Public Document Pack

Health and Wellbeing Board

Agenda

Date: Thursday, 14 December 2023

Time: 2.30 pm

Venue: Bordeaux Room, City Hall, College Green, Bristol

Issued by: Jeremy Livitt, Democratic Services
City Hall College Green Bristol BS1 5TR
E-mail: democratic.services@bristol.gov.uk
Date: Wednesday, 6 December 2023

www.bristol.gov.uk

Agenda

1. Welcome, Introductions and Safety Information

Please note: if the alarm sounds during the meeting, everyone should please exit the building via the way they came in, via the main entrance lobby area, and then the front ramp. Please then assemble on the paved area between the side entrance of the cathedral and the roundabout at the Deanery Road end of the building.

(Pages 4 - 6)

If the front entrance cannot be used, alternative exits are available via staircases 2 and 3 to the left and right of the Council Chamber. These exit to the rear of the building. The lifts are not to be used. Then please make your way to the assembly point at the front of the building. Please do not return to the building until instructed to do so by the fire warden(s).

2. Apologies for Absence and Substitutions

3. Declarations of Interest

To note any declarations of interest from the Councillors. They are asked to indicate the relevant agenda item, the nature of the interest and in particular whether it is a **disclosable pecuniary interest**.

Any declarations of interest made at the meeting which is not on the register of interests should be notified to the Monitoring Officer for inclusion.

4. Minutes of Previous Meeting held on Wednesday 25th October 2023

To agree the minutes of the previous meeting as a correct record.

(Pages 7 - 15)

5. Public Forum

Up to 30 minutes is allowed for this item.

Any member of the public or Councillor may participate in Public Forum. The detailed arrangements for so doing are set out in the Public Information Sheet at the back of this agenda. Public Forum items should be emailed to democratic.services@bristol.gov.uk and please note that the following deadlines will apply in relation to this meeting:-

Questions - Written questions must be received 3 clear working days prior to the meeting. For this meeting, this means that your question(s) must be received in this office at the latest **by 4.30pm on Friday 1st December 2023.**

Petitions and Statements - Petitions and statements must be received on the working day prior to the meeting. For this meeting this means that your submission must be received in this office at the latest **by 12 Noon on Wednesday 6th December 2023.**

6. Women's Health "Hub" - Joanna Copping, BCC and Alexandra Humphrey, Integrated Care Board — 2.40 pm

(Pages 16 - 26)

7. Your NHS Menopause Experience - Julie Bird, Healthwatch — 3.10 pm

(Pages 27 - 65)

8. Director of Public Health Report 2023 - Christina Gray, Bristol City Council — 3.30 pm

(Pages 66 - 97)

9. Integrated Care Partnerships - Verbal Update - Councillor Helen Holland, Bristol City Council — 4.15 pm

10. Care Quality Commission Assurance - Verbal Update - Mette Jakobsen, Bristol City Council — 4.20 pm

11. Health and Well Being Board Forward Plan — 4.25 pm

To note the HWBB Forward Plan.

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12. Date of Next Meeting

The next formal Board Meeting is scheduled to be held at 2.30pm on Wednesday 28th February 2024 in the Bordeaux Room, City Hall, College Green, Bristol.

Public Information Sheet

Inspection of Papers - Local Government (Access to Information) Act 1985

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- promotion of good hand hygiene: washing and disinfecting hands frequently
- while face coverings are no longer mandatory, we will continue to recommend their use in venues and workplaces with limited ventilation or large groups of people.
- although legal restrictions have been removed, we should continue to be mindful of others as we navigate this next phase of the pandemic.

COVID-19 Safety Measures for Attendance at Council Meetings (June 2022)

We request that no one attends a Council Meeting if they:

- are required to self-isolate from another country
- are suffering from symptoms of COVID-19 or
- have tested positive for COVID-19

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Committee rooms are fitted with induction loops to assist people with hearing impairment. If you require any assistance with this please speak to the Democratic Services Officer.

Public Forum

Members of the public may make a written statement ask a question or present a petition to most meetings. Your statement or question will be sent to the Committee Members and will be published on the Council's website before the meeting. Please send it to democratic.services@bristol.gov.uk.

The following requirements apply:

- The statement is received no later than **12.00 noon on the working day before the meeting** and is about a matter which is the responsibility of the committee concerned.
- The question is received no later than **5pm three clear working days before the meeting**.

Any statement submitted should be no longer than one side of A4 paper. If the statement is longer than this, then for reasons of cost, it may be that only the first sheet will be copied and made available at the meeting. For copyright reasons, we are unable to reproduce or publish newspaper or magazine articles that may be attached to statements.

By participating in public forum business, we will assume that you have consented to your name and the details of your submission being recorded and circulated to the Committee and published within the minutes. Your statement or question will also be made available to the public via publication on the Council's website and may be provided upon request in response to Freedom of Information Act requests in the future.

We will try to remove personal and identifiable information. However, because of time constraints we cannot guarantee this, and you may therefore wish to consider if your statement contains information that you would prefer not to be in the public domain. Other committee papers may be placed on the council's website and information within them may be searchable on the internet.

During the meeting:

- Public Forum is normally one of the first items on the agenda, although statements and petitions that relate to specific items on the agenda may be taken just before the item concerned.
- There will be no debate on statements or petitions.
- The Chair will call each submission in turn. When you are invited to speak, please make sure that your presentation focuses on the key issues that you would like Members to consider. This will have the greatest impact.
- Your time allocation may have to be strictly limited if there are a lot of submissions. **This may be as short as one minute.**
- If there are a large number of submissions on one matter a representative may be requested to speak on the groups behalf.
- If you do not attend or speak at the meeting at which your public forum submission is being taken your statement will be noted by Members.
- Under our security arrangements, please note that members of the public (and bags) may be searched. This may apply in the interests of helping to ensure a safe meeting environment for all attending.

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Bristol City Council
Minutes of the Health and Wellbeing Board

25 October 2023 at 2.30 pm

Board Members Present: Cllr Helen Holland (Chair), Cllr Ellie King (Deputy Chair), Eva Dietrich, Hugh Evans, Christina Gray, Jean Smith, Mette Le Jakobsen, Neil Turney, Colin Bradbury, Annette Billing (substitute for Rebecca Dunn), Pip Martin (substitute for Steve Rea) and Ian Hudson-Murt (substitute for Rebecca Mear)

Officers in Attendance:-
Mark Allen-Richardson, Jeremy Livitt, Carol Slater, Penny Germon, Karen Blong, Claire Ferraro and Nina Skubala

1. Welcome, Introductions and Safety Information

The Chair explained the emergency evacuation procedure and welcomed all parties to the meeting. All attendees introduced themselves.

2. Apologies for Absence and Substitutions

Apologies for absence were received as follows: Heather Williams, Tim Keen, Tim Poole, Penny Gane, Councillor Asher Craig, Joe Poole, Reena Bhogal-Welsh (Temporary Replacement for Abi Gbago), Rebecca Dunn (Annette Billing to substitute), Steve Rea (Pip Martin to substitute), Rebecca Mear (Ian Hudson-Murt to substitute).

3. Declarations of Interest

There were no Declarations of Interest.

4. Minutes of Previous Meeting held on Thursday 13th July 2023

RESOLVED – that the minutes of the meeting held on Thursday 13th July 2023 were agreed as a correct record and signed by the Chair.

5. Public Forum

There were no Public Forum items.

The Chair reminded members to consider submitting Public Forum Statements if they can. She referred to a statement submitted recently by a Councillor concerning NHS dentistry in difficulties concerning had resulted in some helpful action.

6. Congratulations to Councillor Helen Holland

Councillor Ellie King advised members that Councillor Helen Holland had been awarded an Honorary Degree by the University of Bristol for public services she had carried out for Bristol. She advised HWBB members of the breadth and depth of experience Councillor Holland had obtained and the inspiration she had provided.

The Board also noted the work she had carried out nationally with the LGA and which had helped Bristol, fostering a culture of collaboration and respect in the organisation and within different sectors. In addition to sitting on many different bodies across the city, she had also been a long-standing champion for Hartcliffe and Withywood.

7. Care Quality Commission Assessment Framework (Verbal Report) - Mette Le Jakobsen, Bristol City Council

Mette Le Jakobsen gave a verbal report on this issue and made the following comments:

- Since April 2023, the CQC is now able to undertake an assessment of Local Government’s statutory duty concerning Adult Social Care. As a result, Bristol City Council, along with all other Local Authorities who provided this service, would face inspection which was something they had not faced for a long period of time. It should be seen as similar to an OFSTED for adults
- Following the live launch in April 2023, a number of pilots had been carried out along with peer review and self-assessments were taking place along different themes
- Self-assessments were being developed but needed further work to ensure they were fully comprehensive in advance of any inspection
- An Engagement Plan was being developed with as wide a range of partners as possible. The aim was to have the self-assessment shortly and this would then be followed by engagement with partners in November and December 2023

- The formal inspections would start from January 2024 and inspections could commence from any time after that up to 18 months from this date
- The Peer Review would be taking place during the week commencing 11th December 2023. HWBB was requested to advise if they wished to engage in a health session

  Board Members made the following comments:

- The peer review would help as a dry run. A large number of external partners were being interviewed during the process. Engagement from HWBB members was welcomed to help Bristol thoroughly analyse its work
- Information was being obtained from a wide range of sources and for the first 5 pilot inspections. There would be an equivalent new inspection regime taking place within the next few months and involving a pilot in Dorset
- A number of Board members stated that they would be happy to get involved.

The Board noted that there would be sessions form partners with examples of lived experience.

8. Integrated Care Partnership Update (Verbal) - Councillor Helen Holland

Councillor Helen Holland gave a verbal presentation on this issue and made the following comments:

- Bristol's work had been highlighted as an outlier for good partnership involvement. The commitment to increased social value was important but required a proper assessment of how to achieve this and of all the barriers that need to be surmounted. It was a great achievement that one of the Somali led providers had become the largest home care provider in the city
- There had been a presentation from the Black South West Network "Make It Last" at the most recent development session which was part of a drive by the city to ensure more diverse organisations get the chance to engage with their commissioning network

  Board Members also noted that there had been a presentation on the draft Mental Health Strategy. A recent link had been sent out with details and Board Members were encouraged to look at this.

9. Locality Partnership Update - Integrated Care Board

The Board received a presentation on the Locality Partnership Update from Eva Dietrich, Pip Martin, India Barrett and Neil Turney who made the following points:

- The purpose of this project was to improve access to mental health and wellbeing through greater collaboration of work and by focusing on patients' needs
- Approximately 1000 people were involved in providing appropriate intervention at a local level

- Details were provided of the Integrated Community Teams – there were 6 throughout the region with 3 across Bristol.
- MINTs (Mental Health and Well Being Integrated Network Teams) engaged with mental health and were tailored to meet the population needs. Their work included support for various disorders (such as eating and personality disorders) and addressing health inequalities. Key goals were the development of work on people with lived experience and to ensure improved outcomes for those who currently had the poorest access to services
- Rapid Early Intervention Disorder (FREED) could help to reduce problems by up to 50% and provided support on a primary level
- Sequoia Tree – This project would go live next year and would align with the Integrated Teams. It was expected that there would be a huge number of referrals for this scheme and therefore training was currently under way to create awareness for it.
- One main area of focus would be for those people who were long-standing patients in locked rehabilitation units and to bring them back in the community by improving rehabilitation within the community service area. It was estimated that approximately 45% could be brought back into the community with 20% not being able to fully recover and requiring bespoke packages of care. The Board noted that work was taking place with housing providers on this project but that if a provider was unable to meet the required standard they could withdraw.
- Physical Health – life expectancy was approximately 20 years lower for those with mental health problems. Lifestyle interventions significantly increased this
- Integrated Access Partnership – if you call 111, you can now ask for Mental Health Services to provide an assessment and if this was urgent you could call 999. The introduction of this service had decreased the numbers in the Emergency Health Services and referrals to GPs, as well as a reduction of 60% of ambulance callouts
- CAMHS – groups such as the Unplugged Care Team, Student Liaison Service were brought together to create specialist pathways
- The purpose was to provide practical social and emotional support to focus on addressing health and equalities through MINTs through the creation of a One Stop Shop involving faith groups, families and the community sector which would be trauma informed
- There were 6 MINTs across Bristol and South Gloucestershire made up of staff from different organisations including the voluntary sector. Key roles associated with this included the Hub Manager, Clinical Psychologist, Team Administrator, Recovery Navigators, Social Care Leads and VCSEs/Wider Networks. These groups would be collaborative and bring together people with different expertise
- The cohort was for adults aged 18 or over with more complex cases requiring multi agency support. The different groups involved included NHS Talking Therapies, Social Care, Primary Care, Community Development, AWP, VCSE, a Navigator/Link Workers and partnership working
- South Bristol MINT Mobilisation – this involved shared case reviews, recruitment, communications, estates and digital elements, a triage service for communications, talking therapies and a fortnightly case review. The Hub Manager and Hub Administrator were now in place and engagement was already taking place with other agencies that might be needed if relevant. Core membership included the AWP, VCSE, Adult Social Care Team, NHS Talking Therapies and General Practice

- ICE MINT Update – details were provided
- North and West Bristol – whilst these were overall less deprived areas of the cities, they were high in certain areas. Shirehampton Health Centre would act as the base for MINT and would work with the Northern PCNs to create a Well Being Hub to provide social prescribing support
- Reflections showed that shared care reviews were beneficial, it was good to have multi-disciplinary partners involved, as well as dedicated mental health colleagues, consistent language and appropriate governance in instances involving a range of different statutory organisations

In response to issues and questions raised by Board Members, the following points were made:

- This was a superb piece of work which would interface well with student Mental Health Work. There was a need to ensure the drug and alcohol services were more closely aligned with this area of work. Links with the MINT team could help in the current work to search for a new provider
- Dialogue Plus was a supportive conversation tool to discuss all aspects of a person's life and which could be used to obtain support across the BNSSG in a more efficient way and provide further information for assessments and referrals
- MINT teams would become gradually embedded and outcomes assessment would analyse which approaches proved worthwhile
- The measurement of outcomes would help assess which destinations people needed to be subscribed to avoid waiting lists and to help obtain pockets of new investment. This could lead to alternative services meeting the needs of individuals and reduce the pressures of waiting lists
- This service was working extremely well and seemed a very good shift in service provision

The Board noted that THRIVE Bristol provided a link between financial issues and mental health. If this work helped to fill the gap of hard pressed advice services, this would help.

10 JSNA Annual Report - Tracy Mathews (Author), Carol Slater, Bristol City Council (To Present Report)

Carol Slater introduced this report and made the following points:

- The JSNA was a statutory requirement and provided a picture of Bristol, informed decisions on how to (1) design services (2) improve and protect HWBB outcomes and (3) help to reduce inequalities.
- There was a focus on priority cases using JSNA profiles.
- Development - Details of those parts of the city were provided showing good levels of development and those where this was poorer. It was noted that first time entrants to the Youth Justice System were higher in Bristol than the national average
- Healthy Weight – the figures for excess weight were relatively unchanged in Bristol for the last decade. Bristol's figure was slightly lower than the national average and the lowest of all the core cities

- Smoking and Alcohol – Bristol was higher than the national average and this figure was higher in males
- HIV – The prevalence of HIV in Bristol was similar to the national average
- Theme of Healthy Minds – The number of those satisfied with life had decreased since last year due to a combination of factors such as isolation due to COVID and the cost of living etc. The Board noted details of self-harm admissions
- Theme of Healthy Places – Details of health protection were provided related to COVID, Homes and Fuel Poverty, Climate and Ecological Emergencies, Violence and Hate Crimes. The number of fuel poor households was fewer than the national average
- Theme of Healthy Systems – These included assessments of priorities on economic inclusion and the Integrated Care System in the BNSSG. The figures for unemployment were better than in other core cities
- Locality Partnership Health Profiles – This was a great resource which had first been published in July 2022 and had recently been refreshed. It provided an analysis of the localities in comparison with Bristol

Board members made the following comments:

- Locality profiles are very helpful in showing those parts of the city where there are difficulties in key areas ie obesity, diabetes etc.
- Vaping - This was an important tool to support those who wanted to quit smoking but was discouraged in all other groups. Commercial determinants were a key factor in the growth of vaping which was growing amongst non-smokers in western markets and spreading in developing parts of the world, particularly in Africa, amongst all groups.

  There remained a lack of data on the number of children vaping. Initial work in this area to provide a targeted wraparound service had proved very effective in reducing the overall rate of vaping and now needed to be increased. Vaping was an intergenerational problem and was linked to mental health. A piece of work was being carried out in this area and would either be submitted to a future HWBB meeting or would be circulated to them separately.
- This information was widely available for use as required.
- This data indicated how badly certain parts of the city needed help such as Hartcliffe and Withywood that had endemic problems which required specific targeting.

ACTIONS:

(1) JSNA Information to be circulated to the Children's Board and their draw attention to statistics relating to children – ACTION: Carol Slater/Mark Allen-Richardson to arrange
(2) Briefings to be provided to any HWBB representative who requires it on issues such as the Local Plan, Economy and Transport – ACTION: Carol Slater/Mark Allen-Richardson to arrange
(3) Work of group on vaping to be either brought to a future HWBB meeting or circulated separately to HWBB members – ACTION: Christina Gray

11 HWBB Mid-Year Report - Mark Allen-Richardson, Bristol City Council

Mark Allen-Richardson introduced this report . He briefly explained the performance framework and the RAG rating for various areas of work including areas such as Domestic Abuse, Sexual Violence or Gender Harmful Practices, Wider Determinants of Health and an Integrated Care System.

12 HWBB Strategy 2023 Update - Mark Allen-Richardson, Bristol City Council

Mark Allen-Richardson introduced this report and made the following comments:

- The One City Plan had now been updated to reflect the ongoing cost of living and health and care issues
- Healthy Places now includes communities

The Board thanked Mark for the work he had carried out in these areas as part of the LGA review and drawing out themes and strategies from the statistics that was available.

13 One City Many Communities - Penny Germon, Bristol City Council

Penny Germon gave a presentation on this issue and made the following points:

- Bristol City Council's response to COVID and the cost of living had helped to ensure the development of principles that underpin the current collaborative approach
- The work was intentionally focused on inclusion, equity and social justice and around the framework developed for the cost of living crisis. It was highly focused on sustaining and nurturing community foundations and on nurturing welcoming spaces
- Nurturing welcoming spaces had been developed as part of this approach
- Work was taking place across Bristol with city partners such as Quartet and funding was being sought from the community sector to obtain this including from the Shared Prosperity Fund.
- The aim was for 16 Community Hubs to be a conduit for communities and increase horizontal connections for them
- Key messages this winter would be to build on what had been achieved last winter ie provide greater resilience, ensure embedded support was provided not seasonal, tackling increased poverty, provide a framework around the cost of living crisis
- Support for issues like debt and emotional mental health was required for those who kept coming back to request it. Key issues would be part of a follow up event on Thursday 23rd November 2023 – cost of living, welcoming spaces, employment support, one city funding raising and there would be ongoing monitoring of data for this
- In view of the importance of this area, it might be helpful to have a discussion on it as part of a future Development Session

Board Members made the following comments:

- This work could be linked to that being carried out with MINTs
- Tackling loneliness was very important due to the negative impact that it had on mental health. Welcoming Spaces were very important for tackling this and helping to combat inequity in communities
- Our response needed to be embedded since it remained fragile – frequently based around a few volunteers. Some areas had low infrastructure but high need ie Hillfields and Frome Vale
- Nilaari were working with St Pauls Advice Centre but finding difficulties in getting time to support people with PIP (Personal Independence Payment). It was noted that these were comparatively small amounts of money to provide mental and financial support but had a significant impact

14 Healthwatch Consultation (Verbal Report)

Elaine Ferraro provided a verbal report on the above issue. She stated that:

- This organisation provided health services overseen by the HWBB and the ICB
- The re-procurement of this service was currently taking place.
- The existing contract would finish in September 2024. The new contract would operate from October 2024 for a three-year period and was currently managed by South Gloucestershire with Bristol taking the lead role
- Views on this issue were encouraged and some responses had already been obtained. Consultation also included the service specification with some complimentary questions to influence the tendering process
- The views of the Equalities Forum would be promoted through the Healthier Together Communications Group
- Promotion was already taking place through the Social Care Forums

During brief further discussion, it was noted that the Board noted that promotion of consultation was required through key anchor organisations **ACTION: Promotion of the consultation process to take place through key anchor organisations such as VOSCUR – Claire Ferraro**

15 Health and Well Being Board Forward Plan (For Information)

The Board noted the Forward Plan including details of the Development Session on Thursday 26th November 2023. This would involve a Joint Workshop with the Children and Young People's Board including discussion of Women's Health and Health Hubs.

16 Date of Next Meeting

It was noted that the next formal Board Meeting was scheduled to be held at 2.30pm on Thursday 14th December 2023 in the Bordeaux Room, City Hall, College Green, Bristol.

The meeting ended at 4.50 pm

CHAIR ____________________

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

BRISTOL CITY COUNCIL

Bristol Health and Wellbeing Board

Title of Paper:	Women's Health 'Hub'
Author (including organisation):	Alexandra Humphrey, Senior Clinical Effectiveness Manager, BNSSG Integrated Care Board Dr Joanna Copping, Consultant in Public Health Medicine, Bristol City Council
Date of Board meeting:	Thursday 14th December
Purpose:	Oversight and assurance

1. Executive Summary

Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care System has £595,000 one-off funding to develop and establish a women's health 'hub' in line with national guidance. Dr Joanna Copping (Consultant in Public Health Medicine, Bristol City Council) and Dr Joanne Medhurst (Chief Medical Officer, BNSSG Integrated Care Board) are joint Senior Responsible Officers.

We have reviewed local quantitative and qualitative data and are engaging with a wide range of stakeholders to shape how a 'hub' should look for Bristol, North Somerset and South Gloucestershire.

2. Purpose of the Paper

The purpose of this paper is to inform the Bristol Health and Wellbeing Board of the approach we intend to take in Bristol, North Somerset and South Gloucestershire to develop and implement a Women's Health 'Hub'.

3. Background, evidence base, and what needs to happen

The Women's Health Strategy for England sets out a 10-year ambition (2022-2032) for boosting the health and wellbeing of women and girls. A top priority in the Strategy is the development and expansion of 'women's health hubs', which intend to "bring together healthcare professionals and existing services to provide integrated women's health services in the community", focusing on improving access to care and reducing health inequalities. There is one-off funding of £595,000 for each Integrated Care System to develop a 'hub', to be spent by 31st March 2025. The funding is held by the Bristol, North Somerset and South Gloucestershire Integrated Care Board (BNSSG ICB).

There is a broad scope for how a 'hub' is set up and it doesn't need to be a physical space. This is to allow each area to make it work best for the population and to capitalise on existing provision and ways of working. The core services within the scope of a 'hub' are:

- Menstrual problem assessment and treatment
- Menopause assessment and treatment
- Contraceptive counselling and provision of full range of methods
- Preconception care (work to define this is under development at national level)
- Breast pain assessment and care
- Pessary fitting and removal
- Cervical screening
- Sexually-transmitted infection (STI) screening and treatment
- Human immunodeficiency virus (HIV) screening

In order to make an evidence-based decision on what our 'hub' should entail, we have reviewed and synthesised existing quantitative and qualitative data to understand the current needs, outcomes and experiences of women in Bristol, North Somerset and South Gloucestershire. This includes the Bristol Women's Health Needs Assessment and the Bristol Healthwatch Report on Menopause. Please refer to the appendix for further information.

4. Community/stakeholder engagement

We are engaging with a wide range of stakeholders within BNSSG to shape our 'hub. On 7th December 2023 we are holding a workshop for over 50 people with representation from the Integrated Care Board, Bristol, North Somerset and South Gloucestershire councils, maternity, obstetrics, gynaecology, mental health services, general practice, sexual and reproductive health services, community pharmacy, Sirona, Healthwatch and Voluntary, Community and Social Enterprise (VCSE) organisations. We are working with Healthwatch to establish a Patient and Public Reference Group to shape and refine the development and implementation of our 'hub'.

The 'output' from the workshop will be taken to the newly established BNSSG Women's Health Steering Group, which will agree the outline approach to our 'hub'. More detailed planning will then be undertaken through a new Working Group, working closely with the Patient and Public Reference Group.

5. Recommendations

We recommend that the Board endorses the approach to setting up a Women's Health 'Hub' in Bristol, North Somerset and South Gloucestershire.

6. City Benefits

Women make up over half the population of Bristol. An effective 'hub' will improve access to women's health services and experiences of care, improve health outcomes for women and help address health inequalities. The need to address health inequalities is a key focus of this work. Our workshop on 7th December includes dedicated time to explore where the need is greatest and how we could build upon existing services to better tackle inequalities in health.

7. Financial and Legal Implications

The funding for the Women's Health hub is held by the BNSSG Integrated Care Board. Dr Joanne Medhurst (ICB Chief Medical Officer) is the budget holder and is chair of the BNSSG Women's Health Steering Group.

8. Appendices

Please see attached a full briefing paper on our approach to developing and implementing a women's health 'hub'.

Healthier Together

Women's Health 'Hub' development and implementation

1 National guidance on a 'Women's Health Hub'

Women's Health Strategy for England (2022)

The Women's Health Strategy for England sets out a 10-year ambition (2022-2032) for boosting the health and wellbeing of women and girls. It identifies the following priority areas:

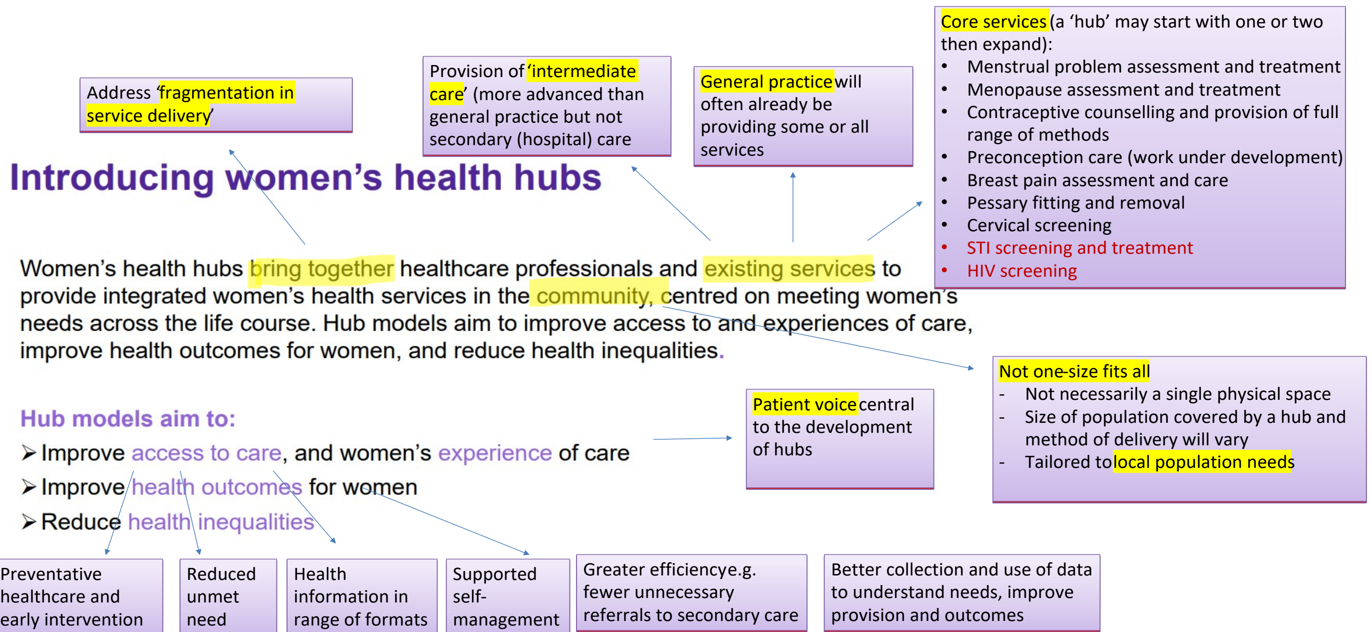
- Menstrual health and gynaecological conditions
- Fertility, pregnancy, pregnancy loss and post-natal support
- Menopause
- Mental health and wellbeing
- Cancers
- Health impacts of violence against women and girls
- Healthy ageing
- Long –term conditions

A top priority in the Strategy is the development and expansion of women's health hubs, which bring together healthcare professionals and existing services to provide integrated women's health services in the community, focusing on improving access to care and reducing health inequalities.

NHSE Guidance on Women's Health Hubs

There is one-off funding of £595,000 for each ICS to develop a Hub, to be spent by 31st March 2025.

The below visual provides a summary of the national core specification of a Hub. The full specification can be found on the gov.uk webpage on Women's Health Hubs.



Key points to note

1) Use of the term 'women' from the national guidance: 'While we refer to women, we recognise that some people who do not identify as women also require access to the services listed and may benefit from care in women's health hubs. These groups will also have specific needs and experiences which should be considered'.
2) The term 'hub' is being used with single quotation marks intentionally. This is because the interim evaluation report on existing women's health 'hubs' across England commissioned by the National Institute for Health and Care Research found that "Stakeholders, including women, have highlighted that the term 'hub' is being used increasingly across health and social care settings, with different interpretations, and considerable scope for confusion". We want to avoid confusion in BNSSG, and this may mean abandoning the term 'hub' altogether.
3) There is a deliberately broad scope for how a 'hub' is set up. This is to allow each area to make it work best for the population and to capitalise on existing provision and ways of working. For example, there is no absolute requirement for a 'hub' to be a physical place, and there is some scope for the services the 'hub' offers to be locally determined.
4) The specification is clinically focused, with many of the core services requiring delivery by qualified healthcare professionals. However, it has been recognised in BNSSG that there is an important role for non-clinical and self-management support for women. For example, managing the menopause, incontinence awareness and signposting to information and services. We also need to consider the importance of the VCSE sector who help meet the needs of specific groups of women, such as sex workers.

See Appendix 1 for a visual of a woman's reproductive life course.

2 Women's health needs, outcomes, and access to and uptake of services in BNSSG

BNSSG ICS serves the areas of Bristol, North Somerset and South Gloucestershire. It is comprised of ten partner organisations; three Local Authorities, two acute NHS Trusts, the mental healthcare trust Avon and Wiltshire Partnership (AWP), the Integrated Care Board (ICB), Sirona (community care) and One Care (representing general practice). The ICS's aim is to meet the challenge of improving poor health outcomes in our local population, which includes realising the Women's Health Strategy as part of a wider priority to address health inequalities.

Synthesis of existing quantitative and qualitative data on women's health

A significant amount of work has already been undertaken to understand the current situation for women in Bristol, North Somerset and South Gloucestershire. The qualitative and quantitative data from these sources has been synthesised into a 'one pager' – see Appendix 2. It provides a high-level oversight and understanding of how well we are meeting the needs of women across the life course, with a focus on those areas of women's health that form part of the national core specification for a WHH. It is recognised that there are limitations to the data we currently have (see Appendix 2 for further detail).

Emergent themes from the data synthesis

INEQUALITIES

1. There are health **inequalities for some cohorts** of women in terms of access to and uptake of services; especially women from ethnic minorities, women living in socio-economically deprived areas or with a Learning Disability.

ACCESS AND QUALITY OF HEALTHCARE

2. There is a **disparity of access to some women's health services in general practice.** e.g., LARC for contraception, heavy menstrual bleeding, Hormone Replacement Therapy (for menopause), pessaries for prolapse
3. The **quality and level of care in general practice i**s variable for menopause and probably menstrual health due to training and expertise and pressure on general practice.
4. **Demand exceeds current capacity** for women's health services (e.g., long waits for LARC and secondary care gynaecology services).
5. There is a **gap in commissioning/provision** around some services e.g. Complex menopause, post-partum contraception.
6. Quality of care within integrated sexual health services is generally good, but **access to sexual health services** is problematic**.**
7. Commissioning and provision are **fragmented.** There is an **opportunity to better connect services** through the recommissioning of sexual health services.

OUTCOMES

8. **Sexually transmitted infections are rising,** and Bristol has relatively **high prevalence of HIV.**
9. **Teenage pregnancies** have been reducing for years but have recently shown an increase.

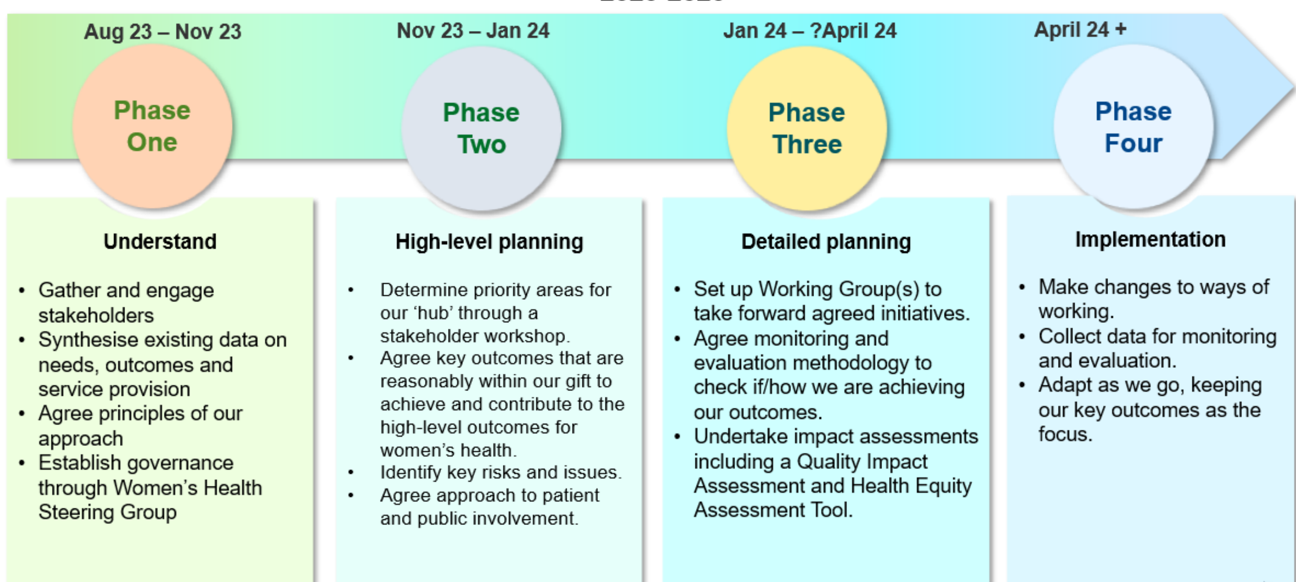
9. **Termination of pregnancy rates have risen significantly** in the last year.
10. We have not yet achieved the national ambition of 80% **cervical screening uptake and HPV vaccination levels could be improved.**

ENABLING WOMEN

11. There is an **opportunity to better enable women** to understand their health needs, know where to find high quality information to support self-care, when to seek medical help and have the confidence to do so. This is particularly notable for menopause, pelvic health and menstrual health.

3 BNSSG approach to developing and implementing a Women's Health 'Hub'

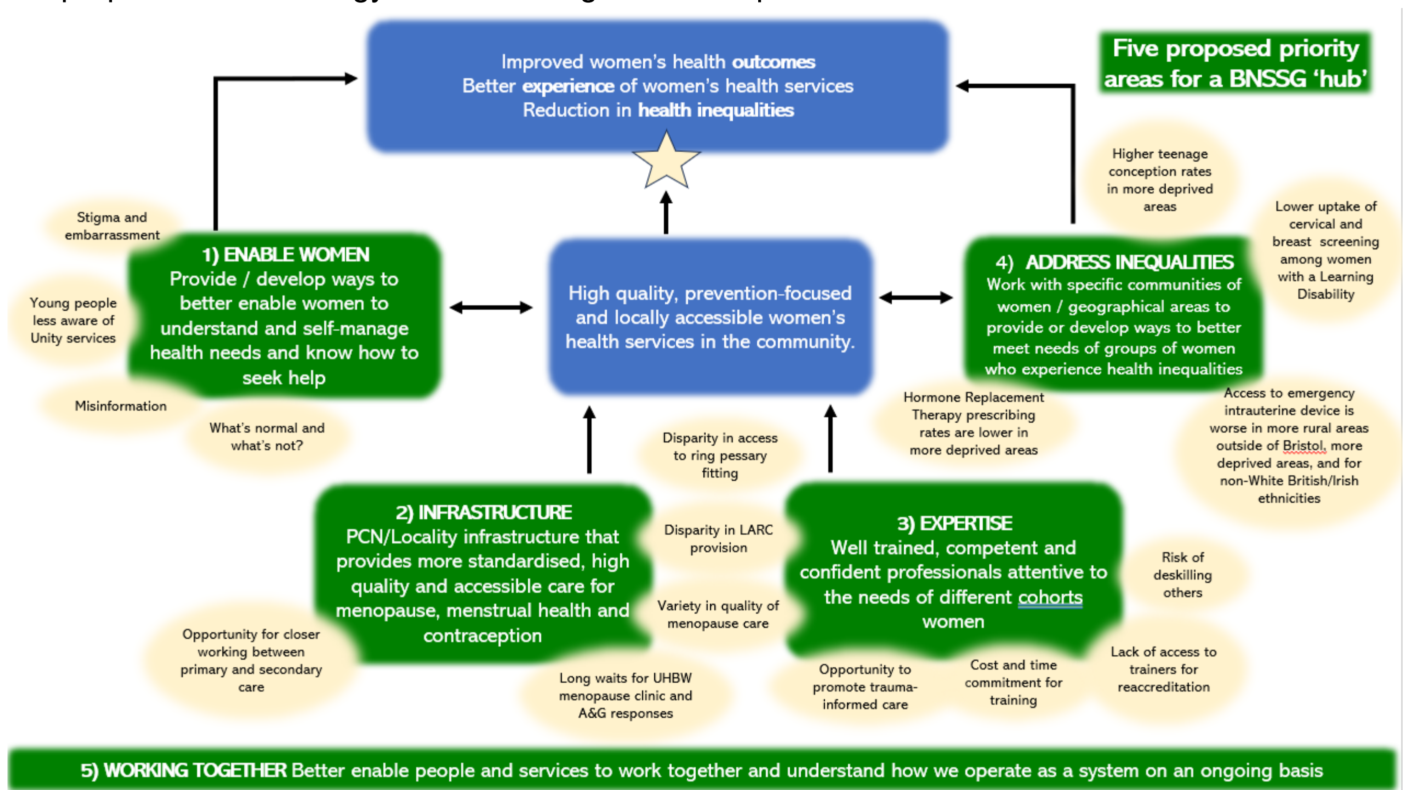
Phases and principles



Proposed priority areas for improving Women's Health services

It is proposed that we meet the ambition to "bring together healthcare professionals and existing services to provide integrated women's health services in the community, centred on meeting women's needs across the life course" through focusing on five complementary priority areas.

The below diagram shows the five priority areas in green boxes. The blue boxes are the outcomes we intend to achieve. The beige 'blobs' reflect some of the data and insights that have helped determine the proposed priority areas, and some of the challenges we face. See Appendix 4 for the proposed methodology for addressing health inequalities.



The stakeholder workshop in December 2023 is an opportunity to gather insights and ideas that will help test, refine and explore these priority areas.

The 'output' from the workshop will be collated and reviewed, and synergies and themes identified. This will be taken to the newly established BNSSG Women's Health Steering Group, which will agree the outline approach to our 'hub'. More detailed planning will then be undertaken through a new Working Group, which will include leadership from general practice, the VCSE sector, secondary care, and sexual and reproductive health. It will work closely with a Patient and Public Reference Group.

See Appendix 4 for a brief overview of the BNSSG Women's Health Steering Group.

Appendix 1

Life course of women's reproductive health

ADOLESCENTS AND YOUNG ADULTS PUBERTY-24	MIDDLE AND REPRODUCTIVE YEARS 25-50	LATER YEARS 51+
Reproductive health needs		
HPV vaccination		
Menstrual health	Menstrual health	
Gynaecological conditions	Gynaecological conditions	Gynaecological conditions
	Cervical screening	Cervical screening
	Gynaecological cancers	Gynaecological cancers
Sexual health and wellbeing	Sexual health and wellbeing	Sexual health and wellbeing
Contraception, pregnancy, fertility, pregnancy loss, abortion care, and postnatal support	Contraception, pregnancy, fertility, pregnancy loss, abortion care, and postnatal support	
	Pelvic floor health	Pelvic floor health
	Early menopause and perimenopause	Perimenopause and menopause
		Breast cancer screening

Highlighted = within core scope of a Women's Health 'hub'

(Highlighted: Menstrual health; Cervical screening; Sexual health and wellbeing; Contraception; Pelvic floor health; Early menopause and perimenopause; Perimenopause and menopause)

Appendix 2 – Data synthesis

Access, uptake, experience and outcomes in BNSSG

A note on inequality and inequity in general
Some population groups and inclusion health groups (e.g. asylum seekers) have poorer access, uptake and experience of services, and poorer health outcomes due to universal barriers that are not specific to one area of health. For example, women who are experiencing severe and multiple disadvantage often avoid accessing the support that they are entitled to due to mistrust and a lack of trauma-informed care (Golden Key, 2019).

A note on gaps in the data
We recognise the gaps in the data and insights, both locally and nationally, and both for health conditions in general and in relation to health inequalities. This issue is noted in the Women's Health Strategy (2022), and it is a national priority to improve the quality of health and health service data collected.

Menstrual health (WHH core service:)
- National data indicates a high prevalence of Heavy Menstrual Bleeding (HMB) and dysmenorrhoea in women. Menstrual disorders account for approximately 12% of referrals into gynaecology.
- There is a lack of information and awareness about what is 'normal' and what is not. Relatively few women seek treatment, partly due to stigma and embarrassment.

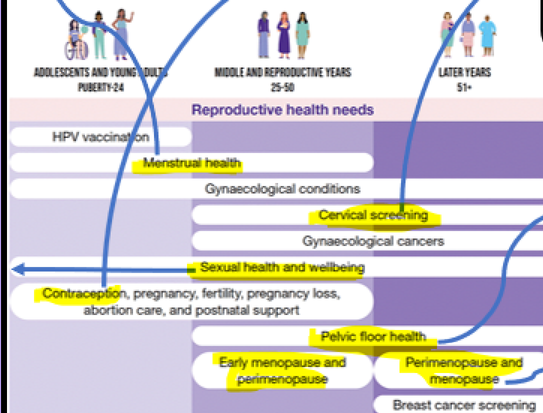
Sexual health and wellbeing (WHH core service)
Access to Unity Services
- Surveys indicate that quality of care is generally good, but access to services is an issue- clinic closures, waiting times and appointment availability.
- A recent Bristol Pupil Voice survey found that most young people had not heard of Unity services
- In Bristol, there is an under-representation in attendance at Unity from deprived residents and ethnic minorities.

Sexually Transmitted Infections
- There is a higher proportion of new STI diagnoses in young people aged 15-24 across all three individual BNSSG councils compared to the England average
- STI data indicates that people from Black communities are either not accessing tests or are not being offered tests.
- Detection of chlamydia in 15–24-year-olds across BNSSG is low.
- Gonorrhoea cases in Bristol have risen rapidly in recent months and are now beyond pre-COVID-19 levels. This is a marker for unsafe sexual activity in a population. Syphilis rate rises are also a concern

HIV
- Bristol has relatively high rates of HIV and it is classified by NICE as an area of 'High' prevalence in 2021. However, the number of people diagnosed with HIV has continued to fall.
- In Bristol, HIV acquired through heterosexual sex disproportionately affects women of Black African heritage
- HIV testing coverage in women in BNSSG in 2022 was significantly lower than the England average, with around 70% either not offered or accepting a test.

Conception under 18
- Teen conception rates have increased in Bristol/S Glos and in Bristol rates are now higher than the England average
- Hartcliffe & Withywood, Southmead & Filton wards, which have higher levels of deprivation, have the highest rates

Termination of pregnancy (ToP)
- ToP rates in BNSSG in 2021 are lower than England average.
- ToP rates rose significantly, locally and nationally in 2022
- Almost half of pregnancies are unplanned in UK



Key: Red text relates to **health inequality** data and insights

Box outline = covers a core need to bring under 'hub' care

Contraception (WHH core service)
LARC
- LARC is twenty times more effective than pills or barrier methods and is highly cost effective .
- GP LARC in BNSSG exceeds national averages BUT significant disparities in no. of fittings between practices and there are long wait times in many. There are various issues around staff, capacity and access to training.
- Low rates of LARC in Unity services, especially uptake in young people services

Emergency contraception (EC)
- Emergency Hormonal Contraception (EHC) prescriptions have significantly fallen over several years. It is not clear why.
- Access to emergency intrauterine device (IUDs) is worse in more rural areas outside of Bristol, more deprived areas, and for non-White British/Irish ethnicities

Condoms: Issuing of free condoms across community and SRH services and through the C-Card scheme has decreased significantly across BNSSG.
Post Partum Contraception is recommended by FSRH and RCOG and NICE but is not routinely given in BNSSG

Cervical screening uptake (WHH core service)
- Bristol is just under the England average for uptake, while S. Glos and N. Somerset are above the England average. All local authority areas, and England as a whole, are under the 80% ambition. (2022)
- Women with LD have lower uptake (c40% vs c70%25-49 age group)
- There is low HPV vaccine uptake across BNSSG (relative to England average). New recommendation that one dose is required not two.

Pelvic health (WHH core service: pessary fitting and removal)
- National data indicates that pelvic organ prolapse affects around 40% of women aged 40+. It's difficult to measure incontinence prevalence due to reluctance to disclose.
- There is a disparity in access: many GP surgeries do not offer ring pessary insertion.

Early menopause, peri-menopause, menopause (WHH core service: menopause assessment and treatment)
- There is high demand for UHBW menopause services: long waits for the menopause clinic and GP Advice and Guidance responses.
- BNSSG Healthwatch report (2023) outlines issues in quality and access of care: feeling nervous, awkward or confused in seeking support; concerns with symptoms being mistaken; not being given enough information. There are racial differences in menopause experience.
- Testosterone is currently an 'amber' drug in the BNSSG formulary and requires referral and initiation by secondary care clinicians

A note on the limitations of BNSSG data:

The data we have only provides a partial picture of what is happening:

1) The data on Unity sexual health services is mostly from 2021 onwards and there are data quality issues with historical data.
2) The Covid pandemic has affected service and activity levels.
3) There are no known national benchmarks for good provision of pelvic health, menstrual health or menopause.

However, the national data is a useful starting point for identifying general issues.

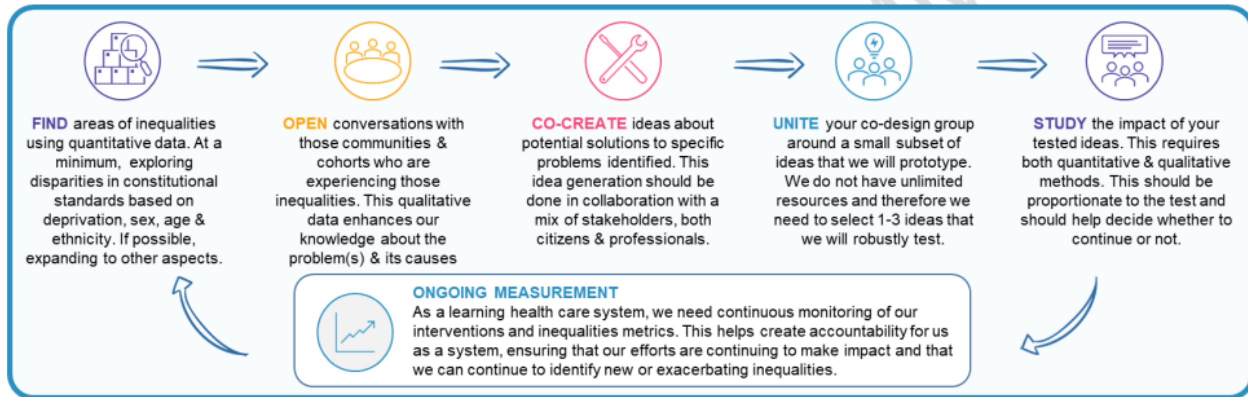
BNSSG-focused sources include:

a) Bristol Women's Health Needs Assessment (2022)
b) BNSSG Sexual Health Needs Assessment (in final draft, to be published in due course)
c) Healthwatch Menopause report (2023)
d) Long-Acting Reversible Contraception (LARC) Audit of General Practice provision (2023, internal report)
e) Somali Women's Coffee Morning – discussion on women's health hubs (2023, grey literature)
f) Create Open Health: Voices for Change - An open innovation project to initiate positive change for people affected by bladder and bowel continence conditions (2022)
g) Bristol Women's Voice - Bristol City Listening Project 2020

The synthesis document will be updated as additional data is gathered.

Appendix 3: FOCUS-ON approach to addressing health inequalities

This approach is being taken by the BNSSG Strategic Prevention Oversight Group



Appendix 4 – BNSSG Women's Health Steering Group overview

The BNSSG Women's Health Steering Group will take a systemwide approach to women's health:

- It will ensure commissioning and provision of services is joined up.
- It will steer and oversee transformational work and continual improvement of women's health services across BNSSG.

Areas of focus may include:

- Developing and maintaining a better understanding of diverse women's needs, outcomes and experiences of health and wellbeing. This will support with development of initiatives and capturing overall impact and impact on specific groups.
- Identifying/developing a framework to prioritise key areas in women's health, in line with these identified needs, to improve women's health and reduce inequalities whilst utilising the principles of prevention and value-based healthcare.
- Optimising existing pathways, services and assets across the ICS to build on good practice and manage cost pressures. This will include co-designing with people and partners.
- Agreeing a short (1-2 years), medium (3-5 years) and long-term (5 years +) ICS plan for Women's Health.

Proposed core membership:

- ICB Chief Medical Officer
- Public Health lead for Sexual Health across BNSSG
- ICB Local Maternity Neonatal System Lead
- ICB lead for data improvement in women's health
- Healthwatch
- NBT Head of Equality, Diversity and Inclusion
- NBT and UHBW clinical and non-clinical representatives
- GP Collaborative Board Medical Director
- Unity Sexual and Reproductive health clinical representative
- VCSE representative

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

BRISTOL CITY COUNCIL

Bristol Health and Wellbeing Board

Title of Paper:	**Your NHS Menopause Experience**
Author (including organisation):	**J.Bird - Healthwatch Bristol**
Date of Board meeting:	**14th December 2023**
Purpose:	**Information and discussion**

1. Executive Summary

Evidence gathered in 2022/2023 shows that women using health services had poor experiences and access when seeking support for symptoms of peri-menopause or menopause.

The insights from this engagement with the wider community have led to a set of recommendations which seek to influence decision making about future health services for people going through menopause. This citizen-led approach supports an integrated care system to deliver better access for people in their local communities, for services to be more effective & efficient and designed to meet needs.

2. Purpose of the Paper

This paper is for oversight and assurance. The Health and Wellbeing Board's vision in their Joint Leadership on Health strategy is to understand unfair disadvantage to individuals and communities with a commitment to reducing women's health inequalities. The qualitative information provided highlights of good practice and present a range of findings that aim to inform the next iteration of the JSNA chapter 'Women's Health In Bristol' https://www.bristol.gov.uk/files/documents/6450-womens-health-health-needs-assessment/file. This work will inform the Steering Group for Women's Health Hubs and reports to one of the Health and Care Improvement Groups (HCIG), an ICS structure for decision-making, for improving Community health services. This work will also link insights into the Mental Health and Wellbeing Integrated Network Teams (MINT).

3. Background, evidence base, and what needs to happen

HealthWatch feedback suggested there was a lack of understanding and consistency around support and treatment for women undergoing menopause at all stages. The recommendations are aimed to address the problem through a local lens with solutions that are timely, relevant and applicable across diverse communities. This is in line with the focus currently undertaken by the National Women's Health Strategy https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

4. Community/stakeholder engagement

Patient informed input, focus and steering groups co-designed resources and survey narrative, draft survey piloted within variety of community settings, workshop created qualitative data collected from across population.

5. Recommendations

- Creation of dedicated women's health hub
- Increased awareness campaign and resources
- Appointment of specialist dedicated leads in PCN catchment
- Provision of database for trusted information with widespread healthcare signposting
- Dual menopause and cultural competence training for health care professionals
- Engagement with local population for peer support and culturally appropriate resources

6. City Benefits

The recommendations are aimed to offer all Bristol Citizens fair and equal access to information and support for menopause care and thus improve associated outcomes city wide.

7. Financial and Legal Implications

Not applicable.

8. Appendices

Full report.

Your NHS menopause experience: Bristol, North Somerset and South Gloucestershire

May 2023

healthwatch Bristol

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Intro

At Healthwatch Bristol, we listen to patient experiences and base our work on the experiences that are shared with us. These experiences also inform commissioners and providers of local health and social care services, highlighting both good practice and areas for service improvement.

This project was driven by feedback shared by Bristol, North Somerset and South Gloucestershire (BNSSG) residents regarding perimenopause, menopause and post menopause support and treatment in 2021/22. This project was also informed by the Department of Health and Social Care (DHSC) Women's Health Strategy for England 2022 (1). This report summarises the feedback we have heard from local people about their menopausal experiences and makes evidence-based recommendations from the key themes that emerged.

About Healthwatch

Healthwatch Bristol's statutory duty and remit, which is laid out in the Health and Social Care Act 2012, is to provide a voice for people who use health and adult social care services. We give people an opportunity to have a say about their local health and social care services, especially those whose voices are marginalised, and we report these views in order to influence service providers and improve outcomes. This means taking public views to the people who make decisions. Healthwatch is committed to promoting equality, and diversity and tackling social exclusion in all our activities. We aim to ensure equitable access to our initiatives and projects. We have a representative on the Health and Wellbeing Boards, Health Overview and Scrutiny Committees, and at the Integrated Care Partnership. We feed issues back to the government via Healthwatch England and the Care Quality Commission (CQC).

Aim

This project aimed to collect responses to a survey from people in the Bristol, North Somerset and South Gloucestershire area. We wanted to hear from at least 200 individuals, including from the multicultural communities that make up the three areas' demographic profile.

Our objectives involved creating a survey that could be accessible to many individuals, including translating the survey into four different languages. We intended to reach individuals who are marginalised or harder to hear from. We did this by partnering with organisations who work in these communities.

We also planned to bring printed surveys to local community events and reach out to local community leaders to help disseminate the information. By spreading awareness about the survey through our social media channels, community engagement opportunities, and through key contacts in the council, community, and local healthcare providers, we aimed to have a cross section of responses for the survey.

Executive summary

The initial feedback collected by Healthwatch Bristol which led to the creation of this project suggested misdiagnosis of menopausal symptoms, and lack of education for those who are transitioning through the stages of perimenopause, menopause and post-menopause.

Healthwatch collected feedback from 379 residents across Bristol, North Somerset and South Gloucestershire between October 2022 and March 2023, to provide evidence-based recommendations around quality, access and experience for local people. Our research explored how people are diagnosed, treated and supported during their menopause – and identify where there are gaps in services.

A steering group made up of members of the public and professionals co-produced the survey questions based on lived experience. We reached marginalised communities with the support of organisations that work with these communities. We translated the survey into four additional languages and printed hard copies of the survey to reach those who are digitally excluded.

This evidence has helped us formulate the below recommendations

- Create a specialist walk-in hub or community clinic for women during menopause, providing follow-ups and reviews, which can be accessed without referral.
- Ensure awareness information is sent to all women in preparation for pre-menopause, so women know which services are available for support, including accessible options.
- Appoint designated leads in each Primary Care Network who provide specialist advice and signposting on the menopause.
- Launch an awareness campaign that takes menopause and its symptoms seriously.
- Health settings should signpost to trusted information including those online about the menopause, with information that resonates with our diverse local communities.
- Mandate menopause and cultural competence training to health professionals who offer menopause support, to enable women to make informed choices and avoid myths.
- Create co-delivery services of support in the BNSSG area for the menopause, encouraging peer support.

Headline statistics

- We collected a total of 379 survey responses.
- 60% of respondents answered that they would prefer a 'hub' or 'clinic' specifically for menopause or women's health. 26% answered 'maybe', and 11% answered 'no'.
- 33% of respondents believed their symptoms were mistaken as a different health problem, rather than being due to the menopause. 21% were unsure of this.
- Half (50%) of the respondents felt their healthcare provider knew their symptoms were perimenopausal, compared to 50% who did not. 54% of perimenopausal individuals felt they had been supported by their healthcare provider, 46% felt they had not.
- 70% of post-menopausal respondents felt they were not given enough information by a healthcare professional at this stage.
- 27% of respondents felt their healthcare worker's advice was 'somewhat helpful', compared to 12% that found it 'extremely helpful', and 18% who found it 'not helpful at all'.
- 65% of respondents would rather have seen a female doctor for support with the menopause, compared to 34% who did not mind.
- When asked whether the healthcare worker explained clearly what was causing their symptoms, 23% of respondents said this was not explained clearly at all, 30% said this was somewhat clear, and 8% said their symptoms were clearly explained.
- In terms of understanding the different treatment options for symptoms, 15% of respondents claimed they did not understand them at all, whereas 34% felt they understood these clearly.
- 42% of respondents felt taking Hormone Replacement Therapy (HRT) was 'extremely' helpful, whereas 25% of people stated this was 'somewhat' helpful, and 3% of people said HRT was not helpful at all.
- The most common feeling respondents had when accessing healthcare support for the menopause was nervousness (28%). 20% felt awkward, and 17% felt confused.

Findings

- There are low expectations when seeking medical support for the menopause, as many respondents feel healthcare professionals are unfamiliar with symptoms and don't recognise the condition.
- Respondents' symptoms have been mistaken by healthcare professionals, primarily confusing these with mental health difficulties.
- Many respondents felt their menopause symptoms were not handled with compassion by healthcare professionals, and that they are not listened to.
- Respondents wanted better access to NHS information regarding the menopause in a digital format and more information available inside care services.
- Respondents said a healthcare hub or clinic with professionals who specialise in topics such as the menopause would help individuals feel more comfortable accessing the right support.
- Perimenopausal individuals felt they struggled to be diagnosed, despite having voiced concerns to a service that perimenopause may be the cause of their symptoms.
- Many post-menopausal individuals felt they were not given enough information on this stage.
- Confusion about links to a risk of cancer inhibits some from using Hormone Replacement Therapy (HRT). Healthcare professionals refused some individuals HRT because of their history of cancer.
- Respondents said healthcare professionals did not provide advice around alternative treatment options to HRT.
- 38% of respondents stated the organisation they work for has a menopause policy, compared to 38% who said there is no policy in place. 23% were unsure of whether their work had any provision for this.
- Respondents said follow-up care is lacking, including checking whether prescriptions are still suitable.
- Some individuals felt forced to choose private healthcare services for diagnosis, treatment and ongoing support for the menopause.
- Cultural differences impact how some communities perceive and talk about the menopause and service providers should be aware of this.
- Individuals with long-term conditions can struggle to separate the symptoms of the menopause from their condition. The menopause can worsen the effects of some individuals' long-term condition symptoms.
- Examples of good practice have been included from respondents who felt their symptoms were cared for well.

Background

The menopause is defined by the NHS England Menopause Network (2) as beginning when an individual has not had a period for 12 consecutive months. Typically, it happens between the ages of 45 and 55, but for some this can be as early as 40 (3). Premature menopause can happen at any age if women or girls don't produce ovarian hormones.

There are transitioning stages of the menopause. Perimenopause is the time leading up to the menopause – from the start of menopausal symptoms until after a woman has experienced her last period. Post menopause refers to being 12 months and one day without a period, however symptoms may continue and may require ongoing support. On average symptoms last around 4 years from when a woman's periods end, however, around 1 in every 10 women experience them for up to 12 years. There are over 30 symptoms that fall under the umbrella of menopause (4). These symptoms can occur during both the perimenopause and the menopause.

There are currently 13 million perimenopausal or post-menopausal women in the UK, however 41% of the UK's 33 medical schools do not have a mandatory menopause education program for their students. Almost 60% of doctors leave university with no education on menopause despite half of the population experiencing these at some time in their lives (5).

The lack of education around menopause was a theme that came from initial feedback and prompted this research, which is explained in our Theory of Change (appendix 6). This research therefore explored what information local services provide and if they are knowledgeable on the topic of menopause.

The National Institute for Health and Care Excellence (NICE) which sets out guidelines for the diagnosis and management of menopause recommends an individualised approach and says explanations should be given regarding stages, benefits, risks of treatment, and lifestyle modifications that are supportive (6). It recommends women are encouraged to talk about their symptoms, are made aware of hormonal and non-hormonal interventions, that psychological and sexual impacts should be discussed, and regular treatment and symptom reviews undertaken. Healthwatch Bristol's survey questions were designed to investigate whether NICE guidelines are followed and where gaps exist locally.

Research has found that the menopause can happen earlier in black and minority ethnic communities, and there are racial differences in the menopausal experience (7). We were keen to understand if there was inequity in healthcare support for the menopause and whether these were geographical or demographic. Our survey asked whether individuals felt that their race, ethnicity, or any other protected characteristic influenced their access to menopausal support from health care services.

Nationally, the Liverpool Women's NHS Trust is one of few in the UK dedicated to a broad range of care for women's health. The Trust has a dedicated

menopause clinic within their gynae service (8). In our local area of Bristol, North Somerset and South Gloucestershire (BNSSG), University Hospitals Bristol and Weston (UBHW) NHS Foundation Trust at St Michaels' Hospital runs a menopause clinic as part of their gynaecological service (9) This is accessible via GP or consultant referral, not self-referral.

Some BNSSG GP practices have created support groups for patients going through the menopause. However, currently the only universal service in the Bristol area is UHBW's menopause clinic.

Our research on the menopause aligns with local and national government initiatives, due not least to emerging figures regarding working days lost and increase in mental health issues and quality of life are impacted by the menopause (10). In October 2022, the All-Party Parliamentary Group on Menopause (APPG) said that more needs to be done urgently to help women, including boosting support in the workplace, introducing fresh training on symptoms for health workers, and improving access to treatment. Their recommendations included inviting millions of women across the UK for an NHS health check aged 45 to discuss the menopause. They also suggested that HRT prescriptions should be free of charge (11).

This research also ties in closely with the 10-year ambitions of the women's national health strategy for the menopause (12) which highlights the importance of awareness of the menopause from a young age, normalising the menopause, and ensuring primary care professionals offer evidence-based treatment options. This project will feed into the Women's Chapter (13) of the Bristol City Council's Joint Strategic Needs Assessment (JSNA) (14), which brings together expertise from local community leaders to understand and agree the needs of local people. The JSNA provides evidence for making decisions about local health and care services and enables commissioners to plan and fund services that meet the needs of their whole local community. The insights that come from this project will also be taken into consideration by the Bristol Women's Commission, who identify key issues for women and produce the Women's Strategy for Bristol.

Methodology

We began the project by forming a steering group, inviting individuals to an informal session to discuss their experiences of the menopause. We reached out to partner organisations using our social media channels, various online platforms and using networks in BNSSG.

We divided the numbers of attendees into two groups. In both groups, a member of staff and a Healthwatch volunteer were present. The staff member's role was to facilitate conversations with the group members based on a set of semi-structured questions. The volunteers' role was taking notes and facilitating conversations.

The steering group were given the option to be contacted for future contributions to an initial survey draft. We adapted the survey based on their comments. The draft was sent to key contacts representing diverse and marginalised communities to ensure these communities had the opportunity to co-design the survey with us, which is an aim highlighted in our Equality Impact Assessment (appendix 7).

After meeting with a Healthwatch volunteer who is trained in creating easy read materials, we were able to identify and ensure key terms were well defined. This was particularly important for the translation of the surveys into four commonly spoken languages in Bristol, to reach Somali, Urdu, Polish and Hindi speaking communities.

We disseminated the survey through partners and community organisations. We also had help from Bristol City Council and local healthcare services.

We created posters to display our contact information, a project summary and a QR code taking respondents straight to the survey using a smartphone or device. The posters were placed in community centres, leisure centres, hospitals clinics, and in GP reception areas. Flyers were created for face-to-face engagement events. We targeted newsletters within the voluntary sector and integrated health partners.

We printed the survey in five languages including English and arranged free postal returns. Some staff and volunteers were involved in helping respondents by filling in the survey over the phone for them.

In March 2023 we hosted a high-profile workshop at Bristol's International Women's Day event in City Hall with local charity Bristol Women's Voice what attracted widespread attention.

International Women's Day event: 'Your NHS Menopause Experience' workshop

With the assistance of a volunteer, we used interactive graphics to discuss desirable healthcare services for the menopause. The results of the workshop were recorded and included within this research.

Survey

The survey ran from December 2022 through to March 2023. The total number of responses was 379, with 250 fully completed surveys and 129 partially completed surveys. The online survey was created using Smart Survey and had a total of 54 questions (included as appendices 1-5).

This survey utilised a 'branching' tool of Smart Survey. Respondents were taken on a certain path of questions depending on their answers to a previous question. For instance, if an individual answered that they were of a particular protected characteristic, such as from a minority ethnic background, they would also be taken to a set of certain questions. These questions asked the respondent whether they felt their characteristics influenced the way the menopause is perceived by the respondent, or whether this affected the care they received. We decided to ask these sets of questions to understand the cultural and socioeconomic impacts of healthcare for the menopause.

Findings

We decided to place the demographic questions at the end of the survey. Each respondent was asked the same demographic information questions. We do not have demographic data of all respondents, which we believe is due to survey fatigue.

Demographics

Table 1: Area of BNSSG that respondents are living

Where respondents are from		Number of respondents
Bristol		151
North Somerset		60
South Gloucestershire		31

Table 2: Age differences of survey respondents

Age Range	Number of respondents
25-49 years	73
50-64 years	150
65-79 years	21
No response	5
Prefer not to say	1

Table 3: Ethnicities of respondents

Ethnicity	Number of respondents
Asian/Asian British: Any other Asian/Asian British background	1
Asian/Asian British: Chinese	2
Asian/Asian British: Indian	2
Asian/Asian British: Pakistani	1
Black/Black British: African	3
Black/Black British: Caribbean	1
Mixed/multiple ethnic groups: Any other Mixed/Multiple ethnic group background	1
Mixed/multiple ethnic groups: Asian and White	1
Mixed/multiple ethnic groups: Black African and White	1
No response	10
Other	3
White: any other White background	19
White: British/English/Northern Irish/ Scottish/Welsh	199
White: Irish	6

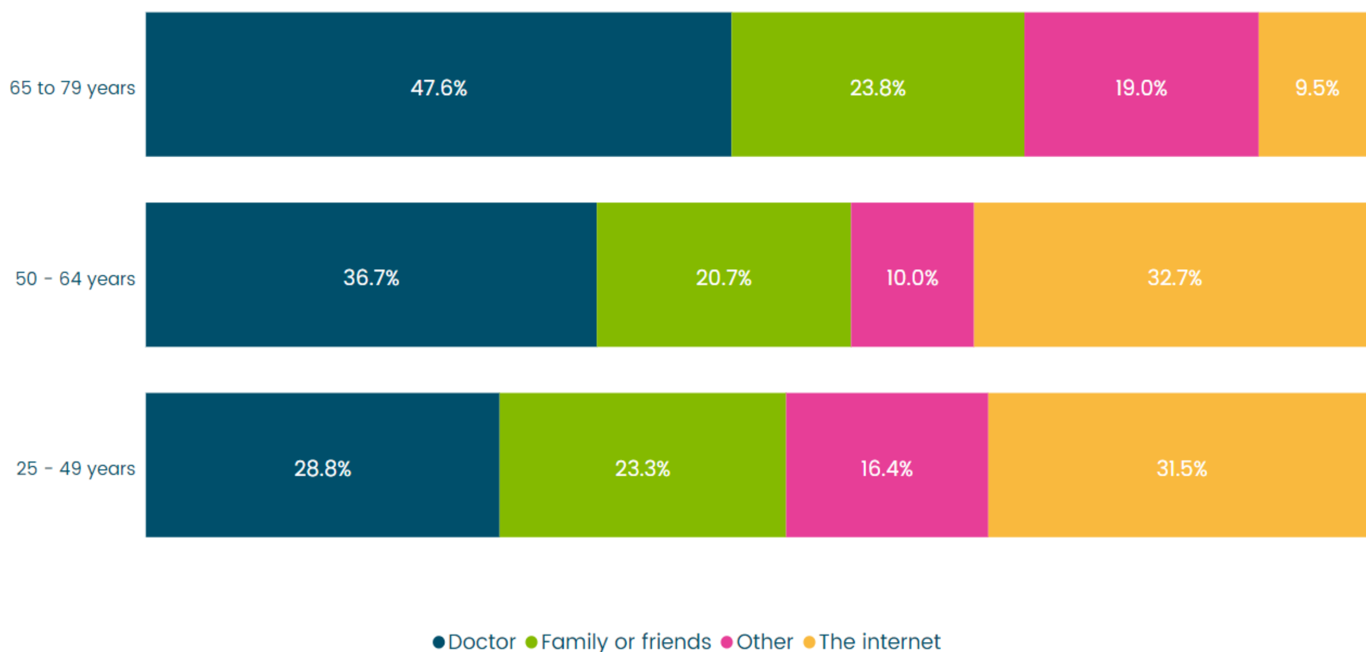
Table 4: Financial circumstances of respondents

Financial status	Number of respondents
Just getting by (I have just enough money for living expenses and little else)	54
No response	8
Prefer not to say	11
Quite comfortable (I have enough money for living expenses, and a LITTLE spare to save or spend on extras)	144
Really struggling (I don't have enough money for living expenses and sometimes run out of money)	6
Very comfortable (I have more than enough money for living expenses, and a LOT spare to save or spend on extras)	27

Table 5: Percentage of respondents who identify as having a long-term condition or as a disabled person

Disabled person or having a long-term condition	Percentage
Yes	29%
No	70%
Prefer not to say	1%

Chart 1: ‘what was the first place you went to for advice, information or treatment of the menopause?’ by age group.

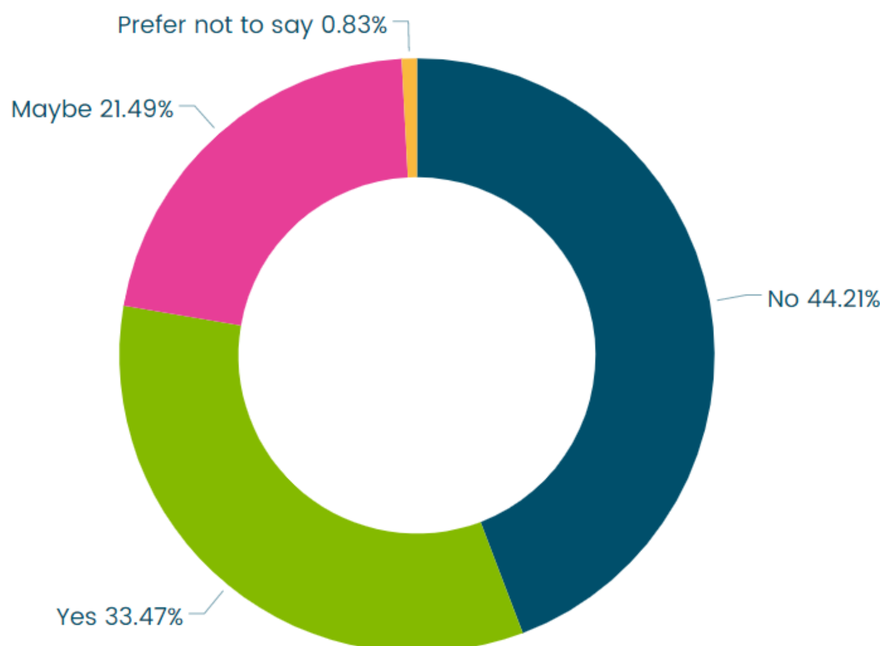


Within Chart 1, there is a difference between ages of respondents regarding their first point of contact for advice, information, and treatment of the menopause. We can see that the younger the age, the fewer respondents sought advice for the menopause with a doctor. In the youngest group, the internet was the most used place to access information. This suggests younger individuals rely more on online platforms for healthcare advice and information than directly through healthcare services.

Key Themes

Symptoms and their diagnosis

Chart 2: Responses to the question 'Were your symptoms mistaken as a different health problem, rather than menopausal?'



As shown in Chart 2, 33% of individuals felt that their symptoms were mistaken, with 21% saying 'maybe'.

Open text answers to our survey supported this finding with some respondents stating their symptoms were misdiagnosed by health professionals as issues with mental health.

- Multiple respondents were prescribed 'anti-depressants' first, before later treating symptoms as menopausal. A respondent who lived with debilitating symptoms for 7 years wrote, 'I went back to my GP practice after 7 years of being into post-menopause, still struggling with symptoms that had been put down to mental health. I had been given anti-depressants and anti-anxiety medication which did not work.'
- One respondent told us that the 'GP said I was too young (to be in menopause) and I should try antidepressants. I refused as anxiety and low mood were a consequence, not cause, of my hormone changes.'
- Another said, 'I was signed off work with low mood.'
- 'With hindsight many early symptoms were put down to depression that were actually hormone related.'
- 'I was told I was depressed and given antidepressants.'
- 'I had blood tests for thyroid problems and was offered anti-depressants which I refused. I knew it was not depression.'

- ‘Each symptom was initially viewed as a separate matter rather than holistically as one or linked.’
- Some found that they were not supported when they asked for help.
- ‘My periods went very sporadic, and the GP gave me one blood test but said it was all okay. It wasn’t until a year or two after they had been stopped completely that I went back and got help.’
- One respondent wrote, ‘it’s not so much that they were misdiagnosed, more that links haven’t been made and support offered.’
- 'It was a struggle to get GP to accept symptoms as peri-menopausal and not just menstrual.’
- Other conditions sometimes got confused with menopausal symptoms.
- ‘GPs seem to struggle to differentiate between what is or could be caused by the menopause.’

Training and awareness of health professionals

People we spoke to felt a lack of training affected the care that they received from healthcare professionals.

- One of our respondents wrote, ‘I had worsening PMS, insomnia, gum problems, heavy periods, breast pain… I’m really shocked how poorly women are treated and how inadequately GPs are trained’.
- Another wrote about her poor care, ‘my GP was a young man, and I wonder if he had any training on the menopause at all.’
- ‘I was peri-menopausal from 42 years of age. GP was dismissive, diagnosed anxiety and depression but the tablets made it way worse, it took until I was
- ‘49 years old before I was taken seriously, GPs seemed to have very little knowledge.’
- ‘We need all practitioners to have basic training and a specialist prescribing nurse in each GP practice.’
- ‘GPs need support and training in the practice that can then support other professionals.’
- ‘I would like to see all doctors trained to understand perimenopause, and the correct knowledge, support and guidance to be there from all GPs.’
- One respondent felt that ‘the lack of knowledge within the GP sector means a failure to recognise how debilitating the menopause symptoms can be.’
- ‘More training and support for healthcare professionals is vital as many do not know enough to treat the menopause well.’
- A respondent suggested that ‘more healthcare professionals getting menopause training’ would beneficial.

Chart 3: Respondents answering the question ‘did you find your doctor or healthcare worker’s advice helpful?’

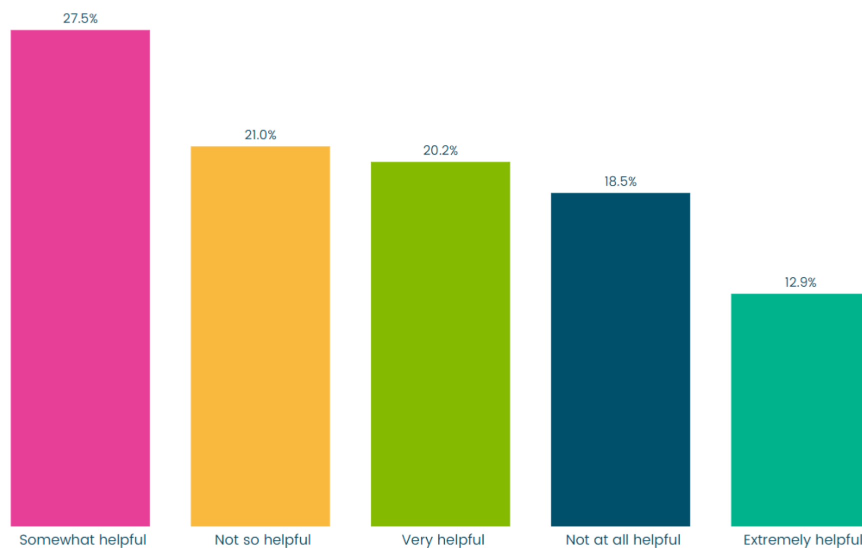


Chart 3 shows 27% found that healthcare professionals' advice was ‘somewhat helpful’. 21% ‘not so helpful’. 12% of respondents said that advice was ‘extremely helpful’. Only 20% of individuals found their health care professionals advice very helpful.

Attitudes of healthcare professionals

This project began with feedback from people who felt they were not listened to when accessing healthcare services for the menopause. This was further highlighted in our survey:

- One respondent wrote, ‘I felt as though I wasn’t being listened to’.
- Another said that the healthcare professionals gave ‘No information’ and that it is a ‘constant battle to be listened to.’

Some respondents felt that their healthcare professional did not have compassion or sensitivity:

- ‘As an overweight woman who has gone through the menopause at a younger age, I feel I wasn't taken seriously at all, no help was offered and all I was told that it was down to being overweight.’
- ‘My symptoms just weren't received very sympathetically. I had to request treatment. This is 9 years ago.’
- ‘There's always a reluctance to engage in any conversation about menopausal issues.’

- ‘I was told by my female GP; every woman has gone through it and just to get on with life.’
- ‘My initial GP was either totally disinterested or he lacked any knowledge of this area. Now, I have a knowledgeable female GP who has put me on HRT to tackle some symptoms.’
- My GP was totally unsympathetic.’
- ‘The GP dismissed my symptoms as trivial…they had a “get a grip” attitude.’
- ‘My symptoms were ignored by the GP who was reluctant to give me any time or help.’
- One felt dismissed and said, ‘they should not be treating you like you’re hysterical’.

Being informed about the menopause

Respondents to our survey said they were not signposted to helpful information by healthcare professionals.

- One respondent wrote ‘almost all the information I’ve found out is through my own research into my symptoms.’
- ‘I had to convince my doctor it was perimenopause through careful research and drawing the dots with my own symptoms.’

Many people used the survey to point out the need for specialist information and support for women.

- ‘A lot of my friends have struggled to get good information and support from their GP about the menopause.’
- ‘A respondent felt there should be ‘more information about less talked about symptoms like memory loss or brain fog.’
- Another needed ‘more advice relating to getting through the menopause.’
- ‘Improve the communication and education for women that this is a natural, normal process.’
- ‘Self-help groups that provide good information to the questions people need answering, or something like this online.’
- ‘I think knowing where to go for advice and support is so important. There could be community groups online or face-to-face where people can go for support’.
- One respondent recommended that ‘having awareness sessions online’ could help.

- 'The menopause needs to be discussed with every female at a health check. I wish I had the information before I started developing symptoms.'
- 'Simple leaflets and written down information (including doses and advice).'
- 'I think more information needs to be in the public domain so that women don't suffer in silence or avoid seeing a GP.'

Community based specialist services

Almost two thirds of our respondents said they wanted designated 'hubs' or community clinics. This is reflected in written responses:

- 'Not only is it impossible to get a GP appointment, but I would also prefer to talk to someone with specific expertise in women's health and the menopause.'
- 'It would help having specialist services so that women can receive up-to-date information and care.'
- 'Bringing gynaecological, menopause, cervical and breast screening with contraceptive services, and diagnostics all together would make a massive difference.'
- 'If attending a (community)hub decreases pressure on GPs, then I am okay with that.'
- 'I have a complicated gynaecological history so it would be great to go to a clinic or hub.'
- 'This type of specialist care would be very helpful especially to ensure treatment is in line with current thinking and techniques.'
- 'The menopause can be very complex. A hub with specialists will have a better idea of complex cases.'
- 'It would give me confidence to know I was speaking to menopause trained professionals. I think GP appointment times are too short for women to properly understand what's going on and make informed decisions on treatment options.'

Chart 4: Responses to the question: 'would you prefer a clinic or hub that is specifically for menopause or women's health?'. Answers split based on ethnicity of respondents.

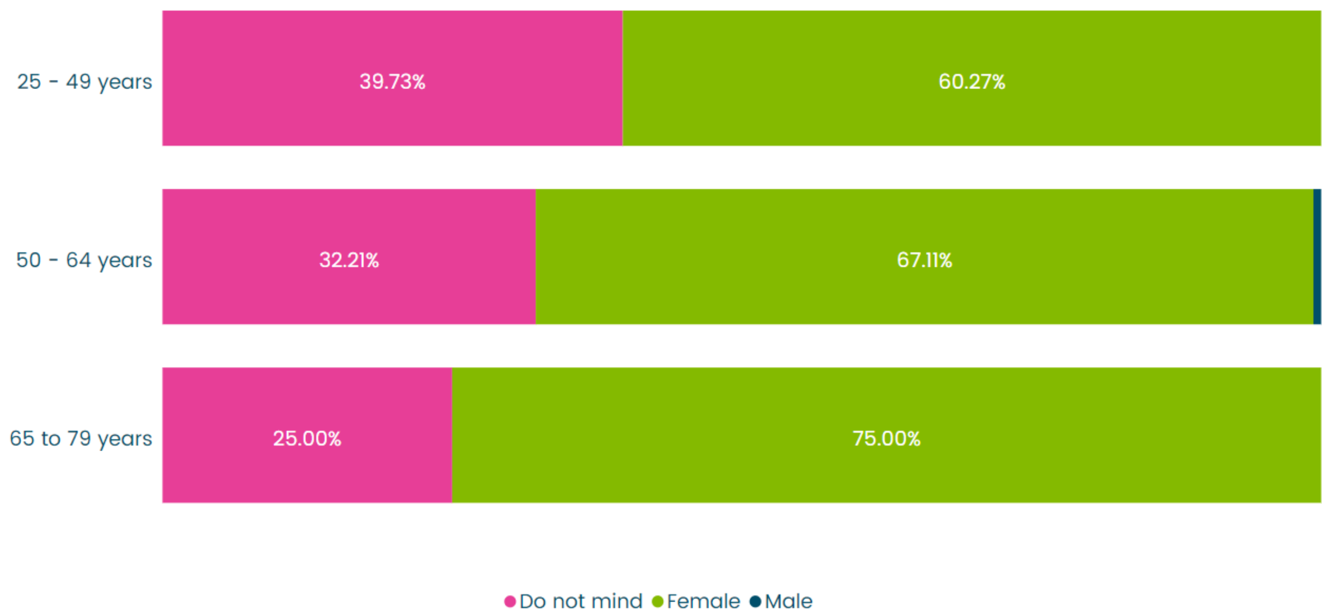
70% of respondents with ethnicities who do not identify as 'White:' said they would prefer a designated women's hub/clinic compared to 59% of 'White' communities. Those who do not identify as 'White' are more comfortable with visiting a community space for women's healthcare needs. This preference may be reducing the likelihood of these communities seeking help from a GPs or healthcare professional and may lead to health inequalities.

- 'If there was a dedicated clinic, I would have come forward for help sooner.'

75% respondents aged 65-79 years of age said they would have rather seen a female health professional than a male. This is compared to the youngest age range, 25-49 years of age, where 60% of respondents would have rather seen a female professional.

Charts 4 and 5 show the response by age and ethnicity. These differences are important to consider when creating new services for people going through the menopause.

Chart 5: respondents answers to the survey question, “if you could choose, would you have rather seen a male or female doctor or healthcare worker?”



Recognising differences in experiences for those in the perimenopausal stage

Chart 6: respondents answers to the question: if you are perimenopausal, did your doctor or healthcare worker know your symptoms were due to perimenopause?"

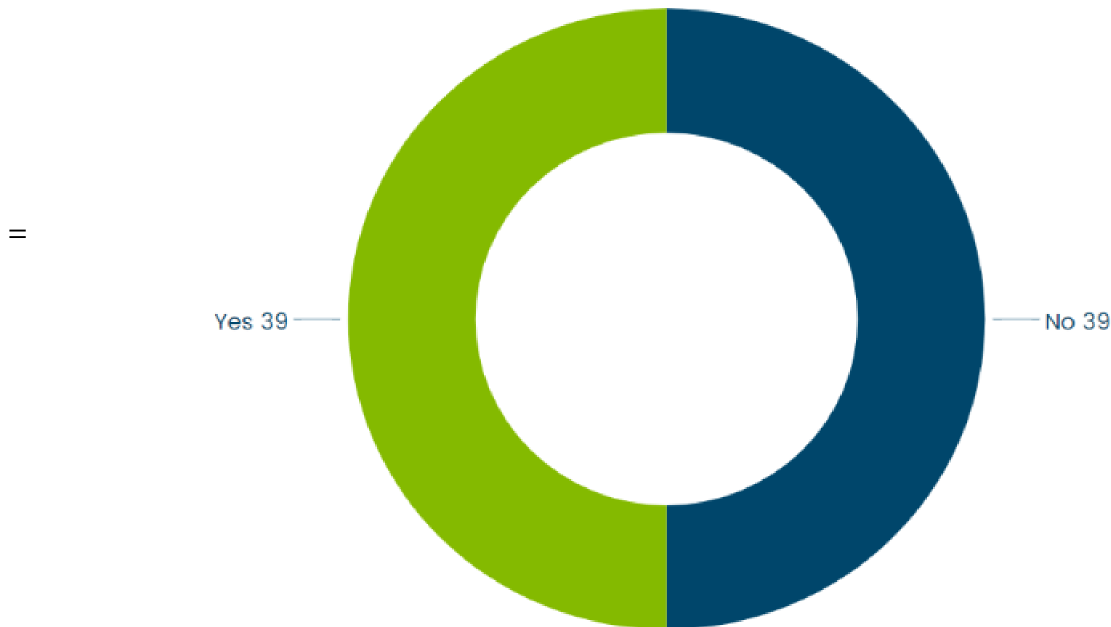


Chart 7: respondents answer the question: "if you are perimenopausal, do you feel you have been supported by your doctor or a healthcare worker through the peri-menopausal stage?"

Chart 6 shows whether doctors or healthcare workers recognised menopausal symptoms. 54% said they felt that had been supported by healthcare professionals 46% of respondents felt they were not.

In open text responses individuals said they struggle to have their symptoms taken seriously.

- One respondent wrote, 'I have spoken to many GPs about my symptoms, and was told other things like, I'm too young, depressed.'
- 'At first, I was dismissed by my doctor as they said I was too young (aged 44), I eventually (was) listened to and put on medication'. 5 years later.
- 'I was told repeatedly by my GP that I was depressed and suffering from anxiety because I was too young.'
- 'Perimenopause wasn't their first or even second thought in reference to my symptoms despite me voicing that I thought they were.'
- 'My doctor has told me I'm too young. They don't accept that I know my body and that I can feel that things are changing.'

Recognising and supporting postmenopausal stages

Of the 74 respondents who answered this question, 44 said that they did not feel they were given enough information.

- One respondent who is post-menopausal, said they are 'still taking HRT to control mood ' but didn't know why.
- Others felt they were given 'no advice' or 'no information.'
- Some felt they had to pay for private consultations with an expert' or had to 'resort to the internet.'
- One individual said they had been 'experiencing hot flushes and mood swings for over 20 years.'
- 'No follow up. No diet or lifestyle advice, only prescription and no review.'
- 'Through suffering from different symptoms, it has prompted me to keep going back to my GP, and because of that I've learnt more.'
- 'You're just left to get on with it.'
- 'I didn't know symptoms would go on so long or that new ones would start.'

Alternatives to HRT treatments for the menopause

112 respondents disclosed that they are taking HRT as their primary treatment option for the menopause, however a proportion stated reasons for not using it:

- ''My doctor explained vaginal atrophy could be reduced by HRT but I was too scared to use HRT because of hearing it was linked to breast cancer.'
- One respondent said myths about HRTs link to cancer had put her off. 'I feel I have missed out of the benefits of using HRT such as reducing risk of osteoporosis and heart disease'.

Some individuals told us their request for HRT was refused:

- 'Because my mother and sister had breast cancer, I was told I couldn't take HRT. No alternative was discussed.'
- One health professionals 'said I wouldn't be able to have HRT due to my mother's stroke.' and has had no support after that.'
- One respondent who has had breast cancer said 'they didn't have a clue about the fact that I could still receive HRT, so was refused it. I have gone through years of suffering because of this.'
- 'After being told it was probably menstrual and being encouraged to have a coil fitted, the GP eventually relented and agreed to give me HRT - it felt like I had to fight to get it.'

Some respondents felt they would like to hear about alternative options, however, there appears to be a lack of knowledge:

- 'I would like to discuss the options rather than read them on a website', one respondent wrote.
- 'I have just left my job because of my cognitive decline, which made my job stressful and impossible. I now need to find something else & keep coping with what feels like dementia because HRT hasn't helped it, and I don't believe there is any other support or help available.'
- 'I had to suggest could I be perimenopausal. Then I was just given standard hormones despite wanting to discuss a different route after speaking with a specialist.'
- 'Was offered HRT but the doctor could not really offer my advice on how this would interact with other medications I am taking for a long-term health condition.'
- 'I was put on a low dose of HRT, but never again as it led to being partially to blame for a pulmonary embolism not long after. There is not enough information given about the potential risks of HRT.'
- 'Healthcare professionals should be more up to date with prescription options.'

Going private for menopause care and treatment

A reoccurring theme was respondents' decision to seek private healthcare services.

- One respondent wrote, 'I tried for 4 months to get an appointment with my GP and ended up having to see a private GP at significant cost'.
- 'I was told by the doctor that she had no experience of the menopause. So I was forced to seek private advice.'
- 'Awful experience throughout primary and secondary care medics. Had to go private. Ageist and sexist health policy – it's a disgrace.'
- 'I went to my GP when I first started getting symptoms. I was given anti-depressants. Eventually, after 3 years of struggling with multiple symptoms I went to a private menopause clinic.'
- 'I am now going back to the doctor to ask how to identify a private 'gynaecologist who can help me.'
- 'A real absence of any expertise within the NHS. I created my own hybrid care package by consulting a private menopause practitioner.'

Chart 8: 'how much did you understand the different options for treating your symptoms of the menopause?' Divided by economic circumstances.

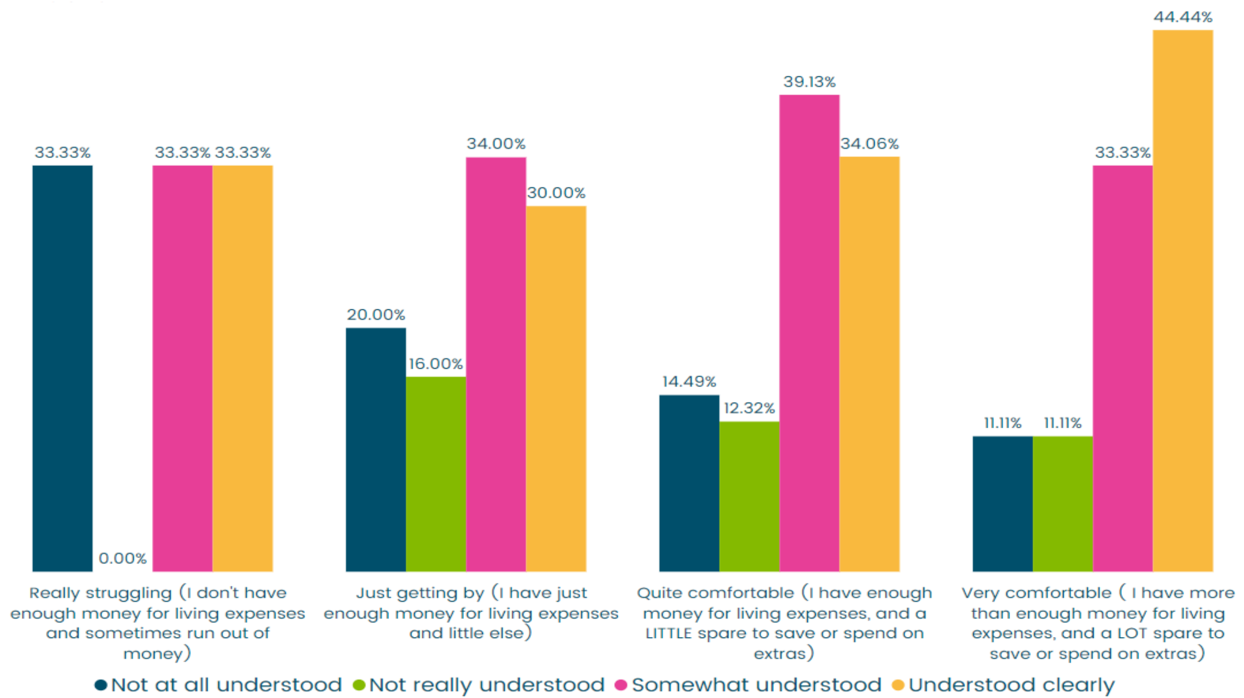


Chart 8 shows that those financially 'really struggling' didn't know their treatment options. Those 'very comfortable' financially and able to afford private services, had a better-quality experience of menopause care and more available treatment options.

Understanding the importance of cultural differences

Chart 9: 'did the doctor or healthcare worker explain what was causing your symptoms?' Divided by ethnicity of respondents.

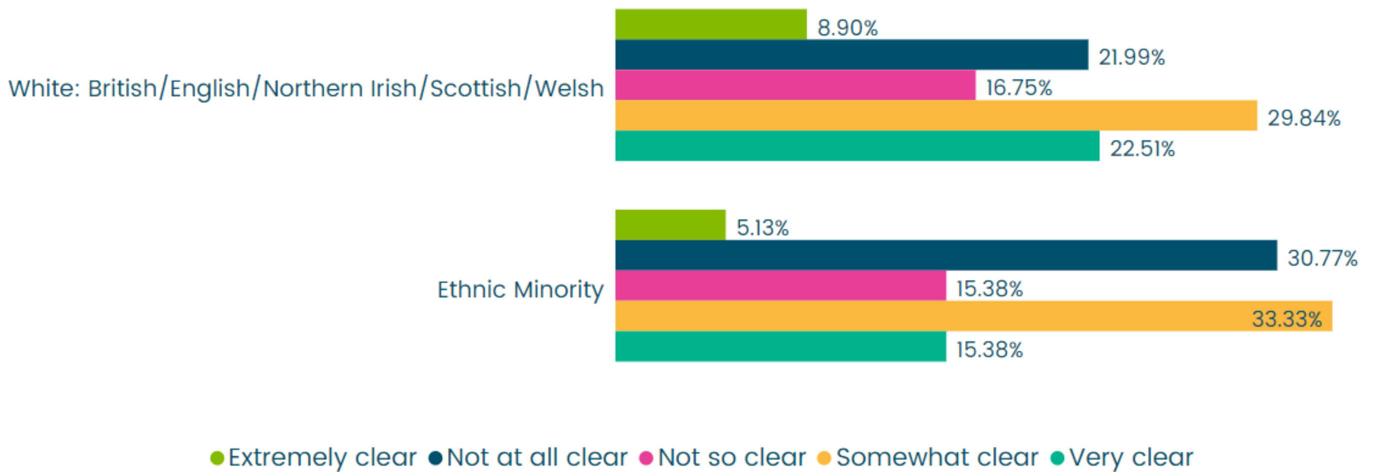


Chart 9 shows that 30% of individuals who do not identify as 'White' found a healthcare professional's explanation of what was causing their symptoms 'not at all clear'. 33% found the explanation from their healthcare worker 'somewhat clear'. There may be language barriers to understanding healthcare professionals due to English being a second language, however confusion may have been caused by limitations to professionals' cultural awareness. Some responses reflected these issues:

- 'The menopause is very personal and not something we share in my culture.'
- I saw a male GP, so I was nervous and embarrassed.'
- 'More information is needed, such as drop-in sessions and workshops.'
- 'It is still a bit of a taboo subject. This barrier really needs to be broken.'
- 'There is little information (about menopause) seen anywhere in my community.'
- 'In my culture (I am Somalian), we struggle to talk about these types of changes. A lot of us think the menopause means the end to our lives, so we do not want to accept help.'
- One respondent wrote, 'no one talks about it, even the British.'

Training around diversity and the menopause would be a significant step forward and would help to break down the barriers to accessing healthcare for these communities and the heath inequality this fosters.

The impact of disabilities and long-term conditions

63 individuals had a disability or condition and remarked on the way it affected the response to their symptoms of menopause. Many said the symptoms became mixed up , both by themselves and clinicians. For instance:

- One respondent wrote it is 'difficult to know if it's (my) condition or menopause'
- Another individual wrote this has 'somewhat confused my symptoms.'
- Others mentioned the issue of 'Chemotherapy accelerating menopause' and 'similar symptoms made gaining support more challenging'
- For one person there was a concern about using HRT because of 'Misunderstanding of hormones versus my type of cancer ' and a 'perception of increased cancer risk.'
- Respondents felt that their access to HRT had been affected by their disability, 'it has affected the response , I was told HRT was not suitable.'
- A diabetic individual said they 'tried the oestrogen gel first, which dropped (my) blood sugars.... I feel diabetic patients should be warned this is possible.'

  There were reports of conditions or disabilities exacerbated by the menopause. One respondent wrote, 'I already have migraine disorder, this got worse during perimenopause.'
- Another individual says, 'I have suffered anxiety for a very long time, but symptoms have been exacerbated by menopause.'

Examples of good practice

There are numerous examples of good practice that respondents wanted to tell us about, that they say should be built upon.

- One respondent said, 'the GP sent me links to an excellent series of videos to watch in my own time which were really informative'.
- One said, 'GP took (my) symptoms seriously and suggested lifestyle changes to help manage the menopause' leaving the respondent feeling 'listened to' and 'validated'.
- Another respondent wrote 'my GP was a very good listener and very willing to be led by my thoughts too on my menopause, and possible treatments'.
- 'I asked a general question when seeing the nurse about an issue and she listed other symptoms that I had and didn't realise were related. She alerted me to perimenopause before I had considered it. Excellent.'
- 'I was prescribed HRT for a couple of months, and I did not feel quite happy, so my doctor suggested herbal remedies which reduced symptoms within a year.'

Peer Partnership Model

One of our steering group members suggested that 'Support groups, greater awareness and sources of information are needed.' We asked them to explain.

A local voluntary service known as Peer Partnership have rolled out peer support services for people living with HIV and have now extend their model to Type 2 Diabetes and long COVID. They told us that the basis of these peer support sessions is to provide mentees with the support needed to feel less lonely and isolated and feel better able to self-manage their condition during and following the support sessions. The Peer Partnership have created a proposal for their model to be used for menopause, to support mental wellbeing. Their work includes peer and health care professional-led workshops, semi-structured peer support groups and mentoring. This service would be an asset to a women's hub or walk-in clinic.

How we could have improved our survey?

Our survey assumed respondents had sought healthcare support from local services. We soon became aware that many people choose not to seek any type of support. However, to pursue the purpose of this project which is to identify themes from public experiences of care, we continued to focus on those voices who tell us about using or trying to use public healthcare services.

We wanted to hear from a diverse range of cultures within our community, and our translation of the survey into four different languages helped us do that. However fully overcoming cultural sensitivity around the menopause and intersectional difficulties arising when attempting to discuss it, was a barrier to accessing some communities. Knowledge about the ways different cultures speak about and understand the menopause is missing and should be addressed by further research so that our services can reach all sections of our communities and help to reduce health inequalities.

Recommendations

- Create a specialist walk-in hub or community clinic for women during menopause, providing follow-ups and reviews, and which can be accessed without referral.
- Ensure awareness information is sent to all women in preparation for pre-menopause, so women know which services are available for support, including accessible options.
- Appoint designated leads in each Primary Care Network who provide specialist advice and signposting on the menopause.
- Launch an awareness campaign that takes menopause and its symptoms seriously.
- Health settings should signpost to trusted information including those online about the menopause, with information that resonates with our diverse local communities.
- Mandate menopause and cultural competence training to health professionals who offer menopause support, to enable women to consider all options and avoid myths.
- Create co-delivery services of support in the BNSSG area for the menopause, encouraging peer support.

What's next?

Next steps

- Healthwatch Bristol's 'Your NHS Menopause Experience' will inform the Women's Chapter of the Bristol City Council's JSNA (Joint Strategic Needs Assessment).
- Healthwatch Bristol's 'Your NHS Menopause Experience' will inform the Women's Chapter of the Bristol City Council's JSNA (Joint Strategic Needs Assessment).
- Healthwatch Bristol will advise local service providers and healthcare professionals of the results and recommendations of this project.
- Healthwatch Bristol will update local Sexual Health Boards.
- Healthwatch Bristol will continue to collect feedback on menopause services and signpost people to available support.
- We will track responses to this research to influence plans for women's health and care services in the BNSSG area.

A special thank you

We at Healthwatch Bristol would like to thank those who took part within this survey. We would also like to thank all external organisations who helped us to disseminate our survey, and put us in touch with key contacts who have helped us reach wider communities of individuals, such as:

Caffi Health

Sirona Health & Care

Sirona Health Links Service

Opoka (Polish Women's Group)

Our volunteers have a steering role in our projects, and we would like to thank Ann Mary, Suzanne, and Jemma from Healthwatch Bristol, North Somerset and South Gloucestershire for their continued support.

Provider responses

Shane Devlin, Chief Executive Officer, Bristol, North Somerset and South Gloucestershire Integrated Care Board

Thank you for sharing this really helpful review with us and the ideas and recommendations this has generated. In BNSSG we are committed to working with colleagues such as Public Health, General Practice and Secondary Care to improve services to women, in line with the Women's Health Strategy, which is one of our priorities within our Joint Forward Plan. Dr Joanne Medhurst our Chief Medical Officer is the champion for this strategy and a programme of work to review and implement recommended improvements under the leadership of the Health and Care professional Executive will take place in the future. We will incorporate this valuable feedback into our developing plans.

Currently Primary Care prescribing data shows that we are, like other parts of the country, investing considerably more on HRT treatment. Last year 22/23 we spent £2.8 m on HRT therapy which is an additional £1.03 million than in 21/22. Further work is needed to review who is accessing treatment and the value that this is bringing to our population.

We look forward to working with you in the future to ensure we have the optimum services and access for women.

Penny Gane, Chair, Bristol Women's Commission

Huge congratulations to Healthwatch on their excellent research into women's experiences of healthcare in relation to the menopause. This research provides solid evidence of the need for more responsive service provision and highlights the importance of better training for GPs and all health professionals. We will continue to work together to set up women's health hubs in the city and to influence decision makers both locally and nationally.

Jo Burgin, GP Academic Clinical Fellow at the University of Bristol

This report highlights women's experiences accessing menopause care in BNSSG and the work required to meet the needs of women whose lives are affected by menopausal symptoms. There is a clear need for further research to listen to the voices of traditionally underserved communities and identify barriers to accessing good menopause advice and care. I welcome the call for more investment in women's health and hope this will reinforce the importance of menopause care outlined in the Women's Health Strategy for England.

Kyra Bond, Chief Executive Officer, Womankind

We welcome the findings in this report that acknowledges the menopause can have a profound and debilitating effect on many women's lives. We agree with all the recommendations and the need to prioritise timely access to holistic treatment, personalised information and compassionate care for women across our region.

Carol Slater, Head of Service - Public Health, Communities and Public Health Division, Bristol City Council

Menopause has traditionally had low visibility in health and care settings as well as more widely in public arenas, despite it affecting more than 50% of the UK population. It's therefore timely that Healthwatch have taken a lead by publishing this important report.

The report sets out some stark findings about how a lack of awareness, a reluctance to discuss menopause openly and inconsistent access all affect the experience of women in Bristol. Areas of good practice are highlighted but sadly the report underlines how far we still have to go to improve healthcare advice and support for all – which is why it's so important that Healthwatch are giving menopause the high profile it deserves.

Anisa Patel, Engagement and Wellbeing Manager, North Bristol NHS Trust

The report is an excellent start in researching and understanding the experience of individuals accessing menopause support in the BNSSG area. It highlights some useful findings and the recommendations, in particular the introduction of a walk-in clinic, will be positive steps forward in delivering an improved menopause experience.

The report's findings give us a broad picture of numerous difficulties experienced by women accessing support from health professionals on the menopause and highlights the stark need for change in delivering improved services and medication. The report highlights the need for greater support in accessing menopause support particularly for ethnic minority communities and those groups who experience a significant degree of health inequality due their socio-economic group. More outreach support is required to engage and support these communities both in research and delivery of services.

The key question this report and its stakeholders need to answer is: how can we succeed in delivering the best for our society when we know that at least 50% of our society will be affected by this health issue in their lifetime, which is currently under supported and under resourced?

Monira Ahmed Chowdhury, Head of Equality, Diversity & Inclusion at North Bristol NHS Trust, Senior Responsible Officer for EDI at Bristol, North Somerset and South Gloucestershire ICB and Co-Chair of the Bristol Women's Commission Health Task Group

I note the Healthwatch report on menopause and its findings. I will endeavour to ensure that the report and its outcomes are linked appropriately to various initiatives relating to women's health, especially as employees within health and care.

Appendices

Appendices 1, 2, 3, 4 and 5 – surveys and their translations

Appendix 6 – Theory of Change

Appendix 7 – Equality Impact Assessment

Appendix 8 – reference list

To view or download the appendices for this report, please visit www.healthwatchbristol.co.uk/your-nhs-menopause-experience-may-2023

If you require this information in an alternative format, please email helen@healthwatchbnssg.co.uk.

Healthwatch Bristol
Unit 21
Union Gallery, The Galleries
Broadmead
Bristol
BS1 3XD

www.healthwatchbristol.co.uk
t: 03300 553251
e: contact@healthwatchbristol.co.uk

@HWBristol

Facebook.com/bristolhealthwatch

Bristol Health and Wellbeing Board

Title of Paper:	DPH Annual Report 2023 The Power of Us: We are Bristol, One City Many Communities
Author (including organisation):	Christina Gray
Date of Board meeting:	14/12/2023
Purpose:	Information and discussion

1. Executive Summary

The title of the 2023 DPH annual report is 'The Power of Us: We are Bristol, One City Many Communities'. The report explores the importance of strengthening communities and the subsequent benefits of community development for health and wellbeing outcomes of local populations.

The individual chapters of the report describe the impact of community development on different aspects of society:

1) **Social capital theory**, which describes human networks of connection, norms and trust, creates the conditions for health and wellbeing.
2) **Asset based approaches** value 'what's strong, not what's wrong' in communities. Purposeful action, with and by, minoritized and excluded communities is needed to overcome the discrimination and other intersectional factors which lead to health inequalities.
3) The places in which we live are where many of our social connections are formed and the **built and natural environments** play a key role in facilitating this.
4) **Creative and cultural activities** improve people's health and wellbeing. Several local programmes which implement arts and culture, and activities to boost **mental wellbeing** are included in this chapter.
5) **Community ownership and co-production** can enable communities to mobilise, grow and own local resources. This is possible when we support and sustain local community action.
6) The **One City, Many Communities approach** to the Covid-19 pandemic and the cost-of-living crisis have shown just what is possible when as a city we act with intent to remove barriers, to listen, collaborate and share leadership and resources.
7) **A Call to Action** – see Recommendations

2. Purpose of the Paper

The publication of a DPH annual report is responding to a statutory duty from the Secretary of State for Health and Social Care. It is an independent report on a topic relevant to public health and to the local population, chosen by the Director of Public Health. It gives the opportunity to explore the evidence base on that topic and informs the local Joint Strategic Needs Assessment.

3. Background, evidence base, and what needs to happen

Social relationships play a hugely important part in our individual wellbeing. Indeed, social isolation and loneliness can be as bad for our health as other risk factors such as smoking. The extent to which we have control over our lives, have good social connections and live in healthy, safe

neighbourhoods are all important influences on health. While social groups and communities can help us maintain and enhance our sense of self-worth through collective self-esteem. These community-level factors are some of the building blocks for good mental and physical health and can buffer against stressors throughout our lives.

This report explores the science underpinning why communities are important for health and what we can do in the city to create the conditions to help promote and support positive, thriving and resilient communities.

Extensive national and international literature is cited throughout the report including studies and evaluations from disciplines of sociology, arts and culture, architecture, urban planning and public health, alongside local case studies which include the voice of Bristol communities. The principles within the report align to the Bristol Health and Wellbeing Strategy's vision and the BCC Corporate Strategy.

4. Community/stakeholder engagement

We have included the voice of different communities embedded throughout the report with eleven different 'The Power of Us' stories. This builds on the success of a public event held at the Council in March 2023 called 'People Power'.

5. Recommendations

The final chapter of the report is a call to action. Creating the conditions for health through community requires commitment from everyone; individuals, businesses, the NHS, the voluntary sector, the local authority and of course, communities themselves.

Everyone can support the creation of One City, Many Communities by:

- Finding ways to promote, nurture and enable local community action and leadership
- Creating the conditions to support local community owned infrastructure
- Taking an asset-based approach to developing communities, by focusing on what's strong and not what's wrong
- Actively engaging in networks for community connection and knowledge exchange
- Investing in the development of trusting and trusted relationships
- Developing the conditions to support collaboration, co-production and shared decision making.

6. City Benefits

The DPH Annual Report demonstrates how taking a 'We are Bristol; One City, Many Communities' approach to building community power and wealth has potential long-term benefits for citizens and keeps our focus on equity, social justice and wellbeing to find sustainable ways forward, supporting people most impacted by low income, poverty and inequity.

7. Financial and Legal Implications

No financial implications. Legally, the publication of the Annual Report 2023 ensures compliance with the statutory duty under Part 3 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

8. Appendices

The full report is published on the BCC website: [Director of Public Health annual report 2023/24 (bristol.gov.uk)](https://www.bristol.gov.uk) There is an easy read version available.

The Power of Us

One City, Many Communities

Director of Public Health Annual Report 2023

Acknowledgements

I would like to take this opportunity to thank the people and communities whose stories have been an inspiration and which demonstrate the Power of Us. These stories were collected in April 2023, with the exception of the Black South West Network (BSWN) case study on page 24. They have not been edited.

Also thanks to the editors and contributors who have brought it all together:

- **Claire Ferraro**,
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- **Julia Foligno**,
  Community Development Practitioner
- **Mark Allen-Richardson**,
  Senior Public Health Specialist
- **Bethan Loveles**s,
  Public Health Registrar
- **Adele Mildon**,
  Senior Public Health Specialist
- **Elise Hurcombe**,
  Arts Development Manager
- **Sado Jirde**, Director
  and **Chiara Lodi**, Senior Research Officer,
  Black South West Network
- **Paul Housden**,
  Transformation and Commissioning Manager,
  Adult Commissioning.

Foreword

Social relationships play a hugely important part in our individual wellbeing. Indeed, social isolation and loneliness can be as bad for our health as other risk factors such as smoking.[1,2]

The extent to which we have control over our lives, have good social connections and live in healthy, safe neighbourhoods are all important influences on health.[3] While social groups and communities can help us maintain and enhance our sense of self-worth through collective self-esteem.[4]

These community-level factors are some of the building blocks for good mental and physical health and can act as a buffer against stressors throughout our lives.

Communities are live, dynamic, delicate eco-systems established through the connection and action of the people who are part of that community. People's identities and allegiances may shift over time and in different social circumstances.

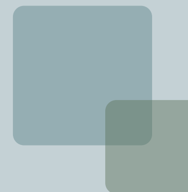
A community is a group of people who have common characteristics or interests. Community may arise from a sense of shared identity[5], affiliation or common bonds or may be linked to a place, neighbourhood or country.

And of course, we should remember that while social connection is vital for our health and wellbeing, communities can also be conflicted and uncomfortable places.

However, the thing that all communities have in common is that they share a story, sometimes called an identity forming narrative.[6] It is this storytelling that helps people share aspects of who they are and what is important to them.

Vibrant, cohesive and inclusive communities are our most important asset.

In Bristol and across the country, there are some inspiring examples of community organising, community ownership and community wealth-building.



In this report, with the support of some wonderful stories of community in action, I explore the science underpinning why communities are important for health and what we can do in the city to create the conditions to help promote and support positive, thriving and resilient communities.

I hope that you will enjoy reading this report as much as I have enjoyed writing it.

Christina Gray
Director for Communities and Public Health, Bristol City Council

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Chapter 1: Communities and Health

Social capital is a well-established theory which describes human networks of connection, norms and trust.

Social capital research explores the impact and quality of these networks which can be positive, facilitating coordination and cooperation for mutual benefit, or can be negative, creating closed groups and promoting exclusion.[7] Robert Putnam's research in Italy demonstrated that social capital was more apparent in regions with historically dense networks of medieval towns and formal associations encouraging collective action.[8]

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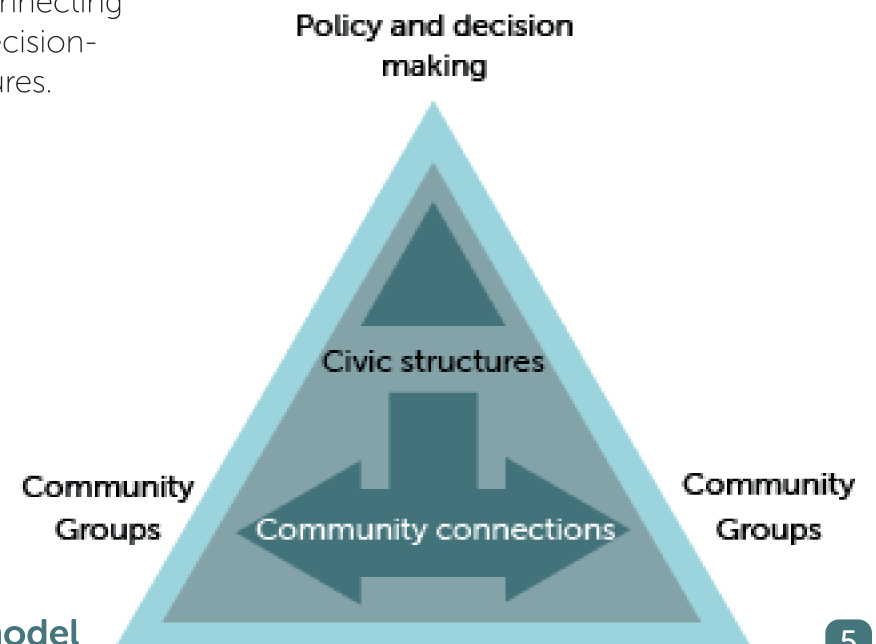
The stronger these positive networks and bonds, the more likely it is that members of a community will have access to trustworthy information, provide social support and co-operate for mutual benefit. In this way social capital creates the conditions for health and wellbeing.[9]

Most recently, the Covid-19 pandemic highlighted just how vital communities are for cty resilience through building circles of trust, sharing learning, delivering services and providing feedback.[10]

Social Capital theory proposes two distinct dimensions of community connectness, horizontal connection, between groups and vertical connection to policy and decision making. Asset-based community development (ABCD) is an approach which celebrates what is strong (not wrong), and enables horizontal, people-to-people, connections at a community level. However, vertical connection is required to enable communities to effect change by connecting them to resources and policy and decision-making abilities, through civic structures.

Social Capital theory also reminds us that there are positive and negative types of connection. In our community making we need to build on the best qualities of openness, inclusion, honesty and fairness. We can all think of examples which are closed, excluding or worse. I spoke about this dimension of community and the importance of ensuring that young people in particular have access to positive networks and feel that they have voice and influence in my Director of Public Health Report, Mental Wealth (2019/20).



Social capital model

The Power of Us: Social Action for Everyone – Ruby, Lannie, and Keira

"We live in Hartcliffe, studying at Sixth form. In 2021, we went to an activity looking at social action, and ended up forming Social Action for Everyone (SAFE), a group for young people interested in community. In 2022 we organised a 'Reclaim the Night' walk in Hartcliffe raising awareness of violence against women and girls. Later in the year we took part in the Bristol Youth Conference and had a conversation with Bristol's Mayor, Marvin Rees, about what it's like for young people in South Bristol."

"Youth Community Meal - We had talked a lot about the cost-of-living crisis and welcome spaces. Youth Moves had funding for social action projects and we applied. For six weeks, we cooked meals (with the help of our mums) and fed around 120 young people."

"In August, we held a picnic in Wilmott Park, the Community Development team and Hartcliffe and Withywood Community Partnership helped. We set up a table and gazebos, had sports, we welcomed youth groups. The police were there too. We wanted local families with children to have a free day in the holidays. Over 100 people came."

Key message

Ruby, Lannie, and Keira were inspired to act, whilst attending free training in their community. Supported by the council, local organisations, the police and local people, they were able to raise awareness, elevate young people's voices, and access funding to support local families.

The Power of Us: St Christopher's Brislington Over 55 Luncheon Club – Pat and Bill Campbell

"We've been going for five years, we said that when we retired, we'd like to do something more in church and would like to do a luncheon club. We both love cooking and meeting people."

"People come here early with potatoes and vegetables to cook. Eight of us in the team. In the beginning we didn't know how popular it would be, but very quickly people came and kept coming."

"I like the company. I love the food. I get to meet up with my neighbours. I also got to know other people that don't live so close that I wouldn't have otherwise met so it's kind of broadened my knowledge of people that live around here. I think it's important because it gives us something to look forward to; that can mean a lot to someone who doesn't see many people."

Key message

"If you've got an idea and there's a couple of other people, find out where you can do it, and go for it, you've got to have the support behind you."

Bill, Pat, and the other volunteers use their passion for cooking to connect with their neighbours, using the asset of the church hall and relationships with community groups. Relying on food donations, people's time, and a small fee for lunch, they bring people together monthly.

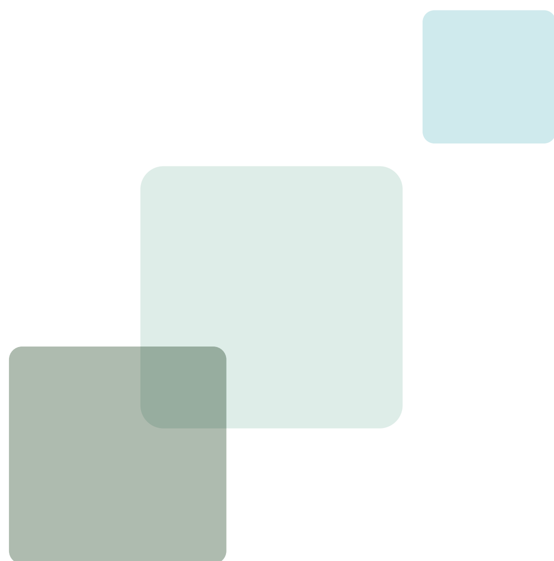
Chapter 2: Communities and Power

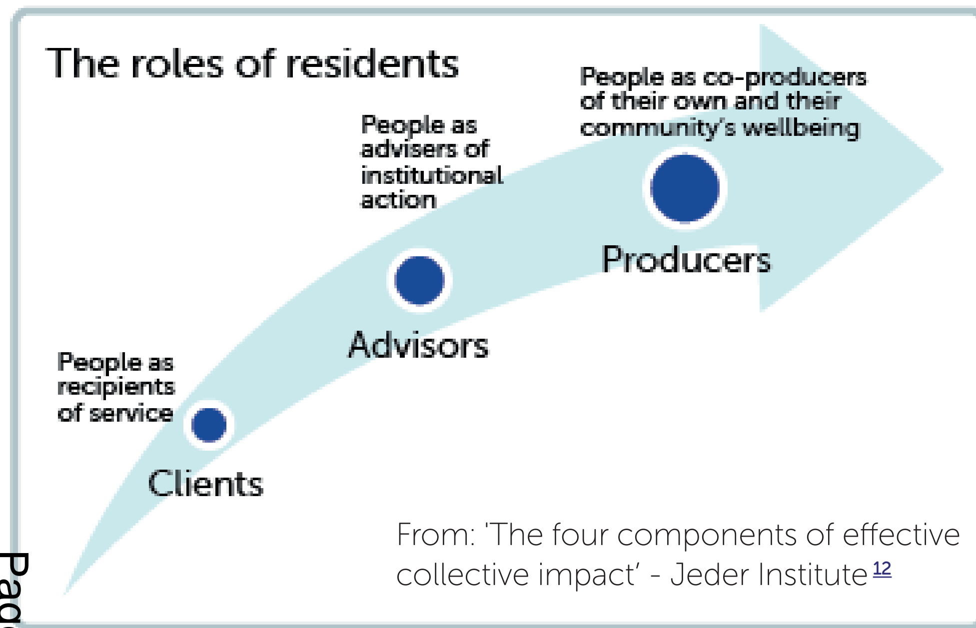
Communities, and the people within them are rich in skill, talent and ideas. Asset-based approaches value "capacity, skills, knowledge, connection and potential in a community."[11] This approach supports the aspiration within 'Fair Society, Healthy Lives' – The Marmot Review 2010 which identifies that; "Effective local delivery requires effective participatory decision-making at local level. This needs individuals and communities who are informed, engaged and able to act."[3]

The table describes some of the differences between an approach which focusses on 'whats wrong' and one which focus on community assets, skills and talents:

From ... Deficit approach	To ... Asset-based approach
Focus on problems, deficits or weakness; focus on past failures	Focus on opportunities and strengths; focus on future possibilities and successes
Local people as 'customers', 'clients' or 'service users'	Local people as 'citizens'
Provide services to people	Develop and co-produce services with people
Responds to 'problems'	Finds opportunities for growth and social change, gives people ownership of their experiences
Reliance on outside 'experts' and bureaucractic systems	Non-bureaucratic, focus on people's strength and knowledge, prioritises community
Grants or funding given to agencies or government	Grants or funding given to local associations or groups
Programmes are the answer	People are the answer

From: A glass half-full: how asset approach can improve community health and wellbeing.[12]





From: 'The four components of effective collective impact' - Jeder Institute [12]

Power was originally defined by Max Weber, renowned German sociologist [1864 - 1920], as "the ability to control others, events or resources [and] to make happen what one wants to happen in spite of obstacles, resistance or opposition." [13] Later, American sociologist Talcott Parsons [1902 - 1979] developed a more positive and shared definition of power where it flows from a society's potential to coordinate human activities and resources to effect positive change.

Academics publishing in The Lancet journal argue that social inequality limits full participation in democracy and adversely affects mental and physical health across all ages, contributing to health inequities.[14] Research by Dr Richard Wilkinson, made popular in 'The Spirit Level' [15] describes how exclusion directly affects the body through activation of a stress response, resulting in both short and long-term biological changes with intergenerational consequences.

This generates population-level differences that are perpetuated by pervasive historical, economic drivers.[16]

Discrimination is intersectional with race, gender, migration status, ethnicity, religion, poverty and other dimensions overlapping with lived experience, civic status and access to systems of influence.[17]

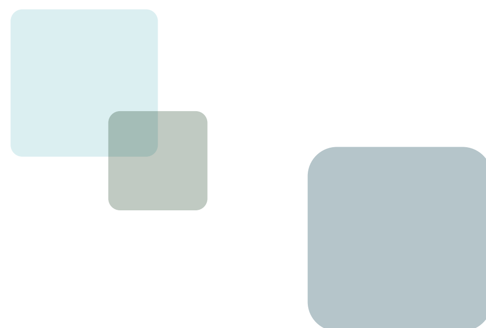
These multiple factors play a key role in the structuring of communities and is why purposeful action, with and by, minoritised and excluded communities is essential if we are to address these health inequalities.[16]

It is often said that we value what we count and we count what we can see. Traditional evaluation approaches measure effectiveness using specific outputs or metrics. This inevitably preselects for short-term financial and overly simplistic priorities and often fails to capture the vibrancy of community activism, connectedness and resilience, and the soft power which reflects the true value of community activity.

As I have described, communities are complex, dynamic and multi-layered. Effective community action and community building is long-term, incremental, cyclical and often best understood through stories communities tell about their experiences.

New Local, an independent policy think tank, describes the differences between these two approaches as an 'evidence paradox', as described in the table.

If we are serious about community building, we need to think carefully about how we evaluate effectiveness. The final chapter of this report describes the developing Bristol's 'One City, Many Communities' approach which provides a framework to support this.



Evidence required by the state-market hybrid paradigm	Nature of community power
Guided by metrics	Guided by ethos
Quantitative	Qualitative
Immediate	Long-term
Large scale for efficiency	Small-scale for impact
Within a service silo	Embedded in the community
Related to a service output	Related to individual outcomes
Focused on proving	Focused on improving
Reporting data	Recalibrating relationships
Uniformity	Pluralism
Policy implementation	Human-centred design
Linear	Adaptive
Immediate cashable savings	Avoids costs occuring

From: New Local. (2021). Escaping the Community Power Evidence Paradox.[18]

The Power of Us: One Green Kitchen - Anne Su

“Run entirely with volunteers, our vision is to have green meals to change the world’s future. We focus on food, culture and community, sustainability, wellbeing, and empowerment. We support marginalised groups such as the elderly and women from diverse backgrounds."

"We have women attending from Hong Kong, Malaysia, Pakistan, Ireland, India, Egypt and Somalia. Everyone is welcome. We have been running weekly food hubs, wellbeing activities and cooking and eating together sharing ideas and insight on how we could work together as one community to promote food sustainability across Bristol."

"I’ve really enjoyed meeting new people from different cultures, learning from them. Women sharing experiences has been a great opportunity. We can talk about what’s happening in the world with climate change and eating healthily.”

Key message

One Green Kitchen has harnessed the power of volunteers through inter-generational and diverse opportunities for people to be involved in their community. From wanting to give back to their community to gaining work-based skills, volunteering is a vital part of community building.

Anne uses her insight and lived expertise to reduce the barriers communities face in connecting with others. As a Community Champion, she helps bridge the gap and build trusted relationships between residents, communities and institutions.

The Power of Us: Brandon House Community - Fartun Osman

"I am a British Somali and mother of five children and I have lived in this area for 15 years.

At first, we didn't really know anyone but then we started to come together, with an activity for the kids, called Jumpstart.

After that, as neighbours we decided to have parties to bring the community together and to get to know each other. At our first party, neighbours came out to join in and they liked the idea of having a garden party. Our neighbours helped with setting up and it was a success.

We had the Lord Mayor (Paula O'Rourke) as our guest. Now we are trying to renovate our community room with help from the council thanks to the help of Paula O'Rourke and the Community Development Team. In the future, as neighbours we intend to come together and organise more events and help each other."

Key message

Self-organising around an activity like a party, and bringing people together, can lead to action around other things that matter. Connecting with civic power through working with the Lord Mayor and support provided by the Housing Department and Community Development team has helped to support the unlocking of a community asset.

Chapter 3: Communities and Places

The places in which we live are where many of our social connections are formed and the built and natural environments play a key role in facilitating this.

Built and natural environments refer to the characteristics of the places where people live, work and play, including schools, workplaces, hoomes, streets, communities, parks/recreation areas, green (i.e. grass, trees and other vegetation) and blue spaces [19].

An ever-increasing body of research indicates that the environment in which we live is linked to many health and wellbeing outcomes including social connectivity[11]. These links, however, are often complex and are influenced by many factors.

The importance of place has been especially evident since Covid-19 when we spent the majority of time in our homes and neighbourhoods. For some, this led to a strengthened sense of connection with their neighbours while for others, their loneliness and isolation was heightened. Access to green and blue space was highly valued.

Green space can be urban or rural and can include both public and private spaces such as parks, gardens, playing fields, play areas, woods and other natural areas such as cemeteries and allotments, green corridors, rivers and canals.

Natural spaces improve social cohesion and can help bring communities together, especially in urban settings, where people can engage in social activities and connect to their communities[20]. Evidence from a systematic review suggests that green space is associated with a number of community wellbeing outcomes including:[21]

a. boosted social/community cohesion

b. improved families' wellbeing

c. improved individual mental wellbeing

d. improved social relations/interactions

e. increased individuals' knowledge/skills

f. increased social capital.

Evidence also suggests that access to green and blue space, including urban greening, may reduce loneliness [22].

The location, access, quality, quantity, maintenance and useability of the green space are all key considerations.[23,24,25]

Green space which is accessible and appropriate for the needs of the community is more beneficial. Access to good quality greenspace, however, is often unequal, with people from less affluent communities less likely to live near accessible, quality green space[26]. Increasing the use of good quality green space for all is likely to reduce health and wellbeing inequalities.

Our streets are what make places vibrant and keep communities strong. Good street design and walkability has an impact on physical and mental health, but also on social interaction[27]. This is supported by a systematic review undertaken in 2018 which summarised that there is a significant relationship between social capital and the built environment, specifically between social cohesion and access.[28]

A walkable neighbourhood is widely recognised to be mixed-used, complete and compact and have good connectivity. Evidence has informed a set of principles known as the Healthy Streets Indicators which include the following:[29]

- Everyone feels welcome
- Are accessible
- People feel safe and feel relaxed
- There are things to see and do
- There is adequate shade, shelter and places to stop and rest
- Spaces are not too noisy
- People choose to walk and cycle
- The air is clean and roads are easy to cross

Hugh Barton, author of 'Shaping Neighbourhoods for local health and global sustainability', reports studies have shown, unsurprisingly, that there is a strong relationship between traffic levels and community. High traffic flows can make crossing roads challenging and conversations difficult which can lower the number of neighbours known by residents. Places where children can play lead to more social contact and an increased sense of ownership of space. On busy roads, street trees and wide pavements can give a sense of separation from traffic.[30, 31]

Improving access and walkability to recreational and non-recreational destinations (such as grocery stores, schools and other amenities) was also found to impact positively upon social interaction among older adults.[19] Age-friendly design and environments are important to support health and enable everyday mobility.[32] This includes community spaces in accessible locations which are vital for community activities such as community halls, faith spaces, clubs, libraries and leisure centres. These shared spaces provide opportunities for people and communities to come together, facilitating social connection and a sense of community.[30]

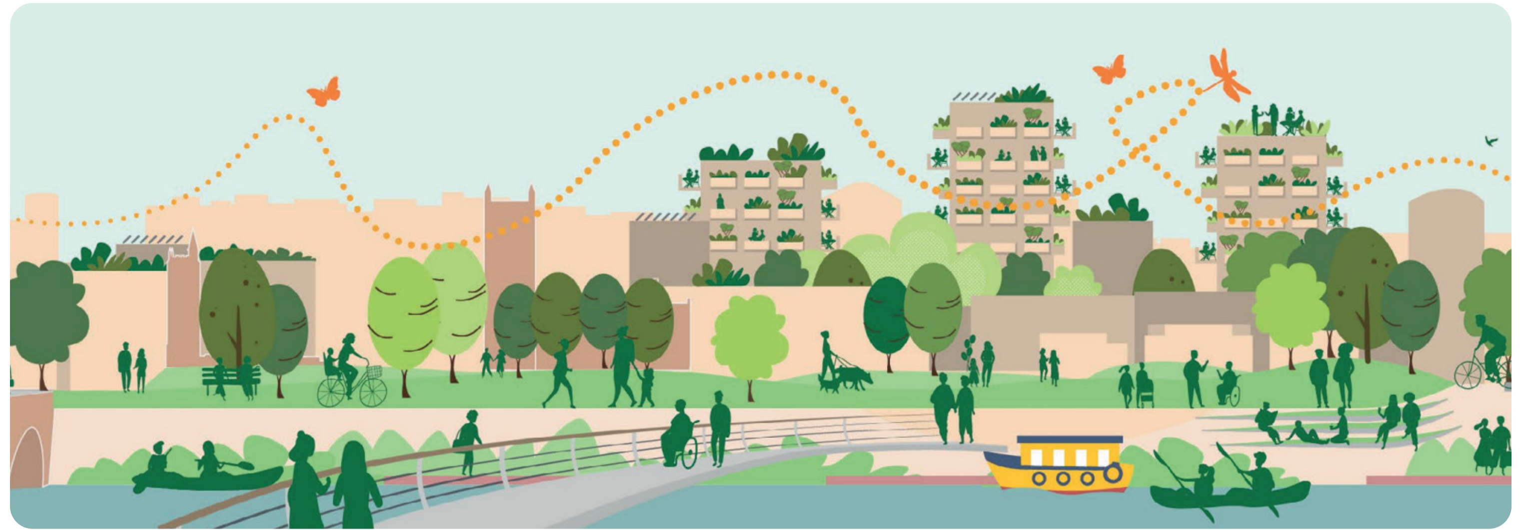
We spend a large proportion of our lives within buildings, from our homes to our workplaces, and their design can impact our health and how we connect with people.[33] Housing is a key determinant of health and wellbeing.

Where someone lives is more than just a roof over their heads. A healthy home is affordable, warm, safe and stable and is somewhere that helps connect people to their community, work and services.[34] A healthy home is integral for good health and making small improvements can have profound impacts. For example, improvements to residential lighting and interventions to reduce hazards in the home can lead to improved social outcomes and reduce fall-related injuries among older adults.[19]

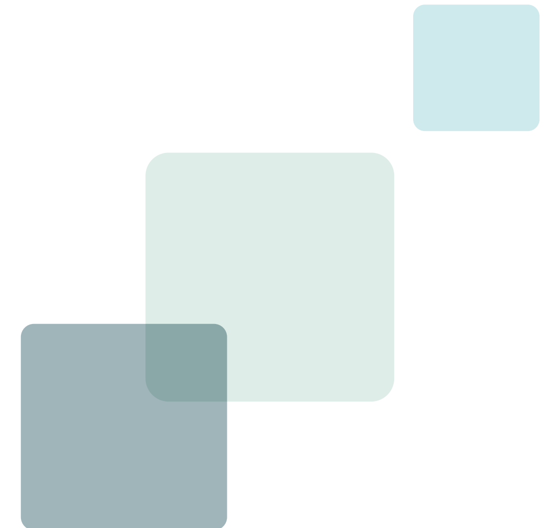
Good design of communal areas (such as shared entrances, utilities and facilities) can also facilitate community interaction and help build relationships by providing opportunities for people to mix and bump into each other.[36]

Ensuring that neighbourhoods include varied housing provision of different tenures and property sizes enables people to stay within the same neighbourhood as they age and their housing needs change, which helps maintain a sense of community.[33]

A positive contribution to communities of place are homes which meet the needs of older people and disabled people supporting independent living and enabling engagement in community life. In the future, there is an opportunity to ensure that homes are being built to M4(2) standard (accessible and adaptable dwellings) and that there is an adequate supply of homes which are M4(3) standard (wheelchair user housing). Some research suggests that, adopting a tenure blind approach – where the design of different tenures are indistinguishable from each other – can help prevent distinguishing between people from different tenures and avoid preconceptions about neighbours.[37]



Bristol City Centre Development and Delivery Plan.
Image: Grant Associates



The Power of Us: Fox Haven Nature Garden - Sally and Luke

"We started as a community, in the wasteland over the back of our flats, overgrown by brambles, removing all waste, bringing back the shrubs and plants. I used my skills to build fences, making the garden look nicer. We keep vegetable beds for children, enticing them into growing plants. Me and a neighbour wrote to the council asking if we could turn it into a nature garden and the Communities Team and Housing Officer supported us to get things happening."

"We went door-to-door discussing the field, to all surrounding households and they said, 'we want the field to be cleared and maintained so wildlife can use it and we can enjoy it'. The council, having seen the work done, granted us a new fence, prompting our group to plant trees and flowers beds. Now there are birds, hedgehogs and bats, and it brings the neighbours together. It's a sanctuary for us all."

Key message

Luke and Sally used their passion and skills to connect with neighbours, improving the place where they live. By building relationships with the local authority and sharing resources, they have created a sense of belonging for everyone.

The Power of Us: Pen Park Pickers – Adele and Alfie

"My son Alfie, now aged 11, created the idea of our litter picking group. He is a keen advocate for making the world a better place and was frustrated by the local area. Every time we took our dog for a walk, we would be taking pieces of litter out of her mouth. We asked Sustainable Southmead to come over to this area for a litter pick and they suggested we start our own group. So that is exactly what we did!"

"On the last Sunday of every month we have our litter pick. It has created a lovely community group and the area is visibly much cleaner and safer. Even on non-litter picking days, our team will report any areas of concern, do an extra pick even. But we also look out for each other, often having small get togethers involving tea and cake. Pen Park Pickers has had a positive effect on the local area and the health and wellbeing of the local residents."

Key message

Residents coming together to take action in their community has benefits for their own wellbeing as well as the wider community.

Chapter 4: Communities, Art, Culture and Wellbeing

In 2017, an All-Party Parliamentary Group on Arts, Health and Wellbeing (APPGAHW) undertook a major inquiry into the role of the arts and culture in health and wellbeing.

The inquiry yielded a substantial report – Creative Health: The Arts for Health and Wellbeing – providing evidence that creative and cultural activities can have a positive impact on people's health and wellbeing.[38]

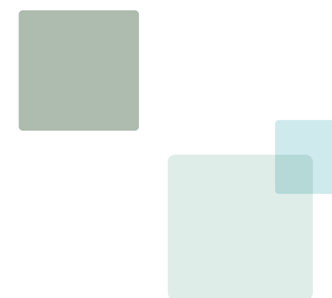
Arts engagement can improve mental health, help with the self-management of long-term health conditions, promote healthy ageing, tackle health inequalities and begin to address obesity. Around 9.4 million people in England participate in the arts through more than 49,000 amateur arts groups, with others engaging in informal creative activity in their homes and communities.[39] As the biggest public-sector investor in culture, spending over £1 billion per year, councils help to forge the partnerships necessary to realise the health and wellbeing benefits of the arts and culture.

Bristol is a city known for its creativity and innovation, which in the health and wellbeing sphere has resulted in a thriving network of community organisations and partners piloting innovative approaches to social prescribing through access to culture.

There has been an growing interest in approaches known as social prescribing, which is connects people to groups and activities in their community to improve health and wellbeing.

Thriving Communities Bristol brought together partners working in arts and culture, nature and physical activity and social prescribing. It was funded by the National Academy for Social Prescribing Thriving Communities fund, with match funding from Bristol Beacon, Age UK Bristol and Bristol's cultural and creative industries. Lead organisation, CreativeShift CIC, has 15 years' experience delivering creative wellbeing activities to adults experiencing isolation and mental health challenges across Bristol. Its model connects primary, secondary and community health through bespoke arts interventions delivered in the community, to support people to engage with wider community assets and services. Its work has been integrated into the local social prescribing framework since 2013.

Participants reported improvements in mood, attention and loneliness. They described feelings of increased social connection, self-efficacy, confidence, and moments of awe, beauty and escape. They valued the sense that activities took place in a safe space that was created and held by trusted specialist facilitators. Data from the project suggests that the workshops had a significant impact on momentary wellbeing, both mood and social bonding and especially on anxiety reduction (increased calmness and relaxation).



The Power of Us: Community Play

The community play was an activity for parents and caregivers of lockdown babies and young children affected by isolation during the pandemic. Participants were referred via link workers from a Children's Centre. Sessions took place weekly for two hours at Trinity Community Arts venue and encouraged creative play in natural surroundings between parents, carers and their children.

Participants across the projects described moving from feeling alone to feeling they belonged to something bigger. They talked about a developing sense of connection within the group and about feeling generally more socially connected. Caregivers in Community Play reported feeling closer to their children. Groups were felt as inclusive, safe and motivating spaces. Artist facilitators played a crucial role in creating and shaping these spaces; they set the tone, which was characterised by kindness, enthusiasm, collaboration and a lack of judgement.

The Power of Us: Sound of the Forest

Sound of the Forest is a programme for young people aged 8-11 experiencing mental health challenges who were referred by young people link workers from Southmead Development Trust. It was co-designed with link workers and young people, and co-delivered by Forest School and theatre practitioners in local woodland. Participants spent two hours each week after school exploring nature connectedness, forest school and creative activities such as poetry and sound recording. The theatre practitioner worked with the children to create an audio walk of the woods.

The first two chapters of this report set out how asset-based approaches can increase community cohesion and a sense of belonging which have positive impacts on individual and communities' wellbeing. Published reviews summarising the evidence for community-based interventions on mental health and wellbeing found many examples that address individual or social determinants of health.[38,39]

Thrive Bristol aims to improve mental health and wellbeing by focusing on how different parts of our city, such as our communities, our places of education and work and our homes, can keep us mentally healthy. The community programme supports local wellbeing projects to bring residents together through a wide range of activity that has included Men in Sheds, Friends of Parks groups, physical activity sessions and a community market.

Other examples include:

- **WECIL**, a disabled people's organisation, runs a befriending service that connects disabled adults with a volunteer befriender on the phone or online. Creating matches between people with shared interests gives people the opportunity to speak about things that matter to them, helping with feelings of isolation and low mood.
- **Dhek Bhal Elders** a group for South Asian elders helped bring people back together after lockdowns and learn IT skills to communicate more easily with friends and family elsewhere.

A current focus for Thrive Bristol is peer support, working in partnership with **Changes Bristol** to provide volunteer-led wellbeing groups in Welcoming Spaces that were set up in response to the cost-of-living crisis. Changes Bristol is a mental health charity formed by people with lived experience who came together to build a support network for those experiencing mental distress. Sessions provide a comfortable space for people to share how they are feeling and to discuss a mental wellbeing topic.

Mural in Stokes Croft produced for Changes Bristol. Photo credit: Jenna Steadman-Bailey, Remain Indoors Photography

The Power of Us: Bristol Umbrella Singers - Kate Staniforth

The Old Library on Muller Road wanted groups to start using its community space. Kate decided to see if she could start a choir, and Bristol Umbrella Singers (BUS) was formed.

"It's a fully inclusive choir that meets weekly, everyone is welcome, and we have so much fun together. We have built great relationships with local organisations and have performed at various events across the city, giving disabled people the opportunity to be seen and heard."

"Our highlight was performing at the Choir Festival at the Bristol Beacon. Parents and support workers joined in too. The choir provides a supportive and safe space for people to come together, make friends and build confidence. When we sing, we feel positive health benefits (better mood, reduced anxiety). Each term we learn new songs (members choose and suggest songs) and we learn them with harmonies, actions and Makaton signs."

Key message

Collaboration and sharing experiences are vital to creating stronger communities. BUS brings people together in an inclusive and safe setting for everyone to thrive. The group enables disabled peoples' voices to be heard, disabled people to be seen and encourages equal participation, providing a sense of belonging and inclusion.

Chapter 5: Communities, decision making and resource allocation

Enabling communities to mobilise, grow and own local resources is an approach supported by Local Trust, a funding organisation spearheading a proposal to establish a Community Wealth Fund using the funds within bank accounts which are dormant. We have some inspiring examples of this in Bristol.

Local Trust has invested in Bristol, supporting Ambition Lawrence Weston to undertake the feasibility and development of a wind turbine on Bristol City Council land. This is set to be the largest onshore turbine in England and is a formidable response to fuel poverty and sustainability with benefits for the local community.

Southmead Development Trust is working with the local residents group, Arnside and Glencoyne Square Regeneration Project and Bristol City Council on one of the biggest community-led housing schemes in the country with 187 flats and mixed use on the ground floor. This is an ambitious project which responds to the priorities in its Community Plan.

Another example is the community of Bedminster Down who purchased Zion Community Centre, by raising £230,000 through a community share offer. Right across Bristol we see the ingenuity of organisations, rooted in communities, to secure community assets and generate community wealth.

Participatory decision making is a key component in developing community resource allocation and in 2022, staff from several voluntary, community and social enterprise (VCSE) sector organisations took part in a participatory grant-making process for Thrive Bristol. Collective priorities were identified, and the grants programme was designed to address these.

Grants were subsequently awarded to increase accessibility of advice and wellbeing services, staff wellbeing and reflective practice.

From this work, a health and wellbeing consortium has been formed to sustain the relationships and learning between diverse organisations with a common purpose to address the complex impacts of poverty. The consortium is looking at new approaches, including how to measure impact. As a result, several organisations have felt empowered to only take funding from bodies they trust or that allow them to work in a way they find important.

"We are aligning with our purpose as an organisation and not just doing stuff because funders want that information. Really being quite strict: 'this is what we are here for and this is what we will measure." Lucie Martin-Jones - Head of Community Services, West of England Centre for Inclusive Living (WECIL)

A further example of community resource allocation through participatory decision making is Bristol City Council's Community Resilience Fund (CRF).

This fund was established in response to a report entitled 'Designing a new social reality' by Black South West Network[40] which assessed the impact of the Covid-19 pandemic on Bristol's community and voluntary sector and presented a framework for promoting greater community resilience. The fund builds on the Citizens' Assembly model and the Port Resilience Fund by involving over 100 citizens from diverse backgrounds, community groups and elected councillors, to decide together how to invest £4m in community buildings and infrastructure.

These inspiring examples show what is possible through community ownership and co-production. This is not easy or quick. All of these examples are the result of many years of community activity and leadership. But this provides a glimpse into what is possible when we support and sustain local community action.

The Power of Us: The Ardagh Community Trust (Horfield Common) - Sam

"The Ardagh was once a little-known space on Horfield Common. After ten years of work from a dedicated team of local residents, we secured a Community Asset Transfer (CAT) from the council and have repurposed the old toilets into a welcoming and inclusive café. There is a food growing project linked to the local holiday club, a choir, Tai Chi and a food bank. It's completely community led, and we now employ over 20 local people."

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Many people have been involved throughout this project and it would not have happened without a huge collective effort; local residents, our trustees, amazing volunteers, local councillors and the Parks Forum. It just wouldn't have happened without everyone working together."

Photo credit: www.theardagh.com and Sam Thomson

To read more of Sam's story and to find out about more community led action in Bristol's Parks, please visit the [Parks and Green Spaces](#) website.

Key message

Horfield Common is a Community Asset Transfer (CAT) from Bristol City Council parks department to The Ardagh Community Trust. CAT enables the local authority to "transfer land or buildings from the council's freehold ownership into the stewardship of third sector organisations."

The Power of Us: Building Equity in Adult Social Care commissioning – Sado, Chiara, and Paul

The **Make it Work programme** offers a real-life example of true co-production in practice. Black and Minoritised providers were offered a safe space to learn and share learning with the Adult Social Care commissioning and procurement teams. This collaboration resulted in tangible positive changes in the lives of everyone involved and the impact is already being felt by Black and Minoritised communities in the city.

The programme achieved a staggering £377,000 increase in economic benefit for the Black and Minoritised Adult Social Care Sector in Bristol. Most importantly, it opened strong lines of communication for genuine reflection and learning involving different people and sectors. A full learning and evaluation report can be read and downloaded from the Black South West Network [(BSWN)'s website](website).

The programme created the space for Bristol City Council to reflect upon how it works in partnership with black-led small and medium sized (SME) organisations and voluntary, community and social enterprise organisations in co-producing policy and strategy that ensures a more level playing field in terms of opportunities to provide services to the local authority in the future.

This work contains valuable learning not just for Bristol City Council, but also for its strategic partners across the Bristol, North Somerset and South Gloucestershire (BNSSG) Integrated Care Board (ICB), for how we strategically commission and co-produce diverse and relevant services within our local communities.

The provision of more culturally appropriate and diverse services is one of the key outputs that will develop from this work.

"The Make it Work programme has been very insightful and very informative. I have appreciated it. I think you are obviously propelling us, which is something we need in the community. I am very happy that I was this privileged. Thank you."

"It's been a wonderful programme. Having access to advice, commissioners, mentors. It is a very comforting environment."

"The beauty of Make It Work for me is that it was organic. It was about listening to organisations involved and finding out what they wanted. For me, its been a really positive experience. Genuinely, everybody involved has been positive."

Chapter 6: One City, Many Communities

As the wonderful stories in this report show, people all over Bristol are taking action to build the foundations for wellbeing and health.

Through the Covid-19 pandemic and cost-of-living pressures, individuals and communities have found new ways of working together and making an impact with everyone playing their part. As a result, Bristol becomes greater than the sum of its parts.

As we responded to the early days of the pandemic, individuals and communities stepped forward to look after one another. This was our greatest asset.

However, we know inequity undermines community connection making it harder to come together, organise and take action. We need to be purposeful about building community cohesion and resilience, ensuring everyone has a voice and can act on the things they care about.

The One City, Many Communities response to the cost-of-living crisis has shown again just what is possible when as a city we act with intent to remove barriers, to listen, collaborate and share leadership and resources.

One City, Many Communities

Together we are building something unique and powerful which we want to strengthen and accelerate. This is being called One City, Many Communities.

Partners have committed to taking what has been developed, keeping our focus on equity, social justice and wellbeing to:

- find sustainable ways forward, supporting people most impacted by low income, poverty and inequity
- continue to build community power and community wealth for the long term

We continue to live through challenging times.

We have committed to collaborate, share resources and align resources.

19 April 2023, One City, Many Communities event, City Hall, Bristol

Welcoming spaces and community response to cost of living event at City Hall, 19 April 2023

Over the winter of 2022 – 2023, 105 welcoming spaces led by communities for communities and launched by the Mayor, opened their doors all over Bristol. They were supported by city-wide organisations to improve access to advice, wellbeing, support and funding.

This surge of energy and action came from the tenacity and personal commitment of unsung heroes all over Bristol as well as the investment of money and time over decades to build community infrastructure. We cannot take this for granted. We need to put communities at the heart of what we do and invest in the things that grow the power of us.

We all have a role to play. Public sector organisations, business and developers are pivotal in creating the conditions for communities to thrive. The decisions we make about urban design, placemaking, housing, health and social care services, parks, waste, public amenities, and the economy all contribute to community life for good or ill. Aligning our collective assets and releasing the enormous potential requires commitment.

As the evidence sumarised in this report suggests, there are a number of essential conditions that need to be nurtured to support community resilience:

- the bringing together of different worlds of public sector, business, and communities (to build better understanding and trust)
- supporting communities to grow their own capacity in social action and leadership
- freeing communities to have greater control over resources and enabling civic participation
- a commitment to learning together what works.

The wonderful and inspiring stories throughout this report show just some of the 'Power of Us'. However, this cannot be taken for granted. The ability to respond quickly in a crisis and the ability to achieve things like local energy production and housing, all depend on a long term commitment to community building, community action and community leadership.

This is not the responsibility of the local authority alone, indeed, as austerity bites further, it can't be. Resilient communities are positive for the economy, for health and for the environment. Every sector and communities themselves have a role to play, and we are all beneficiaries.

Celebrating the work of Community Champions

Chapter 7: A call to action

Creating the conditions for health through community requires commitment from everyone; individuals, businesses, the NHS, the voluntary sector, the local authority and of course, communities themselves. Everyone can support the creation of One City, Many Communities by:

- Finding ways to promote, nurture and enable **local community action and leadership**
- Creating the conditions to support local **community owned infrastructure**
- Taking an **asset-based approach** to developing communities, by focusing on what's strong and not what's wrong
- Actively engaging in **networks** for community connection and knowledge exchange
- Investing in the development of trusting and **trusted relationships**
- Developing the conditions to support collaboration, co-production and **shared decision making**.

Further information

Ambition Lawrence Weston – Home - Ambition Lawrence Weston

Community Resilience Fund – Community Resilience Fund (bristol.gov.uk)

People Power – People Power Project - Can Do Bristol

Southmead Development Trust – Home - Geenway Centre

Thrive Bristol – Home - Thrive Bristol

Thriving Communities – Home -Thriving Communites

Welcoming Spaces – Welcoming Spaces (bristol.gov.uk)

Zion Community Centre – Home - Zion Bristol

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DRAFT Forward Plan as of December 2023

All 2:30-5pm at City Hall unless otherwise stated

Wednesday 24th January – development session

Joint workshop with Children and Young People's Board

- First 1001 Days
- Health of children in care and care leavers

Wednesday 28th February – public meeting

BNSSG Mental Health Strategy

BNSSG Joint Forward Plan

Wednesday 27th March – development session

Joint workshop with One City Board TBC