CNet
COMMUNITY NETWORK
BRADFORD & DISTRICT

NHS
Bradford City Clinical Commissioning Group
Bradford Districts Clinical Commissioning Group

WOMEN'S HEALTH NETWORK
INTERIM PROGRESS REPORT
MAY 2016

Contents

1. INTRODUCTION

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

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

Work to establish the WHN, which includes research and mapping, engagement and network development is being undertaken by the CNet Project Development Team. CNet are committed to developing a WHN that is founded on good practice, maximises community assets and engages women living and working in Bradford, particularly those that are seldom head.

CNet are using an asset based community development approach to engage and sustain the involvement of local women and are working in partnership with public, private and third sector organisations that work to support the health and well-being of women. The aim is to develop a WHN that local women take ownership of, which meets the express needs of the women of Bradford and which is informed and influenced by them.

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

2. RESEARCH AND MAPPING

Research is being undertaken on a national and local level to develop an understanding of both good practice and barriers around women's health provision. It also aims to identify examples of best and innovative practice in relation to how women can be engaged in developing women led healthcare and to use these examples to inform the development of the WHN in Bradford.

Alongside the research a local mapping exercise is being completed to identify services and community assets currently working to achieve better health outcomes for women and children in Bradford.

The combination of research and mapping will enable strengths, gaps and needs relating to women's health provision to be identified and recommendations to be made that will support better access and healthcare for women and their families.

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

- **Health:**

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

- **Community Assets:**

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

2.1 NATIONAL RESEARCH

The methodology being used is a combination of desk research and telephone interviews.

For the desk research a simple yet focussed trawl of the internet was completed for evidence of published or unpublished examples of good practice and/or barriers relating to the engagement and involvement of women, in developing women's health provision. A full list of documents and website links will be provided in the final report.

From the results ten areas, with similar demographics to Bradford, were chosen for further in depth research into examples of best practice. Contacts were made and eight out of a proposed ten telephone interviews, using a semi structured interview schedule have been held, with a range of professionals from a variety of public and third sector organisations. If time and budget allow up to two study visits will be made to exemplar projects, in Oldham and Rochdale.

A full list of areas and interviewees will be provided in the final report along with a copy of the interview schedule.

2.1.1 EMERGING THEMES

The following themes are emerging from the desk research:

- **Co-production and asset-based approaches**

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

  The asset-based approach values the capacity, skills, knowledge, connections and potential in a community and is already being used by the Department of Health in at least three of its community programmes, Health Trainers, Community Health Champions and Cancer Champions. The IDeA highlight this as a positive approach that will inevitably lead to better and relevant healthcare.

It is recommended that a combined approach of asset-based and co-production is used in to develop and sustain the WHN.

- **Define a purpose**

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

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

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

- **Inclusion of 'seldom heard groups'**

One of the core aims of the WHN is to be inclusive and accessible to women of all abilities and from all the different communities in Bradford. Examples of best practice identified through the research suggest creative and effective approaches are needed to ensure 'seldom heard' groups are able to access and participate in networks of this type.

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

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

- **Promotion and the use of social media**

Evidence from the research suggests continual promotion using social media can be beneficial when developing and running a network or forum.

The advantages of using social media are that most sites are free, information is instant and wide reaching, it can be controlled and, it allows interested individuals and groups to engage in forums and discussions from the comfort of their own familiar surroundings. Those who are accustomed to commenting and hash tagging will feel comfortable with this and will be able to follow and engage with the WHN, even if they don't attend meetings and events. Furthermore, they will be able to raise awareness to their own followers, friends and family.

Examples of Social Media that could help promote the WHN include:

Facebook – the WHN are in the early stages of developing their own Facebook page. The example below shows the potential impact of Facebook.

Five women (the administrators) from Batley, West Yorkshire created a 'Ladies Secret Group' using Facebook. Within two weeks they had gained 5,000 members. Now in their 7th week they have 8,600 members. The premise of their page is to share food recipes but is not limited to just that. The administrators encourage women to talk about anything on their mind. This has led to conversations relating to health issues such as weight loss and caesarean section aftercare.

Ladies Secret Group, Batley

Twitter - is a quick and efficient way of getting information out to a wide range of people and a way of gathering instant feedback.

YouTube – can be used to upload short videos to promote and share the work of the WHN and to celebrate its successes.

Blogs and Vlogs - Blogs are a series of written excerpts available on the internet, whereas Vlogs use short video clips instead. The WHN may want to consider keeping a blog/vlog diary to document their work.

Using social media will require a dedicated person on the WHN to monitor and manage each of the sites being used and to regularly update them.

2.1.2 EARLY FINDINGS

A total of eight telephone interviews conducted to date have highlighted the following early findings:

- **Knowing and understanding your community**, including identification and consideration of religion, culture and traditions, is key to offering relevant healthcare to women. For example, focus groups held with Bengali women in Leicester identified the reason for not making appointments with the midwives earlier was due to the women feeling they did not need any information from the midwives as they had had children and felt they knew what they were doing. They also relied heavily on the advice of their elders.
- **Genuine involvement** in the development of the network or forum, by the women who will be using it, is critical. The majority of those interviewed suggested a 'top down' approach, where a CCG or other organisation create a network or forum for women, does not work as well as one that is co-produced and owned by the women themselves. For example in Rochdale in 1988 three local Pakistani women got together to create a Women's Welfare Association, they then engaged and involved women from the community and, 28 years on the group is still going strong and has been a tremendous success.
- **Utilising community assets** was viewed to be very important with the majority of those interviewed identifying the need to work closely with a core group of community members, not only in order to reach more women in the community but also to identify and utilise existing skill sets. For example in Leicester a group of young people consulted with 1600 other young people about their healthcare needs and then went on to start an enterprise.
- **Relationships with CCG's** varied across those interviewed with a number experiencing difficulties in engaging meaningfully with their CCG's. However one interviewee had a very strong relationship with their CCG and explained how their organisation sit on the Joint Assessment Board.
- **Barriers to accessing healthcare** whether real or perceived e.g. lack of confidence, religious/cultural beliefs, stigma worries etc., need to be identified and understood if they are to be effectively addressed. Results of a study, 'Women's Voices on Health', conducted by the Women's Health & Equality Forum to examine the accessibility of primary care for women in the UK, suggests certain groups of women will have very particular and specific needs that need to be addressed for better healthcare.
- **Attracting and sustaining interest** is important and reliant on being able to capture the attention of the target audience with something that interests them. An organisation in Hull successfully achieved this by holding fun events and a 'Hull's Got Talent' initiative.

2.2 LOCAL RESEARCH AND MAPPING

Desk based research was used to identify organisations and groups providing services and activities in the areas covered by NHS Bradford City CCG and NHS Bradford Districts CCG, who have a positive impact on the health and wellbeing of women and their children. The research included searches of existing databases for example, DIVA Bradford, Bradford Women's Network Directory etc. and researching the websites of community centres, children's centres, places of worship and other community facilities which host community groups and organisations. In addition request for information have also been widely circulated to community workers, Local Authority ward officers and other individuals who may be able to provide contact details about other groups.

The aim of the research and mapping is to provide both a database of smaller and mostly unconstituted women's group, which could be described as unknown and unheard in terms of their engagement with the CCGs, and a database of community assets. The community assets database will complement the Realising Community Assets Project commissioned by the CCG's and there is agreement between both projects that information will be shared in order to avoid any possible duplication.

In order to gather more qualitative data and identify examples of good practice face to face and/or telephone interviews will be held with a small but representative sample of groups.

2.2.1 EMERGING THEMES

From the local research and mapping data collected and collated to date the following themes are emerging:

- **Variety of groups** – the range of groups is vast and seemingly endless From walking groups to mother and toddler groups, from sports groups to arts groups, from LGB&T groups to luncheon clubs, from faith based groups to groups for victims of domestic violence, from gardening to singing.
- **Contradictory trends** – many groups have become defunct but new ones have arisen - whilst others have changed, adapted and developed and, in some cases, merged.
- **Purpose** – the aim of the group or activity has outcomes and benefits beyond its intended purpose. Chatting and socialising has a pivotal role in member's well-being. However in some cases this can interfere with the activities to the extent that some members leave as the activity becomes secondary.
- **A welcome break** – in many cases the group offers members respite from the family or from the stresses of everyday concerns. Yet at the same time provides an opportunity for members to discuss these concerns, share experience and seek and receive emotional and practical support.

- **Social media** – the increasing use of social media and the internet has contradictory effects. In some cases it is very effective in promoting the group and recruiting new members yet conversely because information is more readily available people can get knowledge, help, advice and solutions without the need to join a group.
- **Good practice** –shows a willingness and ability of groups to adapt and change. Some recognise they have outlived their original purpose and have either closed or changed. Whilst others have adapted their way of operating to incorporate social media to promote themselves and to raise funds, or "do things differently" and offer unusual and more creative activities.

2.2.2 EARLY FINDINGS

Information gathered from the research and mapping has identified the following early findings:

- At least one-third of the circa 250 groups identified from existing databases are now defunct and a similar number require further confirmation.
- Other groups have merged or changed their name and function.
- Some long standing local groups such as the Women's Institute and the Townswomen Guild have now closed or merged.
- New groups have and are being formed.
- There appears to have been a decline in the number of South Asian women's groups, but at this stage this cannot be substantiated as there may be new groups, mergers and name changes yet to be discovered.
- Identification of formalised women's groups amongst the newer Central and East European Communities has been difficult as in the main these tend to be loose social groupings. The one exception is the long established Bradford Ukrainian Women's Association which has experienced a recent growth with 30 new members. Although mostly younger women, who are the daughters and granddaughters of older members, there are some new migrants have also recently joined.

An appendix of examples of groups will be included in the final report to illustrate the variety of groups currently delivering services and activities that positively impact on the health and well – being of women and their children.

3. ENGAGEMENT

The aim of this element of the work is twofold. Firstly to meet with women, from across the areas of NHS Bradford City and NHS Bradford District CCG's whose voices and experiences are seldom heard and, engage them in a dialogue on health issues. Secondly to gain a better understanding, from this dialogue, of their priorities in terms of their health needs; their expectations of healthcare and any barriers they face in accessing it; how they access information on health services and why they choose to access some services and not others.

To gain a good cross section of the variety of women using health services locally, there are two stages to the engagement. The first stage, which commenced in February, is a series of one off conversations with women in community settings, either on a one to one basis or with small groups of women. The conversations with some groups have been free flowing whilst with others their views on specific topics were sought e.g. cervical screening, access to health services.

The second stage, which will commence in June, will be a series of focus groups on topics which emerge as key themes from the first stage conversations and with specific groups who have been identified to garner further views from. The focus groups will enable a more in depth understanding to be gained on particular issues including potential solutions to overcome barriers and ways of delivering services differently. They will also identify other key themes the WHN may want to engage on and, enable women who may be interested in participating in the WHN to be identified, encouraged and supported.

Groups met with during the first stage of engagement include, refugee and asylum seekers, women from white working class areas, LGB&T women, older women, women who have experienced domestic abuse, women who have recently had babies or who are planning to extend their families, women in the probation system, women new to the UK, women from BME backgrounds, mums of school age children, women who are substance misusers, younger women, mums with children with disabilities and women who are carers.

A full appendix of groups engaged will be made available in the final report.

3.1 EMERGING THEMES

From the first stage engagement the following themes are emerging.

3.1.1 ACCESS TO SERVICES

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

- Difficulty in getting appointments. Many women were registered at surgeries who operate a morning telephone queue system and reported how difficult this was to access. This was particularly hard for those without good English and, those who were busy trying to get children ready for school at that time and hence could not spend 40 minutes waiting on the telephone.
- Difficulty in or with, registering with a GP, receptionists, service received, language barriers.
- Lack of translators/lack of understanding of how to access a translator and inappropriateness of some translators (particularly gender).
- There was concern expressed in relation to what information women felt able to share with providers. For example they felt it was important for the health professional to 'like' them

or ‘approve’ of their choices and to avoid being judged or ‘told off’ was a major factor in how care was accessed. Women acknowledged that this might then effect the care or treatment received as the care provider was not necessarily being given accurate information but felt that approval was more of a priority.

- Some, especially vulnerable groups, were suspicious of accessing GP or other health services, particularly if they knew there was information on their medical records relating to previous experiences of domestic abuse, drug/alcohol misuse or mental health issues. In such cases women felt that each time they accessed health services for themselves or their children their parenting abilities were being judged. Their fear of social services getting involved and their children being taken into care results in them not accessing services or doing so reluctantly.
- Several women raised concerns about confidentiality commenting that they did not always feel confident that administrative or support staff would be bound by professional confidentiality. This was a particular concern when they were seen by people they knew or were related to or when accessing specific clinics e.g. Midwife clinics where their reason for attending would be known. They felt concerns in terms of confidentiality could compromise their attendance or would be a cause of stress for them.
- Many women felt that services should be more accessible and locally based but with more put in place to guarantee anonymity or, with the ability of women to be able to use other reasons why they were there if seen by people they know.
- Some women did have good experiences to report and found that they had followed a pathway of referral to a specific service successfully and smoothly and were appreciate when this happened.

3.1.2. LIFESTYLE

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

- Many women feel uninformed about healthy lifestyle choices and are confused about what a good diet should look like for themselves and their children.
- Women feel that the cost of exercise and a healthy diet are barriers and that their roles as mums/ carers restrict their ability to prioritise their own health.
- Healthy eating was reported as expensive and difficult to achieve when preparing food for a family who won’t necessarily want to eat healthier choices.
- There is also confusion over what is healthy and what is not. For example should the concern be sugar, or fat or calorie intake.
- Concern was expressed about the rising rates of diabetes but this was seen as genetic therefore inevitable and also viewed as an illness, not a manageable condition. There is

confusion around Type 1 and Type 2 diabetes and women were either, not aware of what support is available, or do not rate it.

- Older women felt that they did not have enough support or access to good information on how to maintain a healthy lifestyle as they became older.
- Many women reported a cultural incompatibility with a healthy diet and for others it was just seen as too expensive without any guaranteed benefits.
- Many women reported that pregnancy/life with small children is very stressful and that being told to eat healthily, exercise, stop smoking and stop drinking is just not realistic. They feel it is so out of their reach, not relevant or not achievable that they do not feel able to take any steps towards achieving it.
- Difficulty in maintaining a healthy weight during and between pregnancies was raised with many women reporting that they and their families view pregnancy and the post-natal period as a time to relax and enjoy more freedom in food choices. They were not aware of the recommendations to only increase calorie intake in the final trimester of pregnancy. They also felt that any link with gestational diabetes was inherited rather than a lifestyle risk. Those who had attempted to maintain a healthy diet reported family members becoming concerned and putting pressure on them to eat for two.
- In addition to pressure from extended family to eat more there was also pressure not to breastfeed at all or for an extended period. Whilst some Muslim women were aware of guidance in the Quran to feed infants until the age of 2 they reported that tradition and living in extended family networks made this difficult or, that caring for older children made this aspirational but not practical.
- Most women were aware of the risks of smoking in pregnancy but found it a difficult time in their lives to stop or reduce smoking. They felt they had to lie to health professionals about smoking rather than seeking help as they did not want to experience the disapproval of health professionals and did not want to feel they were being judged rather than supported.

3.1.3 CERVICAL SCREENING

Whilst most women were very aware of the risks of cervical cancer and the benefits of attending regular screenings they reported several factors that could impact on the take up of the service. These are summarised below:

- Lack of understanding of what the procedure involves, equipment used, time taken etc.
- Dislike of the procedure itself and/or previous experience of a painful procedure.
- Friends and family telling them it's painful.
- Husbands reluctant for them to access such a service.
- Fear of accessing the service at a building they are not used to.
- Many felt that cervical screening prior to having children and completing a family was inappropriate and a duplication of services.

- Many others felt it was only for women who have been sexually active/promiscuous and reported lots of confusion around smears and sexually transmitted infections (STI's).
- Others felt it was just too difficult to access because of lack of transport/cost of public transport, no childcare for other children.
- An issue, particularly for some Muslim women was in attending before they were married as either they are not sexually active or they are but know that within their family/wider community that this is unacceptable. This coupled with their fear around a lack of confidentially or being seen by people they know when attending for the appointment meant they just did not attend.
- Fear of being recalled and/or test showing some problem. Many women admitted they would rather just not have the test.
- Poor experience with medical staff being brusque in their manner and not sensitive enough to the fears of women.
- Women being afraid of attending when they have missed previous appointments. Even if they want to attend they will miss further appointments for fear of being 'told off' or being 'in trouble' with medical staff.
- Some service providers felt that women would not have understood the letters inviting them for cervical screening so would not have realised that they were expected to attend or why it is important.

3.1.4 APPROACHES TO HEALTHCARE

The differences in approach of healthcare provision in different countries was raised with the key points being detailed below:

- Different approaches experienced from those outside of the UK, particularly in relation to consultant referral, access and prescribing practices.
- Lack of understanding on the part of both service users and providers in relation to charges for different Visa restrictions.
- Differences in maternity care with midwife led seen as inferior, particularly by newly arrived/migrant communities.
- A belief held by some that the indigenous white community receive a better standard of care than newly arrived/ migrant communities.

3.1.5 OTHER ISSUES

A number of other individual issues were raised during the first stage conversations as detailed below:

- **Online Services** - there was a sense that services were moving more online and that patients are being encouraged and expected in some areas to do their own research e.g. Maternity Care. However women reported how, having done this they can face hostility from

practitioners. Many women also highlighted how they struggle with online access so need to seek help from generic support services who do not always have the time, skills, IT access or expertise to provide this.

- **Self-Care** - women reported a lack of confidence in self-care whether in respect to their own health or that of their children. They also reported a lack of trust in pharmacies to provide good quality advice and were surprised at the length of training pharmacists receive. Many were also not comfortable using 111 and not really aware of what it offers and the languages available nor were they confident using a telephone line from a mobile phone.
- **Mental Health** - was an issue which raised lots of concerns. Many women reported how they are reluctant to share any mental health problems they have due to fears of involvement from social services. They also reported a mistrust of medication, stigma and a lack of support from family to seek help. A sense that it's 'wrong' to suffer with poor mental health was particularly true for Muslim women who feel it does not fit with an Islamic framing of being grateful and blessed for what they have in life.

3.2 SUGGESTIONS FOR IMPROVEMENT

A number of suggestions and ideas were highlighted in terms of improving services related to some of the emerging themes detailed in Section 3.1 above. These included:

- Utilising health buses or community rooms, for example in supermarkets or children centres, not for specific clinics such as cervical screening but for the provision of a number of functions. It was felt this would provide easy access without the stress of building up to appointments and would also provide anonymity for people attending.
- More reassurance for patients of the professional boundaries staff have to work within. For example can a staff member access the medical records of people they know etc.
- More reassurance for those who have experienced difficulties in the past in relation to what happens when a GP or health professionals report concerns and what this could result in.
- Make changes to the current appointment booking system in GP Practices. Women are often the main carers for children/elderly people and find it very difficult to access the service at a time when they are busy with childcare and doing the school run.
- Share health information in different ways using a peer group model with the emphasis on support rather than judgement.
- Women talked about liking the type of model run by regular groups where attendance is voluntary but strongly encouraged on issues such as health in pregnancy, healthy eating, smoking cessation etc. It was felt the sessions should be in local supportive environments with childcare.

4. NETWORK DEVELOPMENT

4.1 PLANNING

CNet established a Project Development Team to plan and deliver the project over the eight month period February to September 2016. The team developed a detailed project implementation plan and meet on a monthly basis to assess progress against the plan and to drive the project forward.

The project co-ordinator and chief executive officer of CNet attend bi monthly meetings of the CCG's WHN Steering Group to give an update on progress, discuss any issues arising and share information relating to the themes and findings emerging from the research and mapping, engagement and WHN events.

Recently seven women identified via the WHN events have expressed an interest in forming a core group to lead the work of the network once established. All have been invited to attend future project development team meetings and will be supported by CNet to take ownership of the network post September.

4.2 PROMOTION

The development of the WHN has been widely publicised and promoted via CNet's weekly bulletin and through all of its own networks and, those it supports including the Voluntary and Community Sector Assembly Forums.

Traditional and social media has been utilised to share information and advertise events. Links have been made with the local press and radio stations with an article about the WHN featuring in the Telegraph and Argus and broadcasts being made on Bradford Community Broadcasting (BCB) radio.

Members of the Project Development Team have also been attending relevant networks and events to advertise and promote the WHN, e.g. VCS Assembly Health and Well Being Forum, Patient Participation Group Networks etc.

An easy read leaflet providing information about the network has been produced by Bradford Talking Media and 250 hard copies have been circulated to local groups. The leaflet has also been distributed electronically via a range of existing networks and partnerships.

A dedicated WHN webpage has been established on CNet's website. A WHN Facebook page has also recently been set up and once tested will be open to the public to access, along with explorations into setting up a WHN twitter account.

Currently there are approximately 90 people on the WHN distribution list held by CNet who are a combination of private, public and third sector workers, volunteers and interested individuals.

4.3 MEETINGS

4.3.1 INITIAL EVENT

The first meeting of the WHN was an event held on Tuesday 15th March 2016 from 9.30 am to 12.45 pm at Carlisle Business Centre. It attracted 70 attendees from a range of organisations and groups as well as some interested individuals. The event explored some of the current health issues where outcomes could be improved, the importance of working in engaging and empowering ways and, why a women's health network is needed.

An open space session followed whereby attendees were asked to identify any issues or opportunities related to the development of the WHN that they felt were important or were passionate about. A total of eight topics were identified and a summary of the key points raised during the ensuing discussions are detailed below:

Relationships

- Support during transition periods for examples divorce, separation, starting again, seeking refuge and asylum etc. and the associated issues e.g. blame, stigma, isolation, pressure to return, self-image, sexual relationships, post-traumatic stress syndrome etc.
- Developing relationships between women including those from different cultures and backgrounds so that they can share, understand and support each other.
- Empowering women and building their confidence to make informed choices.

Inclusion

- Exercise, diet and lifestyle and the benefits of the social element of sport.
- Social vs medical model, more compassion within a social model of health.
- For co-creation to work honest communication, real involvement (not tokenism) and true partnerships are needed. It is critical voices are actually heard and responded to.
- The network needs to ensure people with physical and learning disabilities are supported to be included.

Counselling

- Stigma associated with counselling.
- The type of counselling needs to be appropriate to the individual and delivered in appropriate venues.
- Long waiting times.
- More is needed in schools.
- Antidepressants for everything when they may not always be necessary.

Women and Ageing

- More information is needed on how to manage debilitating age related illnesses such as the menopause, dementia and osteoporosis and, the benefits of health and fitness in reducing the impact of age related illnesses needs promoting more.
- Stereotypes around gender for example childcare, maternity, work etc. need to be challenged.
- Experts by experience should be tapped into and utilised e.g. mentoring, skills share, budgeting, DIY etc. and more intergenerational work should be undertaken.

Maternity Services and Family Planning

- Promote services better - explain choices and services available e.g. breastfeeding peer support and, make services accessible e.g. One Stop services, Better Births, Hubs described in the National Maternity Review.
- Interpreting services - issues around not being able to speak freely and not getting the right information.
- Cultural understanding - understanding differences in experiences and providing continuity.
- Ideas shared on what could be done better included continuity, links to other services (sexual health/education) pregnancy planning.

Exercise and Mental Well Being

- Social aspect – building networks, active mum = active kids.
- Learning from what already works 'I will if you will' (Bury, Lancashire) 'play streets' (Leeds).
- Utilisation of schools and green spaces.
- Impact and power of the Womenzone video shown - this should be played in GP surgeries.

Getting Schools and Education Involved

- Neutral, safe environment, platform for issues with space available.
- Outreach - taking services mobile and into schools, no questions why, no stigma.
- Improve partnership working and investment in services – health, MPs, VCS, business, sponsorship, medical companies.

Isolation and Confidence Boosting

- Approachable non-clinical support for different transition periods in a woman's life.
- Directory of services that tackle isolation and help general mental well-being.
- Mobile outreach work for those who do not have the confidence or mobility to access listed services that tackle isolation.

4.3.2 DESIGN WORKSHOP

The second meeting of the WHN was a design workshop held on Wednesday 13th April from 9.15 am to 12 noon at City Training Services. The workshop was attended by 23 women from a range of organisations and groups and well as some interested individuals.

The workshop began with an introduction to the WHN and feedback for the initial event held in March. The early key themes emerging from the national and local research and mapping and, the first stage of engagement were then shared. Attendees then participated is some small group exercises to help shape the design the WHN. The questions attendees were asked to consider are detailed below together with a summary of the responses.

What does a network which listens and responds to the needs of women look like and how does it operate?

Within this one question attendees were asked to consider who is this woman, what is important to her, what are her needs and what does she need to be in place to be able to participate in the network.

Summary of Responses:

- All women living and working in Bradford, but particularly the seldom heard.
- Consideration needs to be given to how women who have low confidence and self-esteem, who are carers or whose first language is not English are enabled and supported to get involved.
- To participate women need; information about the network so they are aware it exists and how they can get involved; accessible local venues that provide a safe space; support with travel, transport and childcare and the provision of interpreters if required; to feel valued and a sense of belonging; to be able to participate at different levels at different times to suit them.
- Support to access the network needs to be in place for example peer support, a buddying scheme alongside a policy of welcome and inclusion. There needs to be transparent two way communication together with timely feedback on how people's participation contributes and influences.
- The network needs to link to other existing network and communication channels and provide flexible and various ways in which women can get involved.

Who does the network need to have relationships with and how will it develop commitment from partners and be able to influence?

As part of this question attendees were asked to consider who does the network need to be in partnership with, how can those partners interact well and how does the network develop commitment and ensure it has influence.

Summary of responses:

- It was identified that the network, as well as engaging local women needs to be involving and working in partnership with a broad range of private, public, and third sector organisation, from the local council to supermarkets and, a variety of professional working within them from commissioners to youth workers.
- For partners to interact well there needs to be cooperation, good communication and effective follow up. Duplication and replication need to be avoided and their needs to be a focus on actions and strong leadership.
- It was identified that things like; sharing good practice and celebrating success; fostering a sense of ownership; clear and open communication; having a long term strategic plan underpinned by a realistic action plan with resources to deliver it will all help to develop commitment and ensure the network has influence.

How do we develop the network now to ensure it is effective in the longer term?
Attendees were asked to consider who needs to be involved, how can the network involve them, when and where should the network be operating and who should it be listening and talking to.

Summary of responses:

- Local women, particularly the seldom heard, commissioners and third sector organisation supporting women need to be involved in the network.
- To involve people the network needs to be owned by passionate, enthusiastic, able and supported local women. It needs to be open and responsive and results and process focussed. It should use big names to promote and endorse it and maximise available community assets.
- A core group from the membership should be formed which meets monthly and acts as an umbrella for other levels/ local membership groups/ themed groups etc. There should be regular network events and an annual celebratory event.
- The network should use a variety of mechanisms from traditional to online and, venues from local to central, to engage and involve people. It should use existing networks across the patch and maximise opportunities to work with big Bradford based public, private and third sector organisations.
- The network needs to be listening to local women, commissioners, providers both public and third sector and the evidence base of good practice both locally and further afield. It should be talking to seldom heard groups, decision makers and partners.

Information gathered during the design exercises has been collated and based upon this some working principles have been drafted. These will be supported and underpinned by an operating framework still to be developed.

4.3.3 FUTURE MEETINGS

A further three meetings of the WHN will be planned and delivered within the timeframe of the project, in May, July and September 2016.

5. MATTERS FOR CONSIDERATION

In line with CNETs community development approach, the priority is to establish a WHN that has a diverse membership and working principles, underpinned by an agreed operating framework, which ensure it is open and accessible to all women in Bradford, particularly the seldom heard.

Once established the WHN will provides a platform for women to raise issues, and concerns that are pertinent to their health and wellbeing. During the development stage it is important that the priorities are identified and agreed by the network members. Experience has shown that the priorities that may be identified will often reflect the priorities set by the CCG's.

There needs to be a shared understanding and agreement about what is meant by a community development approach and that the network is led and directed by the members.

CNet are now moving into the second stage of engagement and network development where the information gathered during the first stage will be linked with the clinical priorities that the CCG are looking to address.