CNet
COMMUNITY NETWORK
BRADFORD & DISTRICT

NHS
Bradford City Clinical Commissioning Group
Bradford Districts Clinical Commissioning Group

WOMEN'S HEALTH NETWORK
FINAL REPORT
SEPTEMBER 2016

"My experience of taking part in the development of the WHN exceeded my expectations. Everyone has always been equally enthusiastic to see this succeed and the information and experiences shared show that it is needed."

Women's Health Network Member

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- Attendance at meetings, events and workshops
- Participation in the WHN Steering Group
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- Participation in either or both the first and second stages of engagement.

Women's Health Network Project Team

Project Lead: Javed Khan
Project Support Team: Janet Ford, Saima Ashfaq
Report Co-Authors: Alan Anderton, Liz Firth, Meena Jeewa and Tracy Higgins
Report Editor: Tracy Higgins

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1. Background

Bradford Community Empowerment Network (CNet) was commissioned by NHS Bradford City and NHS Bradford Districts Clinical Commissioning Groups (CCG's) to establish a Women's Health Network (WHN) by September 2016.

The WHN will support both CCG's to work together to identify and address the health issues and inequalities affecting women and their families in Bradford. It will also help to establish and maintain a dialogue on issues pertinent to women and the development of women's services.

The work undertaken to establish the WHN consisted of three elements. The first included a desk based review of national and local research to develop an understanding of the barriers around women's health provision, and to identify examples of good practice in engaging women in developing women-led healthcare. Alongside the review a local mapping exercise was also undertaken to identify services and community assets working to achieve better health outcomes for women and children in Bradford.

The second element included a two stage engagement process. The first stage involved meeting with women from across the areas covered by the two CCG's whose voices and experiences are seldom heard, and engaging them in a dialogue on health issues. The second stage involved targeted focus groups relating to the three clinical areas prioritised by the CCG's.

The third element was a series of workshops and meetings to develop and formalise the WHN.

These three elements were carried out simultaneously by CNet over an eight month period from February to September 2016. CNet used an asset based community development approach to engage and sustain the direct involvement of local women, and to work in partnership with public, private and voluntary and community sector (VCS) organisations who support the health and well-being of women.

CNet are committed to developing a WHN founded on good practice, which both maximises community assets and engages women living and working in Bradford, particularly those whom are seldom heard. The aim was to establish a WHN that local women take ownership of, that meets their expressed needs, and which is informed and influenced by them.

As the WHN grows and develops it will provide a mechanism to engage with and educate women on issues that have the potential to improve their health and well-being and that of their families. It will also enable public, private and VCS organisations to work with local women to identify and address the issues and inequalities that have a detrimental effect on their health and well-being and that of their families.

2. National Research

2.1 Methodology

2.1.1 Desk Research

Desk-based research was undertaken to gain a broad understanding of how women's groups operate and to identify examples of best practice which could be used to inform the development of the WHN in Bradford. A full list of documents and website links, and details of some specific examples of good practice and success stories can be found in appendix 1.

2.1.2 Interviews

From the results of the desk based research seven areas with similar demographics to Bradford were chosen for further investigation. Telephone interviews using a semi structured questionnaire, see appendix 2, were conducted with ten professionals from a range of public and voluntary and community sector organisations who work with women in the seven areas identified. A list of the areas and professionals interviewed can be found in appendix 3.

As a result of the data gathered via the telephone interviews a decision was taken to arrange a study visit to the Rochdale Women's Welfare Association (RWWA). Three Pakistani women created the RWWA in 1984. The aim of the project was to provide the women of Rochdale with a safe place where they could access help, advice, information on health etc. and have a general 'get together'. The centre now sees up to 300 women a week of all ages. A case study of the visit has been produced which details the background, activities and successes of the RWWA and can be found at appendix 4.

2.2 Developing a Women's Health Network

2.2.1 Summary of Findings

The desk based research identified a number of key areas for consideration when developing a women's health network. These are summarised below.

2.2.1.1 Co-production and asset-based approaches

A number of documents have been produced around co-production and asset-based approaches (see appendix 1). The co-production approach emphasises that people produce outcomes and not 'services'. Although health outcomes are produced through the combined efforts of citizens and services, they are often not recognised or made visible. 'Co-production acknowledges and gives explicit recognition of the role of communities, users and families' (Improvement and Development Agency (IDeA), 2009).

The asset-based approach values the capacity, skills, knowledge, connections and potential in a community and is highlighted by the IDEA as a positive approach that will inevitably lead to better and relevant healthcare. Table 1 below summarises the asset based approach.

Table 1.

Begin by asking questions and reflecting on what is already present	In practice this means doing the following
1. What makes us strong? 2. What make us healthy? 3. What factors enable us to cope more in times of stress? 4. What makes this a good place to be? 5. What does the community do to improve health?	• Finding out what works and generating more of it. • Focusing on what is trying to be achieved not what the problems are. • Cherishing the assets – as soon as people are talking to each other they are working on the solutions. • Actively building the capacity and confidence of communities and staff. • Involving the 'whole system' from the beginning – those left out will be left behind. • Designing in what is needed to achieve the desired future and designing out structures, processes and systems that prevent it. • Ensuring the long term sustainability of the solutions.

The research shows that a combination of co-production and asset-based approaches are required if the WHN is to effectively engage and involve women, particularly the seldom heard, in designing and ultimately running the Network.

2.2.1.2 Defining a purpose

The research emphasised the need for networks to have a clear vision and purpose in order for individuals, organisations and groups to 'buy in' to the process. People are more likely to join or get involved when they know why they are there and what is expected of them.

In addition agreeing outcomes and setting SMART (Specific, Measurable, Achievable, Relevant and Time-Related) objectives, alongside developing and monitoring action plans will give the WHN focus, and enable it to work more effectively with its partners to engage, identify and respond to the needs of local women.

"It is important that everyone is clear about the purpose and aims of the network or forum. With so many competing demands, women's organisations often find it hard to make time to attend meetings. Networks and forums which don't have clarity can be frustrating and not a good use of time. This will affect whether or not people will come to meetings and prioritise network or forum work."

Interviewee

2.2.1.3. Including 'seldom heard' groups

One of the core aims of the WHN is to be inclusive and accessible to women of all abilities and from all the different communities in Bradford. Creative and effective approaches are needed to ensure 'seldom heard' groups are included on to the Network to enable them to have a say in their health matters.

The research uncovered many interesting ways of encouraging and ensuring representation from minority groups. These ranged from 'seat' allocations for specific ethnic groups, to ensuring their voice is heard, to providing financial support to 'seldom heard' groups to help with travel, training or other forum related costs. For detailed examples, please see appendix 5.

2.2.1.4. Women centred working

The research revealed an initiative, developed by Clare Jones at WomenCentre Calderdale and Kirklees, termed 'women centred working'. 'Women centred working' encourages the design and delivery of better services for women facing multiple disadvantages. It has grown out of decades of experience supporting women in the most difficult situations to make positive changes to their lives. Extensive evidence from projects at WomenCentre Calderdale and Kirklees and other women's centres around the UK has shown that 'women centred working' can get to the root causes of complex problems.

There have been three publications by WomenCentre that define the approach, showcase the work and solutions, and discuss ways forward, see appendix 6. A summary of the key points which define the approach of 'women centred working' are detailed in Table 2 below.

Table 2.

The 'Women Centred Working' Approach	
1.	Focuses on women's expressed need and lived experience.
2.	Is underpinned by an understanding of women's needs and lives.
3.	Is informed by an understanding of what works for women.
4.	Is located within a women only, safe and enabling environment.

5.	Takes a holistic approach.
6.	Is delivered with quality and professionalism.
7.	Is delivered in a co-produced way.
8.	Requires specific skills set.
9.	Requires a flexible and supportive working environment.
10.	Facilitates service integration and pathways.

2.2.1.5 Promotion and the use of social media

The research shows that consistent promotion is essential for a network to be recognised, used and maintained. The research suggests that 'word of mouth' is the most popular and effective way of creating awareness, as people are more likely to listen to and act on what they have heard from people they know and trust. However the use of social media was also shown to be beneficial and widely used when developing a network or forum.

The advantages of using social media are that most sites are free, information is instant, wide reaching and can be controlled. It also allows interested individuals and groups to engage in forums and discussions from the comfort of their own familiar surroundings.

Those who are accustomed to commenting and hash tagging will feel comfortable using it and will be able to follow and engage with the network even if they don't attend meetings and events. Furthermore, they will be able to raise awareness to their own followers, friends and family.

Details of social media platforms, e.g. Facebook, along with suggestions as to how they might be used to promote the WHN can be found in appendix 7. In addition the research revealed a number of lesser known sites which have been used specifically in relation to the development of women's networks. These are summarised below:

- **GROU.PS** (https://grou.ps/home) is a leading social groupware platform that allows people to come together and form private or public interactive communities around a shared interest, work or affiliation. The GROU.PS platform is used to create a wide variety of community sites e.g. charity fundraising campaigns, college alumni societies. Any organisation seeking to aggregate and organise people online can greatly improve its effectiveness, engagement and appeal by migrating to the GROU.PS platform.
- **NING** (http://www.ning.com) gives people the tools and expertise to nurture and engage their own online community on the largest, most scalable and integrated social platform of its kind. NING is able to help build new websites, integrate any existing online community into the website and re-launch existing sites.

- **Flickr** (www.flickr.com) is a site that can help manage digital data such as photographs and videos. It is a good way of distributing pictures and videos from events, and promoting them to online communities.

2.3 Interviews

2.3.1 Summary of Findings

The data from the interviews identified a number of aspects which are to engaging and sustaining the involvement of women through the development of a network, and in successfully working in partnership with them to identify and address issues and inequalities that impact on their health and well-being and that of their families. These are summarised below.

2.3.1.1 Know your community

Interviewees suggested that understanding your community is key to offering relevant healthcare to women. This means a better understanding of religion, culture and traditions.

For example, focus groups with Bengali women in Leicester identified why appointments with midwives were not being made earlier. This was due to the women feeling they did not need any information as they already had children so felt they knew what they were doing. They also relied heavily on the advice of their elders.

The focus groups also identified the best ways to encourage women to contact maternity services, and as a result a DVD was produced in relevant languages. This was then made readily available in places Bangladeshi women would visit, such as GP surgeries and play groups. They were also placed in supermarkets in the heart of Bengali communities.

The interviewee did however highlight that not all Bengali communities may yield the same results hence the process of engagement and understanding should be ongoing to recognise any differences, big or small, that may impact on how women access healthcare.

"One Bangladeshi community in one area might be very different to another. Continue engaging with the community - things change. We need to stay in touch with what is happening within the communities."

Interviewee

2.3.1.2 Consultation and engagement

Throughout the interviews consultation and engagement were discussed in depth. Interviewees highlighted a variety of ways in which they have successfully engaged and consulted with their communities. These are summarised below:

- Targeted face to face work, particularly to engage seldom heard groups.
- Using incentives to encourage people to attend and engage e.g. shopping vouchers.

- Tapping into existing groups, meetings and organisations e.g. Quran classes, doula projects, community centres.
- Drawing in specialists to work alongside volunteers and community workers to engage and consult communities on specific topic areas e.g. bowel cancer.
- Training up volunteers, community health champions and working with/employing community development workers.
- Going into the natural settings where communities gather and meet rather than holding meetings elsewhere and expecting them to come to you.

Full details of the examples shared can be found in appendix 8.

"The £20 incentive was a voucher for the local Asian shop that does not sell alcohol or tobacco…one GP did this engagement work without us and without incentives and only one person came! ……We filled rooms. We got a bowel screening professional and she broke it down, and we interpreted where it was necessary and we found out that many of them threw the bowel cancer testing kits away, when received through the post, because they did not know what they were!"

"Go to the women where they are, play groups, add refreshments, tag on, this makes a huge difference. Always use their natural settings. You can put on a great event with food in a nice room somewhere and you will have little turnout – you do a bit of research and find out there are Quran classes going on in a back room of terraced house and you will get a full house, from over 60-70 women".

Interviewees

2.3.1.3 Genuine involvement

There was a clear message from the majority of those interviewed that genuine involvement of women who will be using the network is critical. They suggested that a 'top down' approach, where a CCG or other organisation creates a network or forum for women, does not work as well as one that is co-produced with the women themselves.

Also highlighted was the importance of allowing sufficient time to build women's confidence and empower them so that they are genuinely engaged and meaningfully involved in informing and influencing the network.

"Eight months is it not a long time {to develop a women's health network], one of the key things is the need and outcomes is not what these women are driven by, it is what funders and commissioners are driven by and this needs to be acknowledged. One of the things I have done in my area is changed some of the mind-set, it should be as long as it takes, not governed by deadlines"

Interviewee

Whilst creating a women's health network was viewed as a great thing it was suggested that it can become tokenistic if the right women are not involved in the development and ownership of it.

2.3.1.4 Utilising community assets

In line with the asset based approach, the majority of those interviewed talked about working closely with a core group of community members to not only reach more peers in the community but also to identify and utilise existing skill sets. For example in Leicester a group of young people were trained in engagement techniques and went on to consult with 1600 other young people about their healthcare needs. Whilst in Derbyshire members of the Hindu, Sikh and West Indian communities were recruited and trained as Health Champions.

One interviewee who had previously been a Community Development (CD) Worker discussed the asset based approach and felt that this was another way of terming the work undertaken by CD workers.

"All these new terms 'asset based', 'co-production' - so jargonostic, if you look underneath, it is community development work which has been done for years"

Interviewee

Identifying existing skills and developing new skills within communities, through skill sharing, were identified as important as these can build the confidence of individuals and communities, and empower them to develop and deliver services and activities themselves. One interviewee talked about a programme they had developed called 'Finding Me'. This is an empowerment programme for women which encourages them to recognise, value and utilise their knowledge and skills.

"Skill sharing is a main thing we do, that is one of the most important things. We have women that come on board as clients and they learn as we eventually step aside (and make ourselves insignificant). We are at the stage now that women who were clients are now delivering the service."

Interviewee

2.3.1.5 Relationships with the CCG

Interviewees' relationships with their CCG's varied, however the majority highlighted experiencing difficulties in engaging meaningfully with their CCG's. One commented that although very successful work was being undertaken in their area the main input they receive from the CCG is funding for projects.

"We would like to engage with the CCG a bit better but it is very difficult, they are very guarded and there are a lot of changes going on as well. The CCG's should have a good relationship with the VCS to get to 'seldom heard groups', and GP practices need to change and should be open to work with the communities through us too"

Interviewee

Alternatively one interviewee commented on the strong relationship their organisation had with their CCG's and explained the positive impact this has had on improving the health of their communities. Also they stated how representation on the Joint Assessment Board with the CCG's enabled their organisation, which services 66 different communities, to be at the heart of decision making. They also suggested the constant and consistent input they provide to the CCG's is thought to be invaluable and leads to essential and positive developments as well as changes in what and how services are delivered.

"We work closely with agencies and organisations like the NHS and the CCG's to create understanding. We are always engaging with our communities and when we identify a specific problem we have a workshop meeting with the CCG's to discuss the problem and see how it can be solved, and vice versa. For example, there was a lack of interpretation services which caused problems, but we worked with the CCG's and it has improved a lot."

Interviewee

2.3.1.6 Barriers to accessing healthcare

Interviewees were asked about specific barriers the women in their communities face in accessing healthcare. A range of barriers, whether real or perceived, were identified and those highlighted as the main barriers are summarised below.

A) Language

Interpreting services and general health information in the relevant languages were the 'usual' approaches to language barriers. In more specific cases if a certain community was identified as in need of healthcare special measures were taken to target that community. For example, a DVD in Bengali was produced for pregnant women due to health issues in pregnancy.

> *"We have a very active interpreting service, they can access it very easily. They also have the opportunity there to give feedback about the service they have received. So if they have any issues, they are able to tell us about it."* *Interviewee*

B) Culture and traditions

Although not discussed in depth by many of the interviewees, the intricate details within cultures and tradition may cause women not to access healthcare. This could range from Muslim women not wanting to take smear tests to Eastern European women not being aware of the healthcare provision available.

For example, one interviewee identified how the 'traditional attitude' held by some Pakistani Muslim people made the promotion of preventive care difficult. They highlighted that this was a *"battle"* they regularly faced.

A second interviewee talked about Bengali women traditionally relying on and listening to their mothers, mother-in-law and 'elders' when it came to new-born advice, some of which may not be safe for babies. Another highlighted how it is practically impossible to know the ins and outs of every community. For this their organisation develops and maintains links with a 'strong leader' within the different communities, who is able to convey the collective voice of the groups that may not feel comfortable or confident enough to express their needs.

> *"In my experience, they [Pakistani community] have the attitude of it is in 'Gods' hands' but I say God has given you the knowledge to help yourselves, it can get frustrating, you have to remember that they don't have the education and facts, they look at diabetes and call it 'sugar' but don't understand the dire consequence of the disease which could mean going blind or amputation, then they come back with, "well, my gran has*

had it and she is 84" – but they are controlling it and we are trying to prevent you from getting it in the first place."

"We have 66 different community groups and they include all the different EE groups – we have a very good access to a leader for each of the group."

Interviewees

C) Lack of awareness

Women not being aware of the services available to them presents a barrier to them accessing those services. Although many of those interviewed talked about 'creative ways' to access women or specific community groups, they also mentioned why some groups may not be accessing information and services.

"A lot of the times commissioners think that all the relevant information is out there, on the websites and TV. They [Pakistani community] don't see the adverts on TV, they are watching Zee TV, which is beamed into their houses from India and Pakistan and as for information on the website, it is very unlikely they will be accessing the Internet."

Interviewee

D) Confidence

The majority of those interviewed felt that a lack of confidence is the key barrier to women accessing healthcare.

"Emotional health and wellbeing, and self-esteem is the key thing, once you build and have that then they can access services and take up healthy lifestyle advice in a much more meaningful way."

"If you want a woman to improve her health the first thing is to improve her confidence. These kind of things take time. Health literacy is very poor in certain areas and communities."

Interviewees

The desk based research corroborates the main barriers identified above. It also highlighted a major study 'Women's Voices on Health', conducted by the Women's Health & Equality Forum, the aim of which was to examine the accessibility of primary care for women in the

UK. A summary of the findings together with a link to the full report can be found in appendix 9.

The results of this study suggests certain groups of women will have very particular and specific needs that must be addressed for better healthcare.

2.4 Conclusion and Recommendations

2.4.1 Development of the Network

There is substantial literature around both the co-production and asset based approaches and many thoughts and opinions have been provided by those interviewed. Utilisation of both approaches have and will continue to be paramount in developing and sustaining the WHN.

The research shows it is important that the WHN has a clear vision and purpose in order to engage and sustain the involvement of individuals, organisations and groups. It will need to agree outcomes, set objectives and develop and monitor work plans if it is to remain focussed, whilst working effectively with partners to identify and respond to the health and well-being needs of the women of Bradford.

The key to the success of the WHN will be the ability to successfully and meaningfully engage the women of Bradford and sustain their involvement, particularly those women that are seldom heard. As highlighted by the research and interview findings the WHN will need to be creative in its engagement methods and approaches, and ensure these are appropriate to the individuals and groups being targeted.

The ‘women centred working’ initiative is important, it focuses on women holistically and works to better the lives of women in all aspects, including health. The ultimate aim of this approach is to inform and influence commissioners to recognise and respond to the fact that women have very different and specific needs which cannot be categorised and addressed under the one heading of ‘health’.

The necessity to use social media was recognised from the outset of the project. A Facebook page and Twitter account were created, and are currently being used to promote the WHN and to share information. Linking to more established accounts has helped build momentum and the WHN is growing in followers. Three members of the WHN were identified as being excellent on social media, thus have been involved in developing the Network’s digital presence.

2.4.2 Interview Findings

‘Knowing your community’, which ultimately means recognising there are different communities with varying cultures, traditions and needs, was identified as key. This is not to say that an intricate knowledge of every single one is needed, but that a general understanding, especially related to women’s health, is needed.

Many creative ways, some of which are likely to already be undertaken in Bradford, are being used to engage and involve women in identifying and addressing issues which impact on their quality of life and that of their families. Engagement that is centred on the target audience and delivered in ways that catch the audiences' interest were seen to be key. Engaging with communities in their 'natural settings', 'tagging' on to existing groups, and designing exciting events around families, where engagement and consultation would be undertaken, were also viewed as important. Above all the research highlighted the importance of engagement and consultation activity being 'real' and acted upon, not tokenistic.

The findings suggest developing meaningful, active and long-term women's health work takes time and cannot be regulated by the budget and financial constraints of commissioners. It was shown that to have 'proper' conversations with vulnerable women or women from 'insular' communities can often take up to five months. The recognition and acceptance of this would support the WHN to reap long-term and meaningful results.

Whilst the majority of those interviewed felt they did not have a strong relationship with their CCG's, with some suggesting their group was viewed as *"just as another group applying for money"*, the interviewee that did emphasised the positive impact this has had on improving the health of their communities. This highlights the importance of developing and strengthening the relationship between the WHN and the NHS Bradford City and NHS Bradford Districts CCG's, as this will help to yield better health outcomes for the women of Bradford.

The findings show there are multiple barriers, either real or perceived, that prevent women from accessing health services. The WHN will need to work with women, organisations and groups working with women, commissioners and providers in order to understand these barriers better and identify ways in which to overcome them. This will enable the women of Bradford to know what services are available to them and feel confident and able to access them.

2.4.3 Recommendations

Detailed below are the proposed recommendations resulting from the findings of the national research.

Recommendations:

1. Ensure a co-production approach is integral to the ongoing development and work of the WHN.
2. Use the asset-based approach to identify women in communities who have the knowledge, skills and passion to benefit the WHN and ultimately the women of Bradford.

3. Undertake targeted work, with support from CNet, to ensure seldom heard women and the groups representing them are part of the WHN.
4. Develop and agree an initial 12 month WHN Work Plan that is monitored and reviewed on a quarterly basis.
5. Undertake further research to gain a better understanding of how the 'women centred working' approach operates in practice, and identify the benefits of adopting this approach in Bradford.
6. Devote more time and resources to help develop and grow the WHN's digital presence thorough the utilisation of a range of social media platforms.
7. Invite 'Inspire Women', a project run by The Collective Partnership Oldham, to attend the WHN to share their experience of developing a women's project that is working successfully with commissioners.
8. Investigate further the 'Finding Me' programme, designed by Sally Bonnie of The Collective Partnership Oldham, which helps empower women and build their confidence, and identify any benefits to implementing this in Bradford.
9. Special efforts should be made by the WHN to actively engage and involve women from seldom heard and vulnerable groups and support their participation in the network.
10. Innovative ways of recruiting to, involving and promoting the WHN should be tried and evaluated. For example:
    - Utilising opportunities to promote the WHN through existing community events and activities e.g. Family Fun Days.
    - Direct face to face discussions between the women and the CCG's about their health needs and the barriers to accessing services.
    - Involve any local social or social media networks targeting and involving young women e.g. Young Lives Bradford in joint work on relevant women's health issues.
11. The CCG's should view the development and maintenance of the WHN as a long-term ongoing project which will require appropriate resource and support.
12. The CCG's need to develop a protocol for how they will promote, access, utilise, listen to and learn from the WHN.

3. Local Research and Mapping

3.1 Methodology

3.1.1 Desk Research

Desk based research was undertaken to identify organisations and groups providing services and activities in the areas covered by NHS Bradford City and NHS Bradford Districts CCG's, who have a positive impact on the health and wellbeing of women and their children.

The research included searches of existing databases, for example DIVA Bradford, Bradford Women's Network Directory. It also involved researching the websites of community centres, children's centres, places of worship and other community facilities, which host community organisations and groups. Requests for information were also widely circulated to community workers, Local Authority ward officers and other individuals in order to identify smaller unregistered organisations and groups.

The following definitions were used for the research and mapping of local organisations, groups and community assets:

- **Health:**

  'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.' (*World Health Organisation)*

- **Community Assets:**

  'Buildings and land owned by or managed by the community and key individuals who contribute time, skills and resources for the benefit of the community' *(adapted from Locality's definition)*

3.1.2 Interviews

To gather more qualitative data and identify examples of good practice a semi structured interview schedule, see appendix 10, was developed. A selective sample of groups from the database were identified for interview. The sample selected aimed to reflect the diversity and variety of organisations and groups in the database; large and small, self-run or managed/supported by other organisations, open to all or to specific populations, health focused or having other primary aims. A total of 11 organisations and groups, see appendix 11, were interviewed. Of these 6 were interviewed face to face, three took part in a telephone interview and two completed and returned the semi structured interview schedule.

3.2 Database of Women's Groups

The Database of Women's Groups, see appendix 12, includes 231 organisations and groups who provide a wide range of services and deliver a variety of activities. It includes; organisations who host and support several women's groups e.g. Baildon Link, groups specific to women e.g. Anah Project, and organisations and groups which are not exclusively

for women but have a majority of women members e.g. New Horizons, Clayton Village Hall Exercise Group.

The database provides an extensive but not exhaustive list of organisation and groups providing services and activities to support the health and well-being of women and children. For example there are groups based at children's centres and medical centres that do not feature in the database. This is because the primary aim was to develop a database of smaller and mostly unconstituted women's groups, which could be described as unknown and unheard of in terms of their engagement with the CCG's.

3.2.1 Summary of Findings

A number of findings were highlighted from the research undertaken to compile the database, together with the analysis of the data gathered from the interviews. These are summarised below.

3.2.1.1 Scale, breadth and variety

The range of organisations and groups either directly or indirectly helping to improve the health and well-being of women and children is vast and seemingly endless. From walking groups to gardening and singing groups, from arts groups to sports groups, from mental health groups to cancer groups, from faith based groups to groups for victims of domestic violence. Whilst many groups have become defunct, new ones have arisen, and others have changed, adapted and developed, and in some cases merged.

Some are enhancing general health and well-being by providing opportunities for people to socialise, meet new friends, share experiences and skills, and receive peer support. Others are providing specific support to help people manage particular conditions or illnesses e.g. disability, mental health, cancer etc., whilst many do both.

> *"I suffer from anxiety and depression. I am on different pills … I'd heard about the gardening group quite a while ago, but it took me some time to actually come. Once I had been – the group is welcoming, I really enjoyed it, and I've been coming ever since"*
>
> ***Service User***

Some organisations are well linked with other groups, statutory services and facilities, whilst others operate on a small scale and are happy to continue to do so, though more funding would help to expand the activities they can offer their members.

3.2.1.2 Impact

Interview data shows the impact organisations and groups have on the health and well-being of their members can be underestimated, if the only criteria is formal specified health

outcomes. The research and data suggest that the services and activities provided by these organisations and groups make a positive difference to the lives of their members. Common themes to most of those interviewed and also referred to in the publicity from many listed in the database are detailed below:

- **Social contact** – increasing social contact, alongside members having fun and enjoying themselves is seen to be fundamental to the success of the groups. It was highlighted that the social aspects of a group or activity can; reduce loneliness and isolation, provide group and peer support, offer buddying and mentoring, and help to support members through illnesses and crises.
- **Building confidence** – members pushing themselves and encouraging each other to develop new skills, try new activities and sign up to other courses.
- **Improving physical health** – members' fitness levels and stamina can be improved through specific physical activities such as regular exercise classes or developing football/sports skills, or by more general activities such as healthy eating and gardening.
- **Community cohesion** – services and activities can bring different communities together and helps break down barriers.
- **Mental well-being** - activities have a positive impact on the mental well-being of members as they feel encouraged, supported, valued and listened to.

"I've been coming for 3 years. I love coming because you get to know everybody round here, and talk to everybody. It's a great place to come to and really enjoy yourself. We do cooking as well – it's not just hard work. I love coming and I feel a lot healthier and more energetic."

Service User

Those interviewed were asked how they evidence the impact of their work. Responses could generally be grouped by whether the organisation or group was formal or informal.

Whilst informal groups were not required to provide formal monitoring information or reports most did have anecdotal testimonies from their members, photographs, feedback and evaluation forms, records of attendance and membership lists. More formal groups provided monitoring reports, kept client files, recorded individual and group progress, maintained portfolios, recorded achievements and awards, and had independent service evaluations. However the research and those interviewed highlighted often that the aim of the group or activity commonly has outcomes beyond its intended purposes.

3.2.1.3 Innovative and creative approaches

Interviewee's identified the following innovative and creative approaches they used to ensure positive outcomes for their organisation or group, and their members:

- **Social media** – using social media has been a major development for most groups not only to promote their services but for their members to keep in regular touch with each other.
- **Tailored exercise programmes** – providing these for people with specific medical conditions such as chronic obstructive pulmonary disease, arthritis or Parkinson's disease.
- **Cooperative ways of working** – having no hierarchy or leader where decisions are made collectively and everyone is involved.
- **User involvement** - groups run by ex-service users helps bind the group and encourages new people to join and stay involved.
- **Providing a crèche** – providing a crèche and programming activities at times which don not conflict with school pick up times have made activities and programmes far more accessible to parents, particularly women.
- **Holistic approach** - personalised packages of support which ensure successful outcomes for the individual and group.
- **Recruiting volunteers** – volunteers from the local community can appreciate the issues and needs of those within the community and can often communicate better with them.

3.2.1.4 Changes in communication

The main changes in methods of communication for nearly all the organisations and groups has been the increased use of social media.

Of the 11 interviewees 72% (8) cited the use of social media as having positive results for increasing membership, reaching a wider audience and sharing ideas and information. The most frequently used platforms were Facebook and Twitter although YouTube and Gumtree have also been used. However 27% (3) felt that word of mouth was still a far more effective way of communicating for some organisations and groups. In some cases this was seen as crucial to reaching certain communities, particularly new arrivals.

The data and research also show that whilst the increased use of social media and the internet have brought benefits they have also made information more readily available so people can get knowledge, help, advice and solutions without the need to join a group.

E-mails are still widely used by the majority of those interviewed and 55% (6) have their own web page. 18% (2) also make use of local radio and press. Other media cited as useful and having good results included having a banner stand at events, attractive eye catching leaflets/flyers, and advertising on community notice boards.

3.2.1.5 Barriers to engaging and accessing services

Interviewee's were asked to identify any barriers they face in engaging people as well as any barriers people face in accessing their group and/or activities. Detailed below are the barriers highlighted by two or more interviewees:

- **Cultural** barriers included, the reluctance within some communities, for example the African and Caribbean community, to ask for help, the denial of a need for help or scepticism about the help that is offered. Additionally barriers both within and between different communities and the fear and mistrust that exists were identified.
- **Communication and language** were identified as barriers with interviewees commenting that people are not aware of what is available and what support is being offered.
- **Limited resources** were identified as a barrier. Interviewees cited limited capacity to promote services, fund more activities and pay for or subsidise travel costs.

The main barriers identified in relation to people accessing groups and/or activities were:

- **A lack of confidence** in personal abilities and a general anxiety about joining a new group/activity were highlighted.
- **A lack of time** due to people having busy lives with careers and families was emphasised alongside *"time for you"* not being seen as legitimate or important for many women.

Based on the above findings related to cultural barriers it was suggested it may be beneficial for health care professionals to be made aware of the issues that prevent some cultures in engaging with and accessing healthcare services.

3.2.1.6 Ambition to develop and grow

Whilst all those interviewed except one have ambitions to develop and expand services, their plans are dependent on sourcing and securing additional funding. One interviewee also commented that service development would be achieved within their organisation if there was better integration with local health care professionals.

Interviewees confirmed that securing additional funding would enable their organisations or groups to:

- Recruit more staff/trainers or increase hours of current staff.
- Provide training and qualifications for volunteers.
- Extend and improve current provision.
- Provide new activities/classes/programmes and buy new equipment.
- Subsidise activities, reducing charges for members.

- Replicate services. For example, the Isis Project believe their service could be replicated for men.
- Pay for their own premises.
- Become more professional and structured e.g. the Unnamed Women's Football Team.

3.2.1.7 Gaps and improvements in health service provision

36% (4) of interviewees were either happy with current health services or could not identify any gaps in services. 27% (3) did not have a view about what improvements there might be. However the majority did identify improvements, 73% (8), and specific gaps 64% (7) including some similar issues. These are summarised below:

- **A "one size fits all" approach** – it was identified that a more holistic approach to prevention and treatment, which is tailored to meet the needs of the individual and is culturally appropriate, would be beneficial.
- **'Family Doctors'** – it was highlighted that people no longer seem to have a 'family doctor' and that GP's do not know their patients or their family history. This means patients do not build a relationship with any particular GP as they often see a different one at each visit.
- **Appointments** – people find it difficult to make a healthcare appointment and there is an insufficient allocation of time for appointments.
- **Treatment Choices** - it was suggested that people are not offered a full range of treatment choices. For example alternative treatments to hysterectomies being offered for uterine fibroids.
- **Communication** – a number of issues where highlighted in relation to communication:
    - More information in accessible formats is needed, for example braille.
    - GP practice's phone and text messaging services are variable.
    - In addition to raising people's awareness of important issues, for examples female genital mutilation (FGM), people also need to know what services are available and how to access them.
    - More information is required in GP practices about the range of services available not only in practice but also within the VCS.
    - Language barriers can make it difficult for people to understand the system and communicate their concerns effectively.
- **Disability awareness** – increased awareness is needed about patients with disabilities, not only when considering the disability but also when a disabled patient is seeking treatment and care for other conditions. Appendix 13 details the negative experience of one member of the Ladies Disability Group.

3.2.1.8 Women's health issues

Interviewees were asked what they considered to be the main health issues for women in general, and for those women accessing their services and activities. Detailed below are the issues highlighted by more than one organisation or group:

- **Mental Health** was cited by 73% (8) of interviewees as affecting both women in general and their female members. Stress and depression were specifically highlighted by 46% (5) of those interviewed, alongside fear and anxiety which was raised by 36% (4).

  Causes of mental health were also referred to with 36% (4) suggesting loneliness and isolation were significant factors. Other factors included low self-esteem, lack of confidence, bereavement, post-natal depression and, more generally, "the stresses of modern living" also being highlighted. Causes of fear and anxiety cited included; personal safety, the future, ageing, bullying, domestic abuse, intimidation and discrimination.

  Mental health issues are however being addressed by most of the groups though this is not often a planned outcome but a consequence of the group's bonding. The therapeutic role of belonging to a group cannot be underestimated. It gives members a reason to get out of the house, provides a structure to the day/week, and is something to look forward to and prepare for. It also provides the opportunity to talk to other people, discuss problems, share information, receive empathy and support from peers, and above all enjoy an activity or outing together.

- **Disability** - 36% (4) of interviewees indicated that disability and mobility were areas of concern for women within their group but also the wider community. For the Ladies Disability Group it was public awareness of disability that was a prime concern, including awareness amongst health professionals of the needs of people with disabilities.

A number of other women's health issues were raised by the individual organisations or groups interviewed which are detailed in appendix 14.

3.3 Database of Community Assets

The Community Assets Database, see appendix 15 includes a total of 136 organisations. It focuses on places which host, support, run and sometimes resource the groups detailed in the database of women's groups. It has been designed to complement and supplement the "Realising Community Assets" research conducted by Arise Yorkshire Ltd, who are concentrating on community assets which receive funding from NHS Bradford City and NHS Bradford Districts CCG's, and Bradford Council.

Assets not listed are public authority run amenities such as libraries, parks, swimming baths, and some sports centres, schools, children centres and sports clubs. This is because lists and

details of these are freely available from Bradford Council's website. Likewise medical centres which may provide resources and facilities for community use are listed on the CCG's websites so are not included.

Some places are readily identified as community assets as it is their defining role and will also be included in the database being compiled by Arise Yorkshire Ltd. Similarly so will others such as the Parkside Centre in the Bradford Trident Area, and Royds Healthy Living Centre which have a specific mission to improve community health. The vast majority are organisations that play host too many different groups and activities on a regular basis, but who also have their own central purpose.

Most prominent amongst these are the many places of worship and the facilities they provide which may not usually be recognised as community assets. What they have in common is that they provide rooms, safe spaces and other facilities to enable small and informal groups to run their activities, often for free or at a minimal cost.

3.3.1. Summary of Findings

The research undertaken to compile the database together with analysis of the data gathered from the interviews highlighted a number of findings. These are summarised below.

3.3.1.1 Utilising and sharing community assets

The following quote gives a broader definition and understanding of what is meant by a community asset. "Every community has a unique set of skills and capacities to support community development. Small informal groups of people working with a common interest are critical to community life. These don't control anything; they just come together around their shared interest through individual choice. Beyond that there are paid groups of people who are generally professionals and are structurally organized, including public services agencies, private businesses, and the voluntary and community sector. They can all be valuable resources. The assets of these organisations enable the community to utilise valuable resources and establish a sense of collective and civic responsibility." (*Building Communities from the Inside Out: A Path Toward Finding and Mobilizing A Community's Assets*, 1993 by John L. McKnight and John P. Kretzmann).

For these assets to be realised, there needs be a willingness between people and organisations to share their assets. This is often facilitated by people such as community development workers, and key individuals within the community who connect people. It takes time to find out about individuals and develop trust and build relationships between individuals and groups, yet this approach can be seen as peripheral or secondary to the achievement of outputs and targets by funding bodies.

3.3.1.2 Sustaining community assets

Potential funding sources for community assets are seemingly limitless yet the reality is somewhat different. Much funding coming into Bradford has been sourced from the European Union (EU). The result of the EU referendum coupled with the current austerity measures is expected to see a reduction in the funding available and increased competition, thereby making funding harder to source and secure.

For smaller organisations and groups this will be compounded by the fact they do not often have the time or expertise to seek out funding opportunities and complete the frequently lengthy and rigorous application process. This combined with funders regularly setting more and more rigid criteria and monitoring processes, and narrowing the scope of projects, could result in many falling at the first hurdle in their attempt to secure funding to grow and develop.

It is therefore important for smaller and/or informal groups, not dependent on public funding but who raise their own funds or apply for small pots of money for specific programmes, projects or equipment/resources, to have access to 'grants' programmes. For example Bradford Council's Community Chest, and programmes such as the Grassroots Grants programme, managed by CNet, which is now discontinued but has previously provided grants of anywhere between £100 and £5000 to over 800 groups in the District.

3.3.1.3 Working in partnership

Procurement and commissioning processes, and increasingly stringent 'due diligence' demands are, at the very least, encouraging the development of partnerships, consortiums and mergers. In addition the desire of some funding bodies to contract with fewer and fewer VCS organisations and groups is seen to be placing a burden on small groups to take the partnership/consortium route and abandon their traditional informal practices. However, it is these informal operating practices which members of the groups appear to value most.

Whilst for many small and/or informal groups partnership with other organisations and groups is a key factor in their ability to provide services and activities, they would not wish to take the route of becoming part of a larger more formal partnership. Many indicated they would prefer to stay independent and remain focused on the activities and services they have been running successfully rather than be embroiled in such time consuming upheavals.

The need for funding in order to sustain groups does change this perspective. Artificially created partnerships brought together in order to apply for larger commissions have the danger of subsuming the individual, local and more specific role of a small group into a larger, more "generic" and less personal organisation. These partnerships often last only whilst the funding does, and all the time and effort in creating them can be wasted in the

long term. In addition, each partner has its own way of working and set of values, which can lead to uncomfortable and even damaging compromises.

3.4 Conclusion and Recommendations

3.4.1 Women's Groups Database

It is clear from the interviews and the sheer number of VCS organisations and small informal groups providing a superabundance of activities, courses, resources and facilities that these are essential to the health and well-being of women in Bradford, not only in preventative work, but also throughout illness, recovery and beyond.

Better, closer and more trusting relationships without necessarily the need for developing a formal partnership, between these organisations and groups, the NHS and Local Government is in the best interests of women and children's health. It is also vital to the sustainability of the groups and the VCS in general.

3.4.2 Community Assets Database

There is no single answer to the sustainability of community assets. However closer co-operation between asset holders, sharing skills and resources and a better knowledge about what services and activities are available, together with supporting and encouraging self-sufficiency, enterprise and creativity amongst communities would go a long way in helping groups and communities be more resilient. A key issue for consideration is the development of the idea that collaboration between public services and the VCS, together with a holistic approach to community members/patients is needed

In respect to health and well-being there are already initiatives encouraging and promoting cooperation, collaboration and informal partnership work between health services, VCS organisations and individual volunteers. Examples can be found in appendix 16. Such initiatives can significantly enhance relationships between health services and the VCS as it is recognised that VCS organisations and groups provide interventions which enhance the health and well-being of patients.

3.4.3 Recommendations

Detailed below are the proposed recommendations resulting from the findings of the local research and mapping.

Recommendations:

13. Improve knowledge of the facilities, activities and services available and increase awareness amongst GP's, health care professionals, organisations, groups and communities of how to access them. For example:
    - Share and disseminate information about the organisations and groups contained within this report, subject to permissions being granted.

- Improve, enhance and share social media platforms in order to offer as many options for people to find and receive information about the services offered by all providers.

14. Annually review and update both the Database of Women's Groups and the Community Assets Database.
15. Develop a joint Cultural Awareness Programme for health care professionals, community workers and volunteers.
16. Provide training and qualifications for "health and well-being" volunteers to support personal development and encourage long term opportunities.
17. Promote and expand holistic approaches based on a social model of health. For example the use of social prescribing to direct and support people to access activities that are not directly health focussed but have health and well-being benefits, particularly in relation to promoting and sustaining good mental health i.e. gardening.
18. Improve information by providing it in more accessible formats, different community languages and on specific services and conditions.
19. Build on and share initiatives and good practices followed by GP Practices, Health Professionals, VCS organisations and local groups, and create methods to disseminate this on a regular basis.
20. Encourage and support GP practices to work with local community assets to develop and promote joint services that would benefit and support vulnerable people e.g. buddying and befriending schemes.
21. Investigate opportunities to provide small grants for local groups with a broad health and well-being focus.

4. Engagement

4.1 Methodology

The engagement aspect of this work was intended to be two-fold. Firstly engagement with seldom heard women would result in qualitative data on the barriers existing for women and allow for a better understanding of their experiences of the three specific clinical areas as set by the CCG's. Secondly it would increase awareness of the WHN in the women's sector and enable a better understanding of how the network should function in order for women to engage effectively.

4.1.1 Seldom Heard Women

Both stages of engagement have been biased towards hearing the views and experiences of seldom heard groups of women. These are women who are living and using health services in the District but who do not currently have a collective voice in other forms of consultation and engagement. Reasons for this may include: they are newly arrived in the District, are small in number and they often experience multiple barriers, such as language barriers, when accessing health services.

Prior to the commencement of engagement it was agreed to target specific groups of women whose voices and experiences are not heard e.g. women with experience of the criminal justice system. A full list of those targeted can be found in appendix 17. Knowledge and contact details of these groups came from CNet, the team delivering the work, CCG staff and other contacts within the voluntary and women's sector.

The women who participated ranged in age from 17 to their late 50's. However the majority of women were aged between 20 and 35.

4.1.2 Anonymity

Several participants requested that they and the group they associate with remained anonymous in this report. Some women did not feel confident that their details would not be used for other purposes. This remained a concern despite not collecting individual data on those spoken to.

A number of the groups felt they wanted to be able to give their genuine experiences and views of health services without being concerned that any views may impact negatively on any current or future relationship with health services. This was particularly relevant for groups who are currently commissioned by health or hope to be in the future. Others felt that it was important that they weren't judged on their identity and that their experiences should be of value regardless of who they are. These groups agreed to be identified as a particular category of seldom heard women. Appendix 18 gives a list of those organisations and groups who participated in the first and second stages of engagement and agreed to be identified.

4.1.3 Stage 1

For the first stage of engagement contact was made with professionals and volunteers working with women who use local health services, and also directly with women themselves, including some who were not formally engaged with any recognised organisation or group. During this stage 36 women were engaged with. Of these 39% (14) were professionals and 61% (22) were women service users. Interviews took between 20 and 90 minutes each.

The engagement took the form of face to face unstructured interviews with women, either on a one to one basis or in small groups. The focus of these discussions were around barriers that women experienced in accessing health care, particularly any relating to their specific circumstances, along with suggestions of how these barriers could be addressed. The discussions were also used as an opportunity to get their feedback on the development of the WHN and specifically on how best the network should function in order for women to engage effectively. Some of these discussions included the clinical areas agreed upon by the CCG's, however the time spent on each area was determined largely by those being interviewed and inevitably a broad range of topics emerged. The sample of women engaged with came from seldom heard groups or were working with those from seldom heard groups.

4.1.4 Stage 2

For the second stage of engagement a total of 7 focus groups attended by 56 women were held. Each focus group lasted between 1 and 2 hours.

The focus groups were semi-structured and led participants through the three key clinical areas identified by the CCG's, see appendix 19, via the use of a series of questions or prompts, followed by discussion. The particular interest or experience of the groups determined how long each area was discussed. Time was given during each focus group for feedback and ideas for how services could be delivered more effectively particularly in relation to addressing any barriers the women identified.

The intention was to hold more focus groups and whilst there was interest from additional groups the time it took to arrange each session, which mostly needed to be held during term time, meant not all those who wished to participate were able to. Additionally some focus groups were cancelled due to a lack of participants on the day or the unavailability of staff. Finally other groups were interested in participating in the work of the WHN but due to the age of their members the particular clinical areas being focused on meant they could not be prioritised during this stage of engagement.

4.2 First Stage Engagement

4.2.1 Summary of Findings

A range of issues were raised during the first stage of engagement, from which a number of themes emerged. These together with suggestions and ideas for improving services in the areas identified were reported on in the WHN Interim Progress Report which can be found in appendix 20. Two of the main themes are detailed below. The third main theme was cervical screening. This is however one of the clinical priority areas the second stage of engagement focussed on so is reported on in section 4.3.1.1.

4.2.1.1 Access to Services

The main topic raised by women was access to services, particularly access to GP's. A number of points were raised which are summarised below:

- Many women were registered at surgeries who operate a morning telephone appointment system and said how difficult this was to access at the prescribed time of 8am or 8:15am. It was found to be particularly difficult for those without good English and those women busy trying to get children ready for school (see section 4.3.1.3 A).
- Difficulties in registering with a GP and/or with GP receptionists and the service received.
- Language barriers and the lack of translators or lack of understanding of how to access a translator. Also the inappropriateness of some translators such as a male translator being provided for a female patient.
- There was concern expressed in relation to what information women felt able to share with health care professionals. For example women felt it was important for the health care professional to 'like' them or 'approve' of their choices, and that avoiding being judged or 'told off' was a major factor in how care was accessed. Women acknowledged that this might then effect the care or treatment received as the care provider was not necessarily being given accurate information but they felt that approval was more of a priority (see section 4.4.3).
- Some, especially vulnerable groups, were suspicious of accessing GP or other health services, particularly if they knew there was information on their medical records relating to previous experiences of domestic abuse, drug or alcohol misuse or mental health issues. In such cases women felt that each time they accessed health services for themselves or their children their parenting abilities were being judged. Their fear of social services getting involved and their children being taken into care meant they did not access services or did so reluctantly.
- Several women raised concerns about confidentiality commenting that they did not always feel confident that administrative or support staff would be bound by professional confidentiality. This was a particular concern when they were seen by people they knew or were related to or when accessing specific clinics e.g. Midwife clinics where their reason for attending would be known. They felt that concerns in

terms of confidentiality could compromise their attendance or would be a cause of stress to them (see section 4.3.1.3 F).

- Many women felt that services should be more accessible and locally based but with more put in place to guarantee anonymity.
- Some women did have good experiences to report and found that they had followed a pathway of referral to a specific service successfully and smoothly and were appreciative when this happened.

Further information on access to health services was gathered at the WHN Clinical Priorities Workshop held on the 25th May 2016, see appendix 22. This report includes a summary of what enables easy access to women' health services, what the barriers to accessing services are, and suggestions as to what can be done to improve access.

4.2.1.1.1 General Practice Patient Survey

Access to GP's and making appointments form part of the annual General Practice Patient Survey (GPPS), along with opening hours, out of hours NHS services and quality of care received. The survey results published in February 2016, based on data collected between January and September 2015 correlate with the findings on access to GP services identified during both stages of engagement. The national average for patients describing their 'overall experience' of their GP as 'very good' or 'fairly good' was 85%. For the 27 GP practices within NHS Bradford City CCG the figure was just 70%, the lowest figure anywhere across Yorkshire and the Humber by 11%. Of the 27 GP practices only two achieved a rating above the national average. The figure for the 41 GP practices within NHS Bradford Districts CCG was 81%, the second lowest figure across the region.

The response of the CCG's has been to highlight some of the measures they have been taking during and since the survey. They have funded customer care training for GP receptionists and are looking at ways to improve access to local GP services. They are also exploring the development of new models of care, which place patients at the centre of their care. Sharing good practice and resources between GP practices is being encouraged and practices have been working together with Patient Participation/Reference Groups since April 2016 to produce "access action plans". For more detail on the GPPS results published in February 2016 and for examples of initiatives some GP practices are implementing in response to the findings of the GPPS. see appendix 21.

4.2.1.2 Lifestyle

Most women reported that whilst improving their own health and that of their children was a priority, actually knowing how to achieve this and what support they could access to help them was lacking. A number of points were raised in relation to adopting and maintaining a healthy lifestyle. These are summarised below:

- Women reported that the cost of exercise and a healthy diet are barriers and that their roles as mums/carers restrict their ability to prioritise their own health.
- Many women felt uninformed about healthy lifestyle choices and are confused about what a good diet should look like for themselves and their children. For example should the concern be sugar, or fat or calorie intake. Healthy eating was reported as expensive and difficult to achieve when preparing food for a family who won't necessarily want to eat healthier choices. Other women reported a cultural incompatibility with a healthy diet, (see section 4.3.1.2 C).
- Women as they became older felt they did not have enough support or access to good information on how to maintain a healthy lifestyle.
- Concern was expressed about the rising rates of diabetes but this was seen as genetic therefore inevitable and also viewed as an illness, not a manageable condition. There was also confusion around Type 1 and Type 2 diabetes and women were either, not aware of what support was available, or did not rate it, (see section 4.3.1.2 B).
- Many women reported that pregnancy/life with small children is very stressful and that being told to eat healthily, exercise more, stop smoking and stop drinking is just not realistic. They felt it was so out of their reach, not relevant or not achievable that they did not feel able to take any steps towards achieving it, (see section 4.3.1.2.E).
- Difficulty in maintaining a healthy weight during and between pregnancies was raised. Many women reported that they and their families view pregnancy and the post-natal period as a time to relax and enjoy more freedom in food choices. They were not aware of the recommendations to only increase calorie intake in the final trimester of pregnancy. They also felt that any link with gestational diabetes was inherited rather than a lifestyle risk. Those who had attempted to maintain a healthy diet reported family members becoming concerned and putting pressure on them to 'eat for two', (see section 4.3.1.2 E).
- In addition to pressure from extended family to eat more there was also pressure not to breastfeed at all or for an extended period. Whilst some Muslim women were aware of guidance in the Quran to feed infants until the age of 2 they reported that tradition and living in extended family networks made this difficult or that caring for older children made this aspirational but not practical.
- Most women were aware of the risks of smoking in pregnancy but found it a difficult time in their lives to stop or reduce smoking. They felt they had to lie to health care professionals about smoking rather than seeking help as they did not want to experience the disapproval and did not want to feel they were being judged rather than supported, (see section 4.3.1.2 E).

Many of the issues detailed above were raised again during the second stage of engagement discussions relating to optimising health when growing a family, see section 4.3.1.2.

Additionally information gathered on the topic of obesity at the WHN Clinical Priorities Workshop, see appendix 22, is relevant as it reports on what enables women to understand the risks associated with obesity, the barriers to exercising for women and suggestions as to how families can be supported to eat healthier and exercise more.

4.3 Second Stage Engagement

4.3.1 Summary of Findings

4.3.1.1 Cervical screening

Most of the women engaged with were surprised to learn that the rates of women attending their smear tests were decreasing locally. Interestingly most women did not refer to intentionally missing tests as a decision. When ignoring letters and delaying appointments they were sincere in their belief that they would undergo cervical screening in the future. Very few women saw themselves as someone who did not attend their smear tests, even if in reality they had put off their test for up to 3 or 4 years in some cases.

A number of reasons were given for why women missed smear tests. These have been themed and summarised below:

A) Test not necessary

Individuals believing that they did not need a smear test due to never or not currently being sexually active was the most common reason cited. Some women were adamant in their belief that a smear test performed before they were sexually active would 'break' their virginity and would have negative consequences when they married. This view was expressed on a number of occasions but only by a small number of Muslim women. This view whenever expressed was always disputed by others in the group but those concerned often highlighted that older female relatives forbade them to attend a smear test prior to becoming sexually active. Group leaders also acknowledged that they felt ill informed on this point and would welcome clear information so that they could counter any misunderstandings, whether cultural or clinical.

B) Stressful period of life

Life being particularly stressful and busy at the time of their required smear test. When pressed women were unclear about when they felt that they would be able to attend and most thought 'soon' but timescales remained unspecified. Arranging an appointment, the rescheduling of other commitments, making travel arrangements and childcare were all expressed as barriers.

C) Scared of result

Women feeling that they needed to attend when they could 'deal' with the consequences of a test result that was not clear. Many women talked about not feeling mentally resilient enough to cope with being asked to attend a repeat test or further treatment. Again these women believed that they would attend in the near future but could not be specific about

when this would be. For some women the fear of receiving bad news meant they chose to avoid the screening even though they knew the possibility of there being a problem was small. They referred to this as being an irrational choice but still a choice they were making.

D) Previous experience

Previous tests had been painful/uncomfortable/embarrassing and so the test was being delayed due to a general reluctance to put themselves through a painful or unpleasant experience again. For some women the experience was physically painful, for others they referred to the attitude of staff as an issue.

E) Lack of understanding

Some women were confused as to what a smear test is testing for and what the consequences would be of missing tests. A number of women felt that the information received with the test reminder is not effective in encouraging women to attend or in informing them of what is being tested for, what to expect from the test and what will happen afterwards. Many women talked about having little understanding of what their cervix was, where it was and what its function was.

4.3.1.1.1 Proposals for addressing barriers

Discussions relating to what could be done to help increase the take up of smear tests highlighted the following themes:

- **Encouragement from GP/Health Visitor etc**. Many women admitted that until they were nagged or encouraged to attend they would just ignore their reminder. They felt that personal contact was far more effective than letters.

- **Acknowledge Anxiety** Create a space for women to share concerns and anxieties over attending smear tests. Health care professionals should not dismiss or belittle women's anxieties or concerns. Women reported that a health care professional's attitude during a previous test can often mean they don't attend again in the future.

- **Relaxation techniques.** One woman referred to how her experience of breathing techniques used in mindfulness helped her remain calm and relaxed in a recent examination. She felt that some support for women on how to relax prior to and during a smear test would help rather than just being advised to relax, which is not always helpful if you do not know how to overcome your own anxiety at a stressful moment in time.

  Several of the group leaders suggested they would be happy to share simple breathing /relaxation techniques with their service users which could be used in a

number of situations such as during a smear test, examinations performed in pregnancy/labour, dentist visits etc.

- **Workshop.** A one to two hour workshop could cover the information above and address any anxiety or confusion amongst women. It could be delivered jointly by health care professionals and 'expert by experience' volunteers. The workshop would need to be adapted depending on the cultural sensitivities of the women attending. It could also incorporate some basic breathing exercises and relaxation techniques that women could use and share with others.

- **Personalised approach**. Women spoke about the different approaches used by health care professionals and how effective or ineffective these were dependant on the individual woman. Some of those performing a test on a women would routinely show the woman the speculum. This terrified some women whereas others preferred to understand fully how the test was to be performed. It did appear however that few women were asked if they wanted to see the speculum. Many reported feeling that their fears or concerns were not acknowledged or were minimised by the health care professional. Some felt that being told that it would be over with quickly was not necessarily helpful as the length of time was almost irrelevant as the focus was the discomfort/pain/embarrassment not the duration of the examination. Some women reported that a plastic speculum had been used in recent smear tests which they much preferred as they felt the hard, cold sensation of the metal speculum was particularly unpleasant.

- **Clarify Reasons for Test.** Health care professionals should ensure women have a good understanding of what smear tests are testing for, who should be tested, what the procedure involves, what would happen if there were any complications etc. For those women who wish there should be time included to use diagrams to explain what and where the cervix is, what a speculum is etc.

- **Empathy**. Women who had a positive experience of smear tests talked about feeling that they were treated with kindness, that their concerns were listened to and taken seriously, that they were asked permission before starting the test, told how they could stop the examination which they found reassuring, that they weren't rushed and that the process and what would happen next were well explained.

Further information relating to factors that could impact on the take up of cervical screening services, gathered during the first stage of engagement can be found in the WHN Interim Progress Report, section 3, see appendix 20. Cervical screening was also one of the topics discussed at the WHN Clinical Priorities Workshop, and a summary of what encourages

women to attend, what prevents them from attending and suggestions to increase the take up of cervical screening can be found in appendix 21.

4.3.1.2 Optimising health when growing a family

Many of the women engaged with were surprised that this was an area of concern for the CCG's and the WHN. However most women did agree that their own health had worsened and was less of a priority to them since having children. Further discussion identified a number of key areas of concern which are summarised below:

A) Mental health

A majority of the women engaged with identified themselves as having poor mental health. Some had sought help and were receiving medication, but had mixed views on whether this had helped or not. Others felt their mental health problems were due to their circumstances and would not improve without a change in their situation. The individual circumstances identified included employment, lack of money, worries about children and parents, their health, state of living accommodation, the benefit system and changes to benefits, their personal and relationship situations. Only a few felt able to improve or manage their own mental health. The majority identified the group they were attending or the organisation they were in touch with as a support. A few had attended sessions on mindfulness which they felt made a difference and gave them back some control.

B) Diabetes.

Diabetes was a common theme, particularly amongst South Asian women. Many had developed diabetes during pregnancy and felt that this was inevitable. Thus they believed it was due to circumstances beyond their control. Very few women reported active management of their diabetes and most women talked about feeling uninformed and confused as to what diabetes is, why they had it and what could be done to manage it better. There was a real mix of understanding, attitudes and experiences of care and support for their diabetes, particularly gestational diabetes. Some women were receiving good quality support, whilst others felt they were just pushed towards medication and then left alone. A few women were still unclear as to whether they had Type 1 or Type 2 diabetes.

C) Weight and fitness

Few women reported taking regular exercise or said that they felt able to manage their weight. Most suggested healthy eating was expensive and too difficult to achieve as they were focussed on preparing meals which they knew their children would eat along with other family members. Not many felt confident on what a healthier diet would involve or what they should include or exclude. Some reported that sessions at children's centres, for example on oral health, had given them more information on the dangers of fizzy drinks for

their children but almost all said they would welcome more information, guidance and support on how to eat a healthier diet which was affordable.

D) Pre-conception health and family planning

Few women reported that optimising their own health was a factor considered when planning a pregnancy. Many did not see their pregnancies as planned, but rather that they were open to the possibility of their family growing. Hence, they were not using contraception and any subsequent pregnancy was welcome.

Following discussion, a number of women could see that there would be benefits of optimising their health, whereas others felt that they did not practise behaviours which would put any pregnancy at risk, such as drinking and smoking. Some felt that cultural or family expectations meant that their pregnancies were not planned in a way which took into account their physical and mental health, financial situation or age of other children. A number of participants did express a level of regret that they were not able to take other factors into account more, and felt that more education and awareness, in the wider community, of the benefits of planning families was needed.

Some women expressed regret that they could not breastfeed for as long as they would have liked, for example because they became pregnant again or because they had other small children to look after. Other women felt that the size of their family was very much a matter for them and their partners and was not determined by other factors, such as the need for optimising their health prior to conception. Very few women spoke about a desire to return to a particular weight or level of health and fitness as a factor in planning pregnancies or family size.

E) Health during pregnancy

Most women were aware of the guidance against gaining too much weight during pregnancy but very few were aware of the specific health risks. Many talked about the pressure from their families to eat large amounts during pregnancy and talked about the enjoyment they gained from ‘eating for two’ without worrying. Some women felt that due to health guidance changing around additional calorie consumption during pregnancy, it was not factually correct or the risks were not serious.

A few women discussed smoking during pregnancy. Of those a small number felt that the risks were exaggerated by health care professionals. Others knew the risks to their child but identified getting stuck in a cycle of smoking. They found themselves smoking during pregnancy due to stress e.g. feeling unwell, financial stress and stress on their relationships. After smoking they felt guilty, and this along with the pressure from health care professionals to stop smoking, added to their anxiety which they relieved by smoking. These women felt that whilst there is more support and better quality support to stop smoking,

this support should be received by someone not involved in their care during pregnancy so that they do not feel judged. Some particularly liked the idea of regular peer support groups during pregnancy, for women who were still smoking or trying to cut down.

Most women felt that they became less active during pregnancy and felt that family and friends would not be supportive of them taking up exercise during pregnancy due to the perceived risks.

F) Contraception

Women seemed to feel that information and support was readily available, and most had been encouraged on multiple occasions by health care professionals to consider contraception soon after having a baby. The keenness of health care professionals on this subject was a source of amusement to many.

4.3.1.2.1 Proposals for addressing barriers

Discussions to identify ways in which services could be delivered differently or benefit women more was quite difficult as most did not see an issue with their health, or the risks of weight gain, management of diet etc.

In order for the WHN to address specific concerns a different approach will be needed that is personalised to the particular women being engaged. However the discussions that took place did enable the following summary to be made in relation to the four areas below which emerged as themes:

- **Mental Health.** The intention was not to focus on this as a themed area of interest as the CCG's were simultaneously carrying out a piece of work around mental health. However, women saw their mental health as being intrinsically linked to their wider health so therefore saw it has relevant to the discussions on the other clinical areas.

  Most groups were keen to hear about techniques to better manage their own mental health. Some women talked about how they felt it affected all areas of their life, from relationships, to parenting, to how they plan their diet, to managing their budget etc. Those groups who had experience of specific approaches such as mindfulness were broadly very keen to continue developing their skills.

- **Diabetes.** It was not clear whether the vast range of experiences of support and understanding was an issue of communication failure, differences in service delivery or availability of services.

  A number of women felt that the support available was geared towards the older generation and that there wasn't enough support for them as younger women.

Some suggested support be linked to schools and children's centres as places where younger women attend. Many women were surprised at the concept of diabetes as a condition which can be self-managed and were interested to learn more about what steps they could take to do this.

- **Weight and Fitness.** Most women felt unable to manage their weight, particularly during pregnancy. Some felt that there should be more group-based models of support during pregnancy and that a regular ante-natal group, where women could receive information, advice and guidance on how to manage their weight and stay active, would be useful. Others suggested if it was not compulsory to attend then they would not go but felt if they were 'enrolled' on a group, and given an appointment in the same way they receive a midwife appointment, then they might be more likely to go. They felt that being put under an 'expectation' to attend rather than just being handed a leaflet did make a big difference in how they viewed an activity. It was also suggested incorporating exercise into the group would be beneficial as some women felt they would be strongly discouraged from exercising during pregnancy as family would think it a risk to the baby.

  In more general terms most women did not know how they would approach improving their fitness if they wanted to. Most cited the cost of activities such as swimming, the challenge of attending an activity, and difficulties of childcare etc. as barriers. Few women saw walking as exercise and where discussions did take place about walking, such as 10k steps a day, getting off the bus a stop early, walking to school, there was a fairly positive response as most women felt it was something within their reach. Some did however feel it was not viable as a year-round activity as walking in winter can be difficult because of the weather, but also because either they or family members would not feel safe with them walking in the dark in the areas where they lived.

- **Partnership Approaches.** At this stage there are no further detailed specific recommendations to make as to how to address the various health issues which fall under this area of concern and any approaches would need to be tailored to the specific group concerned. In general it would seem wise to explore collaboration with maternity services and those delivering diabetes care to maximise benefits to women and to use expertise which already exists amongst health care professionals the VCS in these areas.

4.3.1.3 Managing children's health

This issue was a common cause for concern for all the women engaged with who had children or were responsible for caring for children's health.

During discussions women identified a number of areas of concern. These have been themed and summarised below.

A) Access to GP's.

Many of the women engaged with had experience of the GP practice system of accessing appointments via phone call at 8am or 8:15am. For women with children this was identified as the worst possible time of the day to make an appointment. Some older children should have already left for school by this point so women spoke of the difficulty in deciding whether to keep them at home in the hope of getting an appointment. For those with younger children the difficulty was finding the time to make the phone call at a point in the day which many women described as the most stressful, as children needed help getting ready or needed to be kept entertained. The situation is exacerbated by the fact that it can often take a long time to get through to the surgery to make an appointment, with some women commenting that due to the high volume of calls it can sometime be impossible to even get through at all.

B) School absence policy

Some women felt when their child was off school it was best to take the child to the doctors. They explained this was so they would not get judged for keeping their child off school unnecessarily even though schools do not require a doctor's note.

C) Lack of confidence

Many women felt that it was best for their child to be seen by a doctor when they were ill and many reported feeling reluctant to administer calpol or other medication without the doctor's approval or guidance. The majority of women did not know the difference between a virus or bacterial infection or which conditions would be helped by medication and which just need care at home. Many women did not know what an average temperature was and what temperature would need medical attention, and many did not own a thermometer.

D) Lack of knowledge/awareness of alternative services

Women admitted that even if they did know about other services they preferred to access help directly, via a GP or A&E. A range of reasons were given for this including; not trusting a diagnosis by the 111 service over the phone, a belief that seeing alternative professionals such as a pharmacist or practice nurse would just waste time, as they cannot prescribe and are not experts, and not wanting to take risks with their child's health. Some did not know that other services existed.

E) Immunisations

Only a small number of women engaged with had concerns about attending the necessary appointments for their children's immunisations with most reporting that they attended appointments.

F) Confidentiality

Many women cited concerns about levels of confidentiality when accessing healthcare. Most concerns related to their local GP practice but for others the concern was broader. For some the concern related to them having fled domestic abuse or having had to move area and being concerned about their details being shared. For others the concern was knowing someone or being related to someone who worked in their local practice. Many felt convinced that their personal information would be accessed and highlighted that they did not know how to prevent this from happening. For some women this meant they did not access healthcare as timely or as often as they otherwise would.

4.3.1.3.1 Proposals for addressing barriers

As only a few women felt that they accessed their GP or A&E services unnecessarily when their child was unwell, discussion on what would encourage more appropriate use of services was difficult. However discussion highlighted the following suggestions:

- **Short courses/workshops on common childhood ailments.** Many of the women expressed an interest in learning more about managing their child's health together with information on the various options of where care can be accessed. It was suggested such courses/workshops could happen in schools or in children's centres.

- **Confidentiality.** More reassurance that staff are not able to access information on patients they know is needed. Some women suggested this could be displayed publicly in surgeries to reassure patients.

- **Increased awareness of healthcare options.** Clear and simple information on the various ways to access health care, for example GP, 111, online etc. and when these should be used. Women felt this information should be distributed with the Red Book, be displayed publicly, could be printed on a fridge magnet or in other ways that can be easily accessed when needed.

Managing childhood illness was also one of the topics discussed at the WHN Clinical Priorities Workshop, and a summary of what enables women to manage their child's illness appropriately and with confidence, what prevents some women deciding on appropriate action, and suggestions to improve women's confidence to make the right decisions can be found in appendix 21.

4.4 Conclusions and Recommendations

4.4.1 Women's Groups and Networks

Groups and networks are important to women, not only as a way of supporting their own good health via information and sessions attended but also in recognising that women are part of many social networks. Hence by investing in individual or small groups of women,

the benefits spread much further as women share what they know with many other women in their lives. These networks are influential so the importance of correct health messages cannot be underestimated.

4.4.2 Health Messages.

The ways in which health messages are given to women needs revising. Many women reported being confused about health messages or how to implement health messages. There was a lack of awareness within the women's sector as to whether health messages actually have an impact on health and lifestyle. Lots of information is provided but not enough consideration or support for how to implement health messages is given. For example women may have an awareness of the importance of physical exercise but do not know how to include this in their lives and cited barriers such as cost, time, mental health, resilience, weather and childcare.

4.4.3 Peer Support

It is important to recognise the role and strength of peer support models and models not delivered solely by health care professionals. Women placed a value on the relationship with their health care professional but felt that where there was a risk of being judged for a poor health decision, such as smoking or poor diet, they would lie rather than risk being judged. Women did not feel this happened when in a peer support group or when working with non-health professionals as they felt less likely to be judged.

4.4.4 Collaborative Approaches

For the engagement aspect of this work it was agreed to conduct a mixture of individual conversations/interviews and focus groups on the agreed topics. Whilst these were largely successful in obtaining feedback on specific topics and the proposal for a WHN, they were not as successful in generating new ideas or alternative ideas/ways of working. This is not entirely surprising in itself as asking a group of service users how things could work differently without providing them with knowledge or information from those providing the services have is quite restrictive.

It will be vital for the WHN moving forward, or any organisation engaging via the network, to be clear about the purpose of the engagement and how the data gathered will be used to inform and influence service planning and commissioning. Focus groups and one-to-one conversations/interviews can be effective in developing a better understanding of barriers/perceptions/attitudes of service users but tend to be less effective in developing ideas and creating alternative ways of working. If the objective is to also create more collaboration, increase levels of engagement from service users and generate different models of service delivery then different models of engagement should be used such as co-production. It would also need noting that this further level of engagement would require a

longer timescale and deeper level of commitment and engagement from those currently commissioning and delivering the services concerned to be effective.

4.4.5 Difficulties of Engagement

For a variety of reasons the second stage of engagement proved more difficult than initially envisaged and the following are worth considering for future work:

- **Timing.** Both Eid and the school holidays had a big impact on the availability of groups. The majority of groups took time off for the summer holidays and began winding down their activities some weeks prior to schools finishing. Any future engagement work needs to be planned around the availability of staff of women's organisations and women themselves, and lead in times need to exist to enable communication with women's groups prior to any engagement.

- **Lack of interest.** There was not an overwhelming level of interest to participate in the second stage of engagement focus groups. Many of the groups approached already participate in consultations with health and other bodies. Some members of staff reported that including too many consultation sessions per term can result in fewer women attending their groups. For others they did not find the topics particularly interesting or relevant. Most women had not heard about the WHN so had no awareness of what they were contributing to, nor was there an existing record of engagement and impact to benefit from.

- **Real cost of engagement.** Many groups were keen that their frustration of the perception that engagement with women and service users is free at the point of engaging with women should be fed back to the CCG's. If groups and service users are not compensated in some way for their engagement, the VCS are absorbing this cost. Some organisations were reluctant to engage because no financial incentive was being offered to the organisation or the participants. As other consultations taking place at the same time were offering financial rewards this did result in little interest from some groups.

- **State of the voluntary sector**. As evidenced in other parts of this report, it is known that locally that the VCS is shrinking each year. Some women's groups either no longer exist, are run by fewer staff on less hours or are dependent on volunteers. Again this made the process of arranging to visit or meet with women more difficult than anticipated.

- **Relationship Risk**. A number of organisations were hesitant to engage. For some this was because they had not heard of the WHN so were reluctant to engage in a process they did not feel would have an impact because it was unknown to them. For others this was because they were either commissioned or hoped to be

commissioned by the CCG's and were concerned that anything negative which emerged during the engagement process could damage the relationship they had built up with the CCG's. As a result some organisations requested anonymity whilst others declined to participate.

- **Commitment**
  A number of participants and group leaders highlighted that establishment of the WHN will require long-term support and commitment from the CCG's through appropriate channels. They felt that there needs to be an attitude of openness and that consultation should be participative, creative and ensure that the outcome is a true reflection of the discussions, demonstrating genuine co-production.

4.4.6 Recommendations

Detailed below are the proposed recommendations resulting from the findings of the first and second stage engagement.

Recommendations:

22. Develop a range of community based themed workshops facilitated jointly by health care professionals and 'expert by experience' volunteers, targeted at specific groups which not only share health messages but support women, organisations and groups to implement those messages. For example:
    - Cervical Screening Workshops that incorporates information of what it is, who should be tested and why, 'myth busting', what the procedure involves, what do the results mean, what are the treatment options etc and techniques on how to relax during an examination.
    - Healthy Eating Workshops that provide guidance, information and support on how to eat an affordable healthier diet.
    - Planning a Family Workshops that educate and raise awareness not just of women but their families and the wider community of the benefits of pre-conception health and family planning.
    - Diabetes Workshops for younger women linked to schools and children's centres that provide information, advice and support.
    - Managing Common Childhood Illnesses Workshops that provide information, advice and support which help parents to manage their child's health, and access the most relevant and appropriate care if required.
23. Explore providing stop smoking support during pregnancy through peer support groups facilitated by 'experts by experience' volunteers.
24. Explore developing a more formal 'enrolment' process for ante natal classes/groups and incorporate an element of physical activity into the session.
25. Explore ways of improving access to indoor and outdoor sport and physical activities for women.

26. Further develop care and support packages tailored to the needs of individuals and their families.
27. Explore alternative GP appointment booking processes that recognise and respond to the findings in this report, see section 4.3.1.3 A.
28. Provide clear and simple information on the various ways to access health care e.g. GP, 111, Pharmacy and when these should be used. Examples for distributing this information included the Red Book, through production and distribution of fridge magnets.
29. It is important to engage women as equals in the redesign of services to ensure effective solutions that are accessible and beneficial to the women of Bradford. This must include partnership working between commissioners, VCS organisations and groups, and the women.
30. When engaging seldom heard women it is important to recognise and value the trust that has been nurtured by the VCS organisations and groups supporting those women. These organisations and groups provide a 'gateway' to access and engage seldom heard women and consideration should be given to compensating them appropriately.
31. Consider those women not in networks or groups and reassess regularly who are the seldom heard women as they may change in geographical areas and within particular areas of health services.

5. Network Development

The activities, including meetings and workshops, which took place between February and April 2016 to develop the WHN are detailed in the WHN Interim Progress Report, see appendix 20.

Since April there has been one further WHN workshop in May and two further WHN meetings, one in July and one in September. The two hour workshop held on the 25th May 2016 focused on four topics; Access to Health Services, Cervical Screening, Childhood Illness and Obesity. A total of 28 people from a range of organisations and groups, and interested individuals attended the workshop.

Following presentations on each of the four topics attendees explored what factors enabled or prevented women from accessing health services, having smear tests, making appropriate decisions when managing childhood illnesses, and managing the risks associated with obesity. They also identified what could be done to; improve access to health services, improve the take up of cervical screening, support and enable parents to better manage childhood illnesses, and support families to eat healthier and exercise more.

Participants rotated around discussions groups, facilitated by WHN members, thus enabling them to contribute to each of the four topics. The views and suggestions gathered were collated and themed, and can be found in the WHN Clinical Priorities Workshop Report, see appendix 22.

The WHN meeting held 21st July 2016 was to formally develop the network. It focused on the structure of the WHN, including terms of reference and membership, and how the WHN will link with existing forums such as Bradford District Women's Forum and Bradford Assembly Health and Well-Being Forum. This meeting attended by 25 members also explored the role and responsibilities of the Chair(s) of the WHN and two interim Co-Chairs were selected to serve an initial term of two months. At the last WHN meeting held 22nd September 2016, which 19 members attended the terms of reference, see appendix 23, and the role and responsibilities of the WHN Chair/Co-Chairs, see appendix 24, were agreed.

Currently there are 105 women from a range of organisations, groups and interested individuals on the WHN email distribution. Of these 39 have responded to a recent email to formally opt into the WHN confirming they wish to remain involved and on the WHN mailing list, only two not included in the 105 chose to opt out.

Testimonials from some members of the WHN, see appendix 25, are evidence of the passion and enthusiasm that exist for a WHN and the welcome opportunity the WHN provides for women to share their experiences of health and social care, highlight areas of concern and suggests ideas for improvements. There is a desire supported by a strength of commitment

by members to see the WHN succeed and to play an instrumental role in improving health and social care services for the women of Bradford and their families.

"I have found the WHF a very effective group, it has made so much progress in such a short time scale. In order to build on the work done already, the WHF will require vital financial support to further maintain and sustain the forum, so that in turn it can make a much needed difference and help cater for the needs of women in the Bradford District"

"There's been a real energy and positivity in seeing women working together; negotiating, sharing and learning from their experiences and talking about the best way forward for how we can make things better for women across the district. I have a real sense of being part of something positive and which has a "can do" approach."

"I attended with my baby & left feeling empowered to help it (WHN) grow. Every meeting Verona & I have attended has been welcoming & enjoyable. I have connected with a broad range of people & gained an abundance from listening to others knowledge & experiences whilst sharing my own."

"I look forward to working with the WHN and our current & future partners to find a way to hear the women that are unheard, see the unseen & reach those that feel isolated or unreachable for whatever reason."

WHN Members

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6. Next Steps

To develop and grow the WHN further and secure its long term future it is suggested the WHN, NHS Bradford City and NHS Bradford Districts CCG's give further consideration to the findings within this report and that the recommendations be the focus of further work as detailed below:

- agreed, prioritised and owned across the WHN and the CCG's
- discussed further to ensure they are meaningful, unambiguous and clear proposals
- turned in to 'SMART' (Specific, Measurable, Attainable, Realistic, Timely) objectives where possible
- formulated into an action plan for implementation

Appendix 1: Full list of documents and website used in the desk research and examples of good practice and success stories

1. A glass half-full: how an asset approach can improve community health and well-being – I&DeA

http://www.local.gov.uk/c/document_library/get_file?uuid=bf034d2e-7d61-4fac-b37e-f39dc3e2f1f2 (Health Champions example, Pg 11)

2. Development of a Method for Asset Based Working

http://info.wirral.nhs.uk/document_uploads/Downloads/NW%20JSAA%20Report%20v1.0.pdf

3. Head Hand and Heart Asset Based Approaches in healthcare

http://www.health.org.uk/sites/health/files/HeadHandsAndHeartAssetBasedApproachesInHealthCare.pdf

4. What is co-production?

http://personcentredcare.health.org.uk/sites/default/files/resources/what_is_co-production.pdf

5. Co-production: A New Healthcare Model for the 21st Century

http://www.opm.co.uk/blog/coproduction-a-new-healthcare-model-for-the-21st-century/

6. Women's voices on health – addressing barriers to accessing primary care – Women's Health & Equality Consortium

http://www.maternityaction.org.uk/wp-content/uploads/2014/05/Access-to-Primary-Care-report-FINAL.pdf

7. How to develop a women's network or forum – Women's Resource Centre – October 2010

http://thewomensresourcecentre.org.uk/wp-content/uploads/1_wrc_how_to_develop_a_womens_network_or_forum.pdf

8. Women Centred Working – Defining an Approach – WomenCentre

http://www.womencentredworking.com/wp-content/uploads/2014/08/WCW-defining-an-approach-document.pdf

9. Showcasing Women Centred Solutions – WomenCentre
http://www.womencentredworking.com/wp-content/uploads/2014/09/WCW-A4.pdf

10. Taking Forward Women Centred Solutions – WomenCentre
http://www.centreforwelfarereform.org/uploads/attachment/507/taking-forward-women-centred-solutions.pdf

Websites:

1. Bilingual Health Advocacy

http://whfs.org.uk/index.php/what-we-do/past-projects/30-bilingual-health-advocacy

2. Hodan Somali Community - Health Empowerment and Engagement Club for Women

http://www.hodan.org.uk/what-we-offer/health-empowerment-and-engagement-club-for-women/

3. AETNA – Why engaging women as decision-makers improves health care for all

https://news.aetna.com/2015/04/why-engaging-women-as-decision-makers-improves-health-care-for-all/

4. BME Health Forum – Good Access in Practice. Promoting community development in the delivery of healthcare

https://news.aetna.com/2015/04/why-engaging-women-as-decision-makers-improves-health-care-for-all/

5. Royal College of General Practitioners, Inclusion Health. Improving access to health care for Gypsies and Travellers, homeless people and sex workers

http://www.rcgp.org.uk/news/2013/december/~/media/Files/Policy/A-Z-policy/RCGP-Social-Inclusion-Commissioning-Guide.ashx

6. Department of Health – The Gender and Access to Health Services Study

https://www.menshealthforum.org.uk/sites/default/files/pdf/gender_and_access_to_health_services_study_2008.pdf

7. Royal College of Obstetricians and Gynaecologists. Bringing to life the best in women's health care

https://www.rcog.org.uk/globalassets/documents/guidelines/highqualitywomenshealthcareproposalforchange.pdf

Examples of good practice and success stories

1. Inspire Women Oldham

http://www.oldham-chronicle.co.uk/news-features/8/news-headlines/98430/inspirational-women-land-250000-lotto-cash

www.vaoldham.org.uk/sites/vaoldham.org.uk/files/VAO%20newsletter%20Autumn%202012.pdf (Page 5)

2. Rochdale Women's Welfare Association

www.rochdaleonline.co.uk/sites/rochdale-womens-welfare-association

3. The Older Peoples Partnership Group – Hull

www.hull2017.co.uk/discover/article/older-people-get-creative-september/

4. Hull All Nations Alliance (HANA) and Eastern European Engagement

http://hanaonline.co.uk

Appendix 2: National Research Semi Structured Questionnaire

CNet are in the process of developing a women's health network on behalf of Bradford City and Bradford Districts Clinical Commissioning Groups. As part of the work, we are speaking to people across the country about their experiences of involving women in the development of women's health services. By health services we mean any service or activity that contributes positively to women's (or their children's) health and well-being.
This interview is being recorded for reporting purposes, quotes will be used (anonymously) – (obtain permission here).
You do not have to answer any questions you don't want to.
You can ask me any questions you want throughout our conversation.

Your details:

Name:	
Organisation:	
Position:	
About your work:	

Section one - your services:

Q1) What services do you provide that aim to improve the health of women?
Q1a) What services do you provide that aim to improve the health of their children?

Q2) How do you identify what health services are needed for women in your area?

Prompt: Focus groups, women's forum/network, ad-hoc consultation, existing community plans, others?

Q3) What are your positive experiences of using this method of engagement?

Q3a) If any, what are the challenges of using this method of engagement?

Q4) Have you used any 'innovative' approaches in delivering women's health services? If yes, please elaborate on what you did?

Prompt – how did you come up with this approach? Were you advised by the service users/others?

Q4a) What worked? Why?
Q4b) What did not work? Why?

Section two – women's health network*s/groups*?:

Q5) Do you have a women's health network/forum or anything similar in your area?

Yes	
If Yes, what is it called?	***(Go toQ5a)***
No	***(Go to Section three)***
Don't know	***(Go to Section three)***

Q5a) What steps were taken to develop this network?

Q5b) What challenges did you face?

Q5c) How did you 'deal' with the challenges?

Q5d) What were the lessons learnt from developing this network?

Q5e) What advice would you give to those creating a WHN in similar areas to yours?

Section three – engagement with 'seldom heard' women:

Q6) What ethnic minority communities do you have in your area?
(Please list)

Q7) How would you describe the level of involvement of women from these communities in shaping women's health services in your area?

No involvement	*1*
Minimal involvement	*2*
Satisfactory	*3*
Good	*4*
Very good	*5*
Don't know	*6*

Q7a) If 'No involvement' or 'Minimal involvement', please explain why this might be the case?

Q7b) If 'Good' or 'Very good' involvement, please give details on how you have achieved this?

Q8) In general, what are the top three health issues for women in your area?

Q8b) What do you think are the main gaps in women's health provision in your area?

Please state top three.

Q8c) What are the main health issues for specific groups of women in your area?

Section four – examples of best practice:

Q9) Do you have any examples of where you have made changes in communication OR delivery with a particular group of women which has had a positive result? *For example more women from the South Asian community have been screened for breast cancer because the service was moved to a local children centre.*

Q10) Do you have any examples of (or are aware of) any creative or innovative practices that has resulted in more women having a say on women's health services and making a difference? Please state:

Q11) Do you want to recommend any other organisations/contacts who would be worth speaking with outside of your area?

Q12) Are there any comments you would like to add about anything we have talked about today?

Thank you very much for taking time to speak with me. This information will be analysed and used in a report which will be available to you in October 2016.

Appendix 3: List of the areas identified for further investigation and the professionals interviewed

Areas to investigate:

Area
Birmingham
Leicester
Oldham
Derby
North Kirklees
Hull
Rochdale

Telephone interviews

The participants:

Depart/Organisation	**Role / Position**	**Area**
University Hospitals of Leicester Trust	Consultant Midwife	Leicester
Mair Health	Health consultant	Leicester
Voluntary Action Oldham	Manager	Oldham
The Collective Partnership	Manager	Oldham
Birmingham Women's Trust	Head of Patient Experience	Birmingham
Hull All Nations Alliance	Eastern European Champion	Hull
Health Watch Hull	Manager	Hull
North Kirklees CCG	Engagement Manager	North Kirklees
Rochdale Women's Welfare Association	Centre Manager	Rochdale
Derbyshire CCG	Public Health Community Engagement Officer	Derbyshire

Appendix 4: Rochdale Women's Welfare Association Case Study

Organisation:

Rochdale Women's Welfare Association (RWWA)

18 Trafalgar Street

Rochdale

OL16 2EB

Centre Manager: Khalda Manzoor

Background:

This organisation was set up in 1984 by three Pakistani women from Oldham. At that time there were no groups where women (especially from an ethnic background) could visit. Women were meeting in houses for tea and coffee and talking out their problems. With the help of their husbands who had contact with the local councilor, the three women ventured out and secured a two-bedroom house in Oldham to start the Rochdale Women's Welfare Association. Now the organisation sees up to 300 women a week.

The current Centre Manager has a wealth of experience in working with women from different communities. She started work as a Youth and Community worker, working with schools from the age of 16. She was on the management board for the RWWA before becoming the Centre Manager.

Partnerships:

RWWA is part of a network of 23 community centres in Rochdale. They meet once a month and link with the CCG, NHS and GP surgeries to talk about any issues that they have identified and work out ways they can be resolved. A similar process takes place with the BME forum.

The centre also has excellent relationships with local and national organisations including Gaddum, which is a Manchester based organisation that provides counselling training and qualifications. They use centres in the North West to do the 100 hours of training and RWWA is one of them. They have had this essential service of bilingual councillors for 3 years.

Consultations and determining what service to provide:

Two major consultation events take place every year, the International Women's event where they invite all the agencies and volunteers and undertake face-to-face consultations and a family fun day, where they consult with children and families.

The RWWA steering group meets every quarter with the Health and Well Being team and that is where they develop an awareness work programme using information collected from the consultations. This year, the consultation showed women wanted to know about breast cancer, cervical cancer and arthritis. They then ask the professionals to come in and talk to

them about these concerns through workshops that happen four times a year. These are delivered in all the relevant languages and there is a good attendance as they, themselves, requested the topic area.

Key projects and programmes at the centre:

Three peas in a pod

The 'Three peas in a pod' project entailed three local community centres working together to look at women's health. The project included educational and interactive talks as well as gym sessions. The project was deemed a success, as 10 women became gym instructors after the programme. They would like to undertake a similar project again in the future.

Health is Wealth Club

The purpose of this current project is to support women to manage their own health well-being and symptoms of their conditions. It is also to promote and support a healthy lifestyle, gain independence and to support women with dementia including carers and families. This project has started to bring women together which has reduced social isolation and helped create in them a sense of belonging with the club. The women have established friendships, received emotional support and overcome the chronic isolation they have been experiencing. This project aims to provide Mental Health and Wellbeing service provision by promoting early intervention and delivering prevention activities.

Girls Youth Forum

The 'Girls Youth' Forum has participated in many activities, which have been well received by the girls and their parents. Activities include healthy cooking, sports, flower arranging and fundraising. One of their notable successes is their 'stress busters' project where 10 of the young women were trained up by professionals on 'how to relieve stress'. They then created a 'how to de-stress' booklet which they distributed through their roadshow along with giving talks to 4 venues across Rochdale. This year their subject matter is domestic violence.

Publicity and networking

The Centre Manager is always publicising their good work, projects and the centre itself. Appropriate and relevant media was mentioned including a local Asian radio (Crescent radio), events, newsletters etc.

How she makes it a success?

"The staff, you have to equip the staff with the skills and knowledge to help and work with these women. Training is essential, I send them to all the training that is available, it is key to run a successful centre. "

Appendix 5: Inclusion of 'seldom heard groups'

Examples of inclusion (source: http://thewomensresourcecentre.org.uk/wp-content/uploads/1_wrc_how_to_develop_a_womens_network_or_forum.pdf):

Women's Resource Centre Policy Forum

The WRC's Policy Forum for London's women's sector has 15-20 members who are women working or volunteering in the voluntary and community sector, and are members of WRC. Meetings take place three to four times per year with some contact in between.

With London's women's sector being so diverse, it is important that this is reflected in the membership of the Policy Forum. WRC also acknowledges that not all organisations represented engage in the forum on an equal footing because of constraints such as time, resources and funding, and also the under-representation of particular communities in policy consultation. For this reason 'seats' on the Policy Forum are reserved for specific groups of women's organisations, which might otherwise be marginalised or excluded from the forum. These seats are based upon both WRC's membership profile. There may be crossovers, where one organisation may fill more than one seat.

The Policy Forum has a minimum number of seats for groups led by and for different equalities groups of women, alongside other targets that reflect the composition of WRC's membership, and also reflect issues of resources. For example, targets are set to limit the number of second tier and infrastructure organisations on the forum so that the emphasis remains on the experiences and needs of front-line organisations. Also, WRC set a minimum number of very small organisations to ensure that engaging these groups in the forum is a priority. Organisations working in violence against women also have a 'seats' reflecting that this key issue of gender inequality is the focus of a large number of WRC's membership. These expectations are contained in the Policy Forum's Terms of Reference so that everyone is clear about representation on the forum.

There are five seats 'reserved' for organisations led by Black, Asian, minority ethnic or refugee women's organisations and a seat each for organisations led by the following:

- Lesbian and bisexual women
- Disabled women
- Older women
- Younger women
- Minority religious communities of women
- Violence against women
- Mental health.

There are four seats for organisations that have an annual income of less than £100,000. The remaining seats are distributed widely across fields of work, communities of interest, and boroughs. Seventy per cent of all Policy Forum members should be from frontline services. Organisations are invited to apply to be members of the Policy Forum, including

inviting applications from particularly marginalised organisations. Where minimum representation is not reached, research is carried out to identify relevant organisations and they are contacted directly by WRC about joining the Policy Forum.

In addition to paying for travel costs, WRC pays a small donation to organisations who attend meetings as a way of acknowledging the valuable time and expertise of Policy Forum members. The total amount available per meeting is fixed at £250 and organisations indicate whether they would like to receive a payment. The £250 is then shared equally amongst those organisations. This initiative has been positively received by Policy Forum members even though the donations are small.

NEWomen's Network

During 2008/09, NEWomen's Network set up a capacity building fund for marginalised women's organisations and groups in the North East to engage in the network. Grants of up to £250 were made available for:

- Support to attend network meetings and events
- To attend a training course or learning programme
- Support to engage in mentoring with another women's group, organisation or project
- An exchange visit with another women's group, organisation or project.

When Black women's groups were found not to be engaging in events, NEWomen's Network held events specifically for the Black women's sector in the north and south of the region and paid for the time of a Black community development worker to encourage and support women's groups and organisations to engage.

CEDAW Working Group

In March 2009, WRC and the Equality and Human Rights Commission held a conference on the United Nations Convention to Eliminate all forms of Discrimination Against Women (CEDAW) in London.

The conference inspired the formation of the CEDAW Working Group to raise awareness of the convention among women's organisations in the UK and to take forward a strategy for the next UK examination in 2012.

Bursaries for travel, accommodation and care costs were offered to make the CEDAW conference more accessible to marginalised women's groups and those from outside of London. Women came from places as diverse as Belfast, Blackburn, Birmingham, Bradford, Cardiff, Cleveland, Coventry, Derbyshire, Edinburgh, Galway, Manchester, Leeds, Newcastle Upon Tyne, South Tyneside, Worcestershire and more. This meant that from the outset, the Working Group had an inclusive base of organisations from across the UK to draw upon.

These are just a few examples of changes that can be made to increase the number or 'seldom heard' women to be part of a forum / group.

A point to stress is that attending meetings with a group and talking about their needs may not be most appropriate and effective way of engaging and connecting with some groups of women. Other approaches and ways may need to be developed to ensure meaningful inclusion. For example, the Women's Health and Family Services in Tower Hamlets use Health Advocates:

"Health Advocates promoted the health of project users and empowered them to achieve better health outcomes for themselves and their families. Health Advocates negotiated between project users and health professionals to ensure that users understood the issues and decisions that affected their healthcare – this could often involve translating not only between languages, but also between cultural understandings." *Tower Hamlets - Women's Health and Family Services*

Appendix 6: 'Women Centred Working'

Essential reading:

1. Women Centred Working Initiative

http://www.womencentredworking.com/

2. Women Centred Working – Defining and approach

http://www.womencentredworking.com/wp-content/uploads/2014/08/WCW-defining-an-approach-document.pdf

3. Showcasing Women Centred Solutions

http://www.womencentredworking.com/wp-content/uploads/2014/09/WCW-A4.pdf

4. Taking Forward Women Centred Solutions

http://www.womencentredworking.com/wp-content/uploads/2016/04/Women-Centred-Working-Taking-Forward-Women-Centred-Solutions-report-Embargoed-until-18_4_16.pdf

Appendix 7: Social Media Platforms and examples of how they might be used in relation to the Women's Health Network.

Facebook - *a*n example of good use of Facebook, especially to engage 'seldom heard' women could be to 'organically' develop a page for women with a broad theme by a member of the community and allow it to grow (through members asking other women to join). For example, a 'Ladies secret group' created by 5 women (the administrators) in Batley, West Yorkshire gained 5k members within two weeks. In their 7th they had 8.6k members and now (a few months on) they have 14k members. The premise of their page is to share food recipes but is not limited to just that. The administrators encourage women to talk about anything on their mind. This has led to conversations on general to severe health issues from weight loss and caesarean section aftercare.

Twitter - is a quick and efficient way of getting information out to people. For Twitter to work in the best possible as many organisations and relevant people as possible should be connected with. This will lead to followers of those organisations and people connecting with the WHN and so on. This knock on effect will enable information to go out to a widespread of people.

YouTube - could be used to upload short videos of the work that the WHN are doing and to celebrate its successes in the future. The most effective way to use YouTube is to make short films of the successes and achievements of the WHN, which may include interviews with women's lives that have changed for the better and a discussion about their journey, this could serve to not only attract more women of Bradford to join and take part but encourage women from all over the country, (or world!) to develop their own women's health network.

Vlogs and Blogs - are a series of written excerpts on the internet where people can write about anything they want, whereas Vlogs are of the same vein but short video clips. The WHN could keep a 'blog/vlog' diary to document their work.

GROU.PS - is a leading social groupware platform that allows people to come together and form private or public interactive communities around a shared interest, work or affiliation. The GROU.PS platform is used to create a wide variety of community sites, including online e-learning classrooms, fan clubs, charity fundraising campaigns, college alumni societies, and event planning portals. Any organisation seeking to aggregate and organise people online can greatly improve its effectiveness, engagement and appeal by migrating to the GROU.PS platform.

NING - gives people the tools and expertise to nurture and engage their own online community on the largest, most scalable, and integrated social platform of its kind. NING is able to help build new websites, integrate any existing online community into the website and re-launch existing sites.

Flickr - is a site that can help manage digital data such as photographs and videos. It is a good way of distributing pictures and videos from events and promoting them on online.

Appendix 8: Examples of successful consultation and engagement undertaken by interviewees

"We struggled with the Pakistani community, the Pakistani centre is usually used for weddings and not much else – the other two centres are more multifunctional. We had to do more targeted work with them and European communities"

"We got Cancer Specialists Macmillan Nurses to work with us and the Community Health Champions were given money as incentives to give to people so they would attend the sessions with the cancer specialist, we had a good turnout of people which was a steep curve upwards. The commissioners and services think that all the information is on the website but we know lots of those community members don't access that at all …we did a lot of face to face work like this with 10 different communities, Roma, Chinese, Pakistani – the Health Champions went and got these people"

"The £20 incentive was a voucher for the local Asian shop that does not sell alcohol or tobacco…one GP did this engagement work it without us (and without incentives) and only one person came! …We filled rooms. We got a bowel screening professional and she broke it down and we interpreted where it was necessary and we found out that many of them threw the bowel cancer testing kits away when received through the post because they did not know what they were!"

This interviewee suggested that if you wanted to 'fill rooms' then some form of voucher incentive should be used. They explained that some people did not feel that this was an ethical approach, but that they referred them to the example of the GP trying to do the same thing but only one person turning up! They also emphasised that the cost of the vouchers would save a lot of money for the NHS as it would identify cancer cases and therefore potentially be able to be treated.

"It is the investment, the return on the NHS is massive. There were few cases where people needed colonoscopies. The money saved if that person doesn't have to go through treatment."

Other participants mentioned large-scale consultations and engagement at events are used to inform their work and what areas they should concentrate on i.e. domestic violence, breast cancer, alcoholism etc.

"We have a massive celebration which consists of 2 days of entertainment which is free for all, inclusive, something for everybody. We have 40 stalls with lots of information. We also have 'Hulls got talent' – the CCG's want to get involved because it is so big. 2000 people attended last time."

"I would say, make the engagement entertaining rather than shoving down people's throats, trying to find something that will get them out of that door and out to get this information."

"We are grassroots – we see patterns, we recently saw the issue of mental health surfacing so we address this – every year we have international women's day about 300 women attending with stalls and we do consultations – identifying problems. We have 2 specific consultation days as well through family fun days"

Some interviewees talked about access and how they worked 'creatively' to 'get' to the audience they needed to. They ranged from training up Community Health Champions and the use of Community Development Workers for the specific area of women and health to going to places where those community members would go, i.e. their natural settings.

"*Go to the women where they are, play groups, add refreshments, tag on, this makes a huge different. Always use their natural settings. You can put on a great event with food in a nice room somewhere and you will have little turnout – you do a bit of research and find out there Quran classes going on in a back room of terraced house and you will get a full house, from over 60-70 women."*

"When we are engaging on a topic that impacts on women we tend to tap into existing groups, meetings and organisations to gain views that way rather than trying to establish anything new. For example when we looked at maternity, we attended children's centres, parenting groups, VCS, schools, clinics, patient reference groups etc. to gain views of women that have accessed or may access the services in the future. We also work closely with our local Healthwatch."

"What we would like is some active links in the community. With women that are accessing and not accessing our services – through mosques, community centres and Duala projects. We want to go out and get these voices heard, we put in a bid to get someone to do this but we didn't win the bid."

"We got funding from CCG and got funding for a community development officer to work with women on health related projects…The community development worker was experienced and knew the community – she was very used to working with hard to reach women, it was very effective".

Appendix 9: Summary of findings from the 'Women's Voices on Health' study conducted by the Women's Health and Equality Forum.

The following are some findings from the research, for the full report please visit: http://www.maternityaction.org.uk/wp-content/uploads/2014/05/Access-to-Primary-Care-report-FINAL.pdf

Black and minority ethnic women

- Several of the BME women we spoke to had bad experiences of not being listened to by doctors. This was linked with language, and not knowing the correct medical terminology.
- Two women who had undergone FGM spoke of highly traumatic experiences of childbirth, with doctors not knowing what to do. The group said that problems persist, with embarrassment preventing women affected by FGM from accessing healthcare.

Refugees and women seeking asylum

- Having had their passport retained by the Home Office made it difficult for these women to register, as GP practices demanded proof of ID but did not always accept their Application Registration Card (ARC).
- Mental health problems were associated with a lot of stigma in this group.

Women with HIV

- Many participants preferred their HIV-clinic to mainstream health services. They felt that GPs were lacking in knowledge and experience relating to HIV, and that clinic staff were e compassionate.

LGB&T women

- Several women had previous experiences of poor treatment from health professionals, sometimes having other health problems attributed to their sexual orientation. For many, the expectation of doctors reacting negatively had become a deterrent to using health services.

Women with disabilities

- This group of women found registration forms to be inaccessible, jargon-heavy and requiring information they did not have. Two participants had asked reception staff for help to fill in the form but were both told this was not possible.
- Cervical screening is a potential neglected area of health for this group. Many of the women found the issue of sexual and reproductive health difficult and embarrassing to talk about. One had asked several times to see a female doctor for this, but her request had never been adhered to.

Appendix 10: Local research and mapping semi structured interview schedule

Please complete as fully as possible – not all questions will apply

Group / Organisation Pro-Forma

Name Of Organisation / Group	
Name Of Interviewee	
Role Of Interviewee	
Address	
Phone Number	
E-mail	
Website	

Profile Questions

1. Can you tell me what services /activities you provide which may improve the health of either women or women and their children even if the purpose /aim is not specifically to achieve health outcomes. (I.e. social benefits, help and support, confidence building).	
2. How often do each of these services/activities take place? (Details for each service and activity)	
3. Are these services and activities targeted towards specific women e.g. young women, Eastern European women, women living in Girlington or specific health issues e.g. diabetes, sexual health?	

Key Questions

1. What impact does your service have in achieving better health outcomes for women and/or children?	**Impact**
Do you have any evidence to support this / how has this been achieved? **N.B**. For those groups who are not specifically health focussed - i.e. What has been the positive benefits in terms of health and well being that your group / organisation has had on the women and /or children participating in your services/activities?	**Evidence**
2. Do you have any examples of where you have made changes in communication with a particular group of women which has had a positive result? (Eg more South Asian Women have been screened because the service was moved to a local children's centre, or peer research has been used to encourage women to take part in a local group which provides feedback on health services and how they can be improved)	
3. What barriers are you aware of, if any, in engaging with the people you wish to join your group and take part in your activities?	

4. What barriers are you aware of, if any, which people you wish to recruit may have in accessing your services/activities?	
5. What would you / your group like to do or offer to develop your services / activities?	
6. What gaps in services for women and children's health, are you aware of, if any?	
7. What improvements in current health services you / your members would like to see?	
8. What do you consider to be the main health issues for women who are accessing your services / activities?	
9. What do you consider to be the main health issues for women in genera?	

Supplementary Question

Do you work in partnerships with other groups or organisations? If so, what does each partner provide? What can your group offer to other partners?	
For local groups and organisations Do you or your group/organisation wish to: Be informed of our research results? Be included in a directory of health and well-being services for women and children? Become a member of the Women's Health Network?	

Appendix 11: List of organisations/groups interviewed

Name Of Group	Role (if any)	Method
Pennine Chimes Ladies Barbershop Choir	Chair	Face to face
Get2 Gether Mil-Jul	Founder	Face to face
Older and Wilder	Co-ordinator	Phone
Messy Church	One of the group leaders	Face to face
Black Health Forum	Secretary	Face to face
Equality Together Ladies Group	Member - self run group - no hierarchy	Face to face
Unnamed Women's Football Team	Organiser	Phone
Clayton Village Hall Extend Exercise Group	Trainer/Tutor	Phone
West Bowling Community Advice And Training Centre	Community Development Worker	Face to Face
The Isis Project For Women and Children	Manager	Questionnaire
Footprints Family Centre	Chief Executive Officer	Questionnaire

Appendix 12: Database of Women' Groups

WHN Women's Groups Database.xls

Appendix 13: Experience of a member of the Ladies Disability Group

As an inpatient, a member of hospital staff serving her a meal was not aware of her disability and left the meal on a table expecting her to find it. A simple notice above the patient's bed informing staff that she was visually impaired would have been an easy solution, and could be done for everyone who has a similar disability, subject to patient consent.

As an outpatient she went for a mammogram and was asked to strip to the waist by the technician. As a result she started to remove her clothes in the waiting room. Fortunately, all the other patients were women and another patient told her and guided her to the right area.

The third incident was also when she was an outpatient at a clinic. Although she is blind, the NHS worker insisted she underwent an eye test as this is something the Consultant insisted on for all his patients, even though the appointment was not about her vision.

Appendix 14: List of general health issues for women and those accessing the organisations/groups interviewed.

- There should be more mums and babies groups (noting that there are plenty of mums and toddlers group). Many women (and especially those with disabilities) need more support with babies. Child care should also be made more freely available.

- Concern was expressed that many parents should have better access to education and that there needs to be more fun exercise activities for women to engage with.

- It is often difficult for people in transient situations (e.g. homeless people/asylum seekers or refugees) to access services for themselves and families. New migrants, asylum seekers and refugees can fall out of eligibility criteria because of immigration regulations/rules and are therefore unable to afford food or housing, which also meant that the children of these families were not attending school. It was suggested that whilst Bevan House is a service which helps to plug this gap, it needs expansion.

- More third sector services available for people who are experiencing mental health problems, additional to statutory services. Improving Access to Psychological Therapies (IAPT) is not working for a lot of people, who report that it is not straightforward in making a self-referral for IAPT services via GP's and CMHT's.

- There were not enough places for women to play sports - such facilities would encourage more women to self-care. These should be safe places for women to bring children whilst participating in health activities, to encourage them to get out of their domestic routine. This would encourage and facilitate more self-care and a more active lifestyle.

- Young people are also not active enough - and more youth clubs should be available.

- There should be joint services - under one roof in the community and that more support and recognition for the preventative work of the third sector, pre-primary care. The gap needed to be bridged between the third sector and mainstream health services. More understanding and better communication between sectors was essential.

Appendix 15: Community Assets Database

WHN Community Assets Database.xlsx

Appendix 16: Initiatives encouraging and promoting cooperation and collaboration between health services, VCS organisations and individual volunteers

1. Altogether Better – an approach that shares learning about the community health champion model and increases the voice of patients and communities in shaping health and social care services.

Altogether Better are developing Practice Health Champions. These are people who voluntarily give their time to work with the staff in their local GP practice or surgery to find new ways to improve the services that the practice offers, and to help to meet the health needs of patients and the wider community. Practice Health Champions are building upon the success of the Community Health Champion model. In addition to individuals using their life experience, understanding and position to influence their friends, families and work colleagues to lead healthier lives the Practice Champions will also use their passion and understanding of the local community to enrich decision making in GP practices through the development of a greater understanding of local need. Champions will also develop new groups to support the health and well-being of the local community. Practice Health Champions are recruited and trained from the local community. Champions reflect the needs and aspirations of the community that the GP practices serve.

Altogether Better is promoting a social model of health and a community assets approach which enables patients, carers and citizens to play a greater role in their health and in health care - a possible future which the NHS Five Year Forward View has asked to be considered. *http://www.altogetherbetter.org.uk/the-altogether-better-approach)*.

It is developing work in Bradford having started working with 10 GP practices in 2013, and is now expanding to include another 11 practices.

2. Yorkshire and Humber Community Empowerment in Health and Well-Being Network - this is an emerging network, established in mid-2009 to build capacity of colleagues in local authorities, local NHS organisations, the third sector and other partners to work together to empower communities to improve their health and well-being. This regional collaborative network model is led by the Yorkshire and Humber Altogether Better Programme, with partners and stakeholders including the Regional Forum. It will provides a forum for sharing learning, best practice, evidence and information, helping to build relationships across commissioners and providers across the region. *(Also from the Altogether Better website).*

3. Patient Participation Group Network - this brings together patient participation/patient reference groups together to share experiences, discuss common issues and feedback views to the CCG's.

4. Social prescribing (also known as community referral) – this is becoming a more widespread practice. (*See http://www.bradforddistrictsccg.nhs.uk/news/social-prescribing-is-just-the-tonic-for-bradford-patients/).*

5. Events and sessions at GP Practices - to promote VCS activities, sometimes with the support of Patient Engagement Leads and sometimes through the initiative of VCS organisations and individual practice managers.

6. Practices and medical centres - offering rooms and facilities to VCS organisations to enable them to run their courses and activities.

Appendix 17: List of women who voices and experience are seldom heard who were targeted for engagement

- Women we engaged with from the following groups:
- Women with experience of the criminal justice system
- Women with experience of domestic abuse
- Women from Central and Eastern Europe (Polish and Slovak)
- Roma women
- South Asian women (some users of mental health support services) (some newly arrived in the UK)
- White British women from deprived areas
- Younger women (below 20 years of age)

Appendix 18: List of organisations and groups who participated in the first and second stages of engagement.

- Womenzone
- NCT Bumps and Babies (Bradford Action for Refugees)
- Biasan
- Bevan House
- Sharing Voices
- Thornbury Centre
- Cafe West
- Staying Put
- Girlington Centre
- Canterbury Children's Centre
- St Paul's Church, BD8
- Anchor Project, BD3
- Khidmat Centre
- Bradford Doula Project

Appendix 19: Focus of second stage engagement

Following discussion at the steering group meeting on Friday 20th May it was agreed that the second stage of engagement, commencing in June and to be delivered through targeted focus groups, will concentrate solely on the following three specific areas.

1. Access to information and help around planning for families

The focus group(s) will explore:

- Optimising heath before becoming pregnant including weight management and smoking cessation
- Access to services for contraception and appropriate contraception
- Women's views on having to access sexual health services when what they want is family planning advice and support.
- Myth busting

Target Group: Disadvantaged and marginalised women both old and young.

2. Cervical Screening

The focus group(s) will explore:

- Why some women attend for cervical screening and others do not
- The reasons why some women do not attend and what it is that prevents them
- What more could health services do to help increase the number of women taking up the cervical screening service.
- Myth busting

Target Group: South Asian women, Central and Eastern European women and young women.

3. Access to healthcare for common childhood ailments

The focus group(s) will explore:

- The reasons why some people are using A&E or other OOH services e.g. 111, Local Care Direct etc. for the treatment of minor childhood ailments
- What it is that makes them use these services as opposed to other more appropriate services
- What could be done to enable and support people to manage minor childhood ailments more appropriately

Target Group: Women living in Girlington, BD3 (Leeds Road area) and Holmewood.

Appendix 20: Women's Health Network Interim Report

Interim Progress Report.pdf

Appendix 21: Women's Health Network Clinical Priorities Workshop

WHN Clinical Priorities Workshop 2

Appendix 22: General Practice Patient Survey results and examples of initiatives some GP practices are implementing.

Highlighted within this appendix are some of the common issues raised by patients and potential solutions. It is not intended to be a comprehensive analysis of patient feedback in all GP practices within NHS Bradford City and NHS Bradford Districts CCG's.

Desk based research looked at the information on 20 GP practice websites (10 in each CCG area), patient surveys, Patient Participation Group, also known in some cases as Patient Reference Group, reports) and access action plans. The examples of seven medical practices, four from NHS City CCG and three from NHS Districts CCG have been used to illustrate what actions are being taken to address patient issues plus the national General Practitioners Patient Survey (GPPS).

In February, the GPPS survey results were published, based on data collected between January and September 2015, and this revealed that patient satisfaction rates in some areas were well below both the national and regional averages. The survey assessed patients' experiences in a number of key areas:

- access to GPs
- making appointments
- opening hours
- out-of-hours NHS services and
- the quality of care received

The national average for patients describing their 'overall experience' of their GP as 'very good' or 'fairly good' was 85 per cent. For Bradford City CCG area the figure was just 70 per cent, the lowest figure anywhere across Yorkshire and the Humber by 11 per cent. Of the 27 surgeries within the CCG, only two achieved a rating above the national average. The figure for the 41 surgeries within the Bradford Districts CCG was 81 per cent, the second lowest figure across the region.

The chair of Bradford Council's Health Scrutiny Committee, Vanda Greenwood has described the results as "very disappointing." *(Telegraph & Argus report, 16th February 2016)*

Nearly 29,000 copies of the survey were distributed to patients across the three CCG's, but the response rate varied from just 17 per cent in the Bradford City CCG - said to be the lowest rate anywhere in the country - to 34 per cent in Bradford Districts CCG. A spokesman for the City and Districts CCG's said work was underway to support GP surgeries in improving patient satisfaction levels, including customer care training for staff and surgeries being encouraged to share examples of good practice.

The response of the CCG's has been to highlight some of the measures they have been taking during and since the survey. They have funded customer care training for GP receptionists, are looking at ways to improve access to local GP services and there is a willingness to share good practice and listen to patients and GPs about the concerns and challenges experienced in general practice. They are exploring the development of new models of care, which place patients at the centre of their care, will also continue to improve patients' experience. This patient centred model is one of the main improvements suggested by the interviewees in our own small survey, along with a holistic approach to the individual.

It should be recognised that GPs and practices continue to be under unprecedented pressure, with an increasing number of practices struggling to maintain existing services in the face of underfunding, falling staff numbers and rising demand. In Bradford, 77% of the population has attended primary medical practice appointments on at least one occasion in the last year (which is above the national average) and 40% of a GP's time is spent seeing patients that present with minor self-treatable illness. Almost two-thirds of these GP consultations result in a prescription being written which could be treated by over-the-counter medicines provided by pharmacists or require no medicine at all. However, this does not mean that improvements cannot be made, and the CCG's accept this. *(Health and Social Care Overview and Scrutiny Committee)*

Sharing good practice and resources between GP Practices is being encouraged by the CCG's and practices are also working together with Patient Participation/Reference Groups to produce "access action plans". These will focus on access to a wide range of staff within the primary care workforce, not limiting this to appointments with prescribing clinicians. It is hoped that the scheme would encourage the use of a multi-disciplinary workforce, including liaison workers, care coordinators and social prescribers and would mean that patients would be seen by the most appropriate person. There is recognition by the CCG's that a different model of improving access to patients within primary care would suit a particular practice population and that, through creative review of skill mix and perhaps wider utilisation of the voluntary and community sector, unwarranted demand on the clinicians within the practice could be reduced. The development of these plans began in April.

GP practice responses and good practice

Bevan Health Care, rated outstanding following a recent inspection by the Care Quality Commission (published in March 2016) was highly praised for the following initiatives:

- Actively seeking, valuing and acting on feedback from the Patient Participation Group (called Experts by Experience) - the group was involved in the design build and decoration of new premises
- A mental health nurse and a vulnerable migrants nurse were recruited to work alongside a practice nurse, to effectively support patients.

- Clothing, food, oral and personal hygiene packs and 'cold weather packs' (consisting of gloves, socks, a hat, scarf, water and a bar of chocolate) were offered to patients who were in urgent need
- The practice had moved to new premises that allowed it to host other services and provide a "one stop shop" for patients. The teams located in the practice included the homeless team, benefits services, refugee support workers, rape crisis, legal, housing, midwifery and health visiting teams

Farrow Medical Centre - actions and initiatives highlighted in their CQC Inspection Report, published in March 2015

- An additional Saturday morning surgery is taking place during the winter months to help reduce weekend pressure on the local Accidents and Emergency department. The practice is working with GPs from eight other practices in meeting this initiative.
- Each patient aged 75 years and over and those patient who were at risk of hospital re-admission, has a named GP who they mostly see at an appointment. They also contact their patients personally with any follow up information about their treatment or care
- The practice provides a service to local hostels; including the homeless, and mother and child. The mother and child hostel was a short term facility which meant they should have been registered as temporary patients with the practice. To improve the care provision, availability and access to services, the practice registered them as permanent patients
- Good working relationships between staff and other healthcare professionals involved in the delivery of service
- Introduction of clinical triage to reduce waiting times & improve access/continuity of care to specific GPs

Mayfield Medical Centre - their Patient Reference Group Action Plan for 2016-17, includes the following:

- Provide a further rapid access clinic in the early evening once per week
- Hold an information day event to share practice services with the local population and to recruit to the PRG, also work with other agencies, such as Carers Resource, and Age UK
- To work closer with Grange PRG - to share ideas and work together in the forthcoming months whilst going through a Shadow Merge

Low Moor Medical Practice - from the Patient Participation Group Action Plan

- A lack of GP appointments, particularly with female clinicians - feedback indicated a requirement for more lunchtime appointments. Following discussions with the PPG the practice expanded its booking of the services of a locum female Advanced Nurse Practitioner from one session per week to 4 sessions per week. One of these sessions was booked 12-3. It was planned to increase the ANP sessions to 7 sessions per week from May 2015. As a result, feedback received from clinicians, receptionists and from the PPG indicates that the extra sessions were appreciated. A more recent GP

patient survey pointed to an increase in satisfaction from patients over accessing appointments when compared to the GP survey scores of nearby practices.

- Patients complained of prescriptions not being ready on time (for patients and pharmacies) and of errors on prescriptions. The practice receives @ 900 requests for repeat prescriptions per week, Monday being the busiest day. Receptionists have difficulty tracking down prescriptions that have gone missing and of securing a GP signature on urgent prescriptions. The practice has undertook to utilise electronic prescribing from May 2015. The practice has also had a successful bid to secure the services of a pharmacist to work 1 session per week to deal with repeat prescriptions. Electronic prescribing will make the whole process more efficient in that it will prevent paper prescriptions from going astray and will mean that the whole process from the patient ordering on line to the prescription being received in the pharmacy will be carried out electronically. The services of the 1 session of pharmacist time will take pressure off the GPs and will result in a person being able to focus on this task rather than it being one of a number of tasks that a clinician has to undertake, resulting in fewer mistakes, greater consistency of approach and a more patient focussed service as the pharmacist will lead this area.

Valley View - **From their Patient Engagement Lead (PEL) report about their Local Improvement Scheme**

- Mechanisms in place to ensure the practice receives representative feedback - liaised with mosques and women's refuge to promote health awareness, worked with Women Zone in relation to health management, worked with Age UK, organised a presentation by a Pharmacy First representative.
- Additional support for patients - a mental health nurse is present twice per week and Citizens Advice Bureau runs a session on a fortnightly basis.
- Identified a need for education amongst patients and organised English classes to meet this need, also assisted another practice to organise similar classes.
- Weekly health talks on various subjects were given at knitting, mendhi and English classes by GPs, Nurse, Pharmacist, Mental Health worker including breast, bowel and cervical cancer screening services to raise awareness and promote self-care.

The Rockwell and Wrose Practice - General Practice Access Plan 2016/2017

- Stopping the practice of chemists ordering prescriptions on behalf of patients - empower patients to order their own prescriptions and work with local chemists to reduce prescription medicine waste and financial inefficiencies. This will stop the over ordering of medicines for patients (e.g. delivering items that are stopped or not requested and increase the uptake of online ordering. The practice is aiming to achieve this by March 2017
- Investment in premises to improve access for disabled patients - installing electronic doors at Wrose and improving the electronic doors at Rockwell. The aim is to have the work completed by December 2016

- Recognition of the increasing incidence of dementia and the need to increase awareness of dementia amongst all practice staff. It is planned to offer all staff the training to ensure optimal care packages are in place for carers and they are signposted to resources that can support them. The training will enable staff to recognise dementia signs and symptoms and improve communication techniques for patients and carers. The aim is to create a dementia friendly environment. The plan is to complete this by September 2016.

Windhill Green Medical Practice - consistently scored higher than the local and national average in all the recent GPPS survey results. They have responded to patients concerns in previous surveys and have taken actions following the **priorities listed in their Patient Report 2014/15**:

- The number 1 priority was to deal with the number of complaints from patients about being unable to see their doctor of choice. The PPG wrote and developed a poster encouraging patients to see 2 doctors and explained the reasons why. This was also put in their quarterly magazine, The PIL.
- The second largest complaint was appointments running late. The co-ordinating Doctor was introduced whereby one Doctor was responsible for all urgent appointments and on –call each morning. This was later changed to the Duty Doctor. Again, this Doctor has responsibility for all matters that arise or are urgent during the course of the morning surgeries. The appointments for the Duty Doctor are not pre-bookable and are for urgent matters only. The practice finds that this works very well, leaving the other Doctors free to conduct their surgeries without interruption for urgent matters.
- The third largest complaint received was that the practice car park at Windhill was too busy and people who are not patients or staff were using it to park all day and perhaps travel from Shipley Station. Unfortunately, no progress has been made. We are unable to extend the car park. Highways are unable to add disabled bays to the road side. Staff have continued to be vigilant with long stay parking and have put notices on cars when we are sure the car is not parked legitimately on surgery business. Issues such as this one are not easily solved, despite the best efforts of the staff.

There are other sources of feedback from patients and carers via NHS Choices, the Patient Advice and Liaison Service (PALS), Patient Network Groups, Healthwatch and complaints received into the CCG's and the GP Friends and Family Test (now a contractual requirement for practices). Along with those considered in this report, these are put together into a single report named 'Grassroots' - a key report that is scrutinised by the CCG Governing Bodies and Joint Quality Committee, City's Practice Quality Improvement Group and Districts' General Practice Performance and Quality Improvement group.

Appendix 23: Women's Health Network Terms of Reference

What is it?

The Women's Health Network (WHN) is a collective of women living and/or working in Bradford who have an interest in issues affecting the health and well-being of women and their families, with a particular focus on the engagement of seldom heard voices

Mission

To improve the health and wellbeing of women and their families

What does it do?

The WHN provides a space for women, particularly those that are seldom heard, to:

- Share their experiences about current health services
- Explore barriers to accessing health services
- Contribute and have a positive impact on improving health services
- Learn more about what services are available and how to use them
- Ensure they get the information they need to keep themselves and their families healthy
- To improve the health and wellbeing of people living and working in the district through effective partnership working.
- Influence policy, planning, service design and delivery of health services

Working Principles and core values:

- **Equity** – consideration of the needs of all women to enable them to participate in all aspects of the WHN.
- **Openness and honesty** – transparent processes that encourage and enable free discussion and collective decision making.
- **Flexibility** – provide a variety of ways to engage, communicate and become involved.
- **Inclusivity** – work in ways that encourage and support all women to participates and show that they are valued
- **Empowerment** – work in ways that build confidence, raise self-esteem, transfer skills and knowledge and enable women to have more control over decision that affect their lives.
- **Influence change** – work proactively to influence the key decisions that affect the health and well-being of local women and their families

Membership/who can be part of it?

The WHN is open to all individual or groups of women living and/or working in Bradford and, Voluntary, community, private and public sector organisations working to support the health and well-being of women.

Communication

The network will provide an effective channel of 2-way communication between the women of Bradford and Clinical Commissioning Groups, the local authority and other statutory bodies, Voluntary and Community Sector (VCS) networks and organisations.

Task and Finish Groups

Task and finish Groups may be set up as required.

Election of Chair (s)

- The Chair (s) will be elected by the network.
- The process could be nomination and election. Network members may self-nominate, each member will be entitled to vote (one vote per individual/group)
- The elected Chair(s) will serve for a period of two years subject to honouring the commitment set out in the role and responsibilities.

Meetings

i. Open themed meetings will take place quarterly or as necessary. Task and Finish Groups will be set up to arrange and facilitate the open meetings.

ii. A quorum of 3 members of the network must be present to have a meeting or make decisions. Decisions will be made either by majority of the members present or by the wider network using a process of consensus.

Network Activities

Themed meetings, consultations, seminars and workshops will be arranged as required.

Declaration of Interest

Network members may occasionally have a specific interest in the matters under discussion. When these matters involve financial gain and/or interest, a full declaration of interest must be made and no participation in any decision-making or endorsement of proposals on the matter will be allowed.

In what ways can you get involved?

- Join our Facebook group https://www.facebook.com/WomensHealthNetworkBradford/
- Follow us on twitter https://twitter.com/cnet_bradford
- Visit out our webpage http://www.cnet.org.uk/community-development/Womens-Health-Network/
- Become a member of the network to receive and share information about up and coming events and meetings

Appendix 24: Bradford Women's Health Network Chair Role and Responsibilities

1. **Role**

   Chair / Co-chair of the Bradford Women's Health Network (WHN)

2. **Responsibilities**
   - Produce meeting agendas
   - Chair Network meetings in an effective and professional manner
   - Work with Network members to plan events/meetings/consultations
   - Support the set-up of *task and finish groups for specific issues as appropriate
   - Play an active and positive role in increasing awareness of health issues and concerns relating to women and their families
   - Represent and promote the WHN with outside agencies/ stakeholders and attend meetings as required
   - Ensure that the aims, objectives and working principles defined in the terms of reference are duly considered
   - Ensure there is a clear definition between the views of the network and those of individuals
   - Ensure that WHN meetings are conducted in a competent and orderly manner.
   - Ensure that all members have an opportunity to express concerns, contribute to discussion
   - Ensure that discussion, debate and decision making is democratic
   - In the event of non-consensus the chair would be delegated with the responsibility of making or deferring the decision

3. **Experience and skills required**
   - Wide range of knowledge of issues, concerns, current policy and legislation specific to Women
   - Acceptance of the following principles and values of partnership working:

Accountability – clearly defined responsibilities for all decisions and actions
Equality – place equality, diversity and inclusiveness at the core of what you do
Leadership – the sector's representatives will need to think and act strategically
Openness – be as open as possible in all your dealings and relationships
Purpose – be clear about the local sector's objectives and support them with a strong evidence base
Sustainability – ensuring the continuation of the collective voice
Values – identify and build on the values of the local sector

4. Commitment/Shared Commitment

- Attend WHN meetings currently bi-monthly
- Attend stakeholder and strategic partnership meetings as appropriate and represent the views of the WHN.

The period of office is currently 2 years

The WHN reserve the right to request that you stand down if you are not carrying out the duties outlined above.

* task and finish groups are set up to focus on a specific issue/concern and are time limited

Approved September 2016

Appendix 25: Testimonials from members of the WHN

My experience of taking part in the development of the WHN exceeded my expectations. I have attended all but one meeting and the most positive aspect was the combined passion of all women involved from all sectors and all backgrounds. Everyone has always been equally enthusiastic to see this succeed and the information and experiences shared show that it is needed.

Across the ranges of women that I work with one of the recurring issues they self-identify is feeling alone, feeling that they are the only person affected by their issue whether that be abuse, mental ill health, anxiety, loneliness, low self-esteem and lack of education. One worker in one area can only address a tiny amount of these barriers faced by women but working together as an organised network we can all begin to impact and empower more and more women across the district.

Bradford leads the way nationally on issues around abuse and safeguarding, my aspiration for this network is that we can also lead the way for supporting and empowering women to have choices, to have fair and decent local access to opportunities that benefit their health and well-being and so benefit those of their families. I would like to see every community setting working more closely with their local primary care settings/GPS/ schools etc. the places who are more likely to see women in crisis but are unable to offer holistic support so that we, the community are able to offer more immediate support for women which would reduce their reliance on the NHS/public sector. **Michelle Taylor**

I'm in Manningham and we really need the Bradford Women's Health Network in my area. Our areas stats for breastfeeding are low and as a breastfeeding mum there's not much out there for me. This is why I fully support the Bradford La Leche League group that runs voluntarily. There is also a Bradford Birth choices that runs voluntarily that I choose to use over anything run by the children's centres or health visitor drop ins. I try to avoid my local health visitors for fear of pressure from them to use the information they give me which is never suited to my needs.

There needs to be a network available to signpost women where they want to be**.** I was lucky enough in 2014/2015 to have my pregnancy supported by one2one midwives. This was after my GP refused to sign me over to them claiming they had a bad reputation and that she'd "be putting me at risk" if she agreed. I had to wait until over 12 weeks pregnant to signpost myself to their care. A number of mothers in Bradford were devastated when one2one were removed, a lot seeking private health care over the local NHS route.

I'd be very interested in this project going ahead to be able to cater for women better. To hear our concerns and match the need**.** **WHN Member**

The Women's Health Network has given local women an opportunity to share their ideas and experiences of health and social across the voluntary and statutory sectors. It has also enabled women to highlight issues facing them and their loved ones. Many of the women involved in the forum work with women, children and the wider community in various settings, they bring a wealth of knowledge and experience of service user information with them. They are also representative of the demographics of the Bradford District. All the women share their experiences and those of their clients/service users, particularly, where health and social care services are working well, where improvements are needed, also where there are gaps in service provision.

As women we play many roles in our personal and professional lives. Many of us are also caregivers to our loved ones, so who better to help shape local services for women; than the women themselves. I have found the WHF a very effective group, it has made so much progress in such a short time scale. In order to build on the work done already, the WHF will require vital financial support to further maintain and sustain the forum, so that in turn it can make a much needed difference and help cater for the needs of women in the Bradford District. **Shamim Akhtar**

I became involved in the Women's Health Network through my work at Better Start Bradford. We work with expectant mums and with families who have children up to the age of 4. My experience of the meetings and events so far have proved beneficial and worthwhile both personally and professionally. I have gained a real insight into women's issues across the whole district and especially the wards in which Better Start operate which are: Bowling and Barkerend, Little Horton and Bradford Moor. They have connected me to some of the less formal networks in these areas and to women who we may not even have considered at Better Start (especially issues around women's health in pregnancy and how women feel about managing work life balance with very young – i.e. pre-school, children).

There's been a real energy and positivity in seeing women working together; negotiating, sharing and learning from their experiences and talking about the best way forward for how we can make things better for women across the district. I have a real sense of being part of something positive and which has a "can do" approach. **Sally Teasdale**

When I first heard about the women's health network design workshop I was unsure what to expect, but keen to find out more. I attended with my baby & left feeling empowered to help it grow. Every meeting Verona & I have attended has been welcoming & enjoyable. I have connected with a broad range of people & gained an abundance from listening to others knowledge & experiences whilst sharing my own. I have found that the structure of the meetings has enabled me to share views on a number of subjects, whilst providing a great opportunity to discover the barriers that can prevent people engaging with different services. I look forward to working with the WHN and our current & future partners to find a way to hear the women that are unheard, see the unseen & reach those that feel isolated or unreachable for whatever reason. **Rachel Dennis**