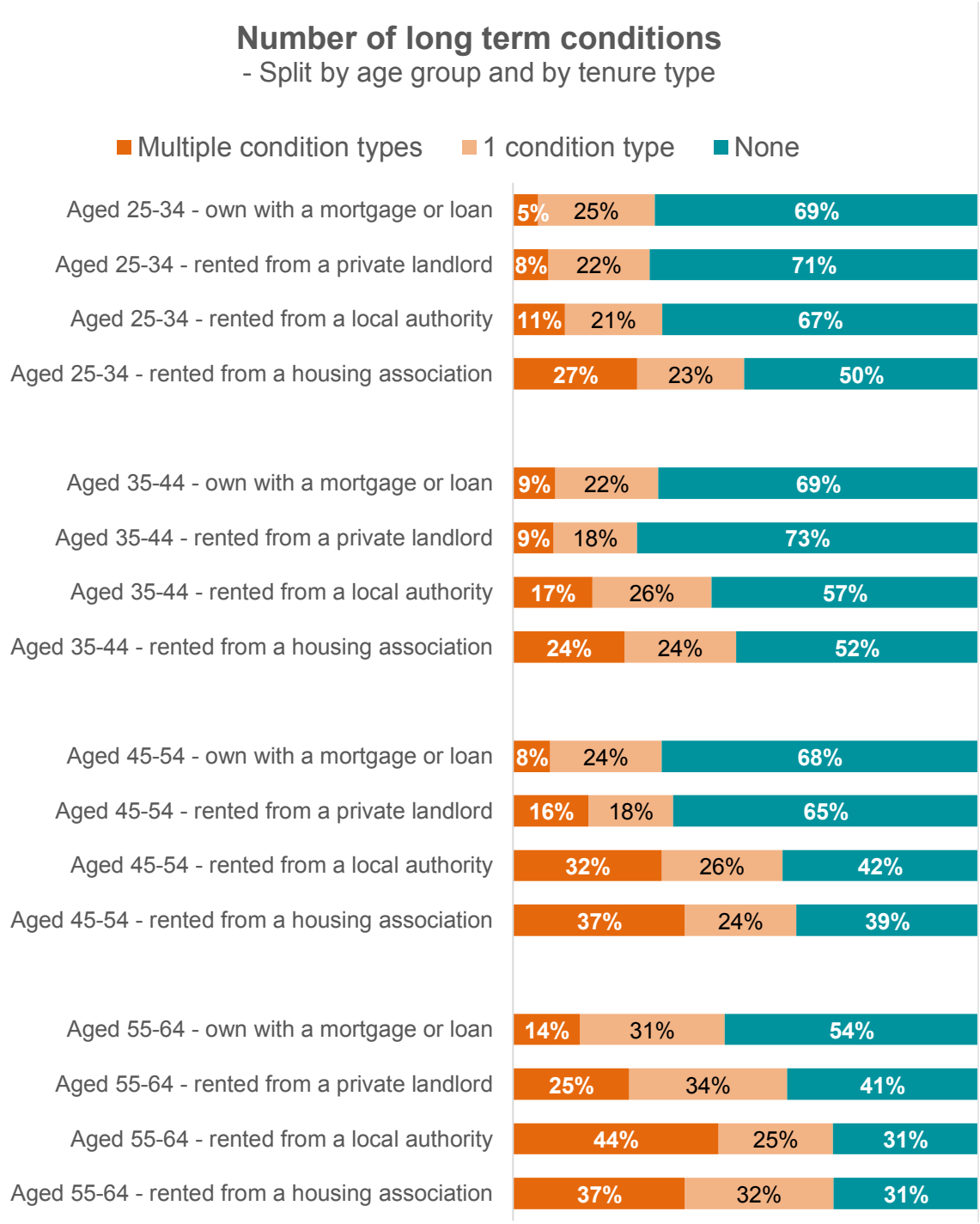


Question: H2. Do you have any of the following long-term health conditions, impairments or disabilities? By long-term we mean lasting 12 months or more.
Base: own outright (337), own with a mortgage or loan (876), part-own and part-rent / shared ownership (87), rented from private landlord (840), rented from local authority (951), rented from housing association (531), living rent free (239), other (107)

Renters from a local authority or housing association are more likely to have two or more long term condition types than homeowners despite the older age skew of those who own their homes outright.

As an example, 7% of mortgage holders aged 45-54 had multiple long term condition types compared 16% of that same age group who rent from a private landlord, 31% of 45–54-year-olds who rent from a local authority, and 35% of 45–54-year-olds who rent from a housing association.

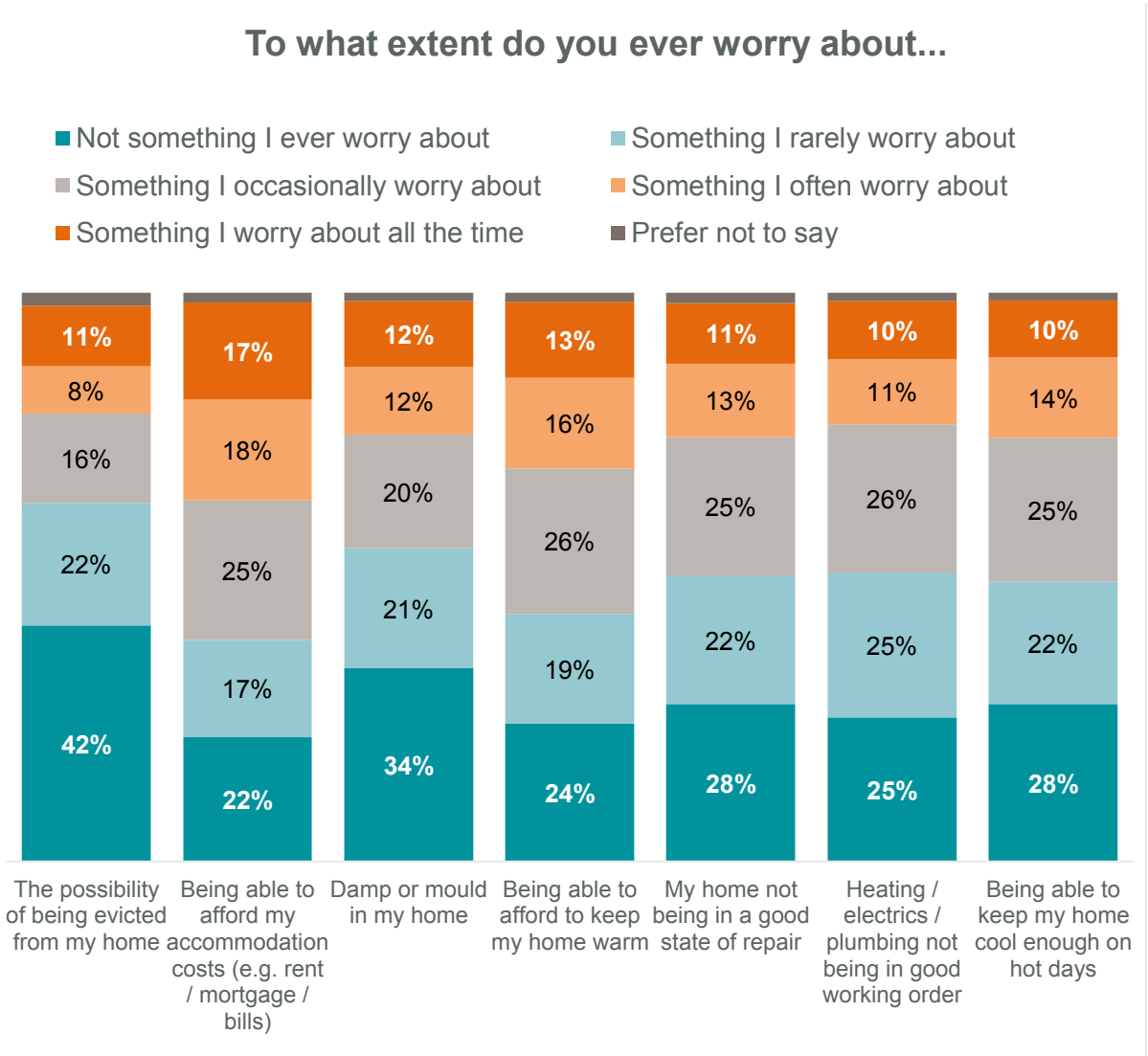
Looking at those age/tenure combinations with a large enough base to report on, we can see that within each one, those renting from a local authority or housing association tend to be more likely to report multiple conditions than mortgage holders or private renters.



Question: H2. Do you have any of the following long-term health conditions, impairments or disabilities? By long-term we mean lasting 12 months or more.
Base: 25-34 own with a mortgage or loan (138), 25-34 rented from private landlord (326), 25-34 rented from local authority (163), 25-34 rented from housing association (99), 35-44 own with a mortgage or loan (271), 35-44 rented from private landlord (193), 35-44 rented from local authority (193), 35-44 rented from housing association (90), 45-54 own with a mortgage or loan (252), 45-54 rented from private landlord (130), 45-54 rented from local authority (216), 45-54 rented from housing association (105), 55-64 own with a mortgage or loan (154), 55-64 rented from private landlord (70), 55-64 rented from local authority (184), 55-64 rented from housing association (130)

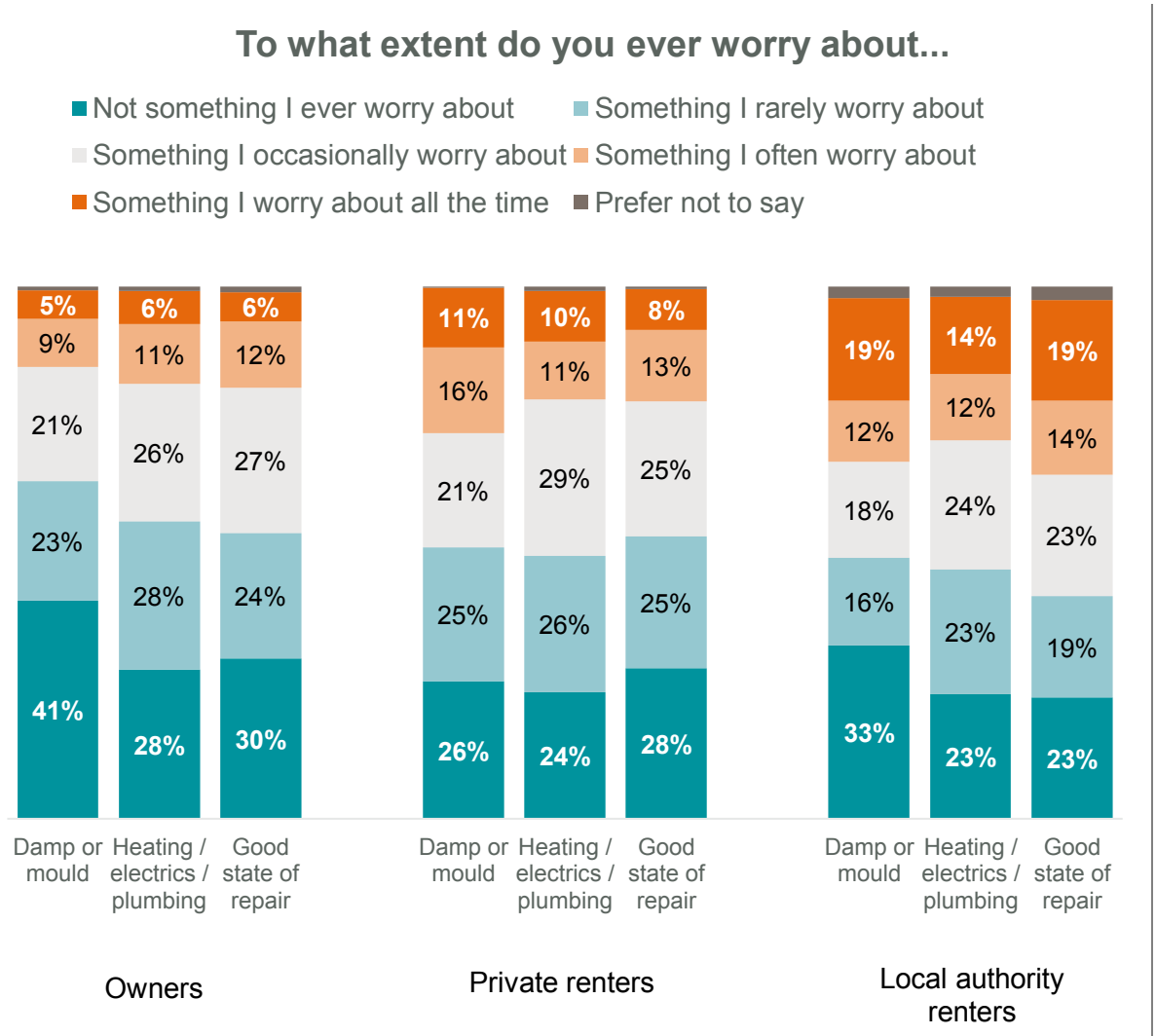
Worries about housing

The most common worries tended to be affordability costs such as rent or mortgage, or heating bills. Among non-homeowners 19% worry about being evicted and 24% of all residents worry about damp or mould in their home compared to 35% worrying about being able to afford accommodation.



Question: L1. Thinking about the home you live in, to what extent do you worry about…?
Base: all adults (4,000)

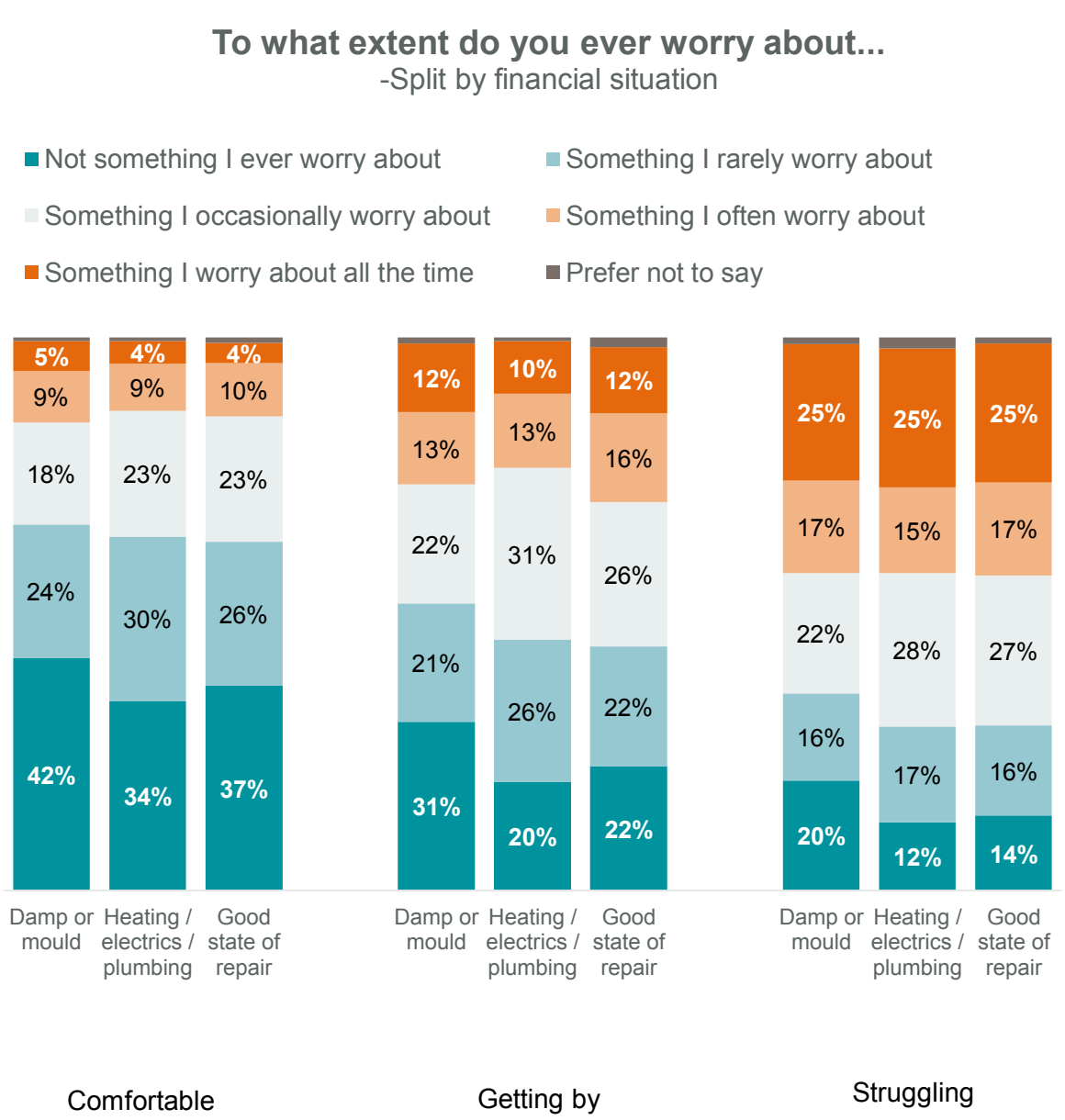
However, when looking at the state of homes, among renters their worries are notably higher:



Question: L1. Thinking about the home you live in, to what extent do you worry about…?
Base: all adults (4,000), owners (1,213), private renters (840), local authority renters (951)

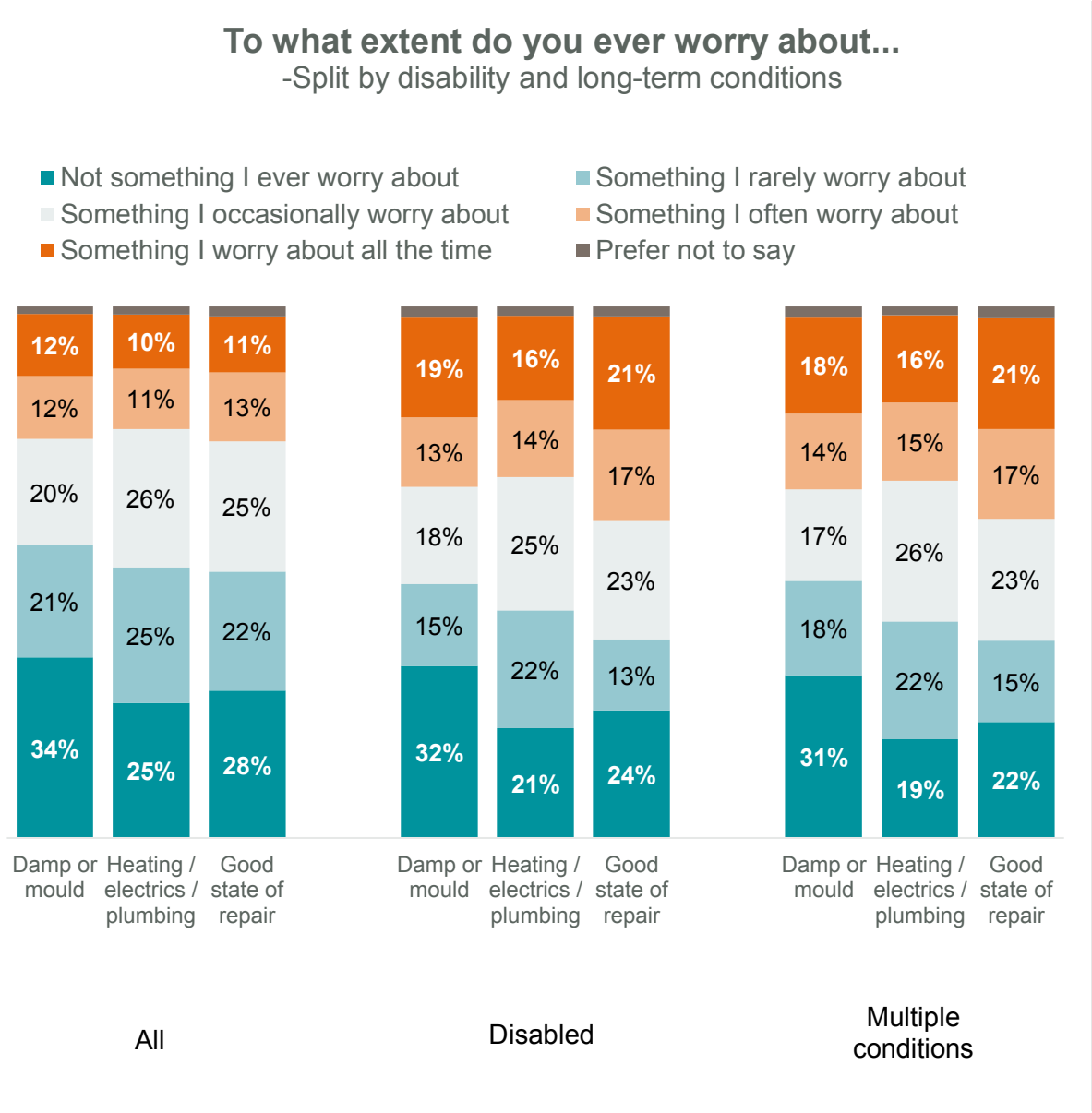
For each measure, private renters are more worried than homeowners while local authority renters are notably more worried still.

Breaking the data down by financial situation shows a clear relationship with worrying about housing issues:



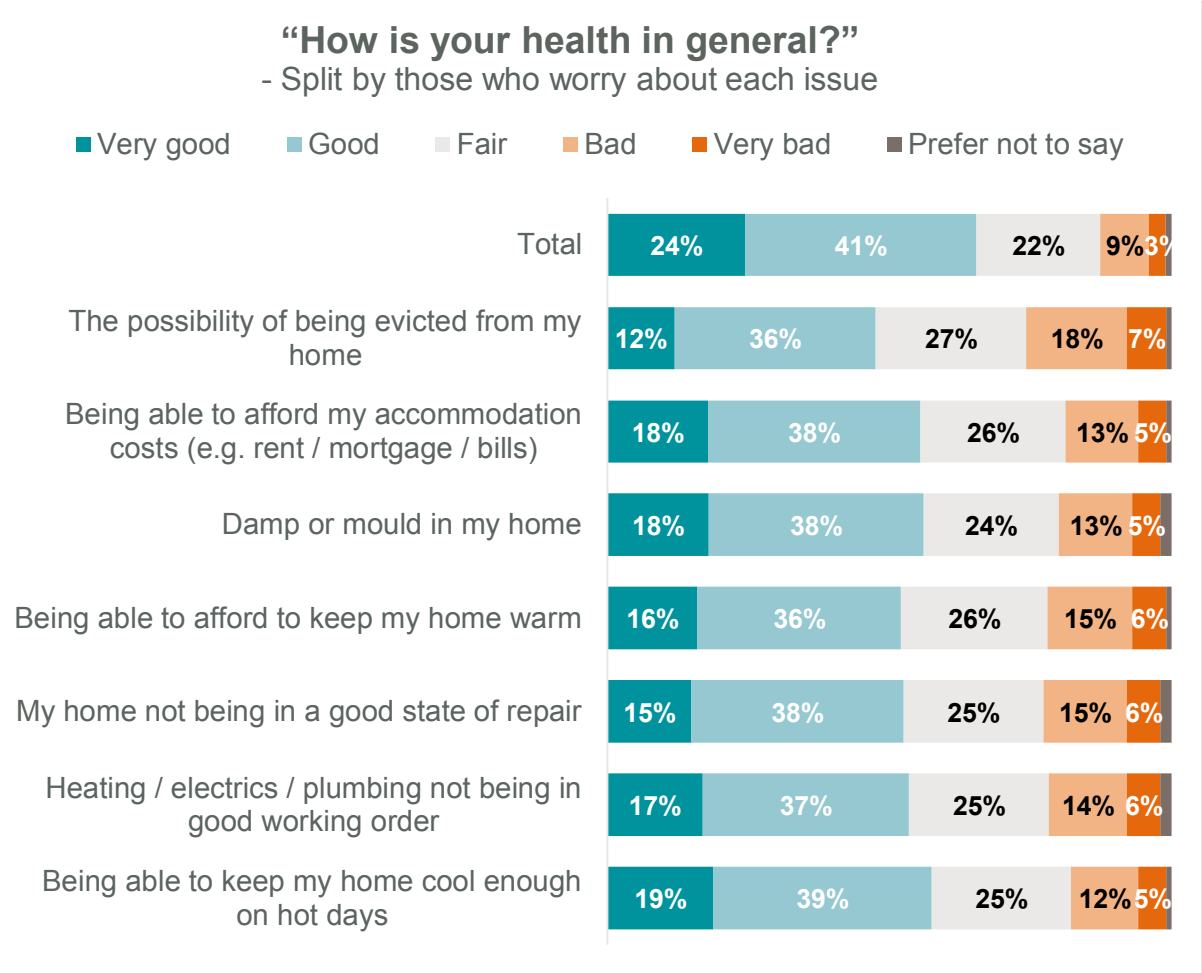
Question: L1. Thinking about the home you live in, to what extent do you worry about…?
Base: all adults (4,000), comfortable (1,958), getting by (1,093), struggling (842)

Similarly, looking at those with multiple long term condition types, and those who self-identify as disabled, we see that these worries are notably higher than among all residents:



Question: L1. Thinking about the home you live in, to what extent do you worry about…?
Base: all adults (4,000), disabled (565), multiple conditions (642)

Looking at self-reported health, the chart below shows this among all participants and then among those who worry about each housing issue. Those who worry about being evicted from their home are more likely than average to say their health is poor, as are those who worry about each other issue, albeit to a smaller degree.

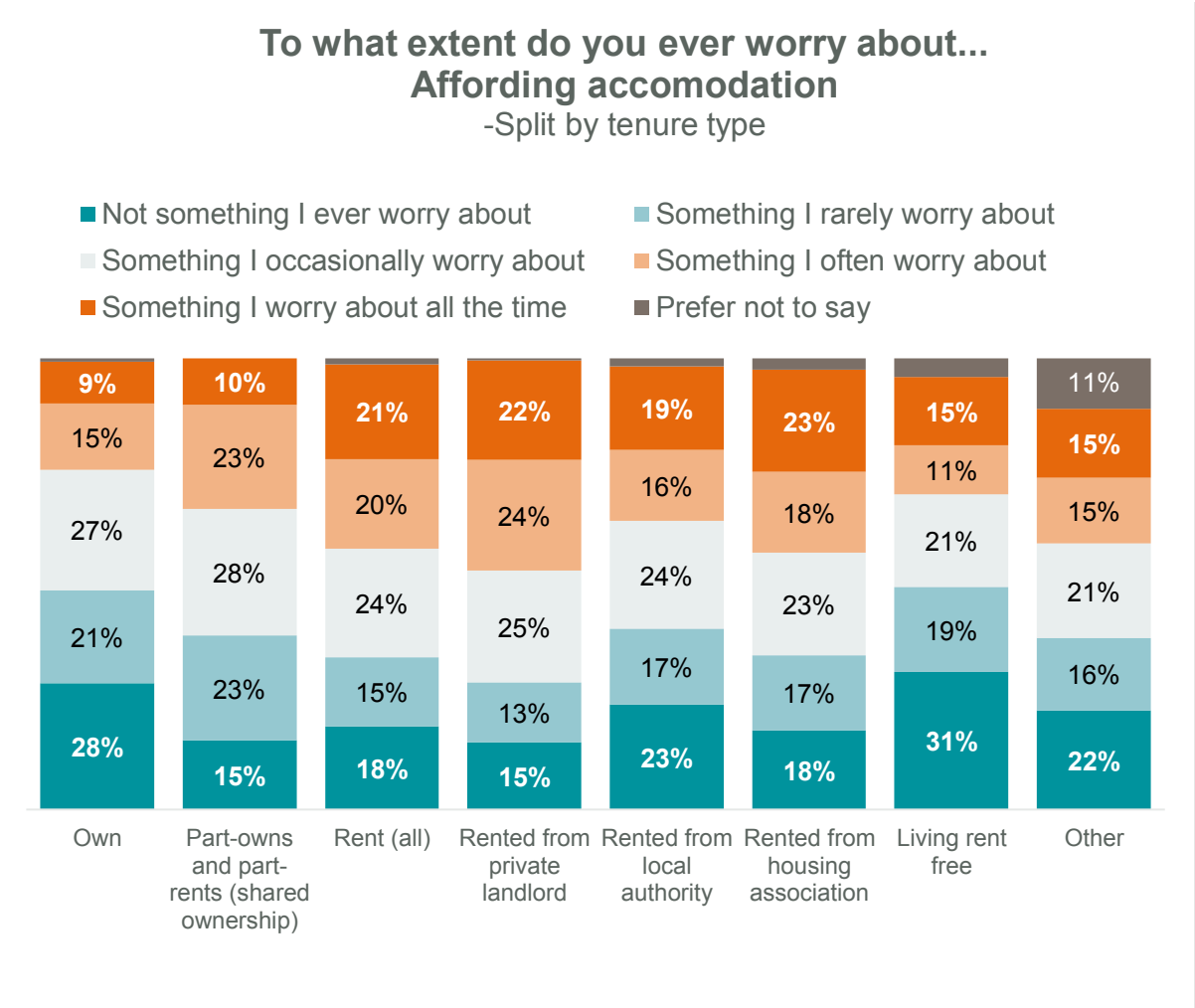


Question: H1. How is your health in general?
Base: all adults (4,000), worry about being evicted (516), worry about affording accommodation (1,341), worry about damp/mould (931), worry about affording to keep home warm (1,165), worry about state of repair (937), worry about heating/electrics/plumbing (870), worry about keeping home cool (930)

Note: being evicted was only asked of non-homeowners

Affording accommodation

Finally, private tenants are the most likely to say that they worry about being able to afford their accommodation:

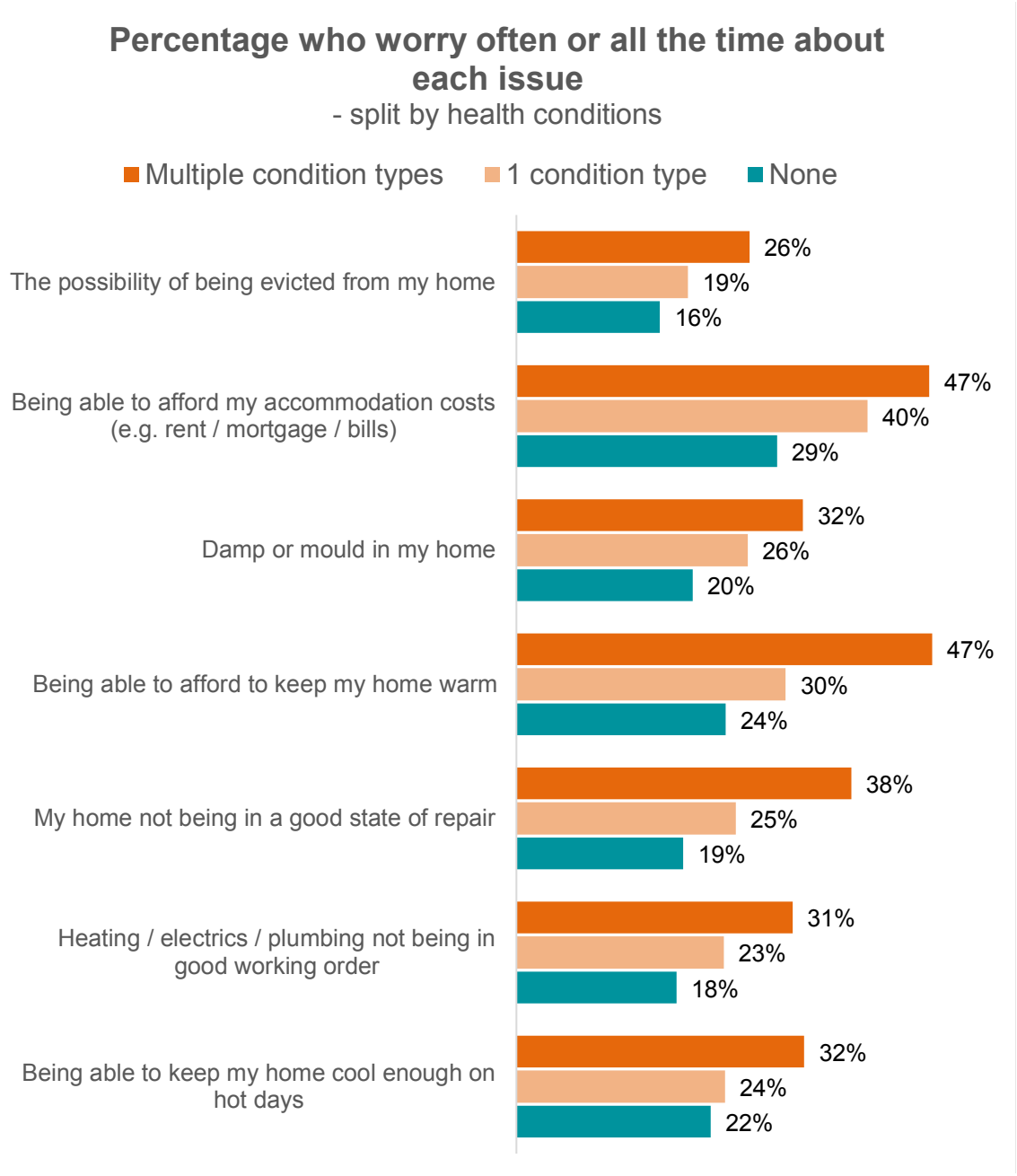


Question: L1. Thinking about the home you live in, to what extent do you worry about…?
Base: all adults (4,000), own (1,213), part-own and part-rent / shared ownership (87), rented from private landlord (840), rented from local authority (951), rented from housing association (531), living rent free (239), other (107)

Just under half (47%) of private renters worry often or all the time about affording their rent and bills – among private renters who are struggling financially this rises to 79%.

One in three (29%) respondents worry frequently about how they can afford to keep their home warm, and this is pronounced among those with a long-term condition. 45% of those with a physical or mobility related condition worry often or all time about heating their home, followed by 44% with a mental health condition, 41% with a long-term physical illness or condition and 40% with a learning disability.

Those with multiple health conditions are more likely to worry about all housing issues compared to those with one condition or no conditions:



Question: H2. Do you have any of the following long-term health conditions, impairments or disabilities?
Base: Multiple Long Term Conditions (642), One Long Tern Condition (976), None (2,382); except for 'The possibility of being evicted from my home' option which is Multiple Long Term Conditions (517), One Long Tern Condition (695), None (1,575)

Ideas from participants to improve poor quality housing

When exploring the various ways that poor housing quality could be improved in the rental sector, participants' suggestions included building better quality housing whilst at the development stage, managing and maintaining properties to a better standard, and providing a voice for tenants to feedback. There was also a certain level of disheartenment due to general distrust in institutions and

politicians, with a belief that poor quality housing would not improve because of the ulterior motivations of the government or pharmaceutical companies.

1. Improved regulations for the rental sector

There was consensus amongst participants that regulations governing the sector need to be tighter and more controlled, particularly for the private rental sector, but also for social renting. For the former, there was a feeling that private landlords are not held accountable for the state of their homes, and there is no official complaints process or official representative body to go to:

> Some sort of regulation for private landlords, that would be really helpful. I don't know, if there's an ombudsman or some complaint procedure in the same way that you have as a social renter, you can escalate problems to make them happen (have them addressed). There isn't really anywhere to go other than maybe the small claims court if your landlord doesn't do something to fix your house in private tenancy. So, it'd be helpful to have some sort of regulation or complaints process. I know that some opt in landlord schemes(where) landlords can opt in to be regulated, but rogue landlords aren't going to do that.

2. Better monitoring and management of properties

Participants stated that properties (both in the private and social renting sectors) should be better maintained, with minimal delays in fixing problems. Additionally, there should be improved monitoring systems in place to check if repairs have been carried out and resolved. This may be achieved by having a designated person who has been assigned responsibility for repairs and maintenance, or an 'inspector' who can enforce action:

> More (consistent) reports on housing conditions and how (these are) treated more time sensitively. So, they have something to work towards rather than things being left and then picked up (if people were to leave the job/case).

3. Improved communication between landlords and tenants, and a platform for tenant's voices to be heard

Some participants felt frustrated after contacting landlords or councils, stating that they do not respond, neither do they adequately address housing issues that have arisen. Participants felt it was important to be kept up to date with news and developments about their property. Some also stated that tenants need to have a platform to voice their opinions and have more say about their housing conditions:

> Whether social or private renting, I think it is the one thing that annoys me the most, the lack of communication. You take time to contact them, they don't seem to have the (respect) to respond to your letter. They need to communicate properly and in any general letters that they write, they need to be specific about

what they are saying. Keep everyone involved and up to date as much as possible to what is happening.

4. Better quality housing to be developed

Participants suggested that when houses are being built, there could be better checks on the land beforehand, better materials used, and higher quality tradespeople used, in order to improve the quality of houses that are being built. Although there is a housing shortage, participants felt that building new houses should not be rushed, as poor-quality developments lead to many more problems afterwards. They mentioned Grenfell as an example of poor-quality material being used:

> I heard where (my) building used to be, (it was) like a pit or something before they built on it. So, I'm just thinking maybe that's what caused the infestation issue in the first place, you know. treat the root cause first before you actually build on it. And don't rush, you see a lot of social housing, and they all get in a rush to be built because they want to make their money quickly. Take the time, otherwise, you're going to have issues.

5. Further funding from the government for renters

There were a few suggestions that the government could help to alleviate the effect of poor-quality housing on health, by providing funding to those in social and private rented housing, to enable them to deal with the increased cost of living:

> Something like (the) tenant association should come up (with a solution) where they can claim partial reimbursement from the government for paying electricity bills or food.
> The government should try to help and fund people.

6. Distrustful view of government and large organisations' motives

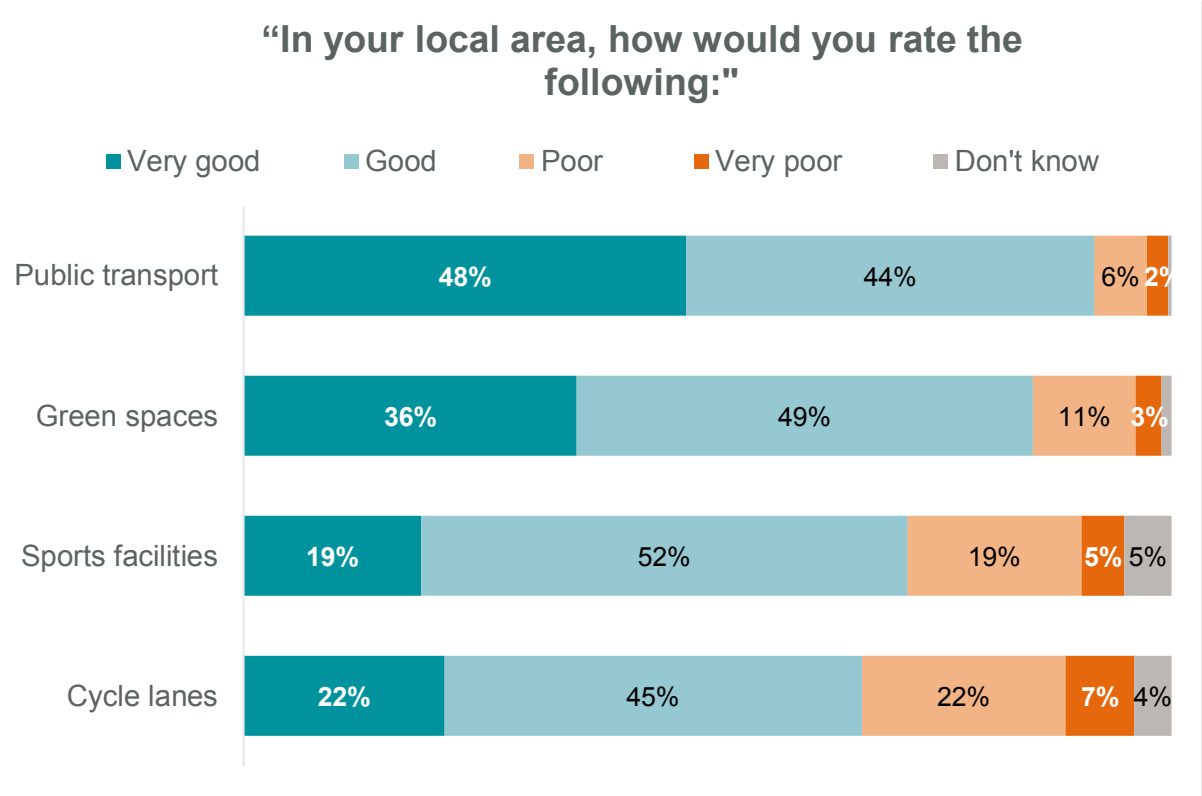
Among a few participants, there was a belief that the government, national institutions and large organisations like pharmaceutical companies had no interest in improving poor quality housing, nor improving the health of people, as they were benefiting from poor health or benefitting in other ways:

> When you look (at it) ... these pharmaceutical companies that are making money from us being ill. So, they don't really want us (to be) well. That's what I think. Deep down, I think they don't want us well, they just want us to be sick, spending money on drugs. It's probably not in their best interest to have everyone happy with their housing situation because someone's making... money.

Ratings of local services

We asked residents to rate four types of local area features: green spaces, sports facilities, public transport and cycle lanes. A 'Do not Use' and 'Don't know' option was also available for each of these. Almost everyone said they used the green spaces and public transport in their area (99% for both), while only 12% said they have not used the sports facilities in their area, and 15% have not used cycle lanes (although these figures may include respondents who chose to give a rating instead of selecting the 'do not use' option). The rest of the findings in these sections are for those that gave a rating.

92% of respondents rate public transport in their local area as good, and 85% of users said the green spaces in the local area are good. While 72% of users rated their local sports facilities as good, almost a quarter (23%) think they are poor. Cycle lanes however had the poorest ratings, with 29% saying their local cycle lanes are poor vs. 67% who saying they are good. Lambeth and Southwark residents align on ratings with the exception of cycle lanes. Southwark cycle lane users are more likely to rate cycle lanes in their local area as good (71%) than Lambeth cycle lane users (64%).



Question: E1. In your local area, how would you rate the following:
Base: all online only sample (2,451)

Across the four amenities we asked about, residents in Rotherhithe were more likely to rate facilities as good, featuring in the top five three out of four times when we rank the neighbourhoods giving the best ratings to each facility. Other neighbourhoods that also tended to feature in the top five across the four amenities we asked about include Dulwich, Waterloo & Southbank, Walworth, Streatham, Borough and London Bridge, and Bermondsey.

Top five neighbourhood areas that rated facilities as good in their local area:

Green spaces	Sport facilities	Public transport	Cycle lanes
East Dulwich (97%)	Dulwich (71%)	Borough and London Bridge (95%)	Borough and London Bridge (77%)
Nunhead and Peckham Rye (97%)	Brixton (69%)	Bermondsey (95%)	Rotherhithe (77%)
Dulwich (96%)	Rotherhithe (67%)	Clapham (94%)	Bermondsey (68%)
Rotherhithe (92%)	Streatham (66%)	Waterloo & South Bank (94%)	Walworth (64%)
Streatham (90%)	Peckham (66%)	Walworth (94%)	Waterloo & South Bank (63%)

Across the four facilities, residents in Old Kent Road and Norwood were the most likely to rate facilities as poor compared to other neighbourhood areas, featuring in the top five neighbourhood areas to rate each facility as poor three out of four times. While residents in Waterloo & South Bank and Borough and London Bridge were some of the most likely to rate facilities as good when it came to public transport and cycle lanes, there were also some of the most likely to rate facilities as poor when it comes to green spaces and sport facilities.

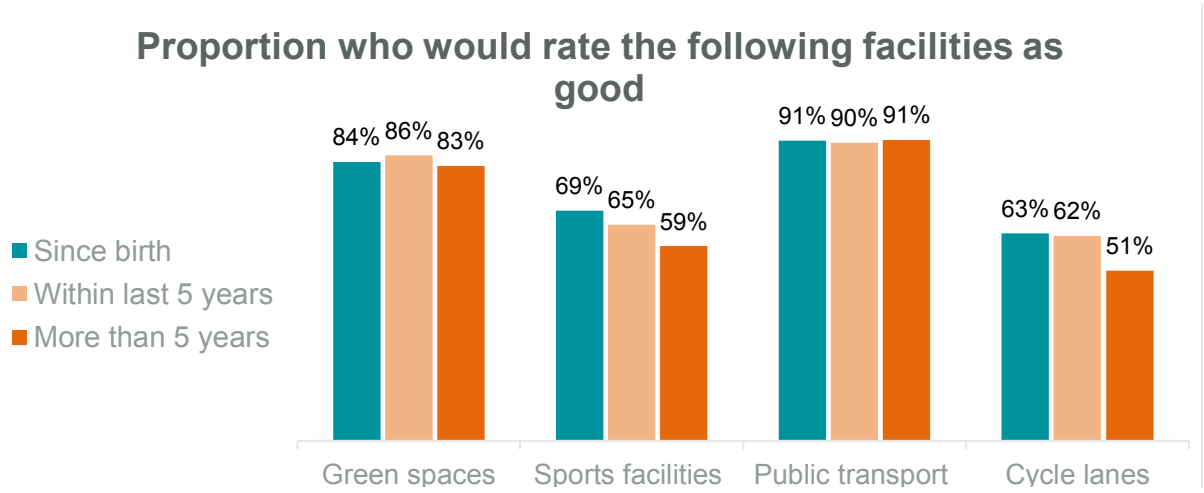
Top five neighbourhood areas that rated facilities as poor in their local area:

Green spaces	Sport facilities	Public transport	Cycle lanes
Borough and London Bridge (25%)	Old Kent Road (34%)	Old Kent Road (17%)	Streatham (37%)
Waterloo & South Bank (24%)	Norwood (26%)	Dulwich (15%)	Norwood (36%)

Old Kent Road (17%)	Waterloo & Southbank (24%)	East Dulwich (14%)	Nunhead and Peckham Rye (35%)
Stockwell (16%)	Borough and London Bridge (23%)	Nunhead and Peckham Rye (10%)	East Dulwich (31%)
Walworth (14%)	Bermondsey (23%)	Norwood (9%)	Peckham (30%)

Residents living in higher deprivation areas are more likely to rate green spaces as poor in their area (17% in highest deprivation IMD Quintile vs 9% in the lowest deprivation IMD Quintile).

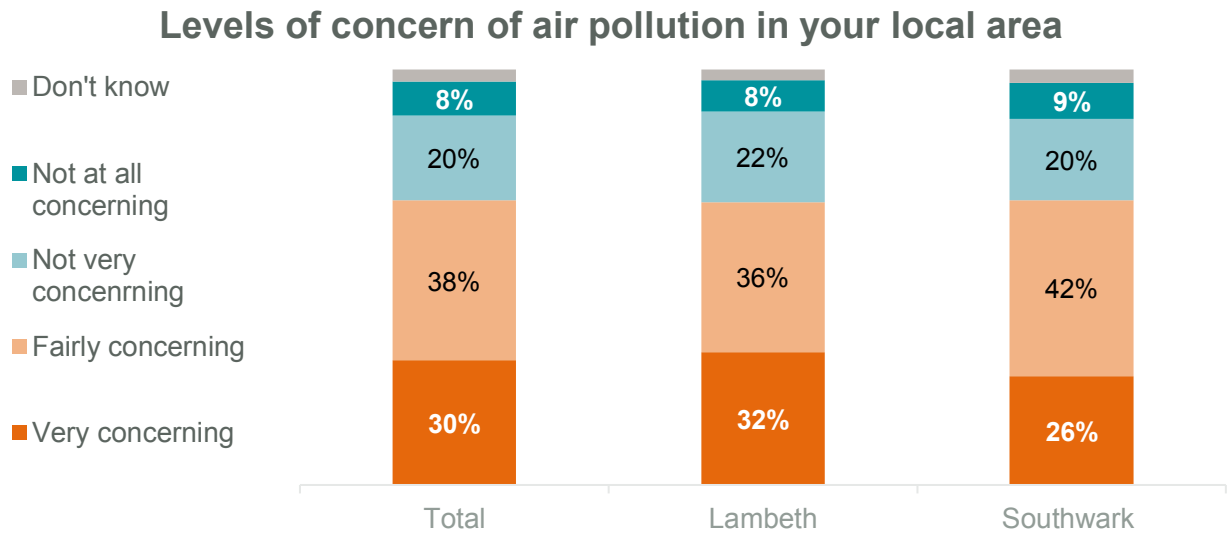
There is no difference in the way that residents who have lived in the two boroughs for different lengths of time feel about green spaces and public transport. However, when it comes to cycle lanes and sports facilities, those that moved to the borough but have lived there for more than 5 years are less likely to rate those facilities as good in their local area compared to those that have been living in the area for less time or have lived there since birth.



Question: E1. In your local area, how would you rate the following:
Base: all online (2,451), Lambeth (1,253), Southwark (1,058)

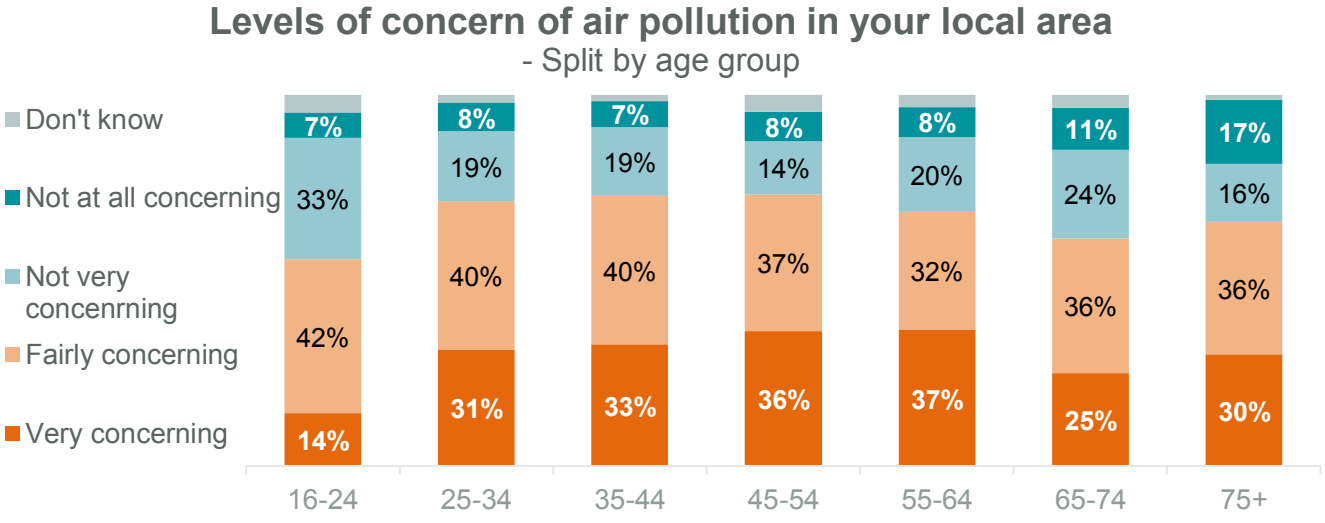
Air pollution in the local area

Over two thirds of residents in Lambeth (68%) and Southwark (69%) are concerned about air pollution in their local area. Lambeth residents are more likely to say they feel 'very concerned' than Southwark residents (32% and 26% respectively). The neighbourhood areas with the highest levels of concern about local air pollution are Borough and London Bridge (77% are concerned) and North Lambeth (74%), while residents in Rotherhithe have the lowest levels of concern (59% are concerned). When residents were asked about how they felt about air pollution levels across the UK concern was higher, with three in four Lambeth (75%) and Southwark residents (77%) expressing concern.



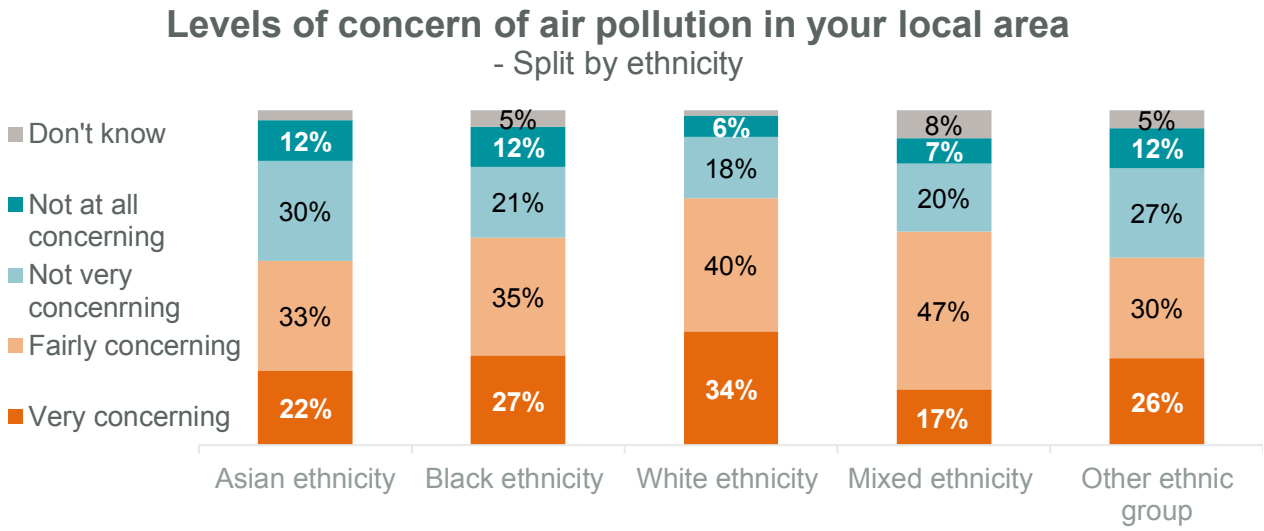
Question: E3. To what extent, if at all, are you concerned about the level of air pollution in your local area?
Base: all online (2,451), Lambeth (1,253), Southwark (1,058)

16–24-year-olds align with most other age groups in levels of concern about air pollution in the UK but are less concerned than other age groups regarding air pollutions levels in their local area. 56% of 16–24-year-olds say they are concerned about air pollution in the local area, while 40% are not concerned. However, 77% of 16–24-year-olds are concerned about air pollution levels in the UK as a whole, while 20% say they are not concerned.



Question: E3. To what extent, if at all, are you concerned about the level of air pollution in your local area?
Base: all online (2,466), 16-24 (276), 25-34 (633), 35-44 (581), 45-54 (413), 55-64 (331), 65-74 (164), 75+ (68)

Concerns about air pollution levels in the local area are higher among those of a White ethnicity than any other ethnic group. Almost three in four (74%) residents of a White ethnicity say they are concerned, compared to 55% of Asian residents, and 62% of Black residents. The gap is smaller when it comes to levels of concern about air pollution in the UK as a whole, where 79% of White residents say they are concerned, as do 74% of Asian residents and 71% of Black residents.



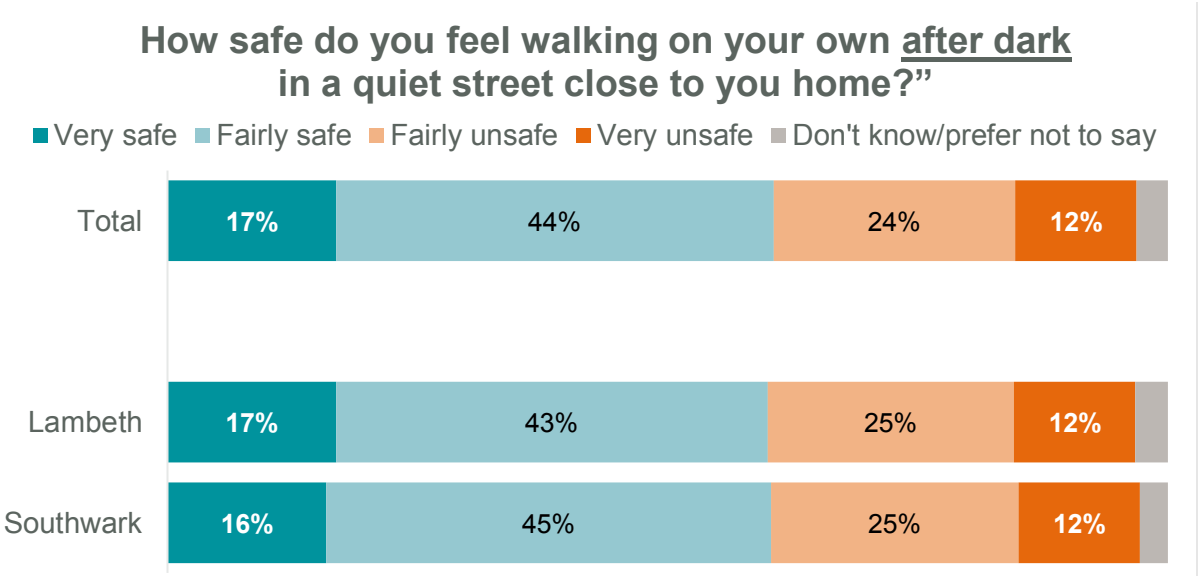
Question: E3. To what extent, if at all, are you concerned about the level of air pollution in your local area?
Base: all online (2,466), Asian (181), Black (466), White (1,501), Mixed (153), Other (128)

Safety in the local area

Feelings around safety is consistent across both Lambeth and Southwark at a total borough level. 85% of Lambeth residents and 88% of Southwark residents feel safe walking on their own during the day in a quiet street near their home.

Question: E2. Thinking of your personal safety, how safe or unsafe would you feel...
Base: all online (2,466), Lambeth (1,257), Southwark (1,069)

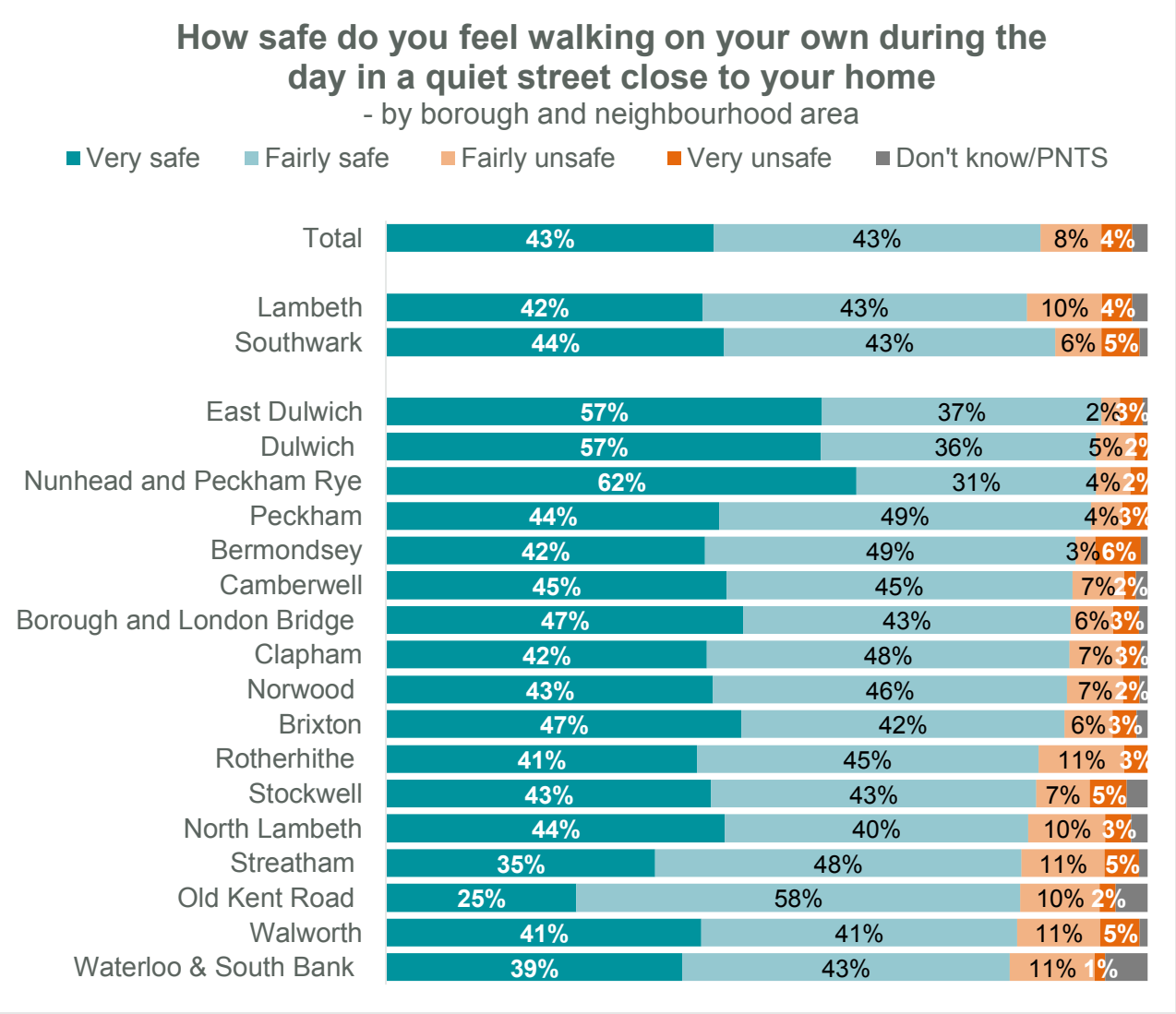
Unsurprisingly, feelings of safety drop when it comes to walking in the dark, with 61% of Lambeth and Southwark residents saying they feel safe, compared to around a third (36% in both boroughs) saying they don't feel safe.



Question: E2. Thinking of your personal safety, how safe or unsafe would you feel...
Base: all online (2,466), Lambeth (1,257), Southwark (1,069)

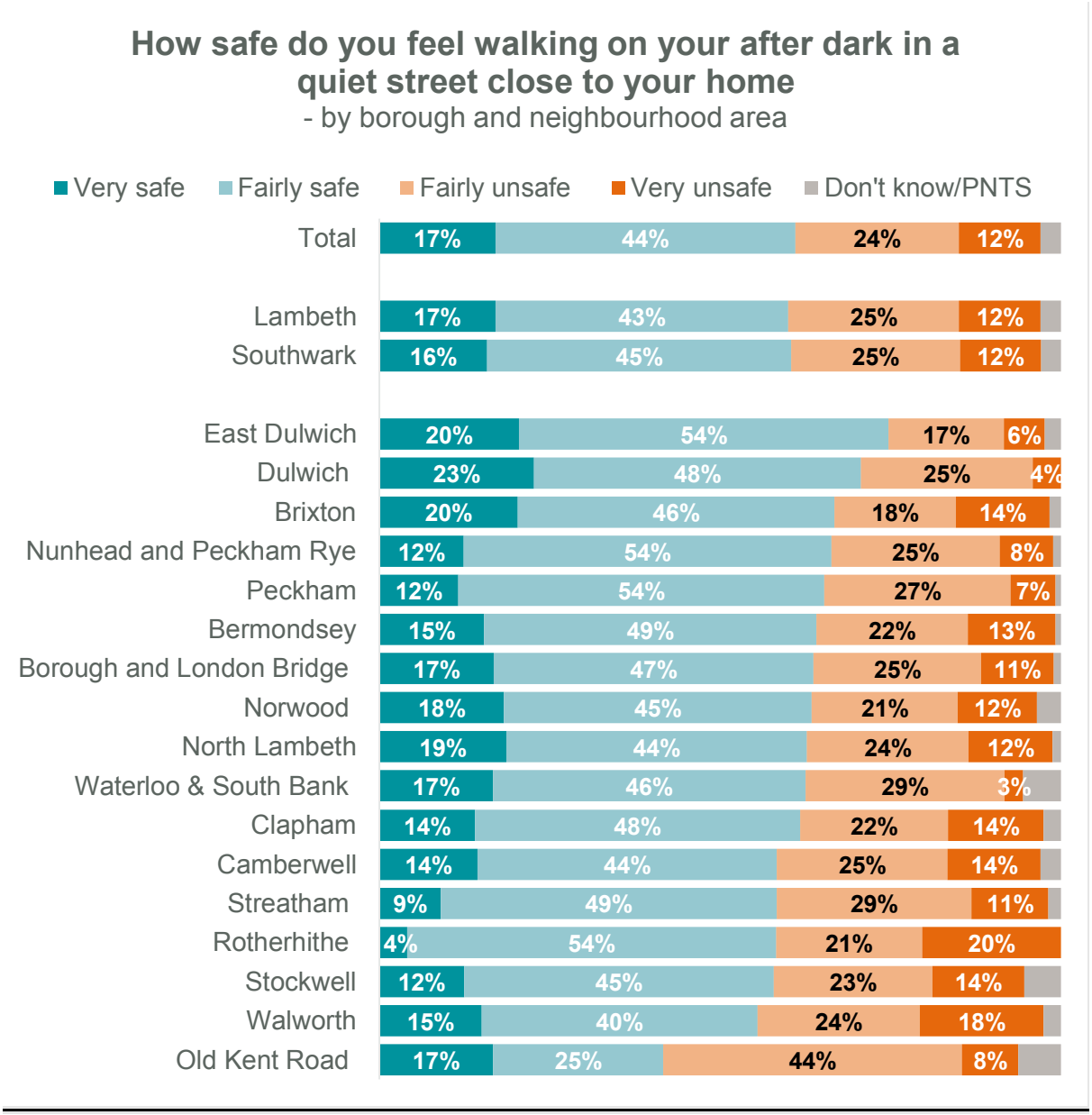
There are some variations in proportions feeling safe looking at neighbourhood area. During the day, residents in East Dulwich (94%) and Dulwich (93%) are most likely to report feeling safe walking alone, while those in Streatham (15%) and Walworth (16%) are most likely to say they feel unsafe. When it gets dark, again residents in East Dulwich (75%) and Dulwich (71%) are the most likely to say they feel safe, while residents in Walworth (42%) and Old Kent Road (52%) are the most likely to report feeling unsafe walking alone.

Residents living in higher areas of deprivation feel less safe walking on their own during the day (80% feel safe in the highest deprivation IMD Quintile vs 90% in the lowest deprivation IMD Quintile). There is an even bigger gap in feeling safe when it comes to walking alone after dark (54% feel safe in the highest deprivation IMD Quintile vs 70% in the lowest deprivation IMD Quintile).



Question: E2. Thinking of your personal safety, how safe or unsafe would you feel...

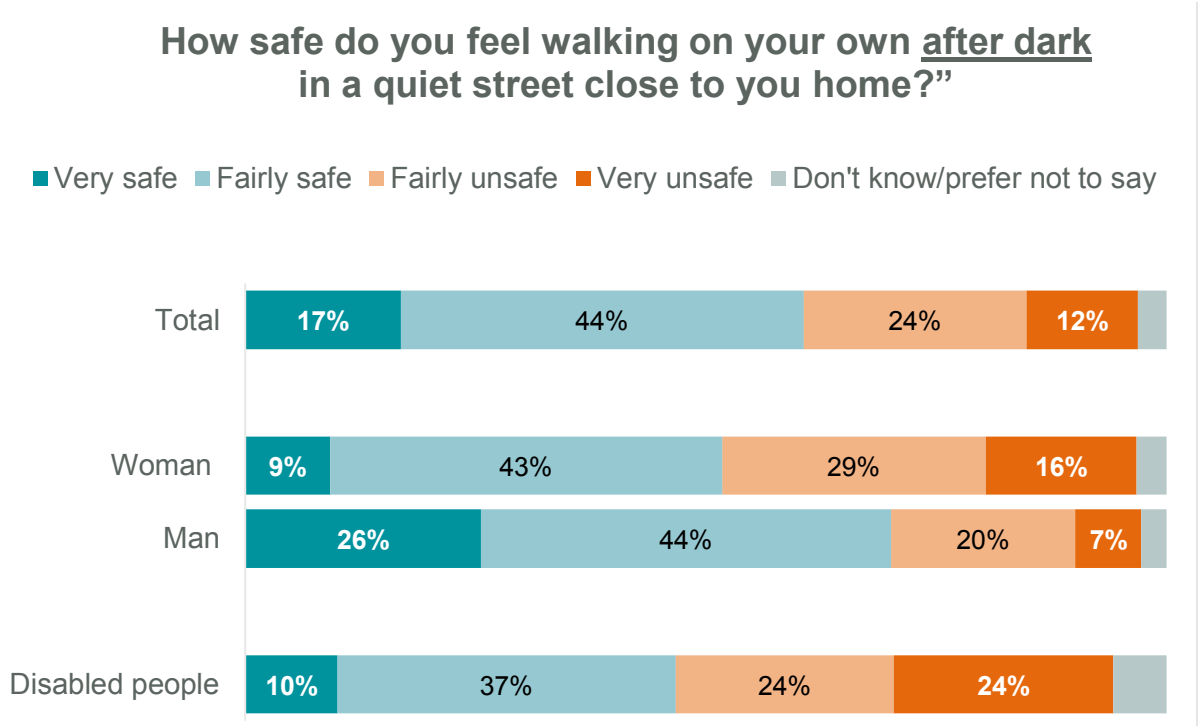
Base: all online (2,466), Lambeth (1312), Southwark (1132), East Dulwich (228), Clapham (325), Waterloo & South Bank (83), Nunhead and Peckham Rye (137), Dulwich (156), Rotherhithe (155), Walworth (291), Peckham (195), Brixton (488), North Lambeth (296), Borough and London Bridge (272), Camberwell (202), Stockwell (281), Streatham (368), Bermondsey (183), Norwood (389), Old Kent Road (90)



Question: E2. Thinking of your personal safety, how safe or unsafe would you feel...

Base: all online (2,466), Lambeth (1312), Southwark (1132), East Dulwich (228), Clapham (325), Waterloo & South Bank (83), Nunhead and Peckham Rye (137), Dulwich (156), Rotherhithe (155), Walworth (291), Peckham (195), Brixton (488), North Lambeth (296), Borough and London Bridge (272), Camberwell (202), Stockwell (281), Streatham (368), Bermondsey (183), Norwood (389), Old Kent Road (90)

There are also some gender differences. At a total level men and women feel similar levels of safety during the day. However, men are more likely to say they feel very safe (51% vs 37% of women), while women are more likely to say they feel fairly safe (49% vs 36% of men). That picture changes once darkness sets in. At a total level, 70% of men say they feel safe walking near their home at nighttime, and a quarter (27%) feel unsafe. On the other hand, only half (52%) of women say they feel safe, and 45% say they feel unsafe.



Question: E2. Thinking of your personal safety, how safe or unsafe would you feel...
Base: all online (2,466), Woman (1,383), Man (1,004)

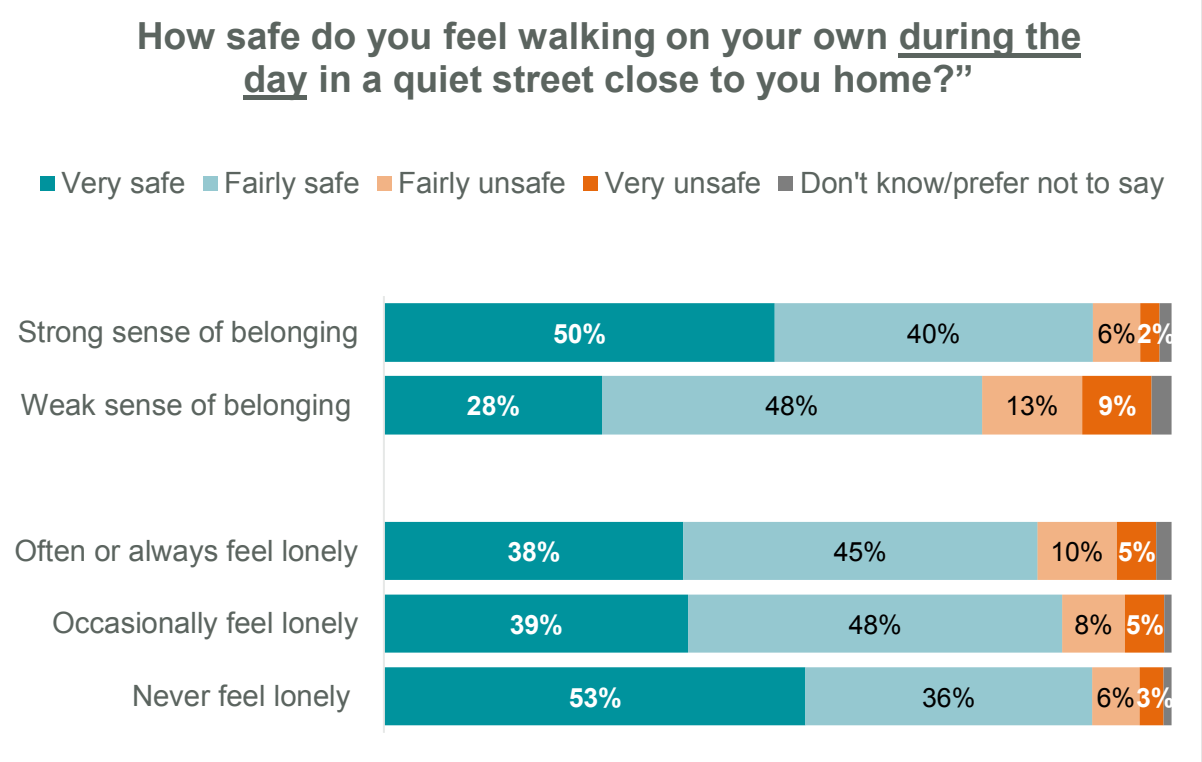
Disabled people are less likely to feel safe than the general population of Lambeth and Southwark. 73% feel safe during the day, while a quarter (24%) feel unsafe. When it gets dark, almost half (47%) of disabled people say they feel unsafe.

Those of a White ethnicity are more likely than ethnic minorities to report feeling safe during the day around their area (88% and 83% respectively), and during the night (63% and 57% respectively). During the day, it is particularly those that ticked 'Other' ethnicity that are more likely to say that they feel unsafe (20%). During the night, those of an Asian ethnicity are the most likely to report feeling unsafe (44%).

There was no notable difference between LGBTQ+ and heterosexual residents on either measure. 37% of LGBTQ+ residents felt unsafe after dark versus 36% of heterosexual residents while figures for during the day were 10% and 12% respectively.

Those that feel a strong sense of belonging are more likely to feel safe than those that have a weak sense of belonging, both during the day (90% compared to 76% respectively) and at night. Two

thirds (67%) of those who feel a strong sense of belonging feel safe at night compared to 44% of those with a weak sense of belonging.

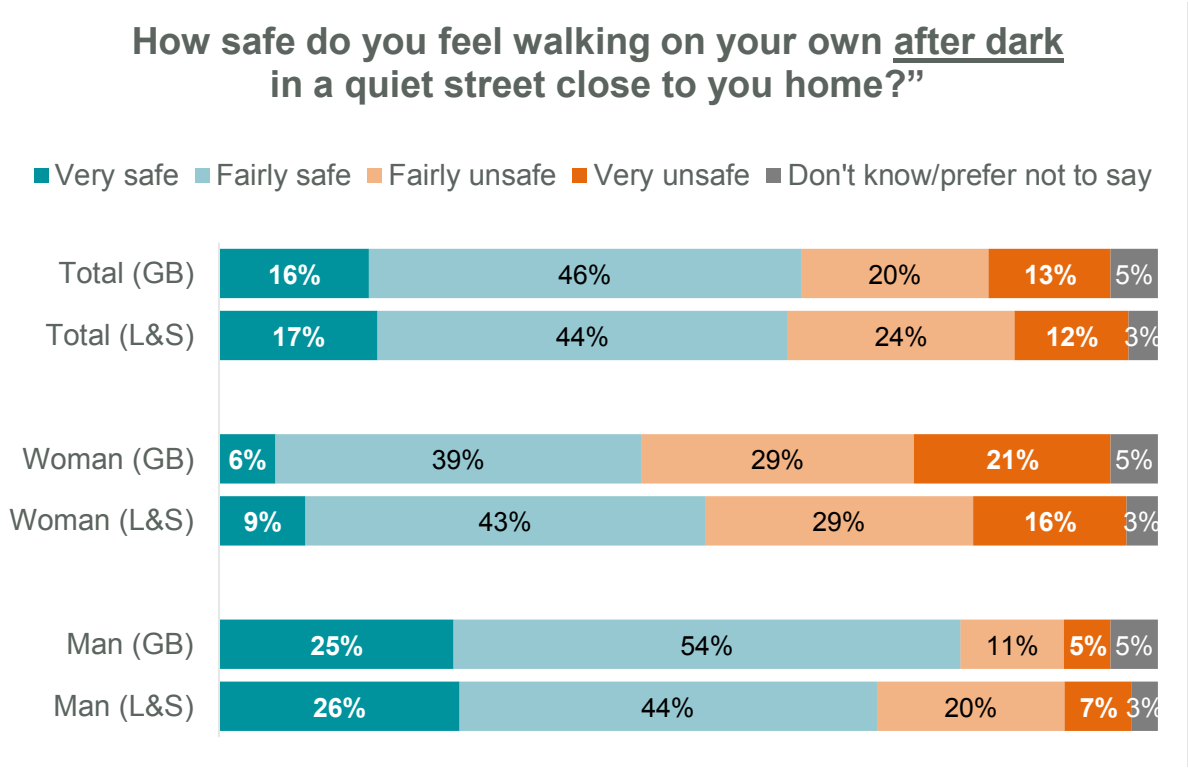


Question: E2. Thinking of your personal safety, how safe or unsafe would you feel...
Base: all online: strong sense of belonging (1,817), weak sense of belonging (649), often or always feel lonely (440), occasionally (1,061), never (750)

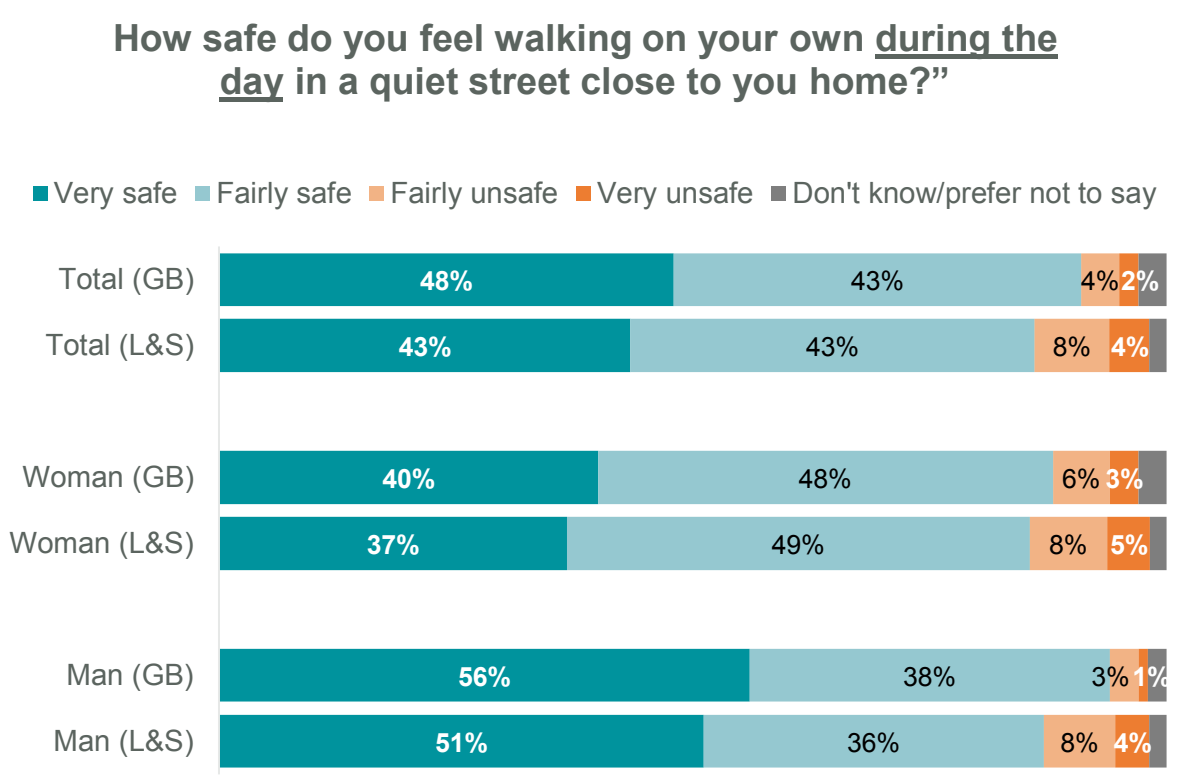
There is also a correlation between safety and feelings of loneliness. Those that never or rarely feel lonely (90%) are more likely to feel safe walking on their own during the day compared to those that often or always feel lonely (83%). This difference is even more marked during the night (70% vs 54% respectively).

Some of the questions we asked in this survey have been taken from other surveys that have been conducted at an England wide or London level so that we can look at whether there are differences in experiences of Lambeth and Southwark residents and of England or Londoners as a whole.

When it comes to safety during the day, there is little difference in perceptions of safety among Lambeth and Southwark residents compared to Great Britain as a whole. However, when we look at data from the Opinions and Lifestyle survey (conducted Feb-March 2022), we find that at night women respondents in Lambeth and Southwark felt safer compared to women across Great Britain. However, men in Lambeth and Southwark are less likely to feel safe at night compared to men across Great Britain.



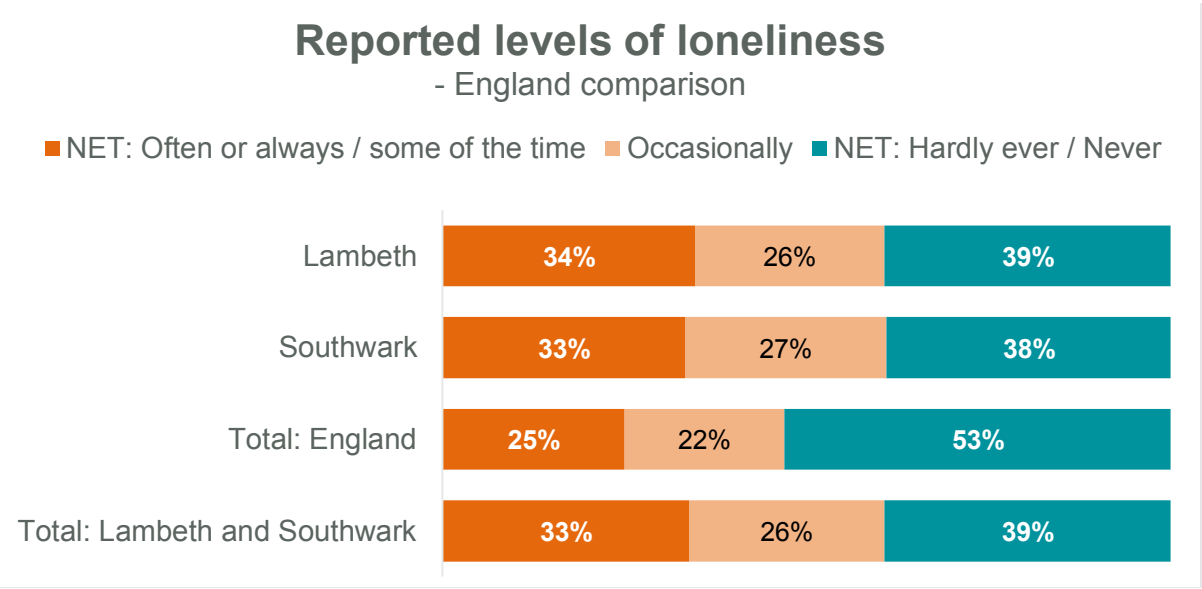
Question: E2. Thinking of your personal safety, how safe or unsafe would you feel...
Base: all online (2,466), Woman (1,383), Man (1,004)



Question: E2. Thinking of your personal safety, how safe or unsafe would you feel...
Base: all online (2,466), Woman (1,383), Man (1,004)

Feelings of loneliness compared to England as a whole

While there is little difference in loneliness levels of Lambeth and Southwark residents, they do report feeling lonelier than of adults living in England as a whole. A quarter of English adults in the Opinion and Lifestyle survey (conducted August 2023) reported feeling lonely always, often or some of the time, compared to around a third of Lambeth and Southwark residents in our survey.



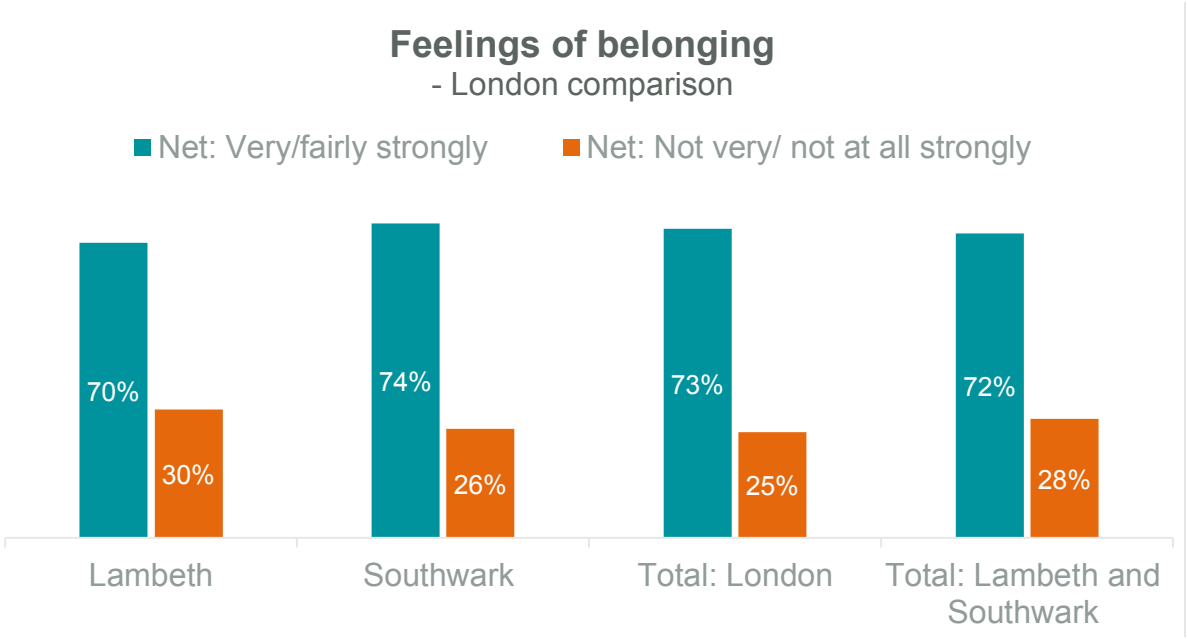
Question: S1. How often do you feel lonely?
Base: all adults (3,942), Lambeth (1,928), Southwark (1,850)

Old Kent Road is the loneliest neighbourhood area, with 40% of residents there reporting that they feel lonely often, always or some of the time. Meanwhile, residents in East Dulwich are the most likely to report feeling hardly ever or never lonely (53%).

Residents living in higher deprivation areas are more likely to report feeling lonely often, always or some of the time (39% in highest deprivation IMD Quintile vs 29% in the lowest deprivation IMD Quintile).

Feelings of belonging compared to London as a whole

Lambeth and Southwark residents feel similar levels of belonging to their local area as other residents across London.



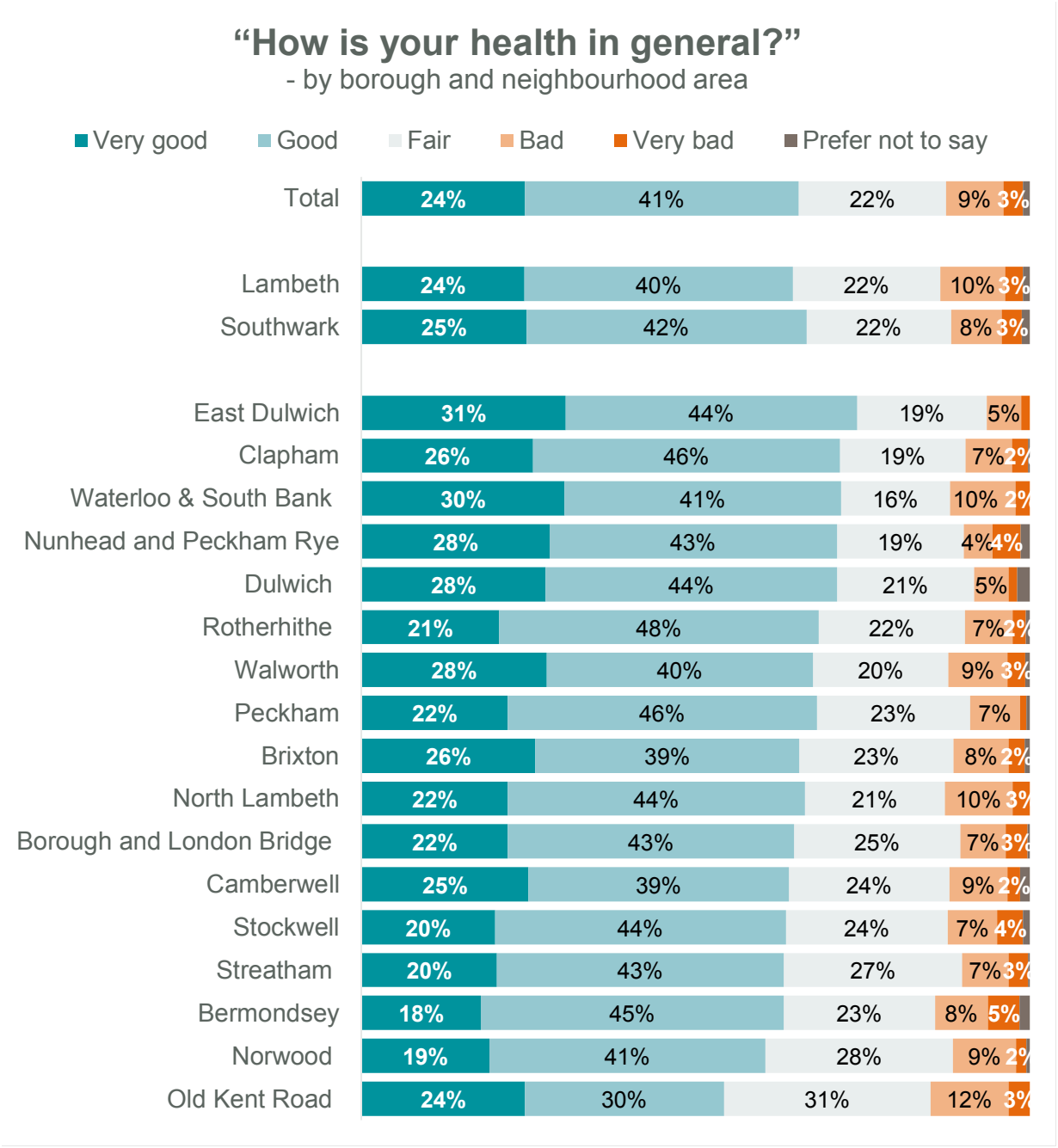
Question: S2. How strongly do you feel you belong to your local area?
Base: all online (2,466), Lambeth (1,257), Southwark (1,069)

Residents in Dulwich and East Dulwich have the strongest feelings of belonging, with 90% and 88% respectively saying they feel very or fairly strongly towards their local community. This drops to 71% in Bermondsey.

Residents living in higher deprivation areas are more likely to feel a weak sense of belonging that those in the lowest areas of deprivation (32% in highest deprivation IMD Quintile vs 22% in the lowest deprivation IMD Quintile).

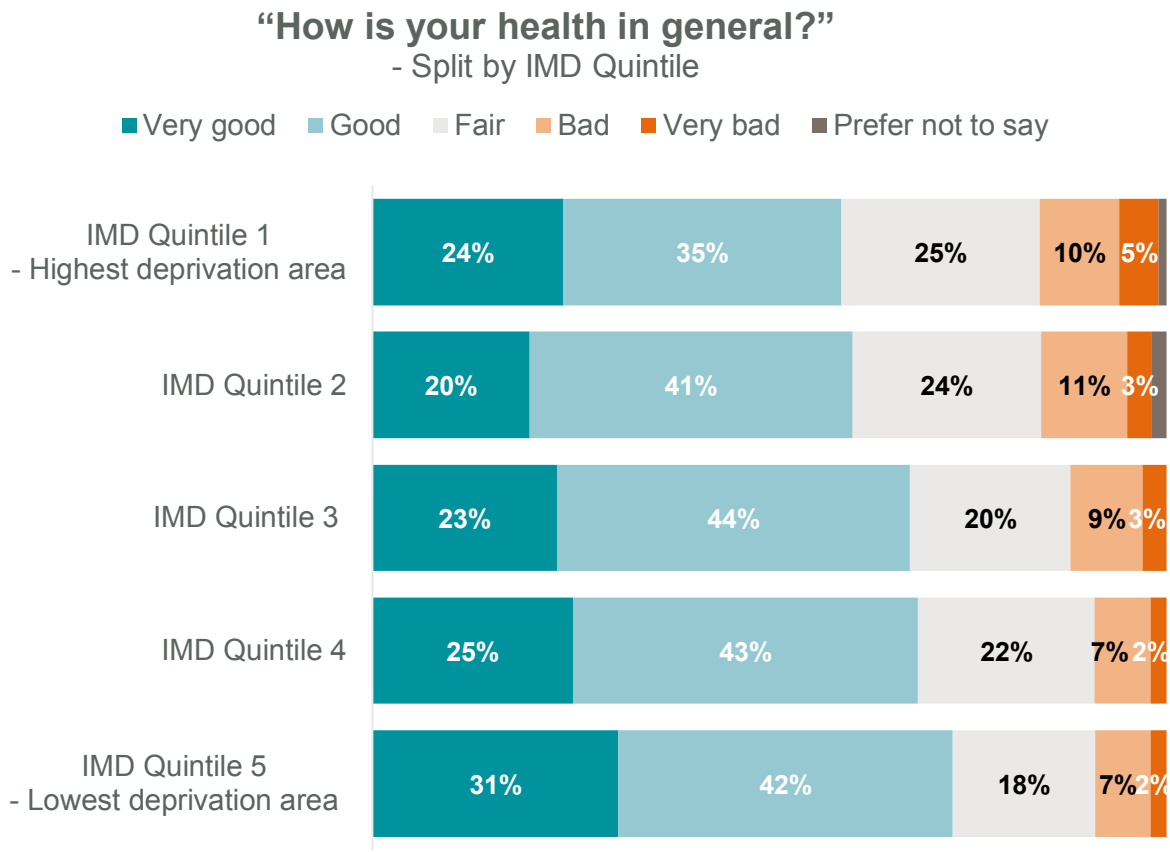
Self-reported health

There is no notable difference in how people feel about their health in Lambeth and Southwark overall. Two thirds of Southwark residents (67%) and of Lambeth residents (65%) would describe their health as very good or good. We do see more variation in responses when delving further into neighbourhood areas. Residents in East Dulwich, Clapham and Waterloo & South Bank are the most likely to score their health as very good or good (74%, 72% and 72% respectively). Meanwhile, residents in Norwood and Old Kent Road (60% and 54% respectively) are the least likely to say their health is very good or good.



H1. How is your health in general?
Base: Lambeth (1312), Southwark (1132), East Dulwich (228), Clapham (325), Waterloo & South Bank (83), Nunhead and Peckham Rye (137), Dulwich (156), Rotherhithe (155), Walworth (291), Peckham (195), Brixton (488), North Lambeth (296), Borough and London Bridge (272), Camberwell (202), Stockwell (281), Streatham (368), Bermondsey (183), Norwood (389), Old Kent Road (90)

Residents living in higher areas of deprivation are less likely to report their health as good (59% report good health in the highest deprivation IMD Quintile vs 73% in the lowest deprivation IMD Quintile)



H1. How is your health in general?
Base: IMD Quintile 1 (640), IMD Quintile 2 (631), IMD Quintile 3 (642), IMD Quintile 4 (629), IMD Quintile (644).

The self-reported health question is drawn from the census[10] and our findings reflect Census 2021 data of there being no difference in the way that Lambeth and Southwark residents overall feel about their health. However, in this survey, residents are more likely across both boroughs to give poorer scores for their health compared to the census data which was collected two years ago. Differences with the census are more likely to be due to data collection methods employed by each survey. Our survey combined telephone, online and community outreach methodology (both online and paper) across a section of the two boroughs, while the census data was collected among every household via online and paper. There was also variation within our survey findings by data collection methods, with those who took part in the survey through community outreach being more likely to say their health is bad. Differences could also possibly be part a reflection of increased levels of sickness and disability reflected in DWP data, with some driving factors of this being the impact of long Covid and rising poverty rates. However, it is difficult for us to know whether this is definitely part of the reason for why there are differences between the two datasets and can only be treated as speculation. Caution is to be applied on comparing the census data with this survey due to the reasons mentioned above.

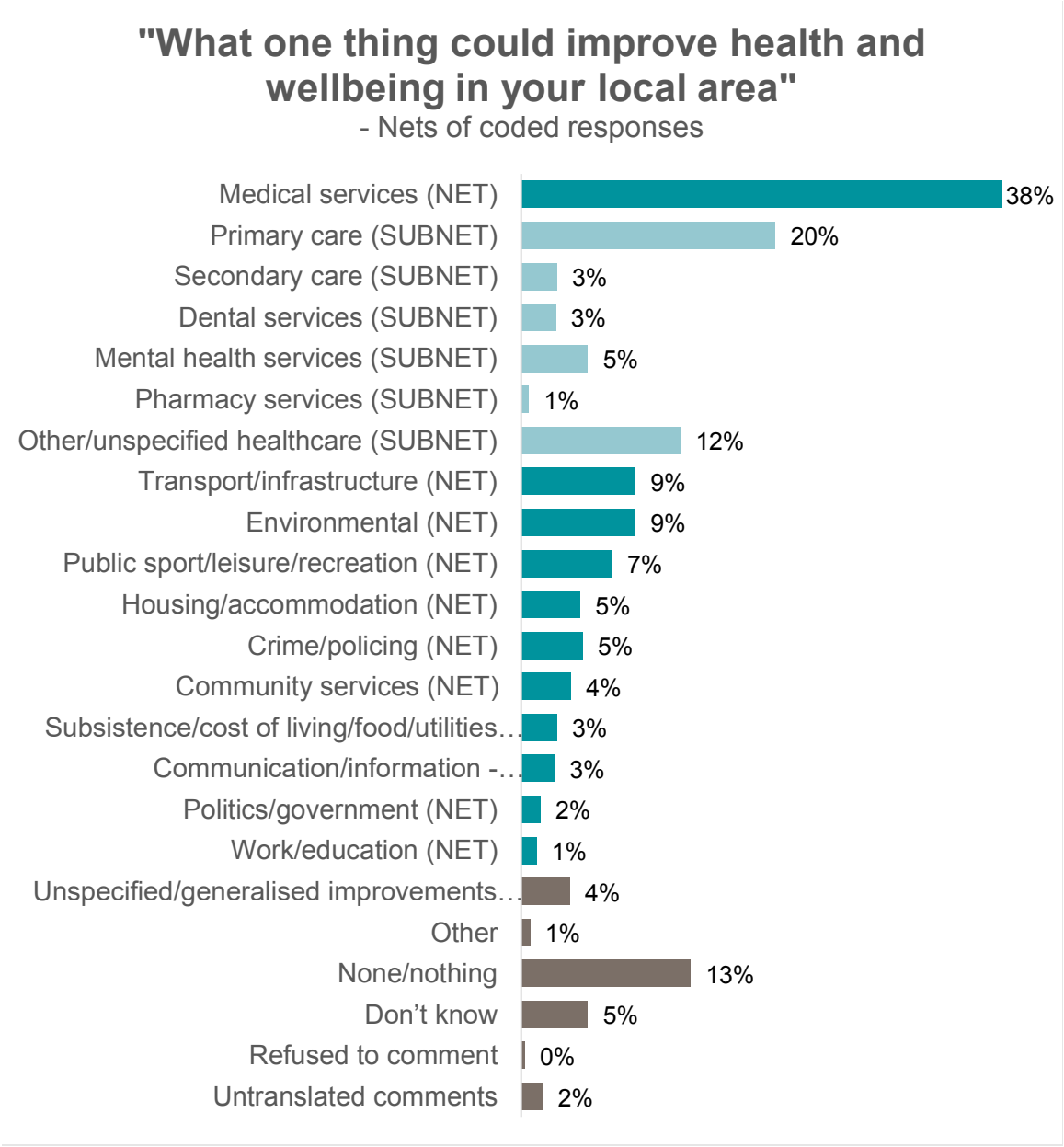
[10] Unlike the census our question included a 'prefer not to say' option, but with only around 1% of people selected this direct comparison can be drawn between our data and census data.

	Very good or good	Fair health	Bad health	Prefer not to say
England (Census)	79%	15%	6%	N/A
Southwark (Census)	84%	11%	5%	N/A
Lambeth (Census)	85%	11%	5%	N/A
Southwark (IUH survey)	67%	22%	11%	1%
Lambeth (IUH survey)	65%	22%	12%	1%

7. Future improvements

The final part of the quantitative survey was an open text question asking respondents what one thing could be done to improve health and wellbeing in their local area. Responses were then coded into 17 general categories (nets) which, themselves, split into 211 more specific categories (codes). A full list is available in the appendix.

Given the topic, the most common category was medical services, which 38% of residents had an answer falling into, constituting 71 of the 211 codes. Therefore, this was further divided into six subnets of primary care, secondary care, dental services, mental health services, pharmacy services and other/unspecified healthcare.



Within "primary care", the dominant answer was "access to GP / clinics" including more appointments, making it easier to get appointments, or having more GPs and clinics generally. 12% of

responses fell into this category. The next most common category was having appointments be face to face rather than online or on the phone (2%).

> "Be able to see a doctor when you want and how you want (e.g. over the phone or in person) and that pharmacies have your prescription in stock."

> "GP need to increase the time slots to see patients. 10min allocation to speak to a patient is insufficient. GP should address the root cause of health issues and not just the symptoms. This is a sticking plaster for health issues."

The dominant code within "secondary care" is access to specialists, hospitals and quicker referrals/more staff (1.3%)

> "Faster access to consultants when you are referred to them by your GP."
> "I am actually concerned about emergency care should I need this due to all the horror stories of long waiting times in A&E".

The most popular codes within the other medical care subnets also relate to improving access, including "unspecified" which is dominated by general comments about making access easier.

> "The standard of care from GP practices, as I've experienced it, [is] woeful. Specifically, mental health care seems close to non-existent."

Within community services, comments tend to be advocating more youth clubs or programmes for young people, for projects, activities, events or clubs, providing opportunities for social connection or interaction.

> "I think there should be more opportunities for the community to come together and enhance bonding; I think this applies to having more youth centres as well as meeting groups to prevent loneliness in the elderly - maybe even something that brings the two together."

Crime and policing focuses on making people feel safer at home or on the streets, with increased visible police presence potentially helping here. Assorted "deal with…" comments include issues such as antisocial behaviour or drug dealers and users.

> "Somebody patrolling the area in the evening. There's a lot of people making noises and taking drugs."

The 9% giving "environmental" responses break down into 2.9% advocating for more greenery and green spaces, 1.7% calling for a reduction in air pollution, 1.7% for cleaner public spaces and 1% for better maintenance and repair of public spaces.

> "Continue driving forward the low traffic neighbourhoods and the fantastic investment which has been happening in parks - de-urbanising and greening Lambeth is the biggest positive for me."

> "The paving stones, she tripped over one and broke her hip."

Transport and infrastructure is a mixture of 2.2% saying reduce traffic or congestion, 2% calling for better and safer cycling infrastructure, and 1.2% for reducing pollution from transport.

> "Active travel provision specifically cycle lanes, school streets and LTNs. Increased physical activity has a remarkable number of positive spillover effects on health and wellbeing.

> "The LTN are an absolute nightmare for congestion and air pollution. By creating traffic jams all up the main arteries around Southampton Way, for example (but also elsewhere) they cause cars to pollute the local area, they are dangerous for pedestrians as drivers get frustrated and try to do stupid manoeuvres and people living on them feel unsafe because there is less thoroughfare".

> "Revise all LTNs so that ALL residents are treated fairly, and some roads do not suffer for the sake of more affluent areas."

Responses falling into public sport/leisure/recreation also focused on better access (2.3%) or cheaper facilities (2.7%) with other responses tending to be more specific versions of these requests.

> "Lower costs of swimming and gym memberships or make free for those not able to pay."

> "More access to leisure stuff, like gyms and swimming pools because we don't have many round here. If there was an outside gym I feel people would use them."

8. Appendices

Methodology | Phase one - co-creation

Introduction

The purpose of this project was to get a deeper insight into the experiences of residents in Lambeth and Southwark and their relationship with health, especially those from underserved groups. Additionally, the aim was to obtain data on social and health outcomes that are granular enough across different social groupings to assess the impact of inequalities on health.

The project was based on a co-creation approach, affirming that residents in Lambeth and Southwark are experts due to their lived experiences, therefore they are best placed to design this research.

Co-creation

Co-creation is 'an approach to working together in equal partnership and for equal benefit, through practising core values such as being inclusive, transparent, human and challenging'[11]. For research, this means recognising and equally valuing the skills and expertise of people with lived experience. Expertise gained through experience should be valued equally to research methodology or topic expertise in the research design and process.

Co-created research involves stakeholders who are embedded in the day-to-day of the study topic. This could include employees, policy-makers, healthcare staff, family members, individuals with health conditions, or anyone else who is directly involved or affected by the research.

The five main benefits of co-created research are:

1. Context

   Experts by experience add invaluable insights about the context and nuances of a situation, issue or event. This makes research more relevant as it directs the focus to the most important issues of topics and can identify unknowns that researchers would miss without experience-led expertise.

2. Empathy

   Experts by experience often have personal lived experiences of the topic studied, this adds a layer of empathetic understanding that is necessary in order to ask the right questions in the right way. Approaching research on sensitive topics without an understanding of how participants may respond is both unethical and ineffective. Creating a safe space where participants can openly share information requires empathy towards their experiences and an understanding of what may trigger negative responses.

3. Language/cultural sensitivity

[11] https://www.ucl.ac.uk/culture/projects/co-production-collective

Experts by experience also bring an understanding of how their peers or community use language and other cultural sensitivities, such as distrust of the medical establishment. This inside knowledge about how research participants communicate and interact is invaluable when designing research and encouraging participant engagement.

4. Impact

   The involvement of engaged experts by experience in the research process from the very beginning can help to promote engagement with the research findings, and in turn lead to greater impact. When stakeholders are actively involved in the research, they have a greater understanding of what is happening and why, and this results in a deep desire to use the findings to create a positive change for themselves and those they are representing. This also serves to reduce imbalances of power, and to put the power of knowledge and influence back into the hands of those who are most affected.

5. Influence

   As well as reducing the imbalance of power by putting those who are most affected at the centre of the research, the co-production approach can also lead to research findings having a significantly greater influence. Historically those who have direct experience of something have been ignored. As researchers, when we talk about the experiences of 'others' it has much less power influencing those who control the levers of change. However, when one of the 'researchers' who led the research also has direct experience they are much more difficult to ignore as they speak about their own experiences. This welcome shift in participatory and co-designed research has been paramount in raising the profile and influence of research findings.

Approach

This research project was designed using a co-creative, collaborative, and explorative approach. This was to ensure that those with lived experience of health inequality were at the centre of the project. A participatory, mixed-methods (inclusive of both qualitative and quantitative research), approach was embedded. This section highlights the methodology that was used in two phases of the project. Phase one (co-creation) was a collaborative process with the co-creation group and focused on the research design of the project. This design phase included conceptualising and formulating the quantitative and qualitative research, which was then carried out as fieldwork in phase two (delivery and engagement).

Clearview Research (CVR) and Opinium were the joint research partners that lead on the qualitative and quantitative research elements, respectively. Impact on Urban Health (IoUH) sponsored this project, the co-creation group (comprising of Lambeth and Southwark residents) were involved in the design. Representatives from Lambeth and Southwark Councils were involved in phase one of the project, providing local knowledge and expertise.

Rapid literature review

CVR conducted a rapid literature review to gain a better understanding of the existing health inequalities in Southwark and Lambeth and to help us to understand previous research that exists around health, and wider social determinants of health. The rapid literature review informed the research and notified the team of the key topics that should be explored.

Co-creation group

CVR recruited and trained seven residents of Lambeth and Southwark to work closely with the CVR team to co-design this research project. The experience and knowledge of the members of the co-creation group helped the CVR team to carry out research with input from those with lived experiences of health inequality.

From the recruitment, a representative sample of people from different social groups, based on demographic criteria such as age, ethnicity, disability and gender, was achieved. This helped to ensure that CVR explored the views and experiences of people with a range of different backgrounds. Below is demographic data of the co-creation group:

Number of participants	7		
Gender	3 Male	3 Female	1 Non-Binary
Ethnicity	1 White (English/British/Scottish/Northern Irish/Welsh)		
	1 Asian - Pakistani	2 Black African	2 Black Caribbean
	1 Mixed Black Caribbean and African		
Age	3, 25-34 years	1, 45-54 years	
	2, 35-44 years	1, 55-64 years	
Sexuality	1 Asexual	1 Pansexual	5 Heterosexual/ Straight
Religion	4 Christian	2 Buddhist	2 Other
Disability	4 Yes	3 No	

The co-creation group worked closely with the CVR team over the year (2023). In the first four months the co-creation group took part in peer researcher training and workshops in research design, so that they were equipped to co-design the quantitative survey which was delivered by Opinium. In this first phase the group also fed into the design of qualitative research which was carried out in phase two. For the following seven months, the co-creation group helped co-design discussion guides for the exploration labs, prioritising areas to explore, and they also took part in a 'Making it Clear' session at the end of the project to learn about both the qualitative and quantitative findings, and to express their thoughts and views on these.

Peer researcher training

CVR trained the co-creation group in CVR's 'Community Research' course level 1. This training took place over three weeks and was designed to provide the co-creation group with knowledge and understanding about the basic principles of research. This was to enable them to feel better equipped to feed into the research design of this project. Opinium and IoUH observed the training sessions, with Opinium contributing their own experience and knowledge to the quantitative research module.

The co-creation group were trained in the following modules:

- The Power of Research
- Ethics and Data Security
- Introduction to Quantitative Research
- Introduction to Qualitative Research
- Introduction to Research Design
- Turning findings into Impact

Research design workshops

After training the co-creation group in the basic principles of research, CVR delivered four research design workshops to create and plan the design of the qualitative research for phase two. Alongside attendance from the co-creation group, Opinium and Impact on Urban Health, these workshops included discussions with wider stakeholder representatives of Lambeth and Southwark Councils, to incorporate their knowledge and expertise of both boroughs into the research design. Each workshop helped us to shape phase two:

- The first workshop was used to review the aims and objectives of the research and to refine the research questions to ensure that it aligned with the overall aims of the project.
- The second workshop focussed on engagement and sampling. We explored target audiences that were important to engage with. This fed into phase two when selecting participants for the exploration labs.
- After reviewing and refining the research questions and creating a detailed engagement plan, the following session focused on exploring different and most appropriate research methods.
- The final session was used to refine and finalise the Project Implementation Plan for phase two.

Input into survey design

Throughout the research design workshops, the co-creation group fed into the creation of the survey themes and structure of the questions asked. They also reviewed the sample survey and helped to finalise this which was then ready to launch by phase two.

Recruitment

In this project, CVR carried out three recruitment activities; one for the initial co-creation group, and two subsequent activities for both sets of exploration labs.

Co-creation group recruitment

To recruit the seven co-creation participants, residents of Lambeth and Southwark who were particularly vulnerable to a variety of health issues or identify as coming from an underserved group were targeted. CVR contacted members of the CVR community which includes residents from both boroughs. Communication material was also targeted to older people, people with long term conditions, people from Black, Asian and minority ethnic backgrounds, those who are unemployed or on lower incomes. Participants did not require a background in research to be able to participate.

Exploration lab recruitment

'Discrimination and lack of trust' exploration labs:

To recruit participants for the first three labs, CVR undertook a stakeholder mapping exercise, to search for organisations in Lambeth and Southwark that engaged closely with the digitally excluded, religious groups, and with those that were socially excluded in any way. CVR then created a database with contact information of relevant stakeholders. After creating a digital and hard copy flyer, CVR then promoted this project amongst those stakeholders, and utilised its social media channels to gain further exposure.

'Poor quality housing and its impact on health' exploration labs:

To recruit people for the second set of exploration labs CVR used a similar method to the first three labs. As these labs were based on housing, CVR undertook a stakeholder mapping exercise of organisations that worked with social and private renters in Lambeth and Southwark, and also made contact with individuals on the CVR community database who identified as socially excluded and as renting. CVR promoted the flyer within its social media channels to ensure wider dissemination.

Project limitations - qualitative research

For the theme of discrimination and lack of trust, one of the target audiences were people who classify as digitally excluded. Although recruitment and marketing approaches aimed to reach all target audiences, there were fewer people than expected who identified as digitally excluded, taking part in the labs.

Project limitations - quantitative research

For the quantitative survey, a key limitation was that this was, for most online participants, a self-completed survey. Telephone interviewers were given an overall briefing to answer questions that arose but there was no opportunity for online participants to ask questions if there was something that they did not understand or if they felt that the questions were ambiguous.

To mitigate these particular challenges, as well as the questionnaire co-creation process described above, the survey was also tested with a handful of participants through CVR's "Thinking Out Loud" exercise which involves participants going through the survey questions, navigating these and providing their feedback on the structure and wording of each.

A second limitation was that, while efforts were made to make the survey available in languages other than English, including outreach to organisations active in these communities, in the end only a small number of people took part in languages other than English. Therefore, the survey is not as representative of those who do not speak English as a first language as it is of the boroughs' population more generally. The 'English not being the first language' representation that was achieved was primarily in Spanish due to successful distribution with one organisation, so the shortfall may particularly affect analysis of the Arabic or Somali speaking populations.

Key learnings from the co-creation approach

As stated, there are immense benefits in co-produced research such as the quality and effectiveness of the research project is much improved. However, with each project, there is always learning to be gained as there is no 'one-size fits all' approach to co-creation. Some of the insights we learned about co-creation from this project are set out below:

1. Method and amount of communication

Early in the project we received feedback from the co-creation group about their preferred methods of communication. Instead of receiving multiple emails about the training sessions or workshops, they preferred to receive just one email either on the day or one day before the session so that they could focus on the most relevant information. Receiving multiple emails was counter-productive in this project as it led to some members being confused, and perhaps not paying attention to the most relevant information. We adapted our communication methods after receiving this feedback and the communication process worked smoothly thereafter. Additionally, we had the mobile numbers of members, and they were happy to receive text reminders one day before, on the day of each session.

2. Allow more time for recruitment of exploration lab participants.

We were very fortunate to have a committed and active co-creation group, and recruiting members was largely unproblematic. However, we had perhaps underestimated the amount of time it would take to recruit members for the exploration labs. Although ultimately, we recruited successfully for all the labs, a learning to take away from this project is that preparing flyers, researching and producing stakeholder maps of relevant local organisations to be contacted, disseminating and promoting information both in hard copy and online, undertaking identity validation internally etc, does require more time and resource than had been allocated for this project. With the second set of exploration labs there was a delay in getting started, so there was more urgency to recruit as quickly as possible for the project to be completed within the original deadlines.

3. Maintain equal power balances between the co-creation group and external stakeholders

As the topic of health inequalities is a source of interest to many external organisations, when co-creating it was very important to try to maintain a power balance between the co-creation group who were experts by experience, and everybody else who were experts by profession. The co-creation group consisted of seven members, and in some sessions where we discussed the research design of the project, external members from both Lambeth and Southwark Councils were invited to also feed into the design. These stakeholders, coupled with our CVR team and the IoUH and Opinium teams, meant that sometimes there were more experts by profession than experts by experience in the room. To avoid the power imbalance, we created a 'stakeholder roles and responsibilities' information sheet which clearly stated that the co-creation group were the main active participants of the sessions.

Methodology | Phase two - engagement

Benefits of mixed methodology

Combining both qualitative and quantitative research methods can result in richer detail, providing an overall top-level picture of findings and trends (through reach), whilst also providing more granular information, in this case, related to lived experience of health. The quantitative method used in this project was the survey, whilst the qualitative method was the exploration labs – both informed by a co-creation process. The quantitative findings answer more of the 'what' and 'how much' whilst the qualitative findings answer more of the 'how' and 'why' questions.

Combining qualitative and quantitative methods can mitigate some of the limitations of each approach. The quantitative elements of the research provide the detailed information that can be lacking from a purely qualitative approach, while the qualitative aspects build a wider picture with which to compare lived experiences that would not be captured by an exclusively quantitative approach.

Triangulating qualitative and quantitative data in this way builds a stronger evidence base that can be used to make effective and relevant decisions going forward. Mixed methods research also allows the research question to be studied more thoroughly, from different perspectives.

In the second phase of the project, various methods were used to carry out both the qualitative and quantitative research, and to ensure that the project effectively explored health inequalities in more detail, through lived experiences.

Rapid Literature reviews

Two key themes were explored in phase two. These were; 'discrimination and lack of trust in healthcare,' and 'poor quality housing and its impact on health.' The project team carried out rapid literature reviews for each theme to gather background research and national data, and to provide local Lambeth and Southwark comparative data where possible. These literature reviews were presented to the co-creation group before discussion guides were co-created so that the group was informed and equipped with relevant background and contextual information.

Design of discussion guide

The co-creation group contributed to the design of the discussion guides for the exploration labs. This consisted of two discussion guide sessions, in which the co-creation group, CVR and IoUH explored the questions relating to discrimination and lack of trust in healthcare, and poor-quality housing and its effect on health, and prioritised these in order of most important for this project. These questions were then asked in the exploration labs to gain a better understanding of the experiences of those living in Lambeth and Southwark.

Exploration labs

CVR conducted six exploration labs which were a mixture of online and in-person sessions. The structure of these labs was framed using the discussion guides created by the co-creation group. Each lab lasted 60 minutes.

'Discrimination and lack of trust in healthcare' exploration labs:

In each of the labs there were between six and eight residents from Lambeth and Southwark. Two of these labs took place online and the final lab was held in-person at Impact on Urban Health's offices. There were three target audiences. These were:

- Socially excluded (e.g. refugees/ asylum seekers, Gypsy/Roma communities)
- Digitally excluded (e.g. older people who are not familiar with technology, those on low incomes who are digitally poor)
- People from religious communities

Table 1: Demographic profile of participants in three exploration labs based on discrimination and lack of trust within healthcare

Number of participants	22		
Gender	8 Male	14 Female	
Ethnicity	1 White (English/British/Scottish/Northern Irish/Welsh)		
	1 Asian - Pakistani	12 Black African	5 Black Caribbean
	2 Latin/South American	1 Mixed Black Caribbean and African	
Age	1, 18-24 years	3, 45-54 years	
	7, 25-34 years	2, 55-64 years	
	9, 35-44 years		
Excluded groups*	17 Socially excluded	11 Digitally excluded	9 Religious groups

* Participants self-selected more than one exclusion category

'Poor quality housing and its impact on health' exploration labs:

In each of the labs there were between six and eight residents of Lambeth and Southwark. Two of these labs took place online and the final lab was held in-person at Impact on Urban Health offices. There were two main target audiences, these were:

- Those who self-identified as being socially excluded

- Social and private renters

For all six exploration labs, we collated demographic information to ensure we selected people from diverse backgrounds, to ensure effective representation from underserved communities.

Table 2: Demographic profile of participants in three exploration labs based on housing and health

Number of participants	21		
Gender	9 Male	12 Female	
Ethnicity	5 White (English/British/Scottish/Northern Irish/Welsh)		
	1 White European	1 any other White background	
	2 Asian - Indian	5 Black African	4 Black Caribbean
	1 Mixed White and Asian	1 Mixed White and Black African	1 Latin/South American
Age	1, 18-24 years	2, 45-54 years	
	6, 25-34 years	1, 55-64 years	
	7, 35-44 years	4, 65+ years	
Disability	7, Yes	14, no	
Rental classification	14 Social renters	7 Private renters	

Survey methodology and approach

Opinium was commissioned to conduct a quantitative survey of adults in Lambeth and Southwark, with the key elements of the brief being:

- Obtain a representative sample of adults aged 16+ in each borough
- Ensure representation from each ward in the two boroughs
- Ensure that the survey was accessible to the widest possible range of participants

In order to achieve a minimum viable sample at ward level, n=50 per ward was chosen as the target, with 25 Lambeth wards plus 23 Southwark wards producing a target sample size of 2,400.

The number of topics the survey needed to cover precluded street-intercept face-to-face surveys while the sensitivity of the topics and the likely low strike rate also made door-to-door interviews unfeasible. Therefore the initial approach taken was for the survey to take place via interviews from online survey panels (which typically have a maximum feasibility of around n=300 for a London borough) to achieve around 600 interviews with the remainder coming from telephone interviews using a combination of random digit dialling based on area code and lifestyle sample (using

telephone numbers from databases where people have opted in and provided some basic demographic data, such as location, for targeting).

With the development of the co-creation stage however, it quickly became apparent that broadening participation was essential. Those who take part in telephone interviews typically skew older and more affluent than the general population. Therefore, the decision was taken to reduce by the telephone element by half, to n=2,000 and instead put time and resources into community outreach to achieve the remaining interviews this way.

Details of this approach are below but, owing to the inability to guarantee responses via this method, a cut-off point was identified in late August to decide whether to continue with community outreach or revert back to having the telephone interviewers continue with the original plan of n=4,000. In the end, this was not necessary as the mailing lists from the two councils, and better than expected performance by online panels, provided a sufficient overall sample size even without other outreach efforts. Further telephone interviews thus became unnecessary.

Community outreach

This took the form of distributing the survey through community groups and the local networks of Impact of Urban Health, the two councils, and various other affiliated bodies.

Method	Description	Interviews achieved
Council mailing lists	Online self-completion via invitations sent out by Lambeth and Southwark councils	844 – Lambeth 517 – Southwark
IUH landing page	The link to the survey on the Impact on Urban Health landing page, also sent out to various contacts	182
OCA Community Kitchen	Distributed among this primarily Spanish-speaking network via email and WhatsApp (incentivised)	72
Integrate	Includes links sent out via Integrate email lists and in-person interviews conducted by Opinium at a Repair Café event	29
F2F recruitment	Flyers with a QR code to take part handed out via street-intercept by face to face interviewers (incentivised)	23

Respondent referrals	A link that becomes available upon completing the survey to share via Whatsapp or social media	15
Opinium staff referrals	Colleagues living in either borough or who sent to friends/family who do	11
Flyers QR code	QR code scans of flyers left in public places	8
Norwood and Brixton foodbank	QR code scans of flyers distributed to foodbank users (incentivised)	6
Community Southwark news page	Link to the survey posted by Community Southwark on Facebook	4
Bell Gardens TRA	Links distributed by the Bell Gardens Tenants and Residents Association in Peckham	3
Lambeth Larder	Links distributed by Lambeth Larder to their mailing list	3
EOS Dance	Link distributed to EOS Dance studio participants	1
Let's Talk Health and Care	Link distributed in this South East London online community	1

Overall sample source breakdown

Online panel	1,503
Telephone	2,001
Community outreach	1,726
TOTAL	5,230

Languages

To remove as many barriers to participation as possible, the survey was made available in five additional languages along with English (Spanish, Portuguese, Polish, Arabic, Somali) reflecting both the languages most widely spoken in the boroughs from the 2021 Census as well as schools data. Leaflets were also created in these languages, but it must be noted that only 71 people took part in a non-English language, with the majority of these coming via the OCA online distribution.

Flyers

Links to the survey via a QR code were made available and printed on leaflets designed by Impact on Urban Health.

These were then distributed in shops, libraries, at events and by face-to-face interviewers to recruit participants by scanning the code and taking part on their phone or other devices:

Each QR code corresponded to variables captured in the survey such as language choice and "channel" which, combined with a record of which batches of leaflets had been sent to which location, allowed for tracking of which batch was successfully obtaining responses. Ultimately though, the number of interviews obtained via this method was minimal compared to the more online-focused methods.

Incentivisation

As per standard industry practice, those taking part via survey panels were given the typical incentive (e.g. points towards vouchers) for the panel they were accessed via. Those taking part via telephone were not incentivised.

The vast majority of those taking part via community outreach were not incentivised. For the final three weeks of fieldwork, an incentivised version of the online community outreach survey script was created, collecting contact information so that a £10 voucher could be sent. Approx. 140 people took part via this link and were paid this way.

Organisations that assisted us with distributing the survey were also paid directly, typically amounts of £100-£350.

For the qualitative research participation, the co-creation members were rewarded with £50 for each session that they took part in, whilst residents who participated in the exploration labs received the same.

Identifying wards

As most people cannot be reasonably expected to know which ward they live in, this was assigned by asking for participants' postcodes. The system conducted a look-up to assign a postcode and IMD score for that participant before deleting the postcode data itself as a further guarantee of anonymity. Approximately 90% of participants were willing to provide postcode data while a

separate question identifying which borough the participant lives in was asked to everyone. In the event that the postcode / ward and stated borough information conflicts, the participant has been excluded from weighting but still included in any neighbourhood or ward-level analysis.

Opt-outs combined with a number of invalid postcode entries means that of our 5,230 respondents, we have ward data for 4,232 (81%). The median number of responses per ward was 86 and the only ward with fewer than 50 participants in the final dataset is St George's in Southwark.

Weighting targets

Targets for weighting were determined by the census and adjusted to account for any participants whose information was conflicting or absent. In these instances (e.g. those not answering the ethnicity question for the ethnicity rim, or those whose borough information was overlapping) the proportion with that status was left unweighted and targets for all other respondents were adjusted proportionately. Overall weighting efficiency was 82%.

This table shows the weighting targets used and, for comparison, the unweighted percentage of the 4,000 sample for each factor. Further on there is a table showing the full demographic breakdown of the sample but, because not all categories useful for analysis were used for weighting, we have shown weighting and the breakdown in two separate tables.

Rim	Category	Target as % of total sample	Unweighted % of total sample
Borough and working status	Lambeth Working Full time	27.65%	28.68%
	Lambeth Working Part time	5.82%	6.63%
	Lambeth Unemployed	2.43%	2.80%
	Lambeth Retired	3.88%	3.28%
	Lambeth Other incl. student	8.73%	7.40%
	Southwark Working Full time	25.71%	25.73%
	Southwark Working Part time	6.79%	7.55%
	Southwark Unemployed	2.43%	2.53%
	Southwark Retired	4.37%	4.68%
	Southwark Other incl. student	9.22%	6.63%
	Borough overlaps or no borough info	3.00%	4.13%
Borough and age / gender group	Lambeth 16-34 Female	9.77%	9.70%
	Lambeth 16-34 Male	9.77%	6.05%
	Lambeth 35-54 Female	7.44%	11.13%
	Lambeth 35-54 Male	8.84%	9.15%

	Lambeth 55+ Female	5.58%	5.95%
	Lambeth 55+ Male	5.12%	5.18%
	Lambeth not male or female	2.00%	1.63%
	Southwark 16-34 Female	9.30%	10.05%
	Southwark 16-34 Male	9.30%	5.33%
	Southwark 35-54 Female	7.91%	10.98%
	Southwark 35-54 Male	8.84%	7.58%
	Southwark 55+ Female	5.58%	5.60%
	Southwark 55+ Male	5.58%	5.75%
	Southwark not male or female	2.00%	1.83%
	Borough overlaps or no borough info	3.00%	4.13%
Borough and ethnicity (total)	Lambeth Asian	3.49%	3.38%
	Lambeth Black	10.28%	13.33%
	Lambeth White	27.07%	26.42%
	Lambeth Mixed / multiple	3.03%	2.88%
	Lambeth Other	2.63%	2.28%
	Lambeth PNTS / none / not answered	2.00%	0.50%
	Southwark Asian	4.73%	3.45%
	Southwark Black	10.73%	12.90%
	Southwark White	25.46%	23.70%
	Southwark Mixed / multiple	2.64%	2.48%
	Southwark Other	2.94%	2.48%
	Southwark PNTS / none / not answered	2.00%	2.10%
	Borough overlaps or no borough info	3.00%	4.13%
Borough, age and ethnicity	Lambeth, Asian, aged 16:24	1.58%	1.27%
	Lambeth, Black, aged 16:24	3.75%	4.10%
	Lambeth, Mixed / multiple ethnicities, aged 16:24	1.70%	1.13%
	Lambeth, White, aged 16:24	13.17%	7.85%
	Lambeth, Other, aged 16:24	1.04%	0.98%
	Lambeth, Asian, aged 35-49	0.93%	1.10%
	Lambeth, Black, aged 35-49	2.60%	3.15%
	Lambeth, Mixed / multiple ethnicities, aged 35-49	0.80%	0.98%

	Lambeth, White, aged 35-49	7.02%	9.03%
	Lambeth, Other, aged 35-49	0.86%	0.90%
	Lambeth, Asian, aged 50+	1.14%	1.00%
	Lambeth, Black, aged 50+	5.83%	6.08%
	Lambeth, Mixed / multiple ethnicities, aged 50+	0.92%	0.78%
	Lambeth, White, aged 50+	9.21%	9.55%
	Lambeth, Other, aged 50+	1.15%	0.40%
	Southwark, Asian, aged 16:24	2.41%	1.53%
	Southwark, Black, aged 16:24	3.82%	4.47%
	Southwark, Mixed / multiple ethnicities, aged 16:24	1.46%	1.10%
	Southwark, White, aged 16:24	10.92%	7.38%
	Southwark, Other, aged 16:24	1.10%	0.85%
	Southwark, Asian, aged 35-49	1.27%	1.27%
	Southwark, Black, aged 35-49	2.69%	3.65%
	Southwark, Mixed / multiple ethnicities, aged 35-49	0.68%	0.88%
	Southwark, White, aged 35-49	6.46%	7.78%
	Southwark, Other, aged 35-49	0.95%	1.08%
	Southwark, Asian, aged 50+	0.91%	0.65%
	Southwark, Black, aged 50+	3.91%	4.78%
	Southwark, Mixed / multiple ethnicities, aged 50+	0.43%	0.50%
	Southwark, White, aged 50+	7.33%	8.55%
	Southwark, Other, aged 50+	0.81%	0.55%
	Ethnicity not answered, borough overlaps or no borough info	3.15%	6.73%
Borough and housing tenure	Lambeth, Own outright	4.67%	3.68%
	Lambeth, Own with a mortgage / loan or shared ownership	10.06%	12.98%
	Lambeth, Rented from a local authority	8.50%	9.35%
	Lambeth, Rented from a housing association	6.72%	7.15%
	Lambeth, Rented from a private landlord	12.97%	10.98%
	Lambeth, Live rent-free, no fixed accommodation, or 'other'	6.00%	4.65%
	Southwark, Own outright	3.87%	3.52%

	Southwark, Own with a mortgage / loan or shared ownership	8.79%	9.98%
	Southwark, Rented from a local authority	12.23%	14.03%
	Southwark, Rented from a housing association	5.37%	5.85%
	Southwark, Rented from a private landlord	11.15%	9.30%
	Southwark, Live rent-free, no fixed accommodation, or 'other'	6.50%	4.43%
	Borough overlaps or no borough info	3.15%	4.13%

Demographic breakdown of the weighted quantitative sample

The table below shows the demographic breakdown of the quantitative survey. The unweighted base are the raw numbers we achieved for each demographic. The weighted base is what that number is for the demographic group once weighting has been applied to make the survey representative. When weighting, the total number of respondents remains consistent, but the composition of the sample is adjusted. For example, as fewer 16–24-year-olds were surveyed than our target, responses from people in this age group were weighted up. Conversely, we achieved more interviews than necessary among those aged 45-54 or 55-64 so these participants' responses were weighted down. Therefore, the figures for each subgroup change with weighting but the total remains the same.

Group	Type	Unweighted base	Weighted base
	Total	4000	4000
Gender	Women	2221	2008
	Men	1634	1845
Age group	16-24	371	477
	25-34	934	1186
	35-44	877	688
	45-54	807	705
	55-64	625	562
	65-74	265	259
	75-79	73	69
	80+	46	52
Working status	Full time	2273	2051
	Part time	593	565
	Retired	340	348
	Unemployed	220	184
	Other incl. student	574	853
	Asian	290	340
	Black	1077	907

Ethnicity – broad categories*	White	2102	2202
	Mixed	223	241
	Other	196	237
	PNTS or no consent	35	23
Disabled (self-identified)	Yes	565	625
Tenure	Own	1213	1140
	Part-owns and part-rents (shared ownership)	87	82
	Rent (all)	2322	2400
	Rented from private landlord	840	1022
	Rented from local authority	951	870
	Rented from housing association	531	509
	Living rent free	239	242
	No fixed accommodation	32	35
	Other	107	101
Dwelling type	A house	1303	1311
	A flat in a purpose built block of flats	1918	1887
	A flat in a converted house or other building	617	642
	Other	133	135
Main language spoken	English	3399	3376
	Other language	602	625
Job type	Regular employee	2181	1999

	Zero hours contract / contracting / freelance / self-employed / other	770	702
Children	Have children under 18 living with them	1614	1555
Sexual identity	LGBT+	523	578
	Heterosexual	3223	3180
Education	Graduate	2252	2227
	Non-graduate	1566	1588
Borough	Lambeth	1951	1953
	Southwark	1884	1882

*While the survey used the Census 2021 ethnicity question, to account for the sizeable Latin American community in the two boroughs, “Latin American” was added to the end of the question followed by an optional open text question asking if the question had given them appropriate options as a safeguard. In general, responses to this question listed specific nationalities or combinations of ethnicities rather than calling the options provided into question. Those selecting Latin American were recoded into the broader “other” group and weighting targets were adjusted to compensate for this based on natural fallout.

Regression analysis methodology

Regression analysis was used to understand further the role of social and economic characteristics on health and wellbeing among residents.

A regression analysis here is useful to disentangle the effects of various factors. For example, the crosstab analysis showed us that in our sample, 30% of participants with a graduate level education reported being in very good health compared to only 17% of those without a degree. However, the differences between these two groups could be for other reasons, such as younger people generally having higher education and being in better health. By running a model where we include both age and education, we can measure the effect of having a degree holding age constant.

The main outputs of the models that are reported are the odds ratio and if the variable is significant or not. The odds ratio quantifies the relationship between the response and explanatory variable. Using the example above, if two people are the same age, how much more or less likely is someone to report being in very good health if they have a degree level education when compared to someone

without. The significance of a variable is an indication of how reliable this association is, in other words, what is the probability that the association could be due to random chance. We report a variable as significant if the probability of this is lower than 0.05.

To understand the socio and economic drivers of health outcomes we modelled two of the survey questions, self-reported health and having a long-term health condition, impairment, or disability.

The same explanatory variables were included in both models, these were: age, financial security, education level, housing tenure, poor housing conditions, gender, sexual identity, and ethnicity.

Approach

Taking as our starting point the topics of race equity, socio-economic status, gender and sexual identity, and existing long-term condition, we identified which survey questions to assign to each topic and used these as our input variables.

The table below shows the questions that were used as explanatory variables:

Topic	Questions to use
Race equity	D6 – Ethnicity
Socio-economic status & material deprivation	L5 – Financial situation
Long-term condition	H2 – Long-term condition – included in experience of services
Housing	D12 – Housing tenure L1 – Worry about housing conditions (damp or mould, poor state of repair, and heating / electrics / plumbing not being in good working order) – included for health outcomes
Gender	D1 – Gender identity
Sexual identity	D8 – Sexual identity
Age	D2 – Age

The output variables that we tested the impact of these factors on were:

- H1 - self reported health
- H2 - conditions / multiple conditions
- C3 – confidence in health services
- C5 – Trust in healthcare professionals
- C6 – Experience of unfair treatment / discrimination

Explanatory variables

Ethnicity: Ethnicity was recoded into the following categories:

- White British
- White Other (including Irish, excluding Irish Traveller, Gypsy, and Roma)
- Asian
- Black African
- Black Caribbean

- Other Black/African/Caribbean background
- Mixed / Multiple ethnic backgrounds
- Other ethnic minority background (including: Irish Traveller, Gypsy, Roma, Arab, Latin American, 'any other ethnic group', 'don't think of myself as any of these')
- Prefer not to say / Don't know

Respondents of a Black African and Black Caribbean background were split from the other broad ethnic groups as they make up a large proportion of the population in Southwark and Lambeth. Other groups (excluding White British) were recoded as broad categories given the number of observations and to limit complexity in the regression models. Respondents who opted out of the ethnicity question, answered 'prefer not to say' or 'don't know' were recoded as one category as to not drop those respondents from the regression models.

Gender Identity: Recoded into three categories, 'Woman', 'Man' and 'Other or prefer not to say'. Given the low number of respondents identifying with a gender other than 'woman' and 'man' these were grouped alongside those answering 'prefer not to say' or not consenting.

Age: Age was treated as an ordinal variable (as categories but with an order), the age-bands used were '16-24', '25-34', '35-44', '45-54', '55-64', and '65+.

Education: Recoded as a binary variable, those whose highest level of education is NVQ 4+ or degree level, versus those who don't or answering 'don't know'.

Financial security: Treated as an ordinal variable with three levels, 'Comfortable', 'Getting by', 'Struggling'. The respondents answering 'don't know' (26), and 'prefer not to say' (85) were dropped.

Housing Tenure: Tenure was collapsed into four categories: Owning outright or with a mortgages, private renting, social renting (from council or housing association), and other (no fixed accommodation, rent free, or other)

Poor housing conditions: Respondents were classified as having poor housing conditions if they answered 'often worry' or 'worry all the time' to all three of the following: 'damp or mould in my home', 'my home not being in a good state of repair', and ' heating/electrics/plumbing not being in good working order'; or answered 'worry all of the time' for two of those items. Respondents that were not coded as being in poor housing conditions, or answered prefer not to say to any of the three items were coded into the 'prefer not to say' category.

Sexual identity: Recoded into three categories, 'heterosexual / straight', LGB+ (including Lesbian, Bi-sexual, Gay, Pansexual, Queer, Asexual, or other), and a 'don't know' / 'prefer not to say category.

Long-term health condition, impairment or disability: Respondents were coded either as having at least one long term condition, none, or as having answered 'prefer not to say'.

Output variables

Self-reported health

For self-reported health the survey question used was 'How is your health in general?', where the response options 'Very good', 'Good', 'Fair', 'Bad', 'Very bad', and 'Prefer not to say' were recoded into a dichotomous variable 'In good health', and 'Not in good health', with respondents answering 'Prefer not to say' dropped from the model (a total of 43 responses).

Long-term conditions

For having a long-term condition, the question text 'Do you have any of the following long-term health conditions, impairments, or disabilities? By long-term we mean lasting 12 months or more.'. Respondents were recoded as having no conditions, or at least one condition; respondents answering 'prefer not to say' were dropped (67).

Confidence in health services

The answer options to the question 'And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?' were 'very confident, 'confident, 'not confident, 'not confident at all, 'don't know', and 'prefer not to say'. The scale was kept and treated as the response variable in an ordinal logistic regression and other responses dropped.

Trust in healthcare professionals

The question was phrased as 'Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem. To what extent would you trust that they would...' and the answer options were "I would trust them completely', 'I would mostly trust them', 'I would not really trust them', "I would not trust them at all", 'Don't know', and 'Not applicable'. All levels were kept to run an ordinal logistic model but those responding 'Don't know' or 'Not applicable' were dropped from the model.

Experience of unfair treatment

Residents were asked how often they experienced unfair treatment when receiving medical care because of personal characteristics; the question text reading: 'Within the past 2 years, how often have you been treated unfairly when getting medical care because of your ethnicity, religion, gender or other characteristics?'. This was answered on a scale of 'never' 'rarely', 'sometimes', 'often', with the option to also answer 'don't know' or 'prefer not to say'. The full scale of the responses was used as the response variable, dropping respondents that answered outside it (469). The same explanatory variables were used as those for the trust items: age, financial security, tenure, education level, gender, sexual identity, ethnicity, and having a long-term condition.

A note on reporting terms and variables

The gender identity question (D1) – 'What gender do you identify as?' – had options for Woman, Man, Non-binary, and In another way (please specify), and Prefer not to say. Therefore the terms "Woman" and "Man" have been used when splitting results by gender. In the full 5,230 person sample, a total of 20 and 32 people selected Non-binary or In another way respectively. Filtering to the 4,000 person reporting sample, these figures drop to 14 and 26 which are, together, too low to reliably report on.

Our question on sexual identity (D8) – 'How would you describe your sexual identity?' - had options for Bi-sexual, Gay, Heterosexual/straight, Lesbian, Pansexual, Queer, Asexual, Other, Don't know and Prefer not to say. Whilst we have used the commonly used term 'LGBTQ+' within the report to refer to participants who identify as one of the options other than heterosexual/straight, as explained above gender identity was asked via a separate question.

As standard, participants were typically given a “prefer not to say” and/or a “don’t know” option. Typically these figures are low and not reported on, however they will occasionally be referred to by “PNTS” and “DK” respectively.

Full quantitative questionnaire

Demographics and screeners

Survey intro – CATI only

CATI_INTRO ASK ALL CATI
SINGLE
Good morning / afternoon / evening,

My name is XXXX calling from Opinium on behalf of Guy's and St Thomas' Foundation.

We would like to invite you to take part in research on health and well-being in Lambeth and Southwark.

Would you have some time to help with that now?

[OPTIONAL IF NEEDED]

Where you are born, grow up, live and work can have a big impact on health. We want to learn more about you, your health, your home, and your environment, to better understand your needs, and the needs of your community. This is so that more can be done to improve health for everyone living in Lambeth and Southwark.

If you find any of the questions upsetting then I can give you the numbers of some charities that might be able to help, please ask at any time.

[MANDATORY:]

Findings will be shared with the Foundation to understand health inequalities in Lambeth and Southwark and inform recommendations.

You can contact us or the Foundation to withdraw your consent, or to access, rectify or erase any personal data held about you. Would you like further details on this or are you happy to proceed?

IF FURTHER INFORMATION NEEDED TICK #2, IF NOT:
Could you confirm that you consent to take part and are happy to proceed?

1. I confirm that I consent to take part in the survey and wish to proceed
2. Would like further information for privacy policies or offline access

CATI_FURTHER_INFO ASK ALL NEED MORE INFO
MULTI

INTERVIEWER:

If participant wants the URL read out (i.e. they aren't comfortable searching themselves):

Opinium privacy policy:
https://www.opinium.com/privacy-policy/

Guys and St Thomas Foundation privacy policy:
https://gsttfoundation.org.uk/privacy-and-cookies/

If need offline access, take postal address so that we can send them the documents

Otherwise tick "happy to proceed" and 'next'

1. Postal address [OPEN]
2. Happy to proceed

CATI and online panel screeners

D2_PANEL_CATI ASK ALL
SINGLE
Which of the following age bands are you in?

1. Under 16 [SCREENOUT]
2. 16-19
3. 20-24
4. 25-29
5. 30-34
6. 35-39
7. 40-44
8. 45-49
9. 50-54
10. 55-59
11. 60-64
12. 65-69
13. 70-74
14. 75-79
15. 80 or over

D4A_PANEL_CATI ASK ALL
SINGLE
Please tell us what region you live in?

1. North East [SCREEN OUT IF CATI / ONLINE PANEL]
2. North West [SCREEN OUT IF CATI / ONLINE PANEL]
3. Yorkshire & Humberside [SCREEN OUT IF CATI / ONLINE PANEL]
4. East Midlands [SCREEN OUT IF CATI / ONLINE PANEL]
5. West Midlands [SCREEN OUT IF CATI / ONLINE PANEL]
6. East of England [SCREEN OUT IF CATI / ONLINE PANEL]
7. London

8. South East [SCREEN OUT IF CATI / ONLINE PANEL]
9. South West [SCREEN OUT IF CATI / ONLINE PANEL]
10. Wales [SCREEN OUT IF CATI / ONLINE PANEL]
11. Scotland [SCREEN OUT IF CATI / ONLINE PANEL]
12. Northern Ireland [SCREEN OUT IF CATI / ONLINE PANEL]
13. Do not live in the UK [SCREEN OUT IF CATI / ONLINE PANEL]

D4B_PANEL
SINGLE
And which London borough do you live in?

1. Barking and Dagenham
2. Barnet
3. Bexley
4. Brent
5. Bromley
6. Camden
7. Croydon
8. Ealing
9. Enfield
10. Greenwich
11. Hackney
12. Hammersmith and Fullham
13. Haringey
14. Harrow
15. Havering
16. Hillingdon
17. Hounslow
18. Islington
19. Kensington and Chelsea
20. Kingston upon Thames
21. Lambeth
22. Lewisham
23. Merton
24. Newham
25. Redbridge
26. Richmond upon Thames
27. Southwark
28. Sutton
29. Tower Hamlets
30. Waltham Forest
31. Wandsworth
32. Westminster

[SCREEN OUT IF NOT LAMBETH OR SOUTHWARK]

D4B_CATI
SINGLE
And which London borough do you live in?

1. Lambeth
2. Southwark
3. Somewhere else in London
4. Somewhere outside of London

[SCREEN OUT IF NOT LAMBETH OR SOUTHWARK]

Survey intro – online and community outreach

INFO BOX

We would like to invite you to take part in research for the largest ever survey in Lambeth and Southwark on health and well-being.

The survey should take around 15 minutes to complete

Where you are born, grow up, live and work can have a big impact on health. We want to learn more about you, your health, your home, and your environment, to better understand your needs, and the needs of your community. This is so that more can be done to improve health for everyone living in Lambeth and Southwark.

The survey is being run by Opinium, with questions developed by members of the local community and facilitated by Clearview. This work is for Impact on Urban Health, which is part of Guy's and St Thomas' Foundation. The results of this survey will be used to research experience of health inequalities in Lambeth and Southwark, and to inform recommendations for example on policy and service design.

The survey is completely anonymous and non-attributable. This means that your name is not included, and no person will be able to be identified individually in the analysis or in any research report. Answers will be reported at an aggregated level (i.e. responses will not be reported at an individual level). No personally identifiable information will be shared with anyone outside the research team.

We have provided the option of 'prefer not to say' where we feel questions may be particularly sensitive.

You can contact the following, if you find any of the questions upsetting and would like to talk to someone:

- Samaritans at anytime on 116 123. This number is free to call. You can also email them: jo@samaritans.org

Your data will be processed according to the UK General Data Protection Regulation (GDPR). Opinium and Guy's and St Thomas' Foundation will be joint controllers of your data. For more information on how your information will be processed and protected, including information on how to contact the data controllers or to exercise your right to withdraw consent, please review Opinium's privacy policy (LINK) and Guy's and St Thomas' Foundation's privacy policy (LINK).

Thank you for taking the time to respond to shape the future health of our local areas.

SCREENER_1 ASK ALL
SINGLE
Before proceeding, please could you confirm that you consent to take part in this survey based on the information you have read on the previous page.

1. I confirm that I consent to take part in the survey and wish to proceed
2. I would not like to take part in this survey [SCREEN OUT]

SCD_OPT_IN
SINGLE GRID

ONLINE: In this survey, we would like to ask some questions that may be perceived as sensitive such as ethnicity, health and sexual orientation.

Providing information in response to these questions is entirely voluntary.

You may withdraw your consent from taking the survey overall at any time by closing this window.

We will not use any of your answers if you do not complete the survey

Do you consent to the collection of information on the following topics?

CATI: Do you consent to us asking you about and collecting information on the following?

You can say "prefer not to say" for any of these questions and can withdraw your consent from the survey overall by simply saying that you'd like to stop and ending the phone call.

We will not use any of your answers if you do not complete the survey.

ROWS
1. Ethnicity
2. Health
3. Sexual orientation
4. Gender identity
5. Religion [ONLINE ONLY]

COLUMNS
1. Yes, I consent
2. No, I do not consent

D1 ASK ALL
SINGLE

What gender do you identify as?

1. Female
2. Male
3. Non-binary
4. In another way [OPEN]
5. Prefer not to say

D2 ASK ALL COMMUNITY OUTREACH
SINGLE

Which of the following age bands are you in?

1. Under 16 [SCREENOUT]
2. 16-19
3. 20-24
4. 25-29
5. 30-34
6. 35-39
7. 40-44
8. 45-49
9. 50-54
10. 55-59
11. 60-64
12. 65-69
13. 70-74
14. 75-79
15. 80 or over

D4 POSTCODE ASK ALL
OPEN

We're now going to ask you for your postcode so that we can tell what area you live in, including your council ward (a council ward is the local area immediately around you, usually everywhere within a 10 minute walk of your home).

We appreciate that this is sensitive so here is exactly what happens:

- The postcode gets entered into the box below
- It then automatically deletes your postcode so we only keep a record of which council ward you live in

[POSTCODE]

SCRIPT TO LOOKUP POSTCODE AGAINST WARD LIST AND IMD SCORE LIST AND AUTO-FILL ANSWERS TO THESE QUESTIONS. POSTCODE IS THEN OVERWRITTEN BY WARD

D4B_COMMUNITY ASK ALL COMMUNITY WITH NO FUNCTIONING POSTCODE
SINGLE

And which London borough do you live in?

1. Lambeth
2. Southwark
3. Somewhere else in London

4. Somewhere outside of London

D5A ASK ALL
SINGLE
In a typical week approximately how many hours do you work in paid employment?

For reference, a typical "full time job" is around 37.5 hours per week

[ALTERNATE ORDER OF CODES 1-7]
1. More than 60 hours
2. 50-60 hours
3. 40-50 hours
4. 30-40 hours
5. 20-30 hours
6. 10-20 hours
7. Less than 10 hours
8. Retired
9. Unemployed
10. Not working due to injury or disability
11. Not working due to studying
12. Other not working

D5C ASK ALL WORKING
MULTI
Please tell us which type(s) of work represents your situation best
1. A regular employee of a company
2. A zero-hours contract where the number of hours you work is not guaranteed
3. Contracting / temporary work where you work for one client/customer for a period of time before moving on to another
4. Freelance work for multiple clients/customers
5. Self-employed and working for your own business
6. Other

D5D ASK ALL WORKING
SINGLE
Does your job pay above or below the London Living Wage?

This is £11.95 per hour.

If you have more than one job, please answer for the one in which you work the most hours in a typical week
1. It pays above this
2. It pays the same as this
3. It pays less than this
4. Prefer not to say

PERSONAL_INCOME ASK ALL
SINGLE

What is your annual pre-tax personal income?

If you would rather not share your answer, please select the “Prefer not to say” option

CATI: BELOW TEXT IS OPTIONAL

By ‘personal income’, we mean your total income received from all sources, including wages, bonuses, pension income, benefits or rents and before tax deductions.

1. Up to £10,000 a year
2. £10,001 to £20,000 a year
3. £20,001 to £30,000 a year
4. £30,001 to £40,000 a year
5. £40,001 to £50,000 a year
6. £50,001 to £60,000 a year
7. £60,001 to £70,000 a year
8. £70,001 to £80,000 a year
9. £80,001 to £90,000 a year
10. £90,001 to £100,000 a year
11. Over £100,000 a year
12. Prefer not to say

D6 ASK ALL WHO CONSENT

SINGLE

What is your ethnic group?

Asian or Asian British

1. Indian
2. Pakistani
3. Bangladeshi
4. Chinese
5. Any other Asian background

Black, Black British, Caribbean or African

6. Caribbean
7. African
8. Any other Black, Black British or Caribbean background

White

9. English, Welsh, Scottish, Northern Irish or British
10. Irish
11. Gypsy or Irish Traveller
12. Roma
13. Any other White background

Multiple ethnic groups / dual heritage

14. White and Black Caribbean
15. White and Black African
16. White and Asian

17. Any other Mixed or Multiple background

Other ethnic group

18. Arab
19. Latin American
20. Any other ethnic group
21. Don't think of myself as any of these
22. Prefer not to say

D6A ASK ALL WHO CONSENT - OPTIONAL
OPEN – NON MANDATORY
OPTIONAL QUESTION

If you don't feel your ethnicity was correctly described by the answer you gave in the previous question, please tell us how you'd describe your ethnicity in the box below.

Otherwise, please click "next" as this question is optional
[OPEN TEXT BOX]

D10 ASK ALL
SINGLE
Do you consider yourself to be disabled?

1. Yes
2. No
3. Don't know
4. Prefer not to say

D11_ONLINE ASK ALL ONLINE
SINGLE GRID
How many children, if any, live with you in each of the following age groups?

COLUMNS:

1. None
2. 1
3. 2
4. 3 or more
5. Prefer not to say

ROWS:

1. Aged 0 to 2
2. Aged 3 to 4
3. Aged 5 to 10
4. Aged 11 to 17
5. Aged 18 or older (grown-up children)

D11_CATI ASK ALL CATI

SINGLE

Do you have any children aged under 18 living with you?

1. None
2. 1
3. 2
4. 3 or more
5. Prefer not to say

D12 ASK ALL

SINGLE CHOICE

Which, of the following best describes your main home?

1. Own outright
2. Own with a mortgage or loan
3. Part-owns and part-rents (shared ownership)
4. Rented from local authority
5. Rented from private landlord
6. Rented from housing association
7. Live rent-free (including rent-free in your parents, another relative's or a friend's property)
8. Other
9. Live in no fixed accommodation

D13 ASK ALL LIVING IN FIXED ACCOMMODATION AT D12

SINGLE CHOICE

What type of accommodation do you live in?

1. A house
2. A flat in a purpose built block of flats
3. A flat in a converted house or other building
4. Other

D15 ASK ALL

SINGLE

What is the main language you tend to speak at home?

The list is based on the most commonly spoken languages in Lambeth and Southwark

1. English
2. Spanish
3. Italian
4. Portuguese
5. French
6. Chinese (all forms)
7. Somali
8. Yoruba
9. Akan/Twi-Fante
10. Polish
11. Arabic
12. Tigrinya

13. Bengali (including Sylheti and Chatgaya)
14. Turkish
15. Greek
16. Romanian
17. Russian
18. German
19. Other (please specify)

D16 ASK ALL
SINGLE
How comfortable are you speaking English when you need to?
For example, to have a conversation on the telephone or talk to a professional such as a teacher or a doctor?

1. Very comfortable
2. Fairly comfortable
3. Not very comfortable
4. Not at all comfortable
5. Prefer not to say

Questionnaire

1 | Urban environment (E)

INFO BOX ASK ALL ONLINE
Now we have a few questions about your local area

S2 ASK ALL ONLINE
SINGLE
How strongly do you feel you belong to your local area?

1. Very strongly
2. Fairly strongly
3. Not very strongly
4. Not at all strongly

E1 ASK ALL ONLINE
SINGLE GRID
In your local area, how would you rate the following:

COLUMNS:

1. Very good
2. Good
3. Poor
4. Very poor

5. Do not use
6. Don't know

ROWS:
1. Green spaces
2. Sports facilities
3. Public transport
4. Cycle lanes

E2 ASK ALL ONLINE
SINGLE GRID
Thinking of your personal safety, how safe or unsafe would you feel…

COLUMNS:
1. Very safe
2. Fairly safe
3. Fairly unsafe
4. Very unsafe
5. Don’t know
6. Prefer not to say

ROWS:
1. walking on your own during the day in a quiet street close to your home?
2. walking on your own after dark in a quiet street close to your home?

E3 ASK ALL ONLINE
SINGLE GRID
To what extent, if at all, are you concerned about the level of air pollution in…?

COLUMNS:
1. Very concerning
2. Fairly concerning
3. Not very concerning
4. Not at all concerning
5. Don’t know

ROWS:
1. Your local area
2. The UK as a whole

2 | Health status and priorities (H)

INFO
Thanks for answering our questions so far, the next few are going to be about your health

H1 ASK ALL
SINGLE

How is your health in general?

1. Very good
2. Good
3. Fair
4. Bad
5. Very bad
6. Prefer not to say

H2 ASK ALL WHO CONSENT
MULTI CHOICE

Do you have any of the following long-term health conditions, impairments or disabilities?

By long-term we mean lasting 12 months or more.

1. Hearing / Vision (e.g. deaf, partially deaf or hard of hearing; blind or partial sight)
2. Physical / Mobility (e.g. wheelchair user, arthritis, multiple sclerosis etc.)
3. Mental health condition (lasting more than a year. e.g. major depression, schizophrenia etc.)
4. Learning disability (e.g. dyslexia, dyspraxia etc.)
5. Long-term physical illness or health condition (e.g. Cancer, HIV, Diabetes, Chronic Heart disease, Rheumatoid Arthritis, Chronic Asthma, Long Covid)
6. No – none of these
7. Prefer not to say

H3 ASK ALL
SINGLE GRID

We're now going to ask you about your feelings on aspects of your life. There are no right or wrong answers.

For each one, please give an answer on a scale from 0-10 where 0 = "not at all" and 10 = "completely"

COLUMNS:

1. 0 – not at all
2. 1
3. 2
4. 3
5. 4
6. 5
7. 6
8. 7
9. 8
10. 9
11. 10 - completely
12. Prefer not to say

ROWS:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, to what extent do you feel that the things you do in your life are worthwhile?
3. Overall, how happy did you feel yesterday?

4. Overall, how anxious did you feel yesterday?

S1 ASK ALL
SINGLE
How often do you feel lonely?

1. Often or always
2. Some of the time
3. Occasionally
4. Hardly ever
5. Never
6. Prefer not to say

3 | Access to care and services (C)

INTRO
Now some questions about your interaction with health services

C1 ASK ALL
SINGLE GRID - ROLLING
How easy was it for you to access any of the following services in the last two years?
This could be for yourself or for someone that you care for

COLUMNS:

1. Very easy
2. Easy
3. Not easy
4. Not easy at all
5. N/A – have not needed this service in the last two years
6. Prefer not to say
7. Don't know

ROWS:

1. A GP
2. A hospital (excluding A&E)
3. Accident and Emergency (A&E)
4. A pharmacy
5. A dentist
6. A health visitor
7. Sexual and reproductive health services
8. Substance misuse services
9. Mental health support services
10. A private healthcare provider
11. Complementary services (e.g. acupuncture, homeopathy)

DO NOT RANDOMISE
CATI RESPONDENTS ONLY SEE TWO OF ROWS 6-11, ALLOCATED RANDOMLY

C3 ASK ALL
SINGLE GRID - ROLLING

And if you were concerned about something to do with your health, how confident would you be that each of the following services would help you?

COLUMNS:

1. Very confident
2. Quite confident
3. Not very confident
4. Not confident at all
5. Prefer not to say
6. Don't know

ROWS:

1. A GP
2. A hospital (excluding A&E)
3. Accident and Emergency (A&E)
4. A pharmacy
5. A dentist
6. A health visitor
7. Sexual and reproductive health services
8. Substance misuse services
9. Mental health support services
10. A private healthcare provider
11. Complementary services (e.g. acupuncture, homeopathy)

DO NOT RANDOMISE
CATI RESPONDENTS ONLY SEE ROWS THEY SAW AT C1

C5 ASK ALL
SINGLE GRID

Imagine you were talking to a healthcare professional (e.g. a GP, nurse, pharmacist) about a health problem.

To what extent would you trust that they would...

COLUMNS:

1. I would trust them completely
2. I would mostly trust them
3. I would not really trust them
4. I would not trust them at all
5. Don't know
6. Not applicable

ROWS:

1. … take me seriously
2. … take my problem seriously
3. … believe what I was telling them
4. … be aware of issues affecting people from my background
5. … be able to help with my problem

C6 ASK ALL
SINGLE
Within the past 2 years, how often have you been treated unfairly when getting medical care because of your ethnicity, religion, gender or other characteristics?

1. Never
2. Rarely
3. Sometimes
4. Often
5. Don't know
6. Prefer not to say

4 | Current living situation (L)

L1 ASK ALL
SINGLE GRID
Thinking about the home you live in, to what extent do you worry about…?

COLUMNS:
1. Not something I ever worry about
2. Something I rarely worry about
3. Something I occasionally worry about
4. Something I often worry about
5. Something I worry about all the time
6. Prefer not to say

ROWS:
1. The possibility of being evicted from my home [EXCLUDE HOMEOWNERS]
2. Being able to afford my accommodation costs (e.g. rent / mortgage / bills)
3. Damp or mould in my home
4. Being able to afford to keep my home warm
5. My home not being in a good state of repair
6. Heating / electrics / plumbing not being in good working order
7. Being able to keep my home cool enough on hot days

L4 ASK ALL ONLINE
SINGLE GRID
Have you or anyone else in your household experienced the following in the last six months?

COLUMNS:
1. Yes
2. No
3. Don't know / prefer not to say

ROWS:
1. ...had smaller meals than usual or skipped meals because you couldn't afford or get access to food?
2. ...ever been hungry but not eaten because you couldn't afford or get access to food?

3. ...not eaten for a whole day because you couldn't afford or get access to food?

L5 ASK ALL
SINGLE
How well would you say you are managing financially these days?

1. Living comfortably
2. Doing alright
3. Just about getting by
4. Finding it quite difficult
5. Finding it very difficult
6. Don't know
7. Prefer not to say

INTERNETUSE1 ASK ALL
MULTI
How do you regularly access the internet?

Please select all that apply

1. House – via fixed broadband connection
2. Work – via fixed broadband connection
3. Mobile phone / tablet - via mobile network connection
4. Public space – via WiFi connection
5. No regular access to the internet

INTERNETUSE2 ASK ALL YES AT INTERNETUSE1
SINGLE GRID
How would you rate each of the following?

COLUMNS:

1. Very good
2. Good
3. Poor
4. Very poor
5. Don’t know

ROWS:

1. Affordability of home broadband
2. Your ability to use digital / online health services

5 | Closing demographics

INFO TEXT
Thank you for answering so far, we’re almost done now.

We just want to ask a few more basic questions about you so that we can compare answers from different groups

S3A ASK ALL ONLINE
MULTI
Do you look after or give any help or support to anyone because they have long term physical or mental health conditions or illnesses, or problems related to old age?

1. Yes – and I am paid by the person I care for
2. Yes – and I am paid carer's allowance
3. Yes – and I am not paid for it at all
4. No [EXCLUSIVE]

S3B ASK ALL ONLINE AND (WITH A CONDITION AT D9 OR AGED 65+)
SINGLE
And do you currently RECEIVE any help or support from anyone because of your long term physical or mental health conditions or illnesses, or problems related to old age?

1. Yes – that I pay for
2. Yes – that they receive carer's allowance for
3. Yes – that they are not paid for
4. No [EXCLUSIVE]

D8 ASK ALL WHO CONSENT
SINGLE
How would you describe your sexual identity?

1. Bi-sexual
2. Gay
3. Heterosexual/straight
4. Lesbian
5. Pansexual
6. Queer
7. Asexual
8. Other [OPEN]
9. Don't know
10. Prefer not to say

D14 ASK ALL
SINGLE CHOICE
Please select the highest level of academic or professional qualification you have completed.

If you weren't educated in the UK, please try to say the closest equivalent

1. No formal qualifications
2. GCSE, Standard Grades or equivalent (e.g. BTEC, S/NVQ level 2)
3. An apprenticeship
4. A Level, Highers or equivalent (e.g. BTEC, S/NVQ level 3)
5. Certificate of Higher Education or equivalent (e.g. HNC, BTEC, S/NVQ level 4)
6. Diploma of Higher Education or equivalent (e.g. HND/Foundation Degree, BTEC, S/NVQ level 5)

7. Undergraduate Degree or equivalent (e.g. BA, BSc)
8. Postgraduate Cert or Dip
9. MBA
10. Other Masters Degree (e.g.MA, MSc, PGCE, PGDE)
11. Doctoral Degree (e.g. PhD, DBA)
12. Professional qualifications (e.g. CIMA, ACCA)
13. Other
14. Don't know

D17 ASK ALL
SINGLE

And how long have you lived in LAMBETH / SOUTHWARK?

Please answer for when you most recently moved to the borough.

1. Since I was born
2. Less than 1 year
3. More than 1 year but less than 2 years
4. More than 2 year but less than 3 years
5. More than 3 year but less than 5 years
6. More than 5 year but less than 10 years
7. More than 10 year but less than 20 years
8. More than 20 years
9. Prefer not to say

D18 ASK ALL ONLINE GIVING PERMISSION
SINGLE

What is your religion?

1. No religion
2. Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
3. Buddhist
4. Hindu
5. Jewish
6. Muslim
7. Sikh
8. Any other religion (please specify)
9. I am not religious
10. Prefer not to say

D19 ASK ALL ONLINE
SINGLE

If you were not born in the United Kingdom, when did you most recently arrive to live here?

1. I was born in the UK
2. Within the last year
3. Withing the last 3 years
4. Within the last 5 years
5. Within the last 10 years
6. Within the last 15 years
7. Within the last 20 years
8. Withing the last 30 years

9. More than 30 years ago
10. Prefer not to say

7 | CLOSING OPEN END (F)

F1 ASK ALL OPTIONAL
OPEN TEXT
If there is one thing you think should be done to improve health and well-being in your local area, what would it be?
[OPEN TEXT]

INFO PAGE

ONLINE PANEL AND COMMUNITY OUTREACH:
If you've been affected by any of the issues in the survey then below is some information on some charities that might be able to provide help or support

CATI:
If you've been affected by any of the issues in the survey then we have the contact information for some charities that might be able to provide help. Would you like me to read these out?

[INTERVIEWER: IF YES, READ OUT ORGANISATION NAMES BELOW, THEN CONTACT INFORMATION IF PARTICIPANT ASKS FOR IT]

ALL:
Samaritans
Provides confidential emotional support for people who are experiencing feelings of distress or despair or finding it difficult to cope.

Phone: 116 123
Phone (Welsh language): 0808 164 0123
Email (24-hour response time): jo@samaritans.org

Mind
Mind offers advice, support, and information to people experiencing a mental health difficulty and their family and friends.

Phone: 0300 123 3393
Text: 86463
Email: info@mind.org.uk

Citizens Advice

Citizens Advice offer advice on a range of areas such as benefits, work, debt and money, housing, health

Website: https://www.citizensadvice.org.uk/about-us/contact-us/contact-us/contact-us/
Adviceline England (free): 0800 144 8848
Adviceline Wales (free): 08007022020
Relay UK - if you can't hear or speak on the phone, you can type what you want to say: 18001 then 0800 144 8884
Adviceline is available 9am to 5pm, Monday to Friday. It’s usually busiest at the beginning and end of the day. It's not available on public holidays.

British Red Cross
Help anyone, anywhere in the UK and around the world, get the support they need if crisis strikes.

Free confidential support line: 0808 196 3651

- END OF SURVEY -

Discussion guides for the exploration labs

Discussion Guide - 'Discrimination, and Lack of Trust in Healthcare'

1. **Welcome, consent and introduction**

We will explore discrimination and lack of trust as two separate issues:

2. **Discrimination:**

Discrimination means treating a person unfairly because of who they are or because they possess certain protected characteristics (e.g disability, ethnicity, age, sexual orientation). Minority groups are known to have more negative experiences within healthcare.

a. Before I ask you about your own personal experiences about discrimination, what are your initial thoughts about discrimination in healthcare?

b. Have you experienced any discrimination within healthcare? If so, please explain - key question (this may be whilst working in a healthcare setting, trying to access treatment, or whilst being treated)
    i. Prompt - Healthcare in the broader sense, dentists, mental health services, substance misuse, pharmacies
    ii. Prompt - was it implicit/explicit
    iii. Was it an isolated incident, or has it been continuous?

c. How might the following groups be affected by discrimination whilst accessing any type of healthcare service? (optional)

d. How does this discrimination affect your future engagement with health services?

e. What can be done to reduce this discrimination? - key question

f. Optional (if we have time): Do you have examples of being treated fairly within the healthcare system?`

3. Levels of trust:

This is related to people's expectations from the healthcare sector or from healthcare providers. It's a firm belief in the reliability or truth of something. Trust can also be defined as a feeling of reassurance or confidence in the sector.

g. How would you define your levels of trust in the healthcare sector overall?

(0 = I have no trust at all, 10 = I completely trust). Put your answers in the chat please

i. Please explain why.
   a. Prompt - does your level of trust change depending on which healthcare service you are engaging with?

h. What other issues of trust may people from the following underserved groups experience?:

a. Digitally exclude

Prompt - they can't access information online, can't communicate effectively because they are less informed, so they do not trust health services as much, or trust develops much slower.

Prompt -since Covid, more and more healthcare information is online, bookings for appointments take place online etc

Prompt - lack of trust in data security, can lead to hesitation of engaging online for healthcare services.

b. Socially excluded

Prompt - groups may not be well informed about how the healthcare system works, therefore feel disconnected and lack trust.

Prompt - certain groups may feel stigmatisation whilst accessing health services, affecting levels of trust

Prompt - Is there a need for anonymity when accessing primary care? How does this balance against the need for more aligned data sharing across health services?

c. Religious communities

Prompt - these communities may feel like their religious beliefs are not being considered, therefore they are less trusting of healthcare providers

i. Do you think overall levels of trust have increased or decreased in recent years?
   d. Please explain

Prompt - especially after national crises such as Covid, or data breach incidents

Prompt - recent studies are showing that people are increasingly trusting friends and family and relying on them for accurate information and health. Although trust in doctors and nurses has increase slightly (+3, +4 points), trust in friends and family has increase the most (+11 points)

j. How does this level of trust affect your future engagement with healthcare services?

k. What can be done to increase the levels of trust within the healthcare system?

6. Prompt - which factors would make you feel more safe, and have more trust in the healthcare system?
7. Prompt - is more empathy needed?

Discussion Guide - 'Housing and its impact on health'

Welcome, consent and introduction

We will explore 'Housing and its Impact on Health' in three sections and then talk about potential solutions

Section 1: What is poor quality housing and how can it affect health?

Differences in the health of people can be caused by many different factors, such as gender, age, ethnicity. But they can also be caused by wider social factors like where you live, how much you earn, the level of education you have had, what job you do etc.

In this section we will focus on how poor-quality housing can affect health.

1. In your experience, what type of housing issues can affect health? (10 minutes) - priority question

   Prompt - cold homes, hot homes (damp, cold, mould, lack of ventilation) noise

   Prompt - overcrowding due to housing shortages

Prompt - unaffordable housing (cost of living), threat of eviction. Nearly 4 in 10 of private and social renters are concerned about meeting housing costs in the coming months

Prompt - lack of access to natural light and green spaces

Prompt - anti-social behaviour

Prompt - lack of accessibility e.g. no lifts

2. In your experience, how can health be affected by poor housing? (15 minutes) - priority question

Prompt - physical conditions (Respiratory - asthma and wheezing, pneumonia. Cardiovascular - heart attack and hypertension)

Prompt - mental health conditions (anxiety, depression, stress), effects on wellbeing, isolation

Prompt - substance misuse and abuse, eating disorders

Prompt - lack of vitamin D and iron (anaemia), malnourishment, stunted growth

Prompt - how can family be affected by this

Prompt - Did you go anywhere to seek help? where?

Section 2: Social v private renters

- A social renter is a tenant that rents their home from the council or from a housing association
- A private renter is a tenant that rents a property which is owned by a landlord

3. What differences are there (if any) in housing quality and its link to health, if you are a social renter, and if you are a private renter? (10 minutes) - priority question

Prompt - national research suggests that private renters live in worse housing conditions than social renters

Prompt - privately rented homes more likely to have damp, less likely to have central heating, and likely to be more expensive than socially rented homes (higher rent increases). Private tenant also have weaker tenancy rights than social tenants

Prompt - socially-rented homes are more likely to meet the national 'Decent Homes Standard,' be more affordable, and offer greater security

Section 3: Lambeth and Southwark

Show slide of Lambeth and Southwark statistics:

- Double the number of households in Lambeth/Southwark live in socially rented accommodation compared to the rest of England
- Over ⅕ (22%) of residents in social rented housing are not in good health (in Lambeth and Southwark, compared to 7% of private renters) - this potentially goes against national research which states that private renters are worse off.

- Significantly higher proportion of black people (47%) live in socially rented housing in Southwark/Lambeth
- More than ¾ of households live in flats/maisonettes or apartments in Southwark (78%) and Lambeth (75%), compared to 22% in England

4. What thoughts do you have about housing and health in Lambeth and Southwark, having seen these statistics?

   Prompt - Many more people live in flats compared to houses

   Prompt - higher proportion of black people are social renters. Does this impact more significantly on health inequality because ethnicity and accommodation are combined?

Section 4: solutions

5. What can be done to improve poor quality housing, so that it has less impact on the health of residents? (15 minutes) - priority question