women's HEALTH NEEDS ASSESSMENT



Nottingham City Council

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Linked JSNAs:

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- Dementia (2018) *Dementia (2018) - Nottingham Insight*
- Domestic & Sexual Violence and Abuse (2018)
  Domestic and sexual violence and abuse (2018) - Nottingham Insight
- FGM (2017) *Female genital mutilation (2017) - Nottingham Insight*
- Pregnancy (2019) *Pregnancy (2019) - Nottingham Insight*
- Severe and Multiple Disadvantage (Multiple Needs) (2019)
  Severe multiple disadvantage (Multiple needs) (2019) - Nottingham Insight
- Sexual Health and HIV (2018) *Sexual health and HIV (2018) - Nottingham Insight*
- Substance (Mis)use (Illicit drugs and alcohol) (2022)
  Substance Misuse (illicit drugs and alcohol) (2022) - Nottingham Insight
- Reducing unplanned teenage pregnancy and supporting teenage parents (2017)
  Reducing unplanned teenage pregnancy and supporting teenage parents (2017) - Nottingham Insight

Abbreviations

A&E	Accident and Emergency
APC	Admitted Patient Care
ASHE	Annual Survey of Hours and Earnings
DfE	Department for Education
DHR	Domestic Homicide Review
DSVA	Domestic and Sexual Violence and Abuse
FGM	Female Genital Mutilation
HES	Hospital Episode Statistics
HNA	Health Needs Assessment
HPV	Human Papilloma Virus
ICB	Integrated Care Board
ICS	Integrated Care Strategy
IMD	Indices of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LARC	Long Acting Reversible Contraception
LGB	Lesbian, Gay, Bisexual
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer +
NAPC	Nottinghamshire Area Prescribing Committee
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PCM	Primary Care Mortality
PCOS	Polycystic Ovary Syndrome
PPI	Patient and Public Involvement
PTSD	Post Traumatic Stress Disorder
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
SMI	Severe Mental Illness
VAWG	Violence Against Women and Girls
WHNA	Women's Health Needs Assessment

Foreward

Being a woman should not be a risk to health.

By Lucy Hubber, Director of Public Health

The health and wellbeing of the women of Nottingham are not only a priority for the city but are also fundamental to the health of our entire community. I am proud to present this Women's Health Needs Assessment (WHNA), a crucial piece of work that sheds light on the unique health challenges and opportunities faced by women in our city.

The data within this document confirms what many of us have long understood: health inequalities disproportionately affect women. While women in Nottingham have a longer life expectancy, a significant portion of their lives is spent in poor health.

As this work highlights, a woman's health journey is shaped by a complex interplay of biology, social roles and systemic inequalities. This is further compounded by the historical underrepresentation of women in clinical research, which has led to less-tailored health solutions. The WHNA brings these realities to the forefront, providing us with a comprehensive and evidence-based view of the situation in Nottingham.

We now have a clear understanding of the key health issues affecting local women, from chronic conditions like depression and hypertension to conditions almost exclusively experienced by biological women, such as polycystic ovary syndrome (PCOS) and endometriosis. We've also identified the significant barriers women face in prioritising their own health, including long wait times, feeling dismissed by professionals, and juggling caregiving responsibilities. Furthermore, healthy ageing and access to safe, quality housing emerge as essential factors that underpin long-term health for women in our city

The report further highlights how these challenges are intensified by wider social determinants of health, including economic disadvantage and the distinct barriers encountered by women from Black, Asian, and minority ethnic backgrounds.

This assessment is not merely a collection of data; it is a collaborative effort informed by the direct voices and experiences of women across our city. Their insights underscore the need for a fundamental shift towards a healthcare system that is more responsive, female-centric, trauma-informed, and accessible.

By working together, we can ensure that every woman and girl in our community has the opportunity to lead a healthy and fulfilling life. We have a shared responsibility to champion women's voices and innovate our services to reflect their lived experiences and choices.

Thank you to everyone who contributed to this vital assessment, particularly the women who shared their stories and insights. Your input has been invaluable, and this work is a testament to what we can achieve when we listen and collaborate.

1 Why women's health?

Just over half of the population are female, meaning there are over 160,000 adult women living in Nottingham (see section 8.2). Research has shown that women face disparities in prevalence of disease, healthcare access and diagnosis, treatment and positive outcomes, in addition to experiencing misogyny, stigma and a lack of knowledge around women's health[1].Women's health therefore differs from men's, partly because of biological differences and partly because of differences in the female versus male social experience[2]. These differences exist within and are exacerbated or ameliorated by government policies and processes, organisations and institutions, wider society, family systems and the individual.

Government Policies and Processes

A national focus on women's health and subsequent policy announcements have led to a need to better understand the health and wellbeing needs of women living in Nottingham City. In 2022 the government published a Women's Health Strategy for England[3], followed by an announcement in early 2023 of £25 million in funding to create women's health hubs to aid with the delivery of the strategy[4]. The proposed hubs would facilitate improved access to healthcare for conditions specific to women such as menstrual problems, contraception, pelvic pain and menopause care, and could be delivered in a multitude of ways including digitally.

Nottingham City has not previously published a Women's Health Needs Assessment, therefore following publication of the national strategy, the Public Health team in Nottingham City embarked on a Women's HNA to enable insight and understanding into the health issues which affect, and which matter to women in Nottingham City. Government policies and processes therefore influence women's health in various ways, including impacting priority areas, directing spending and mandating assessment of need. It is suggested that for every £1 invested in women's health, there would be an £11[A] return on investment[5], which highlights the potential economic benefits of government policies and processes that direct spending.

Organisations and institutions

Women have historically been under-represented within clinical research[6], meaning that solutions for women's health can be considered somewhat less tailored and less advanced than men's health solutions. Even when women are involved in clinical trials, evidence suggests that women from more deprived backgrounds and those from ethnic minority backgrounds are under-represented, a feature that could exacerbate health inequalities[7].

The World Economic Forum suggests that addressing the gender health gap, which exists to women's detriment, could boost the global economy by at least £747.8 billion annually by 2040[8]. In the UK, the NHS Confederation highlights the economic impact of women's health conditions, their impact on the workforce in terms of absenteeism and those who are unable to enter the workforce, and the wider impact that this has on the economy.

The Royal College of Obstetricians and Gynaecologists (RCOG) highlight the significant impact of long waiting times for treatment experienced by women, impairing their ability to live their lives as they would wish[9]. These women are often in pain, and many end up presenting to emergency services such as A&E due to the severity of their symptoms – presentations that may have been avoided if treatment had been available at an earlier stage. The Covid-19 pandemic only exacerbated this issue, with estimates suggesting that waiting lists grew by over 60% compared to pre-pandemic levels. Professionals working within the health and care system, many of them women, are also impacted, frustrated by the barriers to offering the care and support they know is so desperately required.

Organisations and institutions, such as research organisations, employers and healthcare settings therefore frequently continue to exacerbate inequality for women, through inadequate representation and unequal opportunities, for example.

[A] Rounded figure – report states £10.90 per £1 spend

Wider society

Feminine gender roles, such as being primary caregiver or undertaking unpaid household labour, are associated with poorer self-reported health internationally[10]. Women who report conforming more closely to traditional gender roles are more likely to experience chronic illness[11]. Women have historically been stereotyped, considered hyper-emotional, socially (as opposed to analytically or logically) minded and to value communality over personal agency[12]. These gender roles and stereotypes are deeply ingrained within wider society and leave many women feeling compelled to prioritise their gendered societal position and adhere to gendered expectations, often at the expense of their own health and wellbeing.

Family systems and immediate support

Insights from global survey data revealed that: 1) gender norms intersect with other social factors to impact health over the life course; 2) early life gender-normative influences from friends and family differentially impact multiple health outcomes for girls and boys; 3) deviating from gender norms can be harmful to health, particularly if this is met with negative social responses and 4) the relationship between gender norms and health depends on context[13]. The impact of family systems on women can therefore be considered an extension of the wider societal influences on women, except with greater intimacy and personal relevance.

The individual

Biologically, women experience complex hormonal changes monthly and across the lifespan because of menarche, menstruation, pregnancy, lactation and menopause. These hormonal changes impact women's health in a range of ways, including having links to migraines[14] and depression[15]. However, these hormonal and physiological changes also alter women's health-related priorities, behaviours and needs as they age. Young women aged less than 24 years are more likely to have health needs that relate to sexual health, contraception and Human Papilloma Virus (HPV) vaccination, in addition to general health needs such as mental health or support to stop smoking or reduce alcohol consumption[3]. A focus on younger women is important locally, as, due to the high number of students, around 24% of Nottingham's women are aged between 15-24 years[16].

Once women enter the 30-44 years of age range, 42% score highly for depressive disorders, 24% report having at least one chronic health condition and around 20% report having a medical condition that requires ongoing treatment, suggesting a rise in specific health diagnoses for this age group[17].

Women aged 50+ are more likely to engage in screening than younger women and women generally have more interest than men in receiving information regarding heath prevention[18].

For women aged 65+, 31% report having a disability or health condition that limits full participation in daily activities[16], a higher rate than is seen in any of the younger cohorts and one that highlights the need for targeted interventions that address disability and mobility issues by making reasonable adjustments to provide opportunities for healthy behaviour. At least 50% of older women report a diagnosis of hypertension or arthritis within the past five years and 19% report a diagnosis of heart disease or osteoporosis[16]. Osteoporosis is significantly more common for women (1 in 3, compared to 1 in 5 for men) and is closely related to fragility fractures, which are estimated to have cost £31.9billion in 2017 and 2.6 million disability-adjusted life years in 2016 across the five largest European countries and Sweden[19].

Women's health is therefore ever-changing across the life course, in line with women's changing hormones, fertility, diagnoses and ability/disability. Addressing pertinent women's health issues could improve the global economy, reduce the global burden of health and increase the number of years that are lived in good health.

To conclude

Biological sex and socially constructed gender are lifelong determinants of women's health[20]. Women's health must therefore be understood differently to men's, from a biological, societal and from a systems and processes perspective.



2 Current policy / legislation / guidance. Women's Health Hubs.

The Royal College of Nursing (RCN) found that there was little in the way of holistic evidence within the field of women's health[21] – something which looked at various areas of women's health together to create an overall picture to help facilitate care and advice for women. As a result, healthcare for women is often fragmented and can result in delays and negative long term impacts to the health of women.

The Women's Health Strategy[3], published in 2022, builds on the findings of the RCN publication and sets out an ambitious programme of work to ensure that women's health and care is prioritised and that some of the ingrained inequalities, e.g. waiting lists, are begun to be tackled. As mentioned in the introduction, one of the methods proposed to achieve this is to provide funding for the implementation of women's health hubs alongside other support for women such as the menopause work champion (an individual within a workplace who takes on the role of raising awareness, providing support, and driving positive change regarding menopause). The relationship between ethnicity and women's health is also examined, noting that certain health conditions may be more prevalent or severe in women from minority ethnic communities, and that they may approach certain health topics differently due to cultural differences.

Locally, the Nottingham and Nottinghamshire Integrated Care Strategy (ICS) Women's Health Clinical and Community Services Strategy[22] was published in October 2020, with an aim to focus on prevention and early intervention and via a person centred approach, with services delivered in women's homes or in their communities where appropriate. The strategy details a plan to build the workforce and journey pathways relating to women's health using an evidence based model, acknowledging the stages in the life course during which women's health needs may change. Lack of equitable access to services is noted, resulting in an aim to develop consistent and equitable access to services for women and couples across the system, using a sustainable and evidence based service model for the future.

3 Context setting – what do we know about Nottingham?

Nottingham is a vibrant, diverse and multicultural city, with several unique geographical and demographic features that naturally impact on health outcomes. It is tightly bounded – Nottingham City local authority area encompasses many highly deprived inner-city areas, with many of the suburban areas that are perceived as being part of Nottingham actually falling outside of its boundaries.

The population of Nottingham is comparably younger than many similar areas, down in part to the large student population of about 43,000, equal to about 1 in 7 of the population[23].

There is an award winning transport system which has been recognised as the best in England outside of London, and the city holds both a 'Purple Flag' for excellence in its night-time economy, and 'Green Flags' for 17 of its parks and green spaces, which are both quality standards for urban areas recognising excellence in different aspects of city life.

The crime rate in Nottingham is 121.5 recorded crimes per 1,000 population, which represents the likelihood of crime occurring in Nottingham relative to its population. Although higher than the England and Wales average (88.1 per 1,000), this is comparable to other cities, such as Birmingham (121.2 per 1,000)[24].

The satisfaction of Nottingham residents with the city is reflected in the results of local surveys, which indicate that 85% are satisfied with their local area, 93% agree that people from different backgrounds get on well and 92% would recommend Nottingham as a place to live[25].

4 Scope and methodology

4.1 Scope

A HNA is an essential tool to inform commissioning and service planning, which aims to identify unmet health and healthcare needs of a population, and the changes required in order to meet those needs. The Nottingham City Women's HNA will look at women's health from a life course approach, aligning it with the government women's health strategy.

The scope will include women and girls aged 16 and over in Nottingham City and will examine causes of morbidity and mortality of these women. The themes identified in the women's health strategy will be addressed and the scale of the problem in Nottingham identified where data is available. It is acknowledged that some issues will begin to impact on girls and women during their earlier teenage years. Where these issues are identified, care has been taken to ensure they are addressed, whilst also minimising duplication in relation to other workstreams which may already cover these.

Engagement work with women in Nottingham as part of this HNA sought to include the voices of women from marginalised communities, who are often absent from research or consultation into health. It will take into account the things women told us make it easier or more difficult for them to be healthy in Nottingham. This ensures that the HNA is relevant to as many women in Nottingham as possible, and that the resulting recommendations have the potential to deliver truly equitable outcomes for women in the city.

There are a number of other current or recently completed projects which overlap within the field of women's health. These include:

- Children & Young People's Health Needs
- Assessment Maternity Review (Ockenden Review)
- Sexual Health assessment work (prepared as part of a recommissioning process)
- Domestic and Sexual Violence and Abuse Strategy

As a consequence, this women's HNA has a 'light touch' approach to these areas, to avoid duplication of work already commenced or completed.

The areas of severe multiple disadvantage (SMD) and alcohol & drugs will also receive a 'light touch' approach due to the planned production of JSNA documents to cover these topics in 2025-26.

4.1.1 Transgender women

Nottingham City recognises that those who identify as transgender, non-binary, queer or Lesbian, Gay or Bisexual (LGB) may have unique experiences and needs in accessing health information and healthcare, and the barriers and inequalities they face may be different from those of cisgender and heterosexual women. They may experience stigma, the anticipation of stigma or discrimination. The anxiety or stress that these can cause may deter LGBTQ+ women from seeking healthcare and subsequently lead to worse health outcomes[26]. At the last Census almost 5% of Nottingham's population identified as LGBTQ+[27], therefore ensuring that services are accessible and provide for the needs to those from the LGBTQ+ community is essential.

In order to adequately recognise the unique experiences and needs of all of our communities, and to allow for a full and in depth assessment of the needs of the transgender, non-binary, queer and LGB communities, a separate LGBTQ+ health needs assessment will be completed following the women's health needs assessment. This will include assessing the health needs of transgender people. This approach was informed by consultation with the WHNA stakeholder group and the Nottingham City Council LGBTQ+ staff network, with the agreed approach allowing an equitable focus on the health inequalities experienced by LGBTQ+ groups in their own right.

Throughout this document, the terms 'women' and 'women's health' will be used, with the acknowledgement and understanding that not all people requiring access to these services will identify as women. Some data sources also refer to 'male' and 'female', and where these are referenced, these terms will be used for consistency.

4.2 Methodology

In order to accurately assess the health and wellbeing needs of women in Nottingham, several elements were undertaken in the production of this HNA.

a. **Literature search** – A literature search was undertaken to identify relevant literature, research and evidence on the topic of women's health. This was used to identify key findings and gaps in relation to women's health more generally and identify interventions and policy that have been implemented elsewhere, and which is considered best practice.
b. **Stakeholder Group** – To ensure rigour and accountability, a stakeholder group was convened of professionals interested in women's health, and/or who are involved in working with women in the community. This group consisted of key stakeholders from: Nottingham and Nottinghamshire Integrated Care Board (ICB), Nottingham's Community and Voluntary Sector, Nottingham City Council, The University of Nottingham and Nottinghamshire County Council.
c. **Data analysis** – Using locally available data for demographics, mortality and hospital admissions a picture of the health of Nottingham's women was created, their main causes of death and illness, and the things they were most likely to receive hospital treatment for.
d. **Women's Health Survey** – Loosely based on the national Women's Health Survey which preceded the publication of the strategy, a local survey was promoted to women in Nottingham City (or who were registered with a Nottingham City GP) to find out about the areas of health that matter most to them.
e. **Women's Health focus groups and interviews** – Using the survey results demographics of under-represented communities (such as women from ethnic minority groups) were identified. Focus groups and interviews were also undertaken with women who literature review revealed to be experiencing particular health-related inequalities and injustices.

4.2.1 Data analysis

The data analysis of women's health was split into two parts, to look at mortality, or what causes the deaths of women in Nottingham, and then morbidity, to assess the health conditions that women in Nottingham are living with.

4.2.1.1 Mortality

Nationally published data from the Public Health Outcomes Framework was used to assess mortality rates across the whole female population of Nottingham compared to England for the period 2001-03 to 2020-22.

In addition, local data from the Primary Care Mortality (PCM) dataset was analysed to closely examine death rates by age group – specifically, women in Nottingham aged 16 and over. This dataset also allows for exploration of demographic factors relating to mortality, such as deprivation and ethnicity. The time period examined was 1st January 2020 to 31st December 2022.

To break down the data further, the dataset was analysed in two distinct aggregate age groups – 16-74 year olds and then 75 years and over, to allow for differences in the causes of death by age to be identified.

4.2.1.2 Morbidity

In order to examine morbidity (having a disease or condition), data of emergency hospital admissions among women aged 16 years and older residing in Nottingham was analysed. Emergency hospital admissions refer to instances where patients are admitted to hospital unexpectedly and on short notice due to clinical need, typically through A&E departments.

To perform the analysis the Admitted Patient Care (APC) dataset from Hospital Episode Statistics (HES) was used to explore patient demographics, trends in admission rates and variations by age group, ethnicity, and levels of deprivation. Additionally, this data highlights the most common reasons for emergency admissions in this demographic and provides a comparison to admission rates prior to the Covid-19 pandemic.

National data on admission rates for this specific group (women aged 16 and older) are not currently available for comparison and, therefore, are not included in this report.

4.2.1.3 Limitations of data analysis

The use of wide age brackets e.g. 16-74 years within the mortality analysis has a limitation in that some findings may be masked. However, the numbers of deaths in younger age groups are small in comparison, meaning that a further age breakdown makes it difficult to draw meaningful conclusions.

There are limitations with the PCM dataset, specifically that the data may include incomplete records, there may be lags between date of death and availability of data, impacting timeliness of analysis, and the data will only include those who are registered with a GP, which may exclude certain populations. Death figures may also differ from published figures. This is due to differences in data extraction dates.

Throughout this document, data covering different timescales may be used. This is due to differences in the availability of published data at the time of accessing, and the agreement to use full years of data wherever possible.

4.2.2 Qualitative research

In November 2023, a survey was conducted by public health colleagues inviting women in Nottingham to complete a survey on their health. This survey was broadly structured around the national survey used to inform the women's health strategy. 216 women completed the survey. The results were analysed to identify initial themes and to assess the demographics of the respondents.

4.2.2.1 Focus groups and Interviews

To build upon the findings of the survey, a series of focus groups and interviews were undertaken with women who lived in the city or who were registered with a city GP. In this section, the methods for data collection and analysis are described and the findings have been outlined. These have been split into community assets that are supportive of women's health, behaviours women engage in to achieve good health and their barriers and facilitators to those behaviours. The full list of barriers and facilitators can be viewed in a table on pages 73- 90 (Table 6). This table can act as a starting point for health-related intervention design for women, as professionals can identify relevant barriers, facilitators, strategies or behaviours for health promotion that suit needs, goals and aims of organisations, groups and individuals as required.

4.2.2.2 Methods

4.2.2.2.1 Participants

Participants were recruited via the use of a recruitment poster (See Appendix A) and with the support of community groups and community leaders. The aim was to collect data from the most diverse and representative sample possible, but with particular attention paid to ensuring the views of the women experiencing the greatest health inequalities would be well represented.

There were 49 women who contributed to the focus groups and interviews. There were women from all age-groups (18-65+), with the best representation from the 35-44 years age group (11 participants) and the least representation from the youngest age group of 18-24 years (4 participants). The sample was ethnically diverse, with good representation from White British, Black and Asian communities, some representation from the Arab community but without any representation from the White Irish, White Roma or White Gypsy/Traveller communities. Participants' level of education ranged from none to professional degrees, with a modal response of having completed secondary school (13 participants). Participants were primarily in the lowest income bracket, with 29 out of 49 having a household income of less than £20k per annum and with 15 participants preferring not to disclose this information. As many as 30 of the women had no dependents currently, the next modal response was for women to have two dependents (9 participants).

4.2.2.2.2 Data collection

There were 12 one-to-one interviews, and 8 focus groups which each had between two and seven participants in attendance. All focus groups were in-person and some interviews were conducted online, depending on the participants' preference. Data collection occurred at a time and place that was convenient for the participant group and participants were incentivised with a £10 Love2shop voucher. All participants were given the opportunity to read the information sheet, provide informed consent, complete the demographic information questionnaire and ask any questions they may have had, prior to the recorded conversations taking place. All interviews and focus groups were undertaken by at least one member of Nottingham City Council's Public Health team.

4.2.2.2.3 Materials

Informed consent and demographic information were collected using a questionnaire that can be viewed in Appendix B.

A semi-structured focus group schedule was developed (See Appendix C) and then adapted for use in a one-to-one interview setting (See Appendix D). This data collection guide aimed to glean information about: 1) Women's health-related behaviours, 2) Women's barriers and facilitators to health-related behaviour, 3) The benefits and challenges associated with certain demographic characteristics, 4) Environmental and community influences on women's health, 5) Ways to improve health, care and wellbeing services for women in Nottingham and 6) Examples of best practice in the city.

4.2.2.2.4 Data analysis

Recordings of focus groups were transcribed verbatim before being imported into NVivo qualitative data management software for line-by-line inductive coding. Two public health colleagues undertook coding together and disagreements or uncertainties were discussed until agreement could be met with support from wider public health colleagues where necessary. Where data could be mapped to more than one code, cross coding (whereby data is coded to multiple categories) was implemented. Colleagues aimed to identify the broad range of health-related behaviours that women engaged in, and women's barriers and facilitators to health-related behaviour. Topics that were present within the data but did not fit these predetermined categories were also coded, to prevent findings from being limited by the research team's predetermined expectations. Following inductive coding, overarching themes were generated. Themes identified within women's barriers and facilitators to health were then deductively mapped to the COM-B model of health-related behaviour change[28], before being aligned with the relevant health-related behaviour(s) to ensure findings have maximum utility for future health-related intervention design. As such, this analytic process can be considered to combine elements of thematic analysis[29] with framework analysis[30].

4.2.2.2.5 Ethics

The protocol for data collection and analysis was approved by Nottingham City Council's Senior Leadership Team. All participants were provided with an information sheet (Appendix E) that was verbally explained, such that informed consent to take part could be provided. Participants were made aware that the conversations must be kept confidential, that they were under no obligation to take part, could withdraw at any time and did not have to answer any questions if they did not feel comfortable to do so. The pseudonymisation process was explained and all participants were provided with a debrief sheet and signposted to free health-related support following participation. All voice recordings were securely stored and were deleted at the first available opportunity, following transcription.

4.2.2.2.6 Limitations

Despite the best efforts of the researchers, the findings of the qualitative work (Section 12.2) have some limitations. There were some demographic groups of women who were not adequately represented within the research (e.g. White Irish/Roma/Traveller women, disabled women and younger women). Women were recruited with support from local community groups, meaning the sample might have been somewhat biased towards the benefit of these groups. Further, it is possible that the position of the people undertaking data collection, as Nottingham City Council employees, may have impacted participants' responses. Data collection was somewhat limited by the researchers' language skills and because informal translation arrangements were made (where participants translated for one another), increasing the likelihood of misinterpretations. Interpretations of the data are also likely to have been impacted by the positionality of the data analysts, who are both women working within public health.



5 Women, roles and societal pressures/expectations

Societal pressures can affect women's wellbeing. From an early age, girls and women are exposed to views on how they should look, behave and conduct their lives, in a way that is deemed socially acceptable.

A key societal issue impacting women's wellbeing is body image. From childhood, girls and women are exposed to messaging on beauty standards and body type, through mass media, advertising and more recently, social media. A House of Commons committee report recently outlined the links between media exposure and poor body image and noted that numbers of those reporting a positive body image had declined in recent years[31] and the Girls' Attitude Survey 2024 found that 6 out of 10 girls and young women (aged 11-21) are 'consumed by their own negative thoughts about how they look'[32].

Girls and young women are also exposed to body image messaging through social media, with a Mental Health Foundation survey finding that 54% of girls said looking at social media had made them worried about how their bodies looked[33]. The highly curated environment of these platforms with widespread digital alteration of images creates an unrealistic and unattainable standard, which many women struggle to reach, leading to anxiety, low self-esteem and in some cases eating disorders, which consequently affects their physical wellbeing also[34]. Women are more likely than men to experience body image disturbances and eating disorders[35], suggesting women are either subject to greater pressure to conform to societal beauty standards, or that they are inherently more vulnerable to the negative impacts of appearance-based pressure and scrutiny.

Women face additional burdens in their communities due to the expectations of their role as primary caregivers. The care of infants and children disproportionately falls to mothers, even if a partner is available to share their care equally, as does the care of sick or disabled partners[36], and ageing or elderly parents or relatives. The impact of this burden of caregiving has significant economic implications – preventing women from fully participating in the workforce, depending on poor or insecure employment or having to leave the workforce altogether[37]. Without sufficient suitable options for employment these women are more at risk of economic disadvantage[38] in turn is linked to poorer health outcomes, lower life expectancy, and longer periods of life spent in ill health[39].

6 Inequalities

Health is influenced by many factors in everyday life, and differences in these factors contribute to health inequalities for many in society, particularly people living in Nottingham. Gender is a factor that intersects with several of these key issues, making these challenges worse for women in the city.

Women face inequality, simply because they are women. Women earn less than men (median hourly earnings in April 2024 for women in the UK £17.88, compared to £19.24 for men)[40] and are less likely to be in employment[41], despite being more likely to be university educated[42]. Women experience more DSVA than men, with greater severity and impact, including being at increased likelihood of serious injury or death than male victims[43,44,45]. Women live longer than men, yet spend more of their lives in poor health, a trend seen globally[8]. They are more likely to experience eating disorders[35] and chronic pain conditions, yet are more likely to have experiences of pain disregarded, wait longer for evaluation in healthcare settings and are less likely to be referred for further assessment, admitted to hospital and/or be prescribed medication[46].

6.1 Ethnicity

Women from ethnic minority communities face additional inequalities in accessing health and care services. Racial and ethnic inequality exists across various aspects of women's health, and women from Black, Asian and ethnic minority groups are found to have worse experiences and outcomes than White women.

Compounding factors of lack of diversity in training of healthcare staff, cultural differences, previous negative experiences, and systemic racism combine to create additional barriers to Black, Asian and ethnic minority women receiving appropriate and equitable treatment. RCOG have produced a policy position[47] to address this issue. At a smaller geographical level, analysis completed by the NHS Confederation found that local authorities with a higher proportion of people from ethnic minority backgrounds tended to have poorer access to women's health services. This finding is a double blow for those women from ethnic minority groups, who will not only experience poorer access to services due to the demographics of their local area, but if and when able to access services, they are more likely to experience inequality due to their personal characteristics as well. Nottingham has a population of Black and minority ethnic residents that is higher than the England & Wales average (43% of Nottingham's population are from an ethnic background other that White British[48] compared to 25.6% nationally)[49], with the areas of most diversity being those surrounding the city centre (Forest Fields, Radford, St Ann's, Meadows). This information is particularly pertinent for public health and healthcare professionals involved in the commissioning and delivery of services for women, to ensure that structural inequalities are considered and addressed.

6.2 Deprivation and income inequality

Deprivation has a multi-faceted impact on women's health and can have a direct impact on health from an early age due to its impact on education and subsequent employment opportunities.

A governmental report by the Social Mobility Commission[50] found that deprived areas typically saw jobs with lower pay, fewer opportunities for professional roles, and lower quality of education, which may be linked to health literacy and access. Additionally, RCOG highlight the negative impacts that poor health can have on women's educational attainment or progression at work, e.g. continuing to experience symptoms during time spent on waiting lists for treatment[9], which could result in poorer financial outcomes for women in some scenarios. In 2024, the gender pay gap between men & women nationally was found to be 7%[51], on top of the likelihood of women from poorer backgrounds being in insecure or low paid work, which may be a barrier to attending health appointments. This combination of factors shows that women in Nottingham, the 11th most deprived area in the country, are already at a disadvantage regarding health[52]. Additionally, understanding the impact of deprivation across the city, particularly the higher prevalence in northern areas, is crucial for addressing the health needs of local women

In terms of direct impact, RCOG suggest that deprivation impacts on waiting times for women's health services, with those from the most deprived areas experiencing the longest waits[9]. This is in addition to the increase in waiting times as a result of the Covid-19 pandemic. As the pandemic disproportionately impacted those communities from the poorest areas, this provides another example of the multiple layers of inequality in relation to health that impact on women.

6.3 Health literacy

Health literacy means an individual's understanding and knowledge of health and the health system, and their ability to use information to make decisions about their own and their family's health.

The health system and the way in which it provides information to people is an important factor to health literacy – if information is presented that is too complex, not easy to understand, or not tailored to the audience, then important messages may not get through to those who would most benefit. Many factors play a part in an individual's level of health literacy, including poverty, educational attainment, occupation and ethnic minority status, but depending on the circumstances, most could experience difficulties with health literacy at some point in our lives[53]. As Nottingham has a diverse population, with many ages, languages, socioeconomic backgrounds and cultures co-existing, it is likely that some women in the city will have lower levels of health literacy than others. This factor is therefore important when considering any new health campaigns or information sharing, to ensure that it is as accessible and clear as possible for as many as possible.

Women generally have better health literacy than men[54, 55].However, studies show that menstrual health literacy can be limited because of inadequate information prior to menarche, which is linked to stigma, shame and the taboo nature of the topic[56, 57]. Women experienced fewer negative

emotions when they perceived themselves to have had sufficient information on how to practically manage their first period[58], showing how pragmatic health literacy can reduce the negative psychological impact of managing certain aspects of women's health. Muslim women described low health literacy, in conjunction with cultural and personal values related to modesty and privacy, acting as barriers to engaging with health-related services[59]. Furthermore, in Section 12.2.2 - Behaviours to achieve good health, under the subheading of 'Participating in and receiving NHS services,' migrant women and care leavers were identified as women who faced challenges with their health literacy, in terms of understanding and navigating the UK healthcare system. There are therefore subgroups of women who are well represented in Nottingham, that will likely require targeted support to develop their health literacy in ways that are personally relevant, aligned with language skills and culturally competent, for example.

6.4 Severe Multiple Disadvantage (SMD) (including substance use)

In Nottingham Changing Futures leads on work to support people with SMD, which "…refers to the challenges the people we support are facing. It means that people are not facing one issue (such as homelessness or mental ill health), but a combination of very complex issues which can often lead to premature ill-health and in many cases premature death"[60] . Those who experience SMD often have high health needs and are more likely than the general population to experience multimorbidity or poor mental health, as well as finding it more difficult to access primary care and health services.

Research into women's experiences of SMD revealed highly gendered pathways into each of the areas of disadvantage[61]. When combined with experiences of mental health struggles or domestic abuse, and the traumatic nature of these, notwithstanding any other status (for example migrant women, disabled women etc) it is clear that these women are likely to face significant barriers to looking after their health and wellbeing and engaging with services.

Health inequalities associated with SMD can manifest in multiple ways for women and can be extreme. A systematic review conducted in 2018 found that women experiencing SMD had a mortality rate 11.9 times higher than that of the general population[62] and it is assessed that barriers to accessing healthcare services include stigma, discrimination or services which do not meet their needs[63]. Women who experience SMD during pregnancy are more likely to experience poor maternity outcomes, and to have poorer experiences of maternity care[64], which may have a lasting impact on the health of both mother and child.

The most recent estimate in Nottingham was that 5,000 people in the city may be experiencing SMD, with many of these having experienced childhood trauma[65]. It is likely that in the interim period, the number of people experiencing SMD has increased. A separate JSNA on the topic of severe multiple disadvantage is planned for Nottingham in 2025-26, which will provide a more in-depth assessment of the health needs of this population, and the inequalities they face.

Linked to this area of inequality is substance use, including alcohol. A substance (mis)use JSNA was completed in 2022[66]. A JSNA on the topic of alcohol is planned for 2025-26. Hearing the voices of those with lived experience is essential to service improvement, and in 2022 recommissioning work for the dedicated substance use service in Nottingham was undertaken which included consultation with service users. To ensure that the voices of women who have lived experience of SMD, including substance use, were included in this work, the public health team sought to recruit women with experience of homelessness, substance use, sex work and domestic abuse to participate in the focus groups and interviews (see section 4.2.2.2.1).

6.5 Homelessness

Homelessness is a complex issue, often caused by multiple factors outside of a person's control. Homelessness can manifest itself in many ways. Those who are living in B&B accommodation, sofa surfing, temporarily staying with family/friends or rough sleeping, would all be considered officially homeless.

Those experiencing homelessness have significantly worse health outcomes than the general population, with higher levels of frailty and multimorbidity, both of which happen at a younger age[67]. Aldridge et al. found that the extreme health inequalities experienced by homeless individuals were exacerbated in women[58]. Women experiencing homelessness are particularly vulnerable and are exposed to significant risks of harm. Women's homelessness has been linked to childhood abuse, violence and domestic abuse[68], and women typically use different strategies to men to stay safe, including being more likely than men to make efforts to make themselves less visible[69]. They may use indoor spaces to shelter or sleep, such as A&E waiting rooms, on public transport or other public spaces. They may also remain awake throughout the night and instead sleep, in the daytime when more services are open and more members of the public are around. Sex working in exchange for a place to stay is also common.

Women who rough sleep experience significant health inequalities compared to those who do not – data indicates that the life expectancy of women who rough sleep is 43 years old compared to 83 for the general population (for men the figure is 45 compared to 79 years)[70]. They are more likely to have experience of trauma including DSVA, and if they do seek support, it is common for them to have a negative experience with services that are not trauma or gender informed. The rough sleeping census found that often women had left hostel or shelter accommodation over safety and suitability fears, highlighting the fact that services are not designed with a gendered approach. It was also found that women may not always identify as homeless due to associated stigma, and that those who did use services prioritised practical support such as food, housing, health and employment – this aligns with our focus group findings and what women with experience of homelessness, SMD and sex work told us were priorities for them.

Homelessness has been on the rise over the past five years. There were 4,383 homeless individuals known to be in Nottingham at the end of 2023, of which 2,400 (44.9%) were female[71]. Official figures estimated there to be 46 homeless people sleeping rough in Nottingham in Autumn 2023, five of whom were known to be female[72]. Ashfield (in North Nottinghamshire) took part in the census, which identified 41 women who were or had experience of rough sleeping, where the official DLUHC figures counted just one. Although the census did not include Nottingham City, it can be inferred that the true number of women rough sleeping in the city is much higher than the five reported in the official figures, as evidenced by the Women's Rough Sleeping Census 2023[65]. Women's homelessness is more likely than men's to be hidden[64], which means women are less likely to be noticed and supported by outreach workers. This contributes to the over representation of men in official figures (particularly in rough sleeping counts) and together this means that homelessness support services have traditionally been designed primarily with men, rather than women, in mind. This lack of tailored provision is likely to make it more challenging for women to seek and obtain appropriate support. Studies note that those experiencing homelessness have often experienced negative attitudes from staff and services, and that services are often not flexible or holistic enough to meet their needs[73]. These issues are likely exacerbated for women experiencing homelessness, based on the lack of tailored services, to address their specific needs in this regard.

Women who had experience of homelessness contributed to our focus groups, ensuring that their voices were included in the analysis of women's health needs. Work is also ongoing to produce a Homelessness Needs Assessment for Nottingham City, led by the Housing team, which will provide more detailed insight into the needs of local women who are experiencing homelessness.

6.6 Learning Disability

Health inequalities experienced by those with a learning disability are stark. The Learning Disabilities Mortality Review (2022) found that those with a learning disability on average die 23.2 years younger than the general population. This equated to a difference of 19 years for men and 23 years for women. It was also found that a higher proportion of deaths of people with a learning disability were avoidable, compared with the general population (42% compared to 22%)[74].

Those with a learning disability may experience additional barriers to healthcare access, such as knowledge and awareness, poor communication, fear and embarrassment, and limited time[75]. In the case of women, these are compounded by gender related barriers, making healthcare access more difficult and contributing to poor health and early mortality. Despite poorer outcomes for women with learning disability, in Nottingham and Nottinghamshire, efforts are being made to ensure engagement and health checks with this population, with 83.9% of all registered female patients with a learning disability (age 14+) having received a health check as of March 2025.

A JSNA on the topic of Adults with Learning Disability is currently in production, scheduled for publication in 2025-26, which will provide a detailed position on the health and wellbeing needs of those with learning disability.

7 Women's experiences of trauma

The UK Government states: Trauma results from an event, series of events or set of circumstances that is experienced by an individual as harmful or life threatening. While unique to the individual, generally the experience of trauma can cause lasting adverse effects, limiting the ability to function and achieve mental, physical, social, emotional or spiritual wellbeing[76].

Evidence shows that men are at a slightly increased risk of experiencing traumatic events throughout the life course, but that women are twice as likely to develop Post-Traumatic Stress Disorder (PTSD) - the psychiatric condition that sometimes results following experience of trauma - and generally experience symptoms for longer[77]. Up to 44% of women experience childbirth as traumatic, with 3% suffering PTSD as a result[78]. Women experience poorer outcomes following traumatic injury, both physically and psychologically[79]. They are more likely to experience lethal and non-lethal intimate partner violence[80] and sexual trauma, and to do so at a younger age (See Section 11.6 for further details on DSVA), which is problematic because trauma that is experienced earlier in life has a greater and more long-lasting psychological impact[81]. Evidence also shows that having experienced childhood trauma/ abuse is a risk factor for experiencing elder abuse in later life[82]. This, combined with women's increased likelihood of experiencing sexual violence at a younger age and the increase duration of PTSD symptoms typically observed in women, highlights the relevance of the longitudinal nature and impact of trauma for women. In short, women typically experience different types of trauma to men, and the impact of that trauma is frequently worse in terms of severity, duration and possible risk of being re-traumatised.

Although there are no statistics or data showing how many women in Nottingham have been exposed to trauma, evidence shows a direct link between poverty and trauma[83] meaning that experience of trauma is likely to be high across the city, based on local deprivation data. Previous work undertaken by public health indicates that trauma is a key driver of mental health issues in adults locally, and that health and wellbeing approaches should be trauma informed[84]. The report also details the ways in which women experience life events such as homelessness, contact with the criminal justice system or severe multiple disadvantage differently to men. Through the focus groups undertaken as part of this WHNA, local women explained how adverse (often traumatic) personal circumstances were a barrier to health (See Section 12.2.3) and how this impacted their motivation to engage with services and professionals, particularly following experience of sexual trauma or violence (See Section 12.2.6). Considering the likely prevalence of trauma for women locally, and because trauma is a core public health issue, it is imperative to consider its impact on women and their health and wellbeing, and for services to be trauma informed.



[B] Local eHealthscope data accessed via internal SAIU dashboard SID06. Accessed 25/07/2025

8 Socioeconomic determinants of women's health

8.1 A Nottingham woman

The average Nottingham woman is younger than the England average, and more likely to be from a background other than White British.

She is more likely than the average woman to live in an area of high deprivation and is not likely to own her own home. She is less likely to have qualifications at levels 1 or 2, and less likely to be working in full time employment. If she does work, she will likely be earning less than the national average. She will be more likely to say that she has no religion, and she will be less likely to be married or in a civil partnership.

The description of the average Nottingham woman is based on the total population, which is skewed towards the younger generations due to the high student population in the city.

Nottingham's population is 323,632 (Census, 2021), with 50.9% (164,627) females and 49.1% (159,005) males. The city's population density is 4,337 persons per square kilometre, meaning it is a densely populated urban area.

8.2 Age structure

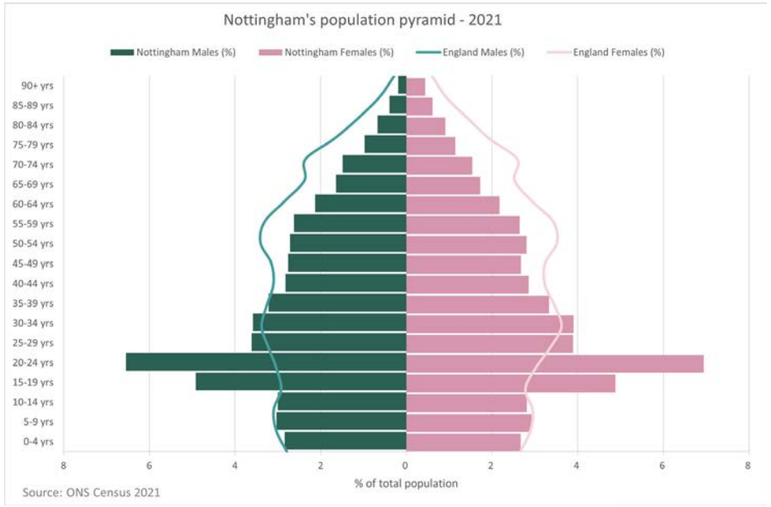
Of Nottingham's total population (females and males)

- 18.3% (59,310) are aged under 16 years (compared to an England value of 19%)
- 69.9% (226,359) are of working age (16-64 years) (compared to an England value of 63.7%)
- 11.7% (37,963) are aged 65 years and older (compared to an England value of 18.2%).

This means that approximately 7 in 10 people in Nottingham are of working age, and within this group, most people are aged between 25-44, followed by those aged 16-24 years. Nottingham has a notably smaller proportion of the population aged 65+ when compared to England.

The population of both males and females aged 45-64 years make up a relatively smaller proportion of the working age population in the city. Nottingham is a significant hub for further education, with two prominent universities contributing to a higher population of university students and which is reflected in the larger bars for 15-19 and 20-24 year olds in Figure 1. This age group makes up 22.8% of Nottingham's total population, compared to 11.9% in England[85].

Figure 1. Age distribution of Nottingham population based on Census 2021



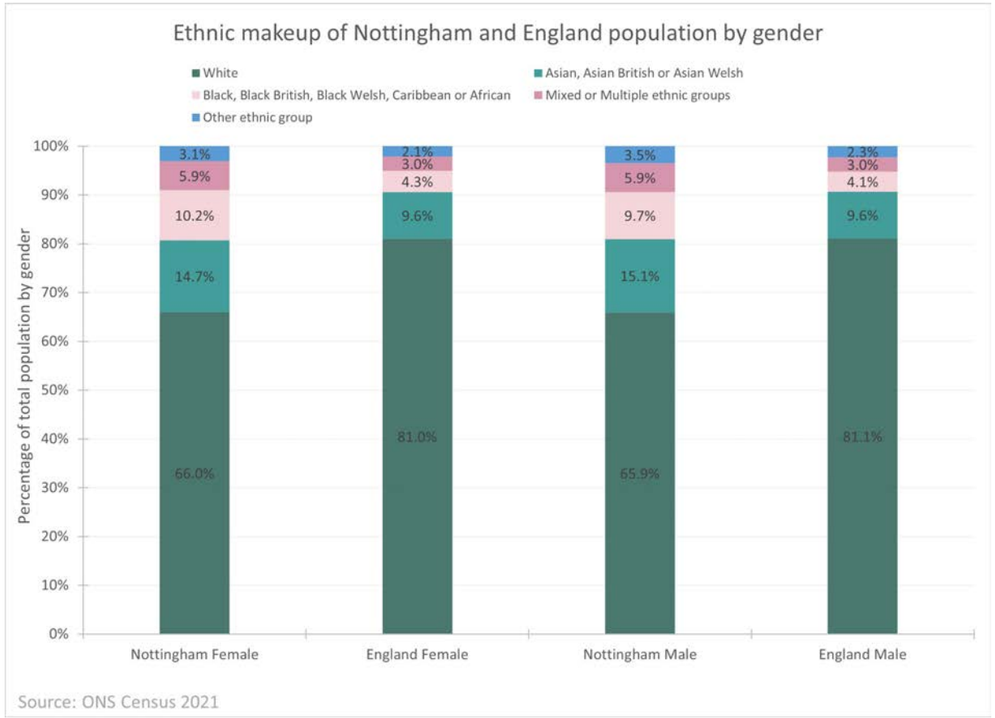
Within Figure 1 it is also seen that in Nottingham more of the population aged over 80 years are women. This mirrors the population distribution seen nationally and is likely due to women having a higher life expectancy than men.

The mean age of women in Nottingham is 36 years, while the median (middle) age is 31 years, both lower than the mean and median ages for women in England (41 and 40 years respectively).

8.3 Ethnicity

Nottingham has a more ethnically diverse population than the England average, according to the latest Census 2021 data where 66.0% of women were from a White ethnic background (including white British and other White backgrounds) compared to 81% in England. Women from Asian backgrounds make up 14.7% of the female population (9.6% in England), 10.2% of women are from Black backgrounds (4.3%), 5.9% have Mixed or multiple ethnic backgrounds (3.0%) and 3.1% are from Other ethnic groups (2.1%). (Figure 2).

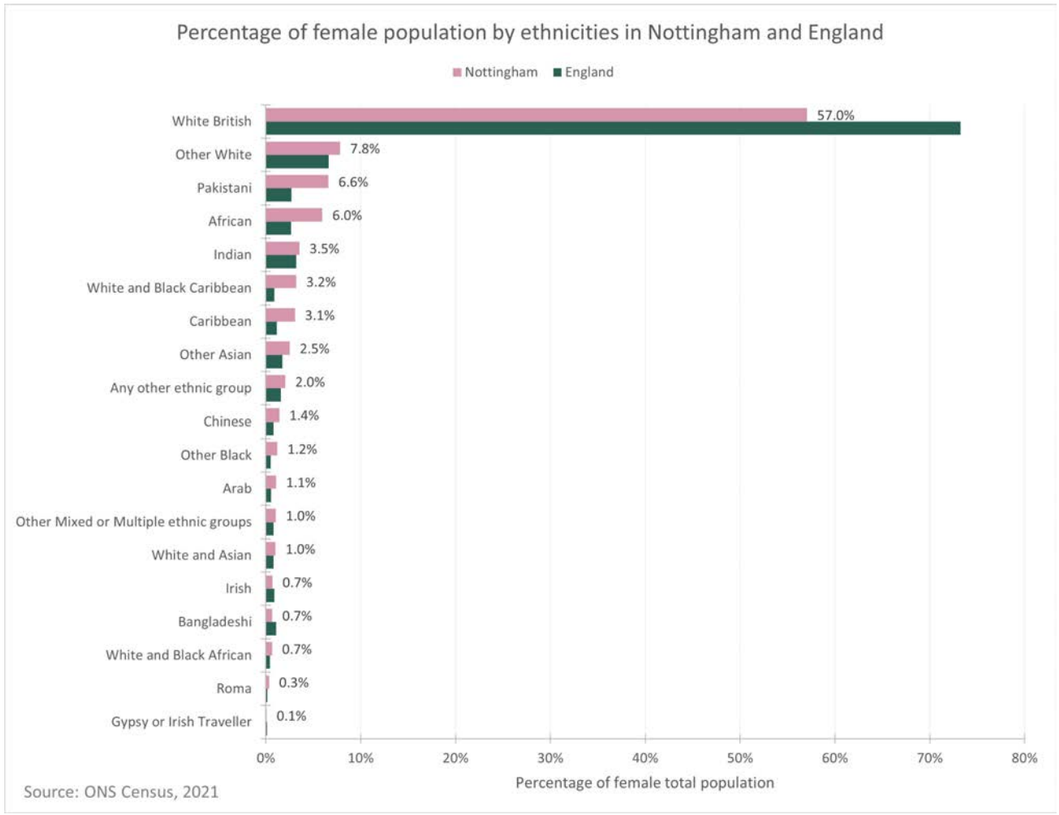
Figure 2. Ethnic makeup of Nottingham and England population by gender



Clear differences in ethnicity by age group are also seen in Nottingham. Of the population (male and female) aged 0-49, around 50% are from an ethnicity other than White British. For those aged 50-64, this decreases to around 30%, and in those aged 65+, only 16% are from an ethnic minority background.

The five broad ethnic groups are further divided into 19 ethnicities (Figure 3), with the figures for Nottingham and England compared in Figure 4. In Nottingham, 57.0% of women identified as White British, 7.8% as Other White, 6.6% as Pakistani, 6.0% as African, 3.5% as Indian, 3.2% as White and Black Caribbean and 3.1% as Caribbean. For each of the remaining groups, less than 3% of women in Nottingham identified as being from each ethnic background.

Figure 3. Percentage of female population by ethnicities in Nottingham and England (Census 2021)



8.4 Sexual orientation and gender identity

Although breakdown by sex is not available, data was collected in the 2021 Census on sexual orientation and gender identity. 85.3% of Nottingham's population aged 16 years and over identified as straight or heterosexual, 2.6% as bisexual, 1.8% as gay or lesbian, and 0.5% as other sexual orientations. Information was not available for 9.8% of the population. When asked about gender identity, 90.6% of the population aged 16 years and over have the same gender identity as registered at birth, 0.4% have gender identity different from sex registered at birth, 0.2% identify themselves as trans men, 0.2% as trans women, 0.2% have all other gender identities. Information on gender identity for 8.6% of Nottingham's population is not known.

8.5 Languages

The languages spoken in Nottingham City aside from English are diverse and reflect the multicultural makeup of the area. Table 1 shows the top 10 languages (after English) spoken in Nottingham City according to the 2021 Census. This may be helpful for services when providing health information e.g. leaflets, posters, to ensure it is accessible to those women for whom English is not their first or main language.

Table 1. Top 10 languages (after English) spoken in Nottingham (Census 2021)

Language	Percentage of population aged 3 years or over
Polish	18.4%
Urdu	10.3%
Arabic	7.7%
Romanian	6.5%
Panjabi	4.5%
Portuguese	3.8%
Italian	3.0%
Kurdish	3.0%
Spanish	2.9%
Persian/Farsi	2.3%

8.6 Religion

In Nottingham, 41.2% of the population stated they had no religion when asked during the 2021 Census, this is higher than the national average of 36.7% (Figure 4). The most common religions in Nottingham were Christianity and Islam with 34.7% of the population identifying as Christian and 12.2% as Muslim, and all other religions representing less than 5.0%. Just under 8% of Nottingham respondents did not answer the question on religion. Religious beliefs may affect how women are able to or feel comfortable interacting with health and care services, for example, needing a female practitioner in the case of Muslim women.

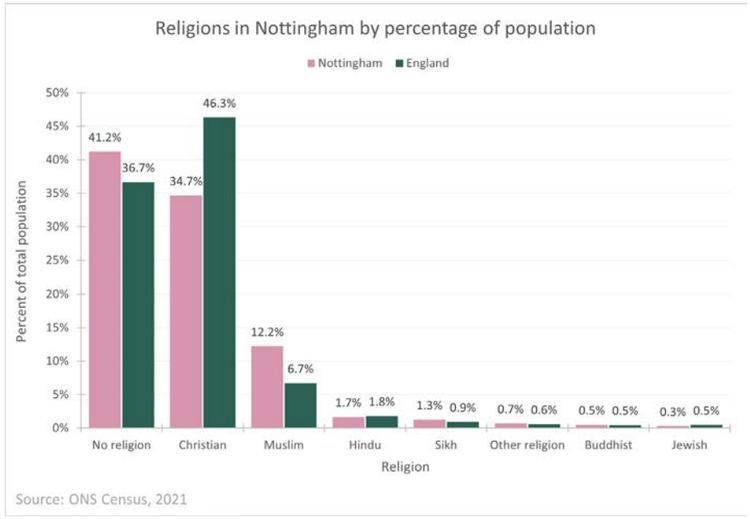


Figure 4. Religions in Nottingham by percentage of population based on Census 2021

8.7 Deprivation

Nottingham is known to have higher levels of deprivation than the national average, with this being spread across all areas of the city. The Index of Multiple Deprivation (IMD) is used to measure and compare the levels of deprivation in different areas. It uses data on topics such as education, crime, income, employment and health to score and rank areas. As can be seen from the chart at Figure 5, over half of Nottingham's women (56.3%) live in the 20% most deprived areas. Just 4.2% live in the 20% least deprived areas. When we compare this with England, we can see how stark the differences are, as in England only 20.2% of women live in the most deprived areas, and 19.6% live in the least deprived areas[85].

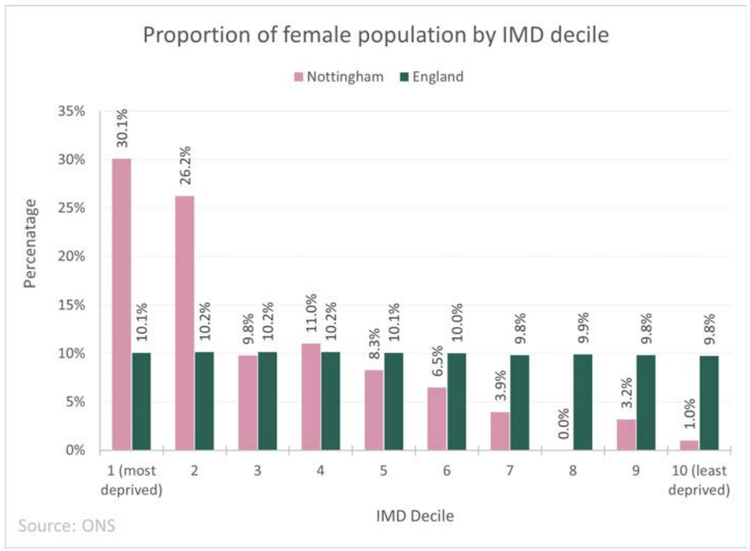
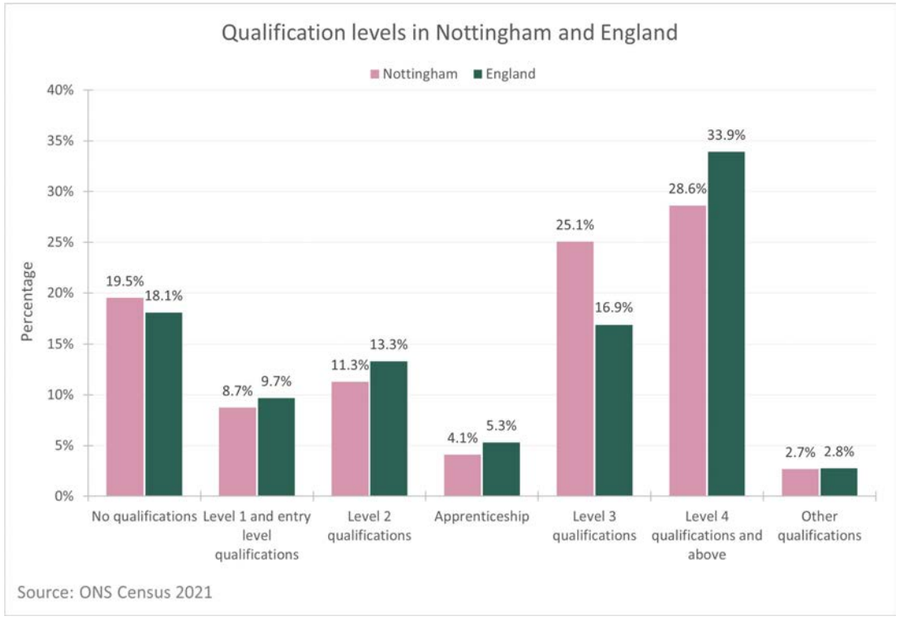


Figure 5. Proportion of female population by IMD decile

8.8 Education

When looking at the levels of educational attainment of the population of Nottingham, it can be seen that slightly more of the population have no qualifications compared to the England average (19.5% compared to 18.1%.) The percentage of Nottingham residents with levels 1, 2 or 4 qualifications as well as apprenticeships is also lower than the national average. In contrast, Nottingham has a higher number of residents with level 3 qualifications, at over a quarter of residents compared to 16.9% in England. (Figure 6) Level 3 qualifications are 'A' levels or equivalent, and the higher proportion in Nottingham may be in part due to the high number of university students, for whom A' level or equivalent qualifications are a pre-requisite to degree level study.

Figure 6. Qualification levels in Nottingham and England based on census 2021



8.8.1 Not in employment, education or training (NEET)

According to data from the Department for Education (DfE), in the academic year 2022/23, around 5.1% (152 females and 190 males) of Nottingham's 16-17 year olds were not in education, employment or training (figure includes those whose activity was not known)[86].

8.9 Housing

Nottingham's housing stock is predominantly within the rented sector, whether this is from the council, another registered provider, or within the private rental market. Only 45% of properties in Nottingham are owner-occupied[71]. Over the past five years, Nottingham City has seen a reduction of 888 properties in its council-owned housing stock, increasing the reliance on privately rented accommodation. This can negatively impact residents as private rentals are generally more expensive and are more likely to fail the Decent Homes Standards, meaning that homes could be of poor quality, or suffer with damp, mould or other problems[87].

Little data is known about the kinds of housing that women in Nottingham are likely to live in, however from council data, we know that female tenants of social housing are more likely to be placed in houses, and male tenants are more frequently placed in flats. As of May 2024, 55.6% of the tenancy holders in Nottingham City Council-owned houses were female. The majority of tenancy holders (74.7%) are aged between 25 and 64 years.

8.10 Marital status and relationships

In Nottingham, 30.8% of people are married or in a civil partnership, which is lower than the England figure of 44.7%. The younger demographics of the city may contribute to this difference. Levels of divorce and separation are similar to the national average, but Nottingham also has less people who are widowed or who are surviving civil partners, with 4.4% compared to 6.1% in England.

8.11 Provision of unpaid care

Nottingham's population aged 5 and over generally report providing unpaid care at slightly lower levels than the England population as a whole, as seen in Table 2 below. The data show that females in Nottingham are more likely to be unpaid carers than males, illustrating that the burden of care falls disproportionately on women. This additional responsibility potentially impacts on women's resources to look after their own health and wellbeing. This theme is explored further in section 12.2.4 of this report.

Table 2: Age standardised hours of unpaid carers broken down by hours of care provided per week and gender (Census 2021)

Hours of unpaid care provided per week	England	Nottingham Persons	Nottingham Females	Nottingham Males
Non-carer	91.1%	90.6%	89.3%	91.9%
19 or less	4.4%	3.9%	4.3%	3.5%
20 to 49	1.8%	2.2%	2.6%	1.8%
50 or more	2.7%	3.2%	3.7%	2.7%

There may be some relationship between deprivation and provision of unpaid care, with 64.1% of those providing 50 or more hours of unpaid care per week living in the 20% most deprived areas in Nottingham, and only 3.8% living in the least deprived areas.

8.12 Economic activity and employment

National data show that Nottingham has higher levels of economic inactivity than England as a whole, with 31% of the population being economically inactive compared to 21.2% in England, and with the local trend being that these levels are increasing (Department of Health and Social Care, 2023/2024).Economic inactivity may arise from several situations, including those who have taken time out of work to raise families, those who are retired or who have a long term illness or disability, and those who are in full time education. As Nottingham has a high student population, and slightly higher than average levels of self-declared disability, this may in part explain the higher level of recorded economic inactivity within the population.

In terms of gender inequalities, women are more likely to be economically inactive than men, with the data for Nottingham indicating that 37.0% females are economically inactive compared to 24.4% males (Department of Health and Social Care, 2023/2024). This gender split may be somewhat reflective of the disparities in unpaid care as seen in section 8.11.

8.12.1 Average weekly earnings and gender pay gap

The gross median weekly earnings for a full time worker living in Nottingham are £589, lower than the England average of £732. Women living in Nottingham also earn less than the national average, with the local median gross salary being £569 compared to £671 for women nationally. These figures are also lower than the median gross salary for men, which is £598 for those living in Nottingham and £783 nationally[88].

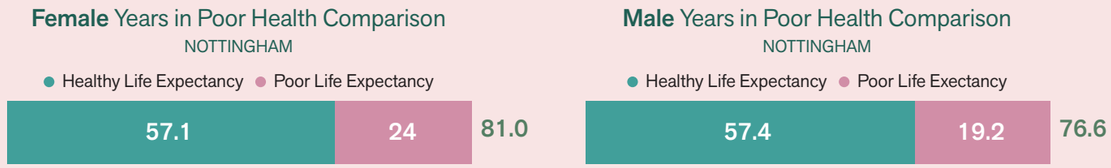
The survey uses data gathered to create estimates of the gender pay gap (based on hourly earnings), with Nottingham's estimated median gender pay gap being 2.8% for full time workers. This compares favourably to the England gap of 8.3%, meaning that Nottingham's women experience less of a pay gap than the national average – a positive finding for gender equality locally – however income deprivation and financial security are a determinant of health and wellbeing, and the low pay experienced by workers both male and female in Nottingham is likely to contribute to disparities in health and wellbeing not only for those workers themselves, but also their offspring.

9 Data analysis – women's health in Nottingham

Women in Nottingham experience poorer health outcomes than the national average. This is reflected in both lower life expectancy at birth and higher mortality rates for those under 75. On average, their healthy life expectancy is 5.1 years shorter than the national figure.

Compared to men in Nottingham, women live longer - 81 years versus 76.6 - but spend more of those years in poor health (24 years compared to 19.2; Figure 7)[48]. As a result, women spend a greater proportion of their lives in the 'window of need'. These disparities are further widened when considering other demographic factors. For example, women from ethnic minority communities report poorer health earlier in life than White women[158] , and women in more deprived areas tend to have shorter life expectancies than those in less deprived areas[39].

Figure 7: Healthy Life Expectancy in Nottingham by sex



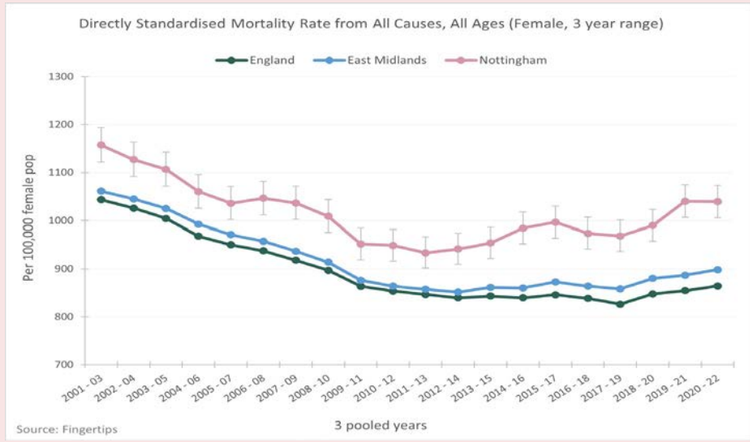
9.1 Mortality – what causes deaths of women in Nottingham?

9.1.1 Trend in Nottingham

Over a 20 year period (April 2001 to March 2022) there has been a decrease in all-cause mortality rates for females in Nottingham, from 1,157 deaths per 100,000 female population in 2001 to 1,039 deaths per 100,000 female population in 2022.

Although the overall trend mirrors what is happening elsewhere in the country, rates of mortality in Nottingham females are significantly higher than rates in both England and the East Midlands.

Figure 8: Directly Age Standardised Mortality Rate from All Causes, All Ages (Female, 3-year range)



The lowest mortality rate in females in Nottingham was recorded in 2011-13 (933 deaths per 100,000 female population) with an increase being seen after this time, with mortality rates increasing from 968 per 100,000 female population (2017-19) to 1,039 in 2019-21 and remaining the same in 2020-22. Although high, this value is significantly lower compared to the highest rate of 1,157 per 100,000 female population recorded in 2001-03. In addition, this increase in mortality could be linked to the COVID 19 pandemic, with the first case in Nottingham reported on the 28th of February and the first death recorded approximately a month later (27th March 2020).

Between 1st January 2020 and 31st December 2022, a total of 3,915 female deaths from all causes were registered in Nottingham for those aged 16 years and over.

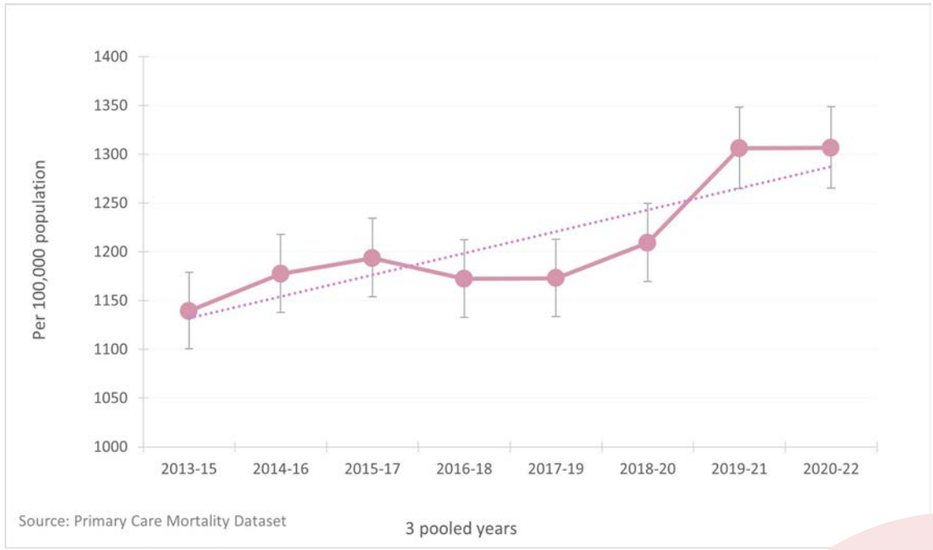
This accounts for 47.5% (3,915 of 8,240) of all deaths in the Nottingham's population aged 16 year and above and equates to a directly age standardised rate of 1,306 per 100,000 female population aged 16 and over.

Compared to the pre-pandemic years (2017-19), there was a 12.2 % increase in the number of deaths registered from all causes for females aged 16 and over in the most recent 3-year period (2020-22). This increase can be attributed to the COVID-19 pandemic

Mortality rates for females aged 16 and above are not currently available at national and regional levels for comparison.

Looking more closely at the period since 2013, the all-cause mortality rate in Nottingham's female population aged 16+ has been on the increase, rising from 1139.3 deaths per 100,00 female population (2013-15) to 1306.6 deaths per 100,000 female population (2020-22) as illustrated in figure 9 below. This equates to a 15% increase in mortality rate in females aged 16+ years.

Figure 9: Directly Age standardised Mortality Rates from All Causes for Females aged 16 years and over.



During this period, the overall trend shows an increase in mortality rates, increasing from 1139.3 (2013-15) to 1193.6 in 2015-17 and then remaining stable between 2015-17 and 2017-19. This is followed by a slight increase and then a more rapid increase between 2018-20 (1209.1) and 2019-21 (1306.1), which is likely to have been impacted by Covid-19 deaths. Rates in the more recent years have remained stable, albeit significantly higher than previous years.

9.1.2 Mortality by Age

Of 3,915 female deaths (aged 16+ years) registered in 2020-22, more than two thirds (69%, 2700) occurred in females aged 75 and over and less than 1% in females aged 16-24 years as shown in Figure 10 below. The proportion of deaths for each age group increases with age. A similar pattern is mirrored in Figure 10b, which shows the age specific mortality rates per 1,000 female population by 5-year age bands.

Figure 10a: Registered Deaths from All Causes by Quinary Age bands (Females aged 16 years and over), 2020-22.

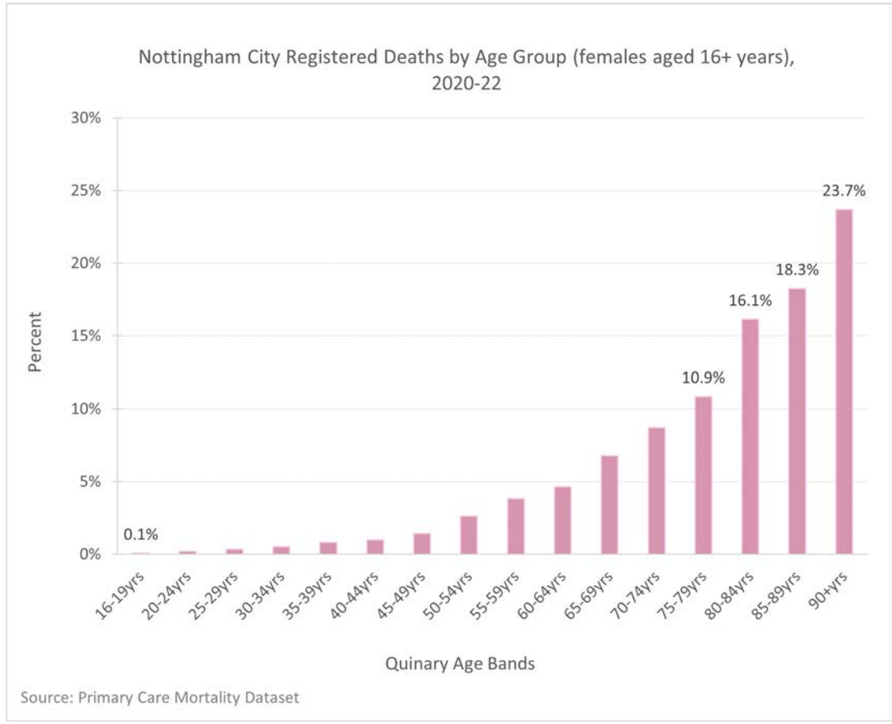
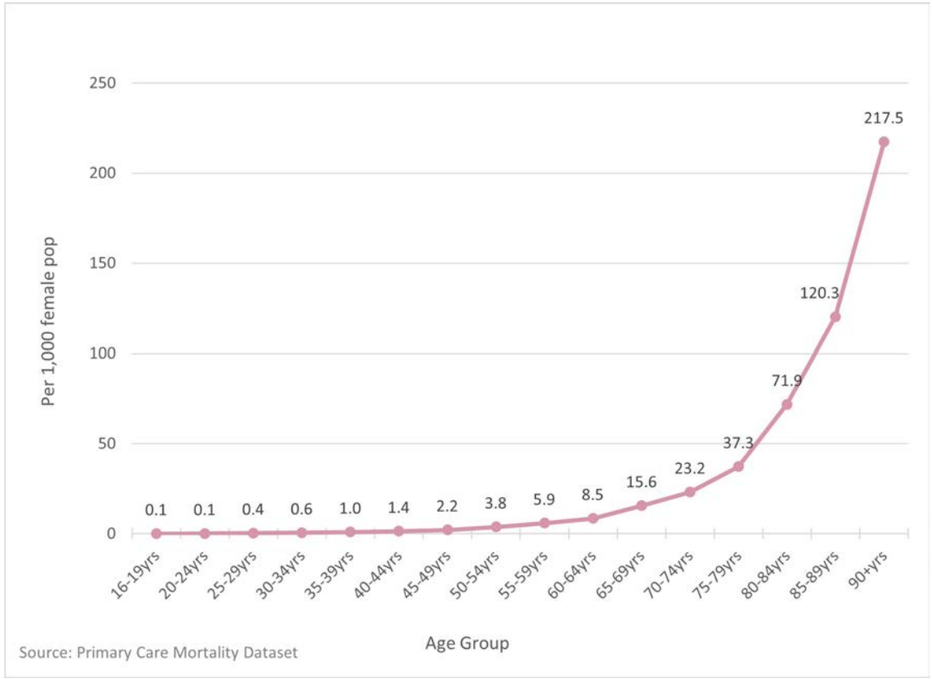


Figure 10b: Age-Specific Mortality Rates per 1,000 female population, Females aged 16 years and over, 2020-22.



9.1.3 Leading Causes of Death

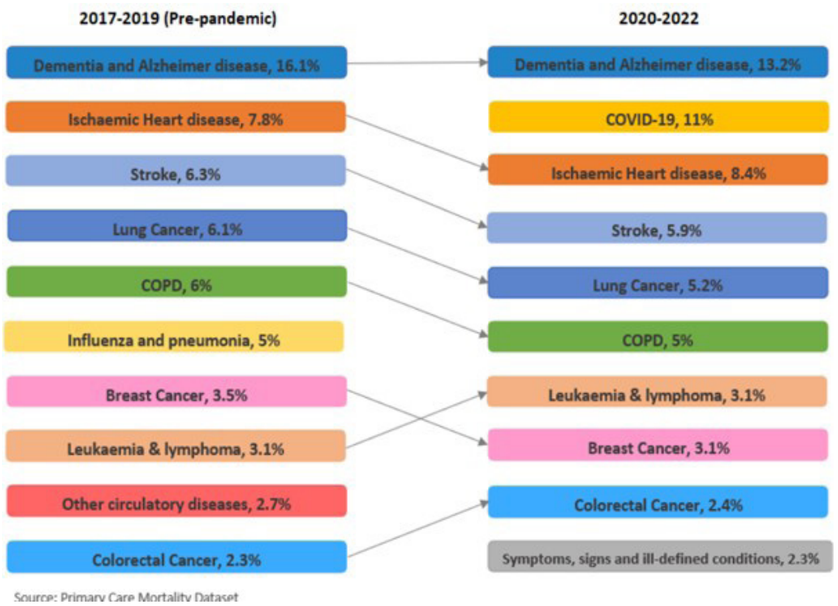
The top 10 leading causes of death in 2020-22 for females aged 16+ years residing in Nottingham are shown in Figure 11 below. These account for more than half (59.6%) of all registered deaths in females aged 16+ years.

In the most recent 3-year period, (2020-22), Dementia and Alzheimer's was the leading cause of death with 13.2% of all registered deaths in females aged 16 years and over.

Following Dementia and Alzheimer's disease, Covid-19 (11%), Ischaemic heart disease (8.4%), Stroke (5.9%), and Lung cancer (5.2%) were other leading causes of death.

Compared to pre-pandemic years (2017-19), Dementia and Alzheimer's, Ischaemic heart disease and Stroke were the top 3 leading causes of death, accounting for 16.1%, 7.8% and 6.4% of registered deaths in females aged 16 and over respectively.

Figure 11: Top 10 Leading Causes of Death in Females Aged 16 years and over





9.1.4 Leading Causes of Death by age group

9.1.4.1 Leading Causes of death for those aged between 16 and 74 years

For females aged between 16 and 74 years, COVID -19 was the leading cause of death in 2020-22, accounting for 10.4% of registered deaths in females from all causes. Ischaemic heart disease and Lung cancer were the 2nd and 3rd most common causes of death in this age group accounting for 9.7% and 8.4%, respectively.

Compared to the pre-pandemic 3-year period, the top 10 leading causes of death for females aged 16 -74 years residing in Nottingham is similar with 7 of the 10 diseases appearing on both lists albeit in different order as illustrated in figure 12 below.

Figure 12: Top 10 Leading Causes of Death in Females Aged between 16 and 74 years

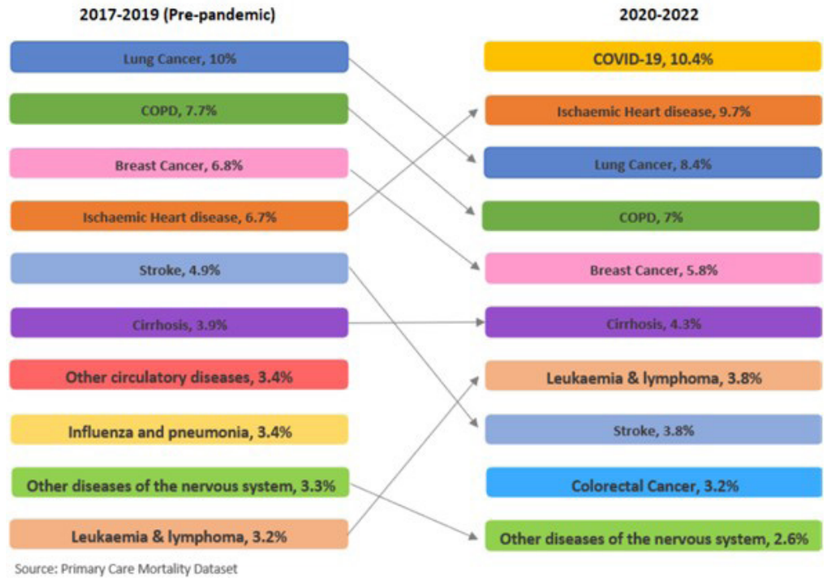
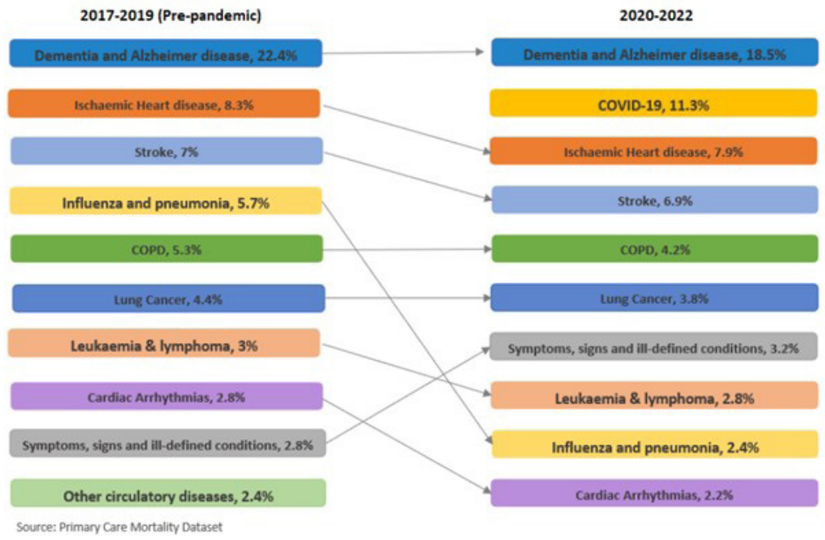


Figure 13: Top 10 Leading Causes of Death in Females Aged 75 years and over



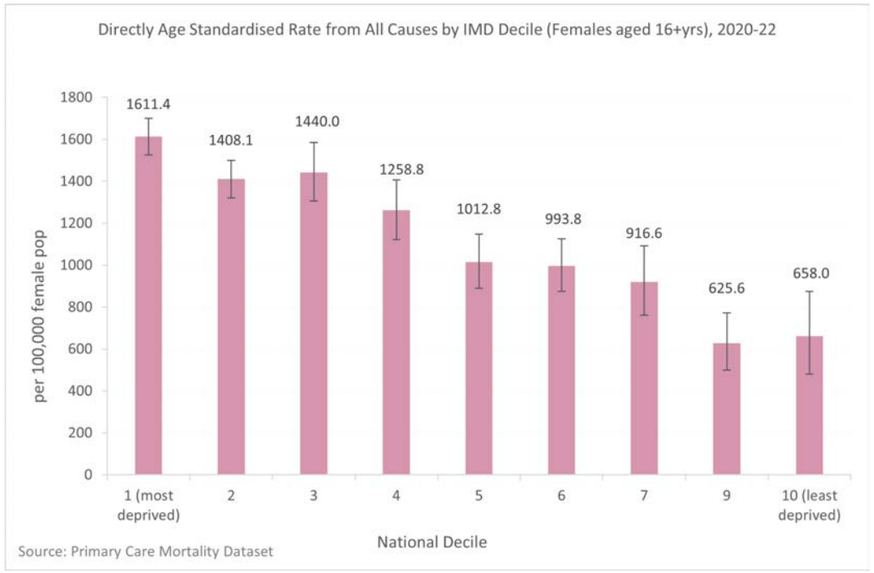
9.1.5 Leading Causes of Death by deprivation decile

As Nottingham experiences high levels of deprivation, causes of death by deprivation decile were examined, to highlight any differences for women based on this.

In 2020-22, the 20% most deprived areas in Nottingham experienced a higher rate of deaths compared to the 20% least deprived areas, recording 60.7% (2376) and 3.7% (145) of registered deaths in females aged 16 years and above respectively. In both the 20% most deprived and 20% least deprived areas of Nottingham, the majority of female deaths recorded in these areas occurred in those aged 75 years and over (66.1%, (1571) and 66.6%, (111) respectively). As a large proportion of Nottingham's population lives in the 20% most deprived areas, it may be anticipated that there would be a higher proportion of deaths in the population from these areas, however as the data in figure 14 shows, there are inequalities in the rates of mortality across the deprivation deciles.

The all-cause mortality rate in females (16+ years) in the most deprived areas of Nottingham is not only significantly higher but also 2.4 times higher than rates in the least deprived areas as shown in figure 14 below.

Figure 14: Directly Age Standardised Rate from All Causes by IMD Decile (Females aged 16+yrs) 2020-22



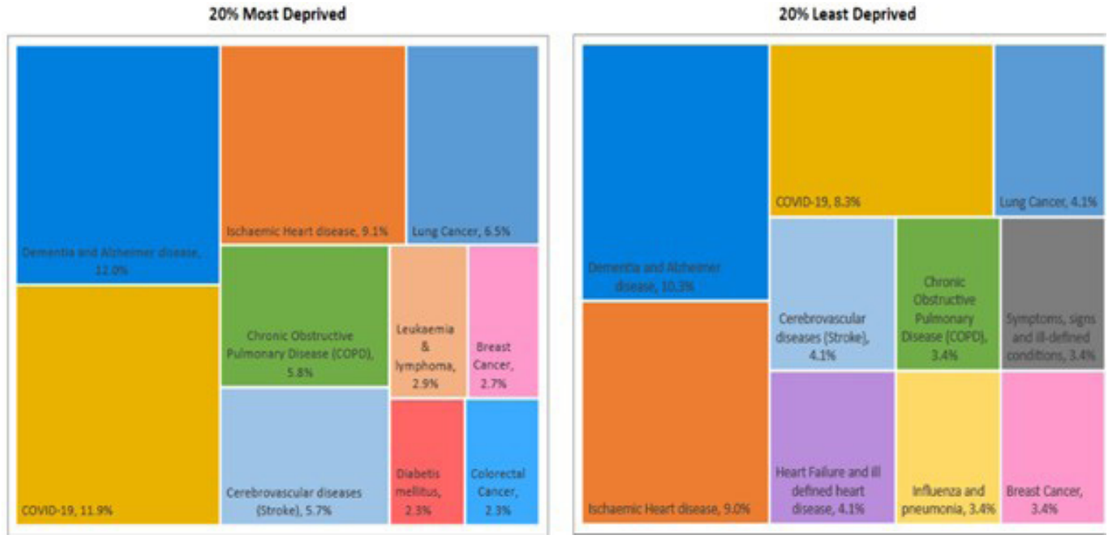
The top 10 leading causes of death in the 20% most deprived and 20% least deprived areas of the city for females aged 16+ years are displayed in figure 15 below. These 10 causes account for 61.2% and 53.8% of all registered female deaths in each time period respectively.

Dementia and Alzheimer's disease was the leading cause of death in both the 20% most deprived and 20% least deprived areas of Nottingham City accounting for 12% and 10.3% of female deaths in the respective areas.

COVID-19 and Ischaemic heart disease were the other 2 leading causes of death in both the 20% most deprived and 20% least deprived albeit in different order.



Figure 15: Leading Causes of Death in the 20% Most and 20% Least Deprived Areas of Nottingham City (Females aged 16+yrs), 2020-22



The key differences that are noted are the bigger impact that Covid-19 had on women from the 20% most deprived areas (11.9% deaths compared to 8.3% in 20% least deprived areas), as well as higher percentage of deaths within women from the 20% most deprived areas from conditions that could be linked to health behaviours; lung cancer and COPD (linked to smoking), and diabetes and colorectal cancer (linked to obesity and poor diet)

Due to extremely low numbers of deaths, particularly in the 16-74 age group in the 20% least deprived areas of the city, further analysis was not carried out on this age group.

9.1.6 Leading causes of death by year

For all years observed, Dementia and Alzheimer's disease remains the leading cause of death in women aged 16 years and over, with the highest number of deaths and significantly higher mortality rates compared to other causes as illustrated in figures 16 and 17 below.

As noted in the report on leading causes of death in the UK 2001 to 2018[89], there are several reasons why the number of deaths from Dementia and Alzheimer's disease has increased in recent years. Dementia and Alzheimer's disease are more likely to occur among older age groups and more people are living longer and surviving other illnesses. In addition, a better understanding of dementia and improved diagnosis is likely to have caused increased reporting of dementia on death certificates.

The number of deaths from Ischaemic heart disease and corresponding mortality rate has remained similar in more recent years accounting for 8.4% of registered deaths in females aged 16+ years in both 3-year periods (2019-21 and 2020-22). From the period 2018-2020 onwards, the impact of Covid-19 can be clearly seen.

Figure 16: Deaths Registered by Leading Cause of Death, Females aged 16 years and over, 2013-22

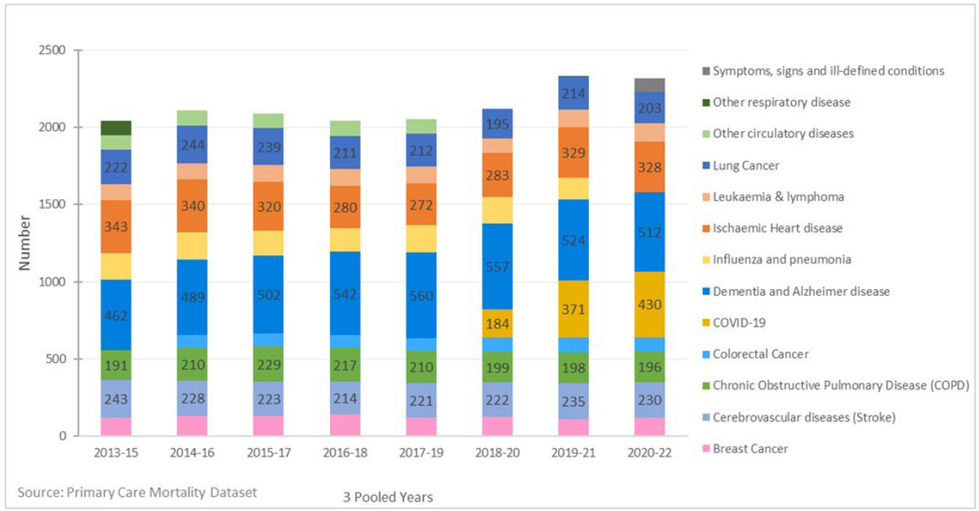
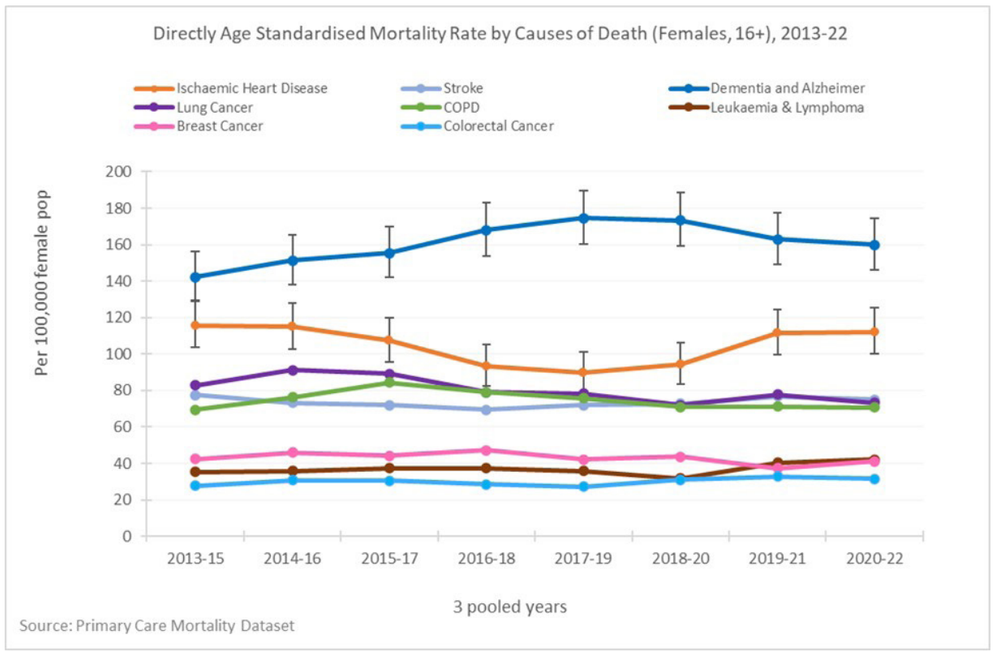


Figure 17: Directly Age Standardised Rate by Causes of Death (females aged 16 years and over), 2013-22



9.1.7 Mortality summary

Between 2001–03 and 2011–13, female mortality rates in Nottingham steadily declined, but rose from 2013–15 onwards, with a notable increase during the Covid-19 pandemic (2019–21). Mortality rates rise with age and are significantly higher among women in more deprived areas, where both overall death rates and causes—such as Covid-19—are more severe.

Dementia and Alzheimer's disease are the leading causes of death among women in Nottingham, followed by Covid-19, ischaemic heart disease, and stroke. Lung cancer also ranks highly, likely reflecting Nottingham's historic smoking rates. These conditions (particularly dementia and Alzheimer's disease) predominantly affect women aged 75+, explaining their prominence in overall mortality figures.

[c] Note that only leading causes of death are presented in figures 16 & 17, not all causes.

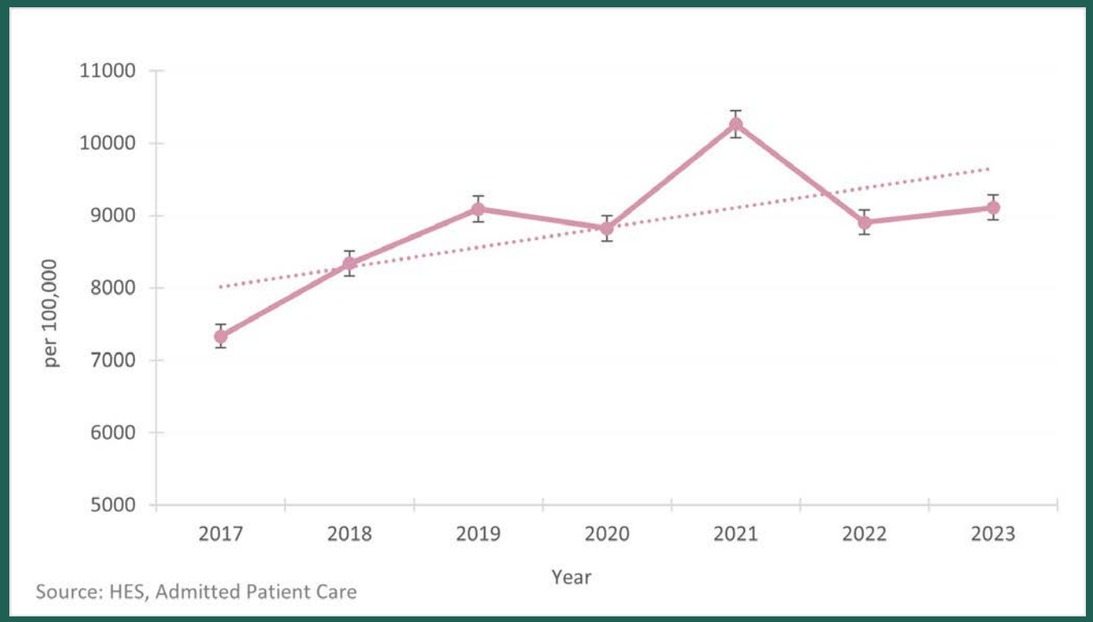
10 Morbidity – what health conditions are women in Nottingham living with?

10.1 Admissions

Between 1 January and 31 December 2023, there were 11,940 emergency hospital admissions, involving 8,795 women aged 16 and over. This equates to a rate of 9,111.7 admissions per 100,000 women in this age group which is similar to the pre-pandemic rate of 9,090.3 in 2019.

Admission rates for this cohort have seen an overall upward trend, rising from 7,332.6 in 2017 to 9,111.7 in 2023, as shown in Figure 18. The rate was highest in 2021 at 10,259.9, likely due to the COVID-19 pandemic (March 2020–December 2021).

Figure 18: Emergency Hospital Admissions, Females aged 16 and over: Directly Age Standardised Rates (per 100,000 female population aged16 and over), 2017 - 2023



10.1.1 Admissions by age group

Figure 19 shows the distribution of emergency hospital admissions among women aged 16 years and older for the years 2019 and 2023.

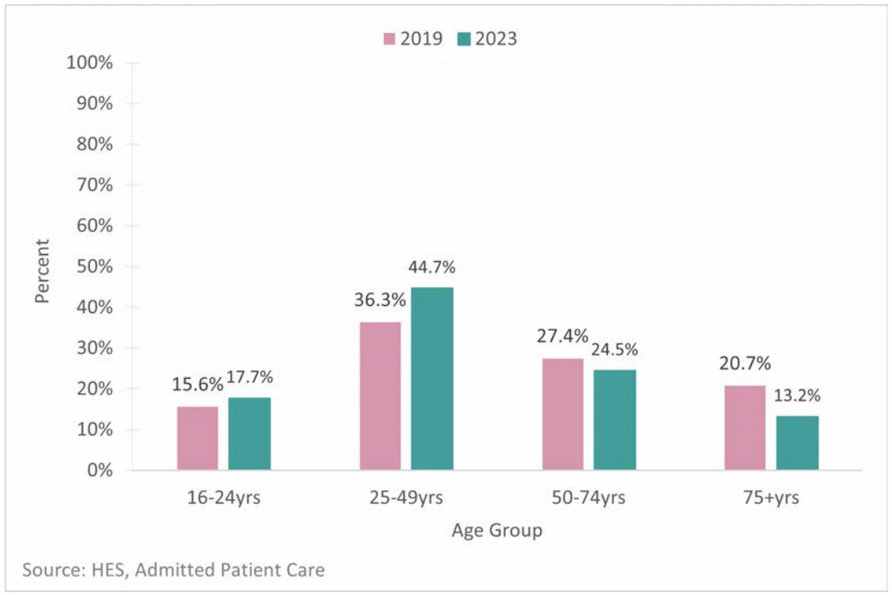
For both years, women aged 25-49 years made up the majority of admissions, followed by the 50-74 year age group. The proportion of admissions in the 25-49 age group in 2023 is higher compared to 2019, rising from 36.3% in 2019 to 44.7% in 2023. Conversely, proportions for the 50-74 age group decreased from 27.4% in 2019 to 24.5% in 2023.

Admissions in women aged 75 years and over saw a notable decline, dropping from 20.7% in 2019 to 13.3% in 2023.

The proportions for the 16-24 and 50-74 age groups are comparable across both time periods.

Overall, the graph highlights a shift in the age distribution of emergency hospital admissions, with a greater proportion of admissions in younger women (16-49 years) and a decreasing proportion among older age groups (50 years and above) in 2023 compared to 2019.

Figure 19: Emergency Hospital Admissions (persons) by Age Group, Women aged 16 years and over, 2019 & 2023



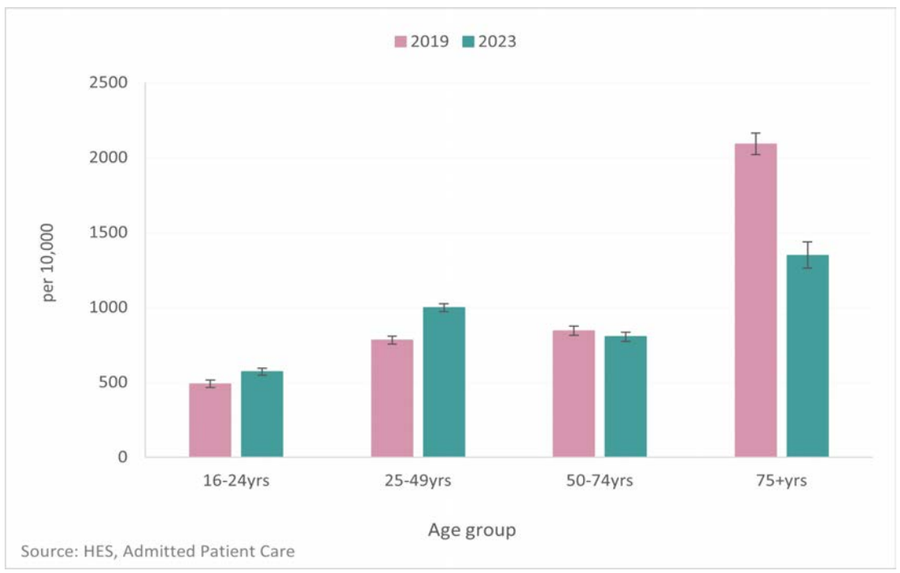
Age standardised hospital admission rates in women aged 75 years and over are significantly higher than rates in other age groups in both 2019 and 2023, as illustrated in Figure 20 below.

Notably, the pre-pandemic admission rate for the 75+ years age group (2,089.6 per 10,000 female population aged 75+ years) is 1.6 times higher than the rate in 2023 (1,346.6 per 10,000 female population aged 75+ years).

For the other three age groups, admission rates in 2023 are significantly higher in the 16-24 and 25–49 age groups compared to 2019 while rates in the 50-74 age group remain similar between the two years.

Rates in the 16-24 age group remains the lowest across all age groups and for both years.

Figure 20: Directly Age Standardised Hospital Admission Rates by Age Group, Women aged 16 years and over, 2023



10.1.2 Admissions by Ethnicity

Figure 21 below compares the percentage distribution of emergency hospital admissions by ethnicity in 2023 with the ethnic distribution from 2021 census for women aged 16 and over.

Of 8,795 women aged 16 years and over admitted, over two-thirds (68.5%) identified as White, 13.7% as Asian, 9.4% as Black and 4.4% and 4.1% from 'Other' and 'Mixed' ethnic backgrounds, respectively.

When compared to the ethnic distribution of women aged 16 years and over from the 2021 Census, there is an over-representation of women from 'Black' and 'Other' ethnic backgrounds and an under-representation of women from 'Mixed ethnic background' group (It is noted that ethnicity may not always be recorded accurately within hospital admissions data, which should be taken into consideration with this finding).

Overall, the distribution of emergency admissions among ethnic groups is broadly consistent with population proportions, although slight variations exist, particularly in the 'Other' and 'Mixed ethnic background' groups.

Figure 21: Emergency Hospital Admissions (persons) by Ethnicity, Women aged 16 years and over, 2023

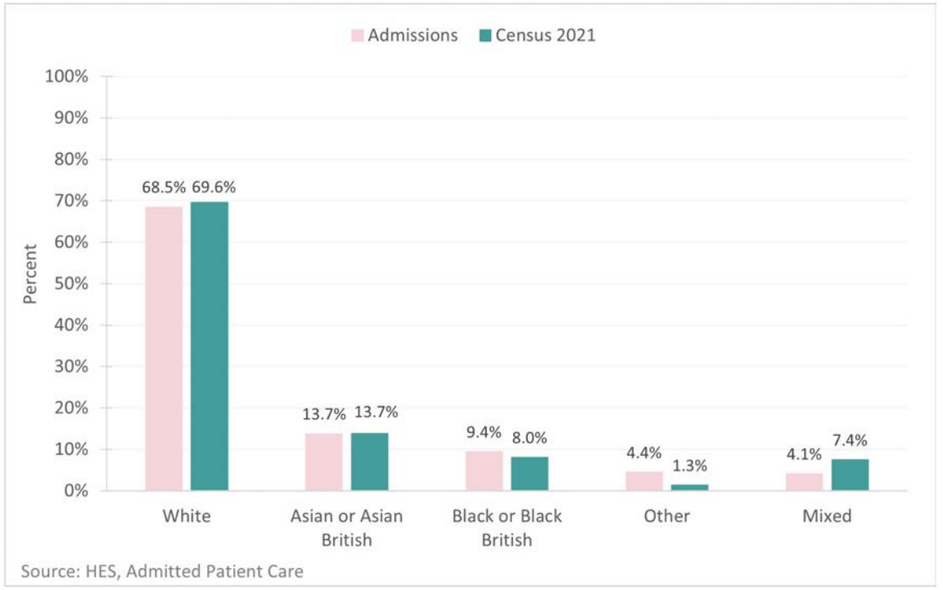
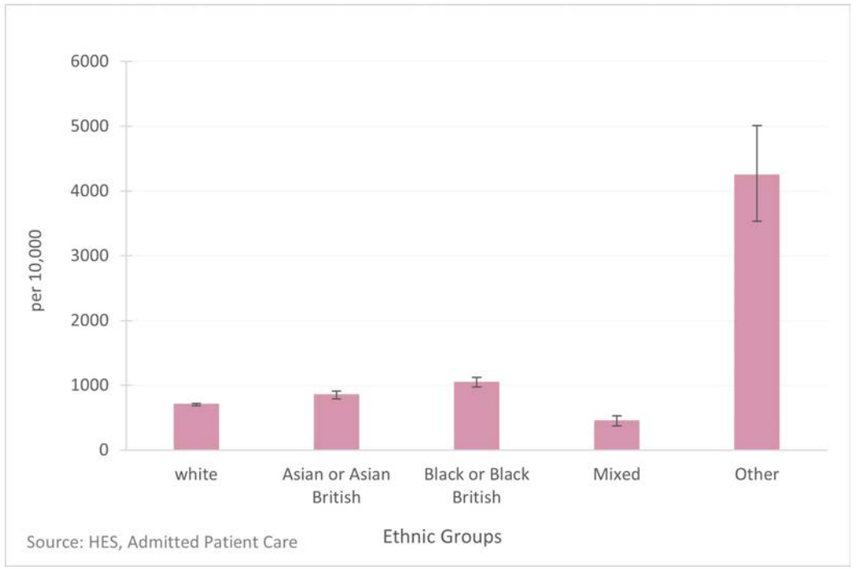


Figure 22 below shows that admission rates are highest in 'Other' ethnic groups and significantly higher than tthe alternative ethnic groups. However, this is due to the relatively high number of admission episodes compared to the population. Women from 'Other' ethnic background account for 4.4% of emergency admissions despite making up only 1.3% of the population of women aged 16 years and over in Nottingham.

The admission rate in women from Black ethnic backgrounds is also significantly higher compared to rates in women from White, Asian, or Mixed ethnic backgrounds. The lowest admission rates are observed among women

Figure 22: Directly Age Standardised Hospital Admission Rates (per 10,000) by Ethnic Group, Women aged 16 years and over, 2023



10.1.3 Admissions by Deprivation Decile

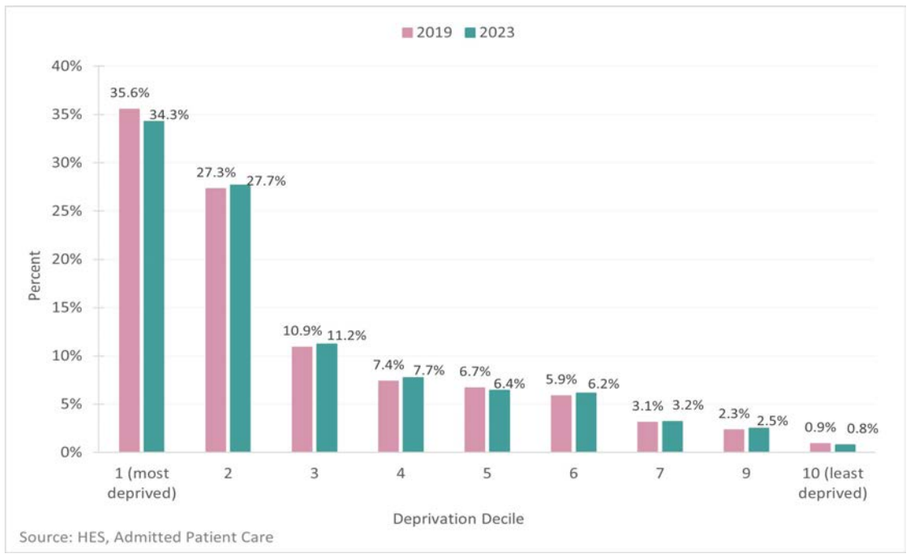
The percentage distribution of women aged 16 years and over admitted to hospital across deprivation deciles for the years 2019 and 2023 is shown in Figure 23 below

In both years, over 60% of women admitted came from the 20% most deprived areas of the city and less than 4% from the 20% least deprived areas.

A similar proportion of women aged 16 years and over were admitted across the city's deciles in both years except for the most deprived decile, where admissions were slightly higher in 2019 compared 2023.

The graph highlights the disparity in admissions with the most deprived deciles accounting for a disproportionately higher percentage of admissions compared to the least deprived deciles.

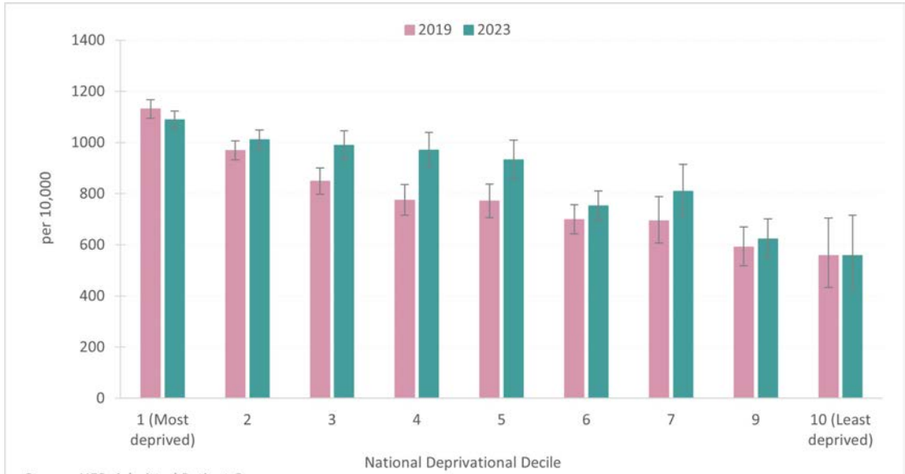
Figure 23: Emergency Hospital Admissions (persons) by Deprivation Decile, Women aged 16 years and over, 2019 & 2023



In both 2019 and 2023, admission rates among women aged 16 years and over in the most deprived areas were significantly higher than rates in the most affluent areas of the city, approximately 2 times higher (1,087.7 per 10,000 female population in the most deprived areas and 558.2 in the least deprived areas). A similar pattern is also observed in 2019 as shown in Figure 24 below.

Admission rates in 2023 are higher than rates in 2019 across 7 of the 10 deciles, though the increase is only statistically significant in 3rd, 4th and 5th deciles. In contrast, rates in the most deprived decile are lower in 2023 compared to 2019, but the difference is not statistically significant.

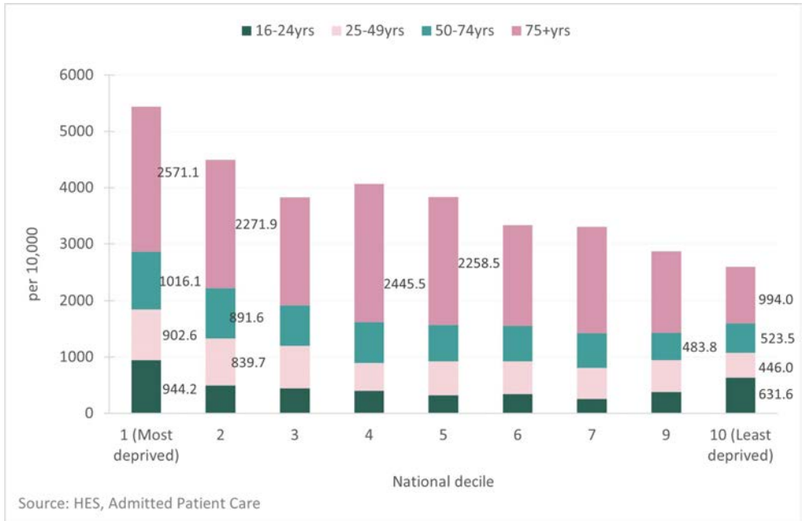
Figure 24: Directly Age Standardised Hospital Admission Rates (per 10,000) by Deprivation Decile, Women aged 16 years and over, 2023



Age specific rates (per 10,000 female population aged 16 years and over) by deprivation deciles are presented in figure 25 below.

Across the deciles, the most deprived deciles consistently show the highest rates across all age groups. Among women aged 75 years and over, rates are 2.5 times higher compared to the most affluent decile. Rates for the 25-49 and 50-74 age groups are approximately twice as high and for 16-24 age group, 1.5 times as high.

Figure 25: Age Specific Rates (per 10,000) by Deprivation Decile, Women aged 16 years and over, 2023



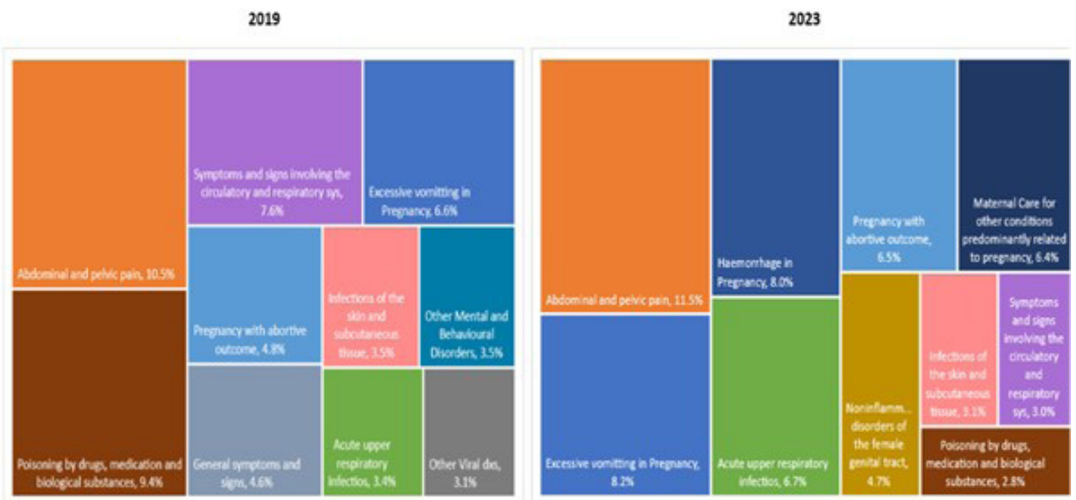
10.1.4 Reasons for Emergency Admissions by Age Group

The most common reasons recorded for emergency admissions in women aged 16 to 24 in 2019 and 2023 are displayed in Figure 26 below. These account for 57% and 60.9% of all admission episodes for both years, respectively.

Abdominal and pelvic pain was the most common reason for emergency admissions in both 2019 and 2023, representing 10.5% and 11.5% of all admission episodes, respectively.

This is followed by excessive vomiting in pregnancy (8.2%) and haemorrhage in pregnancy (8.0%) in 2023 whilst in 2019 poisoning by drugs, medication, and biological substances (9.4%) and symptoms and signs involving the circulatory and respiratory systems (7.6%) were the other two main causes for emergency admissions.

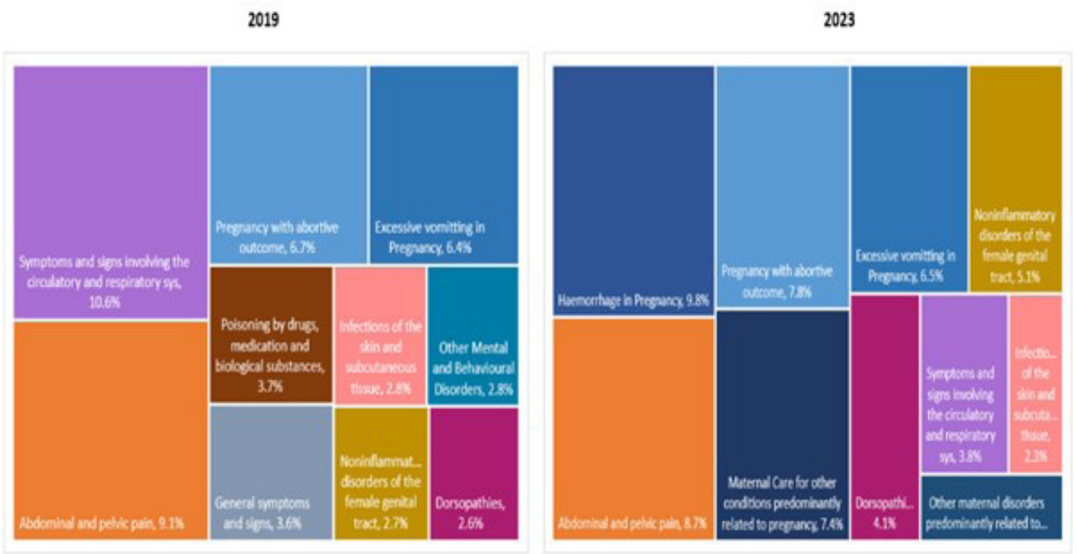
Figure 26: Emergency Admissions in Women aged 16 to 24 years, 2019 & 2023: Top 10 Reasons



The top 10 reasons for emergency admissions in women aged 25- 49 years for 2019 and 2023 are shown in Figure 27 below, these represent over half of all admissions for the respective years.

Symptoms and signs involving the circulatory and respiratory system (10.6%) was the main reason for emergency admissions in 2019 whilst in 2023, haemorrhage in pregnancy (9.8%). This is followed by abdominal and pelvic pain and pregnancy with abortive outcome for both years

Figure 27: Emergency Admissions in Women aged 16 to 24 years, 2019 & 2023: Top 10 Reasons



[D] Data may be affected if there have been changes to coding practices during the relevant time period.

In women aged 50 to 74 years, the top 10 most common causes of emergency admissions account for 52.4% and 46.6% of all admissions in 2019 and 2023 (Figure 28).

In both years, falls were the main reason for emergency admissions in this age group, followed by symptoms and signs involving the circulatory and respiratory systems and abdominal pain in 2019. Conversely in 2023, dorsopathies which are conditions of the spine and the tissues surrounding it, often accompanied by back and symptoms and signs involving the circulatory and respiratory systems were the other top two reasons.

Figure 28: Emergency Admissions in Women aged 50 to 74 years, 2019 & 2023: Top 10 Reasons

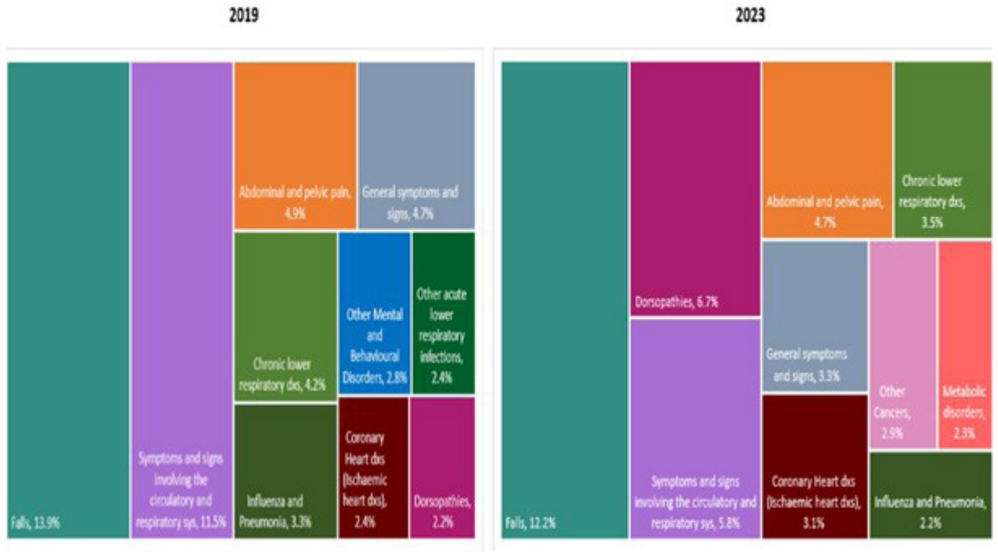


Figure 29: Emergency Admissions in Women aged 75 years and over, 2019 & 2023: Top 10 Reasons

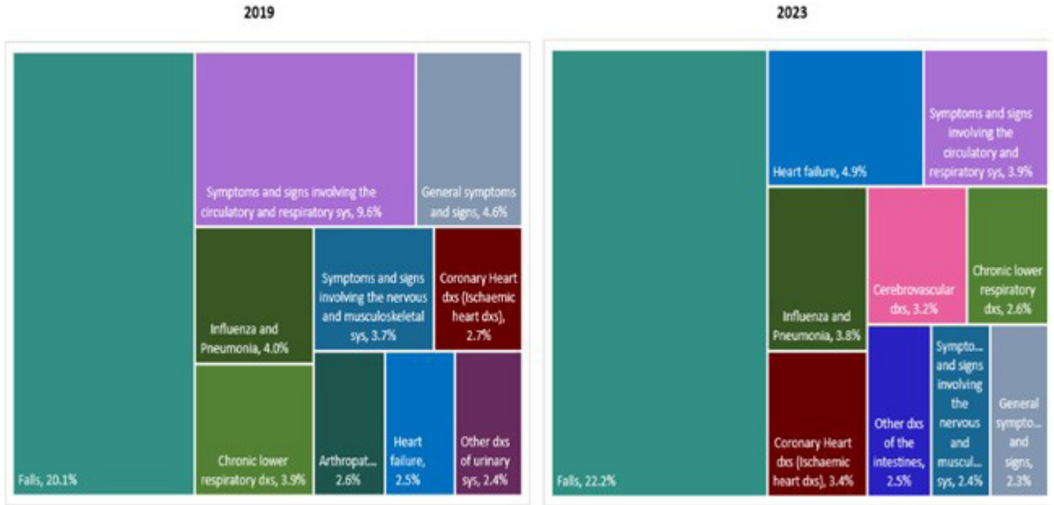


Figure 29 above presents main reasons for emergency admissions in women aged 75 years and over for the years 2019 and 2023. These represent over half of admissions in this age group for both years.

Falls remains the main reason for emergency admissions in both 2019 and 2023, accounting for 20.1% in 2019 and 22.2% of admissions in this age group.

10.1.5 Morbidity Summary

Women aged 75+ are disproportionately more likely to have an emergency hospital admission than other age groups, although by volume, most women admitted in Nottingham city are aged between 25-49 years. Women from 'Other' and Black ethnic backgrounds are more likely to be admitted to hospital than women from other ethnicities, and women from the most deprived areas of the city are almost twice as likely to have an emergency hospital admission as those from the least deprived areas.

The reasons for emergency admission to hospital varies throughout the life course of women. Those aged 16-24 years are most likely to be admitted with abdominal pain or pregnancy related conditions, with this being a similar theme in women aged 25-49. This is not unexpected, given that these are the ages that encompass a woman's fertile years and when she is most likely to need care around pregnancy and maternity, in addition to common gynaecological conditions.

As women age, and move into the 50-74 year age bracket, there is a shift in the kinds of conditions that lead to emergency hospital admissions, with falls, and conditions related to the musculoskeletal system beginning to take their toll on women – perhaps a by-product of the changes experienced during the menopause. For women aged 75+, the biggest risk for emergency hospital admissions is falls, which doubles to become the cause of almost a quarter of admissions for this age group. Older women are also more likely to experience respiratory and heart related conditions.



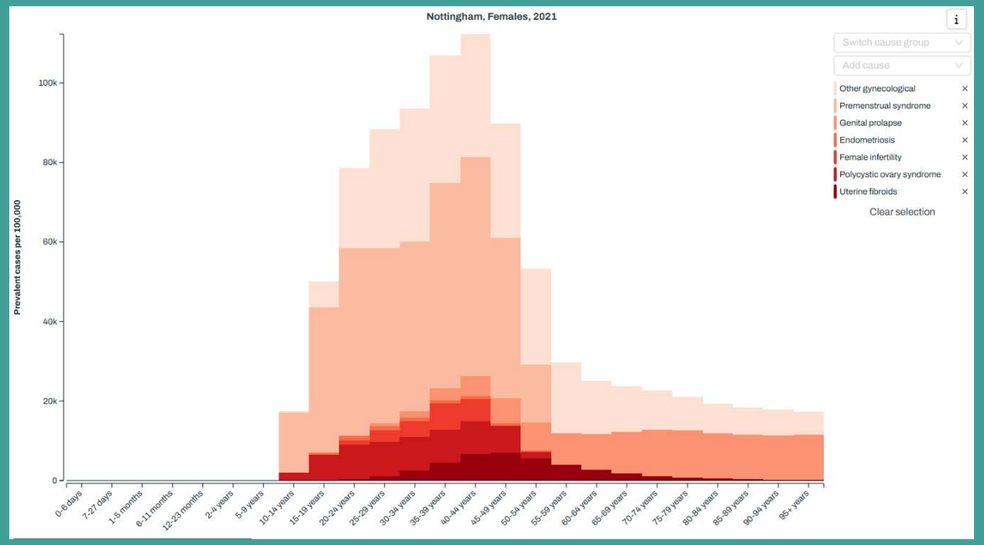
11 Women's health over the life course

11.1 Menstrual health and gynaecological conditions

The area of menstrual health and gynaecological conditions is broad, with conditions of the female reproductive system still considered taboo. Due to the lack of discourse around this specific area of women's health, many women lack the knowledge or confidence to seek medical help, instead coping with the significant impacts on their daily lives by adapting and managing as best they can. Conditions such as heavy menstrual bleeding may be normalised, with women avoiding seeking medical help, sometimes for many years[90].

Local clinical data on prevalence of gynaecological conditions is difficult to analyse due to coding procedures and the multiple ways in which data can be recorded. In order to present a picture of the likely impact of some common conditions, data from the Global Burden of Disease tool has been extracted and presented as Figure 30 below. This provides some information on the prevalence estimates of gynaecological diseases in Nottingham (2021 data)[91].

Figure 30: Prevalence of gynaecological conditions per 100,000 population by age group in Nottingham, 2021



Premenstrual syndrome and 'other gynaecological diseases' have the highest prevalence, and as expected, occur mostly during the period that women menstruate – between the ages of about 15 – 50.

It is noted that the figures offered by the GBD tool are estimates only, and that no local data is easily available relating to many gynaecological conditions. This highlights the issues previously raised regarding the lack of knowledge and published data around women's health, providing further evidence of the requirement for investment in research, data collection and analysis into women's health.

The impact of menstruation on aspects of women's lives such as employment or education is also high, with women reporting not only absenteeism from work due to menstrual symptoms, but more likely, reduced productivity where they were able to attend work or education[92]. In addition, research has found that women from lower socioeconomic backgrounds experience more severe symptoms of heavy menstrual bleeding[93].

The Chartered Institute of Personnel and Development conducted a survey of over 2,000 women aged 18-60 to ask about experiences of menstruation at work and what support would be useful. The findings of this survey were used to create a 'Menstruation and Support at work' report which detailed how employers and educational providers can do more to support their female workers. This includes developing a support framework, training for managers, managing absence with compassion and flexibility, and self-management support[94]. The adoption of such support could

aid in reducing stigma through education and awareness raising. A great local example of work to mitigate period poverty is the University of Nottingham's 'Project Period,'[95] which recognises the difficulties that some women and girls face in affording menstrual hygiene products, and the impact this can have on their education and work. In attempting to mitigate this issue, the university provides free period products across their campuses for both students and staff.

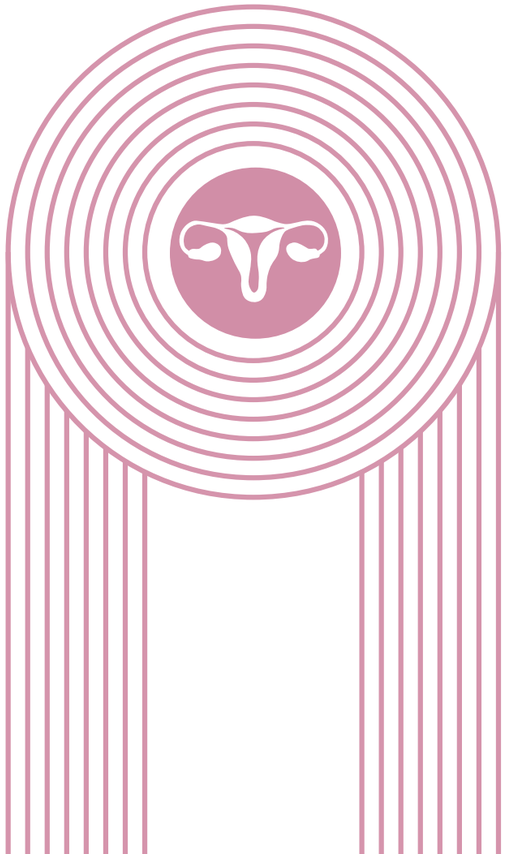
Heavy menstrual bleeding may be a symptom of underlying health conditions such as endometriosis, fibroids or Polycystic Ovary Syndrome (PCOS), with women often suffering for lengthy periods of time whilst awaiting a diagnosis. The length of time it can take for women to receive a diagnosis for endometriosis is 8 years[96], which is contributed to by multiple factors, in the form of patient factors, healthcare system issues and clinician experiences, highlighting the complexity surrounding women's access to healthcare[97]. Women with endometriosis have a higher risk of complications during or related to pregnancy[98], reinforcing the importance of early and accurate diagnosis to avoid later issues. In August 2023, Nottingham Women's Centre submitted evidence relating to women's experiences with endometriosis to the inquiry by the UK Government's Women and Equalities Committee on women's reproductive health. Their evidence included findings that women had not been given accurate or comprehensive information by their GPs, they were travelling to other neighbouring counties to seek essential treatment due to a lack of options in Nottingham, and that women were not offered psychological support to help manage chronic pain caused by endometriosis[99].

Polycystic Ovary Syndrome (PCOS) is a condition linked to frequently reported symptoms such as bloating, excess facial hair, irregular periods, hyperpigmentation and baldness[100]. Worldwide, WHO estimate that around 6-13% of women of reproductive age may be living with PCOS[101]. The data from GBD (Figure 30) indicates that PCOS is seen to mostly impact women in Nottingham between the ages 15-54years, and applying the top estimate of 13% to this age group in Nottingham means that there could be up to 13,000 women with PCOS in the city. The condition is seen to have higher prevalence than endometriosis, although as noted above, some women experience prolonged delays from onset of symptoms to diagnosis, which may be reflected in the prevalence detected.

As women age, it is seen that conditions such as fibroids and prolapse increase in prevalence. Fibroids are usually diagnosed in women of menopausal age, with estimated prevalence in Nottingham being highest in women aged 40-59. (Figure 30) These women may be living with symptoms such as heavy menstrual bleeding, fertility problems, discomfort and a general reduction in quality of life. Research suggests that prompt treatment of fibroids can lead to a reduction of symptoms and potentially avoiding the necessity of surgery[102]. Pelvic Organ Prolapse (POP) is estimated to affect up to 40% of women over the age of 40[103], which could mean around 25,000 women in Nottingham are living with POP, whether this is diagnosed or not. Symptoms of POP include discomfort, urinary incontinence and decreased quality of life. At the present time, no data is available on the prevalence of POP in Nottingham, but the pathway for women to access diagnosis and treatment for fibroids or POP would be through primary care (GP) referral, barriers to which are detailed in Table 5.

Urinary incontinence is a common problem affecting many people, with women who are/have been pregnant or given birth attracting additional risk due to the weakening of the pelvic floor muscles[104]. It is estimated that around 34% of women are living with urinary incontinence[105], which applied to the population of Nottingham aged over 16 would be an estimate of over 46,000. Women experiencing urinary incontinence in Nottingham can self-refer to Nottingham City Care's bladder and bowel specialist service (Bladder and Bowel Specialist service :: Nottingham City Care) as well as accessing support via primary care (GP). Nottinghamshire Area Prescribing Committee published clinical guidance on the topic in 2023, which specifically sets out treatment pathways, including options for menopausal women[106].

Prior to 2018, one option for treatment of urinary incontinence was surgery to implant mid-urethral slings (commonly known as 'mesh'), however a number of complications were reported, such that the NHS has set up dedicated 'Mesh Centres' to support women suffering from side effects of this intervention. Nottingham University Hospitals NHS Trust is home to a Mesh Centre[107].



11.2 Fertility, pregnancy, pregnancy loss and postnatal support

For women aged 18-50, issues relating to fertility and reproductive health can be the most impactful on wellbeing. The recent women's health survey conducted for the Department of Health (published in April 2025) outlined the fact that over a quarter of women experience significant reproductive health issues, and approximately 590,000 women in England are waiting for hospital-based gynaecological care[108]. The wide experience of health issues and delays to care are compounded by a lack of focus on women's reproductive health as area of importance, with the UK Health Research Analysis 2022 report showing that only 2.4% of health and biomedical research funding was spent on 'Reproductive Health and Childbirth'[109].

Another key issue for women is the ability to exercise reproductive autonomy and control over their fertility, which relies on the accessibility of contraception. Since COVID-19 there has been a steady decline in the numbers of women using contraception, particularly hormonal methods and Long-Acting Reversible Contraceptives (LARC)[110]. Suggested reasons for this have indicated an increased discontent with perceived side-effects, a growing dislike of using hormones and a desire for wider choice[111]. This dissatisfaction was also reflected in a recent report published by the British Pregnancy Advisory Service (BPAS) which highlighted the need for greater innovation, choice and sharing of the contraceptive burden with male partners[112].

In Nottingham and Nottinghamshire, the integrated sexual health service was recommissioned in October 2024, and details of the services provided are outlined in section 13.1. Local data indicates that the number of clients of sexual health services in Nottingham in 2024 was 57,532, with 67% of these being female. Females between the ages of 18-39 were the largest client group, and those from the 20% most deprived deciles were represented most in the data. With regard to data on contraception, 2024 data shows the LARC (Long Acting Reversible Contraception) insertion rate was 17.2 per 1,000 female population. In 2023 the rate was 18.6.

Nationally, it is reported that England fertility rate is falling, and in Nottingham, the general fertility rate (measured in terms of the number of live births per 1,000 female population aged 15-44 years) is 42.5 per 1,000 compared to an England average of 54.3[113]. Since 2010, the fertility rate in Nottingham has decreased, a trend that is also seen nationally. The city's large student population may help explain its lower fertility rate, as the way the rate is calculated can be influenced by the size of the population aged 15-24.

The infant mortality rate is seen to be higher in Nottingham than it is nationally, with 5.2 infant deaths per 1,000 live births compared to 4 per 1,000 in England (2021-23), although this figure is the lowest seen since 2016-18[112].

[E] Data obtained from Public Health Sexual Health dashboard, July 2025.

The rate of infant mortality is an important indicator of the general health of the population, and links to economic, social and environmental factors, as well as being indicative of maternal and child health. Factors linked to infant mortality include smoking and obesity in pregnancy, ethnicity and deprivation[114], all of which disproportionately impact women in Nottingham, and which make early interaction with expectant mothers important to ensure they are provided with the information and support needed to increase their chances of a healthy pregnancy.

Maintaining healthy behaviours during pregnancy is key for the health of both mother and baby, but in Nottingham, more women are smokers at the time of delivery than the national average (12.1% compared to 7.4% in England (2023-24))[112] and more women have obesity during early pregnancy (26.2% in 2018-19 compared to 22.1% in England). Women can access support to adopt and maintain healthy behaviours during pregnancy via primary care and their midwives. Additional support is available to pregnant women via Thriving Nottingham who are commissioned to provide support services to pregnant women including smoking cessation and maintaining a healthy weight.

(www.thrivingnottingham.org.uk)

Pregnancy loss, including miscarriage, is sadly a common experience, with around 1 in 8 known pregnancies ending this way[115]. Many miscarriages happen before a person even knows they're pregnant, and while most cannot be prevented, the risk can be reduced by maintaining a healthy lifestyle and avoiding smoking, alcohol, and drugs during pregnancy. In Nottingham, dedicated support services are available for women who experience miscarriage or trauma related to pregnancy loss or bereavement—these are outlined in section 13.3.

As per the scope of this HNA, please refer to the Ockenden Review for information on improvements to maternity services in Nottingham and Nottinghamshire.



11.3 Menopause

Perimenopause is the lead up to the cessation of menstruation, caused by the depletion of oestrogen and progesterone, and menopause is when menstruation has stopped[116]. Menopause typically happens between the ages of 45 and 55, but for a smaller number of women can occur at a younger age. From around the age of 50 onwards, the key issue influencing women's health and wellbeing is perimenopause and menopause.

Although the discourse surrounding menopause predominantly concentrates on the perimenopausal phase and the acute symptoms that are commonly experienced, such as hot flushes, brain fog and vaginal dryness, there are other potentially more significant and longer-term impacts that the menopause can bring. The decline in oestrogen is associated with a greater risk of osteoporosis, insulin resistance and cardiovascular disease[117], meaning this change can present longer term health risks.

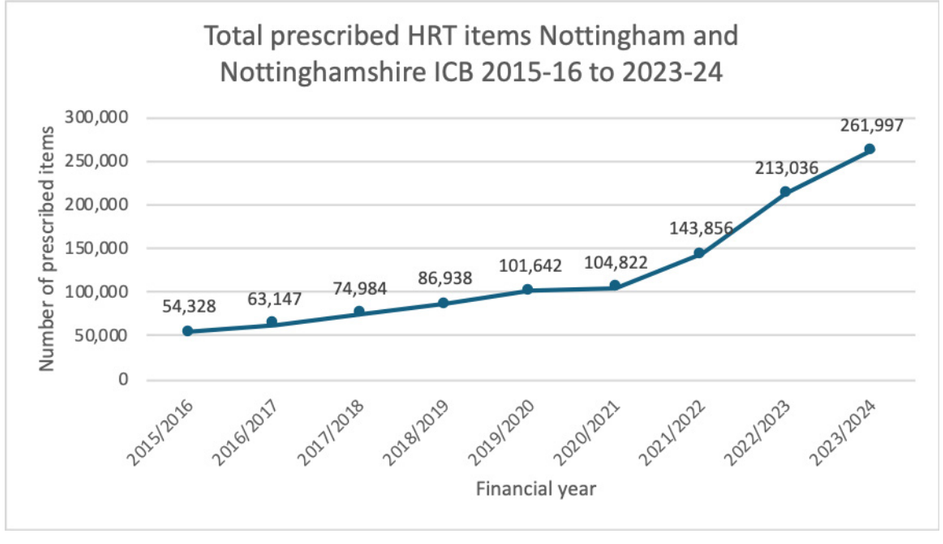
In Nottingham, just over 25,000 women are of menopausal age (45-55 years)[27] and all will have different experiences as they navigate this transition whilst continuing their lives as partners, parents, colleagues etc. Nottingham Women's Centre published a report 'Menopause in the Workplace'[118] in 2020, which although influenced by Covid-19, provides insights into menopause as experienced by women in Nottingham. In particular, many women reported feeling unsupported at work or reluctant to speak up to seek support for fear of negative repercussions. Women also reported not knowing enough information about the menopause and the variety of symptoms (i.e. not just the 'traditional' hot flushes) and that they felt they had not received support from their GP or had been dismissed.

A new Menopause Employment Champion was appointed in the UK in 2023 to raise awareness of issues arising from menopause and work, and to help women to stay in and progress at work whilst experiencing menopause. Nottingham City Council and Nottingham University Hospitals Trust both have menopause policies in place to support staff, with the NUH Trust winning the first 'Menopause Friendly Employer accreditation' in 2021 and their approach being considered the 'gold standard' in the UK[119]. Other large employers in Nottingham with Menopause Friendly Accreditation include Experian and Boots, with Boots also pledging to cover the costs of employees' HRT (Hormone Replacement Therapy) prescriptions[120].

A common treatment for the symptoms of menopause is HRT, which replaces hormones oestrogen and progesterone, the levels of which naturally decrease during the menopause. Not all women will be able to use HRT[121], and in the women's health survey conducted, women in Nottingham frequently reported experiencing other barriers such as feeling dismissed by their GP, or referrals for treatment taking an excessive length of time.

Although data is not available by local authority, Figure 31 shows the total prescribed HRT items within Nottingham and Nottinghamshire ICB. It can be seen that the current total of 261,997 prescribed items is a fivefold increase from 2015-16[122].

Figure 31: Total prescribed HRT items in Nottingham and Nottinghamshire ICB area from 2015-16 to 2023-24



The national data allows for a breakdown of items by deprivation quintile, and across the financial years, shows the total number of prescribed HRT items is higher in the least deprived 20% areas than the most deprived 20%. As Nottingham is a city with a large proportion of the population living in the most deprived areas, it is likely that these inequalities in prescribing would also be seen at a local level.

11.4 Mental health and wellbeing

Mental health is a cornerstone of health and wellbeing, and something which can both have an impact on, but also be impacted by, many areas of life. In considering women's mental health, it is important to remember the context in which women are living (as outlined in earlier sections) where they are more likely to experience deprivation and low incomes, more likely to have taken on caring responsibilities, more likely to experience domestic abuse (see section 11.6) and more likely to spend longer of their lives in ill health, than their male counterparts. Trauma arising from adverse experiences such as DSVA, childhood trauma and negative interactions with professionals can also impact on women's mental health and wellbeing. With these additional stressors, it is perhaps unsurprising that many women experience poor mental health.

Poor mental health is also something that women are more likely to receive a diagnosis for at a younger age and whilst this may again be linked to females propensity for help-seeking, this may also be linked to the hormonal changes women experience during menarche. Data on hospital admissions for mental health conditions in those aged under 18 years shows that females in Nottingham are twice as likely to be admitted than males – a significant difference[112], girls are therefore overrepresented in mental health settings, although the reasons for this remain unclear.

Women living with mental health conditions may find these exacerbated by the difficulties that they experience in accessing healthcare, whether that is for a mental health or any other health condition. RCOG note that women experiencing long waiting times for appointments or diagnoses whilst trying to manage chronic or severe pain or symptoms is likely to have a negative impact on mental health, (RCOG)[9] and many of the women responding to the survey detailed their frustration with long waiting lists for mental health support, including in the aftermath of traumatic experiences such as sexual assault.

Women's mental health is therefore different from men's, both because of biological differences (e.g. hormonal changes and pregnancy) and because of women's socially constructed gendered position within society (e.g. because they are more likely to experience DSVA), which can sometimes be helpful (e.g. because of increased help-seeking behaviour and diagnosis seeking).

Locally, Nottingham has a higher estimated prevalence of common mental health disorders (defined as any type of depression or anxiety) than the England average, with 20.8% of the population (male and female) estimated to experience these, compared to 16.9% nationally[112]. Local NHS data highlights how differences prevail in mental health diagnosis, with data showing that in Nottingham 131.5 women in every 1,000 is diagnosed with depression, compared to 99.6 per 1,000 for men. This may indicate that women are more forthcoming than men in seeking a diagnosis for mental health, and feel more able to seek support.

Data on those accessing NHS Talking Therapies services seems to support the idea that women are more likely to seek help, with more women than men accessing the service in Nottingham and Nottinghamshire in 2024-25 (17,125 women, 8,500 men). Of these, 73% women completed a course of treatment compared to 68% men, although on average men had slightly better outcomes than women (49% men achieved reliable recovery compared to 47% women)[123].

In response to the survey undertaken as part of this HNA, over 73% of respondents stated that mental health (including depression, anxiety, stress and other mental illness) had recently impacted them, and 75% considered that it might impact them in the future. 10% of women surveyed cited mental health as a barrier to looking after their health and wellbeing. These figures indicate the extent to which women are impacted by their mental health, and the importance of relevant and accessible services for them to use when in need of support.

The system in Nottingham has recognised that women may need additional support for their mental health, particularly in the postpartum period, with these women being prioritised in local mental health services, and recent data (20-21 to 22-23) indicates that the rate of access to perinatal mental health services is higher in Nottingham than the England average (92.8 per 1,000 compared to 77.8 per 1,000)[112]. Another welcome statistic which demonstrates the additional support provided to women with mental health needs in Nottingham is that the cervical screening coverage of women with severe mental illness (SMI) in the city is greater than the general population, being 78% in 2024/25.

Nottingham has also recently seen the launch of the 'Nott Alone' service, which provides mental health advice and help for people in Nottingham and Nottinghamshire, including specific advice on topics that may impact women disproportionately, such as body image, eating disorders, memory loss and dementia, pregnancy and post-natal mental health, relationships, self-harm and support for carers[124].

While the support and recognition of women's diverse mental health experiences is welcome, especially given Nottingham's high rates of mental ill health, future services should be designed to be as accessible and relevant as possible to local women, taking into account the city's specific demographics. To this end, the British Medical Association recommends that policies and services should be gender informed and co-designed with women with lived experience of poor mental health[125].

[F] Local eHealthscope data as of September 2024 as presented in SAIU dashboard SID18, accessed 20/02/2025
[G] Local eHealthscope data provided by ICB colleagues, July 2025
[H] Local eHealthscope data as of September 2024 as presented in SAIU dashboard SID18, accessed 20/02/2025

11.5 Cancers

In the UK, 1 in 2 people will develop some form of cancer during their lifetime[126]. Research has indicated inequalities in cancer mortality between males and females, with lung cancer in particular causing higher mortality in women[127].

Additional research has found that as people age, they are less likely to receive treatment for cancer[128, 129], which could indicate that older women in particular may be impacted by a lack of treatment. Similarly to men, as women get older, the risk of developing cancer increases too. Breast cancer is the most common type of cancer for adult women, representing 43% of cancers diagnosed in women aged 25-49 and 34% in women aged 50-74, respectively[130]. Gynaecological cancers are also more prevalent as women get older.

Women from Black backgrounds are more likely to develop aggressive subtypes of breast cancer at a younger age[131]. However, systemic issues such as medical racism can lead to delayed diagnosis and treatment, contributing to more advanced disease and higher mortality rates among ethnic minority women[132].

In Nottingham, cancer prevalence is seen to be higher in women than in men, with the age adjusted prevalence of cancer for women being 44.4 per 1,000 women compared to 39.7 for men. As per the mortality section of this report (section 9), the cancers which most contribute to mortality in Nottingham's women are Lung cancer, Breast cancer and Colorectal cancer.

In Nottingham in 2021 the percentage of cancers diagnosed at stage 1 or 2 is 53.6%, which is similar to the England average of 54.4% (DHSC).[112] Early identification and treatment of cancer is associated with better prognosis[133].

Locally held data as shown in table 3 below indicates that women are more likely to have their cancers either identified or ruled out faster than their male counterparts.

Table 3: Percentage of cancers identified or ruled out within 28 or 62 days, 2023-24

Percentage of cancers identified or ruled out, 2023-24		
Sex	Within 28 days	Within 62 days
Females	80	61
Males	72	56

Screening for certain types of cancer is offered to eligible women, including for cervical and breast cancer, with the aim of increasing early diagnosis and offering treatment to those diagnosed. However, uptake of screening is often lower than public health professionals would like. In Nottingham in 2024 the coverage for breast cancer screening was 62.2%, worse than the England figure of 69.9%, and a figure which has decreased from the 74.1% coverage seen in 2010[112].

Cervical screening in Nottingham has also declined, with 2024 data showing 56.3% coverage in those aged 25-49 years (England 66.1%) which is a reduction from the 73.4% seen in 2010[112]. Figures are higher for the 50-64 year age group, with 72.4% coverage (England 74.3%). Data suggests that inequalities exist between women from different socio-economic groups, with those from less deprived areas being more likely to attend screening.

Reviews of the barriers to screening for breast and cervical cancer in ethnic minority women reveal barriers grouped by thematic areas such as socio-demographic characteristics, health service delivery, cultural, religious and language related barriers, knowledge/awareness, and emotional/support. Resulting recommendations include initiating continuous campaigns and education in public places and hospitals where there are a large population of women from ethnic minorities[134, 135]. Further, and relevant to the care post-diagnosis, The National Institute for Health and Care Excellence (NICE) Equality and Health Inequalities Assessment for breast cancer highlights the importance of patient involvement in decision making, the provision of information in an accessible way, and ensuring culturally appropriate care to try to tackle the inequalities in the way in which women experience care[136].

It is assessed that there may also be inequalities and barriers to screening attendance for women with multimorbidity, disabilities, younger women, women with experience of DSVA or those who have experienced previous traumatic medical procedures.

[I] Medical racism refers to racism within healthcare that leads to dispariJes in access to healthcare, treatment quality and health outcomes. This racism may be insJtuJonalised and structural in nature

[J] Local eHealthscope data of September 2024 as presented in SAIU dashboard SID18, accessed 20/02/2025

[K] Local eHealthscope data as of July 2025 as presented in SAIU dashboard SID06, accessed 25/07/2025

11.6 Health impacts of Violence Against Women and Girls

Violence against women and girls (VAWG) is an umbrella term used to describe any form of violence which disproportionately affects women and girls. This includes domestic abuse and homicide, sexual assault, stalking and harassment, forced marriage, female genital mutilation, so-called 'honour-based abuse' and exploitation. This is the definition adopted by partners across Nottingham and Nottinghamshire as part of the Nottinghamshire Violence Against Women and Girls Strategy 2023-2028137, striving to enhance prevention activity and improve access to services.

Stalking is defined as "a pattern of unwanted, fixated and obsessive behaviour that is intrusive and causes fear of violence or serious harm or distress to the victim"[138].

The above definitions contain some examples of how wide-ranging VAWG can be, but the common elements underpinning all of these crimes are that they disproportionately affect women and girls[139]. This has been argued by some[140] to be the manifestation of misogyny, discrimination and the normalisation of gender inequality.

The National Police Chief's Council Statement in 2024 described VAWG in England and Wales as a 'national threat' that has reached 'epidemic levels'[141] seeing a 37% increase in related crimes recorded from 2018-19 to 2022-23. The prevalence of VAWG in society impacts women's wellbeing in several ways.

The latest Crime Survey of England and Wales (CSEW) estimates 4.2% people aged 16 years or older experienced domestic abuse in the year to end December 2024. Applied to Nottingham's population aged 16+ (269,113 from ONS 2023 mid-year estimates), this creates an estimate of 11,303 people experiencing domestic abuse in the same period. It is estimated that 2.1% people experienced sexual assault during this period, or 5,651 people within Nottingham City. It is noted that these figures are likely to be an under-estimate. The DSVA JSNA (2018) estimated that locally, there could be between 36,355 to 48,525 survivors of DSVA,[142] a figure that is likely to have increased in the period to 2025.

The survey also estimates that 3.1% people aged 16 years or older had experienced stalking (note that the CSEW does not capture all aspects of stalking), which results in an estimate of 8,343 people in Nottingham who have been a victim of stalking during this period.

Widespread victim blaming in society in relation to sexual or domestic violence, can dissuade women from seeking support or reporting to the police. A Women's Aid study in 2022 found that a significant proportion of the population hold abuse survivors responsible for the abuse they experience, and that certain circumstances or behaviours made abuse more justifiable[143]. For women experiencing abuse, their trauma can also be compounded by lengthy and complex justice processes, and poor prosecution and conviction rates – in 2023-24 just 2.6% of reported rapes resulted in a charge or summons, and of these, convictions were secured in just over half (53.4%)[144]. Victim Support also found that the experience of the criminal justice process and long court delays for victims of sexual abuse led to a worsening of victim's mental wellbeing with some experiencing anxiety, depression, Post Traumatic Stress Disorder (PTSD), and even suicidal ideation[145].

Stigma and cultural taboos surrounding women's bodies can also have a negative impact on women's health and wellbeing. Female Genital Mutilation is defined by the World Health Organization as the 'partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons'[146]. The practice is illegal in the UK and associated with the false belief that it confers cleanliness and respectability upon the girl, and increases community status and marriageability, when in fact it is strongly linked to infection, sexual dysfunction, fistulas, HIV and death[147]. FGM appears to be a growing issue in the UK with those presenting at GP and hospital clinics in 2023-24 increasing by 15% from the previous year, according to NHS data[148], something which may be impacted by better training and increased recognition by professionals. Although FGM has been illegal since 1985, ongoing efforts to tackle it are frustrated by its hidden nature and the difficulty of openly discussing the issue within communities at risk, due to stigma and taboo[149].

The NHS does publish data pertaining to FGM[150], however figures are low, and are rounded to maintain patient confidentiality. It is estimated that a maximum of 95 women survivors of FGM were recorded in Nottingham City in 2024, although officially recorded figures are likely to be an under-representation of the true numbers. Previously discussed issues of stigma, lack of cultural awareness and sensitivity, or previous negative experiences of accessing healthcare services may all contribute to a lack of reporting from women, with many cases only being discovered when women seek healthcare during pregnancy or other due to complications arising from other health conditions[151].

Nottingham City Council is a key partner and contributor to the Nottinghamshire Violence Against Women and Girls Strategy, with partners committed to five pillars: Preventing, Responding, Supporting, Including and Strengthening. The council convenes the DSVA Strategy Group and contributes to the joint commissioning of refuge and other services for use by domestic abuse survivors. More information can be found within the DSVA JSNA linked at the start of this document.

11.7 Healthy Ageing

Healthy ageing may have increased relevance for women, because women live longer and spend a larger portion of their life in ill health[8]. The WHO define 'healthy ageing' as creating the environments and opportunities that enable people to be and do what they value throughout their lives[152]. It is stressed that the presence of a disease or health condition is not a barrier to healthy ageing, as many older people manage health conditions and are able to live fulfilling lives. As explored later in this report, the focus group findings with women in Nottingham revealed that being diagnosed with health conditions actually increased women's consciousness of their own health status and became a driver for increased engagement in health related behaviours.

Multimorbidity is a term used when someone has two or more long term health conditions. Although not everyone with multimorbidity will be from an older age bracket, risks of developing multimorbidity do increase with age, and having multimorbidity may have a detrimental impact on a person's overall life expectancy. Differences in lifestyle factors, such as the women's propensity to undertake less exercise than men[153] negatively impact women's health and increase the likelihood of multimorbidity. However, it is also possible that this discrepancy is better explained by women's propensity for help-seeking[154, 155], which means women are more likely to seek and consequentially to receive, a diagnosis.

Data shows that the prevalence of multimorbidity in women in Nottingham is 274.1 per 1,000 population, compared to 232.8 for men. Nottingham's women are therefore more likely to be living with multiple long term health conditions, with the impact felt more keenly by those living in the most deprived areas of the city. This increased likelihood of multimorbidity may relate to women living longer, as the risk of multimorbidity increases with age[156].

11.7.1 Physical health and ageing

Older women are more likely than men of the same age to report having a disability and are more likely to report that their health has declined in the recent past[157].

Some risks to women's health arise from hormonal changes as a result of the menopause, e.g. reduction in oestrogen affecting bones, cartilage and muscle mass which may lead to osteoporosis and increased risk of fractures, and others such as dementia being affected by hormones, physical activity levels and blood pressure.

In response to the women's health survey (section 12.1) most women (58%) felt that long term conditions such as high blood pressure, heart disease, stroke and diabetes could impact them in the future. 47% felt that osteoporosis and bone health would impact them, and over 40% of women felt that loneliness and social isolation was something they would experience. In considering the health needs of women as they age, the provision of support for them to adopt and maintain healthy behaviours or to address existing health conditions before they reach older age would be of benefit to helping women to maintain their health for years to come.

11.7.2 Cognitive health and ageing

Maintaining cognitive health is a crucial element of aging well, and methods to do this can have a positive impact on other aspects of health such as loneliness. Reduced cognitive function is associated with poorer physical health, and decreased quality of life[158].

Dementia describes a group of progressive neurological diseases marked by deteriorating cognitive function, behaviour and thinking, which can develop at any age, but becomes more common as people get older. The most common form of dementia is Alzheimer's Disease (AD), believed to make up around 60-70% of cases[159], and the number of those with dementia is expected to increase as we face an aging population, placing a growing burden on our health systems and demand on resources[160]. Although both men and women can develop AD, women are almost twice as likely to be diagnosed with the condition as men are - the reasons for this are not yet well understood[161], indicating a need for further research. The prevalence of dementia for women in Nottingham is 11.1 per 1,000 population compared to a lower prevalence of 9.6 for men. This is partly explained by the fact that women in general live longer than men, however as the mortality analysis shows, this condition is the main cause of mortality in women in Nottingham.

An additional factor that disproportionately impacts women of an older age and which may have a knock-on effect on health and ability to access healthcare services is that of caring responsibilities. Around a quarter of women in their 50s and 60s have caring responsibilities, work which is often unpaid and can lead to feelings of anxiety, isolation and stress[154]. Feelings of anxiety or exclusion may also arise from the move to digital services, a potential barrier to access to some older women, but which is becoming more common in the NHS and other sectors such as banking. This may impact on women's ability to engage with and access much needed services as their health declines.

[L] Local eHealthscope data at September 2024 as presented in SAIU dashboard SID18, accessed 20/02/2025

[M] Local eHealthscope data as of September 2024 as presented in SAIU dashboard SID18, accessed 20/02/2025

12 Women in Nottingham – their views and experiences

12.1 Survey Findings

From the survey conducted in November 2023, 59% of women described their health as 'Good' or 'Very good', with 16% describing their health as 'Poor' or 'Very poor'



The principal areas of health that women said impacted on them now, or in the recent past were:

- **Mental health** (74% women impacted with high or moderate impact)
- **Menopause and perimenopause** (53% women impacted with high or moderate impact)
- **Health behaviours** (53% women impacted with high or moderate impact)
- **Periods** e.g. heavy or painful periods (39% women impacted with high or moderate impact)

The main areas of health that women felt would impact them in the future were:

- **Mental health** (76%)
- **Menopause and perimenopause** (75%)
- **Cancers and risk of cancers** (65%)

Women reported that they mainly accessed information about health via their GP (20%), the NHS and friends or family (14% each) and social media (13%). The majority of women who responded (60%) also stated that it wasn't easy to access information about women's health in Nottingham. This highlights the importance of ensuring that women's health campaigns are co-designed with women to ensure they are suitable, accessible and user friendly.

Most women agreed that they could access the right women's health services and support for them (53%), however this still means that nearly half of women don't feel able to access the right services, creating a gap in need. The reasons for this were varied, but some themes emerging were difficulties in accessing GP/other services due to waiting times and finding it hard to get appointments, as well as feeling dismissed or receiving a diagnosis and then lack of ongoing support. One particular example highlighted the frustration faced by women who were required to attend multiple appointments for treatment such as coil fittings and cervical screening, and the need for a joined up service where these things could be offered at the same appointment.

Women also highlighted the lack of support for those experiencing the menopause and a lack of mental health support.

> "Diagnosed with severe endometriosis and infertility following a laparoscopy - no post op advice / treatment plan provided / no signposting to support services / 6 month wait for specialist follow up - I continue in pain as usual"
>
> "Accessing a GP isn't easy. People give up when it's a minor concern. You can't ask for a female GP or it takes too long. There are no women's health clinics"
>
> "I am lucky to have a very understanding GP and live near a knowledgeable pharmacist, however, I know others who struggle to access services because they are brushed off as having anxiety or PMS."

The main barriers to women looking after their health and wellbeing were 'Too tired / No energy' (13%), Lack of time (11%) and Mental health (10%), with specific barriers including the difficulties in accessing GP appointments, childcare, and the lack of services specific to women's health/mental health.

> *Trying to contact GP for a referral, the telephone system appears to be obstructive, you have to be fiercely determined and persevere to get an appointment"*
>
> *"GPs inadequate level of training/reluctance to take women's health complaints seriously.*

63% of women said they had made a choice between their health and another area of their life, with children being the most often cited reason.

> *As a carer and mother, others take priority.*

Work was also cited as an area that women had to prioritise over their health.

> *Dr's vs work is common. Pay vs recovery time after an operation, as my employer didn't pay for time off sick.*
>
> *Lack of GP appts has led to me having to ignore health issues due to no availability outside working hours/no ability to guarantee a phone appointment time.*

These answers outline the difficulties women face in looking after their health and wellbeing in a system which is not as flexible or accommodating as they would like it to be.

Women were asked if they would like to access women's health services and support in one place, with a clear majority (87%) answering 'Yes'. Half of those who answered felt that a permanent community venue would be the best place to access services. This is clear support for a women focussed, permanent venue offering dedicated support for women's health needs.

Analysis of survey participant demographics revealed that several groups of women were under-represented (e.g. women from ethnic minority backgrounds, younger women, women with experience of homelessness or domestic abuse). These findings informed the targeted approach to qualitative data collection via focus groups and interviews.

12.2 Focus group and interview findings

12.2.1 Community assets that are supportive of health

There were a range of community assets that women described as being supportive of their health. Women benefitted from community spaces that they could access, to engage in healthy activities and from services that existed to promote good health and/or to prevent ill health.

Definitions

Community spaces that are supportive of health

Spaces within the community that are free for residents to access and which support health, either directly or indirectly.

Health-related services

Activities that are intended to:

1. **Prevent, diagnose or treat illnesses/injuries** and/or
2. **Assess, maintain or improve a person's health, care and/or wellbeing**

Community spaces are important, because they provide free access to health-related opportunities and are supportive of health in themselves. Women from Nottingham primarily accessed community spaces and services that existed within the city boundaries. However, local residents also benefitted from some of Nottinghamshire County's assets, particularly the green and blue spaces nearby, such as Arnold Hill Park, Holme Pierrepoint and Gedling Country Park. The only community space that was dedicated to women was Nottingham Women's Centre. The community spaces women described all fell into one of 8 categories, that can be viewed in Table 4. A full categorised list of the community spaces that women from Nottingham described during the focus groups can be viewed in Appendix F.

CATEGORY
Community centres
Day centres
Green spaces
Joint service centres
Libraries
Wellbeing Hubs
Places of worship
Educational establishments and surrounding spaces

Table 4: Categories of community spaces that women described as being supportive of health in Nottingham

Many of the services that women described as supportive of their health might not be typically considered health-related services. However, a diverse range of services, such as translators for example, were vital for ensuring that some of the most vulnerable women in the city could achieve good health, not just in terms of accessing services, but in terms of integration into community life.

However, few services were targeted towards, or exclusively for, women, despite this being a prerequisite for some women to feel comfortable engaging with services, in certain contexts, such as following experience of sexual violence. The widest range of health-related services was provided and delivered by the community and voluntary sector, followed by the NHS. The health-related services women described during the focus groups could be split into 13 categories, which can be viewed in Table 5. A full categorised list of the specific health-related services that women from Nottingham described in the focus groups can be viewed in Appendix G.

CATEGORY
Campaigns, initiatives and events
Community and voluntary services
Digital technology services
Education sector services
Gyms, swimming pools and leisure centres
NHS Community Care Provision
NHS Primary Care Provision
NHS Secondary Care Provision
Nottingham City Council Services
Nutrition and healthy weight management
Prison services
Response services
Translation services

Table 5: Categories of health-related services that women described as being supportive of health in Nottingham

One woman felt that there were many community assets that were supportive of health locally but described some typical barriers to accessing spaces and services, that echoed the sentiments of many of the women who took part in the focus groups and interviews. She shared:

> *I don't think that there is a problem to find a space here for wellbeing… the problem is to find the time and sometimes motivation.*

12.2.2 Behaviours to achieve good health

Women engaged in 13 categories of health-related behaviours. Interviewers found that women facing greater barriers to health benefitted most from simple, achievable interventions, while those with fewer disadvantages could engage with more complex, time-intensive health behaviours.

1. Physical Activity

Physical activity was the most frequently mentioned health-related behaviour for women, with walking and swimming being the most popular choices. Physical activity supported women's physical and mental health, provided the opportunity for women to be social and allowed women the (rare) chance to do something entirely for themselves, as an act of self-care. One woman explained:

> *I mean, walking is free and in fact, walking is really very good. Particularly as you get older and it's good for your bones.*



2. Nourishing the Body

Women showed an awareness of the importance of nourishing the body, which was achieved through healthy eating (including making healthy swaps), staying hydrated and taking vitamins.

> *There's no age limit to eating healthy, it will always be good for you.*

The complexity with which women considered the way they nourished their body depended on a range of factors including their level of deprivation and their age. Women experiencing the greatest levels of deprivation described simplistic approaches to nourishing the body. For example, one woman accessing support services for street sex workers shared:

> *We've been having two hot meals every day. It might be something small, but we are still having two hot meals a day do you know what I mean and that's positive. The more you eat and especially with your vegetables and your fish, things like that, it's good for your brain. It's good for your mental health as well.*

An older woman explained how she was able to consider her health more deeply, based on her own health status and her doctor's advice:

> *I do take vitamin D because I've also got osteoporosis, and I do take an iron tablet because my doctor said my blood levels a bit low.*

3. Participating in and Receiving NHS Services

Women generally showed an awareness of the importance of participating in and receiving NHS services. They were appreciative of the service and its employees. One migrant woman stated:

> *I thank everybody, especially the NHS. What they have done to me, particularly in this country, I would have been long dead at home.*

Women showed an awareness of the importance of NHS services generally, including breast and cervical cancer screening services, which are typically associated with women's health. However, many women described struggling to get an appointment with a female health professional, which was a prerequisite for some women in some contexts to access certain health services. In particular, those of Muslim faith and survivors of DSVA and VAWG described challenges associated with interacting with male professionals when accessing sexual and gynaecological health services, for example.

The GP was the most frequently discussed NHS service, but it was clear that Care leavers and migrant women had difficulty navigating the UK healthcare system. Both these vulnerable groups described challenges based on a lack of previous experience in navigating appropriate pathways within the UK system. A young woman who was a Care leaver said:

> *With the dentist, like I left my tooth for so long and like… just cause I didn't know how to do it (make an appointment).*

Care leavers faced additional challenges to accessing NHS services because of their lack of parental advocacy (See Behaviour 13 – 'Advocacy' for further details), whilst migrant women faced additional challenges in respect of language barriers and limited social support available locally.

4. Grounding Techniques

Grounding techniques helped women to relax and manage their mental health. Examples of grounding techniques that women described included meditation, breathing exercises, mindfulness, getting into nature, spending time alone, journalling, setting personal and safe boundaries and engaging with religion. One woman told us:

> *I've got a lot of mental health and other issues, you know breathing exercises, I'm taking five minutes out just for myself you know. Even if that's sitting down or meditating (…) you know, just to have that five minutes for myself you know, that's what I do.*

Women who had experienced trauma and crisis found grounding techniques particularly helpful. For some women, the prison service had been instrumental in helping them to develop their skills at a challenging time in their life. This is illustrated by a woman who said:

> *Well, when I was in prison I learnt when I was doing drug courses and stuff, do you know what I mean? It helps. Especially breathing exercises, do you know what I mean? To focus on one thing to clear your mind or even just focus on your breathing. Block everything out, just focus on your breathing, that's good for your mental health as well because that will show that you've got, you've got a lickle control of yourself and your breathing and your mind and stuff.*

5. Creative Activities

Creative activities were a therapeutic act that allowed women to express themselves, escape from reality and boost their self-esteem through a sense of achievement. Activities that women enjoyed included creative writing, singing, painting, sewing, drawing and gardening. One woman told us:

Another explained:

> *I've started gardening and I, you know, I got more and more plants (…), that's not something I was particularly interested in before but it's like being creative and that's my space that I'm creating.*

> *Painting. I find that therapeutic. I've just took on the task of painting my whole garden. I'm halfway there. I've done the front and onto the back. Everyone said I'm crazy, so there's a lot of panels, but I'm finding it quite therapeutic, it's keeping me busy and at the end, seeing the result that I've done will make me feel really good.*

6. Social Enrichment

Women craved social enrichment in their lives. The benefits of social enrichment were best if this was provided by supportive loved ones. However, community/religious groups and leaders were a great source of social support for women. The impact of small interactions with total strangers, however, should not be understated for those experiencing the greatest levels of loneliness and isolation. An older woman who lived alone and who had no social interaction for 8 months during the Covid-19 pandemic illustrated the importance of small social interactions by saying:

> *You get on the bus, and I don't know, you say to someone (…) you just speak to them (…) And I've been thanked on the bus. People have said to me, thank you for talking to me then. Thank you for the conversation, I've enjoyed our conversation. And then you think well, someone else in my position as I call it. You know, obviously I'm quite lonely, I'm quite happy to talk about the weather for 5 minutes, yeah.*

7. Productivity Focussing

Focussing on productivity was helpful for women, who were frequently juggling diverse roles and responsibilities, effectively wearing many metaphorical hats including that of mother, wife, friend and advocate for others. However, focussing on productivity could start with the simplest of things for women facing the greatest levels of deprivation and inequality. One woman who had faced particular challenges explained how she used 'mini goals' to kick start her productivity following a stint of debilitating depression:

> *I'm gonna get up and do, you know what? That piece of paper's been there all day so I'm gonna move it, that's a mini goal.*

For other women, there was a focus on self-discipline and taking accountability, which was considered important for maintaining good health and wellbeing:

> *You want to change something? You gotta change. Something has to change, for something to change.*

8. Avoiding Negative Health Factors

Women understood that avoiding negative health factors, including problematic social groups, was crucial for good health. Health-related behaviours that women tried to avoid included drinking alcohol, smoking, substance use and consuming excessive amounts of caffeine. For some women, aiming for reduction was more realistic than abstinence and could be supported or inhibited by others. Some women were creative in the ways they tried to reduce their engagement in negative health behaviours. For example, one woman joined the group in laughing as she shared:

> *I put lemonade in my wine to water it down a bit.*

9. Health-Related Knowledge and Skill Development

Women understood the importance of developing their health-related knowledge and skills. This was primarily achieved by accessing educational services, which were in the main provided by the community and voluntary sector. Therapeutic services were beneficial in helping women to develop mental health management skills, whilst the prison service provided the opportunity for women to learn grounding techniques that they could utilise and implement within daily life. Women benefitted from learning about fire safety, the relationship between health-related behaviours and health/wellbeing, how to cook healthy meals, medical terminology/jargon and the health implications of ageing (including the menopause). A community leader who works to support migrant women locally described having a health professional in the community centre, supporting women to develop their health-related English language skills:

> *Last night I talked to the doctor. She's going to be a specialist in paediatrics but if we don't understand that means baby in medical words (it's difficult). She immediately translated so we all understand. So, she actually taught us some other words, like premature.*

10. Personal Care and Hygiene

Personal care and hygiene behaviours involved women showering regularly, getting enough sleep, practicing safe sex and keeping their homes clean, tidy and free of mould. This appeared to require more conscious effort for women facing the greatest inequality and having a space to engage in personal hygiene practices was particularly important for women experiencing homelessness. One woman accessing these types of support services shared:

> *Like, to come here and have a shower (…) you feel a lot better in yourself.*

11. Providing Care and Nurture

Interviewers found that women gained personal health benefits from acting as nurturers and caregivers. Women were kept active by their caring responsibilities, which they found rewarding and which were a source of self-esteem. Many women benefitted from the act of caring and nurturing for loved ones. For others, the process of providing care and nurture was formalised, through the act of volunteering, which had the added benefit of supporting people to develop community connections. One woman who volunteers for various organisations explained:

> *I think I'm motivated by wanting to care for people and give back to the community (…) that's a big one for me.*

12. Help-Seeking (including enlisting advocates)

Women's health could only be maintained and improved if they were willing and able to seek help. Women had to seek help for a variety of things that directly or indirectly impacted their health. Often, help-seeking was focussed around accessing social support, mental health support or physical health-related services and advice. However, women also needed help with transport, childcare, overcoming digital exclusion and overcoming language barriers. Being willing to ask for help when struggling was often an initial barrier to health, which once overcome could open many doors. One woman told us:

> *I will ask for that help, I never used to but yeah… I will ask for that help.*

13. Advocacy (enlisting, advocating for others and self-advocacy)

Advocacy was crucial for women to achieve good health and wellbeing. Where women were willing and able to self-advocate, good health was achievable and could be well supported by health professionals. For women who lacked the confidence, willingness, knowledge or skills required to self-advocate, the importance of having others to advocate on their behalf was paramount and this could come in the form of friends, family members, volunteers or professionals. Women who faced additional challenges to self-advocacy (and who therefore benefited from or would benefit from having somebody else to advocate on their behalf) included younger women, autistic women, migrant women (based on limited understanding of UK healthcare systems, language barriers and/or anticipated/experienced/perceived stigma), Care leavers and women from ethnic minorities. Women who were skilled advocates enjoyed and benefitted from advocating for others, often positioning themselves as community advocates supporting vulnerable members of the cultural or community in-group. One woman talked of the importance of her self-advocacy for her health:

> *I don't think it's because of my knowledge and experience. I think it's because of me. It's who I am. I was advocating for myself long before I had any of these illnesses.*

A younger woman who found it more difficult to feel seen and heard by professionals explained:

> *I always get my dad to, like, phone or talk to someone because they always take him more seriously (…) this is really annoying. My dad doesn't have to speak for me.*

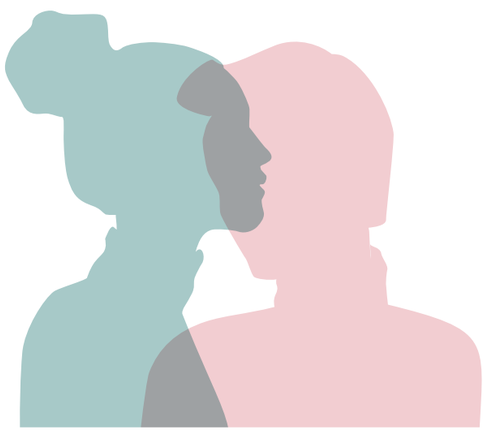
12.2.3 Barriers and facilitators to health-related behaviour

Promoting healthy behaviour is important, so understanding the things that promote or inhibit healthy behaviour is key to ensuring we can support good health. Thus, in this section, we have identified the barriers and facilitators to the healthy behaviours that women from Nottingham described.

These have been categorised according to the COM-B model of health-related behaviour change[28]. The COM-B model of health-related behaviour states that for a person to engage in positive health-related behaviour, they must have the capability, the opportunity and the motivation to do so. COM-B acts as the hub of the Behaviour Change Wheel approach to intervention design[162], making understanding women's barriers and facilitators a good starting point for future health-related intervention design. As such, Table 5 shows women's barriers and facilitators to health-related behaviour in Nottingham, aligned with some suggested health promotion strategies that might address those barriers and facilitators, with the associated health-related behaviours identified and an illustrative quote.

- There were 10 determinants of health-related behaviour linked to women's capability (5 barriers, 5 facilitators).
- There were 31 determinants of health-related behaviour linked to women's opportunity (20 barriers, 11 facilitators).
- There were 13 determinants of health-related behaviour linked to women's motivation (6 barriers, 7 facilitators).

This suggests that whilst women appear to have relatively equal barriers and facilitators to health-related behaviour in respect of their capability and motivation, it is women in Nottingham's opportunity to be active that is most limited. The full list of barriers and facilitators can be viewed in Table 5. Here however, those barriers and facilitators to health-related behaviour that have most salience, importance or complexity, will be discussed.



12.2.4 Capability

Themes that were identified regarding women's capability to engage in health-related behaviour primarily related to issues of literacy/English language skills generally and to health literacy more specifically.

Language barriers compounded issues for migrant women, who had limited understanding of the UK healthcare system and the different pathways that should be taken to access different health, care and wellbeing services. However, interpreters/translators, translation apps/Google translate and translated resources (e.g. leaflets) that were readily available in different languages, to suit Nottingham's diverse demographic could address this somewhat.

One woman, who was translating on behalf of a friend explained how even for women who were health literate, language barriers created difficulties:

> *My understanding is in Hong Kong she is very healthy (…) but here every time she has to use telephone to do the translation or get help from the interpreter, it just makes it a little bit harder, it's just another barrier even though she should understand what they're talking about because she was a nurse.*

However, health-related education was an excellent resource for enhancing women's health literacy and this was particularly useful when it was targeted to suit the needs of specific cultural community groups, who faced their own unique sets of barriers and facilitators to health-related behaviour.

12.2.5 Opportunity

Women's opportunity to engage in health-related behaviour was heavily influenced by the political and economic climate, which was intricately linked to overstretched services and to issues of bureaucracy. Many women described juggling childcare responsibilities, household chores and paid work, which left little available time to consider and promote their own health and wellbeing. This, in combination with the time consuming and complex process of accessing overstretched services via bureaucratic processes and procedures, left women with little opportunity to engage in health-related behaviour such as booking doctors' appointments. One woman described the impact of bureaucratic processes on her opportunity to engage with health-related services and the knock-on effect that this had on her health and on her motivation to engage:

> *It does affect your health immensely because everything is a no or it's a referral or it's a we don't know when or it's a waiting list but it affects your health immensely and you lose the willpower to do things.*

Bureaucracy was particularly problematic in the context of accessing NHS services, most notably the GP. All but one participant described a process of having to contact the GP practice at 8am for an appointment. Many women found this challenging in the context of their role as primary caregiver, as this was incompatible with the morning routine of getting children ready for school. Women were prepared to wait for a long time on the telephone at this time to make appointments for loved ones but were less motivated to do this for themselves. One woman explained:

> *So, you sit, and you wait on the phone for 45 minutes and then they say the appointments are gone so I don't even try to make appointments for myself. I don't even go doctors. You know, if I make an appointment for my mum, if I'm making an appointment for one of my kids then I might… but not for me. It just takes forever.*

As such, the issue of the "8am scramble" for GP appointments appeared to present a disproportionate barrier to health-related behaviour for women. Another woman told us:

> *Being made to ring at 8:00 in the morning just isn't practical when you're a mother and you've got so many responsibilities. Then when they say to me, we've got an appointment in a month… that just puts me off. It's like okay, my health doesn't matter, or this problem at least doesn't matter, it's not important, it's not an emergency, it's not a priority, it can wait a month, good to know, I won't bother then.*

There were a range of adverse personal circumstances and negative isolated incidents that prevented women from engaging in health-related behaviour. Personal circumstances that were negatively impactful for women's health included bereavement, homelessness, unemployment, historic/childhood trauma and experience of DSVA and VAWG. Women's health was also heavily impacted by the struggles of their loved ones, who they wanted to support and who they wanted to see thrive. One woman described how her personal circumstances made prioritising health unrealistic:

> *It's just too much all at once for me because I've got loads of things kicking off. I lost my partner in January so yeah, I were devastated. Everything else has gone wrong since then, my mum's at home not very well, my sister's not very well, she's just had her kid taken off her so there's that and then obviously I found out I were pregnant yeah. I had an abortion when I was 18. I didn't think I could have kids and then boom, so yeah, yeah. It's a bit, I've got a bit, it's a bit, there's a bit too much going on right now so I'm just trying to breathe.*

The Nottingham attacks of June 2023, when three local residents lost their lives, heavily impacted women's perceptions of safety across the city. For many, this could present a barrier to health-related behaviour, as this reduced women's opportunity to engage with health-related behaviours in settings where they felt safe. When asked whether she felt safe in the city, one woman replied:

> *I do, but I think that's because I'm a long time resident of Nottingham. I would not necessarily say that people who have recently moved into Nottingham do, especially after the incident with the stabbings.*

12.2.6 Motivation

Women were heavily motivated to be healthy by their desire to live a long life so that they could be there for dependents and to be good role models. One woman said:

> *I want them to have their mother healthy as long as I can.*

Whilst another shared:

> *I don't want to be like fat and being sick… so that I can care for my family, which is very important to me.*

However, the roles and responsibilities associated with motherhood and the issue of maternal guilt could present barriers. Women were constantly struggling to simultaneously meet the needs of their dependents and loved ones, including their husbands or partners, alongside their own needs. For women, prioritising their own health over that of their loved ones was perceived as selfish and was therefore closely linked to feelings of guilt associated with not being around to fulfil their household and caregiving roles and responsibilities.

Safety concerns were closely linked to the adverse circumstances and negative isolated incidents mentioned above, that limited women's opportunity to engage in healthy behaviours. However, safety concerns were also particularly prominent for survivors of DSVA based on their expectations of what might happen if they engage in certain health behaviours, within certain locations or settings. These women benefitted from additional safety measures on their homes, such as cameras, new locks and panic alarms. One woman said:

> *(I've got a) Ring doorbell, so when I'm out if he comes round, I'll see, and it just keeps people away. And it keeps burglars away. So, you know, it's just me and the girls. So, you know there is an element of - You know, feeling a little bit unsafe at times, so it's nice to have that security.*

These women also felt vulnerable and exposed within the city centre or on public transport, highlighting the need for locality-based services and outreach, as well as private transport options. Survivors were recurrently re-traumatised by the need to repeat their story to professionals, which was related to the revolving door of professionals and the lack of joined up working between different organisations. One woman said:

> *So, in the past 3 1/2 years, this is the third refuge they've moved me to, and it does upset you because you're getting up and then you're moving. And then I've had seven different support workers and ones leaving, and you've just opened your entire life to them. And then the new one comes and yeah, and they don't understand how much it can unsettle you.*

Further, for women who had recently experienced sexual violence or trauma, the importance of having female professionals to support health and wellbeing was paramount. One survivor told us:

> *I mean that's another thing; girls want to speak to a woman. If you've been attacked or raped, you don't wanna speak to a guy, do you? That's the last thing you wanna do, do you get me?*

Female health professionals were also important for Muslim women, in certain contexts.

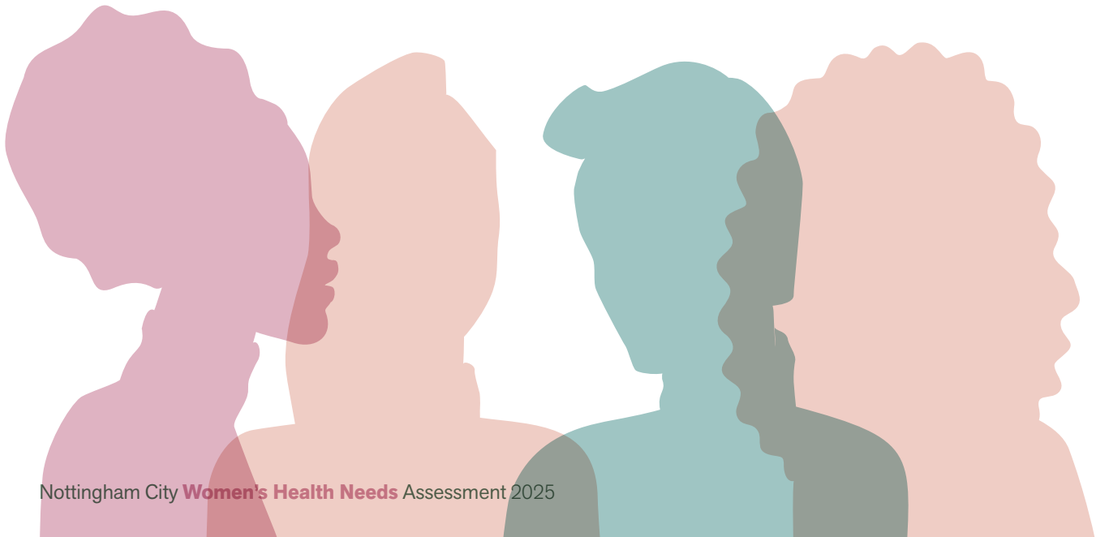


Table 6: Barriers and facilitators to women's health, associated health promotion strategies and behaviours and illustrative quotes.

Barriers	Facilitators	Associated health promotion strategies	Associated health behaviours	Illustrative quotes
Capability				
Limited literacy/ language	Language and literacy skills	▪ Education ▪ Translation ▪ Interpreters ▪ Google translate ▪ Translation apps	All excluding personal care and hygiene	"English is not my first language. I speak French and Arabic, so at the beginning it was very very hard for me. Even for my GP, to speak with the GP or like, say what symptoms I have, it was really very difficult for me. Sometimes they are proposing interpreter, sometimes not, which I was on my phone like Googling translation in every word. I want to say sometimes it's not understandable. Sometimes. Sometimes I'm feeling, I find it difficult to express myself, to express my opinion."
Limited health literacy	Health literacy	▪ Education ▪ Sign posting ▪ Promotion & marketing of health-related services & opportunities	All	"I mean, I think. I think older people need information about how to prevent certain problems like osteoporosis, I mean, it is a problem, they do think it can be genetic, but nevertheless there are some real important steps that people can take."
Limited self-discipline/ personal agency	Personal agency (including self-advocacy and prioritising health)	▪ Education ▪ Skill development ▪ Social support ▪ Professional support	All	"The bottom line is you've got to stop and say…. 'I've got to help myself' in anything, whether it's diet, whether it's activity, whatever group, smoking, alcohol, you've got to do so much yourself"
Neurodivergence		▪ Accessible services ▪ Accessible materials ▪ Reasonable adjustments ▪ Social support ▪ Professional support ▪ Training for professionals	All	"(Masking is) when a neuro divergent individual tries to present as neurotypical, so you try and mask the social anxiety. Trying to mask you know, saying what you're thinking and trying to as well mask the lack of facial expressions and trying to put on the right facial expressions and reading the room and it's really tiring and it kind of takes you out of the moment because you've got to think, OK, conversation has now changed from a happy topic to a sad topics. And now I've got to. adjust to be appropriate. Then change of topic and it's just so much effort."
Physical challenges		▪ Aids and adaptations ▪ Reasonable adjustments ▪ Rehabilitation	▪ Physical activity ▪ Nourishing the body ▪ Participating in & receiving NHS services ▪ Creative activities ▪ Social enrichment ▪ Avoiding negative health factors ▪ Health-related knowledge and skill development ▪ Personal care and hygiene	"I can remember struggling once, as the only way I could get a taxi was to come out the station and then you got to go all the way down the road to find it. And when you, you've perhaps got a stick then… I was…. I've got a problem with my back and then trying to carry something. It's almost impossible. You're absolutely exhausted at the end of it, and it does not take into account, you know, people with mobility issues"

Barriers	Facilitators	Associated health promotion strategies	Associated health behaviours	Illustrative quotes
Capability				
	Protective personal characteristics (e.g. sense of humour, self-esteem)	▪ Social support ▪ Professional support (e.g. CBT)	All	"But I've come to a certain age where I know my worth you know, what, what, what has happened to me has made me stronger and I've forgiven people and forgiven myself, that's why I can move on and say I won't be back on the corner"
	Skills and skill development	▪ Education	All	"I'm learning to ride a bike"
Opportunity				
Financial cost of being healthy (including being on low income)	Subsidies, coupons and free health-related opportunities (including transport costs)	▪ Promotion of free opportunities ▪ Access to advice ▪ Financial resilience and wellbeing training ▪ Funding opportunities	All	"We would all love to go into a gym, but we cannot go into the gym because the gym membership are very high price. We cannot handle that price"
Digital limitations	Digital access and online tools/services	▪ Education ▪ Funding and subsidies ▪ Signposting ▪ Library and community setting promotion/access ▪ Social support	All	"I think it depends if they've got access to the internet really you see, it's whether they've got the access to the internet"
Lack of social support	Social support	▪ Community groups ▪ Community leaders ▪ Signposting ▪ Befriending services ▪ Professionals (e.g. social prescribers and community connectors)	All	"Having the right support and being in the right groups and stuff and finding out what's out there really and I think that helps a lot and if you've got people that's got the same conditions or the same understanding I think it works even better"
Service inaccessibility	Targeted, supportive and efficient health-related services	▪ Training for professionals ▪ Reasonable adjustments ▪ Accessible materials ▪ Outreach ▪ Drop-in services ▪ Community-embedded services ▪ Female-targeted services ▪ Enlisting advocacy	▪ Physical activity ▪ Participating in and receiving NHS services ▪ Creative activities ▪ Social enrichment ▪ Avoiding negative health factors ▪ Health-related knowledge and skill development ▪ Help-seeking	"They do a lot of like support for women. They have tea. You can come in and have a tea and chat with the women and they do a lot of stuff for Muslim women as well"

Barriers	Facilitators	Associated health promotion strategies	Associated health behaviours	Illustrative quotes
Opportunity				
Negative or unsupportive interactions with professionals	Positive and supportive professionals	▪ Training for professionals ▪ Diverse & representative workforce ▪ Time to build relationships ▪ Inclusive policies and procedures	▪ Physical activity ▪ Nourishing the body ▪ Participating and receiving NHS services ▪ Social enrichment ▪ Avoiding negative health factors ▪ Health-related knowledge and skill development ▪ Help seeking ▪ Advocacy	"I very much feel they stigmatised me as somebody with a mental health problem, that I was the cause of the problems with my daughter."
Routines that are unsupportive of health	Routines that are supportive of health	▪ Forward planning and scheduling ▪ Effective time management ▪ Flexible opportunities ▪ Community-embedded services	All	"I don't have time for lunch here. The only exercise that I do is 20 minutes going to school, coming back from school four times a day. Yeah. Walking. Yeah. Which is not too bad, actually"
Transport limitations	Good transport links	▪ Subsidised travel ▪ Community transport ▪ Social support ▪ ASC Personal assistants ▪ Befrienders ▪ Home visits ▪ Online/telephone access	All except grounding techniques and personal care/hygiene	"Knowing that I've got decent bus access is vital because it doesn't necessarily then matter where you are, as long as you can get to wherever you need to go"
Unhealthy environments (including density of takeaways)	Green spaces and nature	▪ Public transport ▪ Social support ▪ Raising awareness of healthy spaces/ opportunities locally ▪ Community initiatives ▪ Volunteering ▪ Planning and regulations	All	"Green space, I'd say that is the most vital one. You have to have somewhere where you could literally commune with nature and I don't mean on Hare Krishna level or whatever, but just go and take your socks off and walk on the grass if need be"
Demographic characteristics that get in the way of good health (being older, overweight, ethnic minority or religious, migrant)		▪ Inclusive services & opportunities ▪ Targeted services & opportunities ▪ Reasonable adjustments ▪ Equality, diversity and inclusion policies	All	"I think it's what they see coming in, so I'd definitely say my ethnicity is the first thing (professionals notice about me), then being a woman is the second thing, definitely."
Limited available time		▪ Forward planning and scheduling ▪ Drop-in services ▪ Community-embedded services ▪ Social support	All	"Do I really want to get up and do this many gym sessions or this much exercise today or shall I just got on with the jobs I've got to do? The washing, cooking, cleaning, I haven't got time to prioritise that"

Barriers	Facilitators	Associated health promotion strategies	Associated health behaviours	Illustrative quotes
Opportunity				
Political and economic climate (including the cost of living crisis and the implications of budget cuts)		▪ Community and voluntary sector involvement ▪ Equality, diversity and inclusion policies ▪ Financial resilience training ▪ Informing citizens re. welfare change	All	"a lot of things have gone by the by because of all the cuts that have happened"
Overstretched health, care and wellbeing services		▪ Community and voluntary sector provision ▪ Health literacy development (understanding systems & pathways) ▪ Community pharmacy access & involvement ▪ Online accessibility and services	▪ Participating in and receiving NHS services ▪ Avoiding negative health behaviours ▪ Social enrichment ▪ Help-seeking ▪ Advocacy	"I know you're going to kick me out (of my appointment) as soon as the times up. Because you've got 20 other people to see, and you're already running an hour behind"
The female burden		▪ Self-compassion ▪ Social support ▪ Subsidised childcare ▪ Free school meals	All	"If the kids want something they call the mother, they not call the father. If the school wants something, they call the mother, they not call the father"
Adverse personal circumstances and negative isolated incidents		▪ Therapeutic services ▪ Social support ▪ Specialist services (e.g. Nottingham Women's Centre) ▪ Female professionals ▪ Response services ▪ Housing support ▪ Police presence	All	"It can be a little bit of a problem because (when you live in a women's refuge) you've got a PO box address, you don't have an address and when they type the address in the system it never shows and then you look left and you look right and you go (whispers) I'm homeless".
Negative social responses (including stigma)		▪ Education ▪ Social support ▪ Outreach services ▪ Community leader endorsement	All	"If you live in a certain area of the city, you, well, (…) they don't see the person they see the area"
Covid-19 fallout		▪ Personal care ▪ Hybrid access ▪ Therapeutic services ▪ Service redesign ▪ Signposting	All	"There were some churches that used to do a lot, but when COVID came, that went so, you know, a lot of things was lost through COVID."
Bureaucracy		▪ Targeted services ▪ Social support ▪ Community and voluntary sector ▪ Self-referral	All	"There's a lot of stuff that NG8 won't (be eligible for) just because your socioeconomic status is judged by your post code, not your personal circumstances".

Barriers	Facilitators	Associated health promotion strategies	Associated health behaviours	Illustrative quotes
Opportunity				
UK climate (including pollution)		▪ Active travel ▪ Public transport ▪ Indoor opportunities ▪ Volunteering and conservation work ▪ Appropriate clothing via clothes banks	▪ Physical activity ▪ Nourishing the body ▪ Participating in and receiving NHS services ▪ Grounding techniques ▪ Social enrichment ▪ Avoiding negative health factors ▪ Help-seeking	"Always here it's winter, but sometimes it's winter mixed with sun sometimes winter mixed with snow"
Lack of joined up working		▪ Communities of practice ▪ Integrated neighbourhood working ▪ Interorganisational events and planning ▪ Cascading information ▪ Self-help directories ▪ Developing partnerships ▪ Locality-based services ▪ Joint service centres	All	"Whatever department you are in with the hospital, it don't match up with your GP records, it doesn't match up you see so sometimes they don't know what you've had done and when you last had it done you see"
Misinformation		▪ Education ▪ Advocacy ▪ Community leader endorsement ▪ Signposting ▪ Social support ▪ Building relationships with professionals	All	"Most of the Asian community, we are ladies scared to discuss about the mental health because when we came here, first thing we hear, if you suffer about mental health (then the) social worker (will be) taking your kids away from you"
	Accessible resources (including translation)	▪ Community engagement ▪ Readily available resources ▪ Plain language principles ▪ Social support ▪ Intelligence gathering (to assess need)	All	"Not everybody's literate, so maybe it may be having a short video in different languages so that people can access on Facebook or whatever. Whichever platform's needed"
	Inclusive workplaces, policies and procedures	▪ Education ▪ Equality, diversity and inclusion champions ▪ Responsive management ▪ Staff networks ▪ Allyship ▪ "You said, we did"	All	"This is the first job that I've had that I felt really supported (…) I had a situation where I had to go to the eye casualty (…) I phoned up work and (they) told me to like (..) go home and get some rest."

Barriers	Facilitators	Associated health promotion strategies	Associated health behaviours	Illustrative quotes
Motivation				
Motherhood and maternal guilt	Desire to be there for dependents	▪ Mother and child activities ▪ Social support ▪ Self-compassion ▪ Forward planning and scheduling ▪ Free opportunities ▪ Signposting ▪ Community and voluntary sector involvement	All	"I'm feeling guilty thinking am I doing something wrong or something? Then you know, you feel bad that you can't afford to put your child in like these activities because you just went them to thrive and have the best opportunities in life like the other kids"
Safety concerns	Safety measures	▪ Install CCTV ▪ Raise Police and CPO presence ▪ Good lighting ▪ Secure refuges ▪ Robust policies and procedures ▪ Councillor 'surgeries' ▪ Infrastructure maintenance (e.g. road surfacing for potholes, pedestrianisation) ▪ Aids and adaptations ▪ Training for professionals to better support women at risk	▪ Physical activity ▪ Participating in and receiving NHS services ▪ Creative activities ▪ Social enrichment ▪ Personal care and hygiene ▪ Providing care and nurture ▪ Help-seeking	"You know all these things happening, people getting stabbed and things like that and the way the society is now... It does worry me (…) I mean, I do go out at night time, sometimes on my own, because obviously we have groups and I go to them and I come home on the bus and stuff but I only go to the group and then go home. I don't hang about in town(…) but it worries me because I think to myself, you never know what's going to happen next, because there's just so much going on"
Health-related resistance (including digital resistance)	Conscious effort to be healthy	▪ Education ▪ Diverse opportunities ▪ Co-production/ service-user led service design ▪ Locality-based services ▪ Drop-in services ▪ Subsidised and flexible services ▪ Non-judgemental advice and support ▪ Empowerment ▪ Community leader endorsement (e.g. religious leaders, community champions)	All	"Many older people are not computer literate and that can have a huge impact. You know, you… many things these days you can't do unless you can do it through a computer and that's a huge barrier (…) but they don't really want to learn and that's a huge barrier (too)"
Negative emotions (including, fear, loneliness and stress)		▪ Therapeutic services ▪ Social support ▪ Drop-ins ▪ Building relationships with professionals ▪ Non-judgemental interactions ▪ Empowerment ▪ Signposting	All	"And if you haven't got that family, you know, I mean I went 8 and a half months during the pandemic and never spoke to a soul. I was at the point of [ending my life]."

Barriers	Facilitators	Associated health promotion strategies	Associated health behaviours	Illustrative quotes
Motivation				
Negative experiences in health, care and wellbeing settings		▪ Education ▪ Advocacy ▪ Building relationships with professionals ▪ Gathering service user feedback ▪ Training professionals ▪ Targeted services ▪ Equality, diversity and inclusion policies ▪ Community and voluntary sector involvement	All	"(The doctor said) I'll give you some antibiotics then and gives me penicillin, which he knows I'm allergic to. They don't read the notes as simple as that"
Negative expectations of health, care and wellbeing settings/ professionals	Building relationships with professionals	▪ Education ▪ Service-user led approaches ▪ Informational resources (expectation management) ▪ Consultation and survey ▪ Tailored approaches ▪ Accessible resources (readily available or available in advance)	All	"I think they give less of a **** about Black people's pain and not prepared to treat it"
	Sense of community	▪ Community groups ▪ Signposting ▪ Community connectors/ social prescribers ▪ Community leader endorsement ▪ Free events and opportunities ▪ Religious engagement	All	"Volunteering is an excellent way (to stay healthy) because not only do you… Not only are you doing something yourself and giving something back (to the community), but you're actually making friends with other volunteers"
	Risk of sanction	▪ Clear communication of expectations and boundaries ▪ Consistent processes ▪ Reasonable expectations and boundaries ▪ Accessible resources (including translation) ▪ Supportive professionals (may help with explaining systems, processes, expectations & boundaries)	▪ Participating in and receiving NHS services ▪ Avoiding negative health factors	"They send you a disclaimer saying that because you haven't booked and we've told you to come so many times, now we're doing a disclaimer that you'll have to go to another surgery if you don't book it… that's when I book mine"
	Health concerns and desire for physical change	▪ Education ▪ Empowerment ▪ Social support ▪ Professional advice ▪ Commissioned services (e.g. thriving Nottingham)	All	"And particularly since I've been unwell, then you know. I'm very, very clear and conscious that everything I eat must be healthy, otherwise not for anything else, because the medication I'm on, it's steroid based. It's putting weight on me, so I'm trying to eat as healthy as I can"

12.2.6 Housing

Housing matters. One woman, who did not have her own home illustrated this perfectly by saying:

> *Just to have my own little place(...) It doesn't ma;er what the place looks like, but just to say I've got a key that's mine (...) that would be perfect.*

Again, the women experiencing the greatest inequalities had the most simplistic desires in respect of what they wanted from housing to support their health. For these women, shelter, privacy and a space to spend time with loved ones was considered "*a dream*."

Some women valued clean, tidy housing. Most women wanted to live in a permanent home, in a safe location with good local transport links, amenities and social support nearby. Women needed privacy and adequate space to house their growing families as well as appropriate safety measures to support their health and to ensure they were able to reach a point of stability and security and to achieve positive mental health. Unfortunately, for some women who were facing certain adverse or challenging personal circumstances such as navigating the asylum seeking process or experiences of DSVA, it was difficult to find or maintain a safe space they could call their own. Whilst response services such as the Police were supportive, some of the necessary safety measures that were put in place for these at risk women left them feeling as though they were under surveillance, with a lack of personal agency and autonomy. One woman who was living in Home Office accommodation whilst seeking asylum told us:

> *"If you've been in an environment with cameras, you are not free (…) it affects your mind"*

The importance of having social support available locally was so great that for some women, rough sleeping in their hometown was a more viable option than being housed elsewhere. One woman told us how living in a women's refuge made feeling connected to loved ones difficult:

> *"I'm not even bothered about the furniture because all four of my kids will happily sleep on the floor. But you know, just to be together, because when you're not together they don't share what's actually happening in their world because they don't' wanna stress you out (…) but having my own house means my kids are free to come and go as they please or when they need some time alone. You know, just having that big worry off my head, it would be perfect"*

For some women, supported living provided a sense of community with added extras such as a communal garden and access to appropriate and targeted health-related interventions such as chair-based exercise.

Supportive landlords and timely home maintenance in affordable properties were important factors, in ensuring that women's homes could adequately support their health.

Here, we've categorised the features of housing that were either supportive or unsupportive of women's health. Important factors for healthy housing were features of the property itself, features of the geographical location of the property, landlord proactivity and responsibility, and cost. Each of these major components was made up of a number of subcomponents. In Tables 7 & 8 below, we've listed the subcomponents that women mentioned to us, although these lists will not be exhaustive. These components are brought to life by illustrative quotes from local women.

Table 7: Features of healthy housing

FEATURES OF HEALTHY HOUSING		
Major component	**Subcomponents**	**Illustrative quotes**
Features of the property itself	▪ Adequate space ▪ Appropriate safety measures in place ▪ Clean and tidy ▪ Ventilation ▪ Heating ▪ Natural light ▪ Stability (long-term arrangements) **Housing to suit personal needs & requirements** ▪ Furnishings suitable for specific health needs ▪ Privacy (which must be in line with religious requirements) ▪ Privacy in general ▪ Decoration to personal taste ▪ Supported living	"I like my house in a certain way, I like it clean, looking neat, polished. (…) I think if it looks nice, it's always a bonus because if you're coming home and you don't like the way your house looks(…) you're just gonna be like ohhhh… I don't wanna be in here" "Comfortable furniture is pretty vital for me because of the connective tissue disorder (…)so if my sofa is really uncomfortable or non-existent or something then that's really difficult because I then can't sit properly and be comfortable and safe" "I can't open (my curtains) because (then) I can't wear my (head) scarf all the time"
Features of the geographical location	▪ Safe (location feels safe) ▪ Local amenities ▪ Good transport links ▪ Close proximity to healthy spaces ▪ Community gardens ▪ Green spaces ▪ Good neighbours ▪ Near to support networks	"My location is good. I can walk to town; I can also get the bus to town… I'm near the shops both ways, there's a shop really close to me" "I like to be able to get on with my neighbours, not as being in the house every five minutes, but just to be polite, respectful and that"
Landlord proactivity and responsibility	▪ Proactive landlord ▪ City Council	"So, I think having a supportive and probably a good landlord is helpful because if there was anything going on in the house which is affecting the health then having someone who can help fix it is helpful"
Stability of arrangement	▪ Long-term contracts ▪ Permanent housing	"I've lived there for nearly 30 years and it's mine"
Cost	▪ Affordable rent ▪ Affordable utility bills	No women in this analysis discussed having affordable housing

Table 8: Features of unhealthy housing

FEATURES OF UNHEALTHY HOUSING		
Major component	**Subcomponents**	**Illustrative quotes**
Features of the property itself	▪ Damp and mould ▪ The 'big brother' experience (especially for people in supported accommodation and refuge) ▪ Lack of privacy ▪ Unsafe (including cuckooing)	"We have a like… a mould in the house and it just worried us a little bit (…) especially in the bathroom, any time anybody used it, it just gave us like a headache"
Features of the geographical location	▪ Local fly tipping ▪ Feels unsafe/local crime ▪ Far from support networks	"But the big problem for me is housing. That is the biggest issue for me right. Born here, went to school here, my mum and dad's here okay, my siblings are here, my children are here, and I am originally born and bred in Nottingham (…) me and my partner had a domestic (…) East Midlands (housing provider) took me to Derby"
Landlord proactivity and responsibility	▪ Dismissive landlords ▪ Delayed repairs	"Our landlord is just …. Really difficult to get things moving, so our boiler broke, and we didn't have any hot water and he said well, you have a kettle don't you? And it's like yes, but you can't put… a kettle over you in the shower because it's going to burn"
Stability of arrangement	▪ Short-term lets ▪ Insecure housing ▪ Hostels ▪ Home Office Accommodation ▪ B&Bs	"I've been from Wolverhampton; I stayed in the hotel for a year before coming here. Living in the house and then they pushed me out again and it was even like I would have been on the street […] and then I'm in the hotel again"
Cost	▪ Price of renting ▪ Cost of utilities	"And rental is disgusting right now because you know, my first thing was I'm only gonna be here (in a refuge) for a week you know obviously, so I'm gonna rent somewhere and go to work (…) but when you're looking at bedsits for £900 a month…"

13 Current offer / what we are doing including assets and services

A full list of available local and national community groups and general healthcare support is available at AskLion ASKLiON Ask Lion - Nottingham City Directory or via the NHS website.

a. Sexual Health and Contraception

The Nottingham and Nottinghamshire Integrated Sexual Health Service (NNISHS) provides sexual health services in Nottingham and Nottinghamshire. They provide a full range of sexual and reproductive health services that are open-access, safe, non-judgemental and evidence-based. People can choose to access the service through a variety of routes, including online services and face-to-face interaction at accessible times and locations. The service aims to provide high-quality, confidential, inclusive, respectful and person-centred care, whilst simultaneously seeking to reduce inequalities in sexual health outcomes. To further achieve this, the service will have a focus on those who are disproportionately affected by poor sexual health (such as those who are younger, men who have sex with men, LGBTQ+ communities, those who are from more deprived backgrounds and from ethnic minority communities) through effective health promotion, prevention and outreach activities.

b. Maternity, perinatal and neonatal

Several areas of strategic work exist to improve maternity, neonatal and perinatal services in the Nottingham area. A perinatal steering group, currently chaired by the perinatal mental health commissioner, includes attendees from Nottinghamshire Healthcare Trust and NHS Talking Therapies. A co-chair approach may be adopted in the future, in addition to a potential widening of remit to include perinatal equity. Nottingham and Nottinghamshire ICB host the Maternity and Neonatal System Transformation Board, which is a partnership aiming to improve the quality and safety of maternity and neonatal services across the area. This area of work also sees the Ockenden Review ongoing, which is an independent maternity review of Nottingham University Hospitals NHS Trust, commenced following significant concerns raised regarding the quality and safety of maternity services within the trust. The aim of the review is to identify areas of concern within maternity care, provision of information, and recommendation of actions to help improve the safety, quality and equity of maternity care at NUH, alongside the handling of concerns that were raised by families or staff. The review is due for publication in June 2026. Further information can be found at: Ockenden Maternity Review.

Within Nottingham City, work is currently underway on the 'Best Start Strategy 2025-2035', which has the ambition to overcome the barriers which negatively impact the health of children and families. As many women referenced their roles as parents or caregivers regarding their health, this strategy is inherently linked to the topic of women's health via the strategy cornerstones of reducing inequalities, improving health, nurturing positive relationships, improving safety and promoting education and learning. The finished strategy is due for publication in Autumn 2025.

c. Mental Health Services

In Nottingham, a specialist community perinatal mental health service is available which provides treatment and support to women and birthing parents experiencing a serious and/or complex illness during pregnancy, and the first postpartum 24 months (where their needs cannot be managed effectively by primary care or talking therapies services).

There is also a Trauma and Bereavement service which sits alongside the community team, supporting women and birthing parents who have serious or complex mental health needs which don't meet the criteria for the perinatal community mental health team, such as birth trauma, tokophobia (fear of childbirth), neo-natal or pregnancy loss or conception issues. (The Nottinghamshire Perinatal Trauma and Bereavement Service (PTBS) | Nottinghamshire Healthcare NHS Foundation Trust)

d. Violence Against Women and Girls services

Nottingham and Nottinghamshire have comprehensive strategic partnerships in place to address violence against women and girls. These efforts are crucial for creating safer communities. The collaboration between different sectors, including domestic abuse, sexual violence, safeguarding, housing and criminal justice, ensures a holistic approach to supporting survivors and preventing further violence. Domestic Homicide Reviews (DHRs) are also an important part of this process, as they help identify lessons learned and improve future responses. A full list of these groups and their remits can be found within the DSVA JSNA document referenced at the beginning of this needs assessment.

14 Unmet needs and gaps – citizenzen, service, knowledge

a. Women's Health Hub

Despite the publication of the government strategy on women's health, and the provision of funding for women's health hubs, difficulties with the short-term and non-recurrent nature of the funding allocation, aside the competing requirement to 'deliver financial balance' were noted by the NHS Confederation. This has resulted in many systems reluctantly deciding to reallocate the budget for women's health to other areas[5]. At the time of writing, Nottingham and Nottinghamshire ICB does not have a Women's Health Hub.

15 What works, and why

Women's Health Strategy[3] – The Women's Health Strategy published by the government outlined some high level actions required to address disparities in women's health. These included:

- Encouraging research centred on women's health issues
- Improvements in the diversity of research participants, to include women and under-represented groups
- Supporting women in research
- Maximising the impact of research
- Improving the quality of health and care data to allow for good quality analysis
- Championing the use of technology to support women's health

Royal College of Obstetricians and Gynaecologists – 'Waiting for a Way Forward' report 2024[9] make a number of recommendations that could help to inform the recommendations of this report to impact at a local level:

Schemes to provide free or subsidised products to manage menstrual bleeding or incontinence
Improved communication and provision of information to women on gynaecology waiting lists to allow them to access support in their communities.
Expand Women's Health Hubs so that women wherever they live can access healthcare and support across the life course

Royal College of Obstetrics and Gynaecologists – Racial and Ethnic Equality in Women's Health Policy Position (2024)[46] includes recommendations at a governmental level, however some may also be applied at a local level to aid in formulation of recommendations from this needs assessment:

Support equitable access to NHS and sexual and reproductive health services through co-production and effective commissioning, with an emphasis on responding to the needs of women from all ethnic groups
Improved data collection to support research into women's health, and work to design women's health services
A commitment to personalised care, and the provision of a high quality interpreting service.

Evaluation of Women's Health Hubs – A rapid evaluation of Women's Health Hubs[163] found that where hubs have been implemented, their scope and operation is diverse, owing to the lack of a standardised definition. The evaluation found that any creation of new hubs should be informed by local needs, and that consultation with women, especially those least well served by existing services, is required.

16 Horizon scanning – what could impact on women's health in the future?

16.1 National

In March 2025, the Health Secretary announced plans to abolish NHS England, with the aim of reducing bureaucracy and spending, providing clearer focus, and enabling the provision of better patient centred care[164]. With the announcement being so fresh, it is difficult to understand how this may impact exactly on women's health, however what is clear is that a radical overhaul of NHS governance will undoubtedly have some level of impact across the system.

Integrated Care Boards will also undergo restructure and cost savings – with ICBs being asked to reduce running costs by 50% within the 2025/2026 financial year. With potential changes to commissioning and delivery of services, and the possibility of increased partnership working, once again the impacts to women's health are guaranteed but as yet unknown.

The UK Government 'Pathways to Work' Green Paper[165], published in March 2025 details plans to make significant changes to the welfare system, with much of the focus being on health and disability benefits. Although there is potential for positive outcomes for women, particularly those seeking more support to get back into work or those claiming Universal Credit for non-health reasons, the proposed changes could also have a negative impact on women. Women who claim Personal Independence Payments (PIP) as a result of health conditions or disabilities may face a cut to their incomes, in addition to potential reductions in Universal Credit payments. These changes could result in additional financial hardship for women, who are already more likely to be on lower incomes. Those women who undertake unpaid care could also see changes which may impact their financial position and subsequent ability to continue to balance their roles as caregiver and employee.

16.2 Local

The Local Government Reorganisation project was announced in the 'Devolution White Paper'[166] published in December 2024, outlining the government's plan for existing local government structures to be simplified. Although several options have been proposed for Nottingham, a decision is not expected until later in 2025. It is likely that any future decision involving a change to Nottingham City's existing boundary could impact on the way in which council services such as housing support or children's services are delivered and therefore have the potential to impact on women's health, positively or negatively.

Nottingham City's Joint Health and Wellbeing Strategy for 2025-2028 is due to be published and is likely to contain areas of focus that will be relevant to the issues raised in this document concerning the wider impacts on women's health, and health behaviours that can support good health.

Locally, a key service for sex workers, POW, has received much praise from those who access its services, however as of June 2025, we understand there have been changes to the offer and availability of services pending a review. It is unknown what the service will look like in the future, but any shrinking of this service is likely to leave a gap in health and wellbeing services for some of the most vulnerable women in Nottingham.

17 Findings

Health inequalities exist within Nottingham's women, particularly those who are from more deprived backgrounds, or who are from ethnic minority communities. This is consistent with findings from wider literature.

An example from the mortality analysis shows that Covid-19 related mortality impacted women from the 20% most deprived areas more heavily than it did those from the 20% least deprived areas. We can also see that women from the most deprived areas of Nottingham are at higher risk of developing and dying from diseases linked to manageable health conditions or health behaviours e.g. obesity, diabetes, smoking, high blood pressure, although these factors are relevant for all women in maintaining good health. Many of Nottingham's women live with multimorbidity, another issue which impacts statistically more women than men. Of the women we surveyed, many were conscious of possible future health conditions and the impact they may have on them and their families, therefore the provision of support for women to adopt and maintain healthy behaviours in a way that is sustainable into older age is vital to support women's health. An important tool for women to manage their health is through the use of community assets, of which Nottingham has many, however use of these could be improved through awareness raising and flexibility to accommodate women with different time commitments and responsibilities.

Overall, the main cause of death for women of any age in Nottingham is Dementia and Alzheimer's disease, however this is likely influenced by the higher representation of over 75 year olds in the mortality dataset. Other leading causes of death across all ages are Ischaemic Heart Disease, Lung cancer, Stroke and COPD. Despite cancer being a leading cause of death in Nottingham's women, many women in Nottingham experience barriers to accessing cancer screening, with the city's screening coverage being below the national average for all types. Women from more deprived areas are less likely to attend screening, and services may often not be sensitive to women's previous experiences, or individual needs. Women in Nottingham recognise and value the importance of NHS services and engaging with them, however we also heard about the barriers to achieving this, such as difficulties in navigating the system, or prolonged waiting times for appointments or referrals. Women told us that they tried to avoid negative health behaviours where possible, or their adoption of strategies to reduce these where abstinence was unrealistic.

Women aged 75 and over are overrepresented in hospital admissions in Nottingham, although the rate has decreased between 2019 and 2023. Conversely, the rate of 25-49 year old women being admitted to hospital has increased over this time. Ethnicity also has a bearing on hospital admissions, with women from 'Other' and Black ethnic backgrounds being more likely to be admitted into hospital in Nottingham than women from other ethnicities. The intersectional nature of women's health inequalities is demonstrated when looking at hospital admissions by deprivation. Not only are women from the 20% most deprived areas of Nottingham significantly more likely to be admitted to hospital than those from the 20% least deprived areas, but this difference is most pronounced for women aged 75 and over, whose risk is 2.5 times higher than their less deprived counterparts. A particular factor that women told us impacted their health was housing, and the importance of having a safe and secure place to call home, which aligns with housing as a building block of health. However, we heard many stories of sub-standard, poor quality or non-secure housing from women in Nottingham, indicating that this area may have a detrimental impact for women's health in the city.

Reasons for hospital admission change over a woman's life course, with pregnancy and abdominal/pelvic conditions dominating admissions data for those aged under 50. As women reach 50 years or older, they are more likely to be admitted as a result of falls, musculoskeletal health and infectious diseases such as 'flu. In women aged 75 and over, falls are the main cause of hospital admissions. Gynaecological disease prevalence and type also changes over a woman's life course, with premenstrual syndrome and 'other gynaecological' diseases seen to have the highest impact on women, predominantly between the ages of 20-50 years. In Nottingham it is estimated that more women are impacted by PCOS than by endometriosis, and from an earlier age. As women age, they are more likely to experience conditions such as fibroids or prolapse. Women from Nottingham told us that they understood the importance of developing their health knowledge and skills, including in terminology and jargon specific to women's health, and highlighted the support they received from the voluntary and community sector to achieve this. These skills are highlighted as of particular benefit to those who have less experience of the UK health system, or for whom English is an additional language, to enable them to navigate health services, both specific to women, but also general and family health services.

There is a gap in the provision of a specific, women centric location or service which could address the often sensitive issues arising for women in relation to sexual, gynaecological and menopausal health needs. Both hospitals within the city have facilities for the provision of gynaecological treatment, and Nottingham has some specific support available to assist women with mesh complications as a result of treatment for urinary incontinence. Sexual health services are also provided from specified locations; however women have indicated that existing treatment provision is sometimes difficult to access due to difficulties in securing a referral, the inability to self-refer ("gatekeeping by GPs"), and barriers of distance or time to attend. Women also told us about the importance of a trauma informed approach, and the requirement for some women to be seen by a female medical practitioner or staff member, whether due to previous trauma or religious requirements.

Menopause was an important current or future perceived issue for many women who responded to our survey, with many women highlighting that they felt unsupported by local health services and unsure of where to turn. There is no specific service for women to access menopause support in Nottingham City. Despite a number of large employers in the city implementing menopause policies and support for their women workers, many women said they felt unsupported at work or reluctant to ask for support for fear of negative outcomes.

Mental health is one of the most important elements of health to women in Nottingham and has clear gender disparities. Women face challenges with their mental health at many stages of their lives, with many suffering poor mental health from early in adolescence. These challenges are exacerbated by the additional pressures that women face in their day to day lives, and the difficulties associated with trying to access health care services, any subsequent diagnosis and waiting times for conditions affecting women. We heard that women employ different strategies to manage and boost their mental health and wellbeing, including practising grounding techniques and taking part in creative activities. Women also explained that social enrichment was key to better mental health and praised the community/ religious groups that provide that support in the city. Whilst Nottingham does have some female centric mental health service provision, specifically around perinatal mental health, feedback from women is that waiting times for mental health services are often too long, and support could be designed to fit the needs of women and their lives better.

Access to green and blue space was high in terms of importance for women in Nottingham, with clean and safe spaces having clear positive impacts on both physical and mental health and wellbeing. Women also discussed their concerns about safety more generally, and that perceptions of safety of an area may impact on the likelihood of women accessing services located in those areas, for example the city centre. Although statistically it is likely that many of the women surveyed and interviewed will be survivors of domestic abuse or sexual violence, this topic was not specifically spoken about by women but may have been an underlying factor to concerns about safety and access to single sex spaces that were spoken about.

Nationally, there are a number of important legislative and policy changes which could have an impact on women's health. Changes to NHS England, the makeup and operation of ICBs and Local Government reorganisation all represent potentially significant changes to the way in which health services are commissioned and delivered, having a certain but as yet unquantified impact on women and how they are able to access those services. Potential changes to welfare claims are also highly likely to impact women financially, with most proposals at the time of writing risking further lessening the incomes of women in particularly poor physical and mental health, or those with already poor levels of financial wellbeing.



18 Observations and Recommendation

This section outlines key observations from the Nottingham City Women's Health Needs Assessment (WHNA) and provides commitments and a recommendation to guide future strategic planning.

Theme 1: Enhancing Access to Women-Centric Services

Observation:

The WHNA identified a significant gap in specific, women-centric services for sensitive health issues, including gynaecological care, menopause support, and sexual health. Women reported difficulties with "gatekeeping by GPs," long waiting times, and a desire for trauma-informed care delivered by female practitioners. The lack of a Nottingham Women's Health Hub was also highlighted.

Theme 2 : Improving Mental Health and Wellbeing Outcomes

Observation:

Mental health is the most significant concern for women in Nottingham, with challenges exacerbated by long waiting times for services. The WHNA found that social enrichment, community groups, and access to safe outdoor spaces are vital for women's wellbeing.

Theme 3 : Menopause Support in the Community and Workplace

Observation:

The WHNA found that a significant number of women are impacted by menopause and perimenopause, with many feeling unsupported by local health services and employers. A gap in dedicated menopause support services was identified.

Theme 4: Strengthening Preventive Health Education for Women

Observation:

The WHNA highlights that many women lack access to accurate and relevant preventive health education, leading to missed opportunities for early intervention and self-care. This is particularly evident in topics such as reproductive health, cancer screening, and healthy ageing.

Theme 5 : Social and Environmental Safety

Observation:

Women in Nottingham expressed concerns about personal safety, particularly in public spaces. These perceptions of safety were identified as a barrier to accessing services and engaging in healthy behaviours like physical activity.

Cross Cutting Observation

There is no one place where system leaders come together to discuss and respond to the challenges women of Nottingham face regarding their health and wellbeing.

Commitments (We will)

- We will build on existing efforts to prevent violence against women and girls (VAWG), strengthening our focus and commitment in this area.
- We will embed women's voices and their lived experience at the heart of service design, continuous improvement and decision making.
- We will develop women-centric research and innovation.
- We will encourage choice in practitioner and continuity of care.

Recommendation

The creation of a system wide women's health needs group that is tasked to create an action plan that responds to the findings of this HNA.

We recommend establishing a dedicated forum that brings together system leaders from across Nottingham to collaborate, share insights, and take coordinated action on the health and wellbeing challenges uniquely affecting women. This group should champion women's voices, foster innovation in research, and ensure that service design and delivery reflect the lived experiences and choices of women and girls in our community.

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The authors would like to thank the members of the Nottingham Women's Health Needs Assessment Stakeholder Group for their input and support during this project.

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Appendices

Appendix A Recruitment poster

Appendix B Informed consent and demographic information

Appendix C Semi-structured focus group schedule

Appendix D One-to-one interview setting

Appendix E Participant information sheet

Appendix F A table showing local community spaces that women in the focus groups described as being supportive of their health in Nottingham

Appendix G A table showing health-related services that women in the focus groups described as being supportive of their health in Nottingham

APPENDIX A:
Example recruitment poster (generic)



APPENDIX B:
QR Cide for informed consent and demographic questionnaire

Hello and welcome.

Please scan the QR code below and complete the form before we start.

If you don't have a device to do this, please let your facilitator know

APPENDIX C: Focus group schedule

Aims:

1. To identify differences in barriers and facilitators to health and health-related behaviour for different demographic groups of women
2. To further explore barriers and facilitators to health and health-related behaviour for demographic groups of women who weren't adequately represented within the survey
3. To further explore specific barriers and facilitators to health and health-related behaviour which weren't well captured by the survey data
4. To generate ideas which will inform future strategies for women's health promotion in Nottingham

Checklist:

Confidentiality	
Respecting one another's opinions	
Not speaking over one another	
If I ask somebody to pause, I'm not being rude – everybody needs to be heard on tape	
Don't have to answer anything you don't want	
Say as much or as little as you like	
Right to withdraw at any time without giving a reason	

Opening Script

We are here today as part of Nottingham City Council's Public Health team because we want to learn about women's experiences of health, care and wellbeing in Nottingham. We have already given out a survey, which you may or may not have completed, and from that, various issues have been identified, and we'd like to talk to you about them to find out more. To make their health better, women in Nottingham told us they do the following:

Access local health services

Stay active

Eat healthily

Keep their brain active

Spend time with others

Take prescribed medication

They also told us that to be healthy they also try to avoid, limit or give up the following:

Smoking

Drug use

High alcohol intake

1 **So today, the first thing I'd like you all to tell me about is whether there are any other things you do to take care of your health, care and wellbeing, that I haven't mentioned (may need to repeat each list).**

Things you do more of

Things you do less of

2 **You've all been chosen to be here today as part of this group of people because you are all/you all have CHARACTERISTIC X. As a woman from GROUP X, is there anything different about your health, care and wellbeing and how you maintain this, compared to other women?**

Prompts

- Benefits/things that make it easier
- Challenges
- Are there any similarities to other women?
- Obviously, each of you belongs to Group X, does anybody feel like they also identify with being part of another group of women, that makes it more or less of a challenge to be healthy? (provide examples if needed)

3 **Here is another list of things that women in Nottingham felt helped them to be healthier:**

- Feeling supported to be healthy
- Having adequate housing
- Having resources to access health, care and wellbeing services/support (e.g. time/money)
- Community spaces that support health, care and wellbeing
- Safe environment
- Environment free from pollution

I'd like to find out a little bit more about how you experience each of these things. What does X look like to you? (Go through the list)

Prompts:

- Are any of those things done well in Nottingham?
- Are any of those things missing, or in need of improvement in Nottingham?
- Is there anything else that we haven't discussed which would better support women's health, care and wellbeing in Nottingham?

4 **Next, we'd like you to think about the health, care and wellbeing services in Nottingham. These include things like your GP or the hospital, but also other organisations like charities and community groups. The following questions are about how services could best support women, you may have more or less to say about some things than others and that's okay. If you'd like to skip a question, just let me know and we can move on.**

- How could services be more accessible for women?
- How could services be more inclusive for lots of different women?
- How could services be more culturally sensitive?
- How could stigma or judgement be reduced when women access health, care and wellbeing services?
- How could services ensure women feel seen and heard, by that I mean feeling their concerns are being taking into consideration seriously?
- What would encourage women to engage with health prevention services? (e.g. vaccinations, screenings, health checks)
- Is there any special knowledge that professionals could have that would better support women's health?
- What additional accessible materials would help support your health (e.g. Braille, other languages)?
- Are there any online services or tools that could better support women's health, care and wellbeing?
- Anything else that health, care and wellbeing services in Nottingham could do differently to better support women's health in Nottingham?

5 **This section is about what things most get in the way of being healthy as a woman in Nottingham. For this section, I'll ask you to think about things that make it more challenging for women to be healthy and then I'll ask you to think about ways that we could overcome those challenges.**

- Is there anything about you as a person that makes you less able to be healthy?
  i. Physically?
  ii Mentally?
  iii. How could this challenge be overcome?
- Is there anything specific about the environment in Nottingham City that gets in the way of being healthy? (e.g. air quality, available green spaces and number of fast food outlets)
  i. How could the environment be more supportive of health?
- Social norms are the often unspoken rules and expectations that we have of certain groups of people. For example, there is a social norm around women being caregivers (even though we know this isn't always the case). Is there anything about the social norms in Nottingham city that gets in the way of being healthy for women?
  i. How could social norms which are negative for women's health be changed?
- Is there anything we haven't discussed that makes it more difficult to be healthy as a woman in Nottingham?
  i. How could this challenge be overcome?

6 **In this section, the questions will be similar to last time but instead we'll be discuss what things most help you to be healthy as a woman in Nottingham? For this section, I'll ask you to think about things that make it more challenging for women to be healthy and then I'll ask you to think about ways that we could make the most of these things.**

- Is there anything about you as a person that makes you more able to be healthy?
  i. Physically?
  ii. Mentally?
  iii. How could this challenge be overcome?
- Is there anything specific about the environment in Nottingham City that supports women to be healthy? (e.g. air quality, available green spaces and number of healthy food outlets)
  i. How could we make the most of this?
- Remember, social norms are the often unspoken rules and expectations that we have of certain groups of people. Is there anything about the social norms in Nottingham city that supports women to be healthy?
  i. How could we make the most of social norms which are positive for women's health?
- What motivates you, as a woman in Nottingham, to be healthy?

7 **Is there anything specific about women's health in Nottingham which hasn't been mentioned today that anybody feels they'd like to speak about?**

8 **Finally, we'd like to know whether there's any really amazing service, organisation, person, place or experience within Nottingham's health, care and wellbeing service offer. We'd like to give you the chance to give credit to them so that we might be able to learn more from them about how to make engaging with health services in the city a more positive experience for women.**

APPENDIX D: Interview schedule

Aims:

1. To identify differences in barriers and facilitators to health and health-related behaviour for different demographic groups of women
2. To further explore barriers and facilitators to health and health-related behaviour for demographic groups of women who weren't adequately represented within the survey
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Opening Script

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To make their health better, women in Nottingham told us they do the following:

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Things you do less of

2 **You're here today as a woman who has/is CHARACTERISTIC X. As a woman from GROUP X, is there anything different about your health, care and wellbeing and how you maintain this, compared to other women?**

Prompts

- Benefits/tBenefits/things that make it easier
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- Are there any similarities to other women?
- Obviously, you belong to Group X, do you identify with being part of another group of women, that you think makes it more or less of a challenge to be healthy? (provide examples if needed)

3 **Here is another list of things that women in Nottingham felt helped them to be healthier:**

- Feeling supported to be healthy
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- Community spaces that support health, care and wellbeing
- Safe environment
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I'd like to find out a little bit more about how you experience each of these things. What does X look like to you? (Go through the list)

Prompts:

- Are any of those things done well in Nottingham?
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APPENDIX E: Participant information sheet

WOMEN'S HEALTH NEEDS Assessment FOCUS GROUP INFORMATION SHEET

Hello, we are part of the Nottingham City Council's Public Health team, and we have been asked to complete a health needs assessment for women living within the city boundary or registered with a Nottingham City GP practice. The aim of this piece of work is to understand how women across Nottingham experience health/wellbeing, including what factors are helpful, what factors act as barriers and what works well and less well across the city to support women's health and wellbeing. This phase of the work involves focus groups, which are small group discussions with women from across Nottingham sharing their own experiences.

Before agreeing to take part, please read the information below carefully and please ask any questions you may have. It is completely your choice to participate or withdraw from the focus group.

What will I be expected to do if I take part?

Should you choose to take part, you will be asked to join a focus group discussion about your health and wellbeing as a woman living in Nottingham/registered with a Nottingham City GP practice. There will be a maximum of eight women in the focus group, and everyone (including you) will be asked to agree to keep the focus group discussions confidential and not share content outside of the group. You are welcome to say as much or as little as you feel comfortable with. A member of the Public Health team will facilitate the discussion, and all discussions will be recorded. If you would like to take part but would prefer a one-to-one interview, please let us know as soon as possible, in order to be able to respond to the request.

Why have you asked me to take part?

You have been asked to take part in this focus group because you are a woman who lives in Nottingham or registered with a Nottingham City GP practice. Over 200 women have already responded to a city-wide survey. However, not all groups of women were adequately represented. Therefore, it is possible that you may have been asked to take part because you belong to one of the groups of women whose experiences need to be better understood/explored. If this is the case, we will be clear with you about why that is. To be eligible to take part, you will need to be over 18 years of age, be a cisgender woman and live within the boundaries of Nottingham City Council's Local Authority.

Do I have to take part?

No. It is up to you whether you would like to take part. A copy of the information provided here is yours to keep. If you decide to take part, you can still change your mind at any point before or during the conversation and leave without giving a reason and without it affecting the way you are treated. If you take part in the conversation however, it will not be possible for the things you said to be removed afterwards, because everything discussed will be anonymised, meaning that it will not be possible to tell who said what.

Where and when will this take place?

All of this will happen in May 2024. If you would like to take part, please complete the expression of information form which you should have received with the recruitment email and again with the email this information sheet is attached to. Each focus group should take between 1 and 2 hours.

Are there any possible risks or disadvantages in taking part?

Some people might feel uncomfortable talking about personal experiences and feelings in front of other people. Remember, you always have the choice not to answer any particular question.

What are the possible benefits of taking part?

We hope that you will find taking part interesting and you will enjoy sharing your experiences, The findings of this research will help the Nottingham City Public Health team to understand what enables women in our city to be healthy. You will receive a £10 voucher in recognition for your time.

When will I have the opportunity to discuss my participation?

Your focus group facilitator will be available before and after the focus group to answer any questions or in case there is something that you wish to share privately. You can also find a contact email address at the bottom of this form should you want to discuss your participation further at any time.

Will anyone be able to connect me with what is recorded and reported?

Only the people present in your focus group would be able to know who said what.

After your focus group, the recording will be transcribed. All names will be replaced with a non-identifiable name and any information that may reveal your identity (e.g. if you mention the street on which you live) will be removed. Whilst we may use direct quotes from you within the report findings, it will not be possible for anyone identify an individual.

Who will be responsible for all of the information and what will happen to it when this study is over?

Nottingham City Council will be responsible for all of the information collected from the focus group discussions. All data collected will be held as an electronic record and in accordance with the Data Protection Act 2018. This will, however, only include anonymised transcriptions and all audio recordings will be destroyed once they have been transcribed.

Who will have access to it?

Only Nottingham City Council's Public Health team and those involved in the professional transcription of the audio recordings will have access to the audio recorded discussions. However, once typed up and identifying information has been removed, anonymised data may be shared with a small number of professionals to ensure appropriate conclusions are drawn.

The findings will inform Nottingham City Council's Women's Health Needs Assessment. Findings may also be discussed/ cited in other reports, articles, publications, presentations and training exercises.

How can I find out about the results of the study

If you are interested to find out the results of this research then once completed, they will be publicly available via Nottingham City Council's intranet.

Researcher/ Research Team Details:

If you have any questions or concerns about the research or your participation, you can contact:

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Public Health Principal Matt Corder: matt.corder@nottinghamcity.gov.uk

Appendix F:

A table showing the local community spaces that women in the focus groups described as being supportive of their health in Nottingham (this is not an exhaustive list of community spaces

Community spaces that are supportive of health	
Category	**Examples**
Community Centres	1. Beechdale community centre 2. Queen's Walk Community Centre 3. Nottingham Ukrainian Cultural Centre
Day Centres	4. Emmanuel House 5. Maggie's Cancer Centre – Nottingham 6. Nottingham and Nottinghamshire Refugee Forum 7. Nottingham Women's Centre
Green Spaces	8. Bestwood Country Park 9. Forest Recreation Ground 10. King Edward Park 11. Stonebridge City Farm and Garden 12. Wollaton Park
Joint Service cCentres	13. Clifton Cornerstone 14. Mary Potter Centre 15. Bulwell Riverside Centre 16. St Ann's Valley Centre
Libraries	17. Nottingham Central Library 18. St Ann's Library
Wellbeing Hubs	19. Nottingham Wellbeing Hub
Places of Worship	20. Mosque 21. St Jude's Church 22. Trinity Church
Educational Establishments	23. School gates

Appendix G: A table showing the health-related services that women in the focus groups described as being supportive of their health in Nottingham (this is not an exhaustive list of community spaces and Services that are female-targeted are denoted with a '♀'.

Community spaces that are supportive of health	
Category	**Examples**
Campaigns, initiatives and events	1. Ask for Angela ♀ 2. Race for Life ♀ 3. She Moves Nottingham (This Girl Can) ♀
Community and voluntary services	4. Advice Centre 5. Age UK Nottingham and Nottinghamshire 6. Autistic Nottingham 7. Chinese Welfare Association 8. Citizens' Advice Bureau 9. Clothes Banks 10. Food Banks 11. Framework 12. The Freedom Programme 13. Good Companions 14. The Helix Project 15. Heya ♀ 16. JUNO Women's Aid ♀ 17. The Level (Framework) 18. Nottinghamshire Hospice 19. Nottingham Muslim Women's Network ♀ 20. Nottingham Recovery Network 21. Nottingham Women's Refuge ♀ 22. POW ♀ 23. Refugee Roots 24. Salvation Army 25. Services for Empowerment and Advocacy 26. Sista's against cancer ♀
Digital technology services	27. Google 28. Translation apps 29. Badger app
Education sector services	30. Nottingham College 31. Bilborough College 32. Schools
Gyms, swimming pools and leisure centres	33. Harvey Haddon 34. Personal trainers 35. Southglade Leisure Centre 36. Victoria Leisure Centre
NHS Community Care Provision	37. The Health Shop 38. Health visitor 39. Peer support workers 40. Talking Therapies ▪ Cognitive Behavioural Therapy 41. Urgent Treatment Centre 42. 111 43. Dentists 44. GP's ▪ Patient participation groups 45. Health and wellbeing coaches 46. Opticians 47. Pharmacies 48. Pharmacy delivery services 49. Social prescribers 50. Support workers
NHS Secondary Care Provision	51. Nottingham University Hospitals NHS Trust ▪ Bone densitometry clinic ▪ Breast Cancer Institute ♀ ▪ City Hospital Maternity Services ♀ ▪ Ear, nose and throat ▪ Eye hospital ▪ NUH City Hospital GU Clinic ▪ Urgent Care 52. Nottingham Recovery College
Nottingham City Council Services	53. Adult Social Care ▪ Community Connectors ▪ Personal Assistants ▪ Social Workers 54. Age Friendly Nottingham 55. Housing Aid
Nutrition and healthy weight management	56. Dietitian 57. Slimming World 58. Weight Watchers
Prison services	59. Ambulance service 60. Fire service 61. The Police
Translation services	62. Translators/interpreter 63. Translation apps

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