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NHS
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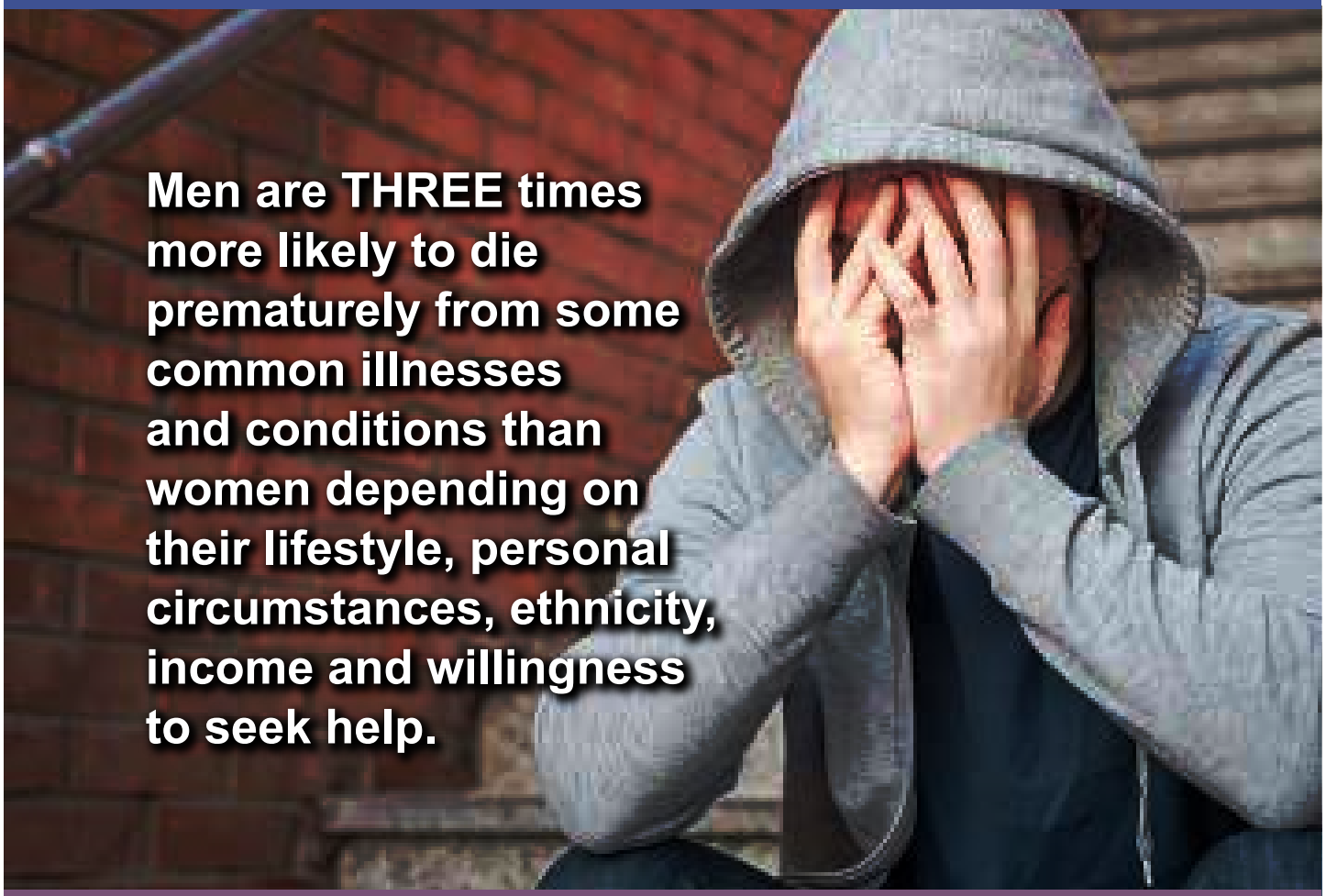
Clinical Senate and Networks

Men's Health

Draft Discussion Paper



Do men and women behave in ways that predispose them to particular health conditions? Do men access fewer public services?

Contents

The report is broken down into sections below:

1 Executive Summary

The Wessex Clinical Senate and Clinical Networks have explored the differences in health outcomes for men and women. The Clinical Senate held a 'Study Day', engaging with stakeholders and charitable organisations both local and national, to address how these inequalities might be addressed. After this event, a literature review was commissioned, information was gathered from a variety of data sources and further views were sought across the clinical networks, culminating in this report.

Key issues that emerged include the need for gender specific approaches to multi-agency suicide prevention, the importance of early diagnosis in improving subsequent outcomes and the need to reach out to men to increase their effective use of existing services.

Although the local data highlight opportunities for improvement, it cannot be achieved without a sustained co-operative approach involving commissioners, local authorities, the voluntary and charitable sector and leisure providers. The key parties are identified in this report.

2 Introduction

Men are more likely than women to die prematurely: 42% of men die before age 75 compared to 26% of women[1].

Men are more likely than women to die prematurely: 42% of men die before age 75 compared to 26% of women[1].

This is a draft discussion paper produced by the Wessex Clinical Senate and Networks which explores the reasons for this and identifies potential interventions tailored to men and women both nationally and locally. We are inviting views on the content of this paper from organisations and individuals seeking to reduce gender health inequalities.

Clinical Senates were established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about healthcare for the populations they represent.

Clinical Networks bring together those who use, provide and commission the service to make improvements in outcomes for complex patient pathways using an integrated, whole system approach for four national conditions and patient groups:

- Cardiovascular Disease (including cardiac, stroke, diabetes and renal disease)
- Cancer
- Maternity
- Mental Health (including Child and Adolescent Mental Health).

Diabetes is dealt with separately in this report because it has been the main focus of the Cardiovascular Clinical Network work programme for the last two years. Primary Care also has its own section because it is the main route by which all services are accessed and where long term conditions are managed and monitored.

The Wessex Clinical Networks identified that there was a difference locally in men's health outcomes in cardiovascular disease, cancer and mental health and that this appeared to be consistent with national patterns. They asked the Wessex Clinical Senate to find out more about the different uptake of local services by men in particular and to establish whether it would be helpful for commissioners and providers to take into account differences in male outcomes when commissioning or providing services.

The Wessex Clinical Senate started this work by holding a study day in March 2017, examining evidence on men's health outcomes. Following the study day, available data in cardiovascular, cancer and mental health services, disease prevention approaches and the delivery of primary care services were examined. Health Education Wessex commissioned a literature search from Oxford University on behalf of the Senate Council.

The Senate Council brought together its findings which were then reviewed by the Wessex Clinical Networks. This identified some additional issues in cardiovascular health outcomes for women. Some assistance in interpreting the data was provided by Public Health England (PHE).

There have been many reports on men's health. The last report found which matched the available data with the research literature for the same range of conditions in the UK was the Department of Health commissioned report 'The Gender and Access to Health Services Study' by the Men's Health Forum and the University of Bristol in 2008.[2]

As far as the Clinical Senate is aware, there has been no review which has attempted to assess whether the national differences in access to health services by gender are also experienced locally, to identify what health services are being accessed by men and women, where outcomes are different and to make recommendations to local commissioners and providers for change.

This paper takes a binary approach in its focus on 'men' and 'women'. The Clinical Senate acknowledges that there are often more significant differences within groups than between groups, but the evidence in this paper adds to the argument that cultural/societal changes are needed as well as the more detailed analysis beyond 'male' and 'female' and application of different (i.e. non-medical) models to health and wellbeing.

In general terms, 'sex' refers to the biological differences between males and females, such as the reproductive organs and genetic differences. 'Gender' is more difficult to define, but the term can be used to refer to the role of a male or female in society, known as a gender role, or an individual's concept of themselves, or gender identity. Both terms were found in the data and literature search on this subject and were often inter-changeable, so this is how the terms are used in this paper. Also, research from the USA was more likely to refer to 'sex' and from the UK was more likely to refer to 'gender'.

Biology may be a contributing factor to the prevalence of disease in men and women (e.g. considerably more woman than men are diagnosed with breast cancer). This is not what is referred to as a 'gender health inequality' in this paper. Sex or gender health inequalities arise because of social, cultural and behavioural factors which could be addressed and for which reasonable adjustments could be made.

Under the 2010 Equality Act, NHS services have a legal requirement to deliver services in such a way that they do not result in direct or indirect discrimination on the basis of gender. It is also important that the NHS advances equality of opportunity and fosters good relations in the public and voluntary sector by adopting best practice.

This is a narrative review rather than a systematic review, so some issues may have not been identified during the preparation of this paper. For this reason, it will be published as a 'draft discussion paper' to allow people both inside and outside the NHS to discuss its findings and recommendations and provide feedback to the Wessex Clinical Senate Council on the issues and proposals raised.

We are actively inviting feedback on our consultation website available at:
http://www.genderhealthinequalities.org.uk

NHS England has national service improvement priorities for cancer, cardiovascular and mental health services and a mandate to strengthen access to primary care, improving prevention and care for patients, as well as placing the NHS on a more sustainable footing. There is also a joint national programme run by NHS England in collaboration with Public Health England and Diabetes UK called 'Healthier You: NHS Diabetes Prevention Programme'[3].

National and local data show higher premature death rates for men with mental health issues and cancer, and poorer health outcomes for men from diabetes. This report demonstrates that the number of men living with complications from diabetes is currently three times more than the number of women living with complications of diabetes. Men are also less likely to be diagnosed by and treated for a mental health problem and less likely to take up bowel and lung cancer screening. Women are less likely to be diagnosed for cardiovascular disease and more likely to be undertreated.

In the last 10 years, the national population screening programmes that included adult men have been extended to bowel screening and abdominal aortic aneurysm (AAA) screening, which is a recent and important development.

Screening is the process of identifying people who appear healthy but may be at increased risk of a disease or condition. There are four national

population screening programmes which include men and they are:

- Bowel Screening
- Abdominal Aortic Aneurysm (AAA) screening
- Diabetic Eye Screening
- Sickle Cell and Thalassaemia screening (which is offered to fathers-to-be, where antenatal screening shows the mother is a genetic carrier)[4].

There are some publically available data from Public Health England which demonstrate the difference between male and female health outcomes. However, there are few publically available data on the difference in access to services by men or women or the impact of services provided by NHS Trusts and other organisations on men or women. These services may be commissioned by Clinical Commissioning Groups (CCGs) NHS England, Public Health England or Local Authorities. The data which are publically available have been reviewed in this paper.

There is evidence from previous health promotion approaches that the following criteria form a good basis for successful engagement with men[5]:

- Using the right setting (often outside statutory services)
- Ensuring the right approach (drawing on male-specific interests and language)
- Actively listening to what local men say
- Appropriate training (initial and ongoing) for those involved in such work
- Partnership working with local community groups, businesses and statutory service providers.

This evidence was reinforced by the presentations at the 'Senate Council Study Day' from a number of interested parties including public health, charities and local football clubs. Representatives from the Men's Health Forum[6], UK Men's Shed. Association[7], A Band of Brothers[8] and the Saints Foundation[9] attended on the day. The charities were contacted via the Men and Boys' Coalition[10]. The Senate Council commended the work of these charities and their commitment to raising awareness of health promotion activities targeted at men, women and children and hoped to see future collaboration between clinical networks, commissioners, local authorities and the voluntary/charitable sector.

Following the presentations, the Senate Council members discussed the issues raised and concluded that men's health inequalities should be taken into account when redesigning, reviewing or changing services and when introducing a new service. But this should not constitute a separate programme. It was observed at the meeting that more analysis and consideration of the gender related differences was required for working-age men and men post-retirement versus women. It was suspected that retirement was more detrimental to men's health than women's health but the evidence shows that the effect is the same for men and women, while the chances of becoming ill appear to increase with the length of time spent in retirement[11].

There is little difference in mortality rates or life expectancy after the age of 75 but men have higher mortality rates than women before the age of 75 (The notes of the 'Study Day' and the presentations which started this work are available on the Wessex Clinical Senate Council website: http://www.wessexsenate.nhs.uk/publications/).

Further data analysis was undertaken after the 'Senate Council Study Day'. The analysis was performed using publically available information.

A literature review was then undertaken, which highlighted that men were much less likely to seek help for their symptoms than women particularly where cancer and mental health services were concerned. Different attitudes to health, socio-economic, physical, environmental and ethnicity factors appear to explain the higher mortality rate in men. There was some evidence from the literature review that despite men's higher mortality from cardiovascular disease when they are under 75 years old, women with cardiovascular disease, and diabetes requiring critical care services are undertreated in comparison to men.

The literature review found that the evidence is not extensive for the health approaches that have been successful in reducing this health gender gap. There appeared to be relatively few publications which addressed this issue directly and those that did often described small scale initiatives.

Multiple studies have confirmed ethnic heritage, employment history, financial stability, and domestic accommodation as significant factors, in addition to gender, health outcomes and health inequalities. A number of these studies also attempted to assess the impact of these factors on health outcomes; in such situations gender differences appear generally to be assigned lesser impact than ethnicity or financial/social status, although this did not appear to have been confirmed by any large-scale, reliable study.

According to the World Health Organisation (WHO) European Region's review of the social determinants of health in 2013, men's poorer survival rates 'reflect several factors: greater levels of occupational exposure to physical and chemical hazards; behaviours associated with male norms of risk-taking and adventure; health behaviour paradigms related to masculinity and the fact that men are less likely to visit a doctor when they are ill and, when they see a doctor, are less likely to report on the symptoms of disease or illness'[12].

The Wessex Clinical Senate Council concluded that men's health should be looked at in the wider context of inequalities, due to the inter-relationships between gender, ethnicity, socio-economic factors and other characteristics. Neither NHS England nor Public Health England have a specific programme on gender inequalities or men's health and the Clinical Senate Council did not recommend that they should. However, more granular analysis is needed by commissioners and local authorities to determine the differences in male and female health outcomes; particularly where men under 75 are concerned and more work is needed to identify how these gender differences could be addressed to reduce inequalities.

The Senate Council found that there was more scope for commissioners, local authorities and providers to work in partnership with the voluntary sector. This could have a considerable impact in encouraging better uptake of services in order to improve health outcomes. A long term investment in effective asset-based community development in Wessex and possibly nationally could make sure that this was sustainable.

There was also a need for commissioners, local authorities and providers to take steps to assess male and female outcomes separately when they routinely and regularly review how their services meet the requirements of 2010 Equality Act.

Hampshire has secured more than €2.6 million of European funding from the EU Interreg 2 Seas Programme 2014-2020 (co-funded by the European Regional Development Fund), which will be supporting a project over the next four years looking into ways of providing services to men within their local communities[13]. The Senate Council noted this work which is testing the evidence base of a new model of service but does not believe that commissioners should wait for this evidence; there are existing models of service in the UK and internationally which have demonstrated improvement in outcomes which could be tried locally.

In 2014[14] a WHO review found that the evidence that men tend to be in worse health than women has not been properly addressed in the health policies and programmes of the major global health institutions, including WHO[15]. They stated that policy-makers tend to assume that gendered approaches to health improvement are primarily or exclusively about women rather than about both genders, a position also adopted by most national governments. Only three countries: Australia, Brazil and Ireland, appeared to have attempted to address men's burden of ill health through the adoption of national, male-centred strategies.

White and colleagues argued that public and policy action to improve men's health should have three targets[16]. The first is in education/schools, where stereotypes about masculinity can be challenged. The second is the promotion of men's health and well-being in the workplace. A third crucial area for policy is to target health services and health promotion towards marginalised men: poorer men,

men from minority populations, men who have sex with men and men in prison populations, all of whom have a higher burden of disease and early death than men in the general population.

Three types of intervention targeting men have emerged in recent years – outreach, partnership and gender transformation – and there is now evidence to support all three approaches:

- Outreach - Interventions in high-income countries (e.g. Australia, the United States and countries of Western Europe) have generally involved outreach efforts aimed at men in pubs and bars, sports clubs, barber shops, schools and the workplace, with a focus on weight loss, smoking cessation and other lifestyle changes. There are examples of local initiatives like this in many parts of the UK and Wessex.
- Partnership - a real partnership between community groups, the third sector and the statutory sector can unlock previously unrecognised social capital and local knowledge. Integrating services with web and social media communication can be a core part of any such programme, and can play a more central role than simple information sharing. There are fewer cross-organisational and cross-sector partnerships in the UK than solo organisational initiatives. The zero suicide initiative described under the Mental Health section of this document is one example.
- Gender transformation – this aims to reshape male gender roles in ways that lead to more equitable relationships between women and men. Such interventions can increase protective sexual behaviours, prevent intimate partner violence, modify inequitable attitudes linked to gender, and reduce sexually transmitted infections[17]. No examples of this type of intervention from the UK were made available to the Senate Council.

There is much to be done and this report provides a starting point for a national policy discussions as well as local cross-organisational investigation how best to address these issues in Wessex.

2.1 What are Gender Health Inequalities or Gender Inequalities in Health?

The Gender and Access to Health Services Study[18] stated that it is widely known that there are differences between men and women in the incidence and prevalence of most health conditions. Sometimes there are clear biological reasons for these differences, but often there are not and 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 Men's Health Forum[19] has defined a male health issue as one that fulfils either of the following conditions:

- It arises from physiological, psychological, social, cultural or environmental factors that have a specific impact on boys or men.
- It necessitates male-specific actions to achieve improvements in health or well-being at either individual or population level.

2.2 What is a Health Outcome?

Health outcomes are changes in health that result from specific health care investments or interventions. The following are examples of health outcomes:

- Preventing death after a heart attack or other emergency through in-hospital care.
- Improvements in a patient's quality of life following surgery for a specific health issue; for example, improved eye sight following cataract surgery.
- 'Activating' patients and the public so that they do not succumb to avoidable conditions, illness and disease, by giving them the right information and support to improve their lifestyles and manage their own care.

3
The Data:

What they tell us about the difference in men's health outcomes

3.1 Socio-economic factors and ethnicity

The Senate Council asked to what extent the poorer health outcomes for men could be explained by economic, social, physical environmental and ethnic factors or whether there was a residual male effect.

In England, the life expectancy gap between the richest and poorest men is 9.3 years. For women the gap is slightly smaller at 7.3.[20]

Data on gender differences in earnings are widely available and well publicised. Men were paid 18% more than women in 2016[21]. However the Senate Council heard evidence from the Men's Health Forum that this statistic masks the fact that men are more likely to be very wealthy (96% of billionaires in the UK were men in 2015[22]) and also more likely to be very poor (in the same year 71% of homeless people were recorded by local authorities as male[23]). The number of homeless people in the UK has doubled since 2010 and the average age of death of a homeless person is 47 years of age[24].

There is evidence that poor economic, social and physical environment contribute to about half of ill-health (40-60% in various studies[25]).

Studies have repeatedly documented a socioeconomic gradient in health in the UK, with people located in the middle of the socioeconomic hierarchy enjoying better health than those positioned at the bottom, but worse health than those positioned at the top[26].

There is a significant social gradient in male mortality: in England and Wales in 2008–2010, men aged 25–64 years in the highest socioeconomic group had a mortality rate one-third lower than men in the lowest group (ONS, 2013). One of the reasons for this difference in premature death relates to suicide.

In an analysis of the 18,998 suicides in men and women aged between 20 and 64 years between 2011 and 2015, by occupation, men working in the lowest-skilled occupations had a 44% higher risk of suicide than the male national average. The risk of suicide among low-skilled male labourers, particularly those working in construction roles, was 3 times higher than the male national average. The risk among men in skilled trades was 35% higher, particularly, plasterers, painters and decorators who had more than double the risk of suicide than the male national average. For females, the risk of suicide among health professionals was 24% higher than the female national average; this was largely explained by high suicide risk among female nurses. Male and female carers had a risk of suicide that was almost twice the national average[27].

How all of the economic social and environmental circumstances might contribute differently to men and women's health outcomes has not been studied extensively. A clear socioeconomic gradient in health was also evident in the research but within ethnic minorities, rates of poor health increased more than others when socioeconomic positions reduced[28].

There is some evidence that the increasing prosperity of a local authority area 'buys' a man more additional months of life than a woman. A 2012 study[29] investigated whether the uneven rise in prosperity between 1999 and 2008 accounted for differential increases in life expectancy in English Local Authorities. Those local authorities that experienced the greatest improvement in prosperity experienced greater increases in life expectancy. The impact of the increased prosperity was greater on men. With each 1% absolute decline in unemployment, life expectancy increased by 2.2 months in men and by 1.7 months in women. With each £1000 increase in average household income in a local authority, life expectancy increased by 1.4 months in men and by 1.1 months in women. The more deprived a local authority was in 1998, the lower the rate at which life expectancy improved. In conclusion, decreases in unemployment and increases in average income in a local authority area explained, to a large extent, why life expectancy increased.

Since the recession in 2008, economic trends have worsened and they are not forecast to improve dramatically over the next 10 years, so this study concluded that health inequalities may widen at a faster rate than in the previous decade.

In section 3.3 on data in Wessex, it can be seen that there is a difference in under-75 mortality which appears to be linked to deprivation. Mortality is worse than the South East England average for a number of preventable conditions, including cardiovascular, cancer, liver and respiratory disease, in Bournemouth, Portsmouth and Southampton.

There has been a decline in the manufacturing sector of the UK economy with a corresponding growth of service-orientated jobs in some regions. Historically service-orientated jobs have been filled by women but today more younger (millennial) men are now doing this work and there are less manufacturing jobs available due to advances in technology. When adjusted for deprivation, areas with higher percentages of workers in the service sector experienced lower rates of death from cardiovascular disease under the age of 75 in comparison to professional or managerial workers.

The reasons underlying the apparent protective effect of service-orientated employment status for deaths from cardiovascular disease are uncertain. Possibilities include differences in age, exposure to occupational hazards and lifestyle behaviours[30]. So male mortality may decrease if more men take up this type of work. Other relationships between type of employment and health outcomes were not statistically significant.

Studies have shown that the unemployed suffer more health problems, including mental health, than those in work and the longer people stay off work when sick, the less likely they are to return[31]. Poor mental health accounts for 47% of long term absences[32].

A Canadian study tested for two and three way interactions between race, gender, income, education and sexual orientation with self- rated health scores from a large survey[33]. The study found significant two-way interactions between gender and income, sexual orientation and income, race and income, and race and gender, in fair/poor self-rated health.

The following groups had the poorest self-rated health scores:

- Men with low income
- Gay, bisexual men and women or those unsure about their sexuality
- Non-white men and women on a low income
- Non-white men
- Women of East Indian, Pakistani, and Sri Lankan origins

In other studies findings for a socioeconomic gradient in psychological wellbeing within ethnic groups were less consistent, with evidence of the reverse pattern observed among Indian and Bangladeshi females[34 35].

The conclusion reached was that in addition to socio-economic factors, there may be cultural reasons driving the behaviour that contributed to poorer health outcomes.

Men from particular ethnic backgrounds report higher rates of long-standing illness[36], higher rates of mortality[37] and are disproportionally represented in aspects of the mental health service such as admissions via crisis-related routes, greater length of in-patient stay and receiving more physical interventions (including restraint and electro-convulsive therapy) rather than counselling or psychotherapy[38].

A 2010 study found that deprivation did not explain the higher levels of mortality in Glasgow in comparison to two very similar UK cities[39]. A 2012 study of health outcomes in Glasgow[40] found that four outcomes remained where differences were not explained by socio-economic factors. These were anxiety, doctor diagnosed heart attack, poor (high) general health questionnaire scores and being overweight. After additional adjustment for behavioural and biological characteristics, significantly higher odds of anxiety (42%) and heart attack (92%) were not explained by socio-economic factors for both male and female residents of the Glasgow area[41].

These Canadian and Glaswegian studies are important because they indicate that there are also behavioural factors which need to be taken into account in designing health services to better meet the specific needs of men and women.

3.2 National Mortality Data

The causes of death for men and women in England and Wales are different. The table below shows the causes of deaths registered in 2017 by males and females[42]:

Table 1: Deaths[1]: place of occurrence[2] and sex by underlying cause and age group, 2017

ICD-10 code	Underlying cause (ICD chapter)	Total deaths	% of Total deaths	Total deaths	% of Total deaths
		Male	Male	Female	Female
C00-D48	II Neoplasms (cancer)	80,077	54	69,575	46
I00-I99	IX Diseases of the circulatory (cardiovascular disease)	69,350	52	64,161	48
J00-J99	X Diseases of the respiratory	35,982	49	37,473	51
F00-F99	V Mental and behavioural	18,039	36	32,726	64
G00-G99	VI Diseases of the nervous system	14,267	43	18,784	57
K00-K93	XI Diseases of the digestive	12,759	50	12,868	50
R00-R99	XVIII Symptoms, signs and abnormal clinical and laboratory findings	3,587	29	8,861	71
U509,	XX External causes of morbidity and mortality	13,186	62	8,040	38
N00-N99	XIV Diseases of the genitourinary system	4,125	45	4,981	55
E00-E90	IV Endocrine, nutritional and metabolic	4,159	49	4,276	51
A00-B99	I Certain infectious and parasitic diseases	2,528	47	2,840	53
M00-M99	XIII Diseases of the musculoskeletal system	1,339	36	2,412	64
L00-L99	XII Diseases of the skin and	754	35	1,378	65
Q00-Q99	XVII Congenital malformations, deformations and chromosomal abnormalities	732	52	680	48
D50-D89	III Diseases of the blood and	538	49	561	51
P00-P96	XVI Certain conditions originating in the perinatal	118	63	70	37
H60-H95	VIII Diseases of the ear and	18	39	28	61
O00-O99	XV Pregnancy, childbirth and	0	0	26	100
H00-H59	VII Diseases of the eye and adnexa	3	43	4	57

1. Death figures are based on deaths registered rather than occuring in a calendar year. For information on registration delays for a range of causes please see our website.
2. Deaths at home are those at the usual residence of the deceased (according to the informant), where this is not a communal establishment.
   Care homes includes homes for the chronic sick; nursing homes; homes for people with mental health problems and non-NHS multi function sites.
   Hospices include Sue Ryder Homes; Marie Curie Centres; oncology centres; voluntary hospice units; and palliative care centres.
   Other Communal Establishments include schools for people with learning disabilities; holiday homes and hotels; common lodging houses; aged persons' accommodation; assessment centres; schools; convents and monasteries; nurses' homes; university and college halls of residence; young offender institutions; secure training centres; detention centres; prisons and remand homes.
   Elsewhere includes all places not covered above such as deaths on a motorway; at the beach; climbing a mountain; walking down the street; at the cinema; at a football match; while out shopping; or in someone else's home.
   This category also includes people who are pronounced dead on arrival at hospital. (Source: Office for National Statistics)

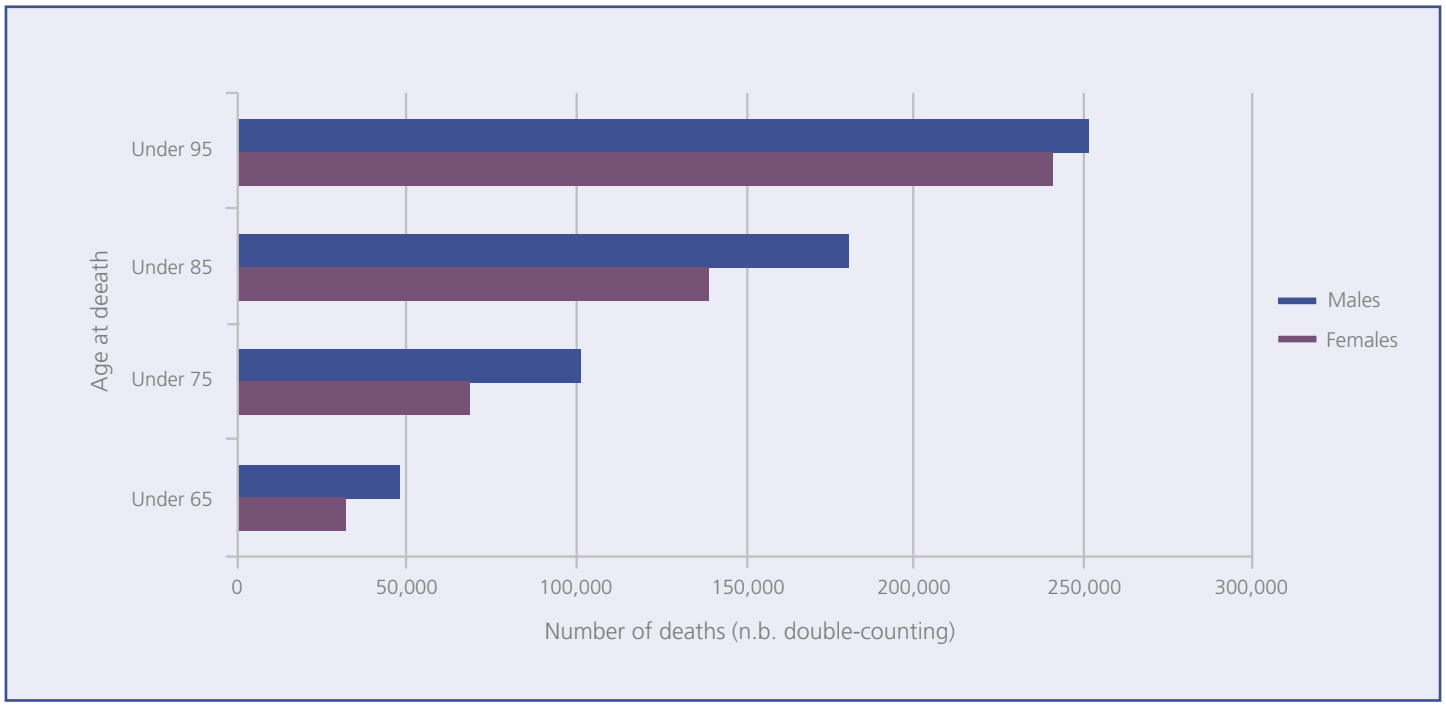
The largest cause of death was from cancer and cardiovascular disease was the second largest cause of death. More men than women died from both these diseases.

62% of male deaths registered were from 'external causes' which includes accidents, intentional self harm and assaults. Men are more likely to have chromosomal abnormalities than women (who have two copies of the X chromosome) which explains the high number of deaths registered by 'congental malformations' and 'certain condidtions in the perinatal'.

There is an interaction between age of death and cause of death. Those living longer are more likely to have a cause of death recorded as diseases of the respiratory system which include influenza and pneumonia or 'mental and behavioural' which includes dementia and Alzheimer's disease. This is explored further later in this paper.

There was a 5 year gap in age at death between men and women in 2017[43]. The following figure shows the deaths in 2017 and illustrates the disparity between males and females[44]. There is double-counting because the number of under 95s also includes the under 85s, under 75s and under 65s but it demonstrates the narrowing dispartity in death by gender as people age.

Figure 1: Number of deaths registered in 2017 by age range, by gender

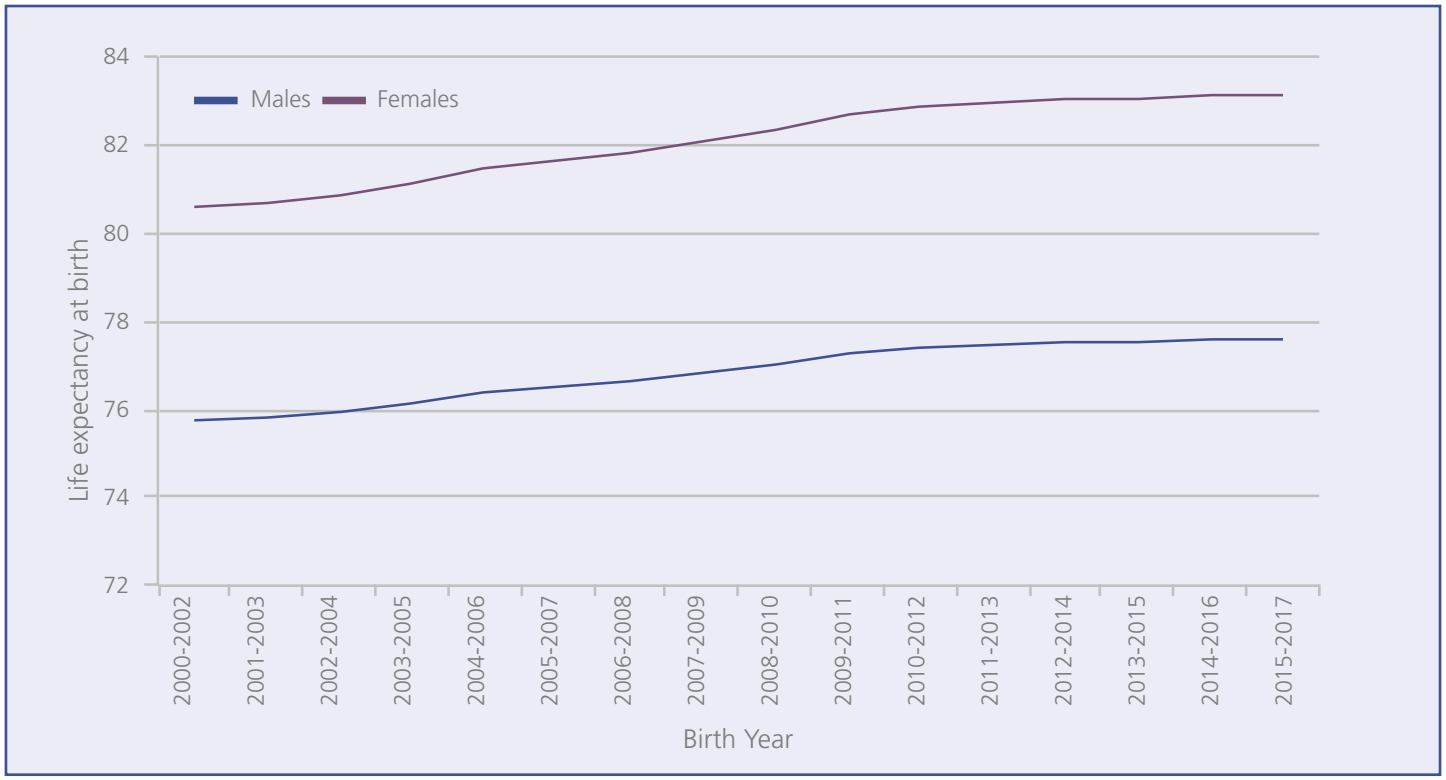


Men's life expectancy had been improving at a greater rate than women's and some epidemiological models compiled in 2015 had predicted that male and female differences in life expectancy at birth would be less than 2 years by 2030[45]. The authors of this research stated that this was 'dependent on improved health, social services and pensions for elderly people to curb the widening life expectancy inequalities and help deprived districts catch up in longevity gains and avoid a divergence in health and longevity'.

However, this increase in life expectancy appeared to be restricted to relatively wealthy men. A systematic analysis for the Global Burden of Disease Study in 2013[46] found that the gains in life expectancy achieved were not experienced in men who lived in the most deprived areas of the UK. Every year between 1990 and 2013, men who lived in the most deprived parts of the UK died 8.2 years earlier than men in the least deprived parts of the UK. The life expectancy of women who lived in the most deprived parts of the UK in comparison with women in the least deprived parts of the UK was 7·2 years earlier in 1990 and 6·9 years earlier in 2013. Over 23 years the life expectancy gap between rich and poor did not reduce at all for men living in deprivation and reduced only slightly for women.

Figure 2 uses Office for National Statistics (ONS) data[47] and shows that if recent trends in life expectancy continue it will be unlikely that there will be a convergence in 2030 of male and female life expectancy at birth[48].

Figure 2: Life Expectancy at birth in the UK from 2006 to 2017, by gender



There has been much discussion about what has led to this flat-lining of UK life expectancy. Many of the advances in life expectancy between 2001 and 2010 have had an effect after the age of 60 years and half of these relate to improvements in the prevention and treatment of cardiovascular disease[49].

There are other reasons for the reduction in the improvement in female life expectancy from 2010, which include rising deaths from lung cancer among women[50]. This might be due to the fact that death rates in men and women reflect past smoking behaviour and women's smoking rates peaked later than men's[51].

For this reason, the differential rates of smoking and cancer in men and women are considered further in this paper under section 4.3 on Cancer.

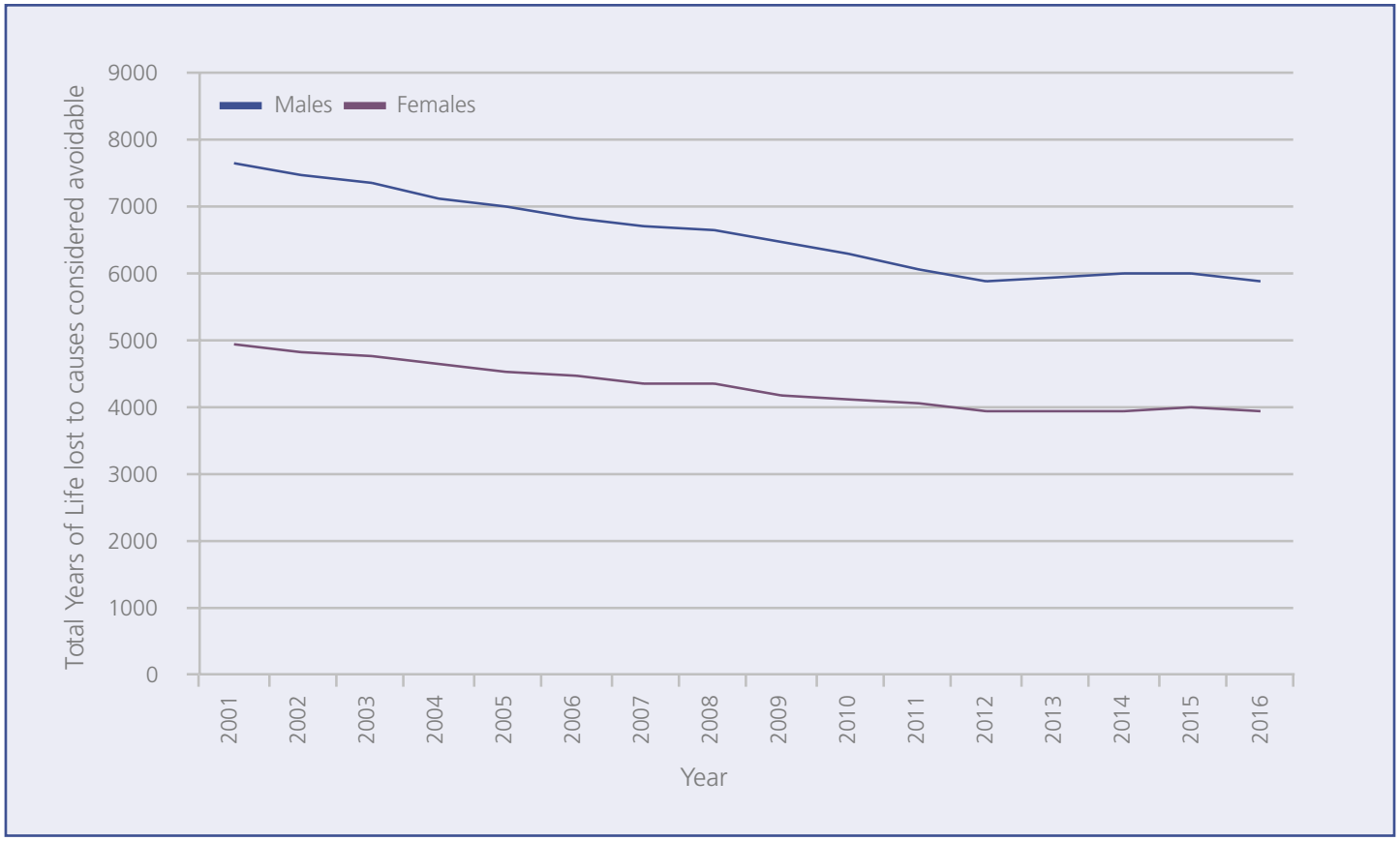
This change also might be due to changes in alcohol consumption. While men remain more frequent drinkers than women, their consumption of alcohol has fallen proportionately more rapidly than women. Every year, drinking too much alcohol causes 3% of cancers in the UK, around 11,900 cases[52].

Because of the levelling off of life expectancy, mortality rates are being monitored closely by Public Health England and others. There was a significant increase in the mortality rate in 2015, with most of the 'extra' deaths that year seen in people aged 75 and over. Public Health England stated that around two-thirds of the excess deaths in women in 2015, and all of the excess in men, could be explained by more people living longer so death was not unexpected. However, there were still almost 5,000 more female deaths than expected that could not be accounted for by population change alone. They have been unable to attribute this higher than average level of deaths to specific causes, but the very cold weather experienced at the beginning of the year and the strains of flu that were circulating (A/H3) were likely to have been contributing factors.

The Wessex Clinical Senate was most interested in how deaths could be avoided. 23% of all deaths in England and Wales in 2015 were statistically considered to be avoidable. The measure of relevance is called 'Standardised Years of Life Lost'. This is an estimate of the average years a person would have lived if he or she had not died prematurely, adjusted for population size (per 100,000 people). This measure

also shows that the reduction in years of life lost for both men and women levelled off between 2012 and 2016 and has not been reducing at the same rate as in the period 2001-2011. The following graph (Figure 3) is drawn from two ONS statistical bulletins[53 54].

Figure 3: Standardised Years of Life Lost due to causes considered avoidable, England and Wales, 2001-2013, 2014-2015



3.3 Local (Wessex) Data on Outcomes and Access to Services

Table 2 was customised from Public Health England[55] data in October 2017 and shows the premature mortality rate by Local Authority in Wessex compared with England. The boxes coloured red indicate that the figure is statistically significant and higher than the England average. Amber indicates that the figure is not statistically different to the England average. Green indicates that the figure is statistically significant and lower than the NHS England average.

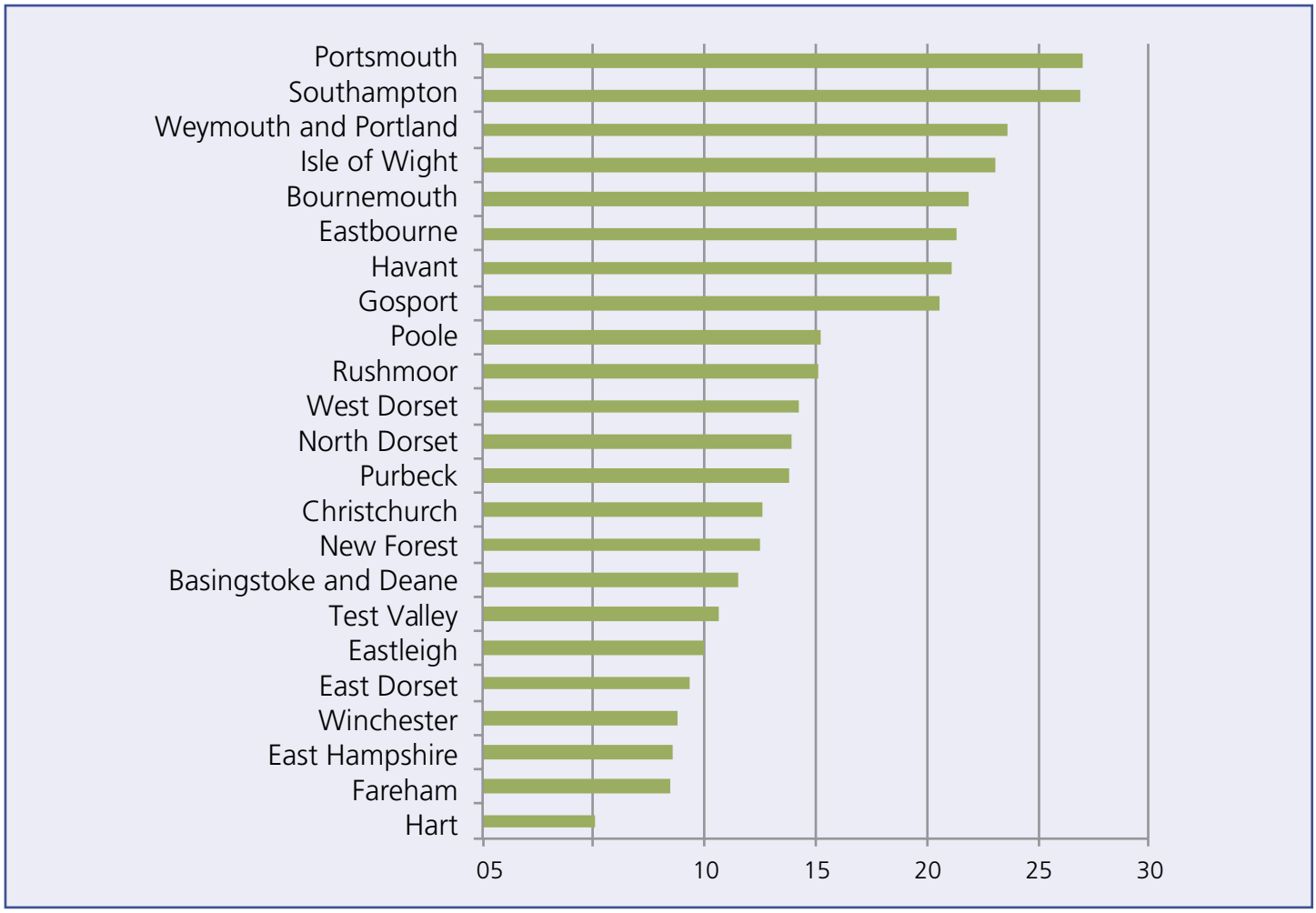
Table 2: Directly Standardised Mortality Rate from all Causes aged <75 by Local Authority in Wessex compared with England average

	Period	England	Bournemouth	Dorset	Hampshire	Isle of Wight	Poole	Portsmouth	Southampton
Overall premature deaths (Persons)	2014-16	334	364	266	272	315	295	414	383
Overall premature deaths (Male)	2014-16	405	443	325	321	403	353	524	478
Overall premature deaths (Female)	2014-16	288	285	211	226	232	240	306	292

Premature deaths are higher for men than for women in every local authority in Wessex. Figure 4 shows the local authorities with the highest deprivation in the South by level of deprivation as recorded by the indices of deprivation last published for England in 2015[56]. As can be seen, there appears to be a relationship between under-75 mortality and the local authorities with highest deprivation in that Portsmouth and Southampton have the highest directly standardised mortality rate in under 75 year olds and the highest deprivation.

Figure 4 also shows that some of the larger local authority areas such as Dorset and Hampshire have district councils in their patch with high deprivation (Weymouth and Portland, Gosport and Havant). The Directly Standardised Mortality Rate for all Causes aged <75 by local authority is available to district council level so the association between premature mortality and deprivation could be examined more closely locally.

Figure 4: Local Authority Areas in the South of England by Level of Deprivation



Age-standardised male mortality rates per 100,000 population are worse than female mortality in some local authority areas for a number of preventable conditions including cardiovascular, cancer, liver and respiratory disease. The South East England table shown below (Table 3) includes Isle of Wight, Portsmouth, Southampton and Hampshire local authorities and councils which are within the Hampshire and Isle of Wight Sustainability and Transformation Partnership (STP). The South West of England table (Table 4) shows similar information for that area and includes Dorset, Poole and Bournemouth local authorities, which are within the Dorset Integrated Care System (ICS). Tables 3 and 4 were customised using Public Health England[57] data in October 2017. The division into South East and South West reflects the new NHS England/NHS Improvement regional boundaries.

Table 3: Under 75 Mortality in South East England by Disease and Gender

Compard with benchmark	Better	Similar	Worse		Lower	Similar	Higher	Not compared

Indicator	Period		England	South East region	Hampshire	Isle of Wight	Portsmouth	Southampton
4.04ii – Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2014-16	◆◆	46.7	38.4	34.7	50.0	50.0	55.9
4.04ii – Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2014-16	◆◆	70.4	58.7	51.9	80.3	72.1	90.2
4.04ii – Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2014-16	◆◆	24.3	19.3	18.6	21.5	28.5	22.5
4.05ii – Under 75 mortality rate from cancer considered preventable (Persons)	2014-16	◆◆	79.4	72.2	67.7	77.1	97.8	88.3
4.05ii – Under 75 mortality rate from cancer considered preventable (Male)	2014-16	◆◆	85.9	77.2	72.0	87.2	113.7	99.2
4.05ii – Under 75 mortality rate from cancer considered preventable (Female)	2014-16	◆◆	73.4	67.7	63.8	67.6	82.8	77.9
4.06i – Under 75 mortality rate from liver disease (Persons)	2014-16	◆◆	18.3	15.1	12.4	18.1	25.8	18.6
4.06i – Under 75 mortality rate from liver disease (Male)	2014-16	◆◆	23.9	19.8	15.7	23.2	36.6	23.9
4.06i – Under 75 mortality rate from liver disease (Female)	2014-16	◆◆	12.8	10.6	9.2	13.3	15.3	13.4
4.06ii – Under 75 mortality rate from liver disease considered preventable (Persons)	2014-16	◆◆	16.1	13.2	11.1	16.5	24.0	17.4
4.06ii – Under 75 mortality rate from liver disease considered preventable (Male)	2014-16	◆◆	21.5	17.5	14.1	21.5	34.7	23.1
4.06ii – Under 75 mortality rate from liver disease considered preventable (Female)	2014-16	◆◆	10.9	9.1	8.4	11.9	13.5	11.7
4.07ii – Under 75 mortality rate from respiratory disease considered preventable (Persons)	2014-16	◆◆	18.6	15.5	13.4	12.8	29.0	34.6
4.07ii – Under 75 mortality rate from respiratory disease considered preventable (Male)	2014-16	◆◆	20.8	18.5	15.0	16.0	36.9	42.9
4.07ii – Under 75 mortality rate from respiratory disease considered preventable (Female)	2014-16	◆◆	16.5	12.7	11.9	9.9	21.3	26.9
Under 75 mortality rate from alcoholic liver disease (Male)	2014-16	◆◆	11.8	8.8	8.3	10.7	18.4	13.6
Under 75 mortality rate from alcoholic liver disease (Female)	2014-16	◆◆	6.0	4.6	4.6	5.4	7.2	6.4
Under 75 mortality rate from alcoholic liver disease (Persons)	2014-16	◆◆	8.8	6.7	6.4	8.0	12.8	10.0

Table 4: Under 75 Mortality in South West England by Disease and Gender

Compard with benchmark	Better	Similar	Worse		Lower	Similar	Higher	Not compared

Indicator	Period		England	South West region	Bournemouth	Dorset	Poole
4.04ii – Under 75 mortality rate from cardiovascular diseases considered preventable (Persons)	2014-16	◆◆	46.7	39.8	46.0	34.4	35.3
4.04ii – Under 75 mortality rate from cardiovascular diseases considered preventable (Male)	2014-16	◆◆	70.4	61.4	68.0	54.8	51.3
4.04ii – Under 75 mortality rate from cardiovascular diseases considered preventable (Female)	2014-16	◆◆	24.3	19.4	24.3	15.6	20.2
4.05ii – Under 75 mortality rate from cancer considered preventable (Persons)	2014-16	◆◆	79.4	71.8	83.7	69.1	75.2
4.05ii – Under 75 mortality rate from cancer considered preventable (Male)	2014-16	◆◆	85.9	78.0	90.5	70.9	81.7
4.05ii – Under 75 mortality rate from cancer considered preventable (Female)	2014-16	◆◆	73.4	66.2	77.3	67.5	69.4
4.06i – Under 75 mortality rate from liver disease (Persons)	2014-16	◆◆	18.3	14.7	22.8	13.5	16.6
4.06i – Under 75 mortality rate from liver disease (Male)	2014-16	◆◆	23.9	19.8	31.2	18.5	22.4
4.06i – Under 75 mortality rate from liver disease (Female)	2014-16	◆◆	12.8	9.9	14.3	8.8	11.0
4.06ii – Under 75 mortality rate from liver disease considered preventable (Persons)	2014-16	◆◆	16.1	13.2	19.8	12.6	14.8
4.06ii – Under 75 mortality rate from liver disease considered preventable (Male)	2014-16	◆◆	21.5	18.1	29.1	17.4	20.8
4.06ii – Under 75 mortality rate from liver disease considered preventable (Female)	2014-16	◆◆	10.9	8.5	10.6	8.2	9.1
4.07ii – Under 75 mortality rate from respiratory disease considered preventable (Persons)	2014-16	◆◆	18.6	14.9	21.6	11.0	14.5
4.07ii – Under 75 mortality rate from respiratory disease considered preventable (Male)	2014-16	◆◆	20.8	17.3	23.3	13.6	15.5
4.07ii – Under 75 mortality rate from respiratory disease considered preventable (Female)	2014-16	◆◆	16.5	12.7	19.9	8.6	13.5
Under 75 mortality rate from alcoholic liver disease (Male)	2014-16	◆◆	11.8	9.9	17.7	9.5	9.6
Under 75 mortality rate from alcoholic liver disease (Female)	2014-16	◆◆	6.0	5.0	7.7	3.5	5.7
Under 75 mortality rate from alcoholic liver disease (Persons)	2014-16	◆◆	8.8	7.4	12.7	6.4	7.6

The Senate Council asked Public Health England what other data were available which differentiated between men and women's health outcomes or measured male and female access to services by Clinical Commissioning Groups (CCGs) or local authorities within Wessex. Public Health England supplied details of what was available in February 2017 and again in October 2018 and this has been reproduced in tables 5 and 6 below.

Do the data available for local analysis add anything to the picture that has already been established from the mortality data that men die earlier and younger than women? As shown in Table 2 premature mortality can be analysed at local authority level. Local authorities know how many men and women are defined as 'employed' or having 'a learning disability'. From the local data, commissioners and providers can see how many men have hip fractures or are detected as having chlamydia. But only 7 out of the 22 measures available for local authority gender analysis provide us with data on uptake of health services such as adults in contact with secondary mental health services or health events such as hip fractures. Only 8 out of 22 measures are relevant to the areas of greatest gender health disparity highlighted in this report. Local authorities may have access to more sophisticated bespoke data than this, but Public Health England's data is publically available and can be easily accessed by commissioners, providers and other interested parties.

Also, these data are difficult to extract from the Public Health Outcomes Framework website by gender as there are no search terms which can be used to find data that are recorded separately for men and women. There may also be data available within local authorities which is not as easily accessible as the Public Health England data.

Table 5: Data AVAILABLE for local (Wessex) gender analysis from the Public Health England Outcomes Framework:

Measures	Number of different data sets	Access to health services	Data available which was relevant to the areas of gender disparity highlighted in this report
Life Expectancy Healthy Life Expectancy or Preventable General Mortality	6		
Smoking prevalence in adults	1		✔
Excess Winter Deaths by various age breakdown	4		
Hip fractures in older people	3	✔	
Adults with a learning disability	2		
Adults in contact with secondary mental health services	2	✔	✔
Mortality rate from causes considered preventable	1		✔
Under 75 mortality rate from all cardiovascular diseases and diseases considered preventable	2		✔
Under 75 mortality rate from cancer and cancer considered preventable	2		
Under 75 mortality rate from liver disease and liver disease considered preventable	2		
Under 75 mortality rate from respiratory disease and respiratory disease considered preventable	2		
Employment	1		
Emergency hospital admissions for intentional self-harm	1	✔	✔
Admission episodes for alcohol-related conditions	1	✔	✔
Hospital admissions for violence	1	✔	
Hospital admissions caused by unintentional and deliberate injuries in children	3	✔	
Chlamydia detection rate (15-24 year olds)	1	✔	
Mortality rate from a range of specified communicable diseases, including influenza	1		
Suicide rate	1		✔
Deaths from drug misuse	1		
Emergency readmissions within 30 days of discharge from hospital	1	✔	
Emergency hospital admissions due to falls in people aged 65 and over	3	✔	

Table 6 below shows the data which were not available for analysis by gender at local level but are available at a national level. Most of the measures could be used to assess the success of preventative interventions and reductions in circumstances which are known to contribute to poor health and wellbeing such as 'smoking prevalence at age 15', 'social isolation' and 'excess weight in adults'. If the data were available at local level by gender it would enable commissioners and providers to better see where there are differences in the health status of men and women to help them to better target resources. However, only 2 out of the 12 measures tell us anything about access to health services as can be seen in the table below:

Table 6: Data NOT AVAILABLE for local (Wessex) gender analysis from the Public Health England Outcomes Framework

Measures	Number of different data sets	Access to health services	Data which would be relevant to the areas of gender disparity highlighted in this report had it been available
Pupil absence	1		
Social isolation: Percentage of adult social care users and carers who have as much social contact as they would like	2		
Child excess weight by various age breakdowns	2		✔
Smoking prevalence at age 15	3		✔
Number of portions of fruit and vegetables consumed daily & proportion of those consuming '5 a day' by various age breakdowns	6		✔
Percentage of adults classified as overweight or obese	1		✔
Percentage of physically active and inactive adults	2		✔
Self-reported wellbeing - with various scores	4		✔
Excess under 75 mortality rate in adults with serious mental illness	1	✔	✔
Self-reported wellbeing with scores	4		✔
Proportion of adults in the population in contact with secondary mental health services	1	✔	✔
Health related quality of life for older people	1		

Another source of data which is available to commissioners and local authorities is that collected as part of the Local Authority Joint Strategic Needs Assessment (JSNA). A JSNA looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services within a local authority area. Of the 147 JSNAs researched and analysed by the Men's Health Forum in February 2015 only 27 (or 18%) had recorded information by gender[58]. A league table was compiled for this review to answer the question 'how gendered are your JSNAs?' Of 147 local authorities in England: Hampshire came 2nd, Portsmouth comes 56th, Dorset 62nd, Isle of Wight 73rd, Southampton City 89th, Bournemouth and Poole 96th.

There has been a general 'Health-Check' programme for everyone between the ages of 40 and 74 years since 2009. By 2013, 33% of the population had been offered a check, approximately 50% of those offered attended the appointment and 45% of these were men[59.] Local authorities would have their own Health Check data and may be able to analyse it by gender but it is not publically available on-line. No local data were made available to the Senate Council so that it could ascertain if uptake in Wessex by men and women was similar or different from the national data.

4 Key Areas of Differences in Outcomes

4.1 Suicide (Adult Mental Health)

The majority of people (up to 75%, some studies suggest[60]) who take their own lives are not, at the time of their death, in contact with mental health services.

Death by suicide is the biggest single killer of men aged 50 and under[61].

As mentioned in section 3.1 about data, the Clinical Senate was most interested in how deaths could be avoided so the emphasis of this section on 'Adult Mental Health' is on suicide and the following section on 'Child and Adolescent Mental Health' is on suicide and self-harm. Suicide and self-harm may be caused by mental distress or by mental illness.

4.1.1 The Extent of the Problem

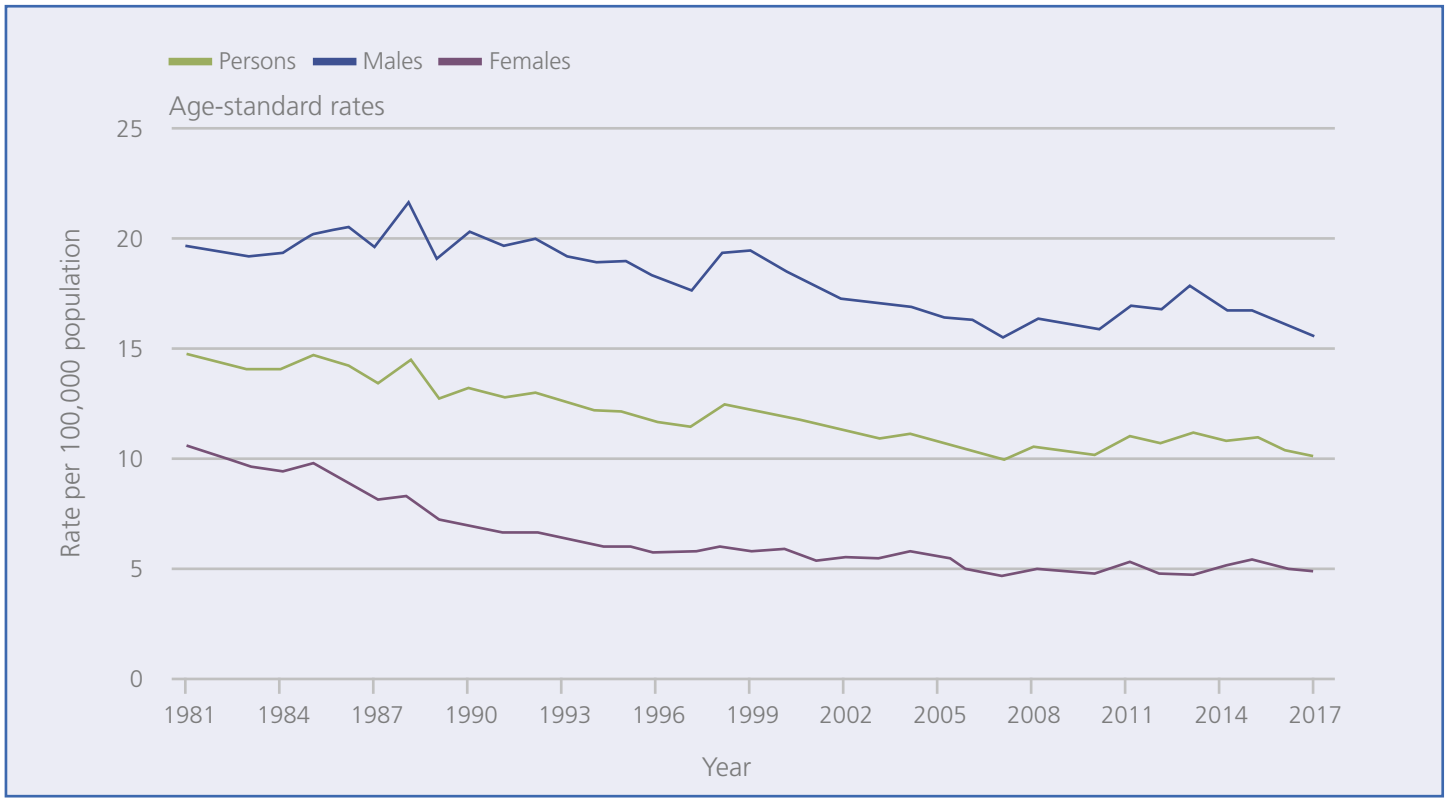
In 2017 there were 5,821 suicides registered in the UK, an age-standardised rate of 10.1 deaths per 100,000 population. The UK male suicide rate of 15.5 deaths per 100,000 was the lowest since our time-series began in 1981; for females, the UK rate was 4.9 deaths per 100,000, this remains consistent with the rates seen in the last 10 years. However male suicide rates are still over three times more than those of female; 75% of deaths by suicide were men[62].

Death by suicide statistics are important for monitoring trends in deaths resulting from self-harm and also provide an important indicator of the wider mental health of the nation. Death by suicide is often the end point of a complex life time history of risk factors and events. Death by suicide does not just affect the individual but can have a devastating impact on the wider family and community. It was thought that for every death by suicide, six other lives are significantly impacted[63] but it has been suggested recently that this is an underestimate and it may affect as many as 135 people who knew the person[64].

Between 1981 and 2007, there was a gradual decline in suicide rates (with some fluctuations). The male suicide rate climbed again in 2008 with a slight drop in 2009-10 then increased again from 2011. There was another slight drop in 2014 (which is not shown on figure 4 below) and this slight reduction continued in 2015, 2016 and 2017, so this is some positive news. There is little evidence as to what lay behind these fluctuations but we know that the highest suicide rates are consistently found in men in their 40s and 50s. The female suicide rate increased very slightly in 2014 from 4.8 to 5.2 per 100,000 but fell slightly in 2015 and has remained relatively stable since then. The male suicide rate was three times higher than the female and has been so since the mid-1990s[65].

The most recent National Confidential Inquiry into Suicide and Homicide by people with mental illness which was published in 2018 stated that there were 1,612 patient deaths by suicide in the UK in 2016, this number having fallen in recent years. During 2006-2016, there were 17,931 deaths by suicide mental health patients, 28% of all deaths by suicide in the UK general population.

Figure 5: Age-standardised suicide rates by sex, deaths registered each year in the UK from 1981 to 2017



Local monitoring of suicide data is required if we are to understand how to tackle these fluctuations and to address the discrepancy between males and females. Some local authorities (e.g. Hampshire) investigate every incident. Table 7 below is from the Wessex Strategic Clinical Networks Mental Health Strategy and shows 2012-14 suicide data for the local authorities within Wessex. Three areas within Wessex had a male suicide rate which was higher than the England average and two had a female suicide rate which was higher than the England average:

Table 7: Suicide age standardised rates per 100,000 population, 3 year average for persons, males and females

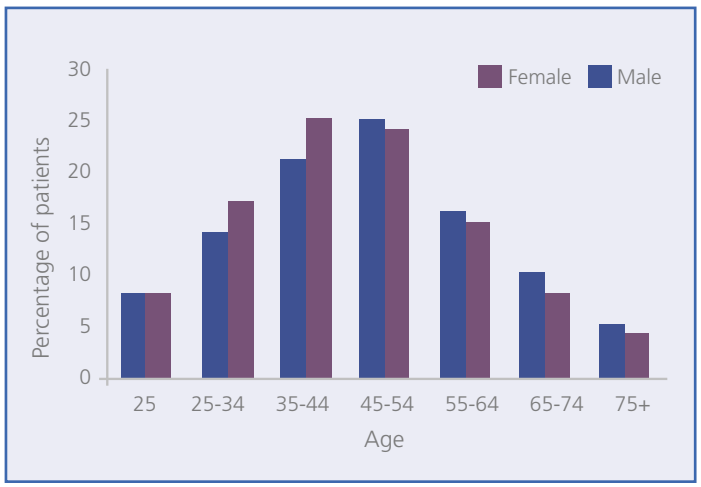
Organisation	Persons	Male	Female
NHS England	8.9	14.1	4.0
Hampshire	8.2	12.4	4.3
Isle of Wight	11.9	20.2	-
Portsmouth	11.7	19.7	-
Southampton	13.3	18.3	8.2
Bournemouth	9.0	12.6	-
Dorset	9.2	13.9	4.6
Poole	7.5	-	-

For patients who died by suicide in the UK, a history of self-harm was common, occurring in 74% of female patients overall and 89% of those under 25.

From 2011, the confidential inquiry team has been asking clinicians to state the main reason the death by suicide occurred in their patients. This definition of 'patients' includes those people with mental illness who are receiving care as an in-patient, as an outpatient or in the community from the secondary care mental health team. 66% of patients who died by suicide were male. Most people with a mental illness are discharged to the care of the GP and primary health care team once their condition has stabilised or improved. The most common reasons given for deaths by suicide in 'patients' were mental illness (46%) and social factors (23%). Other factors (21%) included lack of experience or skill in staff, services not being available, poor out of hours cover, and delays in referral from a GP or other professional.

The age distribution of male patient deaths by suicide to female varies with more male patients aged over 45 dying by suicide as Figure 6 shows[66].

Figure 6: Number of Patient Suicides, by gender and age group (UK, 2006-2016)



N.B. The percentages relate to the percentage of all male or female patients who die by suicide (e.g. 8% of men and 8% of women who die by suicide are under 25 years old).

There were 106 deaths by suicide by in-patients in the UK in 2016, around 7% of all patient suicides and 2% of all deaths by suicide in the general population.

Of the small numbers of in-patients who die by suicide, more deaths by suicide were in men than women but the difference between the genders is not as great as in the general population. There has been a fall in the number of deaths by suicide in in-patient settings. The decline in in-patient suicide numbers may be partly due to changes in the number of admissions as increasingly more patients are treated in the community but when adjusted per 10,000 admissions, rates of in-patient suicide per still fell by 31% in 2006-2016. However in the last five years the rate has remained stable and has stopped declining[67].

In 2016/17 53% of men in contact with secondary mental health services lived in stable and appropriate accommodation, compared with 56% women[68]. Public Health England has flagged that there is a data quality issue with this data but it is the only data available. It shows that 45% of homeless people have been diagnosed with a mental health condition[69] and 71% of homeless people were recorded by local authorities as male[70].

Unemployment has been associated with an increased likelihood of suicide, with this association being greater for men than for women[71]. Employment is lower among people with mental health problems. Only 43% of people with mental health problems are in employment, compared to 75% of the general population in the UK aged 16-64[72].

The gap in employment rate between men and women in contact with secondary mental health services in 2016/17 and the general population aged 16-64 was 74% for men and 61% for women[73]. Public Health England has flagged that there is a data quality issue with this data but it is the only data available.

Local Authorities collect data on people in contact with mental health services who are in stable and appropriate accommodation and in employment, but most local authorities in Wessex do not publish this data by gender (see section 3.3 on data and JSNAs) and where they do there are data quality issues nationally and locally (e.g. data on stable and appropriate accommodation and employment rates).

Several large population-based public health studies in America[74] have found that there are:

- Higher rates of major depression, generalised anxiety disorder and substance use or dependence in lesbian and gay youth than in heterosexual youth.
- Higher rates of recurrent major depression among gay men than in heterosexual men.
- Higher rates of anxiety, mood and substance use disorders, and suicidal thoughts among people ages 15 to 54 with same-sex partners than people with different-sex partners.
- Higher use of mental health services in men and women reporting same-sex partners than people with different sex-partners.

Rates of depression, anxiety and suicidal thoughts were all higher in gay and bisexual men than men in general.

4.1.2 Uptake of Services Provided

National data are provided for access to NHS funded secondary mental health, learning disability and autism services and this showed in 2016/17 that only slightly more women accessed these services than men (51%)[75]. However, it is difficult to interrogate this data locally.

Two relatively new national programmes have been introduced to improve access to mental health services for both men and women. Ongoing assessment is needed to determine whether these national programmes and also other mental health and social care services, meet the needs of both men and women. Some data are available on the new national programmes.

The Early Intervention Services (EIS) for Psychosis programme was designed to improve access to secondary mental health services for these patients.

First episode psychosis occurs most commonly between late teens and late twenties, with more than three quarters of men and two thirds of women experiencing their first episode before the age of 35. This means that areas serving younger populations (e.g. areas with higher education colleges and universities) may have higher rates of psychosis. A small proportion of people will also experience an onset of psychosis before the age of 16 years, with an additional peak in incidence in women in their mid-to-late 40s[76].

At present EIS waiting times are publically available[77] but not by gender and there is no information on how many men and women are accessing the service. It is unclear whether EIS is able to provide equitable care for both men and women presenting for the first time with psychosis.

The main aim of a 2017 study[78] was to explore gender differences for first-presentation psychosis patients at the time of their referral to inner-city London EIS and their outcomes one year later.

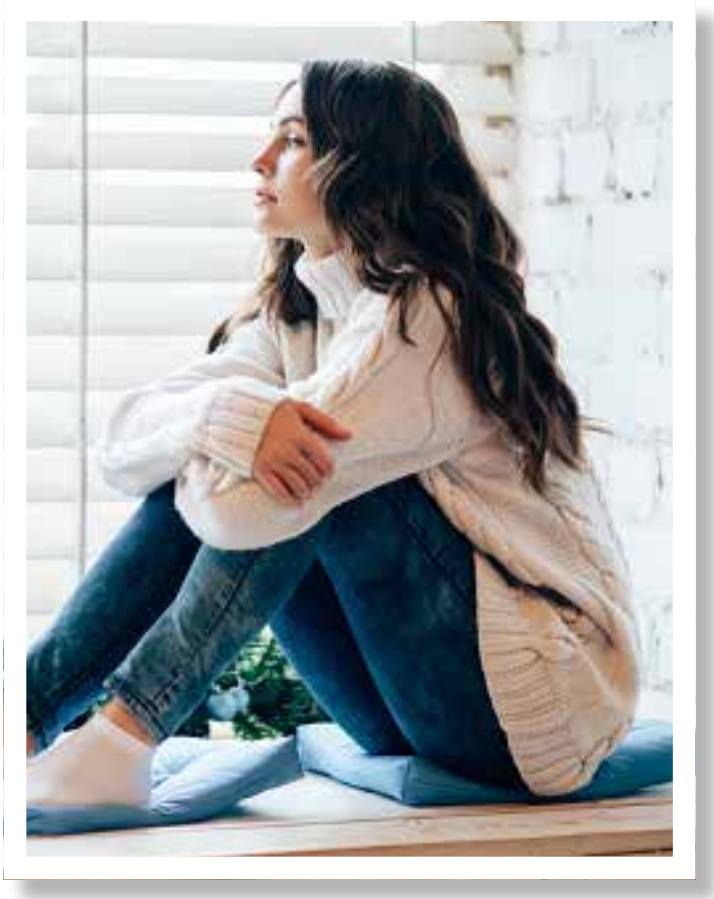
At entry to EIS, male patients presented with more violent behaviour whereas female patients had more suicide attempts. Following one year of EIS care, men were still recorded as more violent towards others whereas women were more likely to have been admitted to a psychiatric ward. Gender differences in clinical outcome, service use and risk behaviours were apparent within the first year of specialist psychosis care. This may be partly due to the different pathways to care taken by men and women and differences in clinical presentation. The study concluded that greater focus was required on the specific needs of each gender by EIS in detection and intervention to improve equality of outcome.

Another national programme is the Improving Access to Psychological Therapies (IAPT) programme which aims to improve access to cognitive behavioural therapies for people with mild to moderate mental illness. Annual analysis of access to IAPT has been published by NHS Digital from 2012/13 but it does not always include a breakdown of the number of male and female referrals, completion of the course and recovery and it is difficult without analytical input to identify progress since then. 2012/13 data showed that more females than males had accessed IAPT. Of the 761,848 referrals to IAPT, 36% were male and 62% were female with 2% gender neutral[79].

The 2016/17 IAPT annual report[87] does not provide male and female data except in the accompanying data tables[80] which provide a lot of detail on ethnicity, sexual orientation, religion and deprivation[81]. Data on gender is available in the Equality and Health Inequality Right Care Packs by CCG but not for England as a whole. These are available at: https://www.england.nhs.uk/rightcare/products/ccg-data-packs/equality-and-health-inequality-nhs-rightcare-packs.

There were 1,385,664 IAPT referrals in 2016/17of which 488,656 (37%) were male and 875,609 (63%) were female. For every man that was referred in 2012/13, two men are referred now, but male access to IAPT has increased proportionately in the five years since 2012/13 by only 1% when men are at much greater risk of death by suicide. Men could make much more use of the IAPT service. In most areas, it is possible to self-refer to the service.

Roughly the same number of men (69%) who are referred to IAPT start the course as women (71%) and a similar proportion of men (58%) who attend the first treatment finish the course as women (60%). This figure could be improved but it can be assumed from the data that IAPT is suitable for both genders.



A survey commissioned by the Mental Health Foundation from YouGov in 2016[83] found that men were far less likely than women to seek professional support and they were also less likely to disclose a mental health problem to friends and family. The survey was the largest of its kind, polling more than 2,500 people and it showed 28% of men admitted that they had not sought medical help, compared with 19% of women. However, the sample size was not representative of the general population; nearly half of respondents had experienced mental health problems compared with a quarter in the general population. Other research has found that a third of individuals who met the criteria for a mental disorder sought professional help. Where men are concerned there is evidence that if they are under 25 years of age or over 55 years of age, then only 9% seek help if they are not disabled and were in a relationship[84]. People often seek help from informal sources, such as friends or family rather than from formal sources such as doctors or psychologists[85 86]. There is therefore a clear need to promote greater help-seeking of health services or deliver health services in a different way which better supports friends and families.

The survey[86] found that a third of women, compared with a quarter of men, had told friends or family about their mental health problem within a month of it arising. More than a third of men, compared with a quarter of women, either waited more than two years or chose never to tell friends or family about their problem. This difficulty in identifying and supporting men in mental distress remains a serious concern particularly in light of the high rate of male suicide.

It is suggested that major depression in men is often under-diagnosed as the diagnostic tools used to screen for depression may use 'feminised' measures; in language used (e.g. 'feeling loved', 'butterflies in the stomach') and the question areas covered (e.g. loss of interest in appearance). Consequently, other tools such as the Gotland

Scale, have been developed to more accurately identify depression in men as they consider 'alternative symptoms' (such as aggression, anger and substance misuse), as well as incorporating more 'traditional symptoms' such as feeling tired and difficulty making decisions[87]. When using such scales, men reported higher rates of anger attacks/aggression, substance abuse, and risk taking compared with women. Analyses using the scale that included alternative, male-type symptoms of depression found that a higher proportion of men (26%) than women (22%) are diagnosed with major depression[88].

It is important to note the strong interconnection between physical and mental health; for example, mental health problems are approximately two to three times more common in people with chronic disease[89].

4.1.3 Possible Solutions

IAPT is equally effective for males and females, so commissioners and providers need to understand why fewer men than are eligible (if the death by suicide rate is used as a proxy for prevalence) are referred or refer themselves to the programme and also why more men than women do not finish the course of treatment, so that the programme could be re-designed so that it is as attractive to both men and women.

The Samaritans produced a report in 2012 entitled 'Men, Suicide and Society. Why disadvantaged men in mid-life die by suicide'[90] with nine recommendations for national government, statutory services, local authorities and the third sector. These are listed in the table below:

Table 8: Samaritans recommendations for suicide prevention (2012)

1. Ensure that suicide prevention strategies include explicit aims to reduce socio-economic inequalities and gender inequalities in suicide.
2. Inform suicide prevention measures with an understanding of men's beliefs, concerns and contexts - in particular their views of what it is to 'be a man'.
3. Enable inter-agency working to address the multiple difficulties experienced by men in mid-life, through clear allocation of responsibility and accountability for suicide prevention at local level.
4. Support GPs to identify and respond to distress in men, recognise the GPs are the most likely formal source of help to be consulted by the age-group.
5. Provide therapies which address the specific psychological factors associated with suicide - particularly, for men, social and emotional skills, managing stress and the expectations of others.
6. Develop innovative approaches to working with men do 'get through' in everyday life.
7. Join up alcohol and drugs strategies and services with suicide prevention, recognising the links between substance misuse, masculinity, deprivation and suicide.
8. Recognise the profound role of social disconnection in the suicide risk of men in mid-life, and support men to build social relationships.
9. Assist men excluded from the labour market to (re)enter employment.

A national strategy for women's mental health was published in 2002[91]. This was a wide-ranging strategy dealing with attitudes and services. It played an important role in identifying female vulnerability in mixed-sex secondary and specialist mental health services. There has been no national strategy for men's mental health, although there was a focus on the prevention of young male suicide in the National Suicide Prevention Strategy 2012[92] and on young and middle aged men in its update in January 2017[93 94].

The Five Year Forward View for Mental Health set out clear recommendations on suicide prevention and reduction in 2016, and made a commitment to reduce suicides by 10% nationally by 2020/21. Alongside this, the then Secretary of State Jeremy Hunt announced a zero suicide ambition for mental health inpatients in January 2018. All Sustainable and Transformation Partnerships and Integrated Care Systems should be delivering against a STP/ICS wide multi-agency suicide prevention plan.

A whole system approach to suicide prevention in the East of England (aiming for 'zero suicides') evaluated by the Centre for Mental Health[95] demonstrated that with a clear and shared vision, challenging objective and willingness to work with local groups given the capacity, can develop and deliver creative and effective local approaches to suicide reduction.

A range of initiatives have been implemented to reduce suicides:

- Training key public service staff such as GPs, police officers, teachers and housing officers
- Training others who may encounter someone at risk of taking their own life, such as pub landlords, coroners, private security staff, faith groups and gym worker.
- Creating 'community champions' to put local people in control of activities.
- Putting in place practical suicide prevention measures in 'hot spots' such as bridges and railways.
- Working with local newspapers, radio and social media to raise awareness in the wider community.
- Supporting safety planning for people at risk of suicide, involving families and carers throughout the process.
- Linking with local crisis services to ensure people get speedy access to evidence-based treatments.

The project was notable in its ability to engage with the 'unusual suspects'. These included staff from coroners, libraries, gyms, housing associations, public houses, social care, ambulance services, faith groups, football associations, CCGs, private security companies and the British Transport Police. The recruitment of local community champions was an exciting innovation.

The evaluators also recommended that local mental health Crisis Care Concordat action plans incorporate suicide prevention methodology and training.

The third progress report of the cross-government outcomes strategy to save lives 'Preventing suicide in England' published in January 2017 recommends 'better targeting of suicide prevention and help seeking in high risk groups such as middle-aged men, those in places of custody/detention or in contact with the criminal justice system and with mental health services'[96]. It mentions initiatives such as the Men's Sheds Association and the joint campaign in 2015-17 between the Campaign Against Living Miserably (CALM) and Lynx[97] which raised awareness of mental wellbeing and male suicide.

The Queen's Nursing Institute funded a project to help male military veterans suffering from Post-Traumatic Stress Disorder better understand their symptoms and how they might manage and mitigate the effects of these[98]. The project developed an innovative psycho-education and skills training course designed with and for hard-to-engage veterans specifically. This project is difficult to evaluate because coroners do not record suicides by veterans and the government believes that this is not possible for a number of practical and administrative reasons[99].

A review of mental health promotion initiatives undertaken between 2005-16 mapped over 50 interventions that were either male-specific or heavily male-focused[100]. MIND recommends a safe space for men to discuss mental health problems. Confidentiality and/or anonymity were key components for the creation of sale spaces.

Being given legitimacy to talk about emotional issues by the establishment of male-support groups and peer to peer support was vital [101]. Perhaps the most significant area is the continued development of interventions through sport; using football venues and football metaphors to engage men in group based therapeutic interventions. This functioned as a franchise across numerous clubs in the North West of England and has been well evaluated[102]. The National Suicide Prevention Strategy 2017 points to other sporting opportunities such as rugby as a means of engagement with young and middle-aged men (http://www.stateofmindsport.org/).

The Local Premier League and First Division football clubs were invited to attend the Senate Council meeting to discuss men's health because in 2015/2016, 75% of match attenders nationally were male. 40% of 18-34 year-olds attended matches in the UK (when only 29% of the population were in this age range) and 14% were from black, minority and ethnic (BME) groups[103]. In 2014/2015, the age of the average adult fan attending matches was 41 years of age[104].

The Senate Council commended the work of the football clubs in running health promotion activities targeted at men, women and children. It hoped to see future collaboration between clinical networks, commissioners, local authorities and football clubs. The Saints v Stigma event in April 2017 was a good example of using football to encourage people to speak up about mental health issues and speak out against stigma.

A new post of Suicide Prevention Officer was established by NHSE South East to lead this work accross Hampshire, Isle of Wight, Thames Valley, Kent, Surrey and Sussex in 2018.

Table 9 shows initiatives already underway in Hampshire County Council.

Table 9: Suicide Prevention Initiatives underway in Hampshire (source: Public Health)

Suicide prevention in Hampshire - examples of work/projects

- Insight research underway to investigate the barriers/ enablers to men in Hampshire re mental wellbing
- Postvention protocol for schools/colleges currently being developed (to support understanding of support available/steps to take/plan to have in place)
- Presented at the Stronger Together, LGBT conference December 2016 – to support services to become more LGBT-friendly
- Leaving prison work – agencies meeting to discuss improving support available for ex prisoners
- Barbers/hairdressers are being trained up (Havant area) to identify mental health issues and signpost to help (partnership with MIND)
- Suicide prevention training for frontline workers being commissioned for delivery early summer 2017
- Making Every Contact Count training continues to be rolled out (supporting front line workers to have healthy conversations and signposts to help)

Hampshire County Council

4.2 Suicide and Self Harm (Child and Adolescent Mental Health)

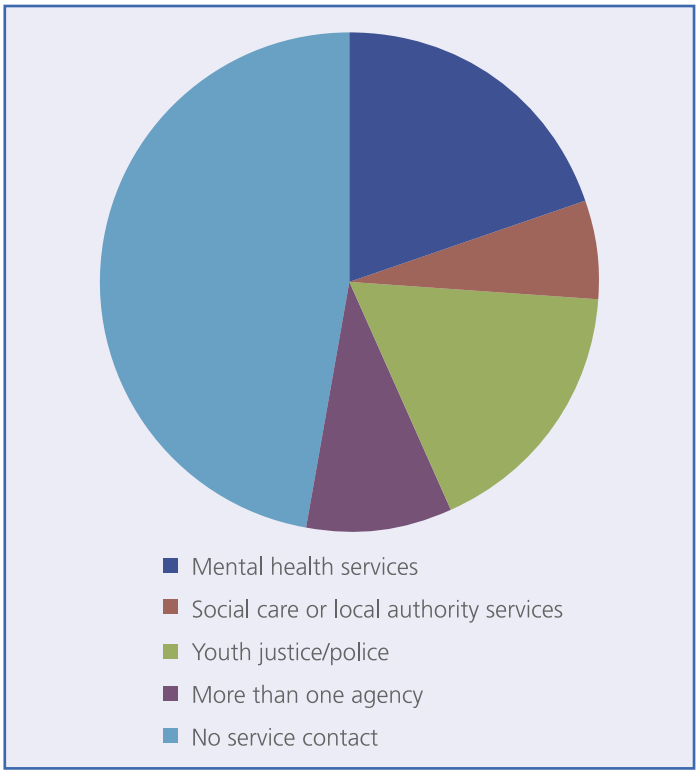
4.2.1 The Extent of the Problem

The children of men who experience clinical depression during the perinatal period from conception to year one following the infant's birth are more likely to experience emotional or behavioural difficulties regardless of whether their mother is affected[105]. Boys aged 5 to 19 are more than twice as likely to kill themselves than girls in that age range[106].

Mental and emotional health problems in boys often emerge in different ways from girls: boys are three to four times more likely to develop an autism spectrum disorder than girls[107]. Anxiety disorders are very common amongst people on the autism spectrum. Roughly 40% of people on the autism spectrum have symptoms of at least one anxiety disorder at any time, compared with up to 15% in the general population. This can lead to sadness or depression and may contribute to the number of deaths by suicide[108].

42% of under-20s who died by suicide had been in recent contact (in the last 3 months) with at least one agency and just over half (55%) had no service contact. Interagency collaboration was variable and risk recognition appeared poor where there was contact[109]. Figure 7 shows with which services the under 20 year olds who died by suicide had been in recent contact:

Figure 7: Recent contact with services in under 20s who died by suicide January 2014 - April 2015



Some families reported that a suicide occurred 'out of the blue'. The UK National Confidential Inquiry into Suicide and Homicide in Children and Young People with Mental Illness[110] states 'that a proportion of the young people who died had not talked about suicide and had low rates of key stresses'.

Where suicide is concerned, the UK National Confidential Inquiry[111] found that most of those who died were male (76%). The number of suicides at each age rose steadily in the late teens and early 20s. There was a changing pattern in the reported causes, reflecting the stresses normally experienced at different ages: academic pressures and bullying were more common before suicide in under-20s, while workplace, housing and financial problems occurred more often before suicide in 20-24 year olds. 25% of under-20s and 28% of 20-24 year olds who died (equivalent to around 125 deaths per year) had experience of a bereavement of a family member or friend.

In 2005, nearly one third of young people reported that they had experienced suicidal thoughts[112].

Results from a large scale study of self-harm across 41 UK schools indicated a prevalence of self-harm in 13% of 15-16 year olds[113]. Suicide is believed to be 30-40 times more likely in people who self-harm than in the general population[136].

A thorough review[114] was undertaken to determine what characteristics result in young people seeking help for self-harm. They include: the presence of suicidal thoughts, being female, alcohol use in females and drug use in males, parental detection of self-harm, greater service provision, not being from an ethnic minority group, older age and negative life events (i.e. bullying). Young people were not asked about their beliefs, values and attitudes.

Where adolescents seek help, peer support is the most common form with up to 90% of those who sought help reporting that they would access their peers rather than a professional or parent when in times of distress[115 116]. However, the fear that 'peers might find out' has also been found to be a reason why young people do not seek help. This contradiction needs to be addressed.

Over five thousand young people between the ages of 15-16 from 41 secondary schools took part in a study[117] which used open ended questioning and sought to find out what young people, who had previously engaged in self-harm, perceived as the barriers to their help-seeking. 10% of these young people had a lifetime history of self-harm. Participants who did not seek help for suicidal thoughts were asked 'Why didn't you try to get help?' The answers to this open ended question revealed three reasons: 'Spur of the moment', 'Not that serious or important' and 'My choice'. These beliefs were more frequently expressed by boys, which may reflect the difficulty that males experience in recognising their own experiences of distress[118] and their tendency to perceive their difficulties as less severe than females[119]. A number of beliefs pertaining to coping independently, were specifically endorsed by boys; 'I can or should be able to cope on my own'[143] and '[We] can solve it ourselves'. This may reflect traditional gender role expectations that influence the development of beliefs about the man's need for autonomy such as the need to solve problems alone, to be independent and in control of their emotions.

In another study[120], 195 young people recruited from community services in Wales took part in workshops and were asked why they might not seek help. Responses included 'Peers might find out'. Concerns about stigma have been endorsed in other research[121 122 123 124]. They similarly reported concerns about: 'Being found out', appearing 'Inadequate' or 'Inferior'. Attitudes about appearing 'Weak' were particularly described by young men, which might reflect their desire to uphold the dominant stereotyped characteristics of masculinity[125].

Numerous studies collated by the Suicide Prevention Resource Center in the USA have shown that lesbian, gay, bisexual and transgender (LGBT) youths have a higher rate of suicide attempts than do heterosexual youths. They estimated that between 30% and 40% of LGBT youth, depending on age and sex groups, have attempted suicide. Similar evidence in the UK is sparse[126].

Research shows that LGBT youths 'who experience high levels of rejection from their families during adolescence, when compared with those young people who experienced little or no rejection from parents and caregivers, were more than eight times likely to have attempted suicide, more than six times likely to report high levels of depression, more than three times likely to use illegal drugs and more than three times likely to be at high risk for HIV or other STDs' by the time they reach their early 20s[127]. The study concluded that the school climate must foster respect because unless students and adults are educated about the LGBT community, then stereotypes and negative attitudes will continue to exist[128]. The presence of gay-straight alliances (GSAs) in schools was associated with decreased suicide attempts. In a study of lesbian, gay, bisexual, transgender and queer (LGBTQ) youth, ages 13–22, 17% of young people who attended schools with GSAs attempted suicide versus 33% of students who attended schools without GSAs[129].

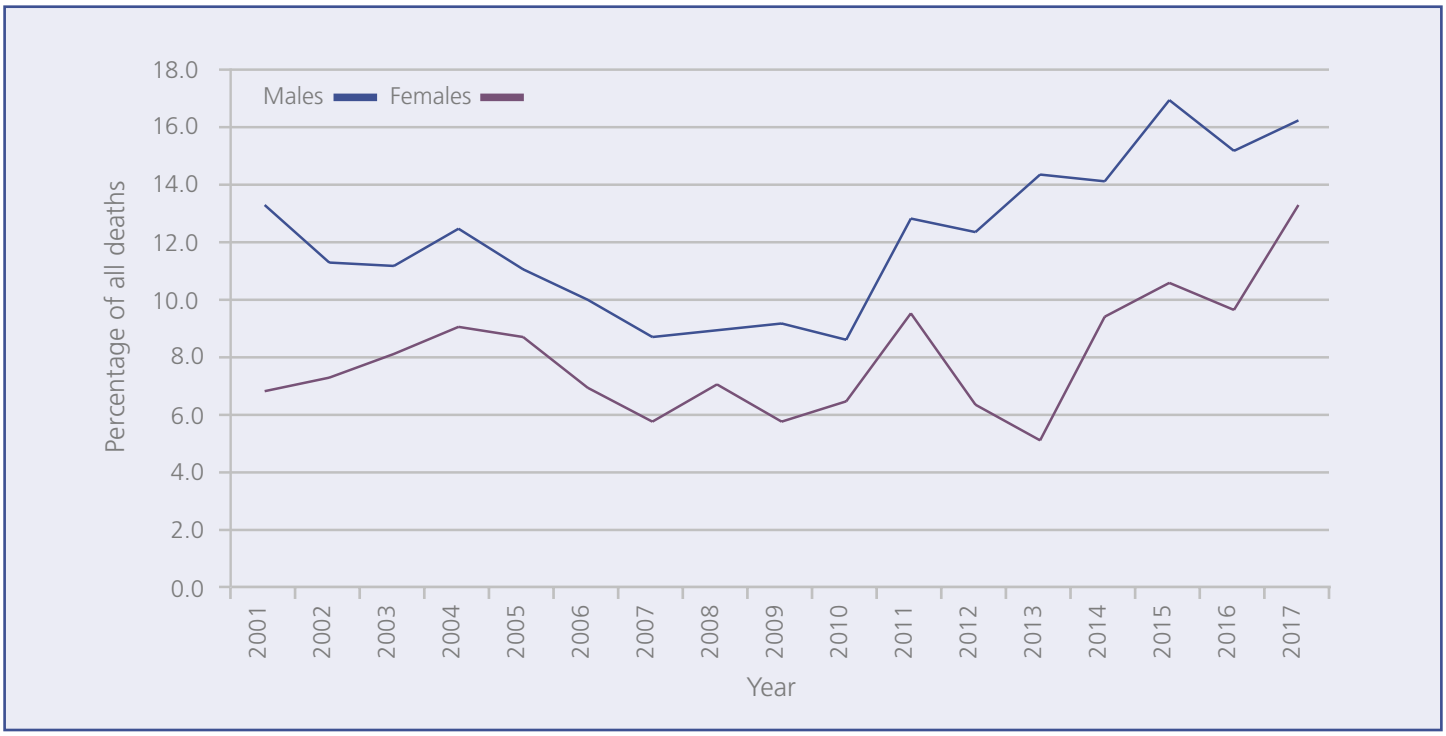
Other research in the USA has reinforced this finding by showing that suicide attempts among high school students fell by an average of 7% following the implementation of the same sex marriage legislation in the state where they lived. The impact was especially significant among gay, lesbian and bisexual teenagers, for whom the passing of same-sex marriage laws was linked to a 14% drop in suicide attempts[130].

A study by Guasp in Britain's schools[131] found that boys are more likely than girls to experience homophobic bullying (66% compared to 46%) and gay and lesbian pupils are more likely to be bullied than their bisexual counterparts.

Of concern is the fact that in 2014 the UK topped the 'Rainbow Index', an annual ranking of LGBT equality published by a European Human Rights Group, but by in May 2018, it had fallen to fourth place[132].

For young people, suicide and injury or poisoning of undetermined intent remained the leading cause of death in 2017[133]. Figure 8 below shows how the proportion of deaths by suicide by gender in thoses aged 5-19 years has fluctuated since 2001.

Figure 8: Proportion of deaths by suicide as a percentage of all deaths by males and females aged 5 to 19 years, 2001-2017



4.2.2 Uptake of Services Provided

Both parents may need support during the perinatal period. Health services have historically targeted women with post-natal depression but there is now evidence that men experience it too and it has an impact on the child.

There is consensus that children and young people do not receive enough support: As few as 25% of children and young people with a diagnosable condition actually access services[134]; only 60% of young people in the UK, who experience severe mental health problems, are believed to receive support from specialist services; only one in thirty have had appropriate interventions at an early enough age[135].

Young people who self harm are at a higher risk of death than the general population. The majority of young people's self-harming behaviours do not reach the attention of professional services[136]. The number of hospital admissions for self-harm are two-thirds higher in girls and young women than in boys and young men[137]. A large proportion of young people who self-harm or who experience suicidal thoughts do not receive appropriate support. Most cases of deliberate self-harm do not end in death by suicide[138] but this highlights a discrepancy between need for help and help received.

There is a discrepancy between the emotional problems perceived by parents and the feelings expressed by their children. Researchers asked parents to report signs of emotional problems in their children at various ages; they also presented the children at age 14 with a series of questions to detect symptoms of depression. Parents' reports of emotional problems were roughly the same for boys and girls throughout childhood, increasing from 7% of children at age 7 to 12% at age 11. However, by the time they reached early adolescence at age 14, emotional problems were reported by parents more in girls, (18%) than in boys (12%)[139].

Three-quarters of all antidepressants for 13-17 year olds are prescribed to girls and young women, yet there is no evidence that the prevalence of depression is greater in girls and young women.

4.2.3 Possible Solutions

In order to develop adequate outreach and preventive programmes, efforts should be prioritised to increase the awareness of deliberate self-harm and related mental health problems among professionals in medical and social services and in the school.

School support, family acceptance, youth groups, friends and the internet are all sources of help which LGBT young people found most supportive.

The solution suggested by Costello et al[140] included the need for parent education to help them identify serious problems and for universal screening to ensure that access to mental health services is not dependent solely on parents. This recommendation is aimed at both genders, but may enable more teenage boys and young men to access health services.

Educational establishments need to introduce a consistent, secular, and dedicated mental health literacy program into the existing curriculum from primary to university level. The announcement in parliament on 19th July 2018 that all schools (including faith schools) in England will now have to teach mandatory relationships and sex education lessons and for the first time, include LGBT relationships, is to be welcomed.

Adult young men in Ireland who had been suicidal in the past were asked about their experiences of seeking help for self-harm and suicide[142]. Youth work settings were identified as a resource for engaging young men in mental health work. Many participants stated a preference for the informal relationship offered by youth workers because they were treated nonjudgmentally and respectfully. This is consistent with the findings of zero suicide projects in adult mental health.

The Centre for Mental Health has evaluated MIND's 'Birmingham Up My Street' Programme[143] which aimed to improve young African Caribbean men's resilience. This project was designed to address the fact that as children, black boys' mental health is no worse than that of white peers, but during adulthood they are far more likely to be diagnosed with schizophrenia or detained under the Mental Health Act. The programme exposed some of the drivers potentially undermining mental health among young black men and showed some of the ways in which they can be addressed. It showed the importance of culturally informed youth work (rather than health) approaches led by positive black role models who proactively reached out to younger men. Resilience and wellbeing was built up through opportunities encouraging personal and vocational growth, providing young men with real educational vocational or employment opportunities. The project showed the value of mentoring, both to the young men who benefited from it and those who became mentors and peer researchers. This model could be effectively extended to other groups of young people.

There is concern that advertising impacts negatively on mental health by portraying the 'perfect person' or suggesting that people should look or behave a certain way and confirm to stereotypical gender roles and that this has a particular effect on vulnerable groups including children and young people[144]. In general, girls use social media more than boys with 40% of girls, and 20% of boys, using it for more than 3 hours per day. Only 4% of girls reported abstaining completely, compared to 10% of boys. The more social media was used, the greater the likelihood of depression symptoms: 3-5 hours of social media use per day was linked to a 26% increase in depression scores in girls and 21% in boys, compared to those who used it for 1-3 hours per day. Social media use for more than 5 hours a day was associated with an increase in depression of 50% for girls and 35% for boys[145].

The internet can also play a positive role. There are Apps such as Blue Ice and Calm Harm amied at young people which are free of charge.

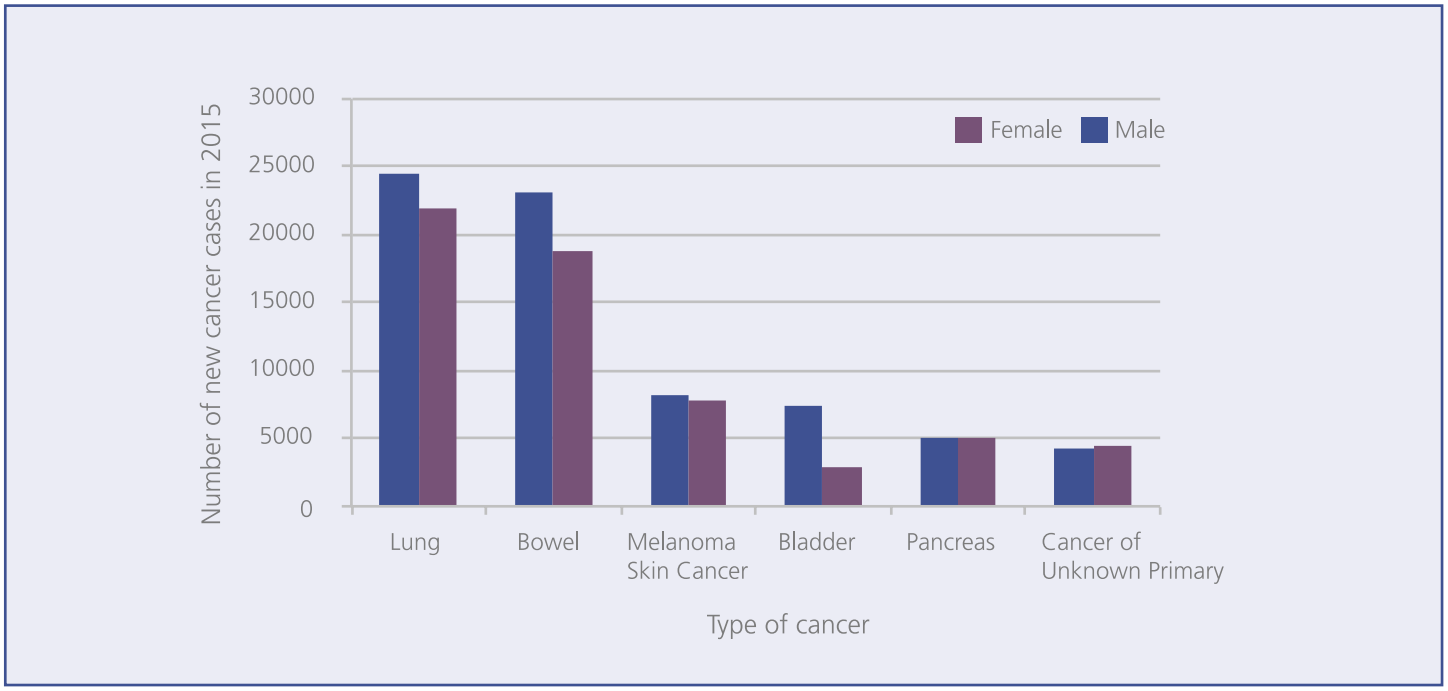
4.3 Cancer

4.3.1 The Extent of the Problem

Mortality is consistently higher in men for virtually all cancers that are non-gender specific. Although there are more than 200 types of cancer, just four types; breast, prostate, lung and bowel account for more than half (53%) of all new cases in the UK (2015)[146].

There is evidence suggesting that men in the UK are diagnosed at a later stage than women for malignant melanoma, lung, bladder and other urological cancers[147]. There is little evidence of any association between gender and time to presentation for either upper or lower gastrointestinal cancers[148]. Therefore, it may be the case, that late presentation is a problem for many but not all cancer conditions affecting men. Figure 9 is taken from data on new cases in 2015 from the Cancer Research UK website, for the cancers where the research has suggested that men are diagnosed at a later stage than women[149].

Figure 9: New cancer cases where the research suggests a later diagnosis for men by gender, 2015



Lung, prostate and colorectal or bowel cancer are the three most common cancers. Lung cancer is more likely to occur in the most deprived communities and prostate cancer in Black Minority and Ethnic (BME) communities according to Cancer Research UK.

Bowel cancer is the second most common cancer in England. In men, it is the third most common cause of cancer death after prostate and lung cancer and in women the third after breast and lung cancer. Gender significantly influences the health outcomes from bowel cancer. The reasons for this are environmental, behavioral and biological[150]. Evidence that there are different causes of bowel cancer in men and women is mounting[151]. The male-to-female ratio for bowel cancer incidence differs for different parts of the large bowel, suggesting different causes of bowel cancer between men and women and the potential need for gender-specific recommendations in bowel cancer prevention.

Prostate Cancer UK publicised 2015 statistics this year which showed that the number of men dying each year from prostate cancer (11,819) exceeded the number of women dying of breast cancer (11,442).

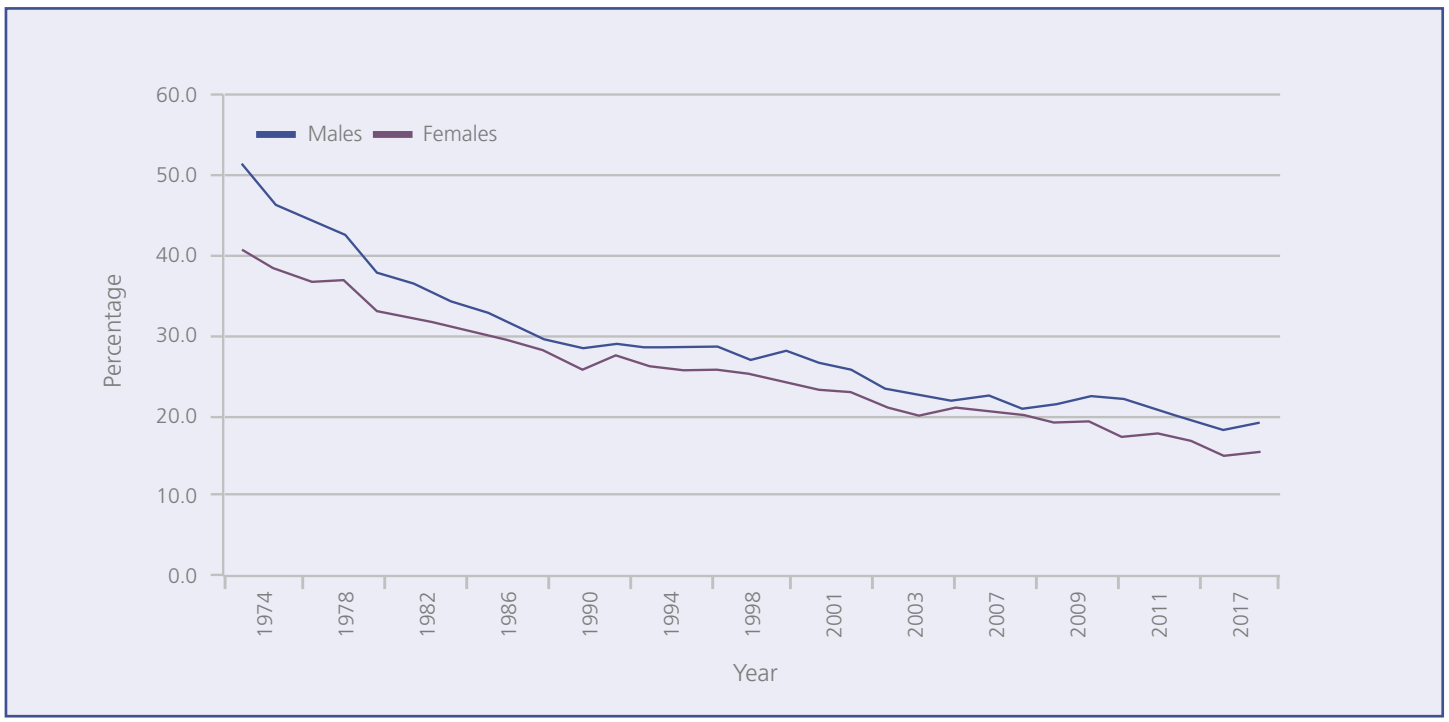
This highlighted the fact that a gender specific cancer in men is now the third most common cancer to die from, after lung and bowel cancer[152].

1 in 4 black men will get prostate cancer at some point in their lives. Black men are more likely to get prostate cancer than other men, who have a 1 in 8 chance of getting prostate cancer[153]. The reasons for this are unclear.

72% of lung cancer is caused by smoking. Men and women from the most deprived groups have more than double the death rate from lung cancer compared with those from the least deprived. 19% of men said that they were cigarette smokers in 2017, compared to 15% of women. Smoking yields similar risks of lung cancer in women compared with men[154], but past rates of decline in these groups should not be taken for granted[155].

The percentage of men who smoked cigarettes has reduced from 51% in 1974 to 19% in 2017 and the percentage of women who smoked cigarettes has reduced from 41% in 1974 to 15% in 2017[156]. Figures 10 and 11 show that there has been a gradual slowing in the reduction of cigarette smoking and frequent drinking with a recent slight increase except where men and alcohol are concerned. This indicates that prevention initiatives are still needed.

Figure 10: Percentage of cigarette smokers, by sex, Great Britain, 1974 to 2017 Aged 16 and over



Alcohol can be linked to at least seven types of cancer. There have been several studies into the links between alcohol consumption and the risk of developing bowel cancer[157].

A percentage of all men aged 16 or over who said that they drank alcohol on 5 or more days in the last week according to the Opinions and Lifestyle Survey[158] had almost halved from 22% in 2005 to 12% in 2017. Women drank less than men in the first year of the survey but their frequent drinking reduced from 13% to 8% between 2005-17.

Figure 11: Drinking frequency in the week before interview, by sex and age, England, 2005 to 2017, Percentage of men and women who drank alcohol on five on more days in the last week

4.3.2 Uptake of Services Provided

The National Cancer Intelligence Network (NCIN) has shown that the percentage of cancers diagnosed as an emergency presentation has fallen nationally from 25% to 21% in males and 23% to 20% in females between 2006 and 2013[159].

An evaluation of patients presenting as an emergency with a new diagnosis of cancer was undertaken in Wessex and published in April 2016[160].

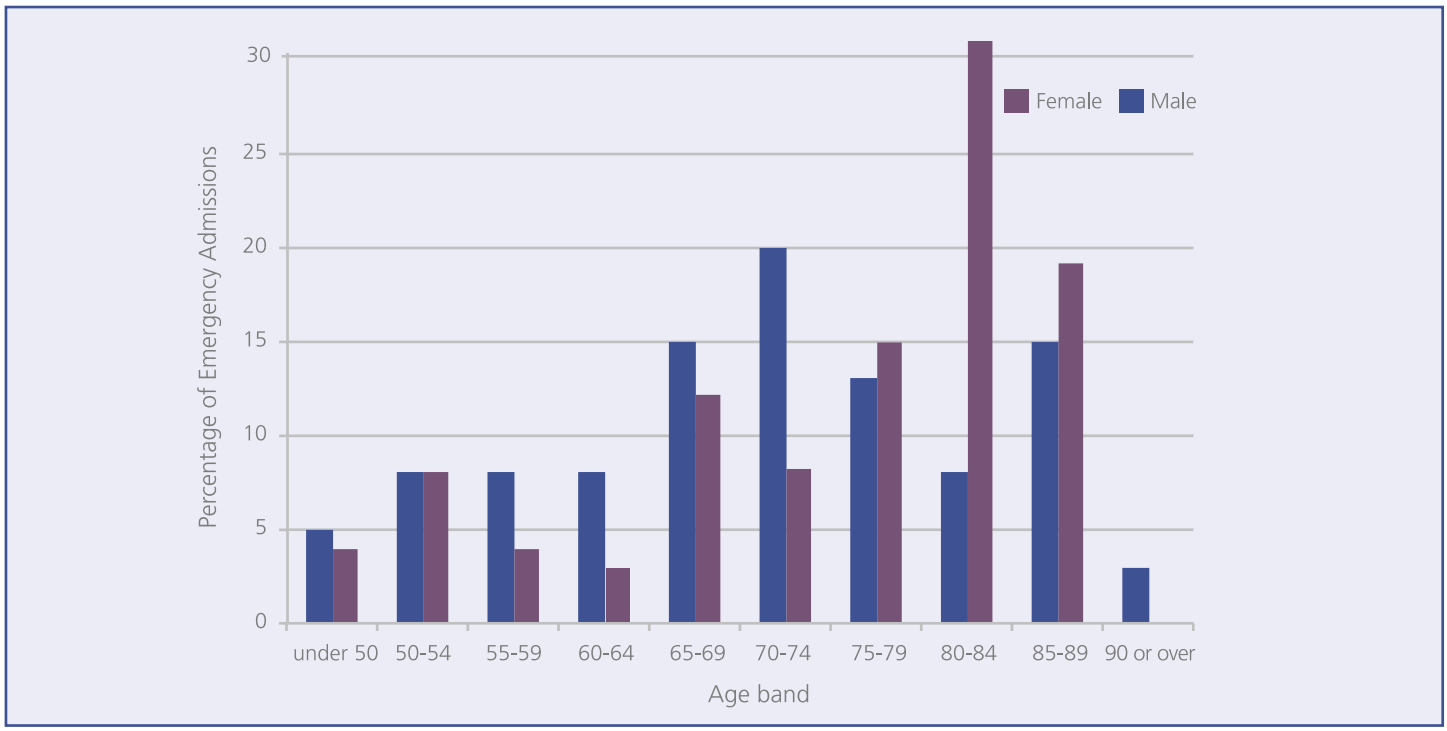
The evaluation was delivered by a team of Macmillan GPs working with the seven acute hospital trusts in Wessex to identify 10 consecutive patients from each trust who had been diagnosed as an emergency presentation of cancer and review their secondary care notes. The GP practices these patients were registered at were then contacted and their primary care records for the preceding two years reviewed. 70 patients were identified for this evaluation. Data for 66 patients (94%) were returned. 40 (61%) of these patients were male and 26 (39%) were female.

In Wessex, the proportion of patients that were diagnosed following emergency presentation has fallen from 25% in 2006 to 18% in 2013.This was lower than for England patients (20%). Data on emergency presentations with cancer by Clinical Commissioning Group (CCG) showed variation across Wessex from 17% to 27%, with all CCGs above the England average except North East Hampshire and Farnham, North Hampshire and Portsmouth.

Men were more likely to present as emergency admissions between the age of 25 and 74. Women were more likely to present as emergency admissions between the ages of 80 and 89.

Figure 12 shows the analysis by age, with a breakdown for both males and females in 5 year increments from 50 – 89 years.

Figure 12: Percentage of Emergency Presentations for cancer by age band for all patients, male and female



The Wessex Cancer study was based on a relatively small cohort of patients and only provided a 'snapshot' of emergency presentations of cancer across Wessex. However, there was a close correlation between the Wessex Study and the results of a much larger London Cancer Evaluation[161] which was conducted between December 2012 and August 2013.

The Wessex Cancer Study made a number of recommendations for improvements but no separate recommendations were made for men and women.

The Bowel Cancer Screening Programme (BCSP) is a national NHS population screening programme[162]. The NHS BCSP offers screening every 2 years to all men and women aged 60-74. Over the past 40 years, there has been considerable disparity in the level of colorectal cancer mortality between European countries, as well as between men and women and age categories. Countries with the largest reductions in colorectal cancer mortality are characterised by better accessibility to screening services, especially endoscopic screening, and specialised care[163]. There is a large body of research on the uptake of colorectal or bowel cancer screening which differentiates between men and women.

Massat et al[164] found that randomised controlled trials of screening starting at age 60 did not show a differential benefit in terms of colorectal cancer incidence or mortality between males and females, but recent studies evaluating screening pilots in people aged 50-69 years living in Scotland using the gFOBt kit found that cancer detection rates increased and there was a trend towards diagnosis at an earlier stage with less advanced disease particularly amongst men[165 166].

Women have a lower colorectal cancer risk compared with men in the UK, but they have been reported to be more likely to return their testing kit[167 168].

The 'Be Clear on Cancer' awareness raising campaign was started in 2010[169] to increase early disagnosis rates in cancer[170].

2014 data show uptake of bowel cancer screening to be slightly lower for men than women (53% for men and 58% for women)[171].

Men in areas of socioeconomic deprivation generally engage less well with screening programmes[172] and there have been problems engaging those from certain minority ethnic groups in both breast and bowel screening notably South Asian[173]. Uptake of bowel cancer screening is lowest in London, in populations of lower socio-economic status, and in particular ethnic and religious groups, notably South Asian communities. An evaluation of service interventions to address this found that personally-delivered health promotion improved the uptake of bowel cancer screening in areas of low socio-economic status and high ethnic diversity. Intervention by telephone and in face to face sessions appeared to be the most effective method[174].

The 'Be Clear on Cancer' campaigns were based around the following key messages: 'If you've had blood in your poo or looser poo for 3 weeks, your doctor wants to know' (bowel) and 'If you've been coughing for 3 weeks or more, tell your doctor' (lung).

The evaluation of the campaign using population sampling demonstrated that the campaign didn't attract any more or any less people from the upper and middle-socio-economic (ABC1) groups[175] versus the lower socio-economic (C2DE) groups. The campaigns reached the broad target audience, but also reached younger and more affluent audiences as well.

GP attendances for symptoms directly linked to the campaigns were also evaluated.

For the bowel campaign, the percentage increase in GP visits for men was significantly greater than the increase for women (37% vs 22%). For the lung campaign, there was no difference in the magnitude of the increase between the two genders (66% for men vs 61% for women), but there was an increase in the number of women consulting their GP for other issues (–1% change for men vs 5% for women).

Men were more likely to think that the advertising told them something new for both campaigns (55% vs 48% for bowel; 50% vs 43% for lung). There was also a trend for men to perceive the advertising as more relevant, although this was not statistically significant for the lung campaign (70% vs 64% for bowel; 57% vs 53% for lung).

C2DE respondents were significantly more likely than ABC1s to think that the lung advert was relevant to them (50% vs 58%) but despite this the lung campaign was less successful in encouraging men in C2DE groups to present to GPs with symptoms. This is believed to be an attitudinal issue.

A new bowel screening test (the FIT test) which specifically measures human blood, rather than any blood (including blood in the diet) is being implemented throughout England from April 2018. It needs only one faecal sample in contrast to the gFOBt kit that needs 6 samples from 3 bowel motions. Pilots in England have shown that people are much more likely to use FIT than gFOBt, which may have an impact on the number of men returning their testing kit.

Some evidence had emerged suggesting that the comparative performance of the FOBT pathology tests may differ between sexes[176]. Women showed more than a twofold likelihood of a false-positive result than men[177]. The faecal immunochemical test (FIT) replaces the guaiac faecal occult blood test (gFOBt) this year but further research will be needed to check that the FIT does not perform differently in men and women.

4.3.3 Possible Solutions

The National Cancer Programme is focusing on early diagnosis with implementation of rapid diagnosis pathways for lung, prostate and colorectal cancer. Several CCGs in Wessex are planning rapid diagnosis pathways for bowel cancer.

The #HeadHigh campaign was launched in November 2017 by the Roy Castle Foundation[178]. The aim of the campaign was 'to end the public perception that patients have brought the disease on themselves by smoking' when around 10-15% of people presenting with lung cancer (often at a late stage of the disease) are non-smokers.

Preliminary results from once-only flexible sigmoidoscopy screening trials performed at age 55 or over suggest greater benefit for men in term of mortality, probably due to the fact that men develop proportionally more distal tumours than women and develop advanced colorectal adenomas (pre-cancerous tumours in the bowel) at an earlier age[179]. Since March 2013, the NHS Bowel Cancer Screening Programme has started rolling out a once-only flexible sigmoidoscopy programme in six areas in England where patients are invited for 'bowel scope screening' around the time of their 55th birthday. NHS England has introduced this programme to most CCGs in Wessex.

Wessex has a prehabilitation project, 'WesFIT', to improve the health and wellbeing of cancer patients prior to surgery. The first patient was recruited to the trial in April 2018 and recruitment will continue throughout the year. Take up of this project by men and women should be monitored.

The Queen's Nursing Institute funded a project to develop a patient-held resource to support the self management of men living with and beyond prostate cancer in partnership with men living with the disease[180].

NICE guidance on smoking cessation and the prevention of alcohol misuse is not gender specific[181 182]. Gender does not appear to be a factor in the success of smoking cessation advice provided by primary care[183]. A population study on smoking cessation in England found that age interacted with gender and social grade: women and smokers from higher social grades had a higher incidence of quitting than men and those from lower social grades specifically in young adulthood[184]. A study from Sweden on smoking found gender differences in reasons to smoke, reasons to quit and strategies to quit smoking and so recommended that strategies and policy decisions should be gender sensitive, taking into account an array of specific needs[185]. There appears to be a consensus that further work is required to develop gender-sensitive smoking cessation programmes along with sex and gender based analyses of smoking cessation among men[186]. A similar study of young adults attitudes to alcohol in Scotland also found gender differences in reasons to reduce drinking and strategies to quit drinking[187]. The alcohol-specific and alcohol-related death rate for men is almost double that of women. This appears to indicate that gender-sensitive strategies are needed for alcohol misuse.

There are a few evidence-based health promotion initiatives aimed at men to reduce smoking consumption including an online, men-centered smoking cessation intervention[188] and a prison intervention based on a participatory comprehensive wellness programme for recovering substance abusers which showed significant improvement for depression (and smoking) amongst those who completed the programme[189].

4.4 Cardiovascular Disease

4.4.1 The Extent of the Problem

Cardiovascular disease accounted for 26% of deaths in men and 24% of all deaths in women in 2016. Premature or preventable mortality from cardiovascular disease is much higher for men than women. Men had an under-75 mortality rate of 70.4 per 100,000 population in England in 2013-15 whereas women had an under-75 mortality rate of 24.3 per 100,000 population in England in 2013-15.[190]

Figure 13 shows the number of avoidable deaths from cardiovascular disease over a 3 year period by gender and age[191].

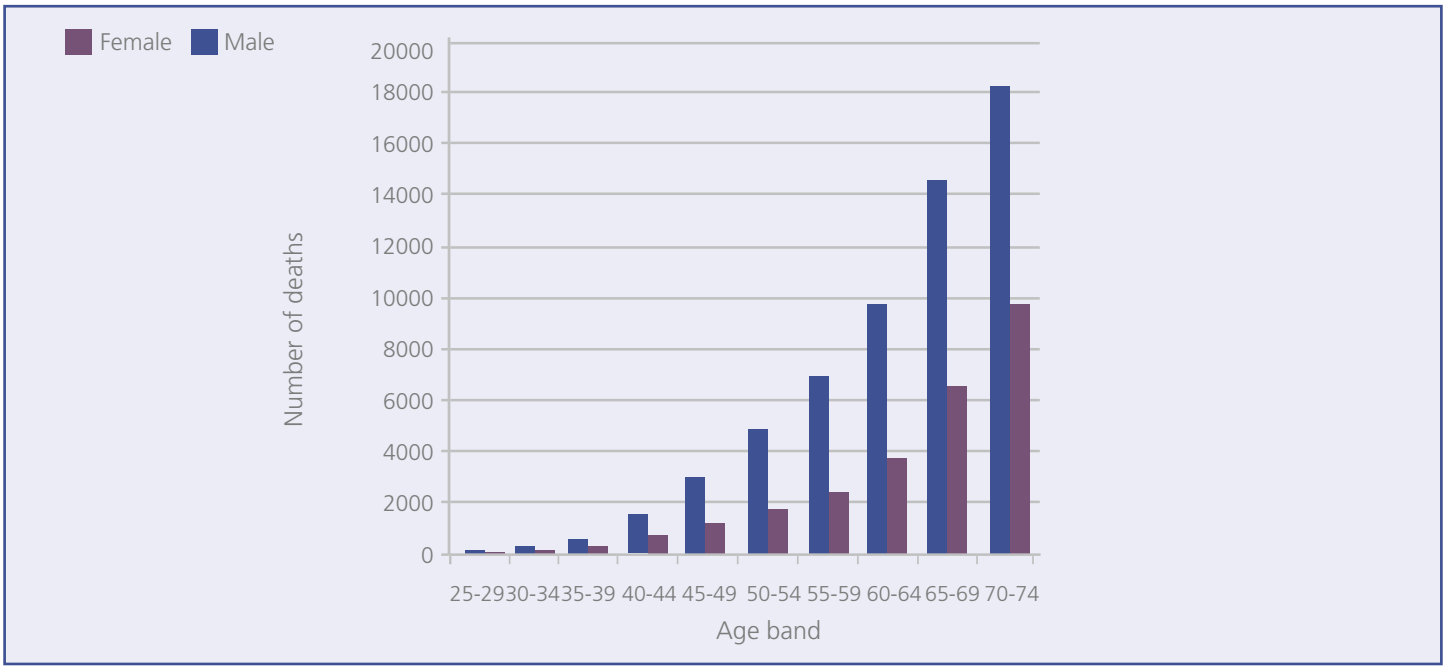
Women have a similar mortality risk to men after revascularisation. Revascularisation refers to process by which narrowed or obstructed arteries or veins are bypassed or opened up by treatment.

Cardiovascular disease rates are higher amongst both women and men in lower socio-economic groups and in Bangladeshi, Indian, Pakistani and Afro-Carribean communities than for the rest of the UK population. Heart UK stated that, in 2008[192], mortality from cardiovascular disease was 50% higher in the most deprived populations compared to the least deprived but research in men aged 35-64 has indicated that population-wide strategies to reduce major cardiovascular risk factors are likely to have greater potential benefits for cardiovascular disease prevention than strategies designed to reduce social inequalities in cardiovascular disease[193].

The physiology underlying cardiovascular disease is thought to differ between women and men but the exact role reproductive hormones play is unknown[194]. There are a lot of publications on sex and gender differences in cardiovascular disease, but awareness of these differences is low[195].

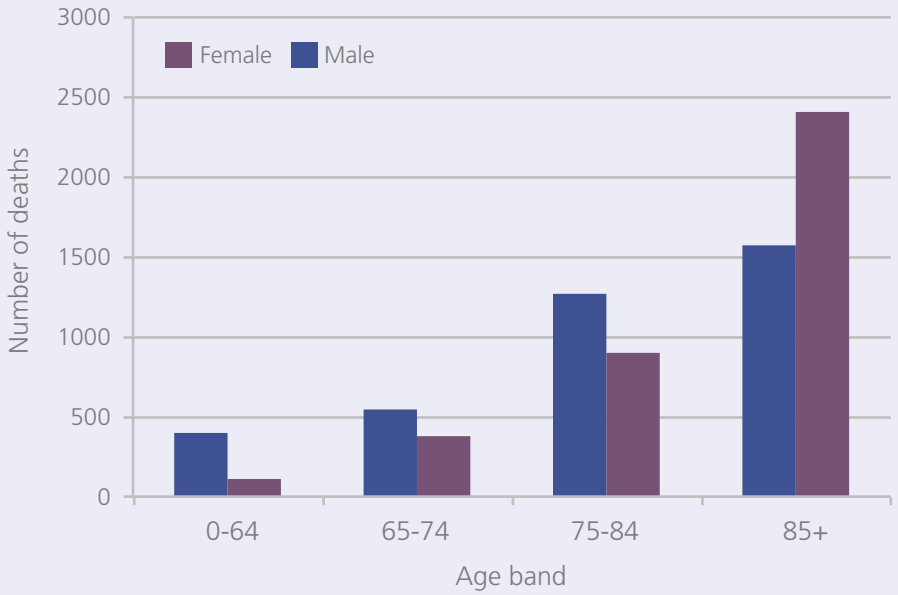
The risk of cardiovascular disease in women increases during and after the menopause, continues to increase in later life and the gap between men and women narrows with women overtaking men after the age of 85. Despite this, the number of avoidable deaths from cardiovascular disease is much greater in men up to the age of 74.

Figure 13: Number of avoidable deaths from cardiovascular disease by gender and age 2014-16



More men than women die in the winter from cardiovascular disease at a younger age. The following figure shows the 'excess winter mortality' from cardiovascular disease in 2016/17[196]:

Figure 14: Excess winter mortality for Cardiovascular Disease by gender and age per 100,000 population, England and Wales 2016/17



A Canadian five-year study (2009-2013) published in 2018[197] estimated that women were 14% more likely to die of heart failure than men within a year of being diagnosed. UK commentators have indicated that this situation is likely to exist in the UK. Men and women in the study had different associated co-morbidities. So, one of the reasons for the lower rate of intervention could be that women are more likely to be older than 85 when they have a heart attack, they are more likely to have co-morbidities so intervention may be risky and they may have consented to palliative care only.

The 2008 report 'The Gender and Access to Health Services Study'[198] found that slightly more men were diagnosed in general practice with cardiovascular conditions defined as serious whilst women were diagnosed with cardiovascular conditions defined as intermediate (based on 1991/92 General Practice data). This data is old but is no longer collected routinely.

A study of 471,998 middle aged UK Biobank participants with no history of cardiovascular disease analysed the sex differences in risk factors for a heart attack[199] and found that women who smoked more than 20 cigarettes per day had twice the relative risk of a heart attack than equivalent men and elevated blood pressure was associated with a more than 80% higher relative risk in women. Hypertension stages 1 and 2, smoking 10-19 cigarettes daily, and type 2 diabetes each were 40% more strongly associated with the risk of Myocardial Infarction (MI) or heart attack in women than men. Although the risk of MI is, on average, about three times higher in men than women, women tend to 'catch up' to some extent if they have certain cardiovascular risk factors. The authors suggest that clinicians should be vigilant when their female patients are elderly, smoke, have diabetes, or have high blood pressure. These findings also highlight the importance of equitable access to guideline based treatments for diabetes and hypertension, and to weight loss and smoking cessation programmes for women and men in middle and older age.

Women may be more likely than men to delay presentation when experiencing symptoms of cardiovascular disease with more women having atypical symptoms which made detection more difficult.

Women with cardiovascular disease were less likely than men to be referred to specialists and have their cholesterol recorded and were less likely to be prescribed some medications. The report noted that there are a number of gaps in the evidence which still need to be addressed. More understanding is needed about the ways in which men and women identify health needs, seek assistance or address their risk factors in relation to cardiovascular disease. These women may have diabetes. The next section on diabetes addresses the increased risk of cardiovascular disease in women with diabetes.

In general, higher mortality in women compared with men was reported at both 5 and 10 years after a heart attack; however, many of these differences in mortality became extremely small after adjustment for age. Gender differences in long-term mortality after a heart attack are largely explained by differences in age, comorbidities, and treatment between women and men.

A Norwegian study[200] investigated mortality after a heart attack with special emphasis on the impact of smoking and gender. It concluded that smoking at the time of the heart attack was associated with increased mortality after 7 years follow-up. In-hospital mortality for the first heart attack was 9% for men and 13% for women. The after-discharge mortality for women was significantly lower than for men. Compared with non-smokers, patients who were smokers on admission had significantly increased mortality after discharge.

A Swedish study looked at data from more than 180,000 people over 10 years and found that three times the expected number of women died in the first year of a heart attack compared to men[201]. Sweden has one of the lowest mortality rates from heart attacks in the world, yet there is a disparity in treatment and outcomes between men and women. The research found that women were less likely than men to receive the recommended treatments after a heart attack.

Women who had the type of heart attack where the coronary artery is blocked by a thrombus, were 34% less likely than men to receive procedures which clear blocked arteries and restore blood flow to the heart, such as bypass surgery or a stent. Women were also 24% less likely to be prescribed statins, which could help to prevent a second heart attack and 16% less likely to be recommended aspirin, which helps to prevent coronary thrombosis.

Critically, when women did receive all of the treatments recommended for patients who have suffered a heart attack, the number of women dying decreased dramatically.

Previous British Heart Foundation (BHF) research has also shown that women are 50 per cent more likely than men to receive the wrong initial diagnosis[202] and are less likely to get a electrocardiogram (ECG), which is essential for swift diagnosis and treatment.

Studies show that women with a primary diagnosis of 'non-specific chest pain' may suffer heart attack or stroke shortly after being discharged from hospitals[203].

Coronary angiography, the 'gold standard' for diagnosing patients with angina (chest pain), typically results in a diagnosis of obstructive coronary artery disease (CAD) in men but frequently fails to identify the cause in 50% fewer woman than men. As a result, many women with chest pain, but with 'normal' angiograms are underdiagnosed and misdiagnosed and treated. Many women with angina are told that they have no significant heart disease. A greater proportion of women (52%) die of sudden cardiac death before their arrival at hospital than men (42%) and this is believed to be due to difficulties with diagnosis. Large-scale randomized trials are needed to better understand the pathophysiology and optimal therapies for women and men with angina and 'normal' angiograms[204].

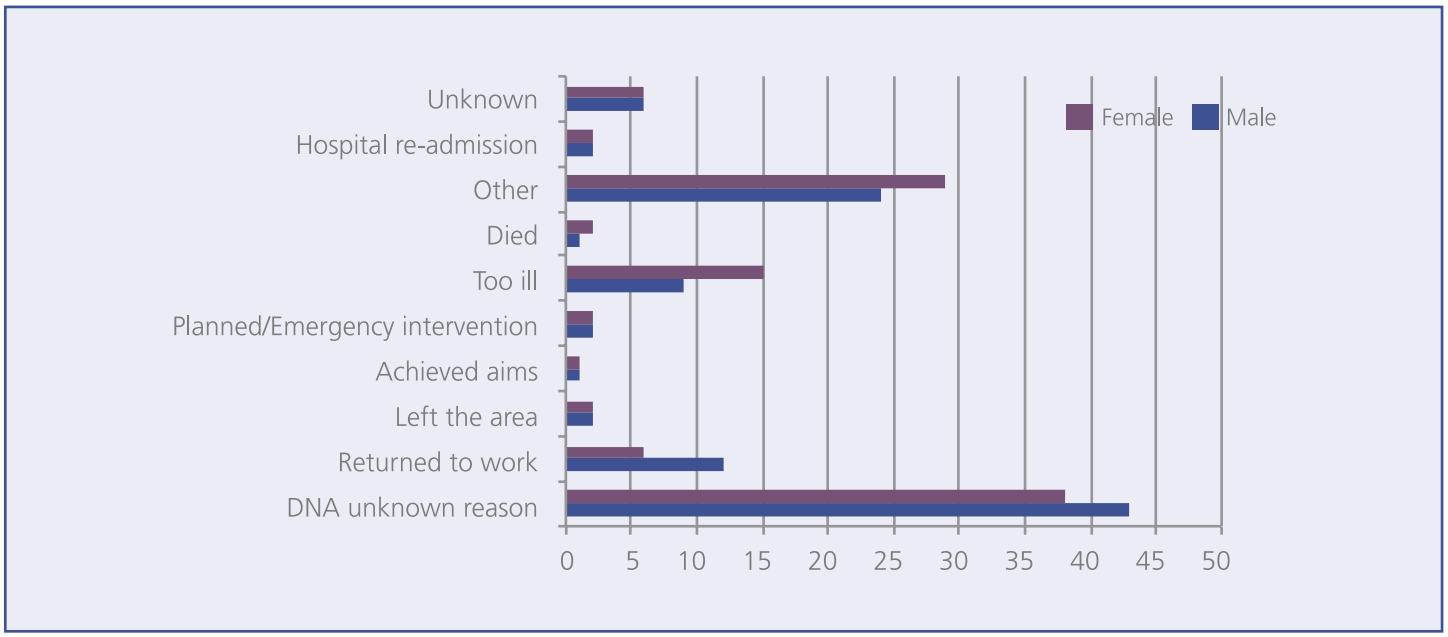
4.4.2 Uptake of Services Provided

A National Abdominal Aortic Aneurysm (AAA) screening programme for men aged 65 years has been introduced. The AAA programme has only recently had full national roll out across all UK countries, and current uptake is relatively high at over 78% nationally (NHS Screening Programmes, 2015). The uptake in Wessex at the time of publication was around 80%. A national review noted that there are important differences relating to lower uptake for men in areas of higher socioeconomic deprivation[205].

The BHF broke down their National Audit of Cardiac Rehabilitation (NACR) Annual Statistical Report 2017 reports for the first time into gender and age. 51% of patients were offered cardiac rehabilitation in 2016/17 but only between 7% and 20% of patients who were eligible were referred, depending on the hospital. 77% of patients who were referred complete core cardiac rehabilitation. The proportion of females and males attending cardiac rehabilitation in 2017 was roughly the same as the year before at 29% and 71% respectively. According to the National Heart Failure Audit in 2016/17 there were 45% first hospital admissions of women with heart failure and 55% of men, so the low female attendance rate is worrying[206]. The figures for Wessex are similar to the UK average at 30% female and 70% male. So, fewer women are attending than might be expected from the hospital admissions. The proportion of women below 75 years accessing cardiac rehabilitation was 25%, versus 40% for women above 75 years of age.

77% of patients do complete core cardiac rehabilitation. Compliance was the same by gender which indicates that fewer women are referred. Of those that didn't complete under the age of 75, the reason why is not much different between men and women as the following pie charts show, except that more men return to work and more women are 'too ill'. The limitations with this audit are that many people were recorded as not attending for an 'unknown reason'.

Figure 15: Men and Women under 75 years not completing cardiac rehabilitation, 2017



Gender does appear to be a predictor for survival among patients suffering cardiac arrest where cardiopulmonary resuscitation (CPR) is attempted. Overall out of hospital cardiac arrest survival for women was lower than for men in the OPALS study[207].

Preliminary research presented to the American Heart Association found that men are more likely to receive CPR in public locations compared to women, and they are more likely to survive after the life-saving measure:

- Overall, bystanders administered CPR in 37% of cardiac events in varied locations.
- 35% of women and 36% of men received CPR in the home, showing no significant difference in the likelihood of one gender getting assistance over the other in this setting.
- In public settings, 45% of men got assistance (55% did not) compared to 39% of women [208]

The authors of this research advocated better CPR training to the public.

4.4.3 Proposed Solutions

Apart from the BHF publication, no other data was found on the uptake of cardiovascular services by men and women.

The literature search found few examples of American and European studies (and few examples of UK studies) since 2008 about how the differential uptake of cardiovascular services between men and women could be addressed, except for a general emphasis on the need to raise public awareness and improve clinician education[209].

There have been a number of projects aimed at preventing cardiovascular disease in men alongside other diseases such as cancer and these are listed in the primary care section of this report.

4.5 Diabetes

There are two main types of diabetes:

- **Type 1** – where the pancreas doesn't produce any insulin
- **Type 2** – where the pancreas doesn't produce enough insulin or the body's cells don't react to insulin

There are currently three million people in England at risk of developing Type 1 diabetes

There are currently five million people in England at high risk of developing Type 2 diabetes. If these trends persist, one in three people will be obese by 2034 and one in ten will develop Type 2 diabetes.

Diabetes was the focus of a NHS England programme of work in 2016/17 and 2017/18. It was not one of the conditions or disease areas reviewed in the 2008 report 'The Gender and Access to Health Services Study'[210].

4.5.1 The Extent of the Problem

The National Diabetes Audit data for England and Wales in 2015-16[211] showed that approximately one-eighth more men than women had diabetes (over 1.5m males or 56% of the total) and about 1.2m females or 44%).There is little evidence that there is a gender gap in the uptake of diabetes services, but the rate of minor diabetic amputation in lower limbs in men is more than triple that of women and the rate of major diabetic amputation in lower limbs in men is more than double that of women. Three times as many minor diabetic amputations in men than women is a puzzling statistic: why isn't it the same as the rate of diabetes or major diabetic amputations?

Traditional risk factors such as dyslipidaemia, hypertension and obesity are greater in Type 2 Diabetes than in Type 1 Diabetes and they explain about half of the increased cardiovascular disease risk[212 213].

Morbid or severe obesity is increasing rapidly in prevalence. Obesity as well as causing obvious physical changes, can lead to a number of serious and potentially life-threatening conditions, such as:

- Type 2 diabetes
- Cardiovascular disease
- Cancer
- Stroke[214]

65% of men are overweight or obese compared with 58% of women, but most weight-loss services attract mainly women.

Cardiovascular disease is the leading cause of death in both Type 1 and Type 2 Diabetes. There is at least a two-to fourfold increased risk of cardiovascular disease in patients with diabetes.

Diabetes confers a markedly increased risk of cardiovascular disease events in both women and men[215] and eliminates the protective effect of female gender on the risk of cardiovascular disease. Diabetes raises the relative risk of heart disease mortality 3- to 10-fold relative to that of women without diabetes[216 217 218 219 220 263 264]. Despite declining cardiovascular disease mortality over the last 30 years in the United States of American population overall and in men with diabetes, women with diabetes appear to have experienced an increase in age-adjusted cardiovascular disease mortality[221].

Men with diabetes were more likely to receive treatment for cardiovascular disease [222].

Studies have suggested differences between men and women in the mortality rate associated with Type 1 Diabetes. A systematic review and meta-analysis found that women with Type 1 Diabetes had a roughly 40% greater excess risk of all-cause mortality and twice the excess risk of fatal and non-fatal vascular events, compared with men with Type 1 Diabetes[223].

Several pathophysiological mechanisms may contribute to the increased risk of cardiovascular disease mortality in men and women with diabetes. Women with diabetes may be subject to even more adverse changes in coagulation, vascular function, and cardiovascular disease risk factor levels than diabetic men[224 225 226 227].

Men over 50 are nearly twice as likely as women to have undiagnosed Type 2 diabetes, which is said to be indicative of insufficient screening in primary care[228].

People with diabetes are over 20 times more likely to have a lower limb amputation than people without the condition. These amputations have a devastating impact and half of those who have them die within two years of the amputation.

Evidence shows that 80% of diabetes-related amputations could be prevented[229].

Women with diabetes have not experienced the same improvement in cardiovascular disease events and mortality as men with diabetes and as women and men without diabetes over the last 30 years[230]. There may be biological and other reasons for these differences, but differences in clinical treatment may also contribute to the excess burden of cardiovascular disease in women with diabetes.

4.5.2 Uptake of Services Provided

A study of a large, clinic-based cohort of patients with diabetes found that they received generally high-quality diabetes care, but women were less likely than men to be treated with aspirin and lipid-lowering therapy. No obvious justification can be given to explain the marked differences observed in aspirin recommendations between diabetic women and men with and without cardiovascular disease[231] Hypertension and hyperlipidaemia are also managed less aggressively than hyperglycaemia[232] in women.

The possibility of differential record-keeping by gender cannot be completely eliminated. That the prevalence of many risk factors and treatments were equal between men and women whereas many of the gender differences were relatively large suggests that this is not the case. Non-prescription medications such as aspirin may have been undercounted and could have been recorded differentially by gender. Paracetamol and ibuprofen were listed more frequently for women. Although more women were taking ibuprofen, the additional number taking ibuprofen was not enough to account for the decrement in those taking aspirin. Another concern is the timing of diagnoses and treatments, which were not determined in this study.

More aggressive treatment of coronary heart disease risk in women with diabetes appears to offer a specific target for improvement in diabetes care.

Figure 16[233] shows that the rate of major diabetic lower limb amputations in men (10.5 per 10,000 population) is twice that of women (4.9 per 10,000 population). The rate of minor diabetic lower limb amputations in men (29.0) is nearly three times that of women (10.8). Since 2017, data on amputations by gender has been included in the foot care profiles published by CCG. The numbers per CCG should be relatively low and this provides an opportunity for detailed patient engagement to find out why the rates are so much higher in men and how this can be prevented.

Figure 16: Breakdown by gender of major and minor diabetic amputation rates 2014/15 – 2016/17, England (Public Health England Diabetes Foot Care Profile England Summary)

There is some evidence that the gap between the amputation rates in poorer performing CCGs and better performing CCGs is widening. Diabetes UK has suggested that the under-use of health services by white men living in poor areas has contributed to the higher of diabetes-related amputations[234].

The risk factors associated with diabetic amputation are deprivation, male sex, and white Caucasian ethnicity. Some studies suggest that South Asian men have a two-fold higher risk of developing Type 2 diabetes and a higher risk of complications from diabetes[235].

The 2014/2015 and 2016/2017 data does show Hampshire and Isle of Wight and Dorset data in comparison with the England average and this is shown in Table 10. The red boxes indicated that the figure is higher than the England average and statistically significant, the amber box is not statistically significant. The green box is lower than the England average and statistically significant.

Table 10: Major and Minor Diabetic Lower Limb Amputation Rates 2014/2015-2016/2017

Indicator	Period	England	Hampshire & Isle of Wight	Dorset
Major diabetic lower-limb amputation procedures	2014/15 - 16/17	8.2	9.7	6.5
Minor diabetic lower-limb amputation procedures	2014/15 - 16/17	21.2	28	17.5

There is evidence for poorer uptake of health promotion services by men than women locally. Only 10% of Hampshire County Council's weight management programme attendees were male and this is consistent with the results of general obesity studies where only 10–30% of participants in weight loss programmes were men[236]. The following reasons have been found for this:

- Men do not perceive that these services are for them
- Men are more reluctant to talk to others about any symptoms they might have
- Men are more likely to exhibit risky behaviours than women
- Men are more likely to be exposed to hazards through work, by virtue of male-dominated occupations such as manual labour[237].

4.5.3 Possible Solutions

Evidence shows that many cases of Type 2 Diabetes are preventable. Strong international evidence demonstrates how behavioural interventions, which support people to maintain a healthy weight and be more active, could reduce the risk significantly of developing the condition. The national DPP has been introduced and early data shows that just under half of the people who have taken up the programme are male – a much higher proportion than typically attend weight loss programmes, while roughly a quarter are from Black, Asian and minority ethnic communities, groups that are at significantly greater risk of developing Type 2 Diabetes[238].

Treating modifiable cardiovascular disease risk factors (such as blood pressure and lipids) and using angiotensin-converting–enzyme (ACE) inhibitors and aspirin reduce mortality in diabetes[239 240 241 242 243].

Awareness of the benefit of asprin has seen aspirin use among adults with diabetes increase. However, many high-risk individuals, especially women and those younger than 50 years still do not use this effective and inexpensive therapy[244].

The Heart Protection Study showed about a 25% reduction in vascular event rates in all subgroups treated with simvastatin, including patients with diabetes and women, regardless of initial levels of low density lipoprotein (LDL) and high-density lipoprotein (HDL) cholesterol[245].

Maintaining a healthy weight and taking reasonable exercise will prevent the onset of Type 2 Diabetes[246].

Men are more likely to engage in weight loss programmes which:

- Emphasise healthy eating and physical activity, rather than 'dieting'
- Are run through community settings, for example sports clubs to which some men may feel a strong sense of affiliation. There are many ideas from around the world[247]
- Offer a 'men only' group option[248]

The source of referral (self or health professional) appears to be significant in terms of successful completion of a programme: people referred by their clinician as opposed to being self-referred are more likely to attend an initial consultation, but are less likely than the self-referred to join a programme and may be less motivated[249]. Men are more likely to attend the initial consultation than women , but this does not seem to lead to more men entering weight loss programmes and suggests that more complex interventions, involving a wider range of starting points than primary care, are needed. Evidence concerning the completion of programmes is also mixed, although the men who do start a programme providing advice and monitoring rather than group activities, appear to be more likely than women to complete the programme and to lose more weight[250]. There is little evidence on why fewer women complete weight loss programmes and lose less weight than men who complete the programmes.

A randomised controlled trial of a gender-sensitised weight loss and healthy living programme for overweight or obese male soccer fans at 13 Scottish professional soccer clubs, led to significant weight loss[251]. This is referred to as the Football Fans in Training (FFIT) intervention and is recommended by National Institute for Health Research (NIHR)[252].

Exercise referral schemes are where the GP makes a formal intervention and prescribes exercise. NICE guidance advises policy makers and commissioners not to fund exercise referral schemes for people who are sedentary or inactive but otherwise apparently healthy as there is insufficient evidence of their impact. They advise that policy makers, commissioners and local authorities should only fund exercise referral schemes for people who are sedentary or inactive and have existing health conditions or other factors that put them at increased risk of ill health. The exercise referral scheme also needs to incorporate the core techniques outlined in recommendations 7-10 of NICE Public Health Guidance 49: 'Behaviour change: Individual Approaches'[253]. NICE also recommended in September 2014 that Public Health England should collect data recording the sex of all participants in any such scheme to identify whether the exercise referral intervention was more effective for males or females or if uptake of the intervention varied by gender[254]. This data doesn't appear to publically available.

4.6 Access to Primary Care

4.6.1 The Extent of the Problem

In 2013, there was a UK wide analysis of routinely collected primary care consultation data[255] which found that the consultation rate was 32% lower for men than women. The number of male and female consultations varied at different ages and there was no 'excess' female consulting in early and later life. The greatest gap between men and women consulting primary care was seen in those aged between 16 and 60 years. It was assumed that this gap was caused by the fact that women consult GPs more when they are pregnant and have young children, but accounting for reproductive-related consultations (such as the birth of a baby or menopause) diminished but did not eradicate the gender gap in this analysis.

However, the view that men 'under-consult' their GP has been challenged. Consultation rates in men and women who had comparable underlying morbidities (as assessed by receipt of medication) have been found to be not that different; men in receipt of antidepressant medication were only 8% less likely to consult their GP than women in receipt of antidepressant medication and men in receipt of medication to treat cardiovascular disease were just 5% less likely to consult their GP than women receiving similar medication.

Other research into whether women consult primary care more than men for two common ailments (headache and back pain) found no significant difference between consultation rates of men and women[256]. The lesson from this research seems to be that once men recognise that they have a health problem, they are just as likely as women to consult their GP.

Men living in deprived areas were less likely to consult their GP than men living in the more affluent areas. Men in low-income employment tend to have less flexible working hours and may lose pay if they take time off to visit their GP. Men who are homeless, or who have been recently released from prison or who are travellers are much less likely than the general population to be registered with a GP. A study of new migrants to the UK from countries with a high incidence of tuberculosis found that women from these countries were 44% more likely than men to register with a GP[257].

A Danish study based on almost 36 million GP contacts and 1.2 million hospitalisations in 2005 hypothesised that men's lower use of GPs resulted in later diagnosis and therefore higher use of hospital services[258]. Denver Men's Health Initiative showed an increase in primary and specialty care visits and a decrease in urgent care, behavioural health and inpatient visits saving $206,485[259].

Men use pharmacy and dentistry services less than women. According to a national pharmacy association interim review published in November 2012, men visited a pharmacy on average 4 times a year compared to 18 times a year for women. The Adult Dental Health Survey for England, Wales and Northern Ireland in 2009 found that women were more likely than men to have made an appointment with an NHS dentist in the past three years (62% vs 54%)[260].

General practices in England's more deprived areas are nearly three times as likely as those in affluent areas to face sanctions from the health services regulator and there have recently been unsubstantiated claims that the divide between GP numbers in rich and poor areas is widening[261].

There have been (unsubstantiated) claims that the divide in GP numbers in rich and poor areas is widening. Data was published by NHS Digital in late 2018 and has been mapped by the BBC to show the 'unequal access to GPs' numbers by CCG. This is available at: https://www.bbc.co.uk/news/health-46912055.

At first sight in Hampshire and Isle of Wight, there appear to be most GPs in the CCGs which have the most deprivation (Portsmouth, Southampton, Fareham and Gosport, Isle of Wight) but deprived wards tend to sit alongside wealthier ones in these areas. Dorset CCG has both deprived and wealthy areas but fewer GPs. Further analysis of the GP numbers by Lower Super Output Area (LSOA) within Wessex might be insightful.

4.6.2 Uptake of Services Provided

The Quality and Outcomes Framework (QOF)[262] is the annual financial reward and incentive programme detailing GP practice achievement results. It rewards practices for the provision of quality care and helps standardise improvement in the delivery of primary medical services. It is a voluntary scheme for all surgeries in England and was introduced as part of the GP contract in 2004. The indicators for the QOF are changed annually, with new measures being introduced and other measures being retired. The QOF awards GP practices achievement points for:

- managing some of the most common chronic diseases, e.g. asthma, diabetes
- managing major public health concerns, e.g. smoking, obesity
- implementing preventative measures, e.g. five yearly blood pressure checks

In general, there is evidence that the introduction of QOF has been beneficial for older people and for men. Quality of care improved under the scheme but quickly reached a plateau and took attention away from care that was not incentivised[263]. No obvious benefit has been observed for ethnic minority groups. For deprived communities, a small but significant benefit has been observed. These differences are mainly due to differences at the practice level.

There have been discussions nationally about moving away from the QOF scheme[264]. A review of 12 QOF indicators from 2010-2017 which were removed in 2014 and 6 which were maintained in 2,819 general practices, found that removal of financial incentives was associated with an immediate decline in performance on quality measures, which suggested that the incentive removal changed the care delivered[265].

An equality impact assessment on any change to QOF needs to be undertaken to ensure that it is not to the detriment of older people and men.

In June 2013, the European Men's Health Forum (EMHF) convened a roundtable meeting in Brussels of a range of primary care professionals to identify the barriers to men's effective engagement with primary care and, more importantly, how these could be overcome. They reached 12 principal conclusions, which were to form the basis for an EMHF work programme going forward (Box 1)[266]. EMHF will also be organising similar roundtables within individual European states to help them develop primary care services that work better for men.

Box 1. European Men's Health Forum roundtable on men's health and primary care: principal conclusions

- Men currently use primary care services ineffectively, contributing to unnecessarily poor health outcomes. This is especially the case for men in disadvantaged groups
- As the population ages, it is essential that more men are empowered and enabled to use services, and receive targeted prevention, to reduce their risk of arriving in old age with a range of diseases
- All primary care services have an important and shared rule in improving men's access and outcomes
- Government austerity programmes are increasing the pressures on primary care and prevention services and it is therefore important to make the economic case for greater investment in these services in order to improve men's health
- The barriers preventing men from accessing primary care must be addressed.
- These include opening hours, appointment-booking systems, cost (particularly for dentist) and a perception that many services (especially pharmacy) are primarily aimed at women
- Health professionals require training on men's health, including on how to communicate better with men (including raising embarrassing issues), tackle the barriers that deter men from using services, and engage with their local communities
- Investment is needed in large-scale outreach services for men, including through workplaces
- Better integration of the primary care professions would improve the care of men and other groups whose needs have been overlooked
- Improving men's health literacy, including their symptom awareness, would encourage earlier use of services and better self-care
- More men's health champions and role models are needed to influence both professionals and men
- There is good evidence that men will use targeted primary care services but there remains a need for more research into men's use of primary care services and how it can be improved
- National health policies should take specific account of men

One measure which should have increased as a result of QOF is the recording of weight and BMI for both men and women in general practice (rather than relying on self-reported weight and height) as this enables easier identification of weight problems and provision of advice. There is a lot of evidence that even brief advice from a primary care or other health professional is effective in stimulating weight loss in patients[267].

Advice from health professions has been shown to be effective in increasing physical activity in mid to older age inactive adults aged between 50 and 70 years[268] but only a minority of obese or overweight patients receive such advice[269]. Men are more likely to lose weight following advice and monitoring rather than as a result of group activities[270].

More women were referred to exercise referral schemes, and more attended initial consultations, but men were more likely than women to complete a 14-week course. Exercise referral schemes seem to be much more appealing and effective with some segments of the population than others namely middle-aged patients (40-69 years)[271].

As mentioned in the section on Diabetes, NICE guidance now advises policy makers and commissioners not to fund exercise referral schemes for people who are sedentary or inactive but otherwise apparently healthy. Policy makers and commissioners should only fund exercise referral schemes for people who are sedentary or inactive and have existing health conditions or other factors that put them at increased risk of ill health. All exercise referral schemes must use evidence-based behavioural change techniques[272]. There are examples of where they have been used for men with prostate cancer (i.e. an existing health condition)[273] but is unclear how many exercise referral schemes are being funded for people who already have this and other existing health conditions nationally and locally. The NICE guidance may have inadvertently halted the commissioning of exercise referral schemes because the Senate Council was not aware of any in Wessex. This change may have adversely impacted on men and the PHE data needs to be reviewed. There are good examples of such programmes for people with existing health conditions elsewhere in England[274].

A systematic review of the evidence shows that among adults, primary care delivered tailored weight loss programmes targeted at individuals from low-income groups and community-based behavioural weight loss interventions and community diet clubs appeared to have evidence of effectiveness,at least in the short term, among low-income women. The authors acknowledged that more research is needed to determine long term effectiveness, as well as more studies among male populations and of macro-level interventions[275].

GP practices identify patients at high risk of diabetes and refer them to the Healthier You: Diabetes Prevention Programme (NHS DPP) which was available in parts of the country in June 2016 and will continue to be rolled out until 2020. A person must have a blood test that shows non-diabetic hyperglycaemia within a pre-diabetic range in order to be accepted on to the programme. This is a behaviour change programme in accordance with NICE guidelines.

Early data show that half of the people who have taken the programme up are male[276] which is higher than previous weight-loss programmes. As the programme is rolled out, commissioners should check that the early uptake by men persists.

4.6.3 Proposed Services

The GP Five Year Forward View promoted models of enhanced primary care provision which may have the potential to reduce gender inequalities, such as more flexible and extended opening hours. The Department of Health have set an objective to recruit an extra 5,000 GPs by 2020. More than 3,000 GPs have entered training this year, 1,500 new medical school places are being made available by 2019 and NHSE plans to recruit an extra 2,000 overseas doctors in the next three years.

The Queen's Nursing Institute funded a number of projects in primary care[277] including projects:

- Offering an individualised service for men with obesity, aiming to attract them into the practice for screening, education and support in Dorset.
- To improve the uptake of men aged 40-65 attending NHS Health Checks, and respiratory, cardiovascular and diabetes chronic disease reviews in general practice in Lancashire.
- To provide high-quality foot care and general improvements to the health of homeless men.
- To tackle late presentation to general practice by men and the less favourable health outcomes they experience following diagnosis and to engage men with healthcare services at an earlier stage.

5 Conclusions/ Proposals

1) SUICIDE PREVENTION:

Commissioners and local authorities should base their suicide prevention strategies for adults, young people and children on the available evidence. There is a need for male specific or male focused interventions alongside general strategies. There is evidence that non-traditional interventions which involve other agencies working alongside the NHS are more effective in promoting good mental health and wellbeing for men and boys. Commissioners and local authorities need to raise awareness by working with charities, leisure providers and sporting organisations to promote mental health and wellbeing and change attitudes, including examples which would appeal to the LGBT community, young people and children. There are several initiatives nationally which have been mentioned in this report and have been evaluated: the use of sporting opportunities, Gay-Straight Alliances in schools, 'Up My Street' and the 'Zero Suicide' programme.

Given that boys aged 5-19 are twice as likely to kill themselves as girls, the opportunities for better communication across services particularly for children and young people would benefit boys and young men as well as girls and women. 42% of under-20 year olds who died by suicide were known to mental health, social care, local authority, youth justice or police services (29% were known to mental health services) and death by suicide is believed to be 30-40% more likely in young adults who self-harm, so better methods of risk assessment, monitoring and management of those at risk of suicide are needed across mental health, social care, local authority, youth justice or police services. There are opportunities for commissioners to explore and develop better predictive models that can be shared by multiple agencies and which are gender sensitive.

2) DISEASE PREVENTION

For a majority of people, Type 2 Diabetes is preventable by weight loss, healthy diet and exercise. Initial data show that as many men as women have been encouraged to enroll in the national behavioural change and weight loss programme for diabetes (Diabetes Prevention Programme or DPP). Commissioners should make sure that this pattern continues. Some CCGs in England have commissioned similar programmes for patients with other conditions such as cancer and stroke and these are likely to yield benefits for men. Exercise referral schemes are recommended by NICE for people who have existing health conditions or other factors which put them at increased risk of ill health and commissioners.

There are opportunities to improve the availability of cardiovascular interventions to women and to increase the number of men and women referred for cardiac rehabilitation. The higher uptake of these services by men does not appear to have translated into lower preventable mortality from cardiovascular disease than women and this needs to be further investigated.

In cancer, the evaluation of the Bowel Screening campaign has shown that it did not significantly increase the proportion of men returning their testing kit. Personally-delivered health promotion advice by phone on bowel cancer has been demonstrated to be the most effective method of

improving bowel screening uptake. Lung cancer campaigns such as the #Head High campaign may raise awareness of the disease amongst men but no evaluation is yet available.

Research is needed to determine if the new bowel cancer screening FIT test, the #Head High campaign, the introduction of 'bowel scope screening' and gender-specific programmes for the reduction of smoking and alcohol are successful in men and women.

There is some evidence that gender-specific programmes to reduce smoking and alcohol use are effective. A number of smoking cessation programmes in the UK specifically targeted at men have been mentioned in this report.

3) EARLY DIAGNOSIS:

Early diagnosis is a particular issue for cancer and cardiovascular services. In cancer, early diagnosis rates in bowel, and lung cancer in men and BME groups could be improved particularly in areas of deprivation. There are initiatives in place to achieve this in Wessex and early monitoring should indicate whether they have been effective.

Overall men have poorer outcomes from cardiovascular disease and lifestyle factors such as weight, diet and exercise also play a part here. If GP practices could provide healthy living advice and follow it up with monitoring, there is evidence that men are likely to respond. Men appear to benefit more from face to face health promotion sessions with a health professional than group activities.

Of concern is the much higher amputation rate for men with diabetes than women. Because of the relatively low numbers, commissioners and local authorities have an opportunity to develop a detailed understanding of why this is happening post-diagnosis of diabetes and what could be done about it.

Improving the cardiovascular treatment of women with diabetes should be a 'quick win' as they will already be known to the service. The public are less confident about performing CPR on women in the street and this could be rectified by national education programmes.

In mental health services, awareness raising is needed on the benefits of IAPT and antidepressants to men. At present Early Intervention in Psychosis (EIP) waiting times are publicly available but not by gender and there is no information on how many men and women are accessing the service so it is unclear whether EIS is able to provide equitable care for both men and women presenting for the first time with psychosis.

Initiatives are underway in Wessex to improve school-based counselling services to children and young people, but there is no centrally held information on how many schools have counselling services, how adequate they are and whether LGBT awareness projects or other projects to help children from deprived areas or from ethnic backgrounds with their health and wellbeing exist in schools.

4) ACCESS TO SERVICES

The evidence indicates that both men and women access primary care services in similar numbers but that 'men use primary care services ineffectively, contributing to unnecessarily poor health outcomes' and this is especially the case in disadvantaged groups. Barriers preventing men from accessing primary care should be addressed such as opening hours, appointment-booking systems, cost (particularly for dentistry) and a perception that many services (especially pharmacy) are primarily aimed at women.

Large scale outreach services are needed for men, delivered in workplaces and other settings, better integration of primary care professions, improvements to men's health literacy including symptom awareness, more men's health champions and role models, further research into men's use of primary care services and national health policies which take specific account of men (page 53).

Austerity appears to have had a greater negative impact on men's health than women's health. Commissioners and local Authorities should be asked how their policies improve access to services for men in the more deprived populations. Commissioners should undertake Equality Impact Assessments which are gender-sensitive. This is particularly important as GP practices merge or close or additional GPs are recruited to ensure that the numbers of GPs in deprived and wealthier areas are both adequate to meet the needs of all populations.

There have been (unsubstantiated) claims that the disparity in availability of GPs in wealthier and deprived CCGs is widening. However, in Wessex, deprived wards tend to sit alongside wealthier wards within CCGs so further analysis of smaller geographical areas such as neighbourhoods referred to as Lower Super Output Area (LSOA) would be necessary to substantiate this assertion. The Clinical Senate and Network hopes to take this work forward with Public Health England who have offered to undertake the analysis. Also, because the Quality Outcomes Framework (QOF) has resulted in men and women being contacted directly by the GP practice and offered a service and has improved the uptake of primary care services by men, if QOF is discontinued, then an Equality Impact Assessment should be undertaken to review the impact on men of whatever replaces it.

There is an opportunity for commissioners and local authorities to review how many of their residents (male and female) are referred for cardiovascular rehabilitation. Wesfit is a new pre-surgery service and the Cancer Alliance should monitor its uptake amongst men and women.

New initiatives such as psychological therapies via the Improving Access to Psychological Therapies (IAPT) programme have not achieved changes in the proportion of men accessing the service over time and there is an opportunity for them to be better promoted to men and/or adapted to better meet their needs. Completion rates for IAPT by men (58%) and women (60%) are similar and could be improved. Data on IAPT access are publicly available by gender by CCG so if combined with data on male/female antidepressants prescribed to men and women, commissioners and local authorities could easily monitor how may men and women are receiving these NICE recommended interventions.

Data on mainstream NHS services is difficult to find and to analyse to see if uptake differs for men and women. So, we were unable to assess whether there was inequality of access to elective care, urgent and emergency care, and other hospital and community services by gender in this report.

5) DATA

More data by gender should be collected, published and analysed by Public Health England and NHS Digital, commissioners, local authorities and providers. These data should show health status, health need, health outcome and uptake of health services by men, boys, women and girls in Wessex. In the health services where data are available by gender, we have seen that there are

sizeable gaps in date on the uptake of particular services by men and boys, women and girls. This may also be true of other health services where the data are not available which prevents commissioners from assessing whether there is equitable access to services. The data that is publicly available by gender is difficult to access and health informatics knowledge is required to extract it.

There are some examples in this report of mortality data which suggests inequity in access to services, such as the under 75 mortality rate per 100,000 population from cardiovascular diseases considered preventable (male) in Southampton which at 90.2 in 2014-2016 was statistically significant and higher than the England average and higher than the under 75 preventable (male) mortality rate from cardiovascular disease in Portsmouth. There are no health service data which can explain what contribution health care plays (such as the number of men and women with diabetes receiving cardiovascular interventions and drug therapy) so further exploration is needed into how this data could be made available. The Wessex Clinical Networks could provide a forum for this exploration.

When NICE recommended that general access to exercise referral schemes was stopped, Public Health England was asked to continue to collect data on the use of exercise referral schemes nationally. This data should be reviewed this to assess the impact on men that this change has had.

6) CALL TO ACTION

Commissioners, Local Authorities, Providers (including Secondary, Community and Primary Care), national bodies such as NHS England, NHS Improvement, NHS Digital, Public Health England, Academic Health Science Networks and the voluntary and charitable sector could work together better to take forward the initiatives outlined in this report. We are therefore asking organisations to comment on these recommendations and to sign up to deliver them on the campaign website, working with Wessex Clinical Senate and Networks on an emerging and ongoing work programme.

ACKNOWLEDGEMENTS

The need for this report was identified at the Senate Council 'Study Day' and our gratitude should first be directed at the charities from the Men and Boys Coalition and the football clubs and councils who attended and provided information.

Debbie Kennedy was the main author of this report, assisted by William R. Roche, Sally Rickard and Jo Wall. NHS Creative helped with design, graphics and suggested changes. Wessex Voices and Health Watch organisations provided valuable input as did Richard Jones, Denise Cope, Subha Muthalagu, Minesh Khashu, Matt Hayes, Nicola Robinson, Nicola Duffield, Nikki Osborne, Sue Newell, Carla Hodge-Degler and Caroline Cross.

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