Buckinghamshire

Men's Health Needs Assessment Report

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HEALTHIER OUTCOMES FOR EVERYBODY

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Quotes - Men's Health

"If I'd known I was going to live so long, I'd have taken better care of myself."

Leon Eldred

"When it comes to eating right and exercising, there is no I'll start tomorrow. Tomorrow is disease."

V.L. Allineare

"Take care of your body. It's the only place you have to live."
Jim Rohn

"What a piece of work is a man, how noble in reason, how infinite in faculties, in form and moving how express and admirable, in action how like an angel, in apprehension how like a god! The beauty of the world, the paragon of animals—and yet, to me, what is this quintessence of dust? "

William Shakespeare

1. Executive Summary

In UK men do not access health services as frequently, or as soon as women; this results in later presentation of long-term conditions, mental health conditions and cancer with the inevitable poorer prognosis for men. Research has identified there is a lack of knowledge about approaches that improve the uptake of NHS services by men.

In Buckinghamshire there is significant disparity in male life expectancy. The greatest contributors to men's life expectancy being lower than that of women are: heart disease; cancer; alcohol related conditions; lung disease and deaths in men aged less than 40 years.

Social and economic costs

The consequences of men's ill health, and men's risk-taking behaviour, impacts on the whole community, both economically and socially as well as by men's partners and their families. Income reduction due to ill-health also reduces men's ability to fulfil their roles within society. There are strong economic and social arguments for improving men's health. Ill health has considerable psychosocial impacts on men themselves. Productivity is reduced by poor physical or mental health or premature death.

Key findings from the evidence review

Key findings from the literature review and epidemiological needs assessment has identified that compared with women men have: higher health risk behaviour; less access to preventative services; less timely uptake of secondary care services; poorer outcomes for cardiovascular disease and cancers; lower life expectancy consistent with their less timely uptake of health services and almost three times standardised mortality rates for suicide and undetermined injury.

Corporate analyses success themes

Through the interviews and the focus groups a number of themes relating to what the drivers and barriers to change were identified. They included: the importance of strong leadership in developing new initiatives to promote men's health; recognising not all men are the same and different strategies are required to target different groups; the importance of promoting positive professional attitudes to men's health; the importance of utilising multiagency support especially for vulnerable men and an overall recognition about regarding the barriers that exist to tackling men's health inequalities.

Key findings regarding geographical patterns across Buckinghamshire

Data from GP systems suggest there are no consistent geographical patterns across Buckinghamshire in the following: the proportion of obese people who are male; male obesity; raised blood pressure in males and raised blood sugar in males.

Key findings regarding mortality

All age all-cause mortality rates are significantly higher in males than females. Rates for both genders are significantly lower in Buckinghamshire than in England overall. Rates of premature (aged <75) mortality from each of the major causes of death are considerably higher in males than females. In Buckinghamshire life expectancy at birth is 81.2 years for men, and for women it is 84.9 years, a difference of 3.7 years for the three-year period 2011-2013. Life expectancy of both males and females in Buckinghamshire has increased steadily in the ten years, in common with the rest of the country.

Key findings regarding health checks

The Health Checks data from GP systems showed that previously undiagnosed diabetes was greatest in the urban areas of Amersham, Aylesbury, Buckingham, and High Wycombe. The percentage of previously undiagnosed diabetes detected at health checks was half as high again in males as in females. This represents a definite health inequality between the genders. Health Checks data from GP systems showed that 51% of invited women attended the Health Check, but only 38% of invited men attended. The percentage of males found to be at high risk of cardiovascular disease was almost double that of females. Male gender is a risk factor for CVD

Recommendation:

GPs in Buckinghamshire should be encouraged to consider the possibility of undiagnosed diabetes in their male patients.

Recommendation: GPs in Buckinghamshire should encourage more of their eligible male patients to attend Health Checks.

Recommendation: GPs in Buckinghamshire should pay more attention to the possibility of heart disease in their male patients at routine consultations.

Recommendation: Health Check providers should consider opportunistic approaches to recruiting men who are likely to be high risk and currently do not attend. For example working with employers to offer health checks in workplaces during lunch hours, or offer checks in pubs, clubs, and employment offices**.**

Key findings regarding participation in sport

Data from Sport England's Active People Survey show participation rates in sport on Buckinghamshire are higher than the averages for the South East Region and England overall. Participation rates have been consistently higher among men than women. Across the county, participation rates (all persons, not available by gender) are higher in the southern half, but lower in the urban areas of Amersham, Chesham, Princes Risborough, and High Wycombe.

Recommendation: Buckinghamshire CC PH department should continue to encourage physical activity, and should particularly concentrate this promotional work in Amersham, Chesham, Princess Risborough, and High Wycombe.

Key findings regarding smoking cessation

Higher percentages of males in Buckinghamshire who set dates to stop smoking succeed in quitting than of females. This is most marked in the over 60s and least in the under 18s, who also have the lowest success rates. Almost 10% of those who set quit dates are of South Asian ethnicity, which make up just over 6% of the population. As Bangladeshi and Pakistani men are known to have particularly high smoking prevalence rates (source: HSCIC Statistics on Smoking, England 2014) this is encouraging.

Recommendation: Buckinghamshire's Stop Smoking services should particularly aim to encourage more young people to give up smoking.

Recommendation: Buckinghamshire's Stop Smoking services should continue to target services among ethnic groups who are at the highest risk of cigarette smoking.

Key findings regarding domestic violence

Three quarters of the victims of domestic violent crime are female. Almost 90% of domestic violent crimes are committed by male. 30% of domestic violence is considered to be alcohol related, rising to 40% when the perpetrator is female or the victim male. There are noticeable age disparities: young adults (18-26) are responsible for the highest proportion of domestic crimes and only 22% of these are alcohol related, while in the over 40s there are far fewer incidents, but half of them are alcohol related.

Recommendation: Buckinghamshire's domestic violence reduction programme should target the younger adult age group, and should emphasise the increased risk of males becoming victims of domestic violence when alcohol is involved.

Recommendation: Buckinghamshire's campaigns to promote sensible drinking should emphasise the role played by alcohol in domestic violence, especially in older age groups.

Key findings regarding male carers

Over 40% of unpaid carers in Buckinghamshire are males, and higher proportions of these report being in bad or very bad health.

Recommendation: Buckinghamshire CC's Adult Services should bear in mind the needs of male carer for carers support.

Key findings regarding cancer

Incidence of all cancers was higher in males in Buckinghamshire than in females, but the difference was not statistically significant at the 5% level. Incidence in males was significantly lower in Buckinghamshire than in England overall.

- Incidence of lung cancer aged under 75 was higher in males in Buckinghamshire than in females, and the difference was statistically significant at the 5% level. Incidence in males was significantly lower in Buckinghamshire than in England overall.
- Incidence of colorectal cancer aged under 75 was higher in males in Buckinghamshire than in females, but the difference was not statistically significant at the 5% level. Incidence in males was non-significantly lower in Buckinghamshire than in England overall.
- Incidence of skin cancer (non melanoma) aged under 75 was higher in males in Buckinghamshire than in females, and the difference was statistically significant at the 5% level. Incidence in males was non-significantly higher in Buckinghamshire than in England overall.
- Incidence of prostate cancer in men of all ages was very similar to those of England and the South East Region.
- 5 year survival of prostate cancer patients was very similar to those of England and the South East Region.

Recommendation: Buckinghamshire CC PH department should ensure that healthy lifestyle messages designed to reduce incidence of cancer are especially aimed at men.

Key findings regarding hospital admissions

Hospital admissions for stroke in Buckinghamshire were significantly higher for men than women. For both genders they were significantly lower than the England rates. There was an apparent national downward trend in from 2002/03 to 2008/09, followed by an upward trend. The picture is unclear, and may be related to the Department of Health's National Stroke Strategy for England, which recommended major change in the system for stroke care and began to take effect in 2010.

Recommendation: Buckinghamshire's CCGs and Commissioning Support Unit should monitor admission rates and outcomes for stroke.

Key findings regarding sexually transmitted infections

Between 2010 and 2013 there was an overall 10% increase in new Sexually Transmitted Infections (STIs) among men who have sex with men (MSM.

Recommendation: In line with national recommendations, men who have sex with men (MSM) having unprotected sex with casual or new partners should have a HIV/STI screen at least annually, and every three months if changing partners regularly.

Recommendation: MSM should avoid having unprotected sex with partners believed to be of the same HIV status (serosorting), as there is a high risk of STI and hepatitis infection and, for the HIV negative, a high risk of HIV infection as 18% of MSM are unaware of their HIV infection.

Recommendation: Bucks sexual health services should seek to raise awareness of syphilis and gonorrhoea in MSM in Aylesbury Vale and Wycombe particularly.

Key findings regarding access to psychological therapies (IAPT)

Men's rates of suicide and undetermined injury are three time those of women. About one third of referrals to IAPT are of men. However men's take-up of IAPT services, at 75%, is similar to that of women and similar proportions of men and women achieve recovery.

Recommendation: It should be a clear priority to focus on increasing referral of men to IAPT.

Policy recommendations

Improving men's health can be achieved through changes in policy that specifically address the inequalities between men's and women's health. In addition policymakers should consider opportunities and partnerships they can make with universities, companies, charities, local authorities, Public Health England, NHS England and the Department of Health

Recommendation: Ensure Men's Health gains wider recognition and that it is specifically addressed in its own right in both public and internally facing key council and statutory health organisation strategic documents.

Recommendation: Ensure Men's Health is placed on the agenda to be specifically addressed by the Health and Wellbeing board and CCGs annually.

Recommendation: Ensure Men's Health and gender impact is specifically mentioned where relevant, in high-level strategy documents, for example included in strategies evaluations and audits undertaken by CC PH; HWB; LA; Allied Health and Social Care Organisations**.**

Data management recommendations

Recommendation: Evaluation and audit should report on gender as a matter of course. The benefits of this approach will be to keep the inequality in men's health an active issue.

Recommendation: the systematic collection and reporting of gender-stratified data for management, process and outcome data.

Health promotion recommendations

Men are often considered hard to reach in relation to the way they access health care. It is important that individuals responsible for health promotion and social marketing specifically address ways to engage with men in Buckinghamshire.

Recommendation: Ensure that consultations and social marketing campaigns offer clear messages that include the consequences of inaction to men

Recommendation: Ensure the prevention services are designed where relevant to specifically target men at different stages during their life-course

Service redesign recommendations

Gender-specific health services have long existed in the area of women's health care emphasis on men's health has only recently been advocated. Service redesign in Buckinghamshire should specifically consider how to optimise male access to health and social care services.

Recommendation: Promote multi-source of access to services, for example by offering flexible routes of referral to weight loss management, smoking cessation and pre-diabetes assessment

Recommendation: Promote activities that minimise patient delay in seeking health care ensure prevention services address those factors which lead men to delay consulting and 'practitioner delay' those factors leading the practicing to delay investigation and therapy

Recommendation: Design outreach services that meet men in places that is appropriate to them. For example places of work, worship, recreation, commercial centres and job and civic centres such as libraries

Recommendation: Promote a shared approach to treatment planning for men with a self-created action plan; getting men to set their own goals and then support them to achieve their own goals

Recommendation: Target Vulnerable At-Risk Men for support to combat isolation, loss of self-esteem and depressive related illness and lack of self-care

Recommendation: Design appropriate interventions for vulnerable male groups; for each target audience that are designed to meet them psychologically and do not require them to conform in order to gain access services

Training recommendations

When training programmes are being reviewed in Buckinghamshire it is important that where relevant men's access to health and social care services is specifically addressed

Recommendation: Promote gender sensitive training to administrative and clinical staff, to ensure the NHS particularly primary care is perceived as welcoming and open to men

Information technology recommendations

When IT systems are being reviewed whether it is in relation to web based services, electronic patient records, or other social marketing methods it is important that Buckinghamshire addresses ways to optimise men's access to health and social care services

Recommendation: Increase online interaction with health services and ensure it is designed to be male friendly.

Recommendation: Review prevention referral schemes and ensure they offer an open access basis, such that men can be picked up and referred if they meet entry criteria and are not excluded because they did not access via the correct route.

Conclusion

In common with the whole of the Country, using standard indicators such as incidence of major health problems, mortality rates, and life expectancy, the health of men in Buckinghamshire is worse than that of women. Men have higher incidence of all the major fatal illnesses, die younger, and live shorter lives. Men are less likely to seek medical advice and treatment, and may be less likely to take up preventative services. The extent to which some of these matters are amenable to health intervention is unknown, but it is important that men's health is specifically addressed in the development of policies and surveillance of the health of the people of Buckinghamshire.

Local authority and statutory health organisations should ensure that gender inequalities and equity are explicitly incorporated in equality impact assessments, strategies, and audits.

Providers should be required to ensure that gender is an item reported in all data collection and management. If standard reporting (eg via national systems) does not include that breakdown then consideration should be given to establishing local reporting systems to supplement the standard reports.

Design of health promotion campaigns, prevention services, and provider services should ensure that arrangements for access minimise barriers to take-up by men. In particular, efforts should be made to get more men to attend health checks, as male take-up is lower, and there are higher rates of health risks (diabetes, cardiovascular risks) identified among men who attend than among women. This may involve improved use of information technology, and perhaps widening the provision of health checks beyond GP practices.

Domestic violence is strongly gender-oriented: 90% of perpetrators are male, and 25% of victims. As age increases there are fewer incidents but incidents are more likely to have alcohol involved. When alcohol is involved men are more likely to be victims. Campaigns to reduce domestic violence should include these considerations in their design.

Adult Care should bear in mind the likely need for carer support in male carers.

In view of the recent increases in STIs among men who have sex with men, it is important that sexual health services and campaigns emphasise the need for safe sex practices and regular HIV testing, and work to increase awareness in men of syphilis and gonorrhoea.

Men's mental health should be a priority area for Buckinghamshire. Only a third of referrals to Improving Access to Psychological Therapies (IAPT) are for men, but (in common with the rest of England) suicide rates among men are three time as high as among women.

Taken together, the results of this Needs Assessment have the potential to form the basis of a programme to:

- reduce health inequalities between men and women; improve men's life expectancy,

- increase staff awareness to promote men's healthy lifestyles, and

- improve health and community service delivery to men.

Please see Appendix 1 - Menu for advocating organisational change to address men's health inequalities

2. Background

Buckinghamshire County Council commissioned PHAST to undertake a Men's Health Needs Assessment. The commissioners' wish the key recommendations from this needs assessment to inform Buckinghamshire's adult population Public Health Prevention Strategy.

This Men's Health Needs Assessment describes the health needs of men over 18 years living in Buckinghamshire in relation to a wide range of key health indicators.

Men's health and wellbeing is an important issue for health and social care in UK. Men face poorer outcomes than women across a wide range of key indicators. Men have lower life expectancy, higher levels of avoidable mortality and higher mortality from almost all common causes of death including cancer, cardiovascular disease and suicide.

Research has shown that although biological factors contribute to men's poor health outcomes[1], the main difference in health outcomes between men and women is due to social factors. Men are more likely to indulge in a range of lifestyle risk factors such as smoking, excess alcohol consumption and insufficient fruit and vegetable consumption. Men are also more likely to participate in a range of high-risk activities, access health and community services less and first consult at a later stage in an illness

Men are more likely to have smaller social networks. In addition, traditional masculine values such as stoicism and self-reliance have been shown to negatively affect the health behaviours of some men[2].

3. Aim & Objectives

3.1 Aim

To undertake a health needs assessment of men over 18 years of age in Buckinghamshire in order to gain a better understanding of their health and to identify evidence-based initiatives aimed at improving the overall health of men throughout their adult life-cycle.

The initiatives are aim to -

1. Reduce health inequalities and improving the quality and length of men's lives.
2. Promote and facilitating men's healthy living.
3. Strengthen health and community service delivery to men.

3.2 Objectives

The objectives are to review the health needs of men over 18 years in Buckinghamshire in relation to a range of epidemiological factors, health indicators including men's access and utilisation of health and social care services. The objectives have been listed under the three components of the needs assessment.

Epidemiological needs assessment

- To review the relevant national and international literature on health needs of men compared with women.
- To describe the adult male population in Buckinghamshire by a range of key demographic variables including age/social class/ethnicity and other relevant variables
- To identify key health needs of adult men through the analysis of a range of key health indicators including mortality, deprivation, long term health conditions, cancers, mental health conditions, substance abuse and other relevant variables
- To analyse the utilisation of health and social care services by adult men in Buckinghamshire and nationally.

Comparative needs assessment

- To use comparative data to identify areas for potential improvement including comparisons with the UK and where possible ONS peers and with the health of women

Corporate needs assessment

- To explore the health behaviours, health seeking behaviours and knowledge attitudes and beliefs of local men

4. Methods

4.1 Epidemiological needs assessment

Literature review of current evidence base for men's health

A rapid review of published peer reviewed literature was undertaken; the review included the grey literature. The central focus of the review was to understand the reason why men do not access health services as often or as soon as women and what interventions successfully increase health service uptake.

The PHAST team reviewed national and international literature on the health needs (and service uptake) of men including issues that addressed: masculinity; socio-economic status; race; ethnicity; sexuality; ability; geography; community; education and employment[76].

The evidence review addressed the health of men over 18 years across their life cycle. The review examined differences between men and women in terms of engagement with and access to services.

The literature review had two stages

1. The review focused on examining the theoretical basis for understanding why this seems to be across cultures and countries and particularly within Western culture.
2. The literature review examined what approaches to improving men's health have been postulated or tested with the goal of pointing out possible approaches that could be used in Buckinghamshire to reduce the gap in life and health chances of men and women by improving the health of men.

The PHAST Team reviewed and analysed available recent data that addressed men's health, in the form of indicators of mortality and morbidity, disability, distress and satisfaction. The PHAST Team examined the structure of service provision, process (e.g. throughput, waiting times and DNAs) and outputs (volume) and understanding of processes, strengths and capacities of local people and communities. The PHAST Team also examined a wide range of quantitative and qualitative data, including user and community views.

PHAST examined: recent WHO publications relating to gender and men's health; reports from key organisations such as the Men's Health Forum in UK; and undertook a literature search of the two areas, identifying several key systematic reviews. PHAST have examined these key reviews and have complemented them with literature searches using Google Scholar, Medline, science citation index, as well as sociological and psychological databases to ensure review coverage.

A set of key questions derived from this review were designed for the community engagement exercise; the community engagement exercise called "lightning" was a face to face questionnaire; it was employed in the engagement strategy titled, "meeting men where men go".

Demographic review

The PHAST team undertook data analysis of routine nationally available data sets and local systems provided by the health intelligence team at Buckinghamshire County Council Public Health Department (BCCPHD). This gave data based representation of health behaviours, burden of disease and health service utilisation of men compared to women. Analysis included data gathered through routine data from primary and secondary care and local management data.

Comparing the health profile of men and women living in Buckinghamshire

The PHAST Team identified nationally and locally available data which described the male and female population of Buckinghamshire in terms of key demographic determinants; including age, socioeconomics, ethnicity and deprivation. The PHAST team analysed the Buckinghamshire population profile and reviewed the life expectancy of men and women. Additional analyses reviewed the causes for excess male morbidity and mortality as well as addressing health inequalities.

Data sources included

- NHS Health and Social Care Information Centre (HSCIC),
- PHE and other sources at local levels of aggregation.
- Eurostat
- Data.gov.uk
- Buckinghamshire County Council C Public Health Department
- Ordnance Survey
- Office of National Statistics
- Where important information was missing PHAST requested local support to from Buckinghamshire County Council and the Clinical Commissioning Group sources. The focus was to identify data that included differences between men and women.

4.2 Comparative needs assessment

The PHAST team benchmarked local Buckinghamshire County Council data against national and comparative Local Authority data (for men and women). Comparative data was taken from the epidemiological approach and combined with: a rapid literature review; review of national policies and guidelines such as National Institute for Health and Clinical Excellence (NICE) guidelines; learning from organisations who have shown their ability to engage with men; and published material on men's health and activities that have been demonstrated to address the particular health needs of men. This wide-ranging approach has enabled the PHAST team to gain a better understanding of the health of men in Buckinghamshire and to identify evidence-based initiatives aimed at improving the overall health of men throughout their adult life-cycle.

4.3 Corporate needs assessment

Engagement with the service users

The PHAST team worked with the commissioners to identify the best local approach to achieving community perspectives, e.g. the views, expectations, perceptions and experiences of local men and their views on health and wellbeing. After a process to understand Buckinghamshire County Council Public Health Department priorities, PHAST focused particularly on user views, directing focus groups, online surveys and in person semi-structured interviewing (testimonials). PHAST approached various organisations including "Men in Sheds", "Who let the Dad's out" "Mankind Project", "Morris Men" and other men's third sector organisations operating in Buckinghamshire.

Organisational engagement

The PHAST Team worked with the project commissioner to identify the best method of taking the temperature of the organisation and the wider health and wellbeing economy around men's health and identifying a strategic perspective of opportunities. The agreed process entailed a snow ball approach of interviews with Public Health Staff and then interviewing key organisational representatives across the Buckinghamshire County Council health economy from Clinical Commissioning Groups, to provider services, council departments and third sector organisations.

The PHAST Team examined good practice through engagement with third sector organisations, which successfully engage men and also learned from their approach to reaching men.

Examination of local key strategy documents

The PHAST Team examined these documents for specific reference to men, fathers or males to see to what degree the need for issues and elements of men's health needs to be considered as separate and different from those of the general population and whether specific references are already embedded into the local health and social care strategies.

The information gathered through these different means was collated and analysed using a thematic approach, to identify key messages to help commissioners.

Thematic analysis

The PHAST Team employed thematic analysis to identify and examine key themes from the qualitative and questionnaire data. PHAST began with a process of familiarising data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and presenting those themes in the report.

Focus groups

The focus group work used the Omni toolkit for focus groups as a starting point[3]. The PHAST Team identified eight areas of interest, which would open up discussion about the knowledge, attitudes and behaviour of men towards health, wellbeing, prevention, consultation and treatment and the NHS and their beliefs about the attitudes of the wider society to men's health. The areas guided open questioning used to prompt discussion within the two focus groups. The open questions comprised:

1. *What do you do to keep yourself healthy?* Diet? Exercise? Other practices (meditation, mindfulness, spirituality etc.?)
2. *Where do you go for information about health?* Word of mouth? Own community? Any particular websites? Can you be more specific?
3. *Who do you go to for help with health? Family?* Have you visited a) a GP? b) Hospital? c) Private therapist? Community health? Local services? NHS Health Check? – a service available to people between 40-74, blood pressure, blood sugar, lifestyle – have you heard of the service?/used the service?
4. *Does anything put you off seeing a professional (e.g. doctor)?* Are there things you wouldn't speak to a female doctor about? Or a young doctor? Does ethnicity make a difference?
5. *Barriers: Do you see any difference with the way your children or younger generations approach their health?* Have there been times when you've wanted to get help and something has stopped you. [e.g. Cost of non-NHS services? Ethnic barriers? Language barriers? Cultural barriers?]
6. *In your family, who lives longer, men or women?* Why do you think this is? Who goes to get medicine? Who takes care of health? Does your wife ever go to the doctor for you? Why is that? Why do you think men live less long than women? Three reasons?
7. How important is it for men to be healthy? How healthy is healthy? Do you prefer to deal with illness when it arises, or keep checking? Is healthy about feeling well, or just not feeling ill? What are the big health concerns for you as men? Can you be too concerned about health?
8. What more could you do to keep healthy? We've talked about diet, exercise, do you think there are any other concerns we haven't covered? What more could you do to keep healthy? What more could the NHS do to keep men healthy? What more could the community do to keep men healthy?

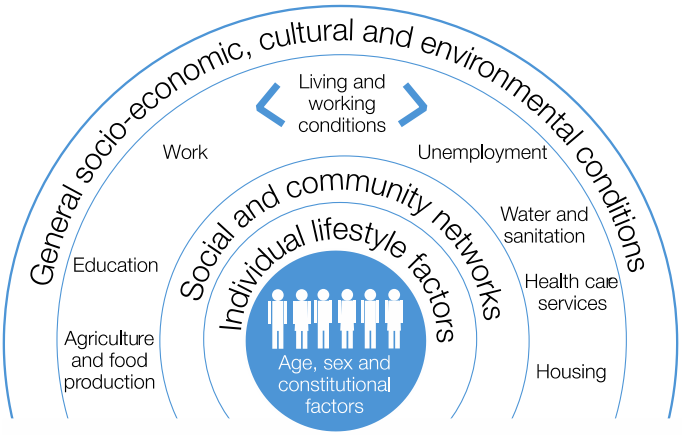
5. Literature Review Findings

5.1 Introduction

There is strong evidence that compared with that of women, men's life expectancy is lower and health worse throughout the life-course. This finding is cross-cultural and persistent at least since records began[4].

Figure 1 illustrates major influences on people's health, and levels of policy interventions that can be applied to improve health of individuals and social equity in populations

Figure 1 - Policies and strategies to promote social equity in health



Source: Dahlgren, G. and Whitehead, M. (1991) Policies and strategies to promote social equity in health, Institute of Futures Studies, Stockholm

5.1 Social and economic costs

Ill health has considerable psychosocial impacts on men. Evidence has identified there are strong economic and social arguments for improving men's health[5].

Productivity is reduced by poor physical or mental health or premature death. The consequences of men's ill health, and men's risk-taking behaviour, impacts on the whole community, both economically and socially as well as by men's partners and their families. Income reduction due to ill-health also reduces men's ability to fulfil their roles within society.

5.2 State of men's health

The 2011 EU publication, "The State of Men's Health,"[6] reported that throughout Europe, men identify themselves as having better health than women even though the evidence contradicts this perception.

It reports that life expectancy is lower for men than for women across all the EU Member States, ranging from 66.3 years for men in Latvia (77.6 years for women) to 80 years for men in Iceland (82.2 years for women). The rate of premature death in men still far exceeds that for women, and is evident across the majority of disease states and that 630,000 male deaths occur in working age men (15-64 years) in Europe as compared to 300,000 female deaths. Cardiovascular disease is the biggest cause of premature death, but this is rapidly being replaced by cancer. This report led to calls for a specific health strategy for men in UK as has happened in the Republic of Ireland[7].

In this report, PHAST present the figures for Buckinghamshire, which reflect a local situation, consistent with the larger picture nationally and throughout the world.

A recent systematic review of the quantitative evidence of the impact of gender on health[8] provides a wealth of evidence and recommendations relating to the state of men's health in England and Wales and also offers salient recommendations, which will be described in section 5.10 Gender and Access.

Therefore the literature review does not focus on proving that men's health is worse than that of women; the local picture is covered in the epidemiological needs assessment. The review focuses on theories of men's health and evidence for public health and other interventions to improve it.

5.3 Conceptual framework of men's relatively poor health

The Health, Illness, Men and Masculinities Framework[9] makes a case for considering gender (the complex of social relations and practices attached to biological sex); to be one of the most important socio-cultural factors influencing health and health-related behaviour[10]. It notes that there is an overwhelming body of health research which suggests that men with similar social disadvantages as women experience poorer health outcomes in relation to disability, chronic illness, injury rates and mortality, and notes that men's health is rarely deconstructed through the lens of gender.

Figure 2 **- Health, Illness, Men and Masculinities Framework**

Source - ***http://health-equity.pitt.edu/4057/1/Health,_Illness,_Men_and_Masculinity.pdf***

The framework has been constructed to demonstrate clearly the ways in which masculinities intersect with other social determinants of health thereby creating health disparities among men, and providing direction for masculine affirming health interventions aimed specifically at men.

The framework illustrates the effect of masculinity throughout the life-course, considered in three main phases of men's life-course. It shows how masculinity intersects with other social determinants of health differently during youth, middle age and the older years. The HIMM Framework authors claim that by adopting the framework and considering gender and its interaction with socioeconomic factors that advances can be made in men's health research, theory development, and direction for policy, education, health care delivery and health promotion initiatives aimed specifically at men in many locales, contexts and countries.

5.4 Fatherhood

The WHO Report "Fatherhood and Health outcomes in Europe"[11] that reported on Ringbäck Weitoft's (2003) longitudinal registry-based study of 700,000 men in Sweden, is the first line of research finding that parenthood and contact with children mostly positively affects men's health. It clearly shows that single non-custodial fathers and single childless men face a much higher risk of premature mortality than co-habiting fathers. Like Umberson (1987), she also found that fathers who lived with their children developed less negative health behaviour, such as various forms of drug abuse, than those who did not live with their children. A possible explanation for this, given by Ringbäck Weitoft, is that children give structure to their parents' lives; they provide much needed company and meaning in life as well as access to other adults. Popay & Jones (1990)[12], Hallberg (1992),[13] Umbertzon & Williams (1993)[14] and Benzeval (1998)[15] reported similar results: divorced and non-custodial fathers generally showed the worst health in form of mental distress and depression than married men living with their children. Bartlett (2004)[16] argues along the same lines but stresses that the health effects of fatherhood are probably mediated by a variety of variables such as the number of children, lifestyle and role competence.

5.5 Cardiovascular disease and cancer

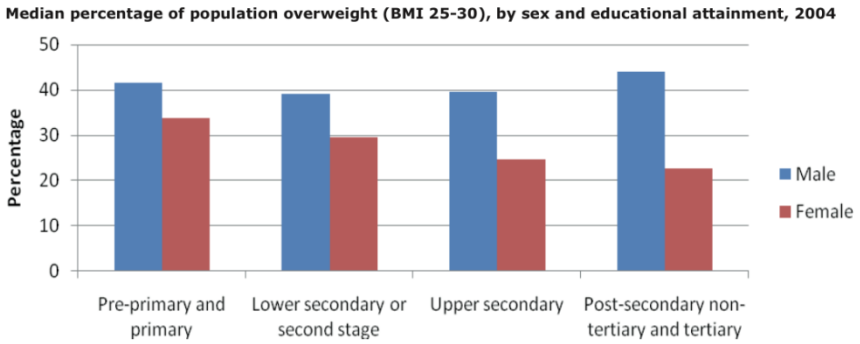
The gender and access study reported that men have a worse premature and total mortality rate for coronary heart disease (CHD)[17]. It was noted heart disease symptoms are different in men and women; in addition women are less likely to be referred to specialists. Critically it notes that despite these differences, there is very little national policy that takes gender differences into account[18] In the UK morbidity and mortality are consistently higher in men for virtually all cancers that are not sex-specific. At the same time, cancer morbidity and mortality rates are reducing more quickly for men than women.

5.6 Major population scale risk factors

There are a number of population risk factors that include obesity, alcohol misuse and sexual health. Figure 3 shows the median percentage of population overweight (BMI 25 – 30) by sex and educational attainment in Europe as a whole. It shows starkly that more men are overweight and that, as education improves, so the percentage of women who are overweight decrease but that in men no such effect occurred.

This may begin to hint at some of the deep-seated challenges and explanations relating to men's health whereby men do not display a socioeconomic gradient of decreasing weight compared with socioeconomically matched women, as Figure 3 illustrates.

Figure 3 Median percentage of population classed overweight by sex and educational attainment (2004) in Europe



Source Eurostat: hlth_ls_bmie

The European Union Study "The State of Men's Health in Europe"[19] shows that the proportion of men and women who are obese is roughly the same, although men are markedly more likely to be overweight than women, and present trends suggest that weight-related health problems will increase among men in particular. The study also showed that women are more likely than men to become morbidly obese. Women are much mo re likely to take part in private sector weight loss programmes and more likely to be treated for overweight in primary care[20]. Also there are important differences between men and women in how they view weight problems. It is probable that men and women take different approaches to weight management and they may find different approaches helpful. It is also possible that health professionals may take different attitudes towards men and women in relation to weight, although research evidence for this is limited. There are no gender-specific national targets in relation to overweight and obesity, and very little consideration of gender in the relevant national strategies.

The Gender and Access Study systematic review[21] suggests that the way that men and women use tobacco, and the way tobacco affects their health, are different. The study suggests that in the light of early signs of cancer easily being confused with minor health problems, men are less likely to consult than women in response to such symptoms. The study also suggests that there is variation experience of the cancer care 'journey' between men and women and that the reasons for these differences are not well understood. More recently, after an historic absence of national strategic guidance, the Cancer Reform Strategy (DH, 2007a)[22] highlighted the need for a better understanding the effect of gender on this care journey.

5.7 Mental health

Women are more likely to report, consult for and be diagnosed with depression and anxiety[23]. It is likely that depression and anxiety are under-diagnosed in men. Suicide is more common in men[24], as are all forms of substance abuse.[25,26] There is a national strategy for women's mental health[27] but no equivalent for men, although there is a focus on the prevention of young male suicide in the National Suicide Prevention Strategy (DH, 2002b). The shortage of knowledge in relation to barriers to service use for both men and women are acknowledged in the equality impact assessment of the Mental Health Act 2007.

5.8 Alcohol

Alcohol disorders are twice as common in men, although binge drinking is increasing in women.[28]

5.9 Sexual health

Incidence rates of all sexually transmitted infections are rising, with the increase being greater in women than men[29]. HIV infection has always been much higher in men who have sex with men, and the rate of infection from heterosexual sex has been decreasing[30]. Gender is addressed frequently in sexual health policy and many sexual health services are for one sex or the other. There is less research available that addresses the link between gender and help-seeking behaviour. The National Chlamydia Screening Programme has pioneered a strategy[31] for increasing the take-up of services by men – currently the only strategy of its kind in any area of health provision. Gender and Access

It is widely known that there are differences between men and women in the incidence and prevalence of most health conditions[32]. Sometimes there are clear biological reasons for these differences, but often there are not. Where biology offers little or no enlightenment, other questions need to be asked:

- Do men and women behave in ways that predispose them to particular health conditions to different degrees?
- Do men and women use health services with different degrees of effectiveness?
- Do men and women receive different kinds of service from the NHS?

The answer is frequently, yes. Sometimes this is to the disadvantage of one sex; sometimes it is to the disadvantage of the other. Occasionally it is to the disadvantage of both. These disadvantages inevitably affect health outcomes.

Gender and Access study

The Gender and Access Study 2008[33] made a number of recommendations in relation to each area of health concern. It is useful to reproduce those recommendations in full.

1. Use and availability of data
There are three ways in which better use of data could help reduce gender inequalities. The first is to undertake a detailed analysis of systems such as the General Practice Research Database to improve understanding of the relationship between gender and use of primary care services. The second is to ensure that gender-disaggregated data (i.e. data showing the differences between men and women) are always used in health planning. The third is to require that data released publicly are always broken down by gender.

2. Future research
The research base in relation to the link between gender and use of health services is surprisingly poor. We recommend that at least one of the leading areas of health policy is made the 'pilot' for developing greater understanding of this issue with a view ultimately to developing more sensitive provision of services.

3. Gender equality schemes and gender impact
The statutory obligations to reduce inequality form part of the Equality Act 2010 and have the potential to reduce gender inequalities in health – but only if they are implemented rigorously. Significant added impetus for taking action to reduce gender inequalities has come from the Equality Act. This legislation requires all public bodies (including all NHS bodies) not only to ensure that services do not discriminate between men and women but also actively to promote equality of opportunity for both sexes. In other words, the responsibility for tackling gender inequalities now rests squarely with those planning and delivering services.

The Gender access study recommended a set of minimum advisory standards emphasising that these processes should always include specific actions intended measurably to reduce differences in the use of services and/or in health outcomes between men and women.

4. The potential value of the Quality and Outcomes Framework
The Gender equality study authors recommended that – on a trial basis – some Quality and Outcomes Framework points be made subject to the achievement of gender-equitable distribution of the service under consideration (e.g. that the record of the service delivered is required to show the percentage of male patients and the percentage of female patients, rather than the percentage of patients per se).

5. Supporting good practice locally
We recommend the establishment of a national Tackling Gender Inequalities programme with the express purpose of supporting, evaluating and disseminating local initiatives seeking measurably to close gender gaps in service use and health outcomes.

6. Influencing healthcare provision outside the NHS
We recommend that the Department of Health and local health bodies actively seek to influence non-NHS organisations in favour of delivering a more gender-equitable service through local planning and commissioning processes. The Joint Strategic Needs Assessment in particular can be an important force for bringing about improvements.

7. Making primary care more flexible
Three models of enhanced primary care provision may have the potential to reduce gender inequalities. These are: more flexible opening hours; the provision of outreach services; and inviting patients to attend for 'Health Checks'. We recommend local commissioning of initiatives following each of these models, monitored for their effect on the gender balance of patient use of services.

8. Tackling Health Inequalities
Gender is the most significant factor interacting with economic status to compound health inequalities. We recommend a review of the actions presently within the health inequalities strategy to ensure that they are implemented in a gender-sensitive way. Most importantly, it is our view that future Public Service Agreements in relation to health inequalities must aim to reduce gaps in health outcome between men and women in parallel with reducing gaps between the least well off and the rest of the population.

5.10 Health promotion programmes targeting men

The literature is clear that men are not a homogenous group in terms of knowledge attitudes and health behaviours[34] and, health promotion activities might therefore be more effective if targeted to specific times in the life course, if material is factual and, health promotion settings are socially acceptable (men only) and appropriate (men-orientated). The involvement of significant others is suggested to improve healthcare access uptake. A one-size fits all approach for men will not suffice; appropriate settings and social groups to which men relate and factual information together with reminders and encouragement from significant others are suggested to offer opportunities for primary health-care access.

The evidence review examined evidence relating to smoking cessation, diet & physical activity, cardiovascular disease, prostate cancer, testicular cancer, preventive health screening, skin cancer and alcohol related harm[35,36,37]. Research suggests that if men's attitudes, behaviours, experience of health care and health outcomes are poorer than women's, then activities, programmes and interventions which are designed specifically for men should be sought.

There is evidence that targeting men specifically is more effective than providing services for the general population. Examples of targeting might include public health promotion material such as posters and leaflets as well as making services "men friendly".

The context of the delivery of material is also important which, it is suggested, target different stages of the life-course and specific demographics, including socio-economic groups. Health-care settings including venue, waiting-room literature and gender of staff within health-care settings may present barriers to men engaging in health-seeking behaviours as well as the medium through which information is disseminated. These elements should be designed to meet the needs of the target group rather than treating men as a homogenous group.

It is suggested that men's access peer support is less than women[41], which may compound men's lack of knowledge, lack of awareness of signs, symptoms and consequences of diseases. There is some evidence that interventions aimed at specific periods in the life-course and, at specific points in the progressions through behaviour change processes may increase effectiveness of those interventions.

Two studies[38,39] suggest that men's decision to access healthcare is particularly influenced by severity and duration of symptoms. Male health-care access is also limited largely to GP's rather than other resources utilised by women, such as pharmacists and GP practice nurses. Gender-associated differences in health related behaviours, social roles and associated stresses (professional or domestic) appear to be potentially harmful. Additionally, some men's perceptions of masculinity and the need for superior status within the home may encourage engagement in risky practices.

Examination of studies[40,41,42,43] of the different components of health promotion programmes to which men may respond well suggested that specific components of health promotion programmes might be identified as the relevant drivers to which men may respond and benefit. These components comprised men-only groups, in which men might benefit from peer support and shared experiences in settings deemed appropriate to their gender. Such groups may enhance health behaviours, healthcare provision in the work environment and health promotion through technology. These studies also reiterated that men's' perception of health are associated with age, the absence or presence of symptoms, their severity and duration, as well as the knowledge and attitudes of significant others.

Two studies[44,45] suggest that gender sensitive context, content and delivery were important components in the uptake of the intervention and were greater when the material was specific, factual rather than emotional support, and specifically timed. Two further publications, one a systematic review[46,47] concluded that personalised communications including health education, combined with patient-reminders by providers improved screening uptake and that patient reminders to significant others also improved screening uptake.

5.11 Examination of gender specific behaviours applied to men

Search on the role of gender on health revealed a large number of publications relating to male identity and masculinity, and that the term "masculinity" frames much of male health-related behaviour, particularly in the younger years when this may result in activity in risky behaviours.[48] As the life-course continues, employment may be a risk factor in itself, with manual workers engaging in employment requiring strength and danger and presenting the risk of injury, whilst sedentary white collar workers may find their occupations, and aspirations, sufficiently stressful to present the risk of mental ill-health and substance abuse.[49]

The appearance of coping alone, either with physical or psychological risks as a key component of the masculine identity, may deter men from seeking healthcare, until severity and duration of symptoms indicate this to be a necessity. This resistance may be further impacted by the perception that females are likely to seek health-care as a matter of course throughout the life-course and, for males to do so may undermine the perception of 'superiority'.

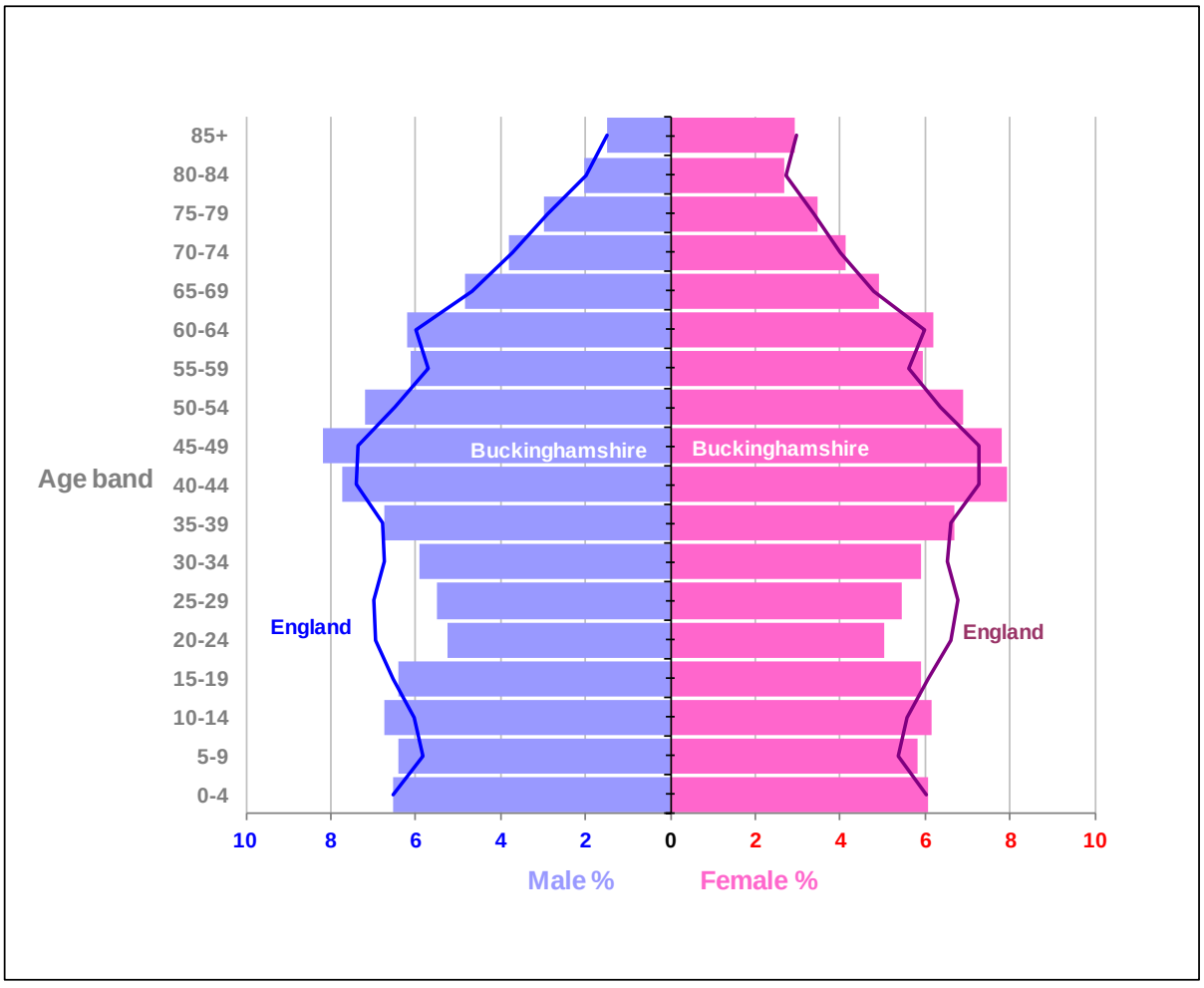
6. Demography and Inequalities

6.1 Demographics

Buckinghamshire population structure by age and sex

Figure 4 shows the populations of males and females by 5-year age, bands, as recorded by the 2011 Census. The figure shows that Buckinghamshire has a similar gender and age profile to England, except that Buckinghamshire has higher proportional of school-age (5-14) and older working age (40-60) people of both sexes than the England average, and lower proportions of younger working-age (20-35) people.

Figure 4 - Population age and sex breakdown, % Buckinghamshire & England Census 2011



Source England Census 20111

Table 1 shows summary population numbers for Buckinghamshire and also how it is expected to grow. The growth rates are shown as annualised percentages and the projected England growth rate is showing for comparison.

From 2015 to 2020 the population of Buckinghamshire is set to increase from 522,596 to 543,787 (+21,191) with an annual growth rate of 0.8%. During the same timeframe the population aged 15-64 is set to increase by 4,674 with an annual growth rate of 0.29%.

Table 1 - Summary Population Projections for Buckinghamshire

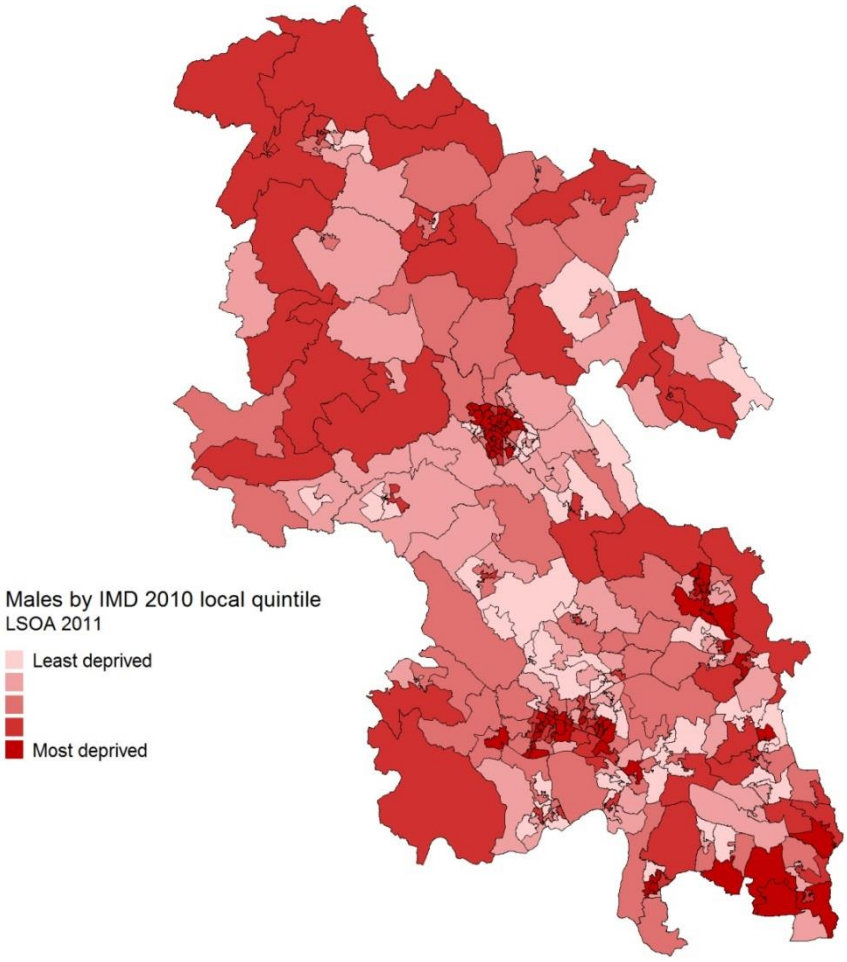
Age	2011 population	2015 population	2011-15 p.a. growth		2020 population	2015-20 p.a. growth	
	This LA	This LA	This LA	*England*	This LA	This LA	*England*
Under 15	95,458	100,074	1.2%	*1.2%*	106,644	1.3%	*1.4%*
15-44	188,067	185,113	-0.4%	*0.2%*	185,187	0.0%	*0.2%*
45-64	138,082	140,736	0.5%	*0.6%*	145,336	0.6%	*0.7%*
65-75	45,033	51,502	3.4%	*3.4%*	53,549	0.8%	*1.0%*
75-84	28,540	31,469	2.5%	*1.6%*	35,864	2.6%	*2.3%*
85+	11,370	13,701	4.8%	*3.1%*	17,207	4.7%	*3.4%*
All ages	**506,550**	**522,596**	**0.8%**	***0.9%***	**543,787**	**0.8%**	***0.8%***

Source: ONS, 2011 census

6.2 Deprivation

Figure 5 shows Lower Super Output Areas defined for the 2011 Census by quintiles of deprivation as defined by the Index of Multiple Deprivation (IMD) 2010. The more deprived the area, the deeper the colour. Note that as LSOAs are constructed to have approximately the same numbers of people in each nothing can be gained from attempting to overlay the numbers of males resident in each LSOA. Nationally poorer health outcomes are strongly associated with higher levels of deprivation. While the most recent data for Buckinghamshire do not fully reflect this (in particular that for Health Checks, section 7.4), targeting intervention at areas of the highest deprivation can still be expected to have the greatest impact on health inequalities.

Figure 5 - Buckinghamshire Deprivation at Lower Super Output Area (2011) level



Source: ONS, 2011 census - Contains OS data © Crown copyright [and database right] (2015

Table 2 shows male populations by District and Quintile of Deprivation within Buckinghamshire, with cells rounded to the nearest 100. Nationally poorer health outcomes are strongly associated with higher levels of deprivation. While the most recent data for Buckinghamshire do not fully reflect this, targeting intervention at areas of the highest deprivation can still be expected to have the greatest impact on health inequalities.

Table 2 - Male populations by District and Quintile of Deprivation within Buckinghamshire

		Quintile of Deprivation				
	Most				Least	
District	1	2	3	4	5	Total
Aylesbury Vale	17500	18500	17000	16100	17300	86200
Chiltern	9100	9100	9000	9000	8900	45000
South Bucks	6400	6400	6500	6400	6700	32400
Wycombe	18400	17800	17000	16000	15400	83800
Buckinghamshire	51400	51700	49400	47500	48200	248300

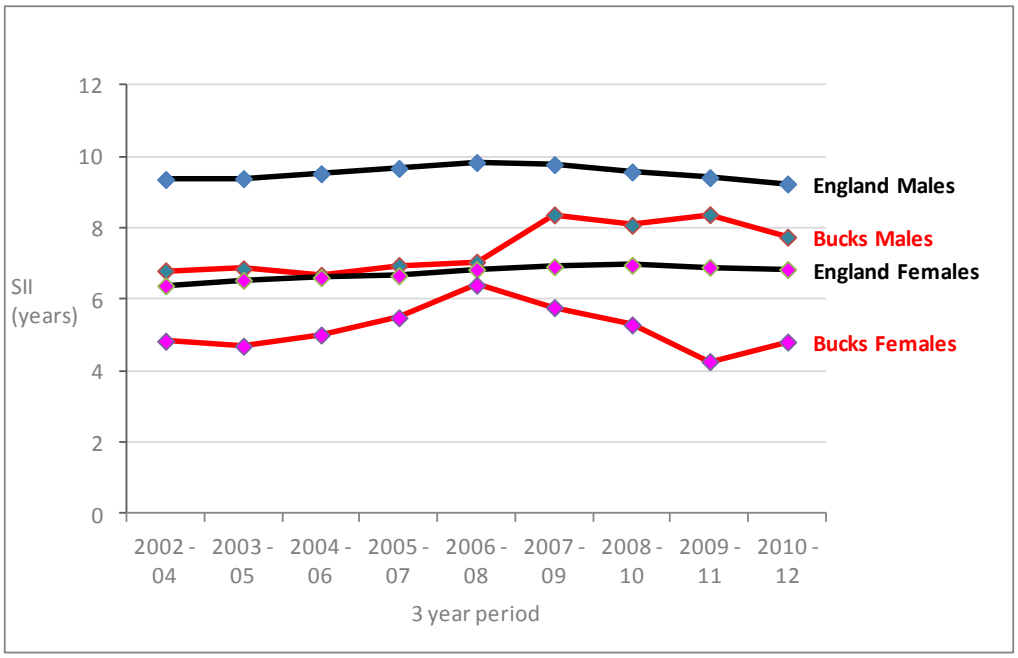
Source: ONS, 2011 census

6.3 Inequalities

The Slope Index of Inequality (SII) is an indicator of local health inequalities.[50] It relates life expectancy at birth to local deciles of deprivation. It was initially developed by the London Health Observatory, and subsequently included in the Public Health Outcomes Framework. Figure 6 shows the SII for Buckinghamshire and England, by gender, from 2002-04 to 2010-12.

As absolute numbers of deaths at Lower Super Output Area Level (LSOA) tend to be fairly small, these confidence intervals tend to be quite wide, even when several years' deaths are aggregated. It is a feature of the SII that as these health inequalities are reduced and the SII gets smaller, it becomes less clear whether the inequality is real. The SII is most reliable when there are substantial inequalities in the area.

Figure 6 - Slope index of inequality (SII) for men & women in Buckinghamshire & England 2002-04 to 2010-12



Source - Public Health Outcomes Framework

Figure 6 shows SII In every period, for both sexes. By this measure of health inequality the local inequalities in Buckinghamshire were less marked than in England overall, and inequalities among males were greater than among females. There was no consistent trend in females. There appears to have been a step-change for males between 2006-08 and 2007-09, which might be due to the revised Index of Multiple Deprivation, which was issued in 2007.

7. Lifestyle and Risk Factors in Buckinghamshire

This section presents data held on Buckinghamshire's GPs' computer systems, and reflects risk factors where this data is held on these systems. Data was provided on rates of obesity, hypertension, raised blood sugar, and diabetes. These factors have long been known to be linked: see for example an editorial in the International Journal of Hypertension[51].

Other factors, such as smoking and exercise, are discussed separately.

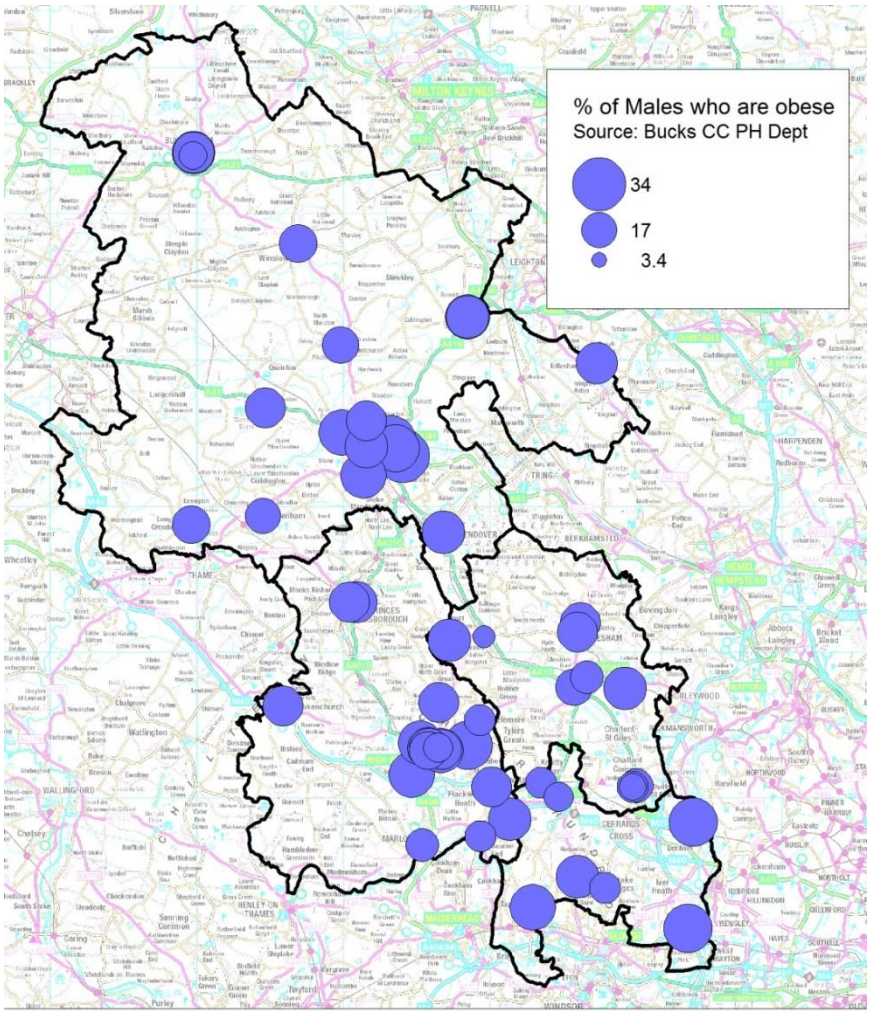
7.1 Obesity in adults

Adult obesity is associated with a wide range of health problems, including musculoskeletal problems, circulatory disease, endocrine disorders, cancer, reproductive system problems, respiratory problems, liver disease, digestive disorders, and psychosocial problems[52]

Overall in Buckinghamshire 20.2% of men and 19% of women measured were classified as obese. Slightly higher proportions of the total number of obese people were male (50.3%) than female (47.7%). There was considerable variation between GP practices: percentages of men who were obese ranged from 7.7% to 33.9%. The percentage of the obese population who were male ranged from 20.6% to 79.8%. In some GP Practices absolute numbers were small, and uncertainty would be correspondingly high, but confidence intervals were not calculated.

Figure 7 shows the percentage of males at each GP practice whose measured BMI was classified as obese. Each circle represents the location of a GP practice. Where GP practices operate at a number of sites the full data is shown at a single location. Where GP practices operate from the same premises some data may be obscured as more than one practice's data may be overlaid.

Figure 7 – The location of the Males in Buckinghamshire who are obese

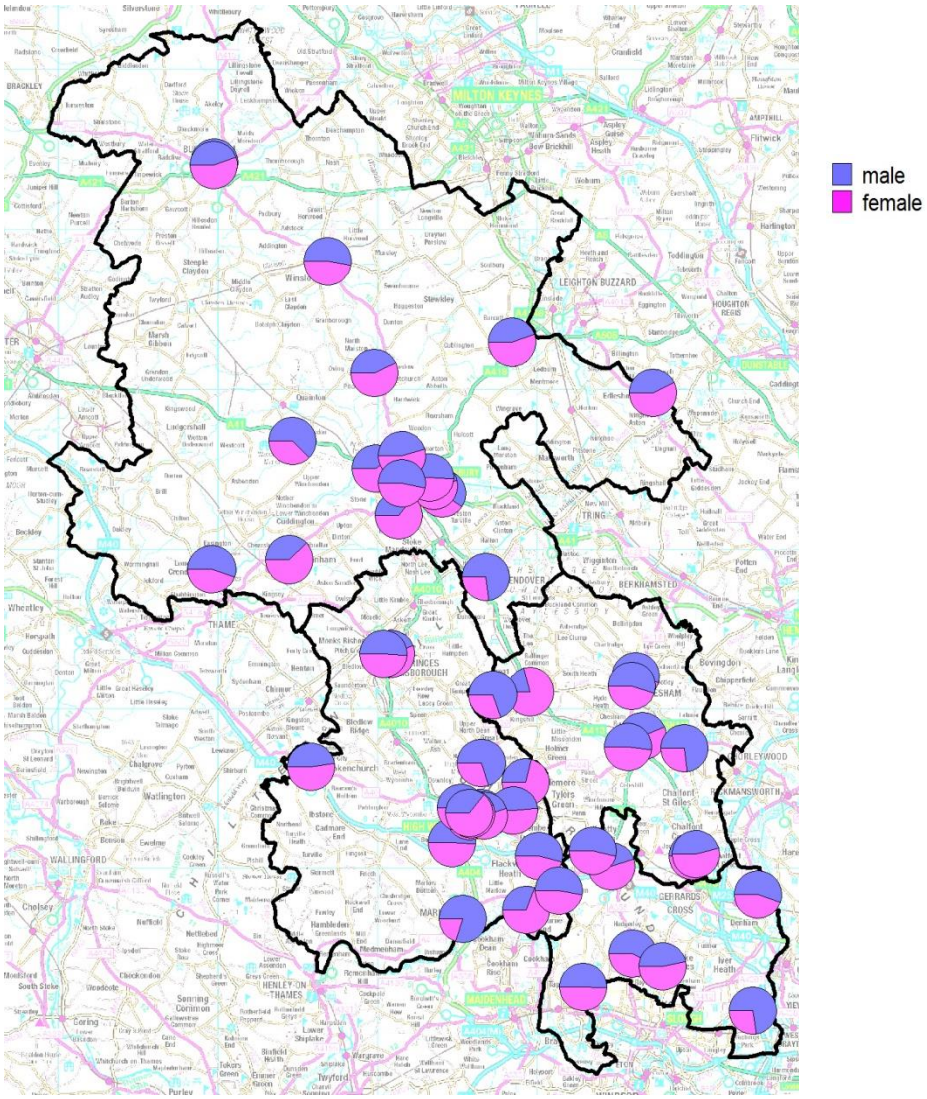


Source: Buckinghamshire Public Health Department, presenting data from GP systems

There is no clear pattern in the variation of male obesity across Buckinghamshire at GP practice level.

Figure 8 shows the fraction of the total number of obese people who are male and the fraction that are female.

Figure 8 - The fraction of the total number of obese people who are male and the fraction that are female.



Source: Buckinghamshire Public Health Department, presenting data from GP systems

This map illustrates there does not appear to be any pattern in the male/female proportions of obese people in the 40-74 year age band across Buckinghamshire.

7.2 Raised blood pressure in adults

High blood pressure is known to increase risks of heart attack, stroke, kidney disease and vascular dementia.[53]

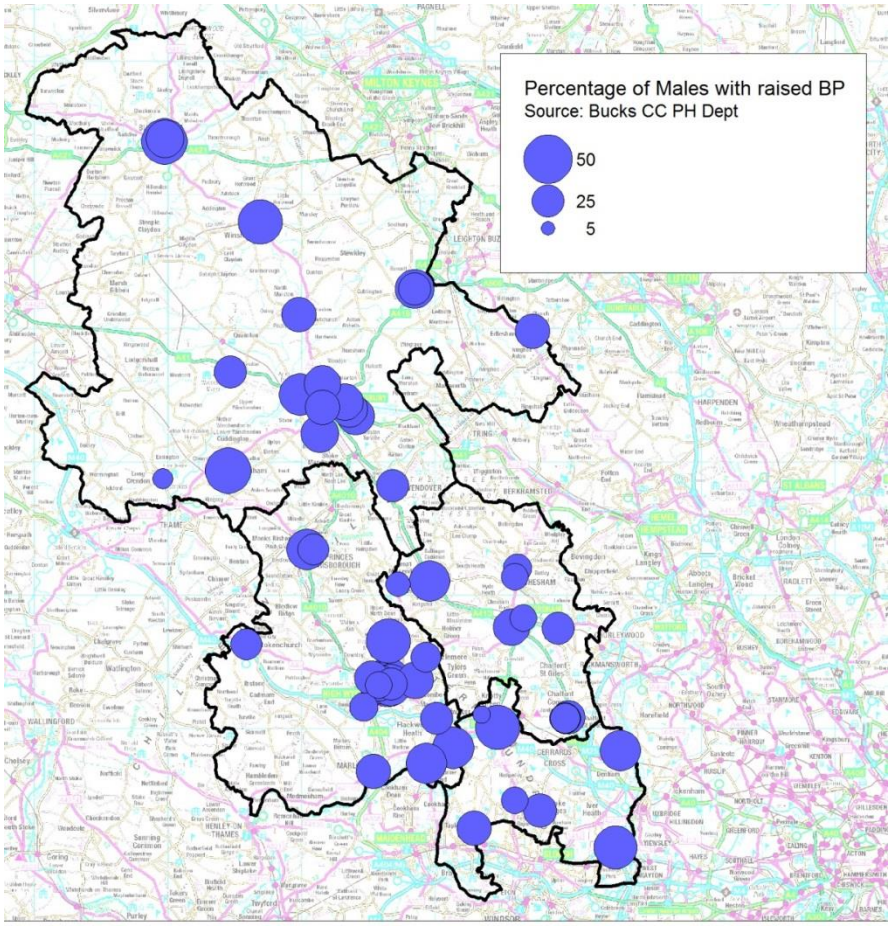
From 1 April 2013 to 28 February 2015, about 22,800 residents of Buckinghamshire had received an NHS Health Check at a GP Practice. Of these, 91% had their Blood Pressure (BP) measured (10,100 men and 10,600 women).

For NHS Health Check purposes, raised blood pressure is defined as greater than 140/90[54]

Overall in Buckinghamshire 27.4% of men and 20.5% of women measured were classified having raised blood pressure. Higher proportions of the total number of obese people were male (56%) than female (44%). There was considerable variation in obesity between GP practices: percentages of men who were obese ranged from 8.1% to 49.5%. The percentage of the obese population who were male ranged from 38.6% to 85.9%. In some GP Practices absolute numbers were small, and uncertainly would be correspondingly high, but confidence intervals were not calculated.

Figure 9 shows the percentage of males attending each GP practice where the measured BP was classified as raised. Each circle represents the location of a GP practice. Where GP practices operate at a number of sites the full data is shown at a single location. Where GP practices operate from the same premises some data may be obscured as more than one practice's data may be overlaid.

Figure 9 – The Location of males in Buckinghamshire with a raised BP

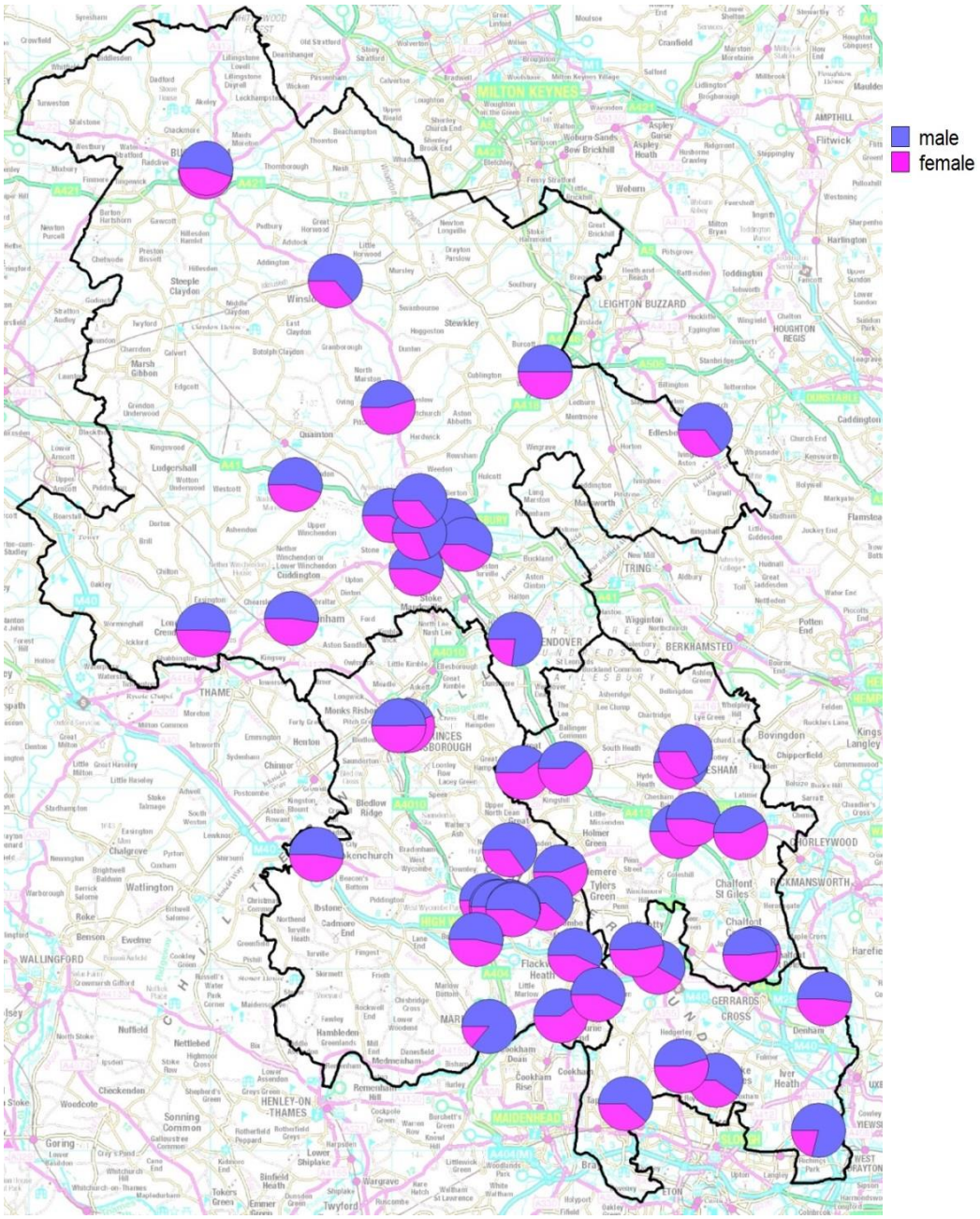


Source: Buckinghamshire Public Health Department, presenting data from GP systems

There is no clear pattern in the variation of raised BP in males across Buckinghamshire at GP practice level.

Figure 10 shows the fraction of the total number of people with raised BP who are male and the fraction that are female.

Figure 10 - The fraction of males and females with a raised BP



Source: Buckinghamshire Public Health Department, presenting data from GP systems

The substantially higher percentage of males with raised blood pressure suggests that targeting preventative intervention on males in this age group could potentially reduce health inequalities, especially in the area of mortality from circulatory diseases, where standardised mortality rates in Buckinghamshire of men aged 65-74 are more than double those of women in the same age group (see separate section).

7.3 Raised blood glucose in adults

Raised blood glucose can be a sign of pre-diabetes. Having high blood sugar levels for long periods of time (over months or years) can result in permanent damage to parts of the body such as the eyes, nerves, kidneys and blood vessels[55].

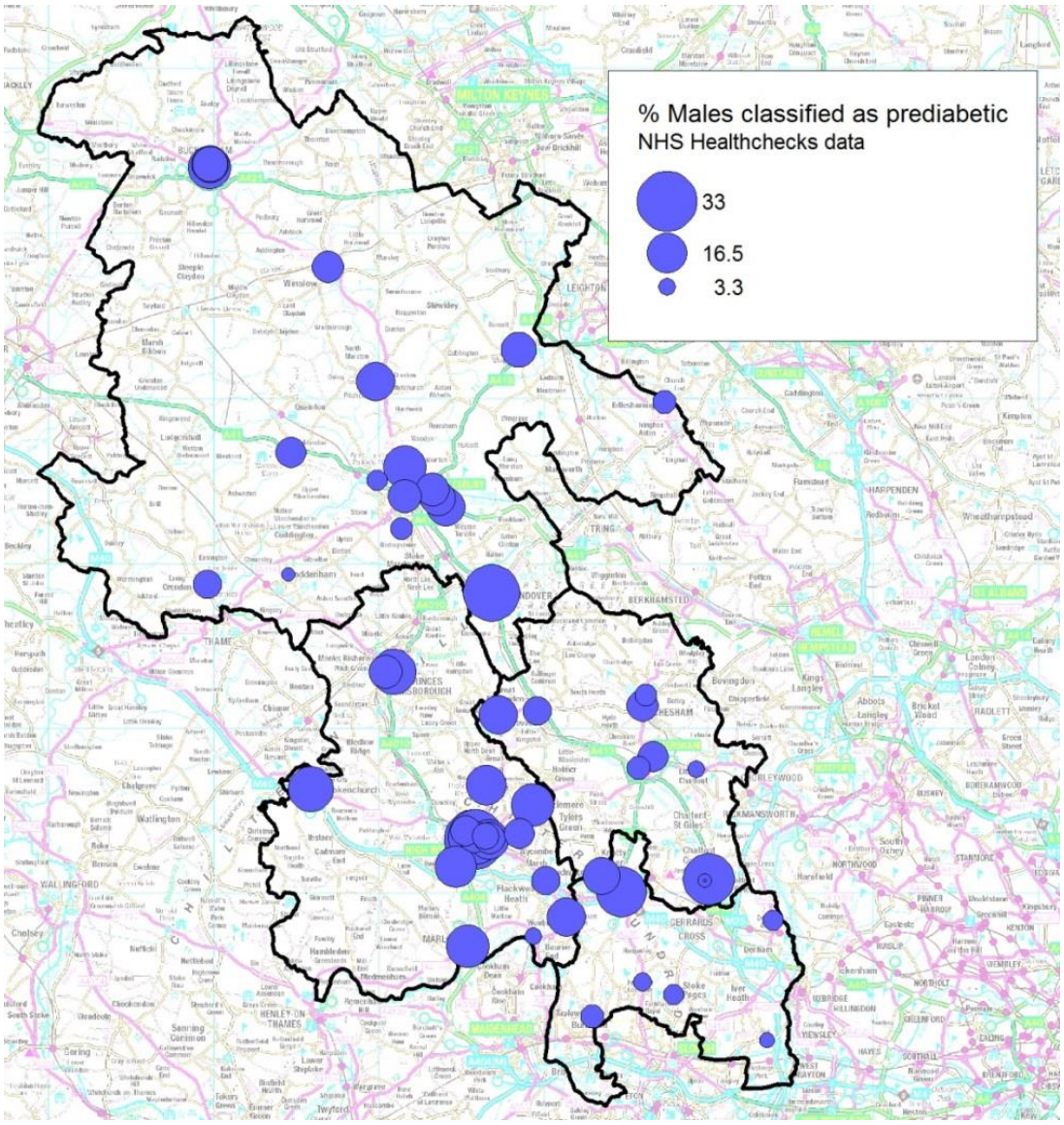
From 1 April 2013 to 28 February 2015, about 22,800 residents of Buckinghamshire had received an NHS Health Check at a GP Practice. Of these, 43% had their blood glucose measured (4,800 men and 4,900 women). For NHS Health Check purposes, blood glucose in the range 6-6.4% (42-47 mmol/mol) is defined pre-diabetic, and level over 6.5 (48 mmol/mol) is used to diagnose diabetes (source: http://www.nhs.uk/Conditions/Diabetes-type2/Pages/Diagnosis.aspx)

Pre-diabetes

Overall in Buckinghamshire 6% of men and 6.6% of women measured were classified as pre-diabetic. Higher proportions of the total number of obese people were female (53%) than male (47%). The findings showed there was considerable variation between GP practices: percentages of men who were obese ranged from zero to 33%. The percentage of the obese population who were male ranged from zero to 100%. In some GP Practices absolute numbers were small, and uncertainly would be correspondingly high, but confidence intervals were not calculated.

Figure 11 shows the percentage of males at each GP practice classified as pre-diabetic. Each circle represents the location of a GP practice. Where GP practices operate at a number of sites the full data is shown at a single location. Where GP practices operate from the same premises some data may be obscured as more than one practice's data may be overlaid.

Figure 11 - The percentage of males at each GP practice classified as pre-diabetic

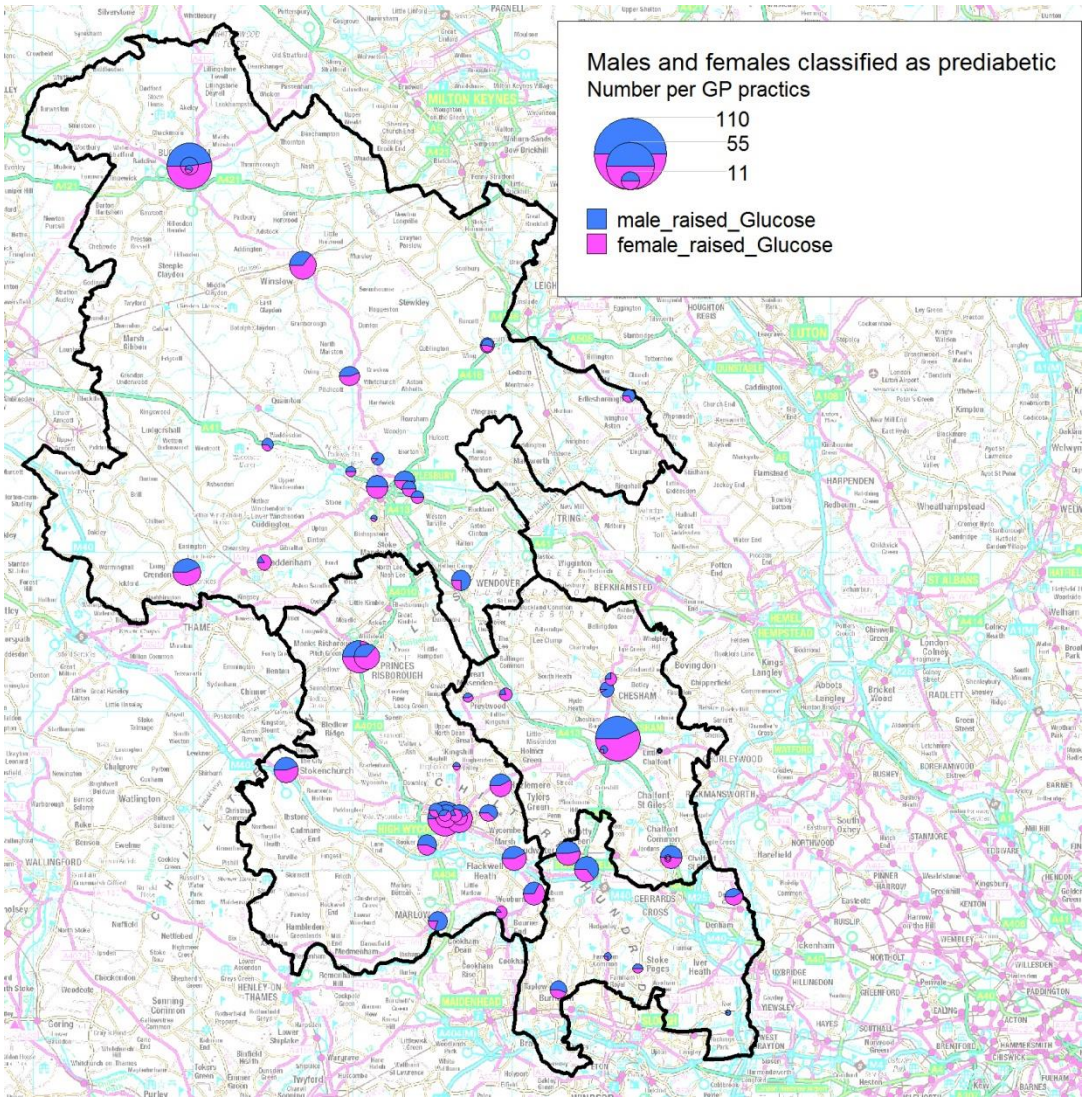


Source: Buckinghamshire Public Health Department, presenting data from GP systems

There is no clear pattern in the variation of pre-diabetic levels of blood glucose in males across Buckinghamshire at GP practice level.

Figure 12 shows the breakdown of the total number of people with blood sugar at pre-diabetic levels, by males and females.

Figure 12 - The total number of males and females with blood sugar at pre-diabetic levels



Source: Buckinghamshire Public Health Department, presenting data from GP systems

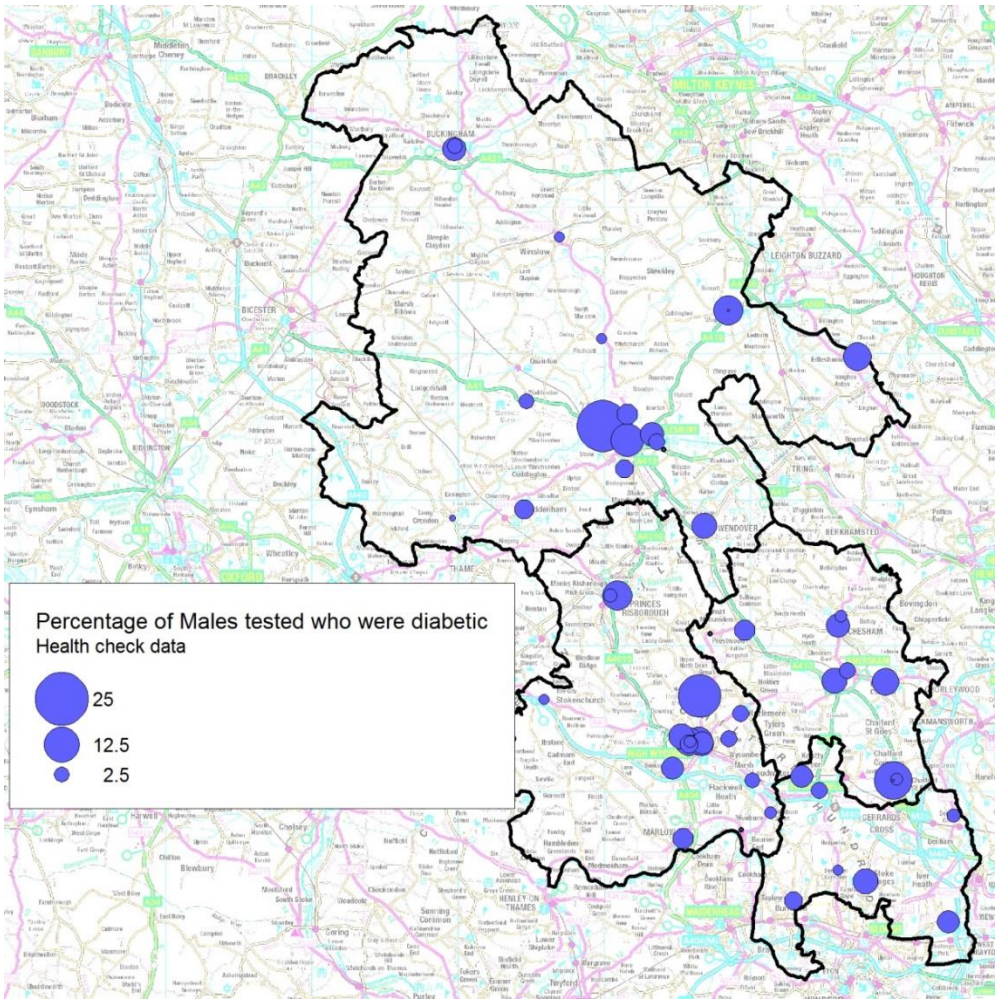
There does not appear to be any pattern in the male/female proportions of pre-diabetic people in the 40-74 year age band across Buckinghamshire. Absolute numbers of pre-diabetic people detected were greatest in Buckingham, Amersham, and High Wycombe.

Diabetes

Diabetes increases the risks of heart disease, stroke, atherosclerosis, nerve damage, loss of vision, kidney disease and foot problems,[56] (sometime leading to amputation).

Figure 13 shows the percentage of males attending each GP practice where the blood glucose was measured and were diagnosed as diabetic. Each circle represents the location of a GP practice. Where GP practices operate at a number of sites the full data is shown at a single location. Where GP practices operate from the same premises some data may be obscured as more than one practice's data may be overlaid.

Figure 13 - The percentage of males whose blood glucose was measured at each GP practice and who were diagnosed as diabetic



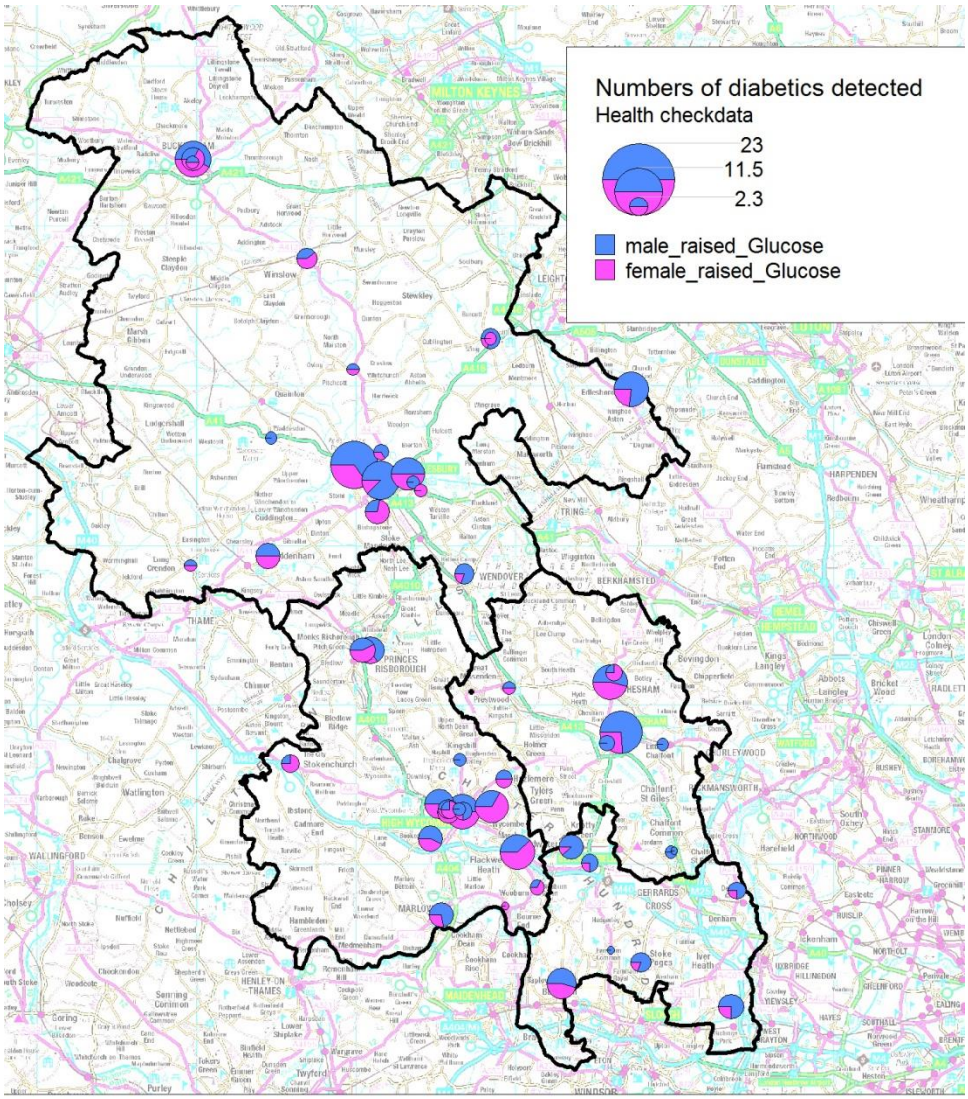
Source: Buckinghamshire Public Health Department, presenting data from GP systems

Overall in Buckinghamshire 4.2% of men and 2.7% of women measured were diagnosed as diabetic. Higher proportions of the total number of obese people were male (60%) than female (40%).

There was considerable variation between GP practices: percentages of men who were diabetic ranged from 2.5 to 25%. In some GP Practices absolute numbers were small, and uncertainly would be correspondingly high, but confidence intervals were not calculated.

Figure 14 shows the breakdown of the total number of people with blood sugar at diabetic levels, by males and females.

Figure 14 - The total number of males and females with blood sugar at diabetic levels



Source: Buckinghamshire Public Health Department, presenting data from GP systems

Absolute numbers of diabetic people detected were greatest in Aylesbury and Amersham (where there were more males than females) Buckingham (where there were similar numbers of each sex) and High Wycombe, where there were more females than males detected.

The percentage of previously undiagnosed diabetes detected at health checks was half as high again in males as in females. This represents a definite health inequality between the genders. GPs in Buckinghamshire should be encouraged to consider the possibility of undiagnosed diabetes in their male patients.

7.4 NHS health checks

NHS Health Checks are available for everybody aged 40-74 who has not already been either diagnosed with circulatory disease, kidney disease, or diabetes, or is known to have certain risk factors. Those eligible comprise that part of the age group who might be expected to benefit from preventative intervention. Between 1 April 2013 and 28 February 2015, about 22,800 residents of Buckinghamshire had received an NHS Health Check at a GP Practice. Of these, 91% had their body mass index (BMI) measured.

In principle, everyone eligible should be invited to a Health Check every five years. Table 3 shows the total population in Buckinghamshire, those eligible for a Health Check, those invited to a Health Check, those for whom a Health Check was done, and those classed as high risk[57] by the Health Check. Figures are presented by gender, and by quintile of deprivation (where Q1 is the least deprived and Q5 the most deprived), as absolute figures and as percentages.

Table 3 - The total population in Buckinghamshire, those eligible for a Health Check, those invited to a Health Check, those for whom a Health Check was done, and those classed as high risk by the Health Check

		Numbers				Percentages			
	Pop 40-74	Eligible	Offered Health check	Health check done	Recorded High Risk	Eligible	Offered Health check	Health check done	Recorded High Risk
TOTAL PATIENTS	242612	180462	52653	22773	451	74.4%	29.2%	43.3%	2.0%
FEMALE	121678	94722	23278	11763	164	77.8%	24.6%	50.5%	1.4%
MALE	120934	85740	29375	11010	287	70.9%	34.3%	37.5%	2.6%
FEMALE IMD Q	25871	20592	5190	2660	37	79.6%	25.2%	51.3%	1.4%
FEMALE IMD Q2	24015	19020	4417	2327	49	79.2%	23.2%	52.7%	2.1%
FEMALE IMD Q3	19422	15297	3967	1939	20	78.8%	25.9%	48.9%	1.0%
FEMALE IMD Q4	21749	16863	4514	2315	27	77.5%	26.8%	51.3%	1.2%
FEMALE IMD Q5	26170	19421	4884	2369	28	74.2%	25.1%	48.5%	1.2%
MALE IMD Q1	24873	17732	5684	2233	64	71.3%	32.1%	39.3%	2.9%
MALE IMD Q2	23114	16517	6138	2363	86	71.5%	37.2%	38.5%	3.6%
MALE IMD Q3	19143	13600	4955	1765	32	71.0%	36.4%	35.6%	1.8%
MALE IMD Q4	21781	15474	5970	2310	68	71.0%	38.6%	38.7%	2.9%
MALE IMD Q 5	27350	19110	6243	2274	24	69.9%	32.7%	36.4%	1.1%

Source: Buckinghamshire Public Health Department

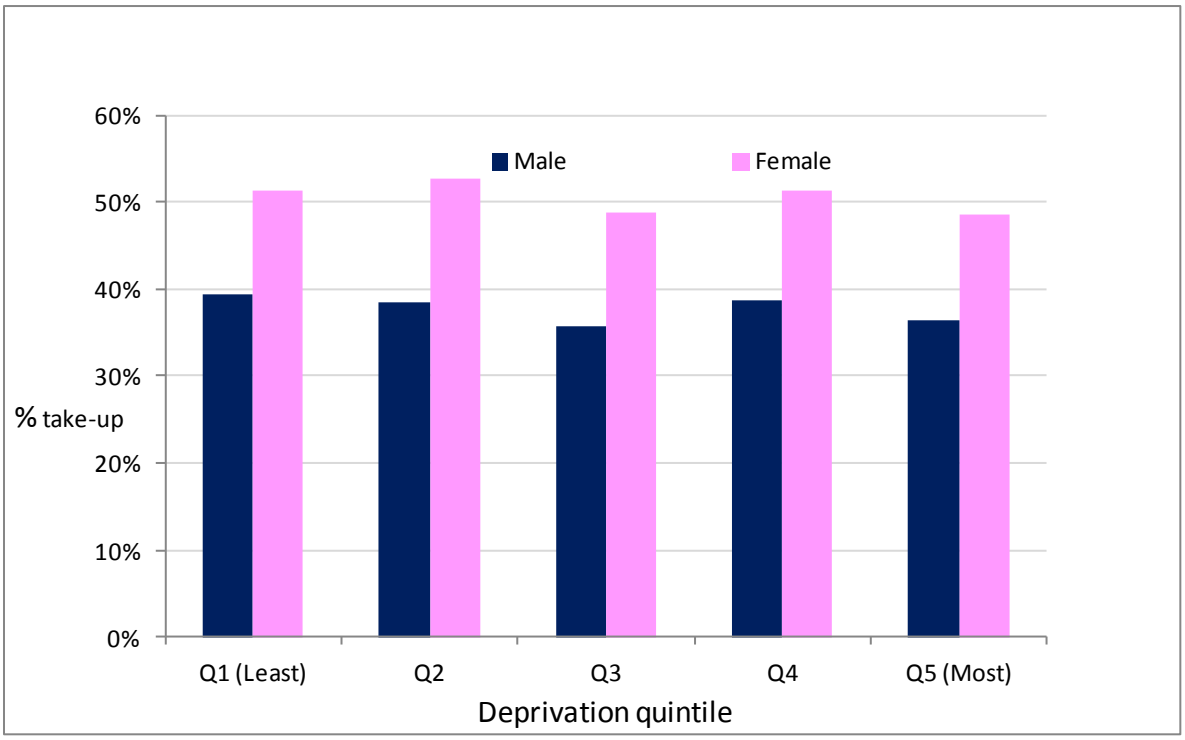
78% of the female population aged 40-74 are eligible, and 71% of the male population. By contrast, only a quarter of the female eligible population was invited to a Health Check, while over a third of the eligible male population was invited.

Of those invited, 51% of females and 38% of males accepted the invitation. The percentage of males found to be at high risk was almost double that of females.

Rates of take-up of invitations and high risk findings, by deprivation quintile, for males and females

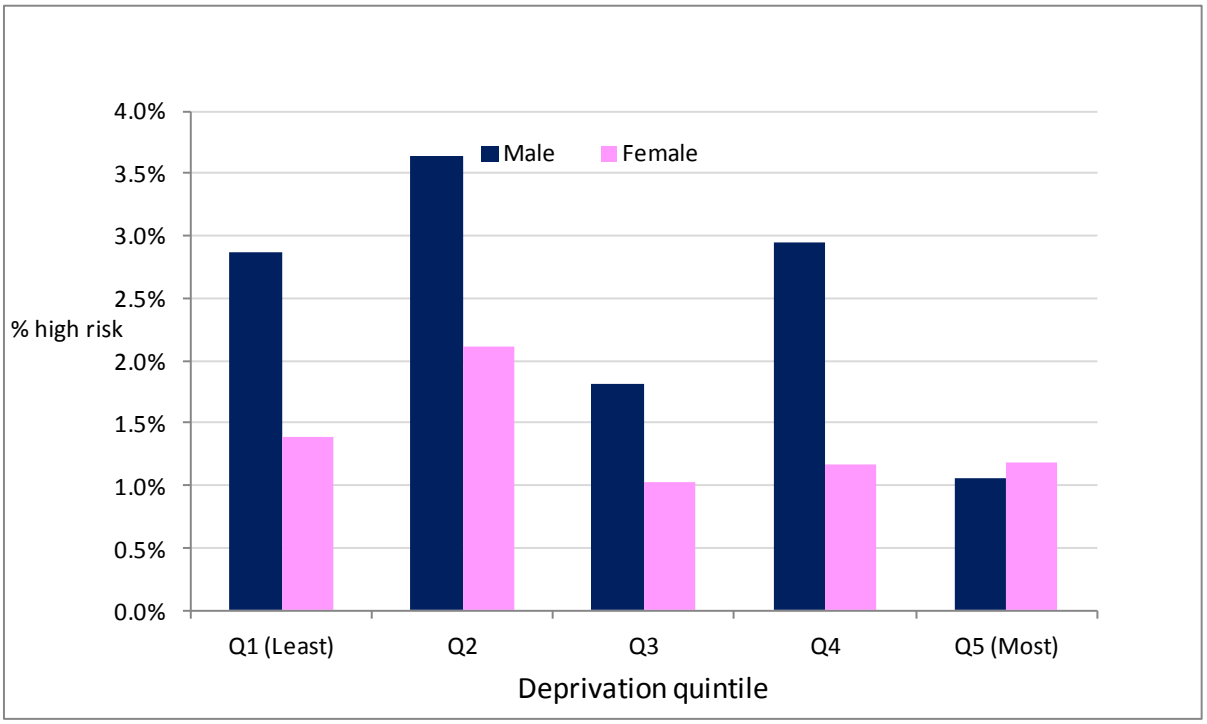
The take-up rates and total number of individuals identified with a raised risk score were analysed by gender and deprivation quintile, as shown in Figures 15 and 16.

Figure 15 - NHS Health Checks percentage take-up April 2013 - Feb 2015



Source: Buckinghamshire Public Health Department

Figure 16 - NHS Health Checks percentage high risk April 2013 - Feb 2015



Source: Buckinghamshire Public Health Department

It is known that as a general principle, poor health outcomes are associated with deprivation: the more deprived, the worse the outcome.
This pattern is not shown by the Buckinghamshire Health Checks data.
There is little difference in Health Check take up rates between deprivation quintiles, and no gradient in high risk percentages across deprivation quintiles.
High risk rates are higher in males than females in all deprivation bands except the most deprived, which itself had the lowest rate. Absolute numbers are fairly small, and there may be substantial uncertainty in the rates arising purely from the play of chance.

7.5 Participation in sport

There is good scientific evidence that being physically active can help us lead healthier lives[58]. Regular physical activity can reduce the risk of many chronic conditions, including coronary heart disease, stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions.

Table 4 and Figure 17 show the percentages of the population participating in sport at least once a week in Buckinghamshire, its JSNA comparators, the South East Region, and England 2014-15. Data is presented as percentages. Confidence intervals are not available, and figures have not been issued disaggregate by sex.

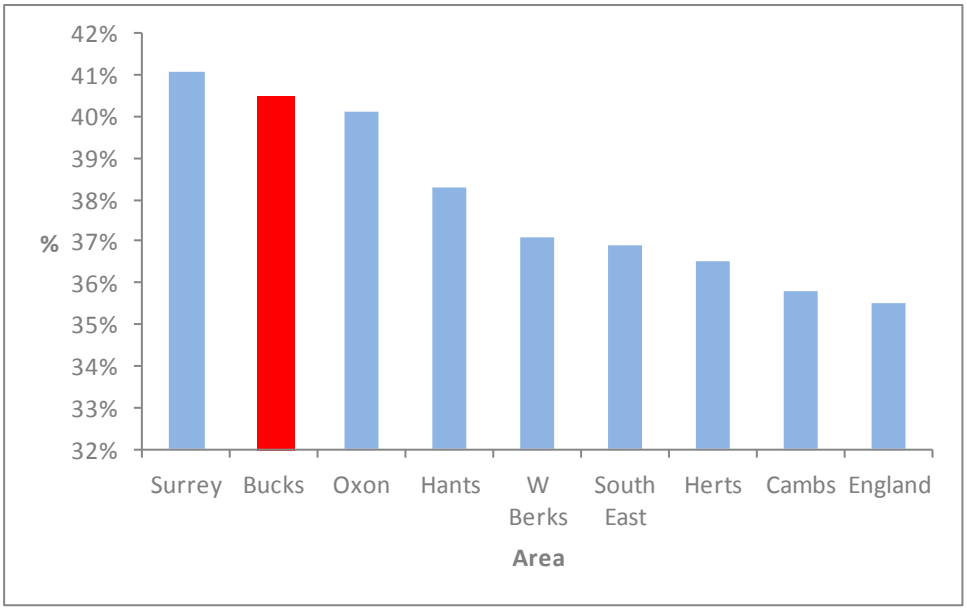
Table 4 - Percentages of the population participating in sport at least once a week in Buckinghamshire

Surrey	Bucks	Oxon	Hants	W Berks	South East	Herts	Cambs	England
41.1%	40.5%	40.1%	38.3%	37.1%	36.9%	36.5%	35.8%	35.5%

Source: Sport England Local Sport Profile and Active People Survey, http://www.sportengland.org, 26 Oct 2015

Figure 17 shows participation rates in Buckinghamshire were higher than the average for the South East region and for England. In the absence of confidence interval data it is not possible to determine the statistical significance of the data.

Figure 17 – Persons aged >16 participating in sport at least once a week, 2014/15, % of the population



Source: Sport England Local Sport Profile and Active People Survey, http://www.sportengland.org, 26 Oct 2015

Trends in participation in sport

Table 5 and Figure 18 show trends in participation in sport for Buckinghamshire, the South East, and England from 2005-06 to 2014-15 (Q2).

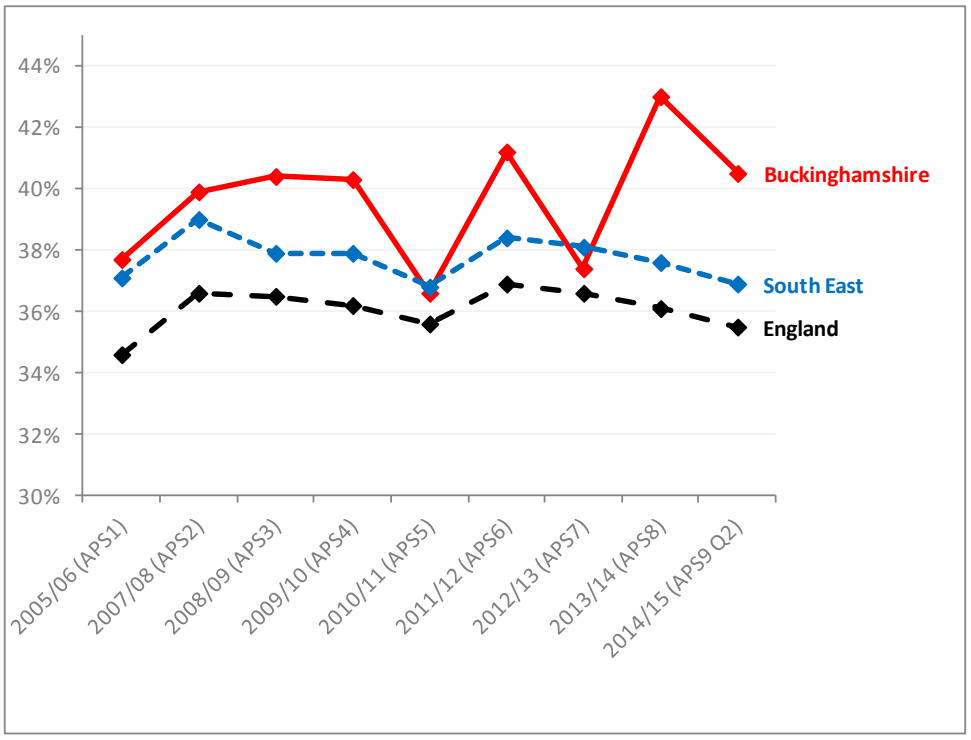
Table 5 - Trends in participation in sport for Buckinghamshire, the South East, and England from 2005-06 to 2014-15

	2005/06 (APS1)	2007/08 (APS2)	2008/09 (APS3)	2009/10 (APS4)	2010/11 (APS5)	2011/12 (APS6)	2012/13 (APS7)	2013/14 (APS8)	2014/15 (APS9 Q2)
Bucks	37.7%	39.9%	40.4%	40.3%	36.6%	41.2%	37.4%	43.0%	40.5%
South East	37.1%	39.0%	37.9%	37.9%	36.8%	38.4%	38.1%	37.6%	36.9%
England	34.6%	36.6%	36.5%	36.2%	35.6%	36.9%	36.6%	36.1%	35.5%

Source: Sport England Local Sport Profile and Active People Survey, http://www.sportengland.org, 26 Oct 2015

Figure 18 shows in seven of the nine years' surveys participation in sport in Buckinghamshire was higher than the South East regional average and that of England overall. The data does not indicate any underlying trends. In the absence of confidence intervals it is not possible to be certain about statistical significance, but it seems likely that most of the year-to-year variation is the result of sampling error rather than indicative of real differences.

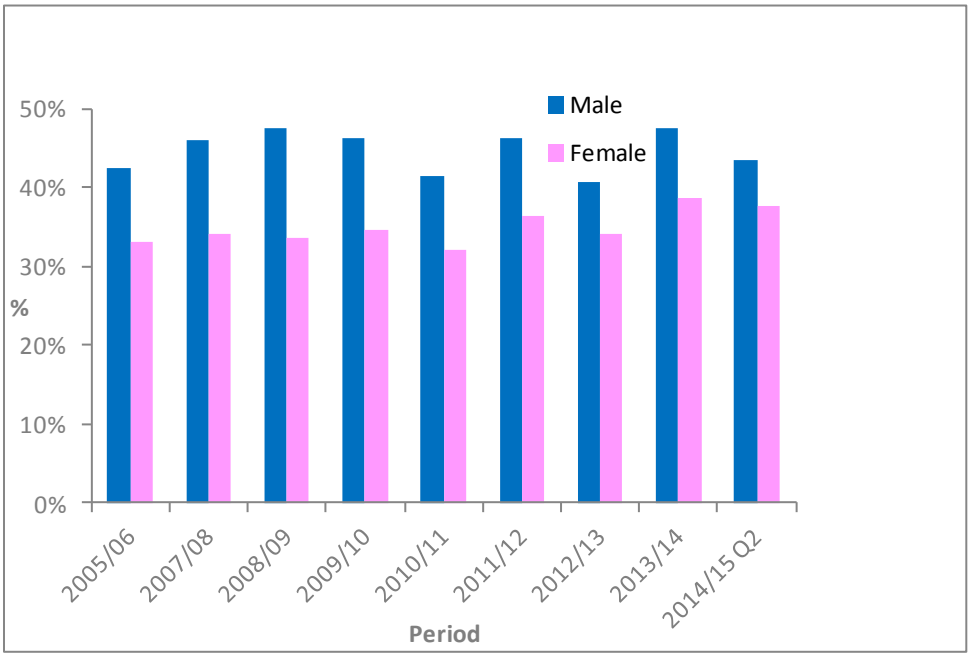
Figure 18 - Persons aged >16 participating in sport at least once a week, 2005/06 to 2014/15, % population



Source: Sport England Local Sport Profile and Active People Survey, http://www.sportengland.org, 26 Oct 2015

Figure 19 shows adult (16+) Participation in Sport & Active Recreation (formerly NI8) by year, frequency and gender. It can be seen that men were more active than women, having greater proportions of men in the more active categories in both time periods.

Figure 19 - Adult (16+) Participation in Sport & Active Recreation (formerly NI8) by year, frequency and gender, 2005-06 to 2014-15 Q2

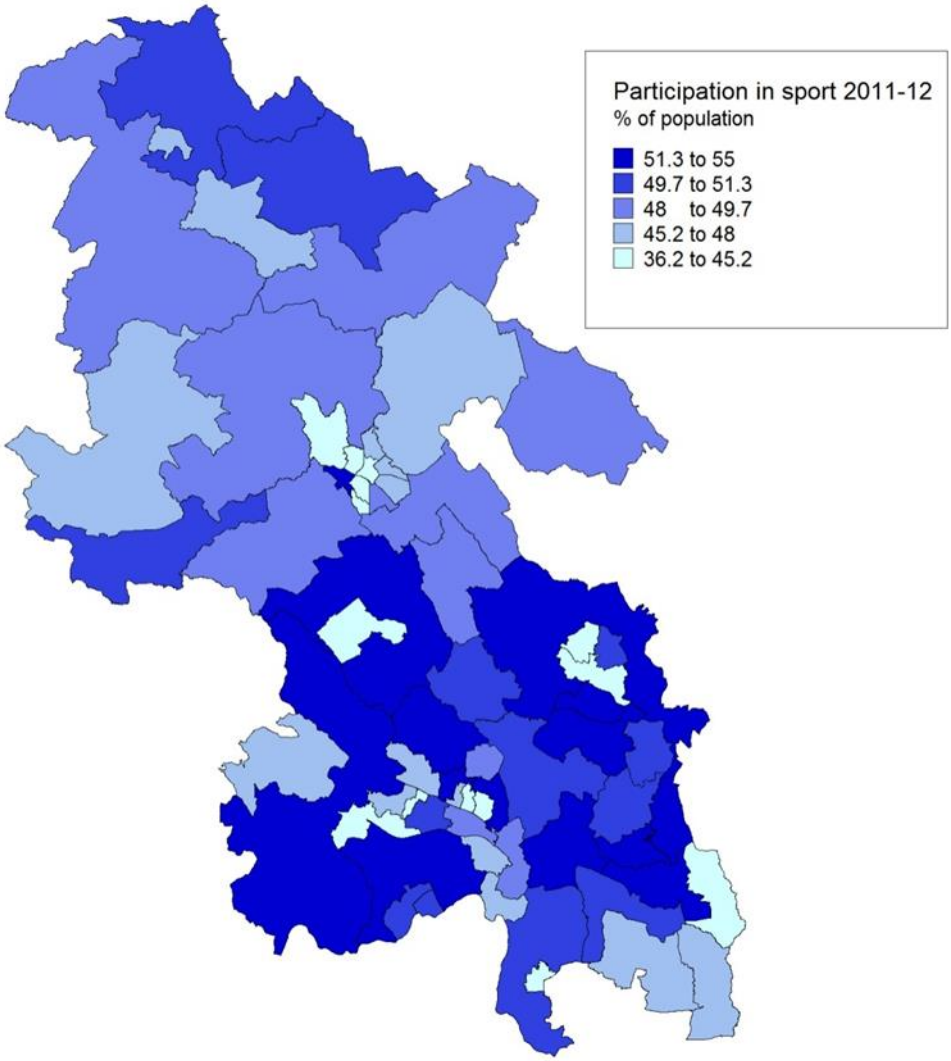


Source: Sport England Local Sport Profile and Active People Survey, http://www.sportengland.org, 26 Oct 2015

Participation in sport across Buckinghamshire

Figure 20 shows participation in sport in Buckinghamshire in 2011-12, at Middle Super Output (MSOA) level, as recorded in the Active People Survey.[59] The Active People Survey is a large telephone survey of sport and active recreation, commissioned by Sport England. The survey measures participation in sport and active recreation, and provides details of how participation varies from place to place and between different groups in the population. Data shows local quintiles of percentages of the population.

Figure 20 - Participation in Sport 2011-2012 % of population



Source: Sport England Local Sport Profile and Active People Survey, http://www.sportengland.org, 5 March 2015

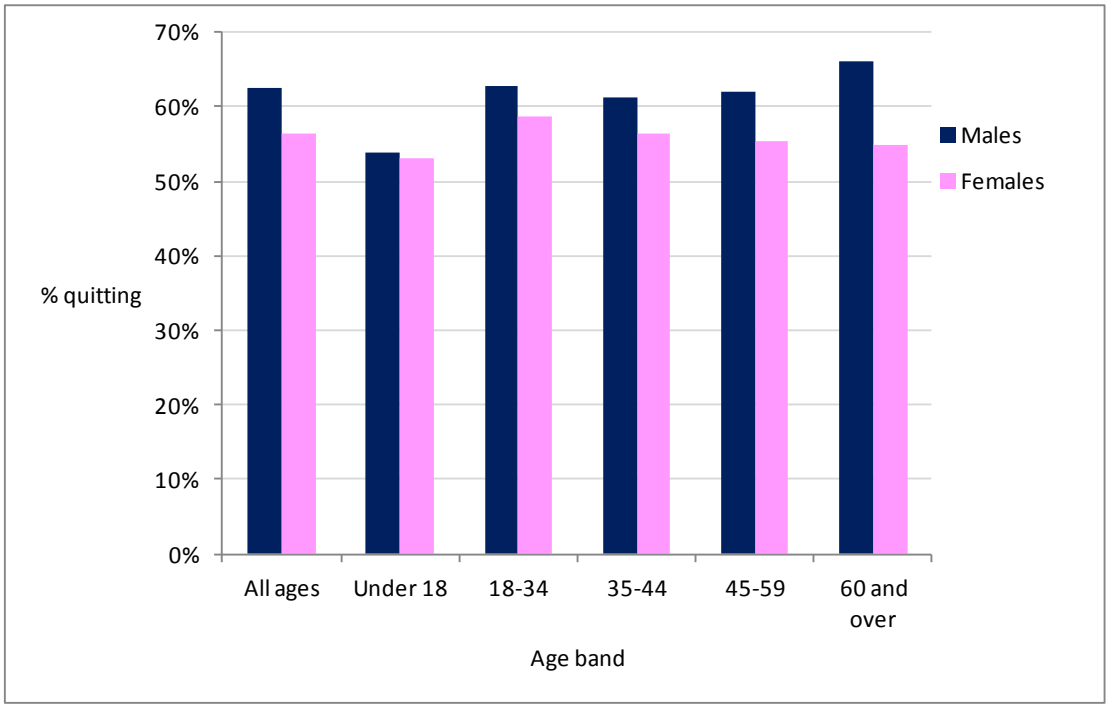
This map illustrates that participation was highest in the southern half of the county, though notably lower in High Wycombe, Amersham and Chesham, and the Princes Risborough areas.

7.6 Smoking cessation

Smoking is the primary cause of preventable illness and premature death, accounting for approximately 100,000 deaths a year in the United Kingdom. Smoking harms nearly every organ of the body and dramatically reduces both quality of life and life expectancy. Smoking causes lung cancer, respiratory disease and heart disease as well as numerous cancers in other organs including lip, mouth, throat, bladder, kidney, stomach, and liver[60].

Figure 21 shows rates of setting smoking quit dates and successful quitting, by gender and age-band for Buckinghamshire

Figure 21 - Percentage of those setting quit dates and successfully quitting, by age band Buckinghamshire 2013-14



Source: Buckinghamshire Public Health Department

Successful quit rates were higher in men than in women in every age band. The effect is most marked in the over 60s.

Considering ethnicity, Table 6 compares percentages of all those setting a quit date with the census 2011 population by broad ethic category.

Table 6 - Percentages of all those setting a quit date with the Census 2011 population by broad ethic category

	Set quit date	Population
White	80.9%	82.6%
Mixed	2.3%	2.0%
South Asian	9.6%	6.4%
Black	1.8%	2.3%
Other	5.4%	6.7%

Source: Buckinghamshire Public Health Department

Stop Smoking Services' penetration is relatively high in the South Asian ethnic groups where the highest smoking prevalence rates occur.

7.7 Men and domestic violence

Buckinghamshire Domestic Violence and Abuse strategy addresses national and local statistics and offers a comprehensive strategy for reducing domestic violence.

Key National Statistics regarding domestic violence and abuse (DVA)[61]

- 1 in 4 women are affected by an abusive relationship at some time in their lives after the age of 16[62].
- Domestic homicides account for approximately one third of all homicides in England and Wales with an average of 2 women killed every week by a current or former partner[63].
- DVA accounts for the highest number of repeat victims of all violent crime[64].
- DVA often starts or intensifies during pregnancy[65].

Domestic Violence and Abuse in Buckinghamshire

- 7,357 incidents reported to the police in 2013/14[66].
- 3,153 repeat incidents reported to the police in 2013/14[67].
- 16,738 women and girls have been victims of Domestic Violence and Abuse in 2013 (more than 2 times police reports)[68].
- 0 domestic homicides in Buckinghamshire between April 2013 and March 2014.[69]
- 1,041 victims supported in 2012/1310[70].

Buckinghamshire want a zero tolerance approach towards Domestic Violence and Abuse and coordinated response to people at risk of it, ensuring that those who are affected are identified, supported, protected and empowered.

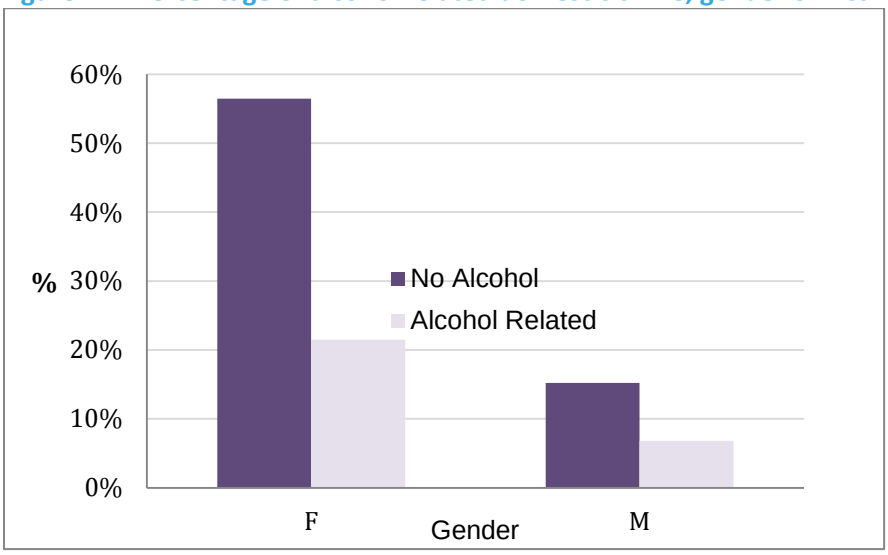
Alcohol related domestic violence

In Buckinghamshire during the year 2013/14, there were 1,990 domestic crimes. Of these, 565 (29%) were marked as alcohol related by the investigating officer. A male victim was recorded in 22% of domestic crimes and almost 1/3 of these were alcohol related compared to just over a quarter of crimes with a female victim.

Figure 22 shows percentages of domestic crime victims by gender, with police assessment of alcohol involvement.

The most recent data on prevalence of binge drinking (over twice the recommended limit on at least one day in a week) is for 2006-08, and gives Bucks at 17.1% compared with England's 20%. This difference is statistically significant at the 5% level. The data was not disaggregated by gender[71]. (Source Public Health England www.localhealth.org.uk, accessed 10 Nov 2015).

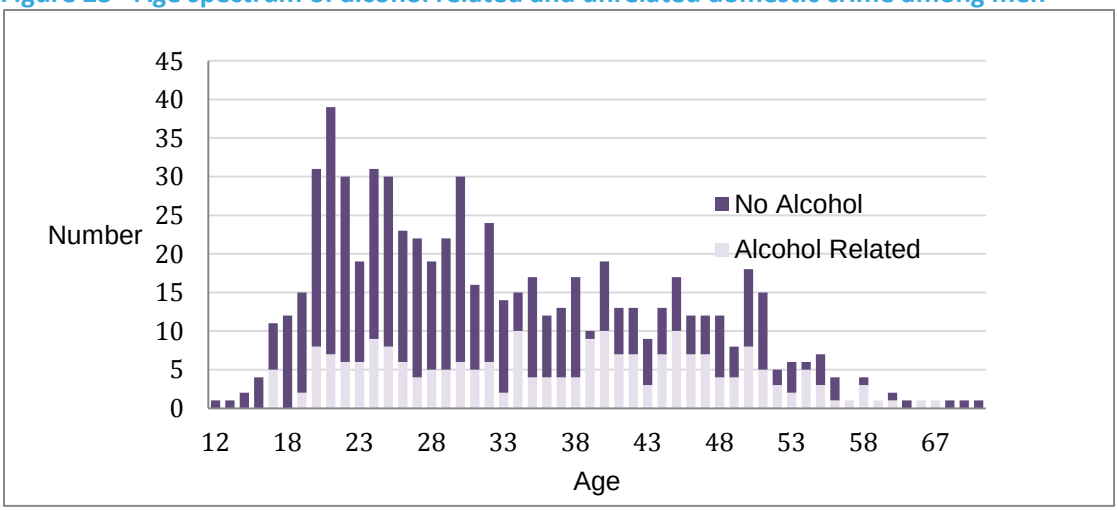
Figure 22 - Percentage of alcohol related domestic crime, gender of victims (2013/14)



Data source: Thames Valley Police 2014

Of the domestic crimes where a male was recorded as the victim; another male perpetrated the crime in 60%, and a female in 40%, of cases. Those crimes with a female perpetrator were more likely to be recorded as alcohol related.

Figure 23 - Age spectrum of alcohol related and unrelated domestic crime among men



Data source: Thames Valley Police

As Figure 23 shows, young adult males (18-26) are responsible for a much higher number of domestic crimes and 22% of these are recorded as alcohol related. Middle-aged and older adults (40 years +) commit much fewer domestic crimes, however they are more likely to be alcohol related with 50% of crimes committed by this age group marked as alcohol related.

In Buckinghamshire, as in the rest of the country, primarily, males perpetrated domestic violence against females. Where males are victims of domestic violence and/or females are perpetrators of domestic violence, these crimes are more likely to be recorded as alcohol related than the traditional male-female offender-victim relationship.

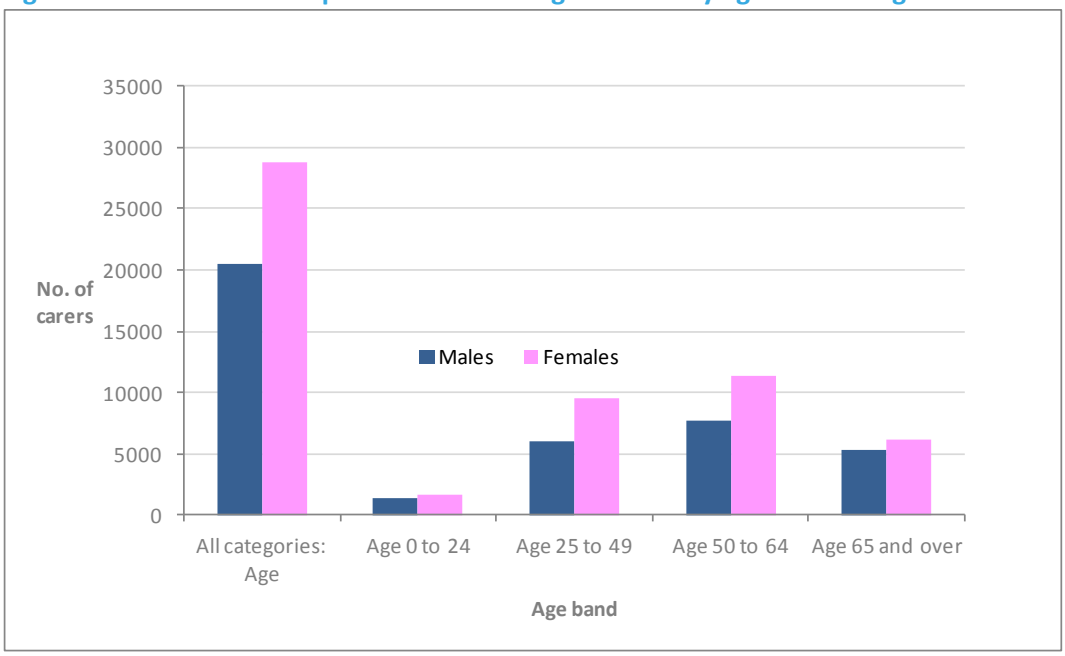
Where males are the perpetrators, young adults (18-26) are responsible for the highest proportion of crimes and approximately 22% of these are alcohol related. In contrast, however, where the offender is aged over 40 years old, 50% of crimes are recorded as alcohol related.

7.8 Social care

Unpaid carers

Figure 24 shows numbers of carers by age band. According to the 2011 Census 20,500 males and 28,800 females provided one or more hours per week of unpaid care.

Figure 24 - Providers of unpaid care in Buckinghamshire by age band and gender

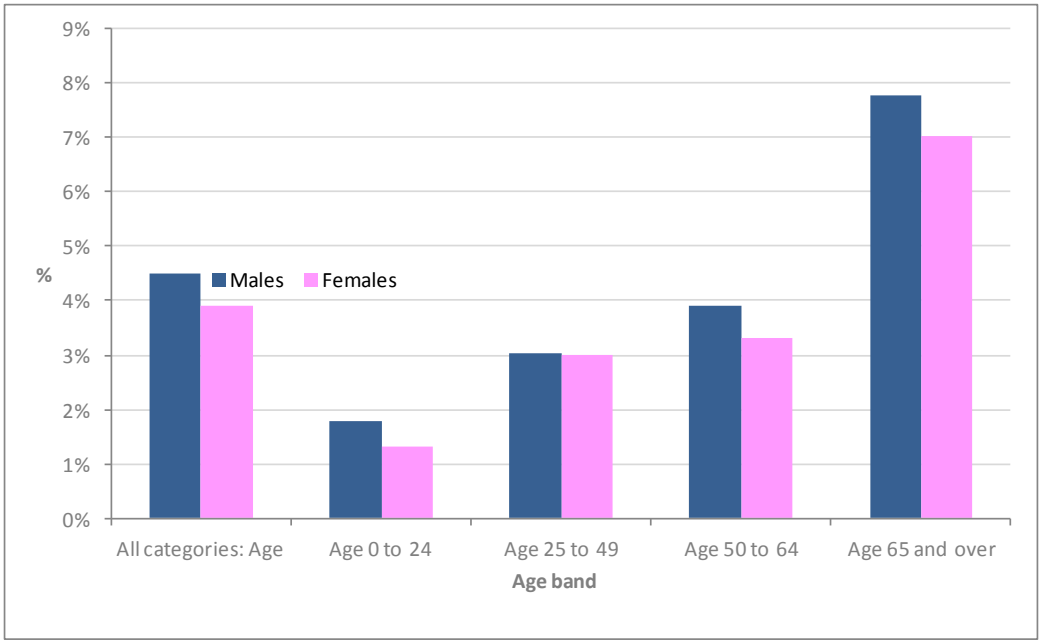


Source 2011 Census

Overall, males make up 42% of unpaid carers in Buckinghamshire, 45% in the 0-24 age band, 39% in the 25-49 age band, 41% in the 50-64 age band, and 46% in the over 65s.

At 10% of the population, unpaid carers make up a similar fraction of the population in Buckinghamshire as in England. In each age-band, higher proportions of male than female unpaid carers reported their health as bad or very bad, as Figure 25 shows.

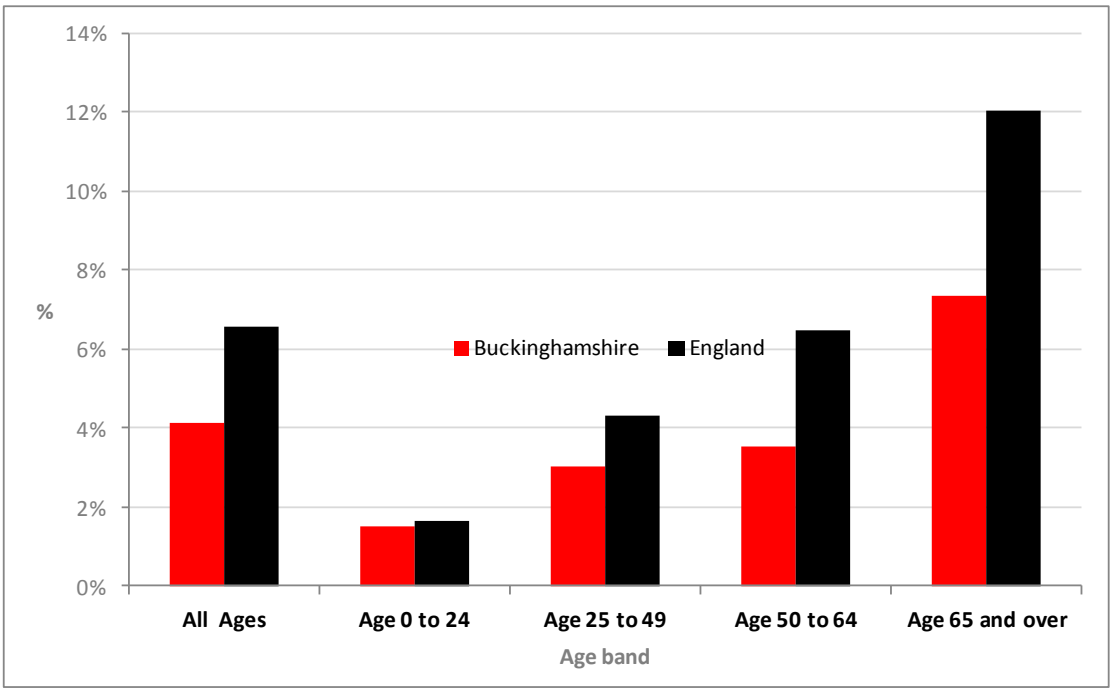
Figure 25 - Proportion of unpaid carers reporting bad or very bad health in 2011 census, by age band and gender



Source *2011 Census*

Figure 26 shows, lower proportions of unpaid carers in Buckinghamshire than in England reported their health as bad or very bad, as the following chart shows.

Figure 26 - Proportion of unpaid carers reporting bad or very bad health in 2011 census, Buckinghamshire and England



Source 2011 Census

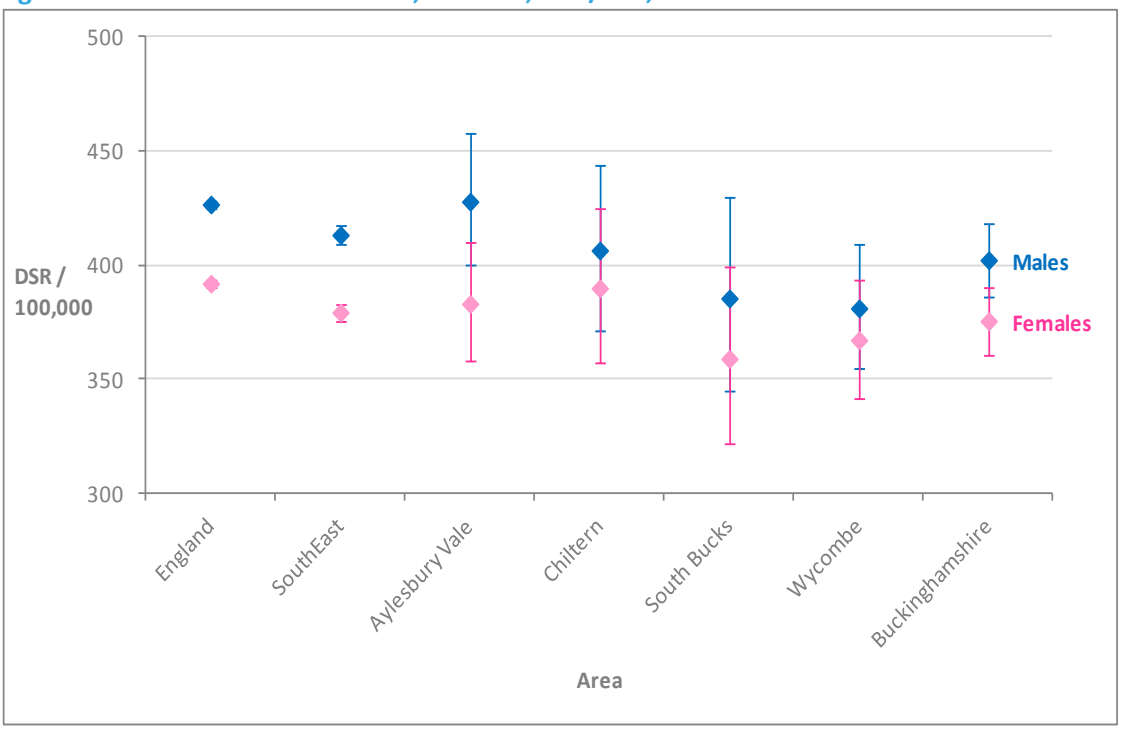
8. Cancer Prevalence Data

The following sections illustrate that the incidence of all the major cancers affecting both genders is higher in males than females. Nationally and regionally level this is statistically significant at the usual 5% level. At the local authority level the difference is not always statistically significant, because of low absolute numbers. Except for skin cancers, incidence in Buckinghamshire tends to be lower than in England overall.

8.1 Incidence of all cancers

Figure 27 and Table 7 show the incidence of all cancers in Buckinghamshire, its component districts, the South East of England, and England, in the three year period 2010-2012, for males and females. Data is presented as Directly Standardised Rates (DSR) per 100,000 using the 2013 European Standard Population, with 95% confidence intervals. Direct Standardisation is a statistical technique that takes account of differences in population structures and enables valid comparisons to be made between different populations. 95% confidence intervals (CI) are best understood as the range within which we can be 95% confident that the true population value lies given the sample measured. CIs are expressed by the Lower Limits (LL) and Upper Limits (UL) of their range

Figure 27 - Incidence of all cancers, 2010-12, DSR/100,000



Source: HSCIC Indicators Portal

Table 7 - Incidence of all cancers, 2010-12, DSR/100,000

	Males			Females		
	DSR	**LL**	**UL**	**DSR**	**LL**	**UL**
England	426.61	424.98	428.24	391.90	390.40	393.40
South East	413.22	409.30	417.17	379.27	375.67	382.90
Aylesbury Vale	427.84	399.71	457.41	383.04	357.67	409.72
Chiltern	406.46	371.29	444.05	389.86	356.80	425.15
South Bucks	385.44	344.90	429.42	358.97	321.55	399.55
Wycombe	381.08	354.35	409.29	367.13	341.92	393.71
Buckinghamshire	**402.21**	**386.41**	**418.50**	**375.48**	**360.87**	**390.52**

Source: HSCIC Indicators Portal

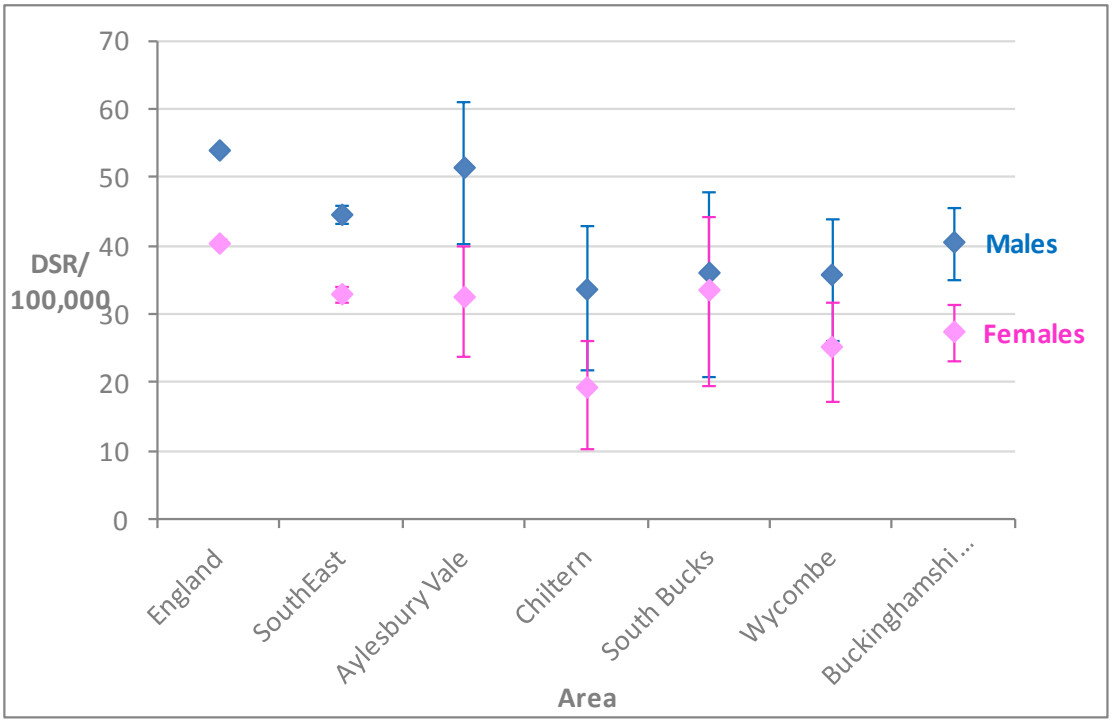
In each area, incidence of all cancers was higher in males than in females. At the England and South East levels the difference was statistically significant at the usual 5% level. At the County and District levels the difference was not statistically significant at this level (as the 95% confidence intervals overlap).

For males the rates for Buckinghamshire and for Wycombe were significantly below the England rate; the rates for the other districts were not. Only Wycombe had a rate significantly below that of the South East.

8.2 Incidence of lung cancers aged <75

Figure 28 and Table 8 show the incidence of lung cancer in Buckinghamshire, in component districts, the South East of England, and England, in the three year period 2010-2012, for males and females aged under 75 years. Data is presented as Directly Standardised Rates per 100,000 using the 2013 European Standard Population, with 95% confidence intervals.

Figure 28 - Incidence of lung cancers, 2010-12, <75, DSR/100,000



Source: HSCIC Indicators Portal

Table 8 - - Incidence of lung cancers, 2010-12, <75, DSR/100,000

	Males			Females		
	DSR	LL	UL	DSR	LL	UL
England	54.10	53.52	54.70	40.46	39.98	40.96
South East	44.67	43.37	45.99	33.04	31.97	34.14
Aylesbury Vale	51.57	41.91	62.77	32.63	25.33	41.37
Chiltern	33.73	24.37	45.48	19.38	12.64	28.43
South Bucks	36.17	24.52	51.41	33.64	22.81	47.79
Wycombe	35.88	27.86	45.48	25.32	18.89	33.24
Buckinghamshire	**40.65**	**35.68**	**46.12**	**27.54**	**23.62**	**31.91**

Source: HSCIC Indicators Portal

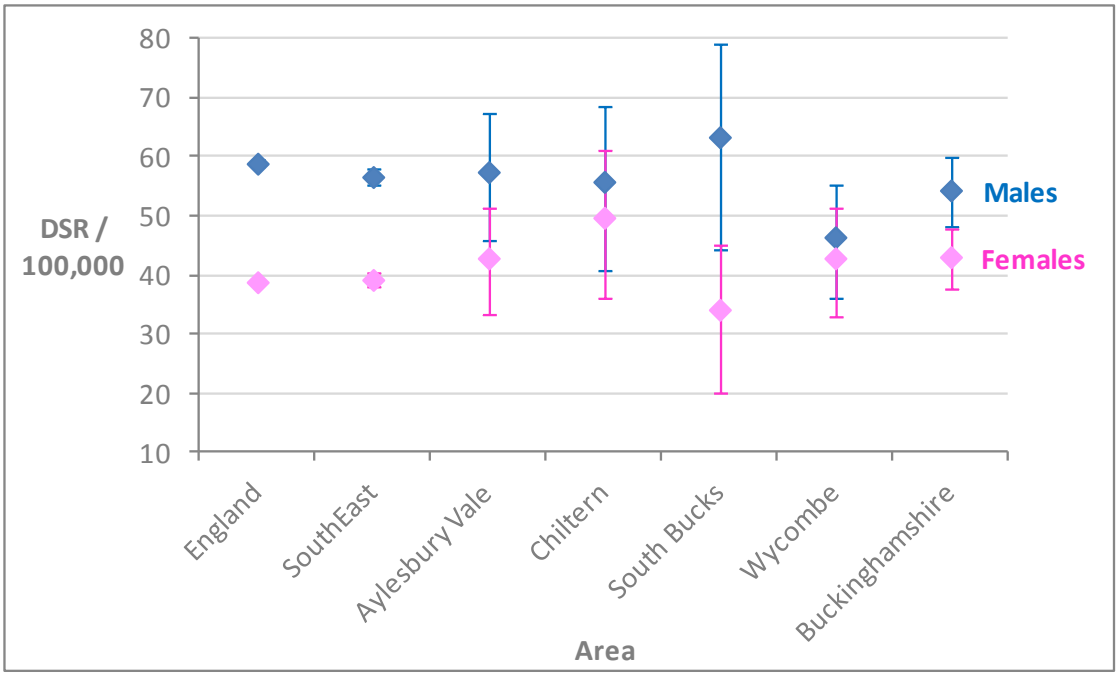
In each area, incidence of lung cancer was higher in males than in females. At the England and South East, Aylesbury Vale and Buckinghamshire levels the difference was statistically significant at the usual 5% level.

For males the rates for Buckinghamshire and all districts except Aylesbury Vale were significantly below the England rate.

8.3 Incidence of colorectal cancers aged <75

Figure 29 and Table 9 shows the incidence of all colorectal cancer in Buckinghamshire, in component districts, the South East of England, and England, in the three year period 2010-2012, for males and females aged under 75 years. Data is presented as Directly Standardised Rates per 100,000 using the 2013 European Standard Population, with 95% confidence intervals.

Figure 29 - Incidence of colorectal cancers, 2010-12, <75, DSR/100,000



Source: HSCIC Indicators Portal

Table 9 - Incidence of colorectal cancers, 2010-12, <75, DSR/100,000

	Males			Females		
	DSR	LL	UL	DSR	LL	UL
England	58.90	58.29	59.51	38.82	38.34	39.30
South East	56.64	55.19	58.12	39.21	38.05	40.40
Aylesbury Vale	57.47	47.43	68.99	42.87	34.55	52.56
Chiltern	55.82	43.25	70.88	49.74	38.43	63.31
South Bucks	63.38	47.67	82.57	34.15	23.34	48.24
Wycombe	46.43	37.44	56.91	42.87	34.44	52.72
Buckinghamshire	**54.37**	**48.65**	**60.57**	**43.07**	**38.17**	**48.43**

Source: HSCIC Indicators Portal

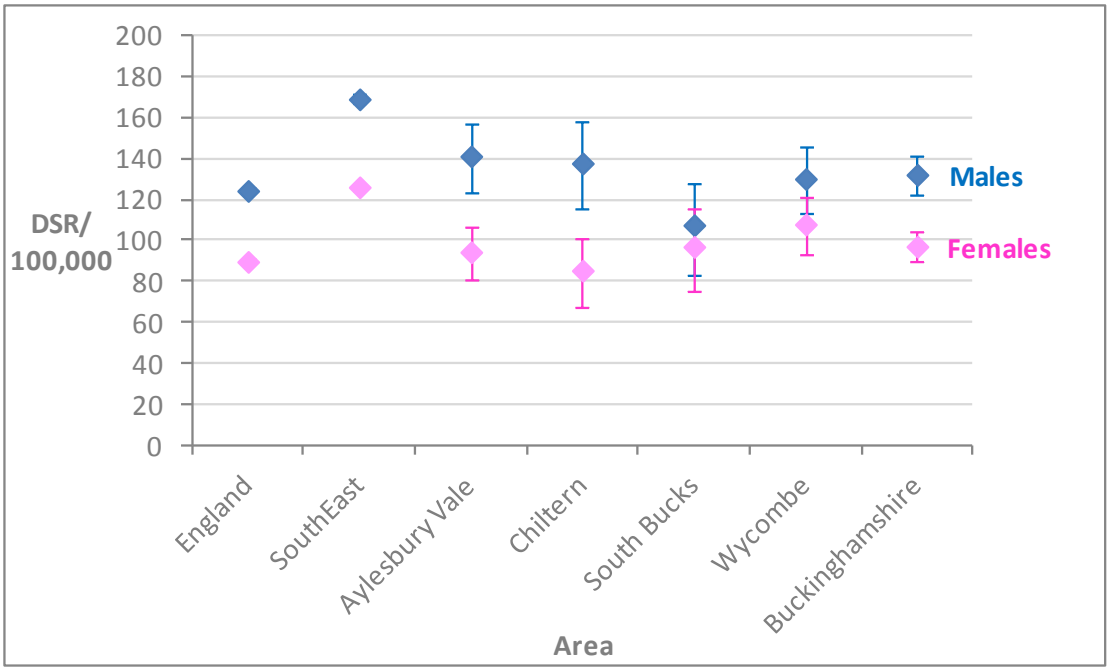
In each area, incidence of colorectal cancers was higher in males than in females. At the England and South East levels the difference was statistically significant at the usual 5% level. At the County and District levels the difference was only statistically significant at this level in South Bucks.

For males the rates for Wycombe were significantly below the England and South East rates; the rates for the other districts were not.

8.4 Incidence of skin cancers aged <75

Figure 30 and Table 10 show the incidence of skin cancers (other than malignant melanoma) in Buckinghamshire, in component districts, the South East of England, and England, in the three year period 2010-2012, for males and females aged under 75 years. Data is presented as Directly Standardised Rates per 100,000 using the 2013 European Standard Population, with 95% confidence intervals.

Figure 30 – Incidence of skin cancers, 2010-12, <75, DSR/100,000



Source: HSCIC Indicators Portal

Table 10 - Incidence of skin cancers, 2010-12, <75, DSR/100,000

	Males			Females		
	DSR	LL	UL	DSR	LL	UL
England	124.29	123.41	125.18	89.68	88.95	90.40
South East	168.98	166.47	171.52	126.06	123.98	128.18
Aylesbury Vale	141.17	125.18	158.62	94.40	81.89	108.27
Chiltern	137.72	117.54	160.36	85.40	70.24	102.84
South Bucks	107.55	86.72	131.86	97.00	78.05	119.16
Wycombe	130.12	114.65	147.09	107.92	94.35	122.88
Buckinghamshire	**132.12**	**123.11**	**141.61**	**97.12**	**89.71**	**104.97**

Source: HSCIC Indicators Portal

In each area, incidence of skin cancer was higher in males than in females. At the England and South East, Aylesbury Vale, Chiltern and Buckinghamshire levels the difference was statistically significant at the usual 5% level.

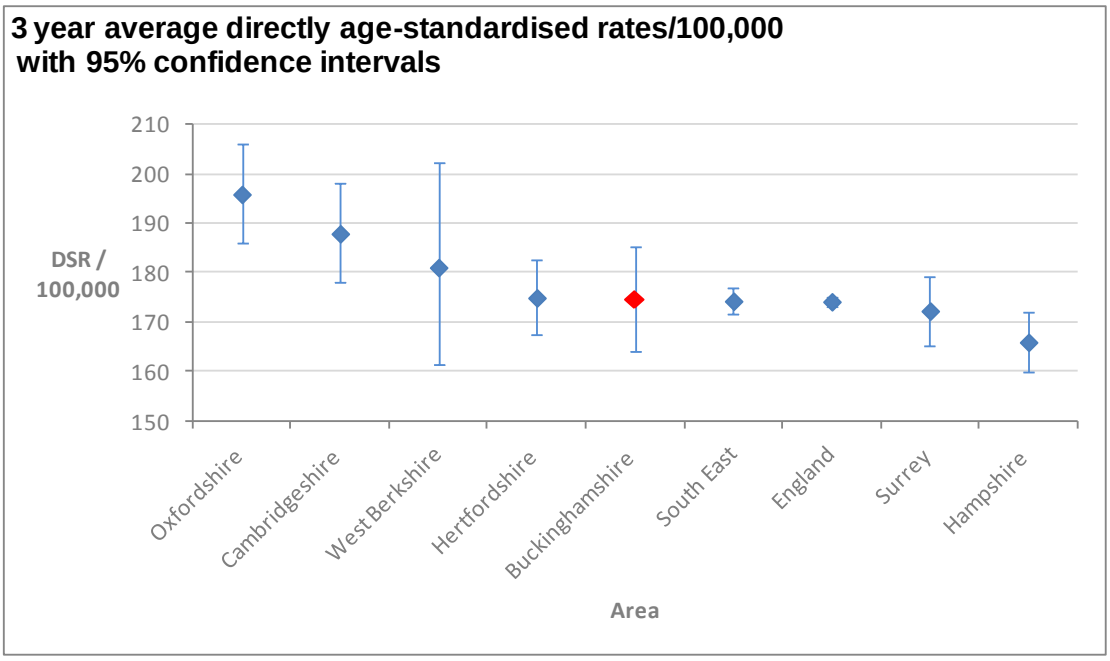
For males the rates for Buckinghamshire and all districts except were significantly below the South East rate, but none were significantly different from the England rate.

8.5 Prostate cancer

Since prostate cancer only affects men PHAST examine it in relation to the JSNA comparator counties as well as South East of England and England as a whole.

Figure 31 shows the direct standardised incidence of prostate cancer in men (all ages) 3 year moving average per 100,000) with comparator counties and national comparison. It can be seen that Buckinghamshire is ranked in the middle of its comparator counties and has a DSR identical to the South East and that of England as a whole.

Figure 31 Incidence of prostate cancer in men (all ages) three year moving average directly age-standardised rates per 100,000) with comparator counties and national comparison



Source: HSCIC Indicators Portal

Survival data

Table 11 shows five year survival[72] of prostate cancer patients diagnosed in 2005-2007 in males aged >15, for the NHS England Thames Valley Local Area Team (LAT) (which includes Buckinghamshire), the South of England NHS Region, and England.

Table 11 Survival data of prostate cancer patients diagnosed in males > 15: 2005-2007

Area	% Survival	Lower 95%CI	Upper 95%CI
England	78.8	78.4	79.3
Thames Valley	78.5	76.2	80.8
South of England	77.7	76.8	78.5

Source: HSCIC Indicators Portal

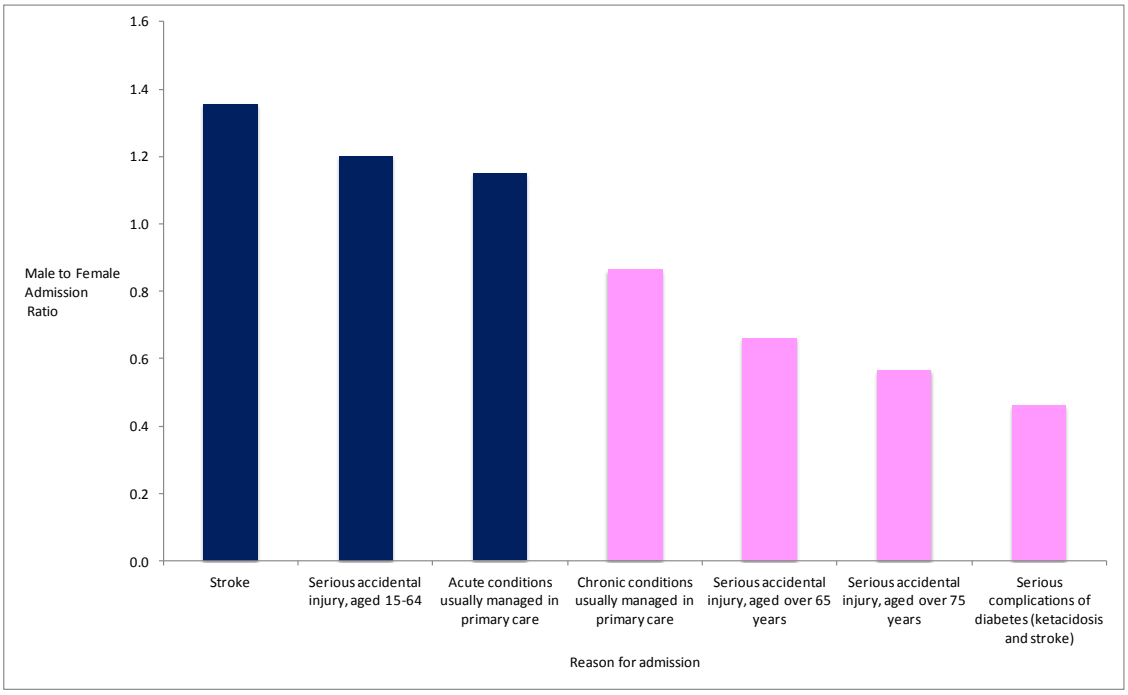
Five-year survival of prostate cancer patients aged 15+ diagnosed in 2005-2007 in the Thames Valley was similar to England and the South of England region during the three-year average period.

9. Buckinghamshire Hospital Admissions Data

9.1 Comparison of admissions between men and women for key indicator conditions

Figure 32 shows the Ratio (men: women) of Direct Standardised Rates of admissions for a number of representative conditions. It shows that for acute and late presenting conditions men had more admissions than women. However for conditions related to more chronic conditions at older ages it showed that women had more admissions than men.

Figure 32 - Ratio Men to Women DSR of admissions for representative conditions



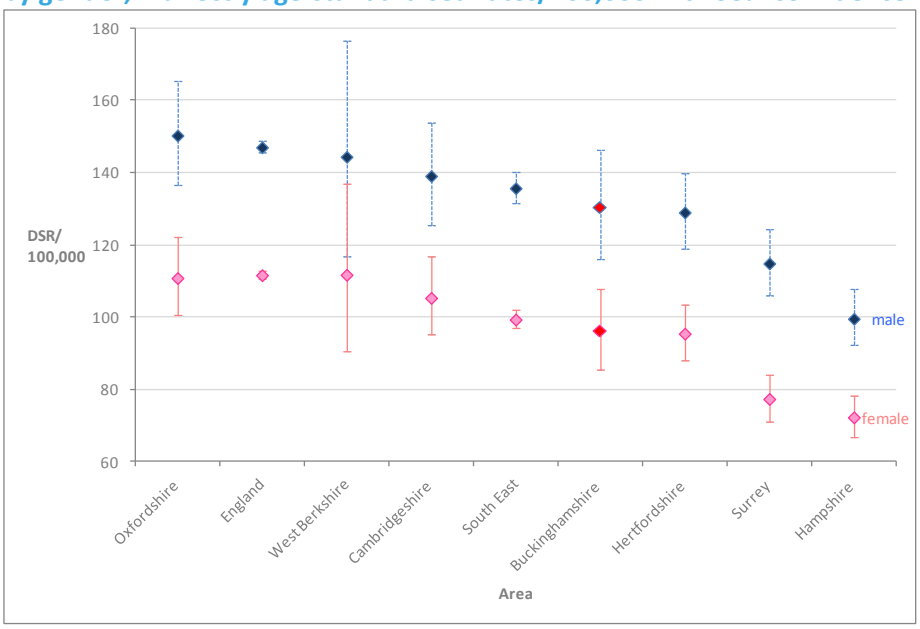
Source: HSCIC Indicators Portal

(Those conditions where the ratio > 1 are indicated in blue for men and in pink for women)*

9.2 Stroke

Figure 33 shows hospital admissions for stroke in men and women resident in Buckinghamshire, JSNA benchmark comparators, the South East Region, and England, for the period 2011/12 (the most recent for which data is available). Data is presented as Indirectly Standardised Rates (ISR) per 100,000, with 95% confidence intervals[73].

Figure 33 -Admissions for stroke, 2011/12, Buckinghamshire JSNA comparators, England, by gender, indirectly age-standardised rates/100,000 with 95% confidence intervals

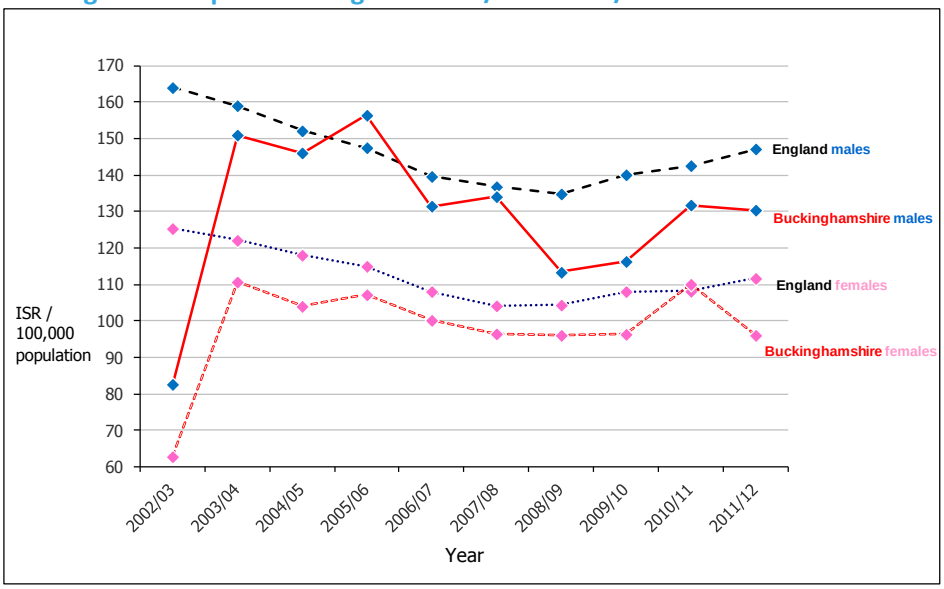


Source: HSCIC Indicators Portal

Admissions for stroke in men in Buckinghamshire were significantly lower than England in 2011/12.
Admissions for stroke in women in Buckinghamshire were significantly lower than England in 2011/12.

Figure 34 shows trends in admissions for stroke for Buckinghamshire and England, by gender, from 2002-03 to 2011-12

Figure 34 - Hospital admissions for stroke in men and women, ISR annual trends for Buckingham compared to England 2002/03 – 2011/12



Source: HSCIC Indicators Portal

Admissions for stroke in both sexes in Buckinghamshire were mostly lower than England. In the admission rates of men were about 30% higher than for women.

There was an apparent national downward trend in from 2002/03 to 2008/09, followed by an upward trend for Buckinghamshire. The picture is unclear. Data anomalies for 2002/03 suggest there may have been data quality issues with this indicator.

10. Sexually Transmitted Infections in Men who have Sex with Men

Sexually Transmitted Infections (STIs) in Men who have Sex with Men (MSM)

10.1 Introduction

This section presents information on incidence of newly diagnosed STIs in men whose sexual orientation is known, who have sex with men. The source for this information is Local Authority sexual health epidemiology reports (LASER) produced by Public Health England for 2013, provided in confidence by Buckingham CC's Public Health Department with small numbers suppressed. Reproduction of figures or charts from these reports is not permitted for Information Governance reasons, but conclusions and inferences from them may be made.

10.2 New STIs which were among MSM, 2010 to 2013

Absolute numbers are small: between 100 and 130 per year across Buckinghamshire. Between 2010 and 2013 there was an overall 10% increase. The highest numbers were in Aylesbury Vale and Wycombe, but these represented smaller proportions of all STIs diagnosed (<10%), while the smaller numbers in Chiltern and South Bucks represented larger proportions of all STIs diagnosed (between 10% and 15%).

LASER reports provided suppressed absolute numbers, which were small, and only tentative conclusions can be drawn from the percentage data. However, it seems likely that new diagnoses of syphilis were disproportionately high in MSM (possibly a majority).

In Wycombe and Aylesbury Vale there were steady increasing trends in the proportion of new diagnoses of gonorrhoea which were in MSM, from 10% to 70% in Aylesbury Vale and 15% to 35% in Wycombe (figures rounded to nearest 5%). No equivalent trend was apparent in Chiltern and South Bucks, where the percentage varied between 25% and 60%.

For chlamydia, genital warts, and genital herpes, no trends were apparent, and proportions were mostly small (generally<10%).

10.1 Sexual health

Chlamydia

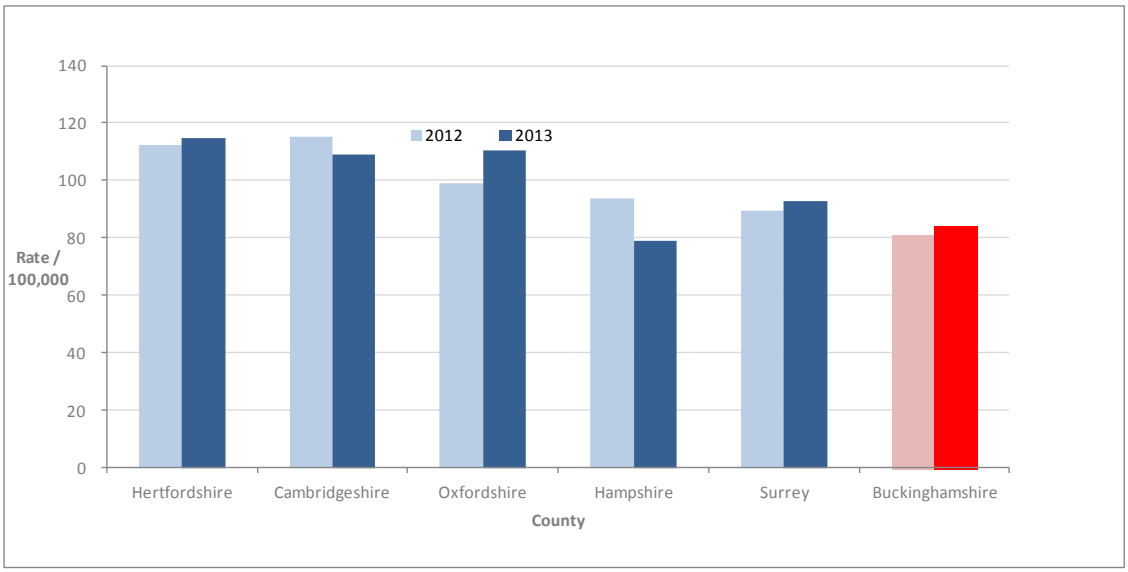
Data on chlamydia is not available for men in Buckinghamshire in December 2007.

Figures 35, 36, and 37 show the diagnosis rates for chlamydia in Buckinghamshire, the JSNA comparators, and comparators for England; (for total only) in 2012 and 2013.

Data are presented as crude rates per 100,000 of population. Confidence intervals have not been issued. Figures have not been issued disaggregated by gender, below England level.

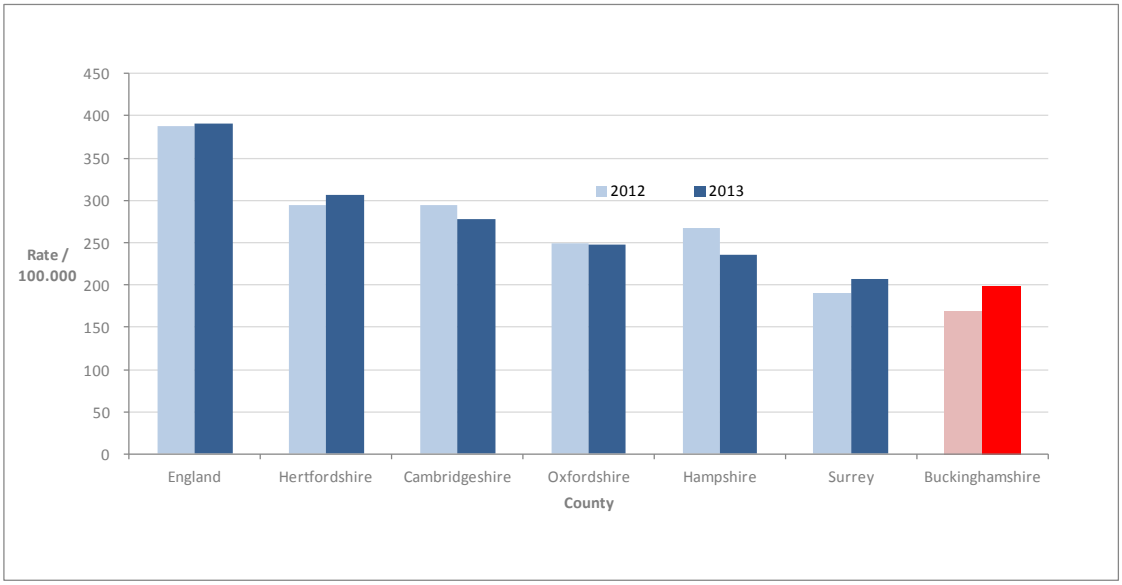
At the England level about 40% of chlamydia diagnoses are for males.

Figure 35 Chlamydia diagnoses aged 25+ 2012-13



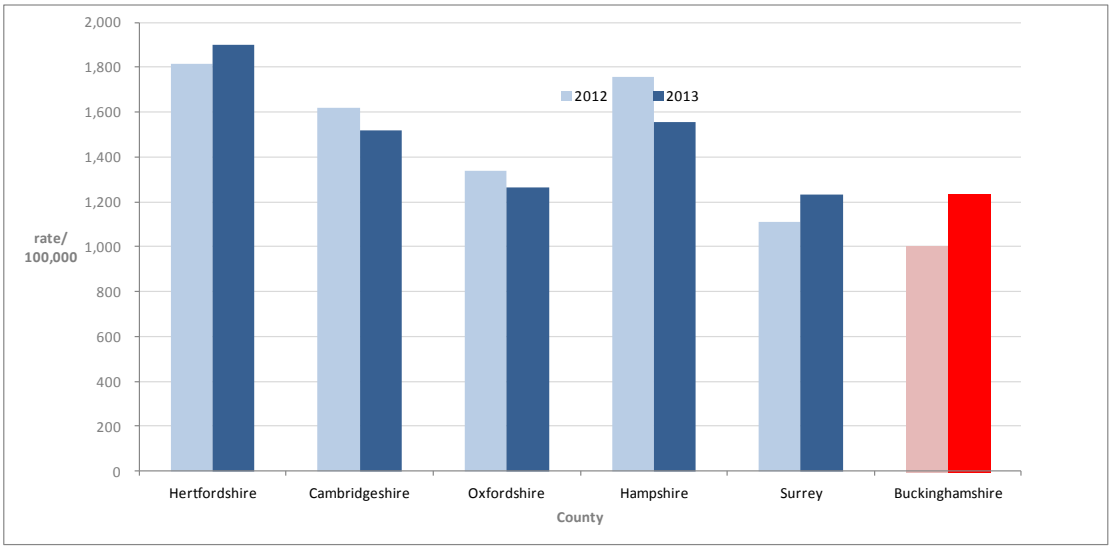
Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

Figure 36 Chlamydia diagnoses total 2012 and 13



Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

Figure 37 - Chlamydia diagnoses 15 -25 2012 -13



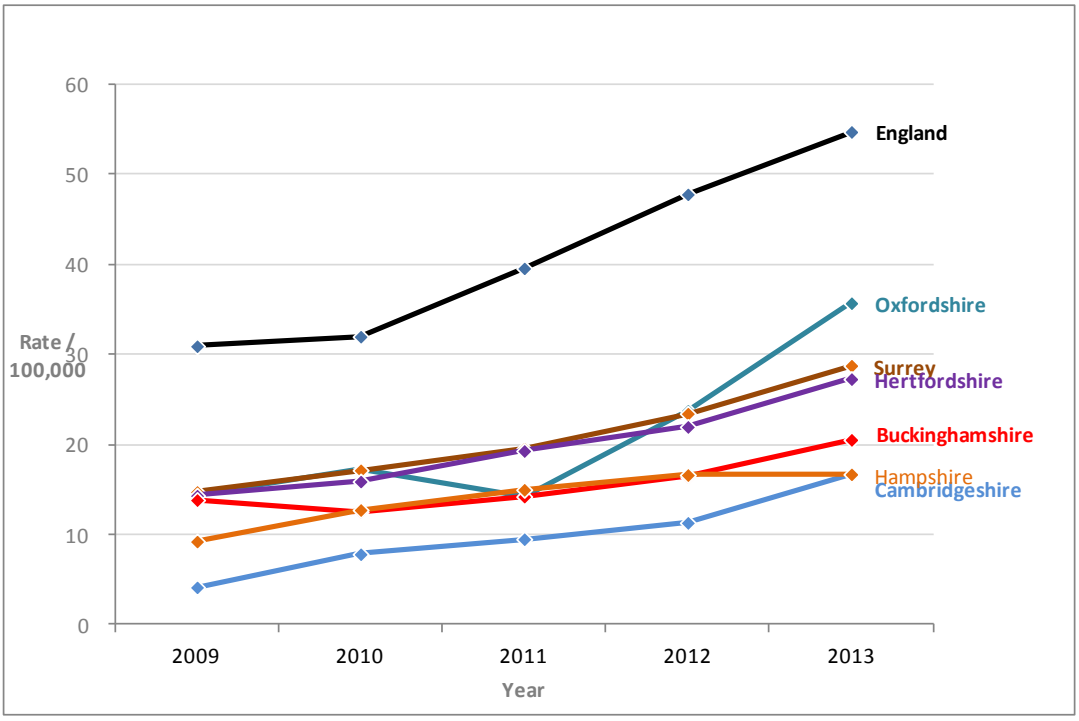
Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

Rates of diagnosis of chlamydia in Buckinghamshire were lower than its comparators and about half the overall England average in 2012 - 2013.

Gonorrhoea

Figure 38 shows diagnoses of gonorrhoea in Buckinghamshire, its JSNA comparators, and England from 2009 to 2013. Data are presented as crude rates per 100,000 population persons.

Figure 38 - Gonorrhoea diagnoses 2009-13



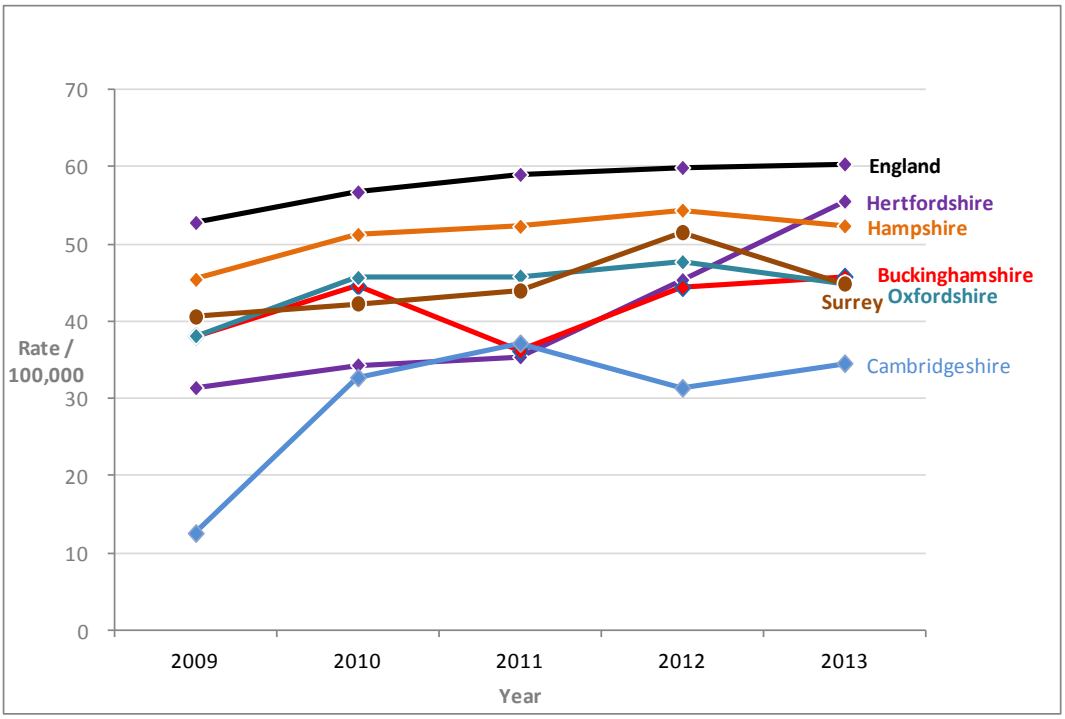
Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

Rates of diagnosis of gonorrhoea in Buckinghamshire are about 40% of the England rate. However, rates have consistently risen over the period, though the rise has been less steep in Buckinghamshire than nationally. Nationally, 75% of gonorrhoea diagnoses are for males.

Herpes

Figure 39 shows diagnoses of herpes in Buckinghamshire, its JSNA comparators, and England from 2009 to 2013. Data are presented as crude rates per 100,000 population persons.

Figure 39- Herpes diagnoses 2009-13



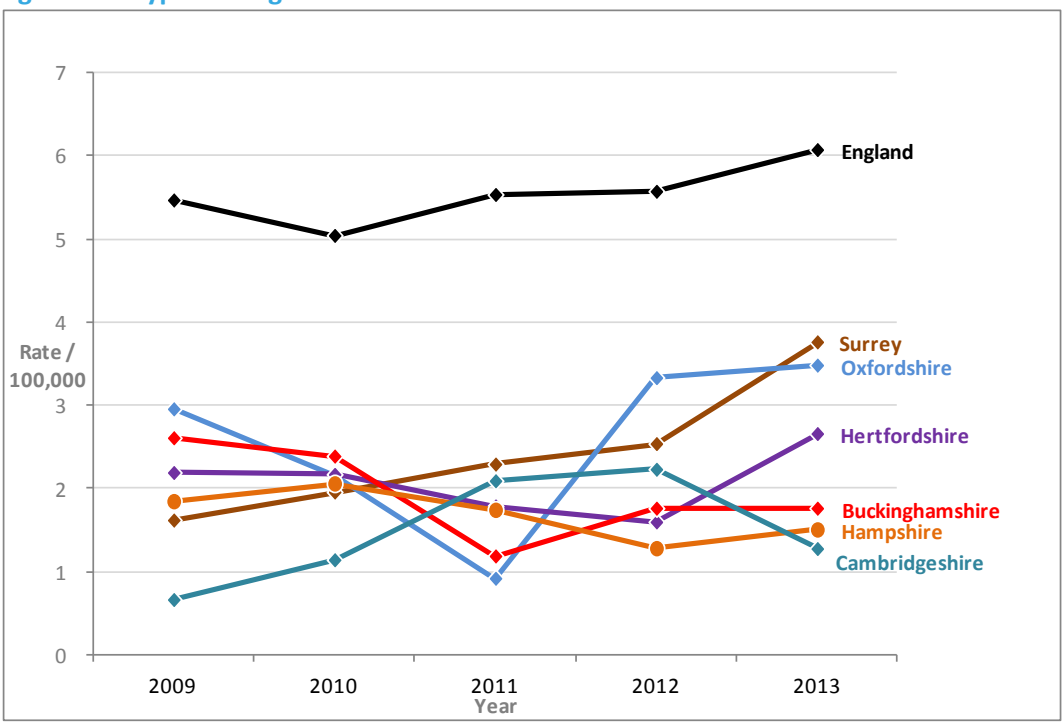
Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

Rates of diagnosis of herpes in Buckinghamshire are about 75% of the England rate. Nationally there has been a consistent but slowing rise over the period. Data for Buckinghamshire do not exhibit this rise. Nationally, just over a third of herpes diagnoses are for males.

Syphilis

Figure 40 shows diagnoses of syphilis in Buckinghamshire, its JSNA comparators, and England from 2009 to 2013. Data are presented as crude rates per 100,000 population persons.

Figure 40 - Syphilis diagnoses 2009-13



Source: https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables

Rates of diagnosis of syphilis in Buckinghamshire are about a third of the England rate. Nationally there has been a rise over the period. Data for Buckinghamshire show a fall, though there is some year-on-year variation. Nationally, about 95% of diagnoses of syphilis are for males.

Recommendation: In line with national recommendations, men who have sex with men (MSM) having unprotected sex with casual or new partners should have a HIV/STI screen at least annually, and every three months if changing partners regularly.

Recommendation: MSM should avoid having unprotected sex with partners believed to be of the same HIV status (serosorting), as there is a high risk of STI and hepatitis infection and, for the HIV negative, a high risk of HIV infection as 18% of MSM are unaware of their HIV infection.

Recommendation: Bucks sexual health services should seek to raise awareness of syphilis and gonorrhoea in MSM in Aylesbury Vale and Wycombe particularly.

11. Improving Access to Psychological Therapies in Buckinghamshire

Table 12 shows numbers of men and women referred to psychological therapies in 2013/14, together with the percentages of referrals entering treatment, and the percentages of those who started treatment who achieved recovery.

Table 12 Numbers of men and women referred to psychological therapies in 2014-14, 2013/14, uptake and outcomes

	No. referred	No. treated	No. recovering	Uptake of Therapy	Recovery % of treated	Recovery % of referred
Men	2828	2141	531	75.7%	24.8%	18.8%
Women	5132	3816	1051	74.4%	27.5%	20.5%

Source: Buckinghamshire Public Health Department

In 2013/14, 7960 people were referred to psychological therapies of which 5132 (64.4%) were women and 2828 (32.6%) were men. A slightly higher percentage of men, who were referred, started treatment. A higher percentage of women who started treatment achieved recovery. These differences are not statistically significant at the usual 5% level.

The different rates of referral between the sexes may be part of a major health inequality. Men have three times the suicide rates yet are referred one third as often as women. When they are referred, there uptake is similar and they get similar benefit. The problem seems to be getting referred in the first place. It should be a clear priority to focus on increasing referral in men.

Men are traditionally more reluctant to seek or accept treatment for psychological problems, while standardised mortality rates for suicide and undetermined injury for men are almost three times those for women in Buckinghamshire, yet here if they are referred they take up the service as often as women do. Nevertheless if psychological therapies are effective in restoring equilibrium then improving access to them for males may be expected to lead to a substantial drop in mortality from suicide.

12. Outcome Data

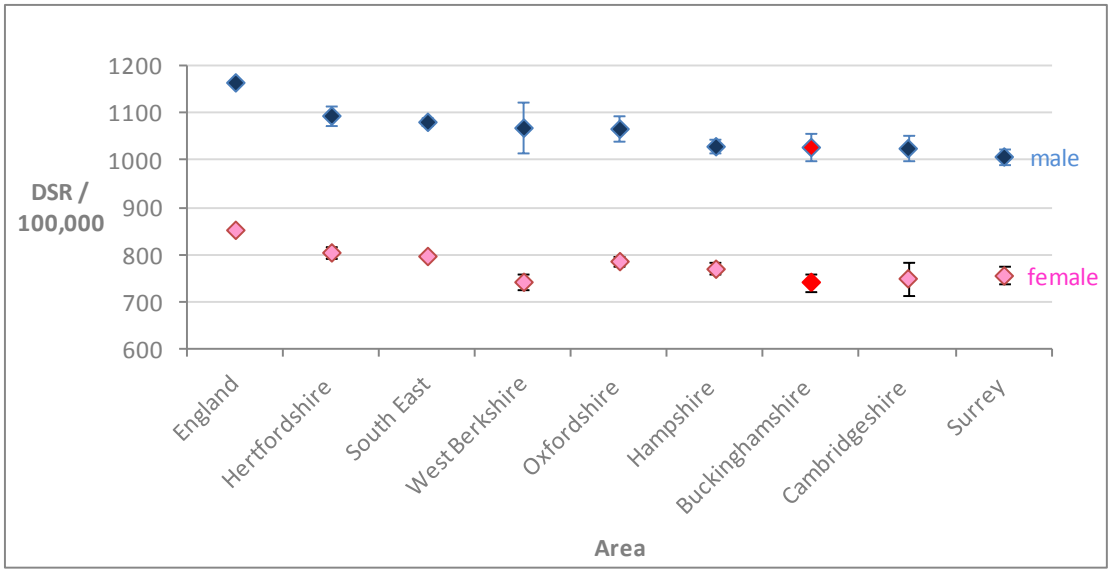
Data was ascertained from Buckinghamshire and JSNA comparator counties (where possible) from nationally available sources. The indicators were chosen as they were the ones for whom the available data included a gender data field.

12.1 All age All Cause Mortality (AACM) in Buckinghamshire

In the three-year period 2011-2013 there were 644 more male deaths than female in the under-75, or 215 more per year on average. This represents an 18% difference between the sexes. These figures are highly statistically significant and demonstrate considerable health inequalities in health outcomes relating to gender.

Figure 41 shows standardised AACM rates for Buckinghamshire (red) along with JNSA comparator counties. It shows that AACM was lower than England and the South East region during the three-year average period, 2011-2013. These differences are statistically significant at the 5% level.

Figure 41 - All Age All Cause Mortality in men and women for Buckinghamshire and JSNA Benchmark comparator counties and England, 2011-13

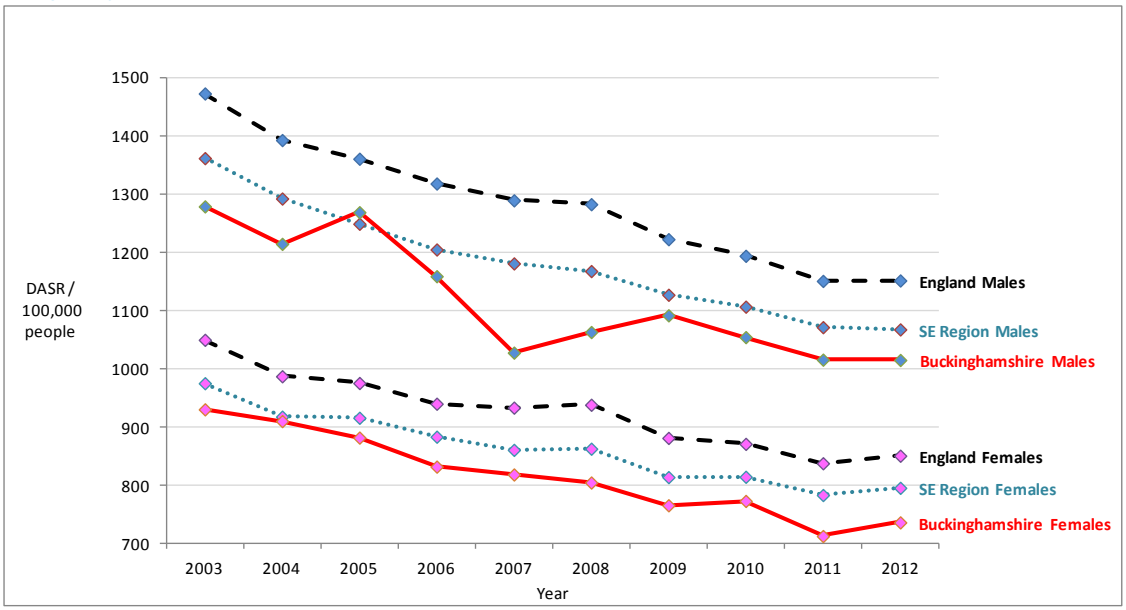


Source: HSCIC Indicators Portal

Figure 41 shows that there is a consistent downward trend in AACM in Buckinghamshire, South East England and the whole of England for both sexes.

Figure 42 shows annual trends in AACM for Buckinghamshire, the South East Region, and England, by gender, from 2003 to 2012.

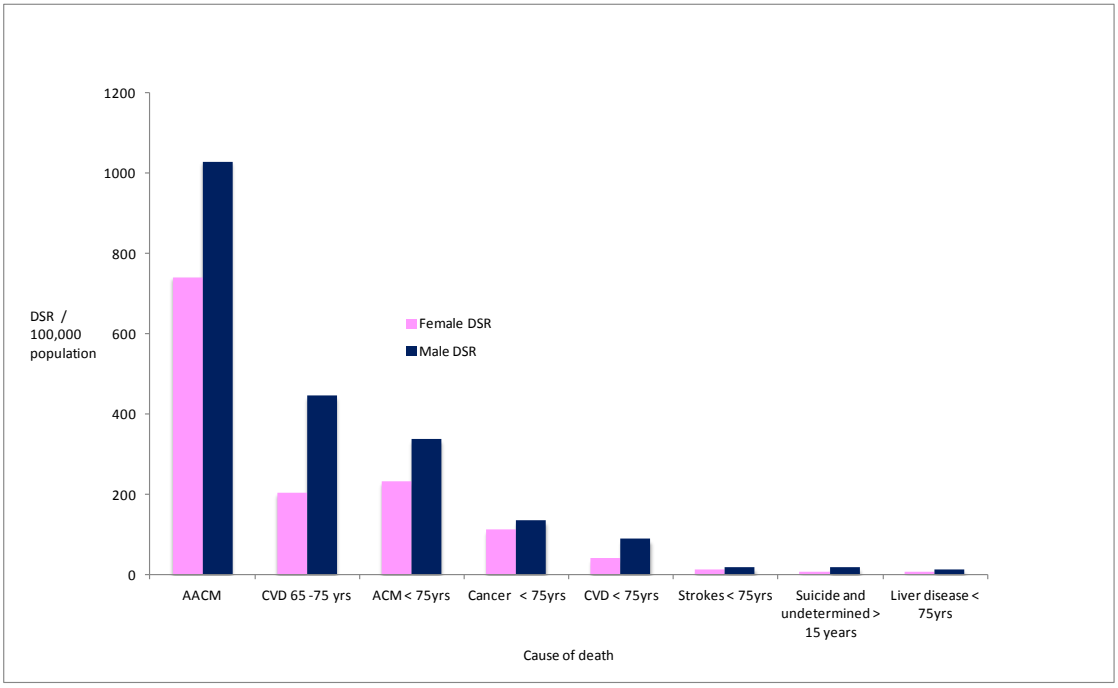
Figure 42 - Trends in Buckinghamshire All Age All Cause Mortality (2003 -2012), DSR/100,000



Source: HSCIC Indicators Portal

Figure 43 shows Direct Standardised Death Rates (DSRs) for key illustrative disorders affecting men and women in Buckinghamshire (including all-cause mortality and premature all-cause mortality). It can be seen that men's death rates are considerably higher for each of these disorders and for all-cause mortality.

Figure 43 - Direct Standardised Death Rate for key illustrative disorders in Buckinghamshire men and women for the three year period 2011/13

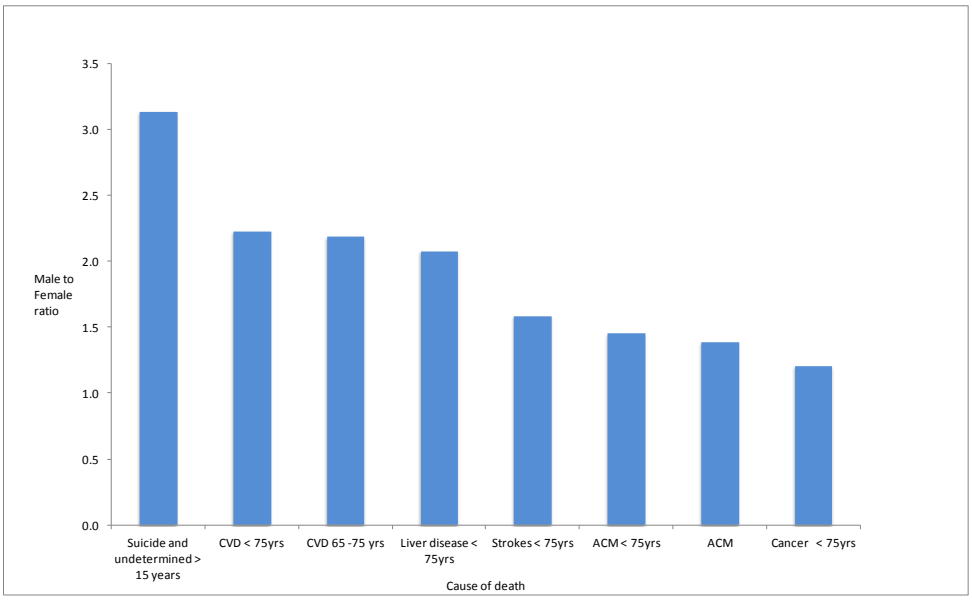


Source: HSCIC Indicators Portal

Ranks were not significantly different.

Figure 44 shows the ratio of the DSR for eight health indicators (men: women) is greater than one, for all of the eight representative indicators for whose data a gender category was available to the needs assessment team. The ratios for these eight ranges from a 3-fold risk for suicide to 1.4 fold risk in all cancers under 75 years. Men had 50% greater all-cause mortality.

Figure 44 - Ratio directly standardised death rates (men: women) for eight representative health indicators for which gender category was available

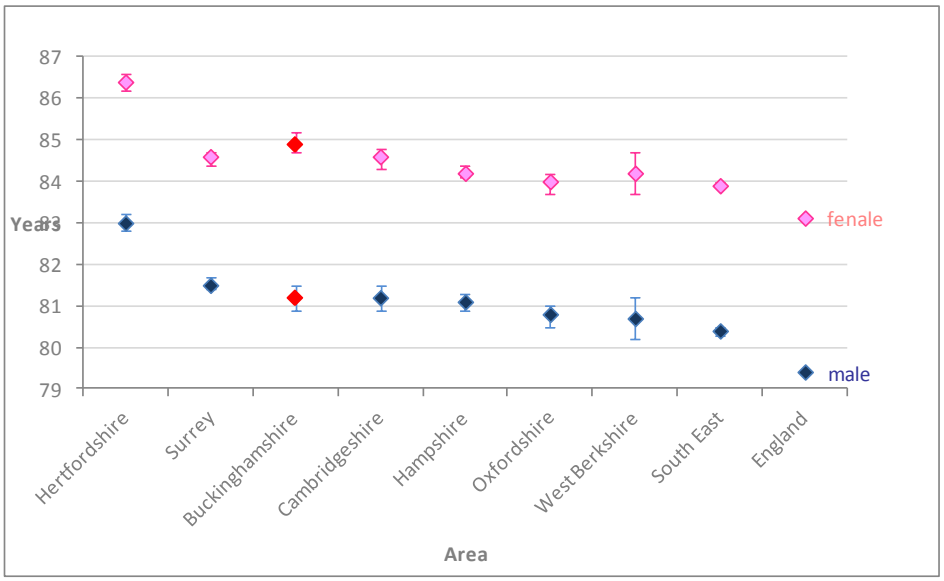


Source: HSCIC Indicators Portal

12.2 Life expectancy at birth in Buckinghamshire

Figure 45 shows life expectancy at birth for males in Buckinghamshire, JSNA benchmark comparators, the South East Region, and England, for the three-year period 2011-2013. Data is presented in years, with 95% confidence intervals.[74] In Buckinghamshire life expectancy at birth is 81.2 years and women it is 84.9 years a difference of 3.7 years for the three-year period 2011-2013.

Figure 45 - Life expectancy at birth for males in Buckinghamshire, JSNA benchmark comparators, the South East Region, and England, for the three-year period 2011-2013



Source: HSCIC Indicators Portal

Life expectancy of males in Buckinghamshire is a year higher than the regional average, and more than 18 months higher than the national average. These differences are statistically significant at the usual 5% level.

Life expectancy of both males and females in Buckinghamshire has increased steadily in the ten years, in common with the rest of the country. It has been consistently higher than the regional and national averages. For females the gap between Buckinghamshire and England widened over the 10 years; for males the gap narrowed slightly in the same period.

13. Suicide & undetermined injury in Buckinghamshire

13.1 Aged >15, suicide and undetermined injury

Mortality rates

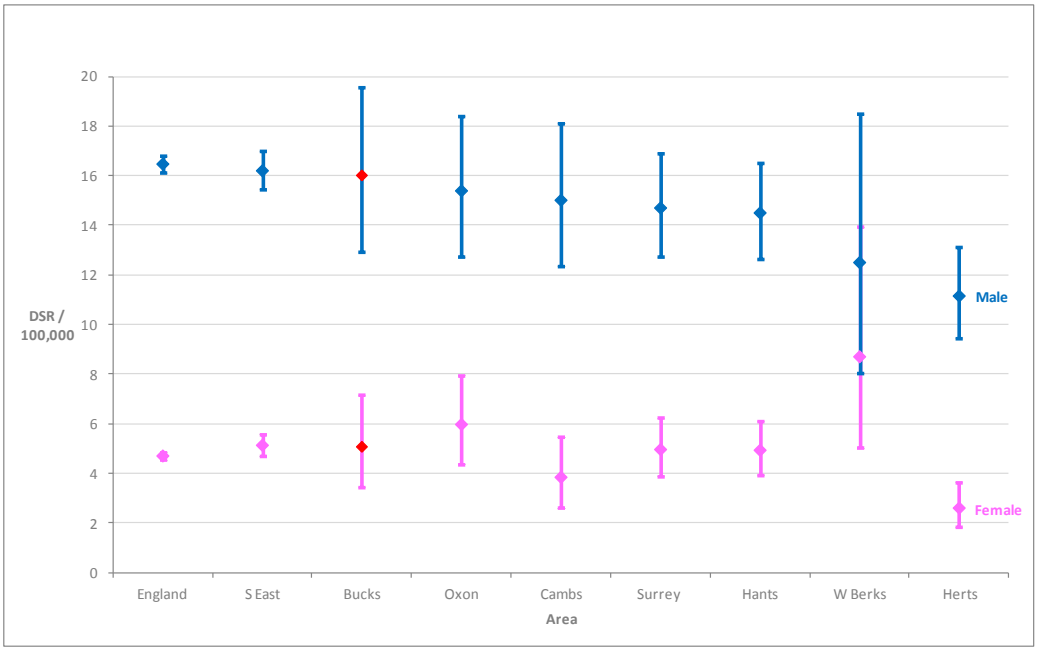
Table 13 and Figure 46 show mortality (aged >15) from suicide and undetermined injury for males and females for Buckinghamshire, JSNA benchmark comparators, the South East Region, and England, for the three-year period 2011-2013. Data is presented as Directly Standardised Rates per 100,000, with 95% confidence intervals.

Table 13 - Mortality from suicide and undetermined injury, 3 year average directly standardised rates/100,000 with 95% confidence intervals

	Males			Females		
	DSR	95%CI LL	95%CI UL	DSR	95%CI LL	95%CI UL
England	16.5	16.2	16.8	4.7	4.5	4.9
South East	16.2	15.4	17.0	5.1	4.7	5.6
Buckinghamshire	16.0	13.0	19.6	5.1	3.5	7.2
Oxfordshire	15.4	12.7	18.4	6.0	4.4	7.9
Cambridgeshire	15.0	12.3	18.1	3.8	2.6	5.5
Surrey	14.7	12.7	16.9	5.0	3.9	6.2
Hampshire	14.5	12.7	16.5	4.9	3.9	6.1
West Berkshire	12.5	8.1	18.5	8.7	5.1	13.9
Hertfordshire	11.2	9.4	13.1	2.6	1.8	3.6

Source HSCIC Indicators Portal, 17 Feb 2015

Figure 46 - Mortality from suicide and undetermined injury, 3 year average directly standardised rates/100,000 with 95% confidence intervals, 2011-13



Source HSCIC Indicators Portal, 17 Feb 2015

Mortality from suicide and undetermined injury in both genders aged >15 in Buckinghamshire was not significantly different from that in England, the South East region, or any of the JSNA benchmark comparators during the three year average period, 2011/13. Mortality rates from suicide in males were three times as high as in females, and this difference was statistically significant at the usual 5% level.

13.2 Trends in premature mortality from suicide and undetermined injury

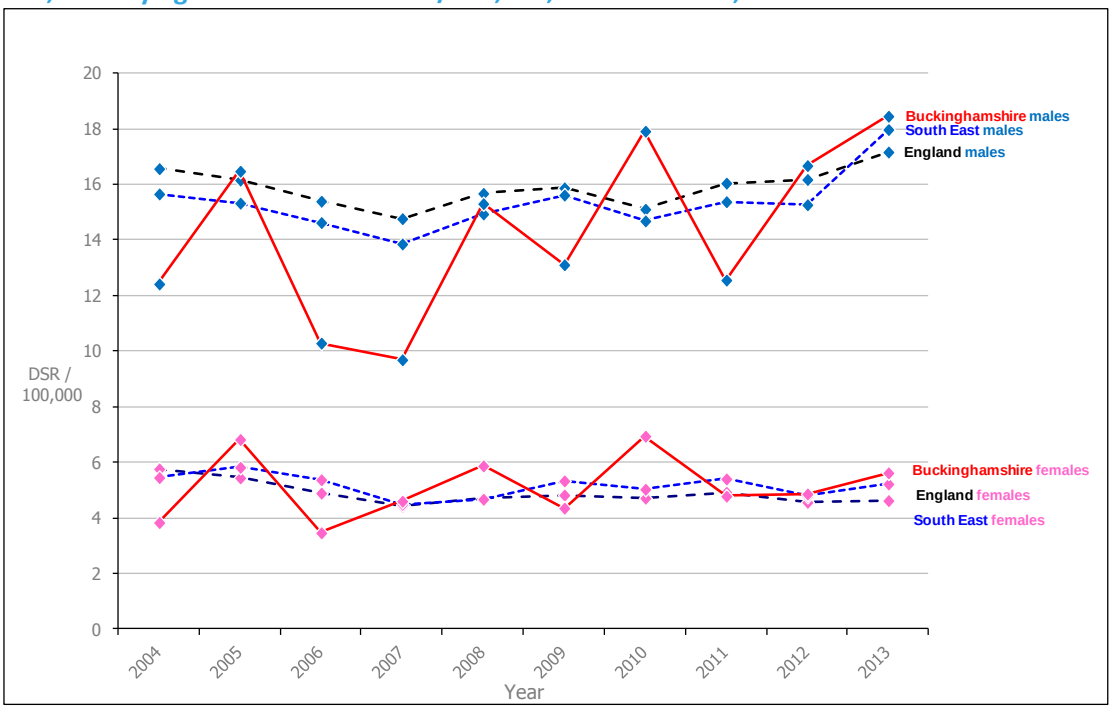
Table 14 and Figure 47 show annual trends in mortality from suicide and undetermined injury aged >15 for males and females in Buckinghamshire, the South East Region, and England, for the most recent ten years for which data are available. Data is presented as Directly Standardised Rates per 100,000.

Table 14- Annual trends in mortality from suicide and undetermined injury aged >15 for males and females

	England Males	South East Males	Bucks Males	England Females	South East Females	Bucks Females
2004	16.6	15.7	12.4	5.8	5.5	3.8
2005	16.2	15.3	16.5	5.4	5.8	6.8
2006	15.4	14.6	10.3	4.9	5.4	3.5
2007	14.8	13.9	9.7	4.4	4.5	4.6
2008	15.7	14.9	15.3	4.7	4.7	5.9
2009	15.9	15.6	13.1	4.8	5.3	4.4
2010	15.1	14.7	17.9	4.7	5.0	6.9
2011	16.1	15.4	12.6	4.9	5.4	4.8
2012	16.2	15.3	16.7	4.6	4.8	4.9
2013	17.2	18.0	18.5	4.6	5.2	5.6

Source HSCIC Indicators Portal, 17 Feb 2015

Figure 47 - Mortality from suicide and undetermined injury in males and females aged >15, directly age-standardised rates/100,000, Annual trends, 2004-2013



Source HSCIC Indicators Portal, 17 Feb 2015

Mortality from suicide and undetermined injury in both sexes aged >15 has been fairly steady over the last ten years in England and the South East Region. In Buckinghamshire there have been substantial year-to-year fluctuations. Though the most recent figures appear high, absolute numbers are small, and there is no clear evidence of any underlying trend.

13.3 Rates of suicide and undetermined injury by age-band

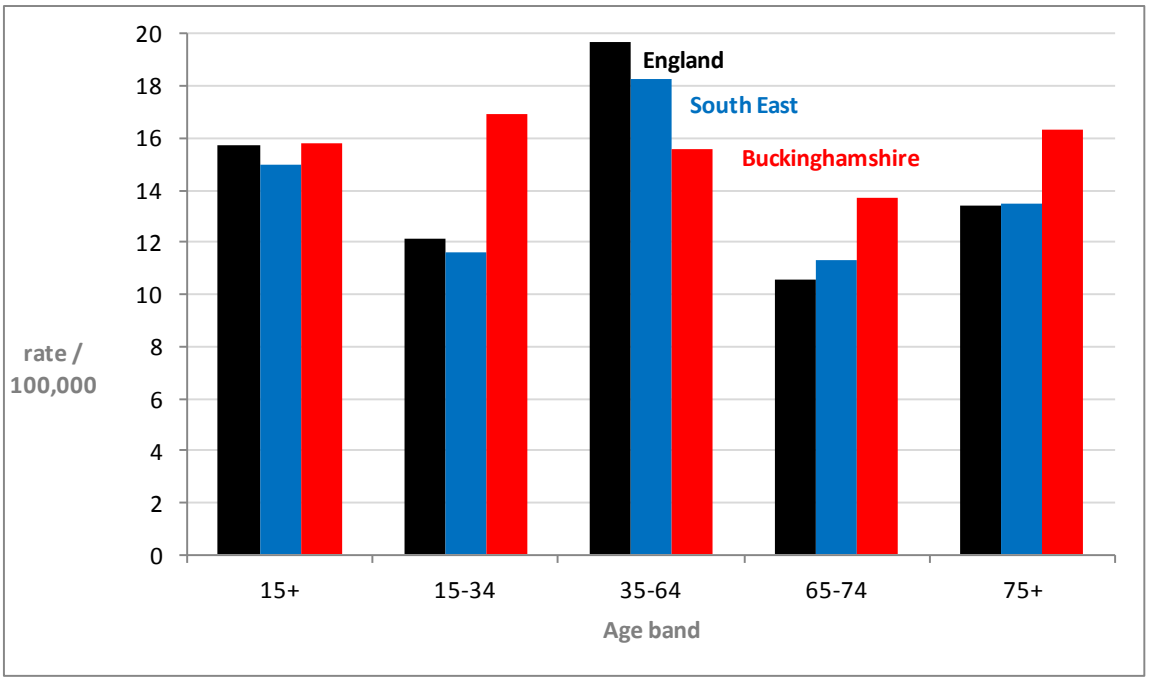
Table 15 and Figures 48 and 49 show rates of suicide and undetermined injury per 100,000 population, for males and females, broken down by age band.

Table 15 - Age related mortality rates from suicide and undetermined injury 2010-2012 (pooled), by age band

	Males					Females				
	15+	15-34	35-64	65-74	75+	15+	15-34	35-64	65-74	75+
England	15.7	12.1	19.7	10.6	13.4	4.7	3.3	5.8	3.9	4.4
South East	15	11.6	18.3	11.3	13.5	5.1	3.1	6.7	3.7	4.8
Bucks	15.8	16.9	15.6	13.7	16.3	5.4	2.9	6.3	5.6	7.1

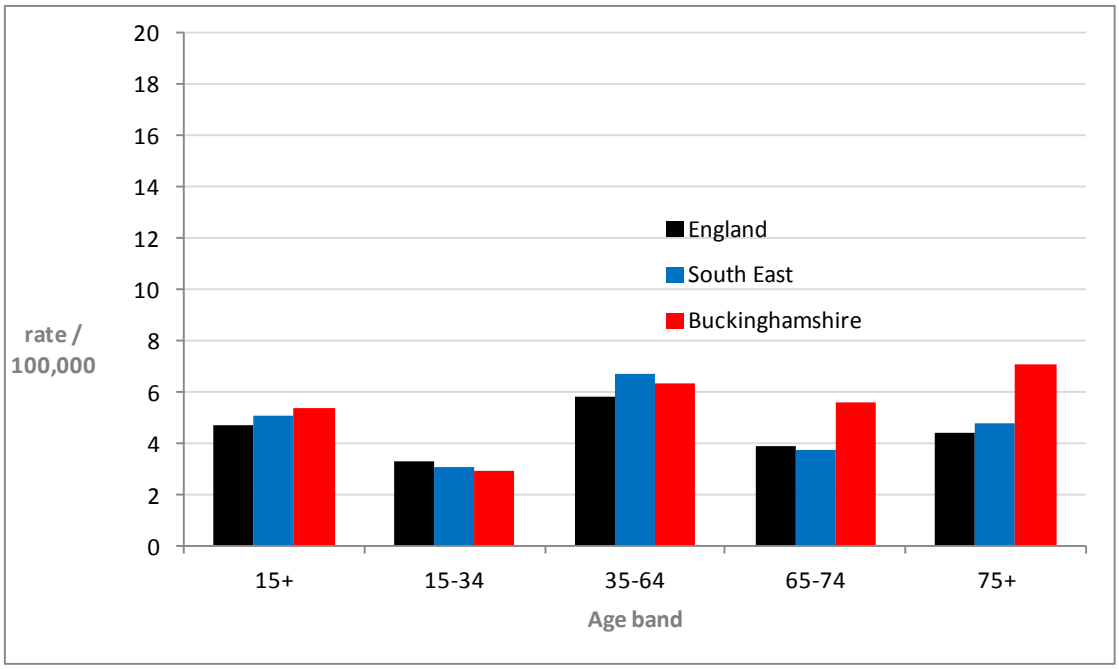
(Source HSCIC Indicators Portal, 17Feb 2015)

Figure 48 - Age related mortality rates from suicide and undetermined injury 2010-2012 (pooled), Males, by age band



Source HSCIC Indicators Portal, 17 Feb 2015

Figure 49 - Age related mortality rates from suicide and undetermined injury 2010-2012 (pooled), Females, by age band



Source HSCIC Indicators Portal, 17 Feb 2015

Overall rates are similar to those in England for all males over 15 years old. However, when disaggregated, the rate in 15-34 year olds is almost 60% higher than that of England , 25% lower than England in the 35-64 age band, and about 30% higher than England in the over 65 year old bands. For females, overall rates in over 15 year olds are 15% higher than in England. This is particularly notable in the over 65 age bands, with the Buckinghamshire rate being over 40% higher than England's for 65-74 year olds, and 60% higher in the over 75 year olds.

Note that absolute numbers are small, and there is insufficient data available to enable calculation of levels of statistical significance in this data.

14. Corporate Analyses

14.1 Structural investigation

PHAST identified, with the help of the Buckinghamshire County Council public Health Department, a number of strategy documents comprising: DRAFT NHS Buckinghamshire Commissioners 5 Year Plan 2014-2019,

Making physical activity a priority Buckinghamshire Physical Activity Strategy 2014 – 2017,

The health of children and young people data supplement and overview Director of Public Health's Annual Report 2014,

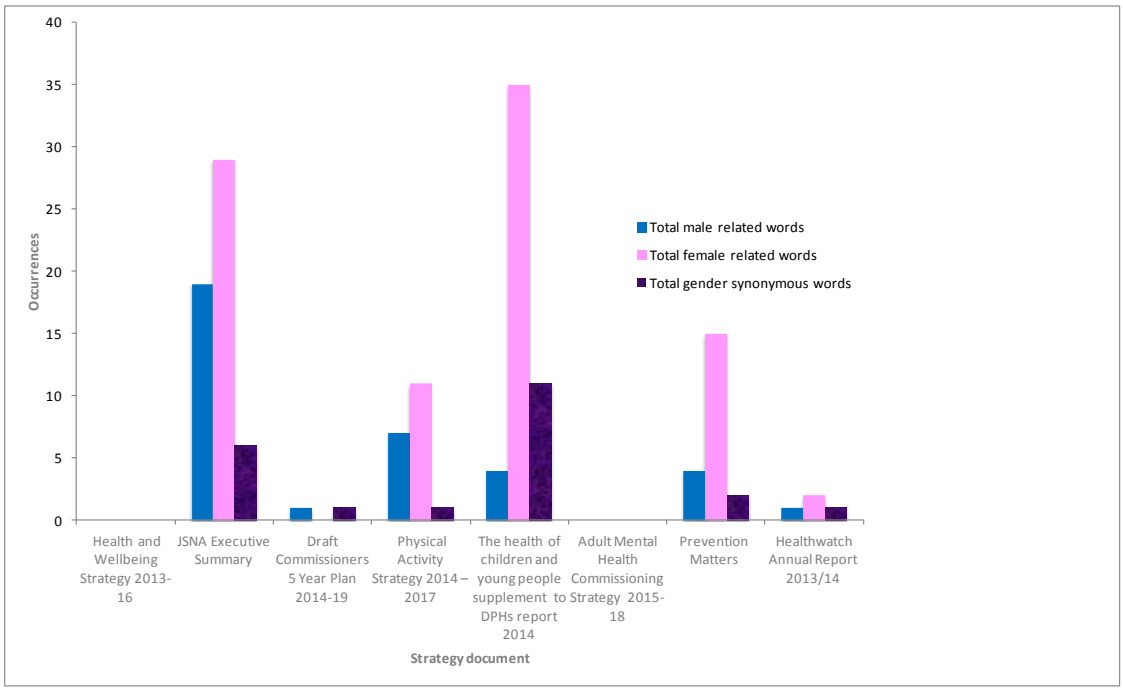
Adult Mental Health Commissioning Strategy for Buckinghamshire 2015-2018,

Prevention Matters: Delivering a prevention-focused model for adult services in Buckinghamshire County Council,

Buckinghamshire Healthwatch Buckinghamshire Annual Report 2013/14

These were then examined to determine the degree to which gender was mentioned as part of those strategies. The frequency of all words was determined for each of those documents and the number of times that gender related words was recorded. Specifically a count of the number of male (man, men, boy, boy, male) and female (woman, women, girl, girls) synonymous words was recorded. The numbers of references to synonyms of gender (gender, sex sexuality sexual) were also recorded.

Figure 50 - Occurrence of gender related words in identified Buckinghamshire County Council strategy document



Source: BCC strategy documents

Figure 50 shows the frequency of occurrence of gender specific and synonymous words in key strategy documents. References to gender were low in strategy documents and also where gender was discussed references to women were far greater than references to men. Some strategies had no references to men, women or gender. This is consistent with

findings from corporate stakeholder interviews where there was general consensus that gender has not formally been recognised as a factor relevant to health improvement in health and social care related strategies in Buckinghamshire. This is despite individual professionals, on questioning, demonstrating some awareness of the relatively poorer health experience of men and reporting on an individual therapist or clinician level, that they require a different approach and exhibit different needs and behaviours to women.

14.2 Questionnaire

PHAST invited men through Buckinghamshire council's partner organisations to take part in an online questionnaire relating to their attitudes and health behaviours. The following is a brief summary of the key findings.

There were 29 respondents from three sources, three from mankind project (MKP), 18 from men who took part in focus groups and eight from local over 50s group. The median age of respondents >60, all but one respondent was white British and the other was white Irish. Of those who responded to the question on employment status 21(80%) were retired, three (12%) were employed full time and 2 (6%) were employed part time.

Respondents were asked if they think about their health when choosing what to eat. Only one respondent (4%) considered that he was "not very health conscious" and 14/29 (48%) considered himself to be very health conscious. 11/28 (40%) considered that they eat healthily. Less than 20% indicated that they rarely or never thought about their health when choosing what to eat.

11/27 (41%) recorded that they were physically active (out of breath/raised heart rate/sweat slightly) for a total of 30 minutes or more. This might have been brisk walking, riding a bike, and pushing lawn mower, sport for example. 60% of men agreed that they do physical activity to look after their health.

Figure 51 shows responses to this question: - In the past week, on how many days have you been physically active (out of breath/raised heart rate/sweat slightly) for a total of 30 minutes or more? For example, this might have been brisk walking, riding a bike, and pushing lawn mower, sport for example?

Figure 51 – In the past week how many days have you been physically active?

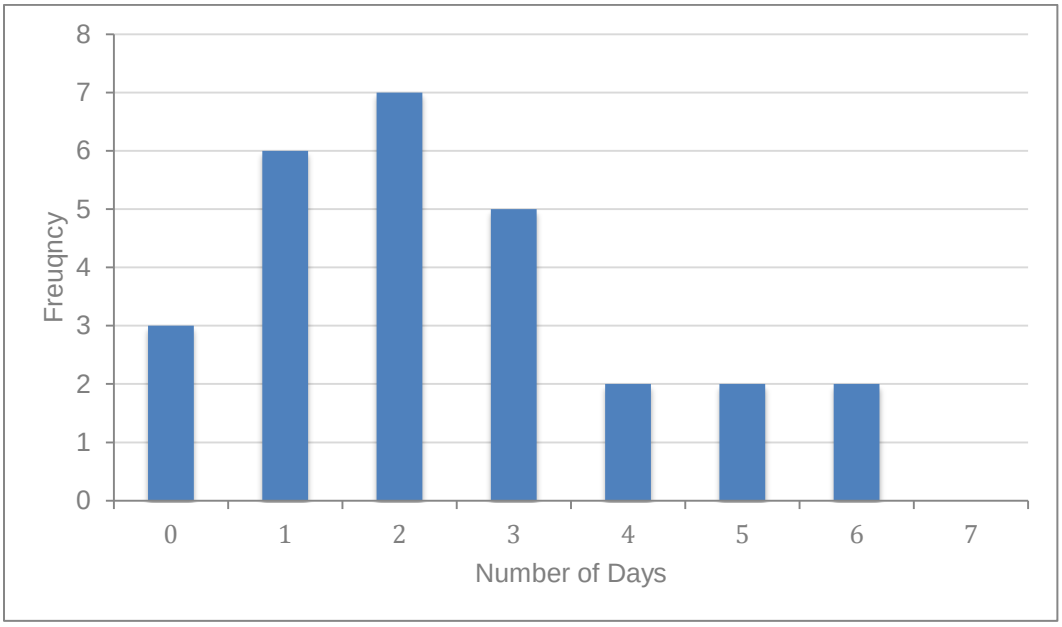
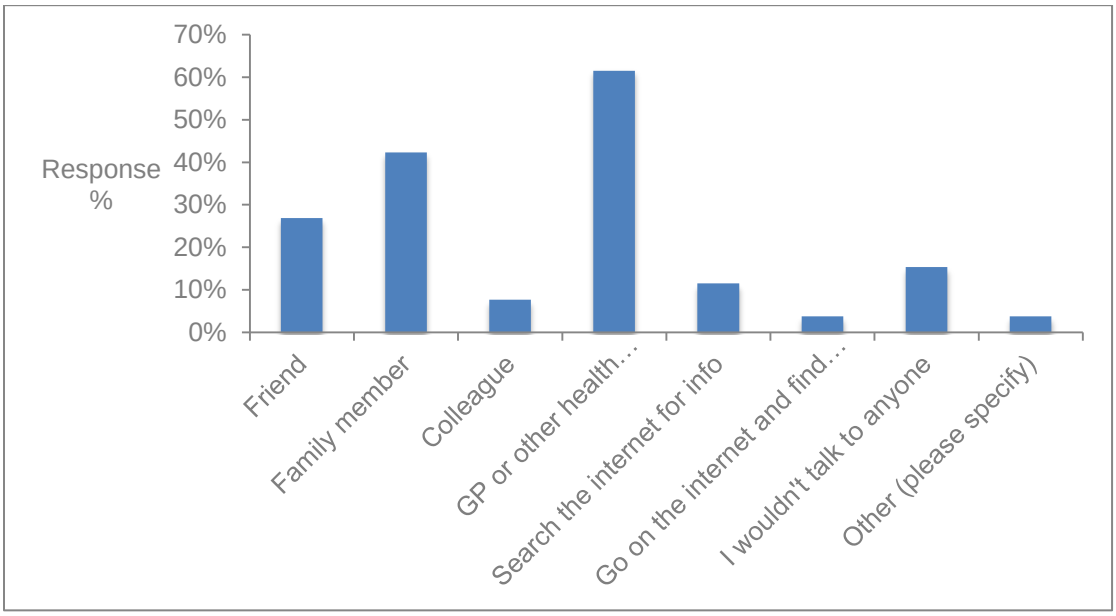


Figure 52 shows the distribution of who men reported they would approach for advice, information or support if they were feeling anxious, depressed or 'low' and this continued for more than a few weeks.

Figure 52 - Distribution of responses to the question "If you were feeling anxious, depressed or 'low' and this continued for more than a few weeks who would you approach for advice, information or support?"



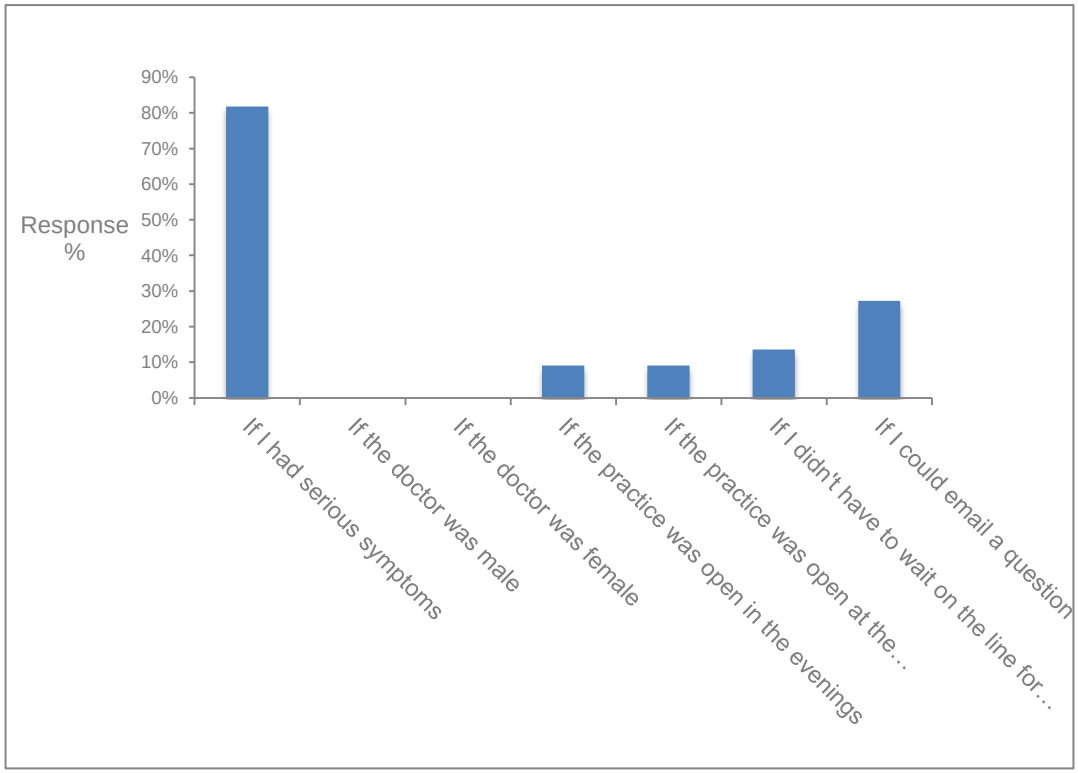
**multiple choices were permitted

GP or health professional, family members and friends were the most popular choices. However it is notable that 20% of men stated they would not talk to anyone. If this is representative, this is a worrying and important finding. 60% of respondents admitted that they worried or had worried about their health.

The median time since the last GP appointment was between one and six months ago about which 96% of respondents said they received what they needed from the consultation. Approximately 30% of respondents said there were health issues they would only discuss with a male doctor.

Figure 53 shows what might make it easier for respondents to consult their GP with a concern. Responses indicated that serious symptoms was the most frequent choice (80%), with convenience being important (45% selected extended opening hours - evenings/weekends or being able to email a question), whilst approx. 15% stated not having to wait on the line for a receptionist to answer, suggesting that an automatic booking system would remove a barrier to consultation for some men. It is notable that no respondents selected doctor's gender as a factor which would make it easier to consult their doctor.

Figure 53 - Responses to the question: What might make it easier/more likely that you would consult your GP with a concern?



9/26 (34%) of respondents acknowledge that they had thought they should go to the doctor but had not gone.

Among those who reported this lack of attendance, a number expanded further as follows:

"It takes 3 weeks to get an appointment"

"Procrastination"

"Didn't think it was important"

"Seemed trivial after deliberation"

"A friend had a cancerous prostate. I don't know whether I should have mine checked."

"Didn't think that the symptoms were serious enough"

"Hoped it would just clear up… Symptoms not serious enough to disrupt a whole day to see a doctor"

These responses mostly indicate men balancing the risk of their symptoms with inconvenience to themselves or others.

Statements such as … "In denial about depression - reluctant to go on medication" suggest the fact of denial playing its part in the action not taken.

All men (100%) reported that it was important for men to keep themselves as healthy as women, yet the actions of men do not reflect the ability of men to achieve this status. If they are representative of men, then their actions do not match their words.

There are three possible explanations

1. Men do not act according to their intentions in this regard.
2. Men act but their actions are less effective because their actions are not as skilful as those of women.
3. Men act but their actions are less effective because there is an underlying unchangeable health disadvantage about being a man.

Men responded to being asked what more they could do to be healthy citing: diet, exercise, smoking and alcohol reduction and reducing stress.

Men responded to being asked what more Buckinghamshire County Council and the CCG could do citing: recruitment of more male doctors, addressing men through families, better public safety for cyclists and campaigns that dwelled on the inequalities in life chances between men and women. Dealing with men meant providing subtle rather than prescriptive guidance, regular check-ups and more flexible appointments. Detailed comments were:

"Encourage men and their spouses to take their health seriously"

"Recruit more full time male doctors"

"Better provision for cyclists on busy roads"

"Free/reduced price gym or swimming pool membership for over 65"s"

"Like the seat belt campaign, keep on advertising. Make a big deal of the statistics on TV."

"Provide good website with walks and cycle routes"

"Subtle rather than prescriptive guidance"

"Regular compulsory check-ups followed by advice from a doctor."

"I would be more likely to see a doctor if (1) I could book an appointment in advance, rather than having to delay going to work in order to ring on the morning and still have no guarantee of an appointment (2) I could see a doctor at lunchtime at a surgery near my workplace (not in Buckinghamshire) or (3) I could see a doctor at the weekend or in the evening."

Through this feedback the men have touched upon many of the key ways that men's health can be improved.

65% of men consider that men's health is equally as good as women's health. This is an interesting and important finding of the questionnaire as it indicates that 65% of men do not realise there is an inequality of health between men and women.

14.3 Thematic analyses

PHAST undertook two focus groups of men resident in Buckinghamshire. PHAST interviewed eleven commissioners, six providers, six members of the public and one external organisation (Men's health forum). One of a group comprised mainly retired Asian male residents and the other comprised four white male residents of working age ranging from 28 -65 years.

Bullet point notes were taken with commissioners and where permission was given, the conversations were recorded. A sample of five transcripts was created, comprising three interviews with members of the public and the two transcripts of focus groups.

A number of cross-validated themes were derived from stakeholder interviews - both professional and lay - and the focus groups. Themes included were both those reported by professionals and also corroborated by men in focus groups, or testimonial interviews or vice versa.

Key themes

Use of thematic analysis revealed five key themes and a number of subthemes described below:

- Beliefs and values contributing to health related behaviours and outcomes
- The need to feel invulnerable
- Habit and social norms
- Denial
- Instinct for measuring oneself through a challenge.

These also subdivided into subthemes.

Beliefs and values contributing to health related behaviours and outcomes

A complex system of societal pressure, values and personal beliefs and values of men interact to determine and limit men's ability to keep themselves healthy through their health related behaviour in looking after themselves, the willingness to seek and accept health and their ability to benefit from that help if they seek and accept it. The following represent sub-themes, identified through the thematic analysis, which may contribute to this complex system.

Stoicism and self-sufficiency as a quality is particularly valued in men and by men:

Men reported that they felt that stoicism was a quality men should have and that they felt they should exhibit.

> *"Yeah, Men just think, "Oh, I'll carry on. That'll go away" or something like that, but perhaps women are more astute to knowing that it could be serious."*
>
> *"My dad, you know, saying that sort of thing and oh I can't go to the doctors, there's like a stigma about going the doctors, especially for my dad, for older men"*
>
> *"There's a part of me saying I really should get myself checked out but then there's another part of me that where things have been proved with an intervention that I've made and because I'm busy and there's a whole load of other priorities, I have chosen to not go and seek medical attention, so."*
>
> *"There was something about just kind of gritting my teeth and pig-headedly getting through it as if it, I mean it doesn't even make sense looking back on it..."*

"I was just thinking there actually, it's stupid because my sister-in-law's a nurse and a friend is a GP but rather than ask them, talk to them, I'll go on the internet and Google it and stuff"

Stoicism and feeling a need to be self-sufficient may lead men to carry on when they have indicators that would benefit changing their behaviour or would benefit from help from a health professional.

Isolation /shame at loss of power-lack of value

Men reported that to be sick could be perceived as a failure or as shameful. With this belief it is possible to see why men might avoid prevention activities, which may reveal sickness in a person with no symptoms. This could explain to a degree, other observations that men needed to have clear unequivocal symptoms and signs before consulting for a medical problem.

Men also described that as they became socially isolated due to adverse life events, they began to take less good care of their health. Men exhibited an external locus of control where their self-worth was a reflection of their perceived usefulness or value to others.

Men described how age, retirement and unemployment often led to: social isolation; poorer communication skills; loss of pride loss due to diminished social status. In turn this led to a negative feedback spiral of depression and anxiety – leading to less ability to cope with bureaucracy and causing frustration with the world outside, leading men to isolate still further and not seek help from professional sources in formal environments such as General Practice.

Quote: "First member of Men's sheds who passed away felt almost inadequate, ashamed that he was unwell"

"Well in the last five years and it probably dates a lot from when my mother died, I'm having to get over and see my dad a bit more and make sure he's okay because he's not really, he didn't cope too well with her dying and being on his own so the times when I do cook I cook for him and then it means I come home and I don't have time to shop for us both and there's no food in my house so I'm single so that doesn't help either, so yeah, and I'm having to make up the time at work and to be honest, after Mum died I did find it a bit hard and so I probably did start drinking a bit too much at that time as well and just think, oh I can't be bothered with the gym and everything else but yeah, that probably is quite a big factor I think in me self and not looking after me self really."

"I think I probably have a better diet because I'm married because both my wife and I are interested in food so we probably, between us we keep each other healthier in that respect, otherwise... And I think basically I'm happier than I would be if I weren't married."

"I felt that having a connection with men was important to me"

"Interventions that reduce isolation such as Movers and shakers and Men's Sheds demonstrate the benefit of talking about isolation for self-esteem, sharing health problems and taking action to improve their participants' health."

Feeling normal

Feeling normal, fitting in, and not behaving in a way that would single a man out was a theme that was touched upon by a number of men and also service providers and commissioners.

"Men need to feel normal – weight watchers"

"Men believe thy should be the head of something"

"I found it a very difficult thing to, to sort of show my vulnerability about sort of mental health problems, to get professional help for it or any kind of help but having got the help."

"You have to go and parade the conditions"

Lower demand for health services among men can be seen to be consistent with the finding that men reported feeling that it wasn't normal, or perhaps (fitting - second quote) to be sick or complain about symptoms, or even need to consider their health. Changing what is perceived as normal for me in this regards must be part of the change that will lead to better health for men.

Habit the social norm

Familiarity with health services

Through (usually) fertility-related interaction with health service (contraception, prenatal and post-natal healthcare), women tend to be initiated into familiar and (relatively) comfortable and knowledgeable use of health services. Men however often do not share these positive, or at least neutral, "healthy" reasons to be introduced to health services and often are introduced due to severe illness, when their fear is greatest and their familiarity least.

One man remarked upon the change in his partner's attitude to doctors relating to her experience of multiple examinations and appointments in primary care throughout her first pregnancy.

"My wife used to be shy of the doctors but got over that very quickly after our first baby"

This unfamiliarity, with health care and therefore familiarity with and trust of it, prior to the vulnerability of illness, or symptoms, may exacerbate men's negative experience of healthcare, engendering a feeling of exclusion and the perception that health care services are not for them.

Life-course –significance of life events on health and self-care

Men appear to become isolated from their health and looking after themselves in the context of negative life events, (e.g. relationship breakup, bereavement, and unemployment). These events are predictable to health and social care providers and the response of some men, also predictable. Considering life-course for health interventions to improve men's health is therefore critical to improving men's health.

"well in the last five years and it probably dates a lot from when my mother died, I'm having to get over and see my dad a bit more and make sure he's okay because he's not really, he didn't cope too well with her dying and being on his own so the times when I do cook I cook for him and then it means I come home and I don't have time to shop for us both and there's no food in my house so I'm single so that doesn't help either, so yeah, and I'm having to make up the time at work and to be honest, after Mum died I did find it a bit hard and so I probably did start drinking a bit too much at that time as well and just think, oh I can't be bothered with the gym and everything else but yeah, that probably is quite a big factor I think in me self and not looking after me self really."

Denial of symptoms

Interviews with providers, and men in Buckinghamshire, indicated that denial of symptoms (or the importance of symptoms) appears to play a role in men's health behaviour.

"Smokers need cancer or an MI before stopping smoking, I ask my patients, can you think of yourself in 15 -20 years' time and translate that to now? Many men seem unable to do this"

"Yeah, I would say it, men are, men will shrug things off … men will not admit they've got summat wrong with em until it's, I think until it's, not too late, but until it's got serious. That's one thing I have noticed, you know, like I've said to some of my friends, "Look, you should go and get that looked at," or "You should go and discuss that," or summat like that. A woman would do it earlier, I think."

"Maybe, you know, men are supposed to have a certain amount of discomfort, that it's something that isn't really, it's too, it's not really worth troubling a professional about, it'll go away and I think an element of denial of the problem that I had, you know"

"Refusal to accept, you know, I'm going to carry on my life as it normally is, I'm not going to take any time off, I haven't got time, too busy, I haven't got time to waste my time going to see a GP"

"Men assume they are healthy"

Knowing isn't enough

"Men know what healthy is and they try but don't always achieve a healthy lifestyle"

"I used to drink and smoke, I don't do that anymore. I probably, I still eat too much, I haven't done enough exercise in my opinion since just before"

"Yeah, I used to do a lot but I've been finding that as I've got older I'm finding it harder to find... The pressure of work's gone up and I'm finding it harder to find the time and energy, I used to go to the gym regularly, eat pretty healthily, used to get a veg box delivered every week but now I'm finding I'm eating ready meals and mainly due to stress at work and not, you know, just slowing down a bit and so I'm really not doing anything I would say to look after myself at the moment, health-wise. "

Feeling welcome

Societal/authoritarian disapproval about male health advice seeking

A number of men reported experiencing a negative reception both by GPs and also by practice staff to either being there at all or else that they were there during working hours without an obvious serious illness or simply receiving a different, less welcoming reception by administration staff (in the GP practice). Men also talked about work place attitudes where time off for medical consultation was frowned upon by line managers/bosses.

"I went to the GP I asked, and it was a female GP, and I said to her I'd like you to check my testosterone levels because I am, I think I might be going through something like the male menopause, well she scoffed at me and instantly what I experienced was a kind of judgement and prejudice and a lack of openness."

"It's like I'm a builder so I don't want to miss, I don't deem it worth missing a day's wages to get the medication when I might get better myself."

"The builder who I work for doesn't want me to be off, doesn't want me to be missing days for whatever reason"

"My dad, you know, saying that sort of thing and oh I can't go to the doctors, there's like a stigma about going the doctors, especially for my dad, for older men"

"I think there's a lot of cultural stuff, you know, the myth that the man being strong, independent, self-sufficient, self-reliant and all that sort of, you know, John Wayne stuff,

suggesting that if you've got an arrow in your leg, you pull it out yourself, you don't go to see the doctor!"

"I feel a bit out of place when I go, you know, often I feel in the minority sitting the waiting room, there's often mothers and babies and older people and yeah."

"I do feel like that even the reception staff are slightly, there's something, it's very subtle but they're slightly like, what are you doing here, you're a young bloke, you should be at work, you know, it don't look like there's anything wrong with you. I get that sort of thing"

"I see it the time before when I was in the doctors and it might just be these particular receptionists, I could be, you know, I could be just unlucky but it's sort of like I actually saw some women getting... How they were spoke to, so just wait over there and they were normal, polite and then there was sort of this disdain where I was watching when a young lad came in to have his appointment so it's not just a personal, you know, from me, I actually saw it..."

Trust of doctors, medics, authorities, the need for a personalised experience, being seen and being heard

Men appear to have the propensity to be suspicious of authority and at the same time also value being seen and heard by authority.

One-to-one attention appears to be valued highly.

"We have to do a lot of work just sort of being there for them, allowing them to talk if they want to talk, being quiet, if they want us to be quiet. Showing them that we will be there for them through their difficult times and that we're not going to abandon"

One health professional noted that in an environment of making savings, staffing levels, the need for early discharge undermines the relationship building that is required to engage fragile men in the therapeutic process.

"The reality as everybody knows, in the NHS and other similar public services would be, cuts over the last six or seven years, in the profession particularly and it's not rocket science to realise that that psychiatry is very resource intensive and so we've got this huge challenge of, even if we know what we think we need to do, there often aren't the resources to do it because it is more person intensive,"

"Helping people with, you know, problem solving skills and conflict resolution skills and assertiveness training. That men are more likely to learn constructive ways of solving their problems rather than resorting to aggression or turning it in on themselves, harming themselves or attempting to kill themselves or turning to drugs and alcohol."

"Lack of resources for supporting with the development of life skills and social intelligence, lack of which exacerbates mental illness"

Putting off going to the GP: Going to the GP a waste of time: Perception that GPs won't do anything.

There was evidence of some suspicion of general practices and GPs:

"I know my GP is not a very, what you might call not a very interventionist GP so I might go and talk to him and he'll say, oh it'll be fine by the Spring or you know, just come back and tell me if it's getting any worse or something like that and often things clear up by themselves so I mean it wasn't a great deal of point other than reassurance in going along in the first place"

Men talked of going to alternative therapies:

"Just a few days ago put my back out, my lower back, I've had this on-going thing and I go straight to the chiropractor because doctors aren't going to do anything for it, as far as I'm aware and I've asked before and they said, no, might give you some anti-inflammatories."

On health check one man spoke of his disappointment that the doctor didn't "do" more.

"I think if I'm honest I do have a few health worries at the moment so I was kind of glad to have the call if anything and going but I must say, I felt a little bit disappointed that, as I say, it just seemed to be a blood pressure test and ask me whether I smoked and that was it."

Another reflected a similar sentiment… "it seemed a bit of a waste of time, you know, because they just seemed to take my blood pressure and that was it but doing it was fine, the nurse was pleasant and yeah."

This sentiment of the doctor not "bothering" reoccurred:

"I just gotta use my judgement and not run to the doctor's every sort of five minutes to get clarification on something that they're probably not even gonna even want to bother checking"

This sentiment was also contradicted … "I was left thinking, why on earth did I suffer for two or three weeks in absolutely increasing agony"

Making general practice "a safe space"

"Feeling welcome is important to men"

"There's already a kind of rigidity in the health providers mentality and to some extent I think some of it would be down to kind of resentment or rigidity in women because women have suffered a lot under patriarchy and I certainly didn't experience any openness or tenderness or curiosity around what it might be like to be a man who's beginning to experience some kind of despair because of the changes that are going on physically and psychologically"

A theme that emerged among respondents indicated that they do not trust authority simply because it is authority and in order to appeal for help, men needed to trust the authority that they turn too. This suggests that to successfully engage a proportion of men, the authority, in this case, health providers, must earn that trust. Seeing the man, really hearing the man, welcoming the man whatever problem or demeanour he comes with were all things that respondents indicated as being important. This can all be view as symbols to indicate an authority deserving of trust.

Buckinghamshire Drug & Alcohol Action Team (Bucks DAAT) group therapy

With respect to group therapy (DAAT) it was noted that women selected to have women only groups while men preferred groups with women as well as men or rejected group therapy altogether.

"Men dip in, show vulnerability, then run away"

Provider respondents indicated that among a group of men there was often a chaotic element that would disrupt the group or destroy any sense of safety and trust in that group. This was mostly not a problem for women. It may be the nature of masculinity, for reasons stated above including, competitiveness, lack of trust, fear of being vulnerable that men expect to not feel safe in groups. The lack of safety in a therapeutic group, although perhaps perpetrated by a chaotic individual in that group, while necessarily diminish trust in the authority that created or held that group.

Rules for the group, careful facilitation and techniques for conflict resolution all help to support individuals who feel vulnerable. It is important that measures are taken to ensure an environment is created that respects vulnerable individuals[75].

Men behaving badly

One elderly respondent spoke of not trusting himself to go to the GP because he expected a poor reception and worried he would become angry.

The same man talked about the need to experience risk/danger - for him this meant racing motorbikes (even as non-smoker and non-drinker).

Interaction with authority can be confused with conflict with authority causing an aggressive response from a man feeling under threat.

"I hate being too comfortable all the time… sometimes I feel like a pussy cat instead of a lion"
"A man's pride is more important than survival"
"Risk taking behaviour is a way of testing invincibility, of tempting fate"

Men report an instinct for measuring themselves through challenge and trying to prove their invulnerability, either through risk taking or else by denial of symptoms or else their potential for indicating something needing medical attention.

Providers of sexual health services spoke in relation to sexual health.

"Vicious cycle of not accepting vulnerability and therefore not taking precautions"

"Men chose AA over Smart Recovery (opposite in women)

"Men do it the hard way"

Men talked of needing to experience symptoms that actually impact on them in a way greater than the perceived stigma of consulting to take action to consult a doctor or medical professional.

Health knowledge

"I have quite a large book, which is a sort of family medical book, I can't remember what it's called, it's quite comprehensive and useful as kind of first look but it's starting to get a bit out of date now. It's probably at least ten years old so I tend to use the internet with the sites that I reckon would be reliable, British Medical Association or US National Institute of Health or something like that and as the men said, cross-check that with other sites, you know, sometimes just one of them is much clearer than the other one, they may give you basically the same information but sometimes one is clearer or more relevant or freer of adverts."

Men reported they were happier to use the Internet; they were aware about how to corroborate what they found there; in addition there was a consensus of the need to check the source and also to cross reference to check validity.

Differences with women

Men described the women in their lives as having a different more assertive attitude to health and healthcare.

"My experience of my wife is that she is much more ready, she will go to the GP quickly and she will be very assertive and she'd demand attention and treatment"

"She has gone as far as to say she will make an appointment for me and make me go but she hasn't actually done that"

"She'd rather not go unless she really has to, that's like, I don't know, that's like shyness from doctors but she just had a baby four months ago so she's sort of lost all that now, she's not worried about anything anymore."

14.4 Corporate analyses discussion

There is overwhelming evidence that in developed countries, men, with similar social advantages or disadvantages as women, experience poorer health outcomes in relation to disability, chronic illness, injury rates and mortality, and they access healthcare less throughout the life-course. Young men are up to three times more likely to die from accidents than young women, four times more like to die from suicide and half as likely to seek out health care. Excess risk continues throughout middle age and old age; expressed in late presentation of symptoms, higher risk taking behaviour, higher propensity for cardiovascular and other illness, poorer compliance with treatment and medication and poorer recovery after treatment. The reasons for the poorer outcomes in men are likely to relate to nature (genetic determined predispositions for disease and behaviours) and nurture, the socio-economic and environmental milieu, which males experience differently from females.[76] Recent research on the role of gender have postulated that the differences may relate in part to the socialisation of men to try to live up to an idealised stereotype of masculinity possessing traits of assertiveness, dominance, control, physical strength and emotional restraint, leading to risk taking behaviour when young, followed by isolation, and unwarranted stoicism when older. This conceptual framework provides a useful background for considering the poorer outcomes of men, the underlying modifiable behavioural causes and the steps that can be taken to modify those negative behaviours throughout the life course.[77]

The epidemiological needs assessment has identified higher risk behaviour in men and less access to preventative services such as Health Check, smoking cessation and weight management services. Men had less timely uptake of secondary care services (in terms of admissions). This showed up as late and excess of male admissions for late presenting conditions while women had higher admissions for long-term conditions at older ages. Men had poorer outcomes in all of the big killer diseases "cardiovascular disease and cancers" and lower life expectancy consistent with their less timely uptake of health services.

Regarding mental health, standardised mortality rates for suicide and undetermined injury for men are almost three times those for women in Buckinghamshire.

14.5 Is there a problem?

The literature review sets out unequivocal evidence that at local and national level men's health chances are worse than women's throughout the life course, and across society and ethnic groups. Men express more risky behaviours at all ages, take up prevention services less, engage in health services for symptoms later and have worse outcomes, culminating in lower life expectancy and an excess of deaths under the age of 75.

The epidemiological needs assessment confirms that Buckinghamshire is no exception to the rule. In the three-year period 2011/13 there were 644 more male deaths than female in the under-75, or 215 more per year on average. This represents an 18% difference between the sexes. These figures are highly statistically significant and demonstrate considerable health inequalities in health outcomes relating to gender.

Evidence suggests that much of the inequality is amenable to change and that change requires an understanding of men, their particular needs, drivers and barriers to looking after themselves and engaging in healthy behaviours and engagement with health services. Useful conceptual measure of the latter is the "patient and practitioner delay" (the excess time from symptom or sign in the man to the time of treatment).

Legislation is in place in UK through the Equalities Act 2010, such that should the Act be actively implemented and enforced, all the levers for addressing this heath inequality should be present.

Considering that the threshold currently in place in the UK for the introduction of therapies and treatment through NICE is that treatments with a cost per QALY[78] of up to £30 000 are likely to be considered for approval for funding by the NHS[79,] the case for material investment in improving men's health is strong. Yet at a local level, an enormous amount could be done simply by a CCG governing body, NHS provider board or health and well-being board acknowledging men's health inequality as a structural issue as such.

Writing into board level strategies, whether public or organisational facing, can set the scene for organisational change, with targets for men's health being a requirement of all service level agreements. Currently there is little mention of gender issues; for example the JSNA (which had the most references to gender) had approximately twice the number of mentions of the words girl, women, and female as it does to boy, man, or male and only six references to gender synonymous words.

Table 16 - Frequency of occurrence of male, female and gender related words in key Buckinghamshire strategy documents

Strategy Document	Total male related words	Total female related words	Total gender words
Health and Wellbeing Strategy 2013-2016	0	0	0
JSNA Executive Summary	19	29	6
Draft Commissioners 5 Year Plan 2014-2019	1	0	1
Physical Activity Strategy 2014 – 2017	7	11	1
The health of children and young people supplement to DPHs report 2014	4	35	11
Adult Mental Health Commissioning Strategy 2015-2018	0	0	0
Prevention Matters	4	15	2
Healthwatch Annual Report 2013/14	1	2	1

Men's health could be and should be mentioned, specifically, in high-level strategy documents such as the JSNA and HWB Strategies.

Slope index data from Buckinghamshire shows health inequalities were significantly greater in men than in women.

There was a mixed picture from interviews with commissioners and providers about the urgency and scale of men's health inequalities and some disconnect between the local perception of commissioning managers and local lower male participation rates (smoking cessation, Health Check) and poorer health outcomes (men are dying earlier and quicker of cancers, CVD, have more suicide and depression).

There is most definitely a challenge relating to men's health inequality in Buckinghamshire, which it shares with the whole of the UK and beyond. The solutions are structural and societal and much can be done where there is political and organisational will.

14.6 What is the solution?

Men friendly services

Reducing patient delay (the time taken for patients to "demand" help for their health "need") must be minimised where possible to ensure men take up health services when they are offered, in a timely manner. Also practitioner delay must be minimised, (the time taken from diagnosis to treatment, including any steps for investigations and referrals). Health Check provides a useful illustration of some of the issues around patient and practitioner delay.

78% of the female population aged 40-74 and 71% of the male population are eligible for Health Check. In Buckinghamshire, a quarter of the female eligible population was invited to a Health Check, while over a third of the eligible male population was invited. Of those invited, 51% of females and 38% of males accepted the invitation. The percentage of males found to be at high risk was almost double that of females.

It can been seen that for Health Check invitations, Buckinghamshire is doing extremely well to reach and to invite more men than women since men are less likely to take up the invitation. The absolute number who accepted the invitation was similar in men and women. However since invitation acceptance is much lower among men and the number of at-risk invitees was much greater in men than women, a multi-pronged strategy is required, not only to increase numbers of invitations but also to improve uptake. A particular approach to the invitation of men is required that differs from the invitation for women.

Evidence from the literature suggests that branding (colour, style, images that include men) is important. It is also important to stress the consequences of not attending health checks and to men and to provide services "where men are" through outreach, the pub, in clubs, at work, etc. Much of this has already been put into practice in Buckinghamshire where Health Check has already been delivered in innovative ways (outreach at mosques, and further work is planned (e.g. working with licensing minicabs (currently in discussion), Wycombe Wanders football ground, workplace, refuse collection, Arriva Buses, Business first, outreach in retail parks) yet conversion rates remain very low showing that reaching is not enough. Reaching then convincing is what is required. The quality of interaction once the target men are reached is vital.

Commissioners of Health Check in Buckingham are aware that the service is successfully interacting with more women than men and there is at least informal understanding with providers that particular focus on men as a high-risk group is required. The high level of engagement with men, inviting them to take up Health Check is testament to the success of this understanding. However PHAST recommend that that where possible there should be formalised targets not only for engagement and invitation but also targets for successful screening uptake amongst men. This will cause the focus of attention to be on the invitation process itself to make it more attractive to men.

Health Check commissioners also recognise the need to do more and to meet men's needs in terms of offering out of hours appointments, using wording and visuals that are appropriate and focused on men to improve uptake.

Access to services via different referral methods including self-referral

Promote a variety of access models to reduce inequalities. For example the pre-diabetes referral service in Buckinghamshire was initially funded uniquely for referrals from Health Check. This introduced inequality since men were disproportionately declining or ignoring their Health Check invitation. Linking of referrals to one service from one unique source risks increasing inequalities if men are disproportionately absent from the referring services. PHAST understands that access to this pilot service is currently under discussion and negotiation between commissioners and providers. PHAST recommend that any agreement focuses on targets for the proportion of men to enter the pre-diabetes scheme with the flexibility to recruitment from outside the Health Checks to allow for the possibility of targets for men recruited to Health Checks are not met.

A access model that enables different routes to services is more conducive to a men-friendly health service and Health Check might consider an even more overtly opportunistic approach to that taken already, working more with employers to undertake sweeps of workplaces during lunch hours, perhaps providing sandwiches so employees do not miss their lunch. Health Check might also "flash mob" pubs, clubs, job centres, shopping centres and libraries, etc. "*to catch men where men go*" and offer the service there and then. As one interviewee said "*I would have thought if some of the Health Checks could be offered at the work place rather than a GP's surgery that would make a lot of difference...*"

15. Corporate analyses success themes

Through the interviews and the focus groups a number of observations, ideas and suggestions relating to what the drivers and barriers are to change in the outlook for men's health recurred. They are listed in the following sections.

15.1 Looking for leadership

CCG respondents noted, "If it was on the HWB agenda then it would be a CCG priority". There is clearly openness among commissioners, providers and health professionals to address men's health inequality. Yet a clear strategic directive would provide considerable momentum and focus for organisations and departments to kick into action. The Equalities Act-of 2010 provides a legislative basis for the responsibly of statutory agencies for ensuring gender equality in health provision and outcomes, as elsewhere in society. This legal framework in concert with the clear evidence from this needs assessment, provides a coherent, compelling case for taking a strategic approach, naming the problem and potential methods of addressing it in strategy documents and ensuring that service level agreements have clear process and outcome related targets (i.e. not just invitation to preventative services such as smoking cessation, weight management and others, but also uptake and completion of treatment).

15.2 Meeting men where men go

A number of services repeatedly acknowledge the need to "catch them there and then" in the form of outreach, youth space bus, national testing week (sexual health) etc.

15.3 Branding specifically for men

Interrogation of commercial partners demonstrated their understanding of the problem of engaging men and the way that have brought to bear commercial approaches to marketing and business and the degree to which they understand challenge engaging men remains despite over 50 years of tackling the problem. Nevertheless it is from commercial partners like Weight watcher that some of approaches with most potential arise.

The Weight watcher interview reiterated that branding darker colours, depicting men doing the recommended action, the use of gadgets (apps), use of humour all whilst also conveying a sense of urgency where critical, timed delivery (during the year e.g. weight loss in summer) and in key points in life course were also important.

A notable successful health campaign, celebrating masculinity is Movember, the charity encouraging men to grow a moustache in the month of November, raising money for prostate cancer charities. The enduring popularity of this campaign demonstrates the desire of men to exhibit their masculinity, protected by doing so in a humorous way whilst also being part of a movement, "doing it together" with the support and affirmation of women and social networks. These features should be considered in local campaigns and service delivery.

15.4 Not all men are the same

Multiple respondents remarked upon the need to understand that not only are men not the same as women, but also not all men are the same as each other; single and younger men need to be addressed in a different way to older married men for example. This needs to be articulated both at a policy level and also local level. Segmentation and customer insight techniques should be employed to ensure that programmes, campaigns and services go beyond simply considering men differently from women, although this is a start, further they must provide for the diversity among men.

15.5 Men need a reason to look after their health

Men need a reason to look after their health. In the young this is related to societal pressures to take risks and test invulnerability. Bonding through sport can channel competitive energy whilst allowing men to support each other in a structured safe environment of the sports team. One example of this was a DAAT recovery football team where substance misuse levels dropped to zero (in some members) as the team became more and more successful, winning their division.

In older men schemes such as Men's Sheds reskilling older men for "a purpose" such as providing voluntary community service (handyman, gardening etc.) reduced isolation and empowers men to revalue themselves and consequently take more interest in looking after themselves and their health, relieving them from a downward spiral of isolation, low self-worth and self-neglect and ultimately avoidable ill-health and early death.

15.6 Men want to be seen and heard

Men want to be seen and heard before they trust authority and value flat hierarchies when it comes to their health. A further theme came from interviews but also from the evidence from Health Check that it is not enough to reach men (more men were reached than women), they need convincing to engage (less men engaged and those that did were at much higher risk) and that takes time and attention, and the right sort of attention. High levels of invitations to eligible men are important but conversion rates indicate whether men are engaging with services, for Health Check conversation rates remain well behind women. An example of a successful approach for increasing conversion rates was that of a Weight watchers pilot for men with pre-diabetes, described in interview. Each man spent time with a clinician, who explained that their condition predisposed them to a number of risks, explaining those risks clearly and graphically. Then once men signed up for the programme of weight reduction, participants all began the programme at the same time as a group and the group again was pre-briefed on the risks and the importance of what they were doing. This dual approach of a group created without hierarchy because everyone started together, no one feeling the "new boy", along with a shared experience of hearing the risks and high stakes, led to very high levels of course completions and success in weight loss.

A further approach which was described as working better for men was a shared approach to treatment planning- a self-created action plan; getting men to set their own goals and then support them to achieve their own goals

Training of professional and administration staff about how to interact with men, and the clinical importance of doing so, is also important since "feeling welcome", such an abstract and yet vital factor for engaging men, appears to be a critical factor in men consulting, returning and ultimately engaging in therapies that could save their lives.

15.7 Societal attitudes

The need to change attitudes and behaviours was described by respondents and particularly how this must start with children in schools. There is a need to change the culture that idolises and encourages boys to aspire to the lone macho male figure. There needs to be reduction in stigma around men showing vulnerability along with challenging stigma around sexual health. Currently the content of Sex and Relationship Education (SRE) in schools (for which a specific curriculum is not currently prescribed), offers little opportunity to direct changing attitudes in a coherent and consistent way.

15.8 Professional attitudes: health services are for men too

The IAPT example, described below is a stark illustration of how men do not get offered services that they would benefit from, to tragic effect.

While in 2013/14, 7,960 people were referred to psychological therapies of which 5,132 (64.4%) were women and 2,828 (32.6%) were men. A slightly higher percentage of men, who were referred, started treatment. A higher percentage of women who started treatment achieved recovery. Although men have three times the suicide rates they are only referred one third as often as women, yet once referred, men's uptake was similar and they received similar benefit.

Somehow psychological therapies are not something offered to men, in anything like the same proportion as women. This can change thorough a cultural shift to help health professionals break through male social taboos around health and offer the services in a way that men can accept them. Mental health seems to be on the extreme end of the spectrum but illustrates a theme that is ubiquitous throughout healthcare.

15.9 Multiple agency support

The stakeholder interviews and focus groups indicated the need for multi-agency approach taking a holistic approach" to the needs of particularly for the most vulnerable men with multiple issues of offending, accommodation, drug and alcohol and poor mental ill health.

15.10 Barriers to tackling men's health inequality

There has been a lack of wider political will related to a passive long term societal acceptance of men's health inequality. Without a broader national political will, local commitment is harder to garner and maintain.

There is currently a dearth of published recognition of the problem of men's health inequality in Buckinghamshire County Council documents and strategies for health commissioners by which to be guided. Consequently service level agreements lack reference to the needs of men. As a result, there are few formally agreed measures to address men's health inequalities by providers.

The economic cycle has determined the need to cut public spending. The need to reduce budgets necessarily impacts on the ability of the Council to react to the need of considering men separately in commissioning of services.

Reduced manpower on front line services will likely increase men's health equalities because the things that men need, become less available (time explaining and empathising, building trust etc.).

The "ground up approach" to delivering preventative social support, employed by "Prevention Matters" because of budget restraints, is at odds with the needs of vulnerable isolated men who are unlikely to ask for help and remain "invisible men". Waiting for these men to identify their own needs will not provide an effective strategy.

16. Key Findings and Recommendations

16.1 Literature review

Key findings from the literature review and epidemiological needs assessment has identified that compared with women men have -

- Higher health risk behaviour
- Less access to preventative services such as Health Check, smoking cessation and weight management services
- Less timely uptake of secondary care services (in terms of admissions)
- Poorer outcomes in all of the big killer diseases "cardiovascular disease and cancers"
- Lower life expectancy consistent with their less timely uptake of health services
- Almost three times standardised mortality rates for suicide and undetermined injury

16.2 Mortality

All age all-cause mortality rates are significantly higher in males than females.

- Rates for both genders are significantly lower in Buckinghamshire than in England overall.
- There is a consistent downward trend in AACM in Buckinghamshire, South East England and the whole of England for both sexes.
- Rates of premature (aged <75) mortality from each of the major causes of death are considerably higher in males than females.
- In Buckinghamshire life expectancy at birth is 81.2 years for men, and for women it is 84.9 years, a difference of 3.7 years for the three-year period 2011-2013. Life expectancy of males in Buckinghamshire is a year higher than the regional average, and more than 18 months higher than the national average. These differences are statistically significant at the usual 5% level.
- Life expectancy of both males and females in Buckinghamshire has increased steadily in the ten years, in common with the rest of the country. It has been consistently higher than the regional and national averages. For females the gap between Buckinghamshire and England widened over the 10 years; for males the gap narrowed slightly in the same period.

16.3 Geographical patterns across Buckinghamshire

Data from GP systems suggest <u>there are **no** consistent geographical patterns across Buckinghamshire</u> in -

- The proportion of obese people who are male
- Male obesity
- Raised blood pressure in males
- Raised blood sugar in males

16.1 Policy

The need to improve men's health should be explicitly considered on NHS and local authority policies.

Recommendation: Ensure Men's Health gains wider recognition and that it is specifically addressed in its own right in both public and internally facing key council and statutory health organisation strategic documents.

Recommendation: Ensure Men's Health is placed on the agenda to be specifically addressed by the Health and Wellbeing board and CCGs annually.

Recommendation: Ensure Men's Health and gender impact is specifically mentioned where relevant, in high-level strategy documents, for example included in strategies evaluations and audits undertaken by CC PH; HWB; LA; Allied Health and Social Care Organisations.

16.2 Data management

Monitoring and surveillance of men's health requires that data be reported separately by gender.

Recommendation: Evaluation and audit should report on gender as a matter of course. The benefits of this approach will be to keep the inequality in men's health an active issue.

Recommendation: The systematic collection and reporting of gender-stratified data for management, process and outcome data.

16.3 Health promotion

Men may be less likely to respond to health promotion campaigns.

Recommendation: Ensure that consultations and social marketing campaigns offer clear messages that include the consequences of inaction to men

Recommendation: Ensure the prevention services are designed where relevant to specifically target men at different stages during their life-course

16.4 Service redesign

Men reported a range of reasons for being less likely to take up or access services

Recommendation: Promote multi-source of access to services, for example by offering flexible routes of referral to weight loss management, smoking cessation and pre-diabetes assessment

Recommendation: Promote activities that minimise patient delay in seeking health care ensure prevention services address those factors which lead men to delay consulting and 'practitioner delay' those factors leading the practicing to delay investigation and therapy.

Recommendation: Design outreach services that meet men in places that is appropriate to them. For example places of work, worship, recreation, commercial centres and job and civic centres such as libraries.

Recommendation: Promote a shared approach to treatment planning for men with a self-created action plan; getting men to set their own goals and then support them to achieve their own goals.

Recommendation: Target Vulnerable At-Risk Men for support to combat isolation, loss of self-esteem and depressive related illness and lack of self-care.

Recommendation: Design appropriate interventions for vulnerable male groups; for each target audience that are designed to meet them psychologically and do not require them to conform in order to gain access services.

16.5 Training

Recommendation: Promote gender sensitive training to administrative and clinical staff, to ensure the NHS particularly primary care is perceived as welcoming and open to men.

16.6 Information technology

There is scope for use of IT to improve access to health services for men,

Recommendation: Increase online interaction with health services and ensure it is designed to be male friendly.

Recommendation: Review prevention referral schemes and ensure they offer an open access basis, such that men can be picked up and referred if they meet entry criteria and are not excluded because they did not access via the correct route.

16.7 Health checks

- Health Checks data from GP systems showed that previously undiagnosed diabetes was greatest in the urban areas of Amersham, Aylesbury, Buckingham, and High Wycombe
- The percentage of previously undiagnosed diabetes detected at health checks was half as high again in males as in females. **This represents a definite health inequality between the genders**
- Health Checks data from GP systems showed that 51% of invited women attended the Health Check, but only 38% of invited men attended
- The percentage of males found to be at high risk of cardiovascular disease was almost double that of females. These percentages were not correlated with deprivation quintile
- Male gender is a risk factor for CVD

Recommendation: GPs in Buckinghamshire should be encouraged to consider the possibility of undiagnosed diabetes in their male patients.

Recommendation: GPs in Buckinghamshire should encourage more of their eligible male patients to attend Health Checks.

Recommendation: GPs in Buckinghamshire should pay more attention to the possibility of heart disease in their male patients at routine consultations.

Recommendation: Health Check providers should consider opportunistic approaches to recruiting men who are likely to be high risk and currently do not attend. For example working with employers to offer health checks in workplaces during lunch hours, or offer checks in pubs, clubs, and employment offices.

16.8 Participation in sport

- Data from Sport England's Active People Survey show participation rates in sport on Buckinghamshire are higher than the averages for the South East Region and England overall.
- Participation rates have been consistently higher among men than women. Across the county, participation rates (all persons, not available by gender) are higher in the southern half, but lower in the urban areas of Amersham, Chesham, Princes Risborough, and High Wycombe.

Recommendation: Buckinghamshire CC PH department should continue to encourage physical activity, and should particularly concentrate this promotional work in Amersham, Chesham, Princess Risborough, and High Wycombe.

16.9 Smoking cessation

- Higher percentages of males in Buckinghamshire who set dates to stop smoking succeed in quitting than of females. This is most marked in the over 60s and least in the under 18s, who also have the lowest success rates.

Recommendation: Buckinghamshire's Stop Smoking services should particularly aim to encourage more young people to give up smoking.

- Almost 10% of those who set quit dates are of South Asian ethnicity, which make up just over 6% of the population.

  As Bangladeshi and Pakistani men are known to have particularly high smoking prevalence rates (source: HSCIC Statistics on Smoking, England 2014) this is encouraging.

Recommendation: Buckinghamshire's Stop Smoking services should continue to target services among ethnic groups who are at the highest risk of cigarette smoking.

16.10 Domestic violence

- Three quarters of the victims of domestic violent crime are female.
- Almost 90% of domestic violent crimes are committed by male.
- 30% of domestic violence is considered to be alcohol related, rising to 40% when the perpetrator is female or the victim male.
- There are noticeable age disparities: young adults (18-26) are responsible for the highest proportion of domestic crimes and only 22% of these are alcohol related, while in the over 40s there are far fewer incidents, but half of them are alcohol related.

Recommendation: Buckinghamshire's domestic violence reduction programme should target the younger adult age group, and should emphasise the increased risk of males becoming victims of domestic violence when alcohol is involved.

Recommendation: Buckinghamshire's campaigns to promote sensible drinking should emphasise the role played by alcohol in domestic violence, especially in older age groups.

16.11 Carers

Over 40% of unpaid carers in Buckinghamshire are males, and higher proportions of these report being in bad or very bad health.

Recommendation: Buckinghamshire CC's Adult Services should bear in mind the needs of male carers for carer support.

16.12 Cancer

Incidence of all cancers was higher in males in Buckinghamshire than in females, but the difference was not statistically significant at the 5% level. Incidence in males was significantly lower in Buckinghamshire than in England overall.

- Incidence of lung cancer aged under 75 was higher in males in Buckinghamshire than in females, and the difference was statistically significant at the 5% level. Incidence in males was significantly lower in Buckinghamshire than in England overall.
- Incidence of colorectal cancer aged under 75 was higher in males in Buckinghamshire than in females, but the difference was not statistically significant at the 5% level. Incidence in males was non-significantly lower in Buckinghamshire than in England overall.
- Incidence of skin cancer (non melanoma) aged under 75 was higher in males in Buckinghamshire than in females, and the difference was statistically significant at the 5% level. Incidence in males was non-significantly higher in Buckinghamshire than in England overall.
- Incidence of prostate cancer in men of all ages was very similar to those of England and the South East Region.
- 5 year survival of prostate cancer patients was very similar to those of England and the South East Region.

Recommendation: Buckinghamshire CC PH department should ensure that healthy lifestyle messages designed to reduce incidence of cancer are especially aimed at men.

16.13 Hospital admissions

Hospital admissions for stroke in Buckinghamshire were significantly higher for men than women. For both genders they were significantly lower than the England rates.

There was an apparent national downward trend in from 2002/03 to 2008/09, followed by an upward trend. The picture is unclear, and may be related to the Department of Health's National Stroke Strategy for England, which recommended major change in the system for stroke care and began to take effect in 2010.

Recommendation: Buckinghamshire's CCGs and Commissioning Support Unit should monitor admission rates and outcomes for stroke.

16.14 Sexually transmitted infections

Between 2010 and 2013 there was an overall 10% increase in new STIs among MSM.

Recommendation: In line with national recommendations, men who have sex with men (MSM) having unprotected sex with casual or new partners should have a HIV/STI screen at least annually, and every three months if changing partners regularly.

Recommendation: MSM should avoid having unprotected sex with partners believed to be of the same HIV status (serosorting), as there is a high risk of STI and hepatitis infection and, for the HIV negative, a high risk of HIV infection as 18% of MSM are unaware of their HIV infection.

Recommendation: Bucks sexual health services should seek to raise awareness of syphilis and gonorrhoea in MSM in Aylesbury Vale and Wycombe particularly.

16.15 Improving access to psychological therapies (IAPT)

- About one third of referrals to IAPT are of men.
- Men's take-up of IAPT services, at 75%, is similar to that of women.
- Similar proportions of men and women achieve recovery.
- Men's rates of suicide and undetermined injury are three times those of women.

Recommendation: It should be a clear priority to focus on increasing referral of men to IAPT

17. Conclusion- Men's Health Priority areas

In common with the whole of the Country, using standard indicators such as incidence of major health problems, mortality rates, and life expectancy, the health of men in Buckinghamshire is worse than that of women. Men have higher incidence of all the major fatal illnesses, die younger, and live shorter lives. Men are less likely to seek medical advice and treatment, and may be less likely to take up preventative services. The extent to which some of these matters are amenable to health intervention is unknown, but it is important that men's health is specifically addressed in the development of policies and surveillance of the health of the people of Buckinghamshire.

Local authority and statutory health organisations should ensure that gender inequalities and equity are explicitly incorporated in equality impact assessments, strategies, and audits.

Providers should be required to ensure that gender is an item reported in all data collection and management. If standard reporting (eg via national systems) does not include that breakdown then consideration should be given to establishing local reporting systems to supplement the standard reports.

Design of health promotion campaigns, prevention services, and provider services should ensure that arrangements for access minimise barriers to take-up by men. In particular, efforts should be made to get more men to attend health checks, as male take-up is lower, and there are higher rates of health risks (diabetes, cardiovascular risks) identified among men who attend than among women. This may involve improved use of information technology, and perhaps widening the provision of health checks beyond GP practices.

Domestic violence is strongly gender-oriented: 90% of perpetrators are male, and 25% of victims. As age increases there are fewer incidents but incidents are more likely to have alcohol involved. When alcohol is involved men are more likely to be victims. Campaigns to reduce domestic violence should include these considerations in their design.

Adult Care should bear in mind the likely need for carer support in male carers.

In view of the recent increases in STIs among men who have sex with men, it is important that sexual health services and campaigns emphasise the need for safe sex practices and regular HIV testing, and work to increase awareness i men of syphilis and gonorrhoea.

Men's mental health should be a priority area for Buckinghamshire. Only a third of referrals to Improving Access to Psychological Therapies (IAPT) are for men, but (in common with the rest of England) suicide rates among men are three time as high as among women.

Taken together, the results of this Needs Assessment have the potential to form the basis of a programme to:

- reduce health inequalities between men and women; improve men's life expectancy,

- increase staff awareness to promote men's healthy lifestyles, and

- improve health and community service delivery to men.

Please see Appendix 1 - Menu for advocating organisational change to address men's health inequalities

18. Acknowledgements

The PHAST team would like to thank Shakiba Habibula and the rest of the Buckinghamshire CC Public Health Team as well as all the interviewees and men who participated in the focus groups particular the Movers and Shakers and Milton Keynes MKP iGroup members.

Copyright statements

Appendix 1 - Menu for advocating organisational change to address men's health inequalities

- Consider resources
- Adopt a conceptual framework
- Adopt a marketing strategy
- State the evidence
- Give Board Presentation
- Adopt champions
- Initially engage key allies (Mayor, head of council, scrutiny committee, key directors in council and partner organisations and third sector).
- Get outside help, Men's health forum, MP, Parliament, EU, University departments
- Put on events, days, petitions, develop a strategy.
- Champions should have goals and milestones to keep men's health on the agenda, to incorporate a gender goal on council strategy (possibly embodied in the HWB strategy).
- Engage Stakeholders through champions and core team
- Champions should engage key stakeholders with specific goals
- Consider Drivers
- Evidence
- Momentum of the men's health needs assessment
- Identify allies in the organisation and beyond.
- HWB potential to guide allied organisation policy (e.g. CCGs and other providers)
- Consider Barriers
- Inertia
- Political sensitises around gender
- Other priorities
- Diminishing resources

Appendix 2: List of data sources consulted

Public Health England

Association of Public Health Observatories

London Health Observatory

Health Survey for England

Health & Social Care Information Centre

Local Health Checks data

Tobacco Control Profiles

Public Health Outcomes Framework

Office of National Statistics

2001 Census

Sport England Local Sport Profile and Active People Survey

Beating Bowel Cancer

Buckinghamshire CC Public Health Department

Ordnance Survey

UK Data Archive

POPPI (see Appendix 3 Glossary)

PANSI (see Appendix 3 Glossary)

Appendix 3: Glossary

AACM	All age all-cause mortality
BCCPHD	Buckinghamshire County Council Public Health Department
CCG	Clinical Commissioning Group
DAAT	Drug and Alcohol Action Team
DNA	Did not attend
DSR	Directly Standardised Rates
GPRD	General Practice Research Database
HSCIC	NHS Health and Social Care Information Centre
IAPT	Improving Access to Psychological Therapies
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LSOA	Lower Layer Output Area
MI	Myocardial Infarction
PANSI	Projecting Adult Needs and Service Information
POPPI	Projecting Older People Population Information System
SII	Slope Index of Inequalities

Appendix 4: PHAST

The Public Health Action Support Team is a leading public health consultancy with expertise in epidemiology, health economics, health/environmental impact, needs assessments and equity audits. PHAST has delivered projects to a wide range of clients such as government departments, Strategic Health Authorities, Primary Care Trusts, Royal Colleges and Charities. PHAST is a Community Interest Company that is committed to using its surpluses and assets for the public good.

PHAST consultants provide evidence based, high quality, outcome-focused public health services and support. PHAST Consultants who have worked within the Department of Health, public health, and in both primary and secondary care NHS settings. Many have worked at high level in the NHS, the Department of Health or in academia. PHAST also has experts in medicine, nursing, pharmacy, reproductive health, health economics, ethics, ecology, psychology, sociology and law. Quality assurance and due diligence processes are in place to ensure all associates work to the highest standard.

The research team has considerable expertise in leading large projects involving quantitative and qualitative research including literature reviews, health needs assessments, evaluations and utilisation management reviews. PHAST has undertaken a large number of evidence reviews. Relevant projects undertaken by PHAST have addressed the complexities of estimating populations. They include the following. The sexual health strategies and needs assessments addressed the LGBT populations in the relevant areas.

NHS England and Ministry of Defence Veterans Musculoskeletal Needs Assessment - On behalf of NHS England, PHAST reviewed the current configuration of NHS services for Veterans in England, this included addressing Veterans' entitlement; the current location of Veterans in England; The aim of the Veterans MSK Needs Assessment was to identify the veteran population in England including where veterans were located in England. This involves detailed data analysis from variety of sources and careful mapping the data across England. The location of MSK services for veterans was also mapped and discrepancies in access to services were identified. The PHAST team identified a series of models that met the MSK needs of Veterans located in England.

West London Alliance Collaboration - Sexual Health Strategy and Vision

Analysing the West London Alliance Collaboration data and writing their strategic report

http://www.westlondonalliance.org/wla/wla.nsf/Pages/WLA-118

Sexual Health Strategy for Northamptonshire - Public Health Northamptonshire County Council - This involved the PHAST team **c**arrying out detailed needs assessments including identifying the LGBT populations analysing sexual health data

Sexual Health Strategy for Buckinghamshire Public Health Buckinghamshire County Council - This involves the PHAST team **c**arrying out detailed needs assessments including identifying the LGBT populations analysing sexual health data

Primary Healthcare Strategy for the London Homeless, commissioned by St Mungo's, London's largest homeless hostel provider in the capital. The health strategy developed by PHAST, addressed the numbers and types of people classified as homeless in London, location of homeless services, inequalities and methods to ensure quality primary care service delivery to the homeless that included physical health, mental health, drugs and alcohol and well-being. www.mungos.org/documents/1362

Appendix 5: References

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66 Strategic Assessment – Thames Valley Police data

67 Strategic Assessment – Thames Valley Police data

68 Home Office VAWG Ready Reckoner tool – based on 2013 population of approximately 515,000

69 Women's Aid Annual Statistics 2014

70 Women's Aid Annual Statistics 2014

71 Source Public Health England www.localhealth.org.uk, accessed 10 Nov 2015

72 Calculations give estimated percentages allowing for "censored data" - those diagnosed with prostate cancer but who die in the period from an unrelated cause.

73 Indirect Standardisation direct comparison is only truly valid between the population in area of study (Buckinghamshire) and the reference population (in this case England) because the indirectly standardised rates calculation does not allow for differences between the population structures of different study areas. We must note this unreliability when considering comparing Buckinghamshire with DSR of other counties. The inaccuracy will depend on how different the local population structures are from each other and from that of the whole of England.

74 A 95% confidence intervals (or CI) is a measure of uncertainty in the underlying data. It is best interpreted as the range within which we can be 95% sure the "true" value lies. If two 95% CIs do not overlap they are said to be significantly different and the 5% level.

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78 QALYs provide a common currency to assess the extent of the benefits gained from a variety of interventions in terms of health- related quality of life and survival for the patient.
When combined with the costs of providing the interventions, cost–utility ratios result; these indicate the additional costs required to generate a year of perfect health (one QALY). Comparisons can be made between interventions, and priorities can be established based on those interventions that are relatively inexpensive (low cost per QALY) and those that are relatively expensive (high cost per QALY).
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