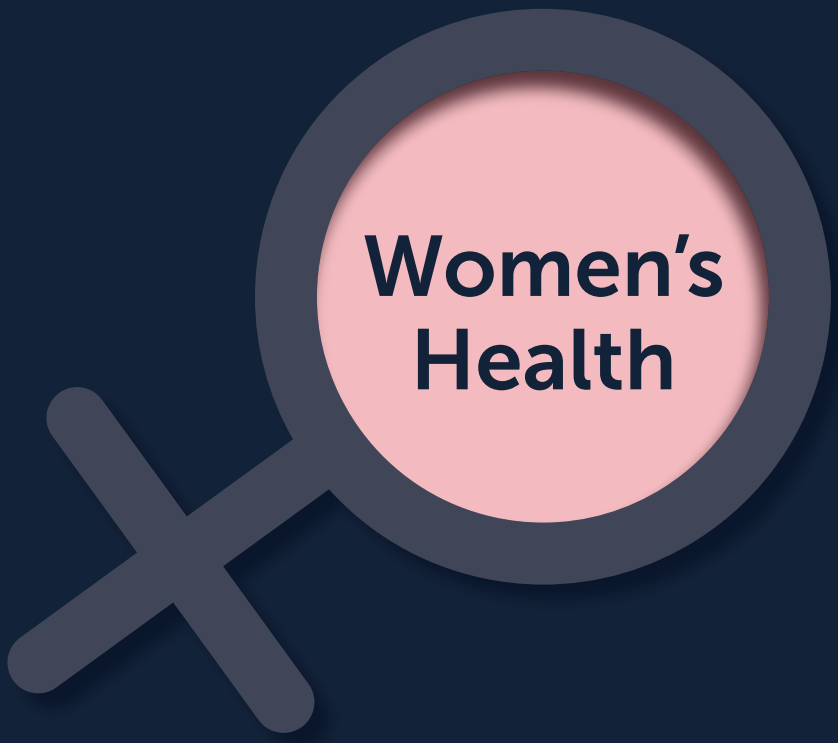
Nottinghamshire
County Council

Director of Public Health and Communities Annual Report

2024-2025



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Introduction

Welcome to my Annual Director of Public Health and Communities Report for the years 2024 and 2025. The production of an annual report is a statutory duty of the Director of Public Health and Communities. Its purpose is to raise awareness of local health issues, highlight areas of specific concern, and to make recommendations for change. Whilst I may refer to this as 'my' annual report, you can see that it has been a shared endeavour, shaped by the insights of women within Nottinghamshire and informed by the priorities they have identified. I am grateful to all residents who have invested their time in producing it. Thank you.

The reason for choosing Women's Health as the topic for my report this year was that although women in Nottinghamshire live longer than men on average, they are spending more years of their life in ill health and this is getting worse over time. This is a different trend to that seen in men. The Women's Health Strategy (published 2022) [1] highlighted a number of barriers for women's health, as not enough is known about conditions that only affect women (or affect women differently) due to women being under-represented in clinical trials. As the strategy highlights, the "male as default" approach has created inefficiencies in how our healthcare system views and treats women, where they may need to see multiple professionals before they reach the right place for care. Men may also experience health inequalities, and these will be addressed through other programmes of work.

Women's health will change throughout their life course, and they will need to consider many different health elements at different stages of their lives. Women on average menstruate for 40 years; this is met with challenges such as accessing gynaecological care, stigma and accessing contraception where wanted. Many women will also become mothers, and may have difficulties during this time, such as miscarriage. Most women will also experience the menopause, the symptoms of which can be significantly challenging and are a leading cause for why women may leave the workforce. Later in life, women are overrepresented in adult social care services, as they are frailer and have higher rates of hospital admissions for falls. We need to ensure that women have the right building blocks of health in place to reduce the number of years lived in ill health.

Importantly, women are not a homogenous group. Despite hearing from nearly 1000 women and girls during our time working on this report, this is by no means representative of every woman in our County. We know that some women, especially from marginalised groups, experience even more barriers than others to accessing healthcare and getting the right treatment when they need it, and this continues to be at the forefront of our priorities in Public Health to reduce these inequalities. Thank you for reading this report - I hope you find it as insightful and thought-provoking as I have.

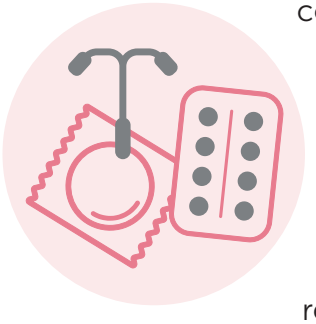
Vivienne Robbins
Director of Public Health and Communities
Nottinghamshire County Council

What's the Story - Why Women's Health?

In Nottinghamshire, there are over 430,000 women and girls, making up 51% of our total population. Although women in Nottinghamshire live longer than men, women spend more years in ill health or disability, with this amount of time increasing. Nottinghamshire has a higher proportion of females with a disability than England, across all age groups, with over half of all disabilities due to musculoskeletal conditions, mental health disorders and 'other' non-infectious diseases (including gynaecological disorders) [2].

51% of Nottinghamshire's population is female

We know there are still areas of work to improve our women's health. Health behaviours are a key example of this. Our work has highlighted that reducing tobacco use, reducing high blood pressure, and improving diet would have the greatest impact on early deaths for men and women [3]. While progress has been made in reducing smoking prevalence in women in Nottinghamshire, lowering smoking in pregnancy remains a key area for improvement [4].



Access to reliable contraception, which is a highly cost-effective intervention, continues to be a key priority. We need to ensure women and girls are able to access the method of their choice in a location and time convenient to them. Like national patterns, the abortion rate in our county is increasing. Further work is required to support women to prevent unplanned pregnancies, particularly for young women following a birth of a child.

Almost all women will experience menopause, and menopause symptoms can severely impact a woman's quality of life. Our research found that this remains a taboo subject, with work required to ensure men, women and health professionals are knowledgeable and empowered to support women's health conditions like this. Treatment for menopause, via HRT prescribing, has highlighted the disparities in women's health across the county. The headline figure of 11.6 per 100 females for our ICS masks significant geographical differences, with prescribing rates in Nottinghamshire ranging from 10.8 per 100 females in Ashfield South to 18.6 per 100 females in Rushcliffe [5]. Research has found that menopause increases vulnerability to depression and anxiety, likely due to oestrogen fluctuations [6].

Mental health conditions are prevalent amongst women in Nottinghamshire, with anxiety and depression the most common health condition cited in those aged under 50 years from our survey respondents. Mental health and wellbeing were mentioned in almost all interviews, making it one of the most frequently discussed topics. Many women did not feel empowered to reach out and ask for help, or when they did, they did not know where to access support. Access remains a key issue for all health services, however, our interviews highlighted that once women had navigated into the right place of the system, many had positive experiences and helpful interactions with healthcare professionals.

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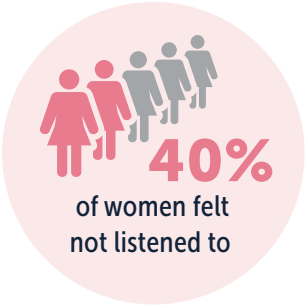


Our survey has highlighted that 2 in 5 women (40%) felt they were not listened to when they accessed health services, and many were having to "fight" for their voices to be heard. This was even more pronounced when accessing care for women's health conditions (e.g. gynaecological conditions (47%), gynaecological cancers (42%) and menstrual wellbeing (41%)). The proportion of women not feeling listened to decreased as age increased.

Over half of all respondents from our survey identified themselves as being a carer, with 7 in 10 (71%) feeling like this role impacted on their health and wellbeing. Of those who required support, a range of proposals were suggested, including flexibility at work, financial aid, respite care and liaison with peer support. Despite this, the vast majority (70%) of respondents to our survey felt supported by their employer and workplace colleagues to manage their health. The Census 2021 in England and Wales found that 59% of unpaid carers are female, with 1 in 4 carers reported "not good health", compared with 1 in 5 non-carers [7].

When examining the burden of early deaths for women, cancers and cardiovascular disease were the highest contributors [8]. Nottinghamshire performs significantly worse for early death from colorectal cancer across all genders, despite the high uptake of bowel cancer screening. Further investigation is needed to understand this difference, especially as the publicly available data does not show inequalities in screening uptake by gender and deprivation at local levels.

We recognise that women and girls from particular backgrounds, such as young people or women where English is not their first language, face additional barriers to accessing healthcare and have poorer health outcomes compared with women in general. Disparities are also prevalent due to economic and geographical differences. This supports the need for a renewed focus to tackling the building blocks of health across a whole society level in all health agendas, to ensure women have a healthcare system that serves us all.

This work is a helpful starting point in considering the women's health in more detail, and has allowed us to examine the wider historical, social and environmental impacts on women's health. There are limitations with what has been presented, as many datasets have not been possible to examine by sex at local levels or explore the disparities that exist within our county by socio-economic status, age or ethnicity, to name a few examples. There is also limited data on specific subject areas related to women's health, such as menopause. Ensuring additional data is available will allow a more thorough understanding of our female population in Nottinghamshire, and the disparities that still exist.

Methodology and Limitations

This report undertook a series of processes to collate both qualitative and quantitative data to build a picture as to what is causing women in Nottinghamshire to live longer in ill health.

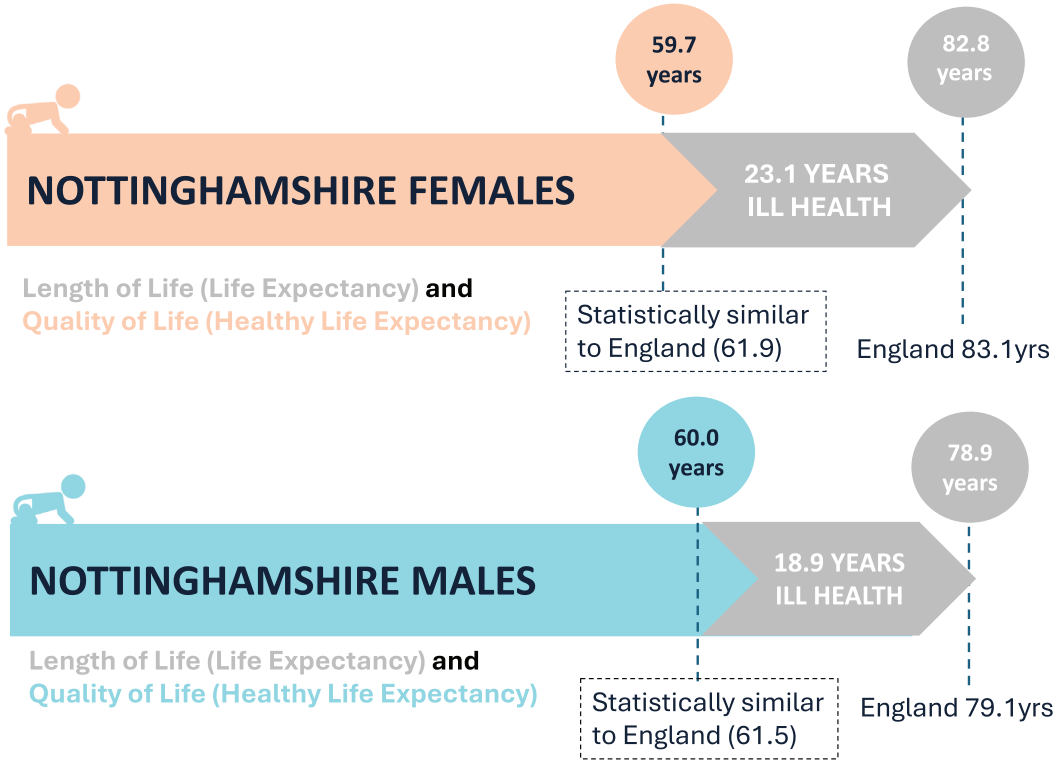
Step	Description
Women's Health Survey	A survey ran for 8 weeks between October to December 2024 to seek views on Women's Health from Nottinghamshire County Council residents, open to those aged 16+. This received 967 responses.
Interviews	Participants for semi-structured interviews were sought from vulnerable groups and groups that were underrepresented in the Women's Health Survey responses. A total number of 9 interviews were completed with 10 participants in the months of January and February 2025. A £25 voucher incentive was offered in exchange for participation.
Quantitative Data Analysis	Available data was examined to understand Women's Health in more detail. However, there are limitations in the data, as often it is not possible to disaggregate data by sex, gender or geography. This can make the local understanding unclear.

This work has a series of limitations that must be acknowledged. This work is not intended to be a large-scale piece of research, nor replace or replicate the work completed by academic institutions on this matter. Limitations encountered were:

- **Quantitative Data Availability:** Many datasets that include a breakdown by sex are often only available at national and regional level, making the local picture unclear. There are limited public data related to specific topics e.g. menstrual and reproductive health, building blocks of health which limit the extent to which the data can be considered.
- **Participation in Qualitative Research:** By virtue of the design of the survey and the recruitment of participants for the qualitative interviews, there was a self-selection bias in the participants, who are likely to want to talk more about women's health and to promote its importance. Whilst there were more women and girls who wanted to be heard (both those who missed the opening window for the survey and the requests for interviews were oversubscribed), it must be considered that not all women, nor all communities of women within Nottinghamshire, have been heard through the work.
- **Women's Health Survey and Interviews:** The interviews could not be double coded due to staffing capacity. Furthermore, to establish key themes from some of the survey questions, answers were randomised to review the data until saturation was reached.

Overall Themes Considered in this Report

Nottinghamshire Healthy Life Expectancy from 2021-23



Years in ill health have increased for both females (previously 21 years in ill health) and males (previously 16 years in ill health) since the previous data point was published.

Figure 1 Healthy Life Expectancy in Nottinghamshire 2021-2023. Source: Public Health Outcomes Framework, 2025

Factors Contributing to Life Expectancy Gap

The below charts show the factors that contribute to the life expectancy gap between the most and least deprived populations in Nottinghamshire in females and males. Data is only available for 2014-16, 2017-19 and 2020-21, but 2020-21 has not been presented due to skewed data from the Covid-19 pandemic.

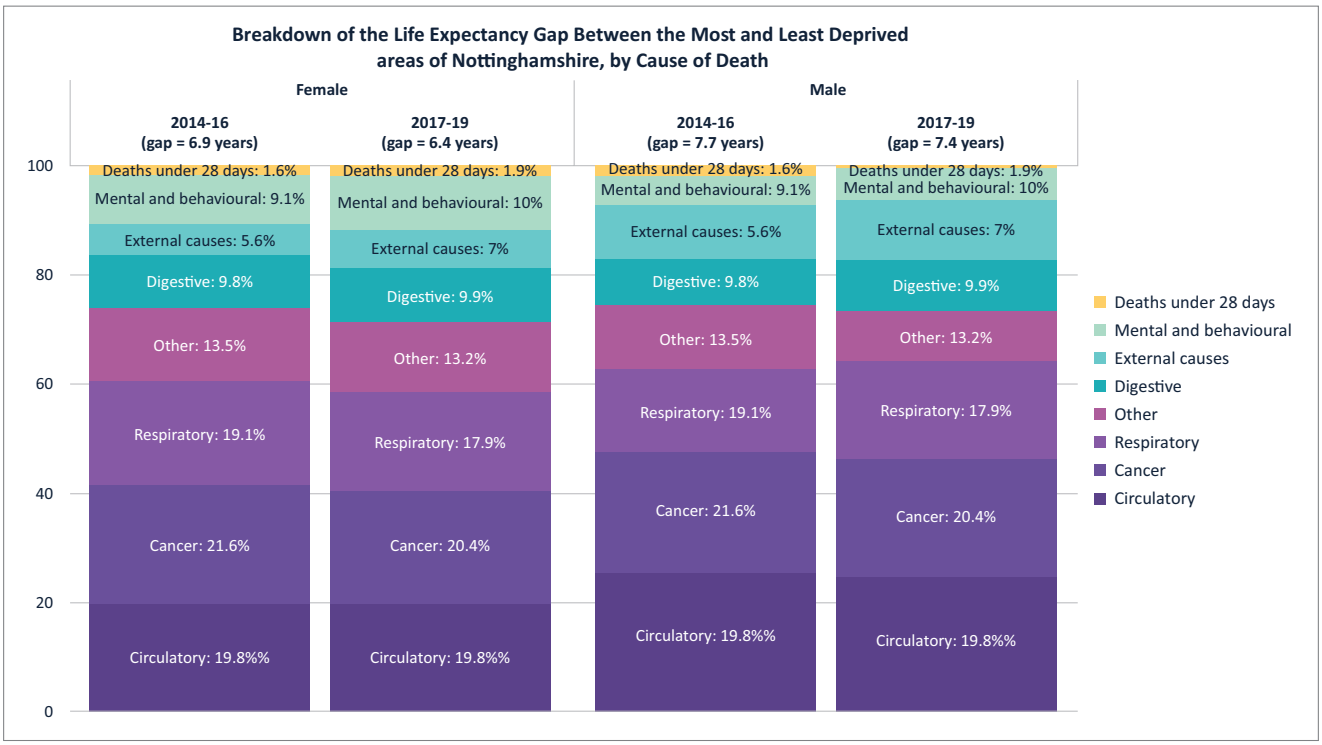


Figure 2 Breakdown of the life expectancy gap between the most and least deprived areas of Nottinghamshire, by cause of death. Source: Data from Segment tool, Office for Health Improvement and Disparities, 2025.

From 2017-2019:

- Females in the most deprived parts of Nottinghamshire could expect to live 6.4 years less than their peers in the least deprived areas.
- Higher death rates in the more deprived areas due to cancer and circulatory conditions accounted for almost half (46%) of this gap, with a further 18% of the gap attributable to respiratory (lung) disease [9].

Disability (Defined by the Equality Act 2010)

Disabled under the Equality Act 2010 refers to residents who assessed their day-to-day activities as limited by long-term physical or mental health conditions or illnesses.

This chart shows the proportion of females and males who were disabled (as defined by the Equality Act 2010) in Nottinghamshire, in the Census 2021.

- Nottinghamshire recorded a higher proportion of females with a disability than England across all age groups.
- NOMIS data, as displayed below shows a higher proportion of Nottinghamshire females (20.4%) recorded a disability than males (17.8%).

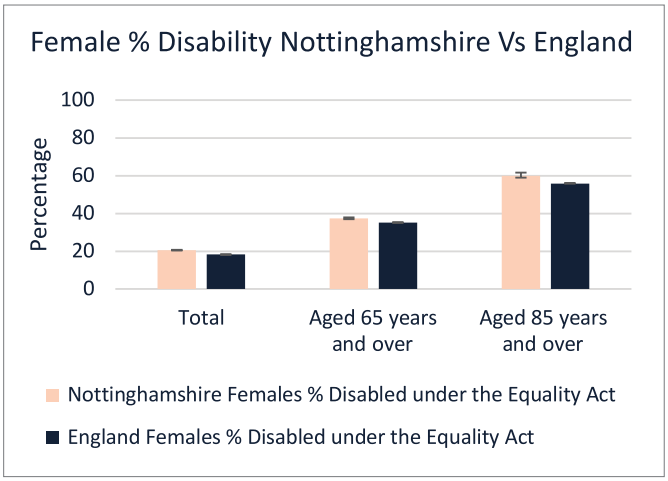


Figure 3 Percentage of females considered disabled under the Equality Act 2010 in Nottinghamshire and in England. Source: NOMIS, 2025.

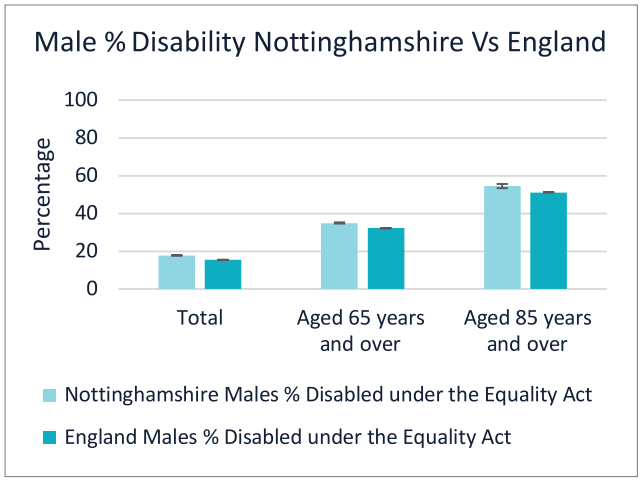


Figure 4 Percentage of males considered disabled under the Equality Act 2010 in Nottinghamshire and in England. Source: NOMIS, 2025.

Data from the Global Burden of Disease Study (2021) shows three groups of conditions account for almost 50% of the years lived with disability for women:

- Musculoskeletal conditions (mainly back and other joint pain)
- Mental disorders (mainly anxiety, depression and other common mental illnesses)
- 'Other' non-infectious diseases – of which gynaecological disorders form over 50%. This means that, for women in Nottinghamshire, there is a greater loss of quality of life due to gynaecological issues than for accidental injuries, chronic chest disease, cardiovascular disease or cancer.

Apart from the top two conditions, the ranking of these conditions are very different for females and males. This suggests that preventative and treatment approaches are adapted for genders. Diabetes, kidney disease and substance use disorders are the only conditions for which women have fewer years lived with a disability than males.

Cancers and cardiovascular disease were the highest contributors to the burden related to early deaths for both men and women. Apart from neurological disorders (including dementia), women have fewer years of life lost for all other conditions.

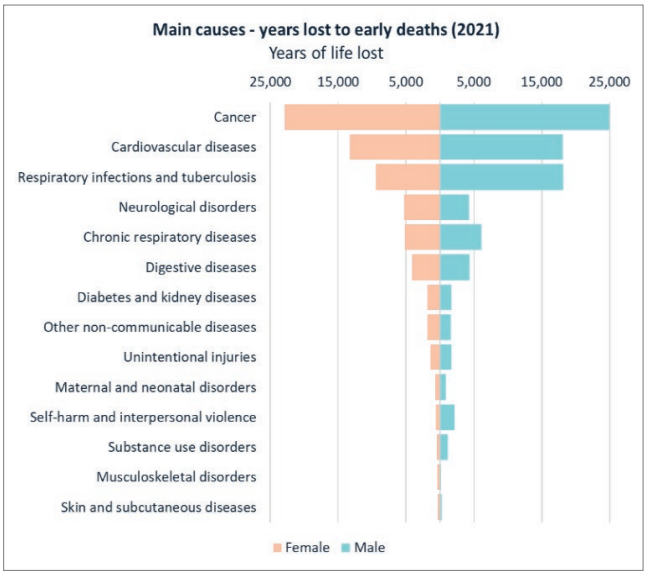


Figure 6 Years lost to early deaths in Nottinghamshire (2021) - Main causes. Source: Global Burden of Disease Study 2021. Accessed 2025.

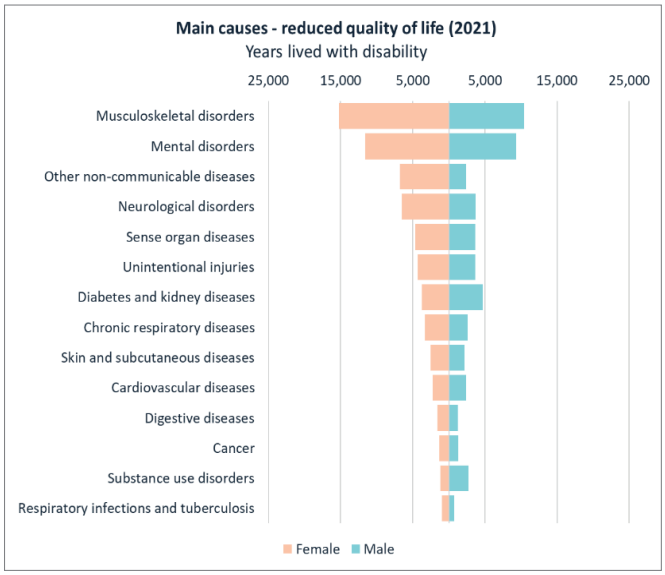


Figure 5 Years lost to reduced quality of life in Nottinghamshire (2021) - Main causes. Source: Global Burden of Disease Study 2021. Accessed 2025.

General Health of Women in Nottinghamshire

Of those who answered our survey, 3 in 5 women (60%) felt their health was good or very good. Bad or very bad accounted for 8% of all respondents who answered the question.

When asked about specific aspects of their health, the majority of respondents had:

- No problems walking about (67%)
- No problems washing or dressing myself (89%)
- No problems with performing my usual activities (61%)
- Have some pain and discomfort (56%)
- Am a bit worried, sad or unhappy (55%)

Respondents were asked to share if they had any health conditions. When examined by age, the most prevalent self-declared health condition/s were:

- Anxiety, depression and autism in the youngest age band (16-29 years)
- Anxiety, depression and perimenopause in 30-49 years
- Menopause, followed by anxiety and arthritis in 50-64 years
- Arthritis, high blood pressure and pain in the oldest age band (64+ years)

Age 16-29 years

Age 30-49 years

Age 50-64 years

Age 64+ years

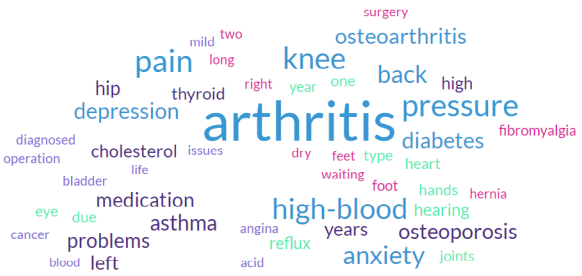


Figure 7 Word cloud analysing the frequency of conditions in Women's Health Survey respondents by age group. Source: Nottinghamshire County Councils Women's Health Survey 2024.

Women's Health Across the Life Course

Analysis of local primary care data shows that sex and deprivation are important factors in the prevalence of long-term conditions. This chart shows on average women in the most deprived areas in Nottinghamshire have their first long-term condition 15 years before their peers in the least deprived areas. This 'health gap' is 8 years for men.

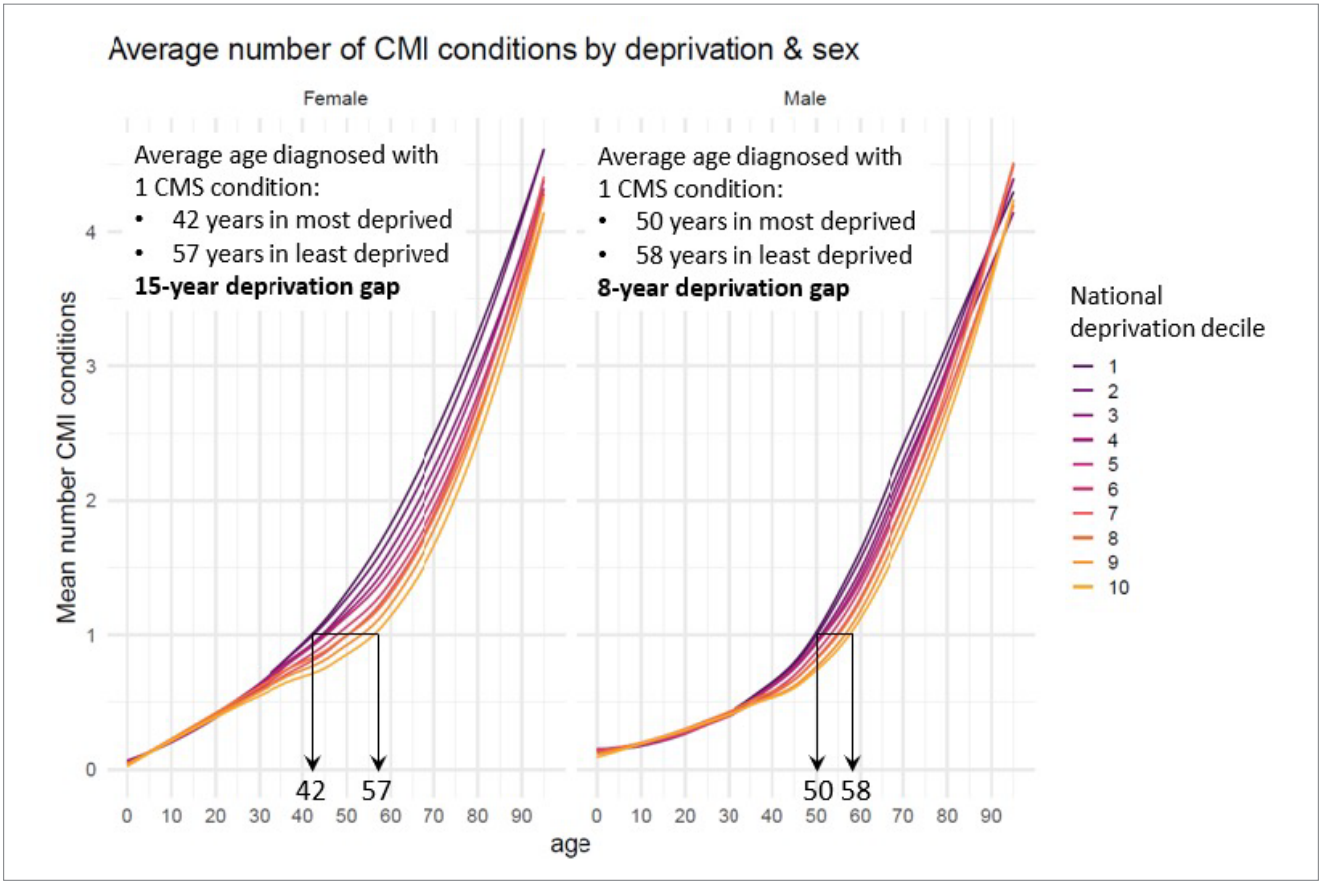
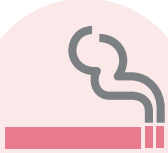


Figure 8 Average number of Long-Term conditions by deprivation in Nottinghamshire. Source: Cambridge Morbidity Index. Accessed 2024.

The evidence suggests that the long-term conditions with the greatest effect on disability-free life expectancy are strongly associated with unhealthy behaviours [10]. This reinforces the message that investing in interventions to reduce known risk factors such as smoking, physical inactivity and obesity in younger adults might be critical in preventing, delaying, or significantly reducing disability and allowing individuals to live independently with minimal or mild disability in older age.



Prevention and Treatment

These charts show the main changeable risk factors associated with reduced quality of life (years lived with a disability) and early deaths (years of life lost). This is based on the best global evidence available in 2021.

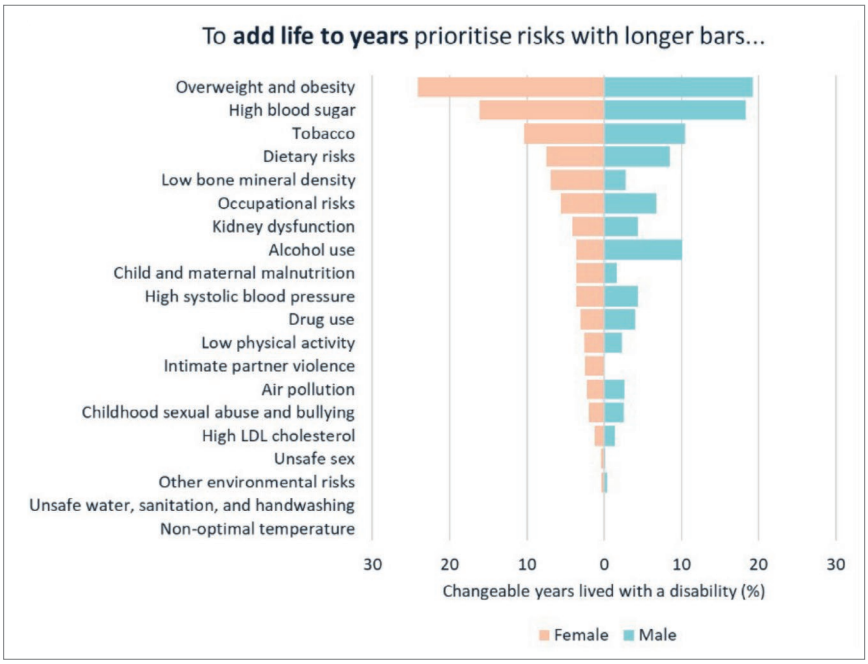


Figure 9 Changeable years lived with a disability in Nottinghamshire. Source: Global Burden of Disease (2021). Accessed 2025.

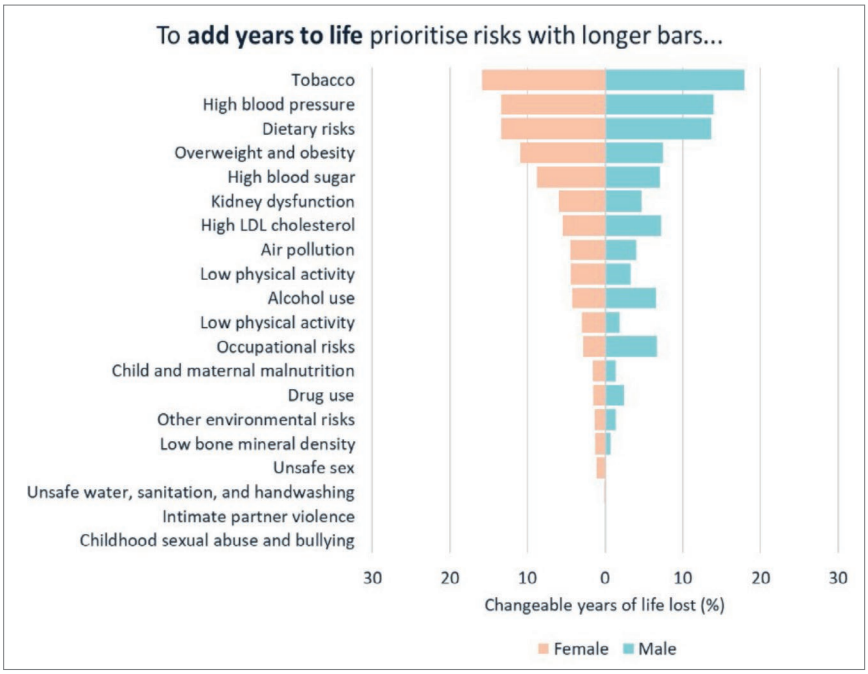


Figure 10 What can be done to add years to life in Nottinghamshire? Source: Global Burden of Disease (2021).

Overweight and obesity is the highest changeable risk factor for quality of life for females and males. The following risk factors have a higher impact on women compared to men for years lived with a disability:

- Low bone mineral density
- Maternal and child malnutrition
- Intimate partner violence

Changing tobacco use, high blood pressure and poor diet would have the highest impact on early deaths for men and women. The following risk factors have a higher impact on women compared to men for years of life lost:

- Overweight / obesity
- High blood sugar
- Kidney dysfunction

Improvements to Health

Nationally published data has shown that smoking prevalence is declining for men and women in Nottinghamshire. However, unlike the national pattern, smoking is more prevalent among women (10.2%) than men (9.7%) in our county (although not significantly different) [11]. Emergency hospital admissions for Chronic Obstructive Pulmonary Disease (COPD) are higher in women than males - a pattern which is observed nationally [11].

The smoking at time of delivery indicator [12] (a measure used to understand the proportion of women smoking throughout their pregnancy) continues to perform significantly worse in Nottinghamshire compared to the national average. The latest percentage of 11.8% ranks 9th highest out of all Local Authorities in England. The trend in Nottinghamshire has shown no significant change over the last five years, unlike nationally, which has significantly improved.

No data is available locally to examine obesity rates or engagement in physical activity by gender.

The most important factors that respondents to our survey stated would improve women's health and wellbeing were:

- Being more physically active
- More time with family and friends, including achieving a better work-life balance
- Eating a healthier, more balanced diet.

Our survey also asked women where they sourced information to support their health. Information to support health was sourced primarily by our women from research articles for the majority of the survey respondents (45%). The second most common source was social media followed by online "resources". Reliance on NHS resources, including 111, was ranked the lowest source of information for all respondents.

Conceptions, Births, Abortion and Teenage Parents

Nottinghamshire recorded 7,739 live births in 2023 [13]. Many women will experience challenges with their health during pregnancy, as well as potentially challenges with fertility and/or miscarriage. As the Women's Health Strategy 2022 states, miscarriage remains a taboo subject; notably there are no local datasets available regarding miscarriage.

Nationally published data has shown that in Nottinghamshire the abortion rate is increasing, for women of all ages and those aged over 25 years [14]. The percentage of abortions in women aged under 25 years who had a previous abortion is also increasing. This is in line with national trends.

The rate of under 25s abortion after a birth in Nottinghamshire has continued to be significantly higher than national average, with the latest data sitting at 30.4% [14]. Further investigation is required to increase the awareness of post-partum contraception need at the local level.

The under 18 conception rate has remained similar to the England rate for the last 12 years. However, the most recent data for Nottinghamshire shows the county has a significantly lower proportion of under 18 conceptions leading to abortion (42.8%) and a significantly higher proportion of teenage mothers (1.1%), compared to England [14].

Other information regarding pregnancy and maternity outcomes can be found in the updated Nottinghamshire Best Start Joint Strategic Needs Assessment (JSNA) and Best Start Strategy (2025).

Cancer and Cancer Screening

Nationally published data has shown that in Nottinghamshire the premature cancer mortality rate has been declining and is lower for women than men. However, for the latest three data points (2019-21 to 2021-23), women have performed significantly worse than national average whereas males have shown no significant difference for two out of three years.

When examining colorectal cancer, the premature mortality rate for males, continues to be higher than females, at local and national level [15]. Across all genders, Nottinghamshire performs significantly worse for premature mortality for colorectal cancer in 2021-23 [16]. Despite this, the uptake of bowel cancer screening in Nottinghamshire continues to increase and perform significantly better than national rates [17]. Further investigation is needed to understand the difference in screening and premature mortality performance. The publicly available data does not show inequalities in screening uptake by gender and deprivation at local authority level.

Cervical cancer screening coverage is decreasing in Nottinghamshire and nationally, but Nottinghamshire continues to perform significantly better than England overall [18]. Breast cancer screening coverage in Nottinghamshire also continues to perform significantly better than nationally [19].

Hip Fractures and Falls

Falls are a major area of concern, as they are an important cause of morbidity and mortality. At a national and local level, figures show that women have a higher rate of hip fractures than men, as well as a higher rate of admissions from falls. Despite this, research shows fall-related mortality is higher among older men [11].

Women in Nottinghamshire aged 80 years and above are nearly five times more likely to be admitted to hospital for a fall compared to those aged 65 – 79 years. When examining admissions due to hip fractures, the proportion rises to over six times more likely between these two age bands [11].

It is important to understand the health conditions that impact women later in life and the modifiable risk factors that can influence women's ageing. Many falls are preventable by removing home hazards, addressing deterioration in muscle strength, balance, and vision, and being alert to medication issues. Furthermore, the Prevention and Equity in Adult Social Care JSNA (2024) [20] highlighted that most older people with mild or moderate frailty are not known to services, which prevents help at an earlier stage.

Mental Health

Nationally published data shows us that women in Nottinghamshire have higher rates of hospital admissions for intentional self-harm, but lower rates of suicide than men [11]. However, research highlights that women are more likely to attempt suicide than men leading to a "gender paradox" [21].

Our survey highlighted that mental health conditions are prevalent amongst women in Nottinghamshire, with anxiety and depression the most common health condition cited in those aged under 50 years. Mental health and wellbeing were discussed in eight out of the nine interviews, making it one of the most frequently discussed topics. Our respondents stated their causes of poor mental wellbeing were childhood trauma, domestic and caring responsibilities, bereavement, international migration and physical health issues.

Specifically, women told us:

- They did not know where to access mental health support or found it hard to access due to long waiting times. Others stated they utilised private healthcare, which was the only way for them to be seen quickly.
- They did not feel empowered to reach out and ask for help.
- Those being supported by mental health services within Nottinghamshire spoke very highly of the support they had received and the benefits of the services.

Perinatal mental health is of significant concern, but this work is being examined under the Best Start JSNA and Strategy, which are being updated in 2025.

Building Blocks of Health

A thriving community requires all the right building blocks of health to be in place: stable jobs, good pay, quality housing, friends, family and community and good education.

Many of our women in Nottinghamshire are missing key building blocks and we must consider how to fix these gaps. Across Nottinghamshire, women are more likely to have no qualifications than men, which is also the case nationally. Both men and women in Nottinghamshire are significantly more likely to have no qualifications than the national average, however, in Nottinghamshire there is a greater difference in the gap between men and women than nationally.

Women in Nottinghamshire are conversely more likely to have Level 4 qualifications than their male counterparts (female 25.4%, male 23.8%), but Nottinghamshire sits significantly below the national average for this.

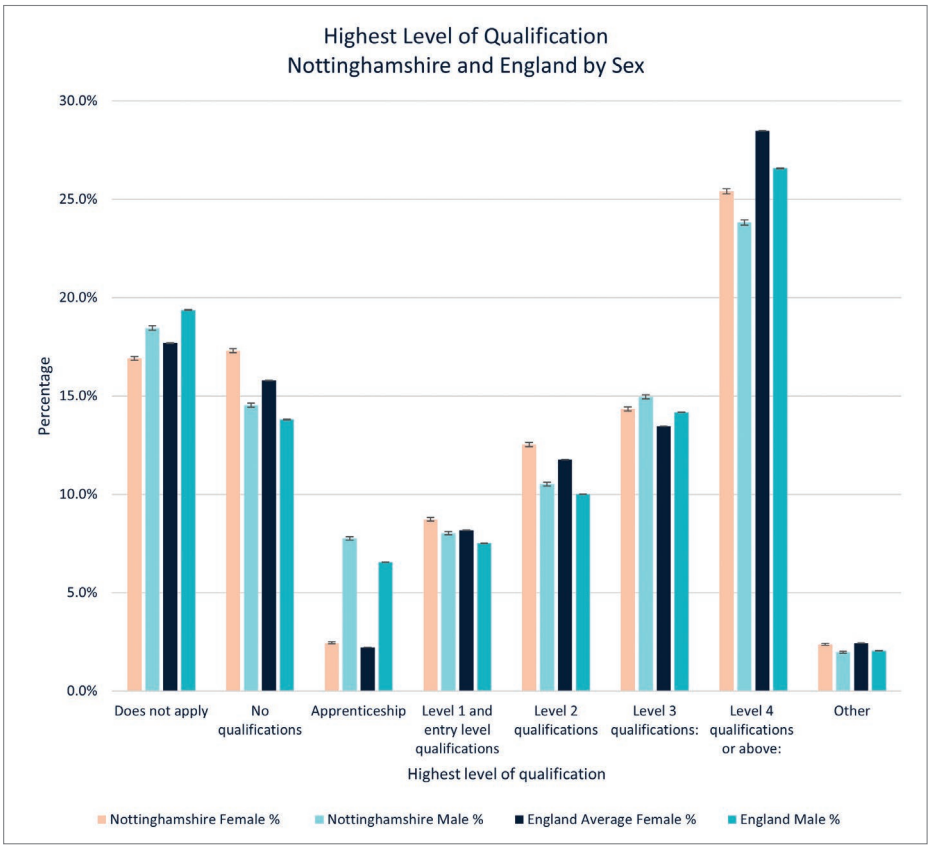


Figure 11 Highest Level of Qualification in Nottinghamshire and England by Sex. Source: ONS Census 2021 data.

Lower levels of qualifications have a strong correlation with lower earning potential, which can impact on financial stability and health outcomes. Financial stability was stated as another important factor to support health in our survey responses. The cost of eating healthy food was a concern in the current cost of living climate, and that there were not always convenient healthy alternatives on the high street.

The environment was considered important by participants, as for many being able to access green spaces boosted their mental health and was an opportunity to connect with the community. There was concern around green spaces being built upon or being too close to roads. Women also wanted to be safe when they exercised outdoors, which was sometimes a building block that was missing.

Employment was a common building block of health concerning women, with many women talking about the need to balance work with caring responsibilities and for their own health needs. The need to work for financial stability was a common theme, but some had reduced work due to long term health conditions and/or the menopause. Women in Nottinghamshire have higher rates of economic inactivity than men, and the gap between the two sexes is increasing. There has also been an increase in economic inactivity due to long term sickness for females in Ashfield, Mansfield and Newark and Sherwood. This is explored in further detail in our Work and Health JSNA (2024) [22]. Many survey respondents did speak positively of how their employers supported their health. Some women however felt their employers could improve their employees' wellbeing by ensuring the workplace is comfortable with proper seating, lighting and equipment, fostering a culture of openness to discuss mental health, and offering healthy food options at work.

Community was an important part of life for most survey respondents. Interview participants talked about female friendships, and in particular female friends and family supporting each other with health and wellbeing and navigating health and care systems together. Others talked about the benefits of the voluntary, community and social enterprise sector for supporting them with their health and wellbeing outside of statutory services, including volunteering as a source of good wellbeing.

Data disaggregated by sex was often not available for many of the building blocks, and this should be something to be considered by partners across the health and care system for the future.

Caring Responsibilities

Nationally, around 9% of the population are providing unpaid care to other adults [23].

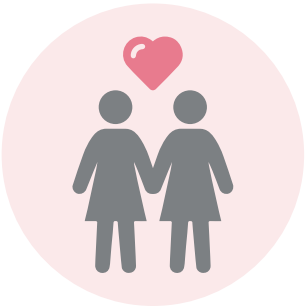
The Census 2021 data shows that in Nottinghamshire 59% of carers are female and 41% are male [24]. This is similar to national proportions of carers.

Almost half (47%) of all women who answered the survey had no caring responsibilities. Nearly 1 in 4 (23%) were the primary carer for a child or children under the age of 18, and 1 in 10 were the primary carer for an older person or a secondary carer.

Of those who have caring responsibilities, 7 in 10 (71%) felt this impacted on their health and wellbeing. Our interviews highlighted the difficulties women faced of balancing their own health needs alongside caring responsibilities, either for dependent children, or other adult family members who require additional support. Women talked about how they weren't able to prioritise their own needs: "I slip to the bottom of the pile, until a wakeup call makes me re-evaluate". Single parents were also highlighted to have additional demands.

However, 61% of respondents in the survey stated there is no further support they need to manage their health and wellbeing alongside their caring responsibilities. Of those who required support, a range of proposals were suggested, which centred around:

- Practical support to the carer including time flexibility at work, financial aid and liaison with peer support e.g. carer support group
- Respite care
- Better education and knowledge of mental health conditions
- Improved access to healthcare and affordable childcare.



Marginalised Groups

Our survey highlighted that women from particular population groups, such as young people and those for whom English is not their first language, face additional barriers in navigating the health system and accessing healthcare.

Barriers to resources not being available in other languages, complex paperwork, and challenges navigating the system were all listed as areas for improvement in how to improve the experiences of these women. Often the Voluntary, Community and Social Enterprise (VSCE) sector stepped in to support where statutory services were too confusing.

LGBTQ+ women are also highly likely to experience health inequalities. Due to the lack of information available locally this report does not examine this in detail, but further insight is recommended to support this population group.

Women experiencing Severe Multiple Disadvantage (SMD) can also experience significant health inequalities, as they often make up a smaller proportion of the population than men, but their needs can be masked by national datasets. For example, national datasets significantly underestimate the number of rough sleeping women there are due to the pattern of rough sleeping being different to that of men. For more information about SMD please see our 2023 Director of Public Health Report.

Violence Against Women and Girls (VAWG)

In Nottinghamshire, as in many other places, women and girls in our communities continue to experience high levels of violence and abuse. In Nottinghamshire, they make up the majority of victims in the following crime categories:

- 90% of rape victims were female
- 84% of sexual assault victims were female [25]
- There is an increasing trend of domestic violence and abuse cases [25], with 76% of identified domestic violence victims recorded by Nottinghamshire police to be female.

These figures are likely underreported and therefore an underestimation of the scale of the issue, due to the hidden nature of VAWG offences [26]. It is estimated that 1 in 3 women and 1 in 5 men will be a victim of domestic abuse in their lifetime [27].

Of those individuals who we interviewed, a third of participants disclosed that they were survivors of violence against women and girls. Participants shared their fear of disclosing abuse or violence against them, feeling like domestic violence doesn't happen to "women like them", highlighting the stigmas and stereotypes attached to VAWG. There was also significant guilt for not leaving the abusive relationship sooner; this is consistent with evidence within Nottinghamshire that, on average women experience up to 30 incidents of domestic abuse before they become known to the police [26].

There were mixed experiences of support services for VAWG. One interviewee had raised concerns that "nothing has been done" and not knowing how to reach out for additional support regarding sexual assault. On the other hand, other participants had more positive experiences interacting with local support services which helped to address shame, stereotypes, and stigma.

Women's Health Conditions

There are a number of health conditions that only affect women.

Endometriosis is a disease in which tissue similar to the lining of the uterus grows outside the uterus [28]. It can cause severe pain in the pelvis and make it harder to get pregnant. Research by the ONS estimated that 4,285 women living in Nottinghamshire received a diagnosis of endometriosis in hospital between 27/3/2011 and 31/12/2021 [29]. The age-adjusted diagnosis rate was 11.4% higher in Nottinghamshire than England. No further local data is available on this condition, which should be noted as a gap in data and intelligence. Data on other gynaecological conditions, such as menorrhagia and adenomyosis are not locally available.

Our survey highlighted that menopause was the most prevalent cited health condition from respondents aged 50-64 years. Our interviews highlighted:

- Participants spoke about the benefits of women being open about their experiences to increase knowledge and reduce any associated stigma.
- Women felt they needed to be better informed about symptoms and support available.
- Increased awareness of the menopause is needed for the entire population, not just women.
- The menopause was seen as a "taboo" subject in the workplace.
- The impact of not being wholly supported through the menopause led women to give up work /reduce working hours.

To better identify those taking Hormone Replacement Therapy (HRT) to treat symptoms of the menopause, the below data focuses on patients identified in NHS Prescriptions data who are women aged 40 years and over and received HRT (Oestrogen).

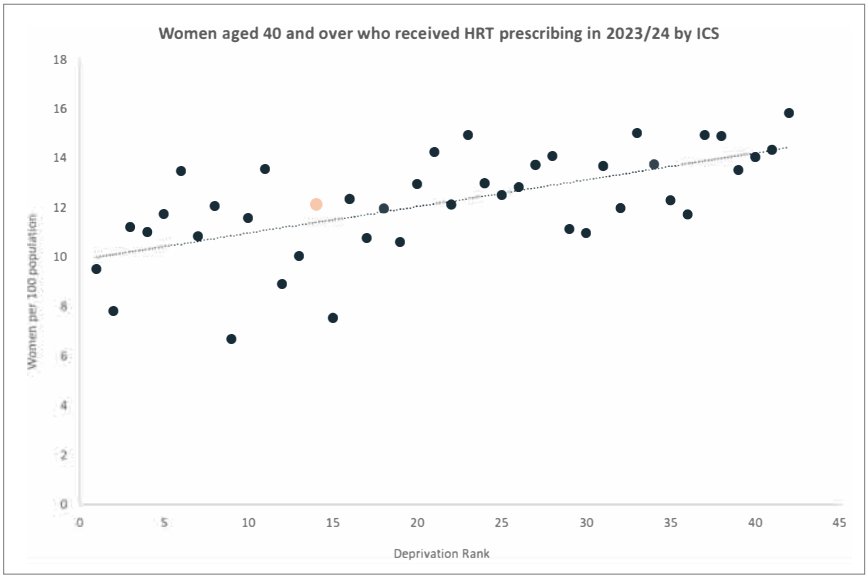


Figure 12 Women aged 40 or over who received HRT prescribing in 23/24 by Integrated Care System. Source: NHS Business Service Authority, 2024.

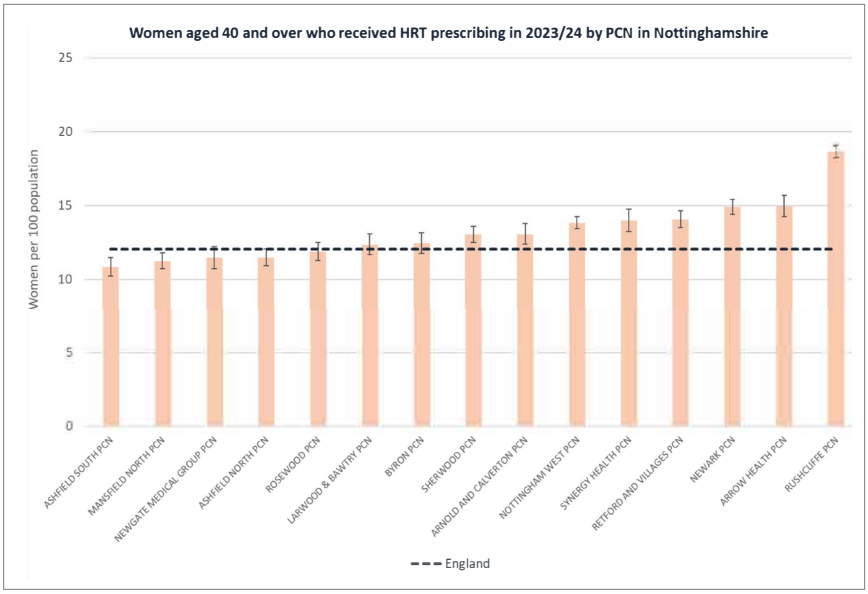


Figure 13 The rate of HRT prescribing by PCN in Nottinghamshire 23/24. Source: NHS Business Services Authority, 2024.

Nationally, there is evidence that there are inequalities in HRT prescribing [5], for ethnic minority groups and women from low socioeconomic backgrounds. Being able to better understand patterns of HRT prescribing will allow for targeted interventions to be implemented to address the evidenced inequalities for groups of marginalised women.

The rate of HRT prescribing for the Nottingham and Nottinghamshire ICS is 11.6 per 100 females aged 40 and over, which is significantly lower than the national average (12.0 per 100 females aged 40 and over) in 2023/24 [5]. There is significant variation in the rate of prescribing between PCNs in Nottinghamshire. The rate is highest in Rushcliffe PCN (18.6 per 100 females) and lowest in Ashfield South PCN (10.8 per 100 females). Further local interpretation and analysis of the data is required to better understand the reasons behind the inequalities in HRT prescribing.

Access to Services

Over 3 in 5 women (62%) of women who answered our survey felt fairly or very satisfied with the health services they accessed. Very dissatisfied accounted for just 4% of all respondents who answered the question.

Of those who answered the survey question, 2 in 5 women (43%) experienced barriers in accessing services.

General barriers experienced included:

- Lack of GP appointments and the process to be seen (e.g. on the day only)
- Length of waiting times
- Limited appointments outside of traditional working hours and the lack of availability of childcare and/or coverage for caring responsibilities
- A strong preference to be seen by a female clinician.

Based on the semi-structured interviews, women described once they had navigated into the right place of the system (i.e. referred onto the right service or once they had overcome the barriers to be seen), they had positive experiences and helpful interactions with healthcare professionals. Before this however, they describe being "passed" around the "fragmented" system.

To improve women's access to services, respondents put forward a range of suggestions that centred around:

- system-level changes, to improve communication and create joined up provision of women's health services e.g. women's health hubs
- better education and training of healthcare professionals and the public on women's health issues
- an increase in specialists and services to treat women's health conditions, such as the menopause
- apply a patient-centred approach to prevention and treatment to take account of the whole person, including all aspects of health and behaviours
- offering "enhanced access" appointments, on evenings and weekends, to accommodate patients with busy schedules or those who struggle to attend during core service hours.

Women's Voices

Of those who answered our survey question, 2 in 5 women (40%) feel they were not listened to when they accessed health services.

A higher proportion of women felt not listened to in women's health services: in services for gynaecological conditions (47%), gynaecological cancers (42%) and menstrual wellbeing (41%). Younger women also felt less listened to than older women.

Based on the semi-structured interviews, 'not being listened to' was one of the most common themes throughout nearly all interviews, across all ages and backgrounds.

Specifically, many women told us:

They had to persistently advocate for themselves, often over multiple visits, months and years. Often this was described as "fights" or "battles" that were needed to be heard.

Following accessing health services, some still felt misunderstood or not treated empathetically.

They had a preference of being seen by female healthcare professionals, where they feel they are more likely to be heard and understood.

Their symptoms were not taken seriously or dismissed upon contact with GPs and other health professionals.

They were not seen holistically, and they would prefer to be seen as "a whole person - not just a collection of bits".

Health in the Workplace and Employment

Economic inactivity is higher for females than males in both Nottinghamshire and from a national perspective. Data from the Office for National Statistics shows there has been an observable increase in economic inactivity due to long term sickness for females in Ashfield, Newark, Sherwood and Mansfield. All other districts had their data suppressed [30].

Our survey examined if women felt well supported in the workplace to look after their health and wellbeing. Of those who answered the survey question, 7 in 10 women (70%) agreed.

The top responses to anything more employers could do to support your health in work/ support you back to work were:

- Ensure the workplace is comfortable with proper seating, lighting, equipment
- Foster a culture to discuss mental health
- Offer healthy food options at work
- Offer support to new mothers returning to work.

Many respondents focused on the positive responses of what the workplace was doing well. Some respondents called on employers to implement some practical considerations such as reducing workload and increasing staffing to improve health and wellbeing. There was also an acknowledgement to raise awareness and destigmatise women's health conditions in the workplace, whilst also providing mental health support. Flexibility of working also came through in the interview data, where women felt that they wanted to continue to work flexibly but either due to caring responsibilities or the menopause, sometimes they were unable to continue.

Recommendations

Our overarching goal is to improve women's healthy life expectancy in Nottinghamshire, ensuring that women spend more time in good health, and the gap between the most and least-deprived areas is reduced. We have therefore produced the following recommendations from our findings.

Theme	Recommendation(s)
1. System-wide Commitment	Establish a system-wide commitment to actioning these recommendations and to reducing inequalities for Women's Health through the Nottinghamshire Health and Wellbeing Board.
2. Access to Healthcare Services	Explore opportunities through integrated neighbourhood working to address inequalities in access to women's healthcare, such as HRT prescribing, access to contraception e.g. for younger women and girls, targeting the areas of highest need and vulnerable groups as highest priority.
3. Women's Voices	Continue conversations with the women of Nottinghamshire to ensure they feel listened to in order to understand how to best support their health and champion their voices.
4. Mental Health and Wellbeing	Work to improve the mental health and wellbeing of women and girls in Nottinghamshire by further investigating what the barriers are for women accessing mental health services and improving signposting to offer support.
5. Health Behaviours	Continue work to reduce smoking in pregnancy and to support women and girls to feel safe to engage in physical activity in green spaces.
6. Building Blocks of Health	Work with anchor institutions in Nottinghamshire to support women in the workplace and prevent female economic inactivity.
7. Violence Against Women and Girls	Champion the healthcare system to be trauma informed and take an increased role in prevention, early identification and provision of support for victims of abuse and violence.
8. Marginalised Groups	Using national research into women's severe multiple disadvantage, we will develop a framework tool that will enable a review of services to identify areas of good practice and gaps in delivery for women. Findings from this review will inform an action plan for improvement where required.
9. Women's Health Conditions	Strengthen existing partnerships to focus on priority women's health issues and use the principle of Making Every Contact Count (MECC) to ensure that healthcare professionals are provided with the training, skills and tools to initiate and have meaningful brief conversations about women's health and health conditions and are enabled to signpost women towards the best care possible.
10. Healthy Ageing and Long-Term Conditions	Support women in Nottinghamshire to Age Well by investigating data to improve early female mortality from colorectal cancer and overall women's health outcomes and consider the impact of musculoskeletal conditions on women's frailty.

Glossary

- **Anchor Institutions:** a large, stable organisation like a university or hospital that is rooted in its community. These institutions play a vital role in economic development and social stability by leveraging their resources to support local initiatives.
- **Building Blocks of Health:** the key building blocks for health and wellbeing include getting a best start in life, education and skills, a good diet, secure employment, good housing, and relationships with family, friends and community. Building blocks like these create the foundations for a society where everybody can thrive.
- **Director of Public Health (DPH):** the Director of Public Health has a statutory duty to take steps to improve the health of the population.
- **Director of Public Health's Annual Report:** it is a requirement for all Directors of Public Health to produce an annual independent report on the health of their local population, which the local authority is required to publish. The report aims to raise awareness and understanding of local health issues, highlight areas of specific concern, and make recommendations for change.
- **Health and Wellbeing Board (Nottinghamshire):** a committee of Nottinghamshire County Council, responsible for improving the health and wellbeing of everyone in Nottinghamshire and reducing health inequalities in our communities.
- **Health Inequalities:** unfair and avoidable differences in health between different groups of people.
- **Hormone Replacement Therapy (HRT):** is a treatment used to help menopause symptoms. It replaces the hormones oestrogen and progesterone, which fall to low levels as you approach the menopause.
- **Integrated Care System (ICS):** partnerships of organisations that come together to plan and deliver joined up health and care services, to improve the lives of people who live and work in their area.
- **Integrated Neighbourhood Teams (INTs):** health and care teams working together to coordinate care for people within a specific community or neighbourhood.
- **Joint Strategic Needs Assessment (JSNA):** is a process where Public Health teams and teams across the ICS come together to understand the health and care needs of a population. This can be presented as a report or sometimes as a dashboard. They usually hold some recommendations about what can be done to improve the health and wellbeing of the people discussed in the report.
- **Make Every Contact Count (MECC):** The MECC approach encourages health and care staff to use the opportunities arising during their routine interactions with patients to have conversations about how they might make positive improvements to their health or wellbeing. This could be utilising a conversation about contraception to talk about healthy weight or smoking cessation, for example.

- **Marginalisation:** the process of social exclusion in which individuals or groups are pushed towards the fringes of a society, being seen as 'outsiders'.
- **Primary Care Network (PCN):** groups of GP practices working closely together across populations of approximately 30,000-50,000 people. They deliver some services together and share staff between them to improve care in general practice.
- **Public Health:** the goal and purpose of public health is to protect and improve the health of the population and to reduce unfair differences in the health and wellbeing of people from different communities.
- **Stigma:** refers to any negative attitude, prejudice, or false belief associated with specific traits, circumstances, or health conditions, without understanding of the facts. There is also internalised stigma, where someone comes to believe the negative messages or stereotypes about themselves and/or their condition.

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