healthwatch Barnet

Men's Health

Understanding Men's Perspectives on Health and Health Services

Banos Alexandrou

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Contents

Executive Summary

- Healthwatch Barnet, the statutory patient advocacy service for the borough of Barnet, undertook this project as part of our 2022/2023 programme of work.
- There have been growing calls for a men's health strategy, given the poor health outcomes for men in comparison to women across a range of health conditions and their low take up of primary care access.
- Healthwatch Barnet undertook qualitative and quantitative research with men living in Barnet between September 2022 and March 2023. The findings are presented in this report.
- We spoke to 50 men as part of the qualitative phase with the help of a range of community organisations. We then surveyed 250 men using an online survey from a leading research panel provider, which was a resource-led decision. Our recommendations are based on canvassing a robust representation of the Barnet population. There is more to do and one of our recommendations is to include further research as part of our mental health services review, to focus on excluded minority groups.
- Our findings support a number of key insights:
    - Men will claim for the most part that they are able to take good care of their health. But income and mental health distress make this harder.
    - For those with mental health issues, being too unwell to look after their health is far more prevalent. If they are living with physical (or neurological) health conditions, looking after their health is also harder than it is for those with no self-reporting health issues.
    - Exercise and diet are the dominant strategies for maintaining health, both physically and mentally. As men get older, they are more engaged and perhaps have more time to attend to their physical and mental well-being.
    - There is however little evidence that men engage in therapy and counselling. More concerningly, those with mental health issues do not appear to be getting any support for them.
    - Pharmacists are the most trusted providers of health information. This suggests the increasing role of pharmacists in primary care is beneficial. However, all sources used are mostly trusted. GPs are still the key information provider for those with lower incomes. There may be some work to do on promoting pharmacists as providers of quality healthcare advice within areas of deprivation.
    - Most men will state they are able to access services for their mental and physical health. But those with mental health issues are disproportionately less likely to feel like this. There is clearly a disconnect between those identifying as having mental health issues (perhaps not an easy thing to admit) and the services available to/ used by them.
    - Worryingly, a significant proportion of men (particularly older men) were dissatisfied with their last encounter with the health service.
- We have provided a set of tactical recommendations flowing from this work, at the end of this document.

Introduction

Healthwatch Barnet

Healthwatch Barnet is the statutory patient advocacy service for residents of Barnet. The service is run by the local Deaf and Disabled People's Organisation (DDPO) Inclusion Barnet as part of its portfolio of community and peer services.

Healthwatch was set up by statute in 2013 with the following objectives:

- Gather views and understand the experiences of patients and the public.
- Make people's views known.
- Promote and support the involvement of patients and the public in the commissioning and provision of local care services and how they are scrutinised.
- Recommend investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC) when required.
- Provide advice and information (signposting) about access to services and support for making informed choices.

Patient and public research is a key element of Healthwatch Barnet's activity, which seeks to address the range of objectives of the Healthwatch service.

This report sets out our work on understanding the male perspective in relation to the health of Barnet residents. It was carried out through a programme of qualitative and quantitative research, including direct engagement with men across the borough.

The case for focusing on men's health

Around one in five men still die before the 'traditional' retirement age of 65: with cancer, suicide and cardiovascular disease being the biggest killers of working age men in the UK[1]. In 2020 men made up 70% of critical care cases with COVID-19 and account for 57% of all deaths[2]. This illustrates the prevalence of risk factors in COVID-19 outcomes in men, with higher incidences of relevant underlying health problems, such as hypertension, diabetes, and lung disease, increasing their vulnerability to the virus[3].

Data shows that men experience higher levels of many common conditions such as heart disease, diabetes and certain cancers [4]. They are also 26% more likely to have type 2 diabetes and 43% more likely to die from cancer[5].

It is fairly common knowledge that male life expectancy is below that of females. Life expectancy at birth in the UK in 2018 - 2020 was 79.0 years for males and 82.9 years for females, representing a fall of 7.0 weeks for men and almost no change for women (a slight increase of 0.5 weeks) from 2015 - 2017.

[1] Men's Health Forum, 'Levelling up men's health: the case for a men's health strategy', 2021.
[2] Public Health England, 'Disparities in the risk and outcomes of COVID-19', 2020
[3] Tharakan T, Khoo CC, Giwercam A et al. 'Are sex disparities in COVID-19 a predictable outcome of failing men's health provision?' Nature Reviews Urology, 2021.
[4] https://www.sciencedirect.com/science/article/pii/S1353829221001453
[5] *https://www.sciencedirect.com/science/article/pii/S1353829221001453*

Men are often considered to be a 'hard to reach' group in preventative healthcare[6]. Under-utilization by men of primary care services has been linked with the higher rates of male mortality, with men found to have less awareness than women of health-related risk factors and symptoms[7]. Indeed, over one third (36%) of male deaths are estimated to be 'preventable'; almost twice the rate of those among women (19%)[8].

Men are 32% less likely to visit the GP[9], with 75% putting off going to the doctor even when showing signs of illness[10]. A 2020 study also shows that they are less likely than women to attend an NHS Health Check[11], which are designed to detect early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia in adults aged 40 to 74[12]. This trend in gendered attitudes towards seeking healthcare is also apparent in mental health services. For example, men represent only 34% of patients referred to IAPT[13].

What causes these outcomes is not explained by biology, such as a tendency to develop heart disease at an earlier age, but by a complex mix of social and identity factors. It is claimed that there is a 'playbook' for boys and men where risk taking is encouraged, and admitting vulnerability and asking for help is stigmatised.[14]

The case for action is clear. The UK Government has signed up to the World Health Organisation (WHO) Europe's regional men's health strategy[15], and this is an important starting point but as yet there has not been a proper articulation of such a strategy in the UK or its devolved nations.

Encouraging men to access services requires a re-consideration of tone and a better understanding of the male perspective around health and wellbeing. This research undertaken by Healthwatch Barnet aims to identify and capture men's perceptions on these topics, so that we might begin the process of changing the status quo in Barnet, and perhaps even provide insight into how this could be approached across the UK.

As Peter Barker, Director of Global Action on Men's Health, stated in a comment piece for the British Journal of Nursing in January 2022: 'It's surely time for a men's health strategy in the UK.'[16]

[6] https://www.sciencedirect.com/science/article/pii/S1353829221001453
[7] https://www.sciencedirect.com/science/article/pii/S1353829221001453
[8] https://wchh.onlinelibrary.wiley.com/doi/epdf/10.1002/tre.842
[9] **https://www.menshealthforum.org.uk/sites/default/files/pdf/mens_health_strategy-case_for_change-final_draft-formatted_bibliography.pdf**
[10] *https://www.manual.co/health-centre/mental-health/mens-health-stats*
[11] https://bmjopen.bmj.com/content/10/11/e042963
[12] https://www.nhs.uk/conditions/nhs-health-check/
[13] **https://www.menshealthforum.org.uk/sites/default/files/pdf/mens_health_strategy-case_for_change-final_draft-formatted_bibliography.pdf**
[14] Ragonese C, Shand T, Barker G, Promundo-US, 'Masculine norms and men's health: making the connections', 2019.

[15] World Health Organisation Regional Office for Europe: 'Strategy on the health and well-being of men in the WHO European Region', 2018
[16] 'Focusing on men's health: it's time for a national strategy', Comment. British Journal of Nursing, Vol 31. No.1, Baker, Peter, 2022

The Picture in Barnet

Barnet is a relatively affluent London borough, being the 8th least deprived out of 33. It also has a higher-than-average male life expectancy when compared to the UK as a whole, with male life expectancy at 82.9 years and female at 86.0. As is often the case though, life expectancy varies greatly between different wards within Barnet, distinguished by the extent of deprivation in a particular area, for example, men in Burnt Oak have a life expectancy which is 8 years lower than those in Garden Suburb.[17]

The rate of suicide in Barnet has been higher in men than women since 2001 but has been decreasing significantly in recent years: from 14.3 (2015-17) to 9.7 per 100,000 (2017-2019). This is lower than the average across England (10.1 per 100,000) and is the 6th lowest rate in London. It is also broadly similar to all other North Central London boroughs, excluding Camden, with which Barnet shares mental health services.[18]

There has been some activity in the borough addressing the need to provide men with mental health support. Andy's Man Club, a suicide prevention charity, recently established its first London branch as part of Barnet's suicide prevention campaign. Barnet council is also working with industries which have the highest proportion of male employees, online and face to face, to support their mental health. It has been promoting the Stay Alive app and Zero Suicide Alliance online training and wants to encourage men to talk openly about their mental health problems, seek help, and where possible to support other men to do the same.[19]

NHS Health Checks are an important component in maintaining population health and, as with primary care services, it is women in Barnet who engage with them more often than men. This is the case across all age ranges. Women are slightly more likely to be invited to an NHS Health Check, as 56% of all individuals are invited. More worryingly, women comprise 61% of all NHS Health Checks carried out.

Aims of this research

It is hoped that this report goes some way to starting a serious conversation about men's health in Barnet by providing primary research evidence from a representative (as far as possible) sample of residents in the borough.

It is a broad-brush approach that attempts to understand male perspectives in the round and to explore access, trust and agency in terms of their use of health services for physical and mental healthcare.

This report concludes with some preliminary recommendations, but it is anticipated that the work will be used as a basis for stimulating and devising engagement and communication strategies for the borough of Barnet. These strategies will need to think specifically about men and the distinctions that arise between the needs of men and women in mental and physical health support.

[17] https://www.barnet.gov.uk/sites/default/files/2021-11/Barnet%20Joint%20Health%20and%20Wellbeing%20Strategy%202021%20to%202025%20-%20full%20document.pdf
[18] https://barnet.moderngov.co.uk/documents/s65855/Barnet%20Suicide%20Prevention%20Strategy%202021%20-%202025%20_cleared.pdf
[19] https://www.healthwatchbarnet.co.uk/news/2022-03-04/andy%E2%80%99s-man-club-comes-barnet

Method and Sample Characteristics

Methodology overview

The primary research fieldwork for this report was carried out between September 2022 and March 2023.

The methodology consisted of qualitative research using focus groups and in-depth interviews; quantitative research; and an online survey of Barnet residents in the form of a research panel, created by the leading panel provider in the UK.

Given the modest resources available to conduct this work we relied on local organisations to assist us in gathering men together for the focus groups and for the qualitative phase we focused as much as possible on men in the more socially deprived areas of the borough. Having said this, the quantitative phase draws on the broad male population in the borough and can be regarded as a robust representation of men across Barnet as a whole.

Qualitative Research

Over **50 individuals** took part in the qualitative research either through focus groups or in-depth interviews. **Appendix A** contains the Discussion/Interview Guides used and can be found at the end of this report.

The areas of enquiry were designed to encompass as many of an individual's health perspectives as possible and considered general perspectives on health, information and access to health services, as well as broader considerations of gender in the realm of male health.

We would like to thank and acknowledge the following organisations for their support in providing access to male respondents: Colindale Communities Trust, The Hive, Age UK and Groundwork Health Champions.

Breakdown of respondents by age and ethnicity:

	White British	Minority Ethnic
Under 50	**17**	**8**
Over 50	**18**	**7**

Quantitative Research

A robust sample of 250 male Barnet residents took part in the online survey. The survey covered a number of themes. Firstly, men were invited to answer a suite of attitudinal statements that sought to understand attitudes towards the maintenance, access and information needs around health, as well as look at the extent to which mental health and physical health were considered in parity with each other.

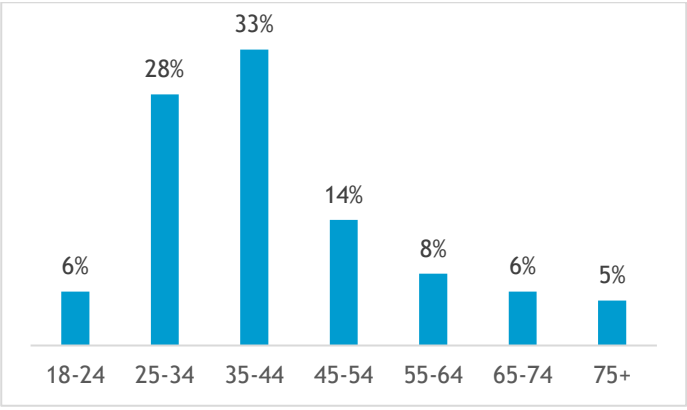
Other information was sought on use of health information, sources of information and the trust afforded to those, as well as some measures on awareness, usage and intended behaviours on NHS Health Checks.

We took great care to gather a range of demographic information: age, ethnicity, household income, presence of dependants and state of health (as self-reported). This was carried out in order to consider the findings across demographic characteristics that are universally understood to impact on health outcomes.

Of course, in some instances – particularly with regard to ethnicity - there were limitations on investigating more specifically the impact of different identities, given the low base from which to analyse. Our research followed the rule of good practice that where a base, (the number of people from which a percentage is drawn) is less than 30, comparisons should not be made across groups with much larger bases. This is because the variation (sampling error) in the measurement is higher as the sample size decreases.

The following figures and commentary provide a breakdown of our survey respondents' sample demographics and illustrates how the survey has broadly captured the overall population of Barnet men.

Fig.1 – Age Breakdown

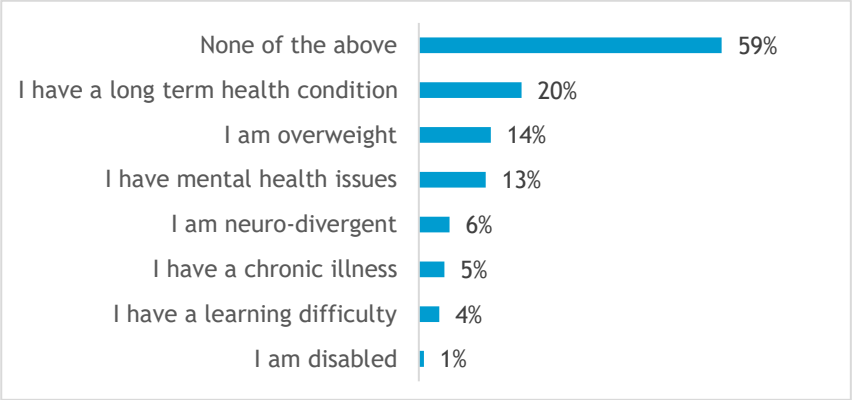


Base – Total Sample - 251

The age profile of the sample suggests it has captured the perspectives of men across all life-stages, and we use age as a key characteristic to consider the survey data by.

Three quarters of survey respondents were working full-time which suggests that this sample is skewed towards the more economically active and of course those who are digitally able – at least to complete an online survey.

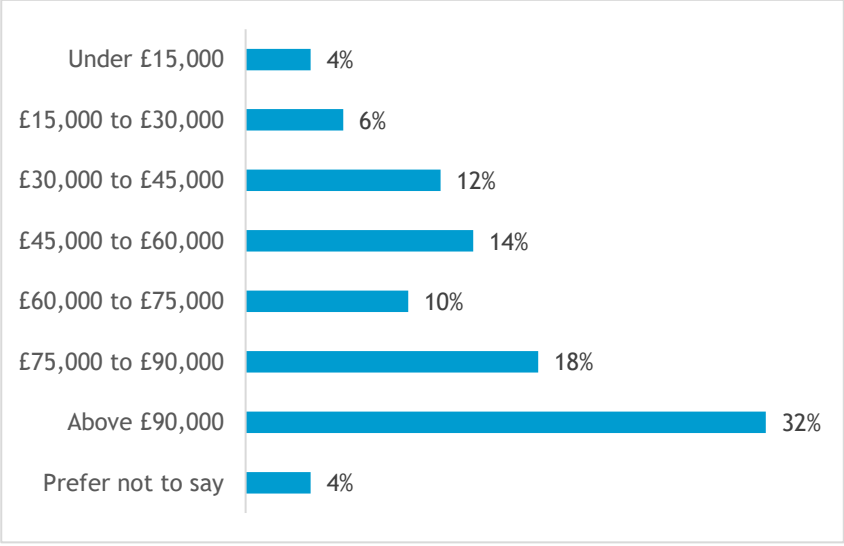
Fig 2. Self-reported health status – Q. Please tick any of the following that best describes your health situation:



Base – Total Sample – 251

Almost two thirds of respondents identified themselves as having no discernible health condition. And only 1% would describe themselves as 'disabled'. As a self-reported measure this may speak to a propensity for men to downplay their physical and mental health issues.

Fig 3. Household income – Q. What band is your overall household income in?



Base – Total Sample – 251

This table illustrates that survey respondents were drawn from across the income spectrum.

The responses suggest the men taking the survey live in relatively affluent circumstances.

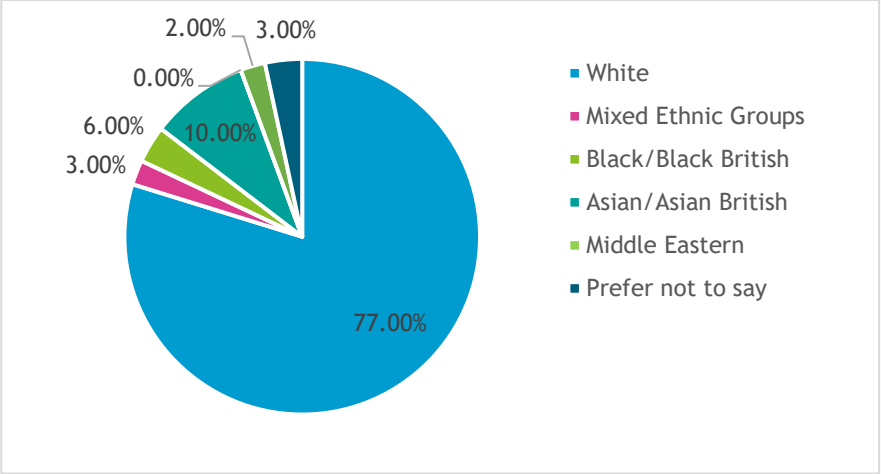
However, it is important to note that the London (and particularly Barnet) cost of living, not least in rental and mortgage commitments, is such that household incomes in the area are by no means affording luxurious lifestyles to the majority of Barnet men.

Also of note is the fact that just over a third (34%) of men in the sample indicated that they were primary carers for dependants under the age of 18 and a quarter indicated they had caring responsibilities for other adults. Such responsibilities often have an impact on an individual's

health and their relationship with health services. We examined survey results across these groups to discern these potential impacts.

Fig 4. Ethnicity – Q. Would you describe yourself as… [categories combined]

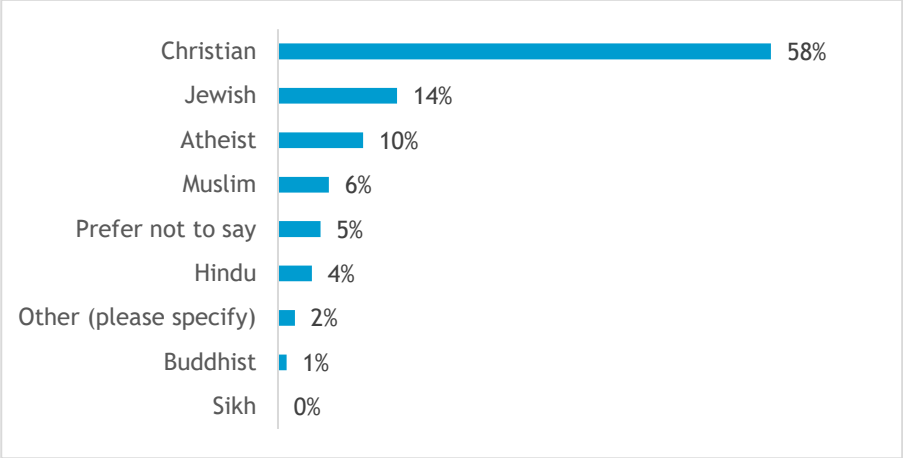
Base – Total Sample – 251



The ethnic mix in the survey is disproportionately white British given the known demographics in the borough. And middle eastern groups are not represented. This is due to the inherent bias in research panels which should be understood to exist. However, the approach provided the most effective way to canvass as broad a range of resident views as possible. Due to the fact it precludes a proper examination of ethnicity, it is recommended that ethnicity be the focus of additional research.

As with all research, it is extremely difficult to gather perspectives across all demographic groups using an online methodology. Resource constraints precluded a more targeted and face-to-face approach in recruiting survey members which, in itself, would have likely brought its own biases in relation to the majority population in Barnet. In this, as in most other, research it is crucial to be conscious of where biases may reside, and to treat data insights accordingly.

Fig 5. Religious beliefs – Q. Would you describe yourself as…



Base – Total sample – 251

As with Ethnic groups, this shows a likely skew towards Christian than would be present in the overall Barnet population. However, it does illustrate representation across the broad religious spectrum in the borough.

Methodology summary

The scope and reach of this research are robust and largely representative of the Barnet population. The qualitative research focus on more deprived areas adds a counterweight to the potential skew in the online survey (see discussion above) and the findings will be articulated drawing on both sources.

It may well be prudent to consider conducting research among specific male communities that have not been captured in this instance, as part of a potential men's health strategy for the borough.

Findings

1 What is Good or Bad Health

At the beginning of the survey, the respondents were asked the broad question of how they would describe good health. For the vast majority of respondents, good health simply meant the absence of a variety of physical (primarily) and, less often, mental, health issues.

More pro-actively a sizable minority pointed to regular exercise and diet as being precursors of good health.

"No aches or pains. No serious illnesses. Still mobile. Still sexually active" (male, 'English', 59) for one respondent sums up the general sentiment of many of the men who took part.

Some did venture that good health is bound up with a regime of regular health checks, and as such was also bound up with the provision of health services.

Bad health was simply the converse of good health in much of the open text provided on the question in the survey.

The qualitative research was able to look a little more closely at this question and sentiments expressed (among older respondents) focused on a state of health that enabled them to say '*useful and productive*'. But conversation ensuing from this broad enquiry led to a number of further insights from respondents.

One key discussion point was how men's health in general did not appear to be a priority for targeting people in the same way it is perceived for women. For one group of white males, drawn from deprived backgrounds, there was a sense that they are a demographic that don't receive the kind of interest or specific approaches that other demographics do, but it is worth pointing out that they did not suggest other demographics should not get the attention but that they felt they should get attention as well. There was also an appreciation among this group that risky behaviours (of which many still indulged) were a smoking gun, so to speak.

For older men there was a recognition that health awareness and maintenance was something that became a preoccupation as one got older, and therefore a relative thing. One respondent in a focus group recounted he had heard that someone at 80 could have the body of a 70-year-old and found this fact to be motivating.

As with the quantitative responses, those in the qualitative research were able to express more emphatically how exercise and diet are key to good health, or at least to maintaining a level of health as they get older that enables them to function and thrive.

Despite the promising evidence regarding male perspectives on mental health, in terms of it becoming less stigmatised, the open question regarding good health very much focused on the state of respondents' physical health. But as the qualitative and quantitative research describes below, the consideration of mental health when prompted became far more central to their perceptions of health than it had at the outset.

2 Taking care of health

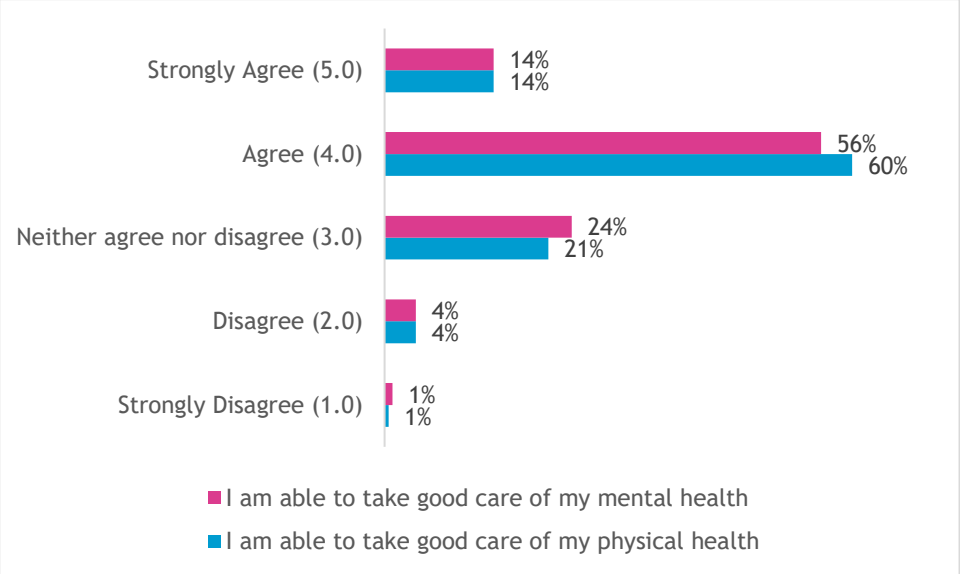
Survey respondents were asked the extent to which they agreed with attitudinal statements regarding their ability to look after their physical and mental health.

In examining these results and those to follow it is worth noting that public research using attitudinal statements will often suffer from 'positivity bias'. When asked for their opinion on such statements, respondents tend to agree more than disagree, particularly when the subject relates to their abilities, or something judged to be socially desirable. This survey is also subject to this bias. Much of the insight in this report, comes from distinctions in responses across demographic groups, rather than absolute levels of agreement or disagreement. This insight can be instructive, particularly in terms of the prevalence of those unable to agree or disagree.

It would be extremely useful to consider deploying this survey again using the same attitudinal statements, to see whether there is change, particularly if there are any communication and policy moves to target men's health over the coming months and years.

Fig. 6 - Ability to manage health - Q. Able to take good care of physical or mental health

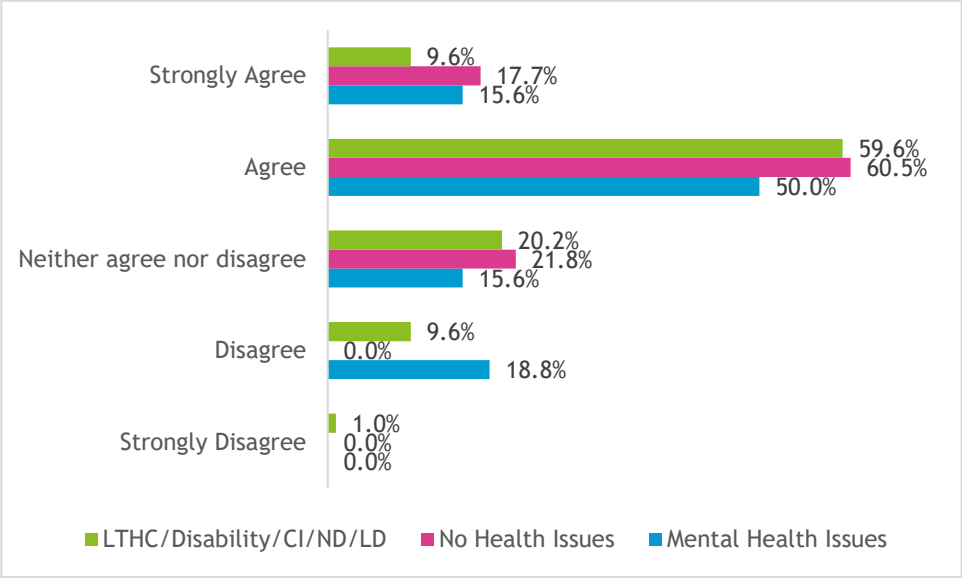
Base - Total Sample - 251



It appears that there is parity to the extent to which the men surveyed felt able to take good care of their physical and mental health. Nearly three quarters agreed that they are able to take good care of their physical health, with only 5% disagreeing. However, more than one in five men are unable to agree or disagree. Interpreting attitudinal statements is not always straightforward in that 'neither agree nor disagree' as an option can be ambiguous. It does indicate that there are a significant minority of men who feel unable to assess their health agency. One may suspect that they constitute a silent minority that may not be attending to their physical or mental health.

Income plays some part in men's assessment of whether they are able to look after physical and mental health, with those earning under £30,000 reporting higher levels of disagreement than other groups (11% and 15% respectively).

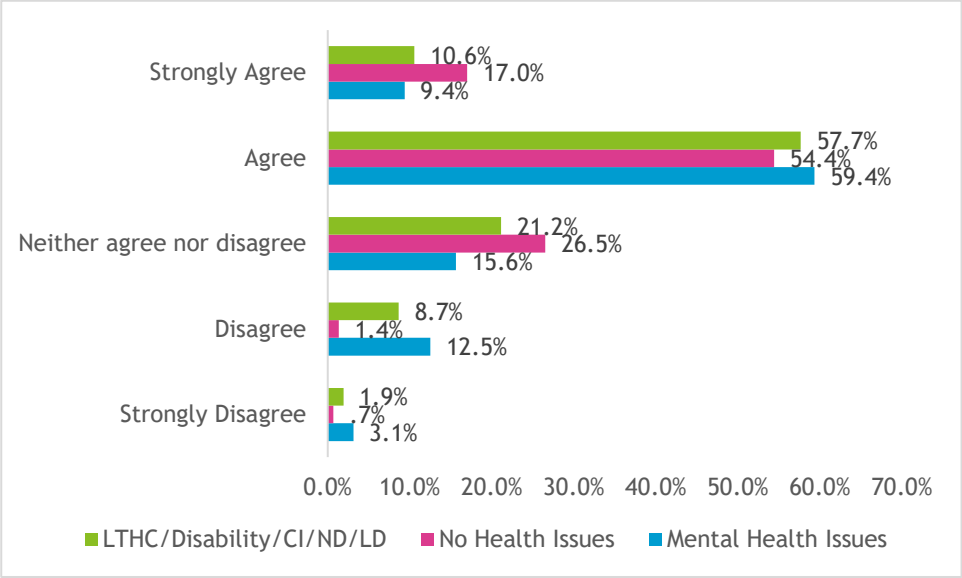
Fig. 7. Health issues and physical health – Q. I can take good care of my physical health – across self-reported health



Base – No Health Condition = 147, LTHC/Disability/Chronic Illness/ND/LD* = 107, Mental Health Issue = 32

*These categories have been amalgamated as splitting them out would make small and very uneven bases. The key thing is that the LTHC+ category denotes a group who claim a range of physical conditions – including neuro-divergence and learning difficulties. The incidence of these were very low and on balance including them into this group made sense.

Fig. 8. Health issues and mental health – Q. I can take good care of my mental health – across self-reported health



Base – No Health Condition = 147, LTHC/Disability/Chronic Illness/ND/LD* = 107, Mental Health Issue = 32

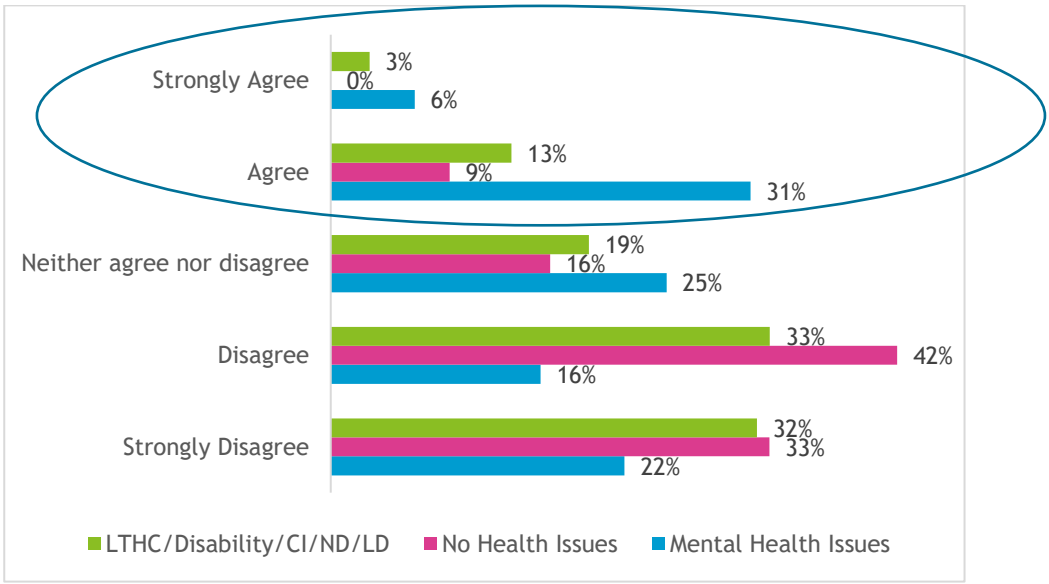
Many participants with mental and physical health issues agreed they are able to look after their physical and mental health but there was a greater propensity to disagree if the individual reports either health status. It was also more pronounced if the individual reported mental health issues. 19% of those reporting mental health issues disagreed that they were able to look after their physical health, and 16% of them disagreed that they were able to look after their mental health.

It is clear that both mental and physical health impact on an individual's agency in looking after their health. Taking into account positivity bias and that a further 1 in 5 who have mental or physical health issues were unable to agree or disagree, a sizable minority of more vulnerable men are unlikely to have agency in their well-being.

In the qualitative work it was clear that taking care of oneself wasn't always within someone's capability. Though we carried out one research session with members of the Hive Walking Football club, where the men were engaging in an event designed to improve physical as well as mental wellbeing. Certainly, within that group the activity was part of taking care of their health and was enthusiastically discussed.

We also explored attitudes towards having the time and money to look after health. Over two thirds (67%) of respondents disagreed with the statement that they didn't have time to look after their health, but 12% agreed this was the case. A similar response was received to the statement suggesting they didn't have the money to look after their health, with15% agreeing this was the case. Interestingly, this figure was fairly even across income groups, indicating that people were comparing different circumstances – e.g., for the more affluent, being unable to afford to look after their health may mean an inability to pay for private care, whereas for those on lower incomes, private healthcare may not be an option anyway. Allowing for these factors and positivity bias, the results suggest time and money is an issue for at least 1 in 8 men in the borough.

Fig. 9. Impact of health issues – Q. I am too unwell to look after my health – by self-reported health

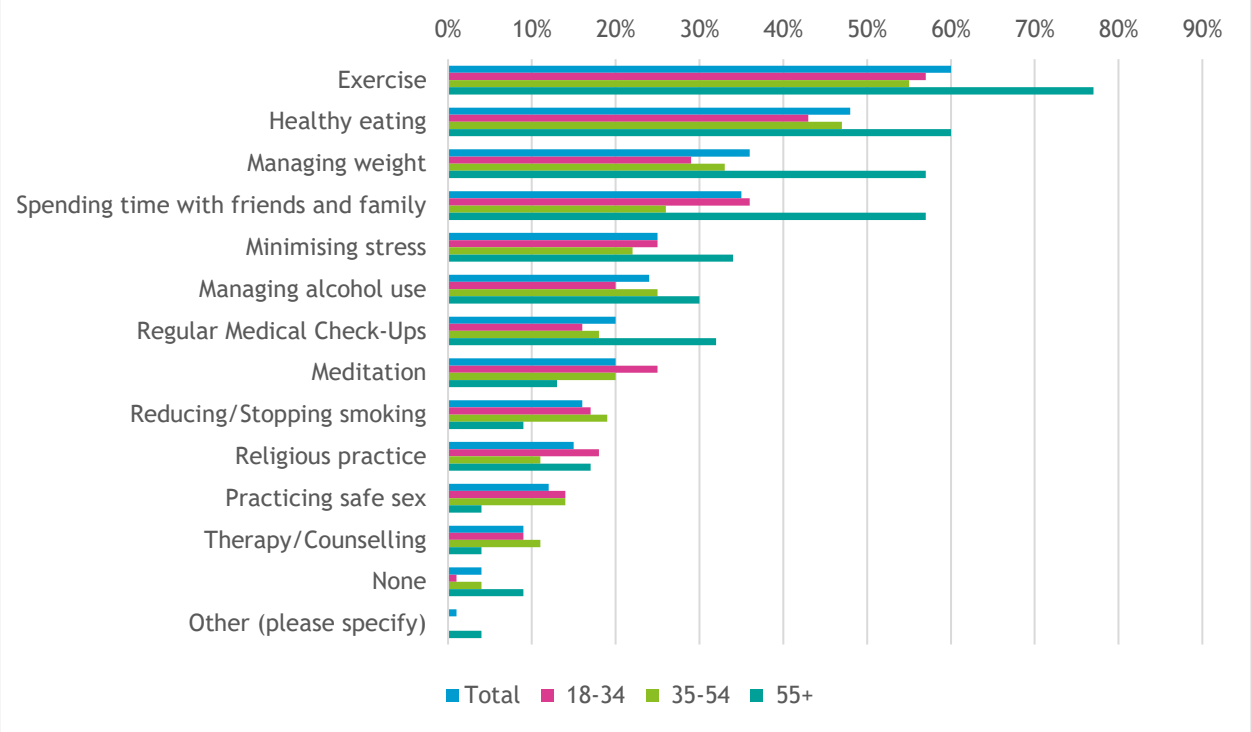


Base – No Health Condition = 147, LTHC/Disability/Chronic Illness/ND/LD* = 107, Mental Health Issue = 32

Over a third (36%) of those reporting a mental health issue feel too unwell to be able to look after their health. Whilst those with other physical (and neurological) conditions and those claiming no conditions do not feel as incapable. Clearly, mental health is a significant barrier for many to their ability to take good care of themselves.

We also asked respondents to indicate what behaviours they engage with in order to improve or maintain their physical and mental health.

Fig. 10. Positive behaviours – Q. Which of the following things do you currently do in order to look after your mental or physical health? (By Age).



Base Total – 251, 18-34 = 87, 35-54 = 117, 55+ = 47

Responses showed that the older the respondent is, the more likely they are to engage in specific health improvement or maintenance activity. The levels of exercise across the sample are promising, though we are unable to understand from this survey the nature of that exercise. Healthy eating occupied the second most common behaviour and certain activities seemed to attract certain age groups more than others e.g., meditation among younger respondents was more pronounced as was stopping smoking, safe sex and minimising alcohol use.

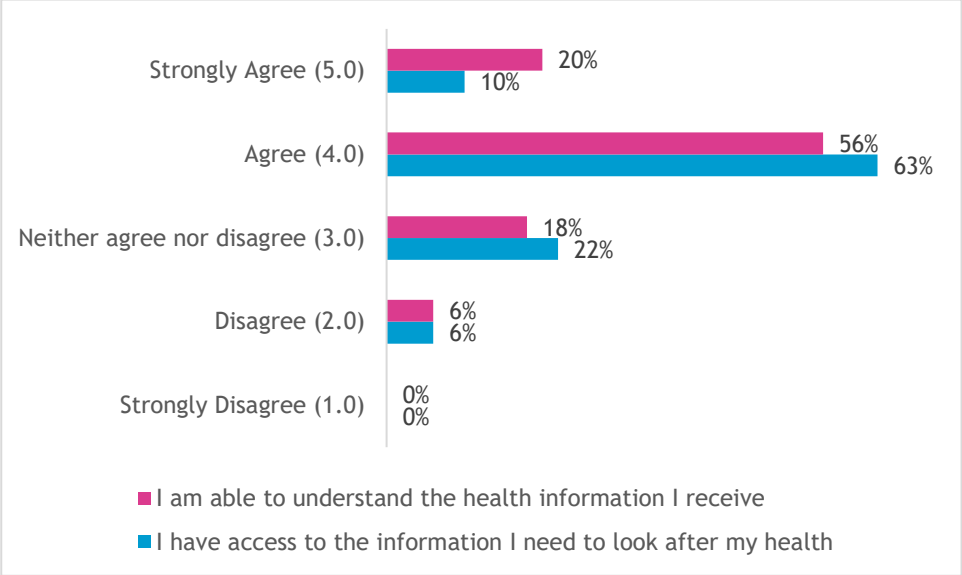
However, this does not indicate whether or not there is a need for greater activity, for example in terms of exercising, minimising weight gain, alcohol use or smoking cessation. It does suggest that there is a clear consciousness around exercise and diet though, at the very least.

Given the impact of mental health on the ability to look after one's overall health, it is hoped that those indicating a mental health issue were engaged in therapy or counselling of some description. However only 16% of this group claimed to engage in these services. This is compared to 10% for those claiming no health issues. This data could point to a lack of affordable mental health services for those in need of them.

3 Information: Use and Trust

Respondents considered attitudinal statements regarding access to and ability to understand, the information they receive.

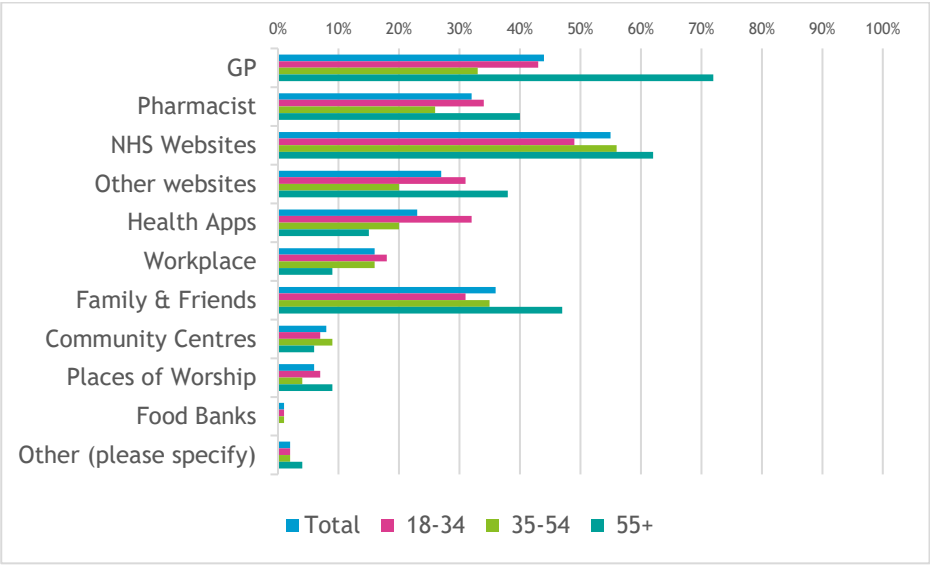
Fig 11. Access to and ability to understand information.



It would appear that men across all key demographics feel largely able to access the information they need and understand the information that they access. However, there is some indication that understanding information improves with age, with the youngest cohort indicating the highest level of disagreement at 8% compared to <1% of over 55-year-olds.

We also asked respondents where they get the information they need regarding their health.

Fig 12. Where do you currently get information on how to look after your health? (By Age).

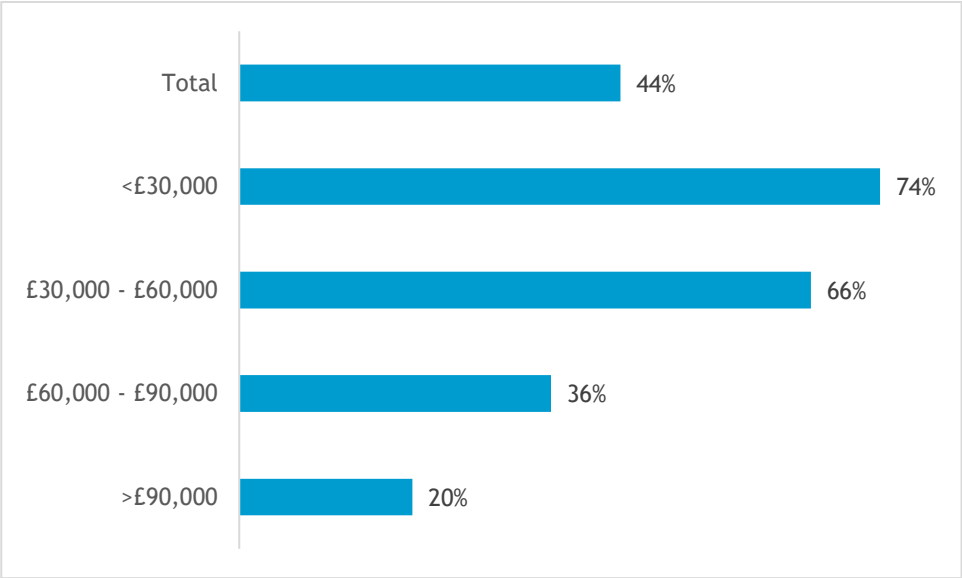


Base Total - 251, 18-34 = 87, 35-54 = 117, 55+ = 47

Fig. 12 suggests there is a higher reliance on GPs the older the respondent is, but it also indicates those over 55 are casting their net a lot wider than their younger counterparts in where they seek health information. Clearly the internet (particularly NHS websites), pharmacists, and friends and family all have a significant role to play in providing health information.

When we consider the channels of information across income bands, we find a stark correlation between lower income bands and reliance on the GP as a source of information (see Fig. 8).

Fig 13. GP as channel used for health information. (By income).

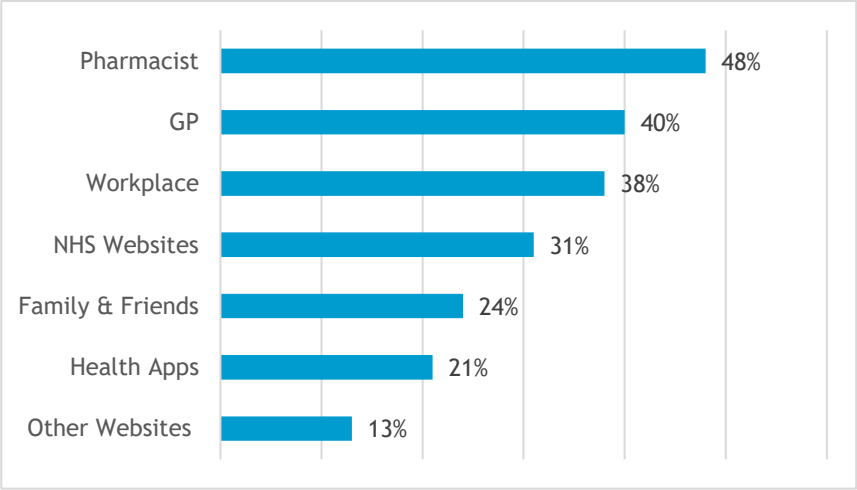


Interpreting this is not straightforward, however, it does suggest that agency could become more limited, the less affluent the participant was.

Respondents in the survey were then asked to rate the extent to which they trusted the various sources of information that they relied on.

Fig 14. Those scoring 9/10 regarding the extent to which they trust the sources of information. (By Age).

1 = Do not trust at all. 10 = Trust completely.

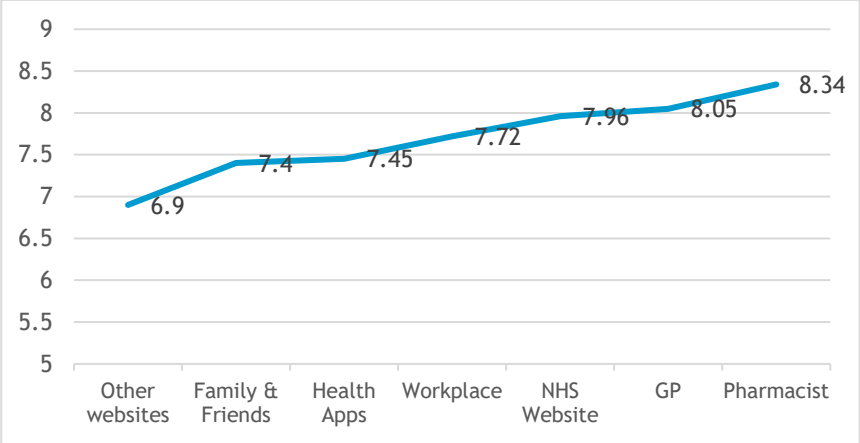


Base* - All Using Information: GP = 110, Pharmacist = 80, NHS Websites = 138, Other Websites = 68, Health Apps = 58, Workplace = 39, Family and Friends = 90 *Only reporting on sources of information where base of respondents scoring is over 30.

Pharmacists, for those that used them, are clearly a very trusted source of information. Those using GPs trusted them only slightly more than others who got information from the workplace.

The following figure provides the means of the score. This indicates that men in Barnet, on balance, trust the information they access regardless of the source. This makes sense as they have chosen to use them, but what is revealing is the distinction that pharmacists have in terms of the role that they play. They will no doubt play an increasingly significant role in the provision of primary care information and services.

Fig.15. Trust in sources used. Mean Scores.

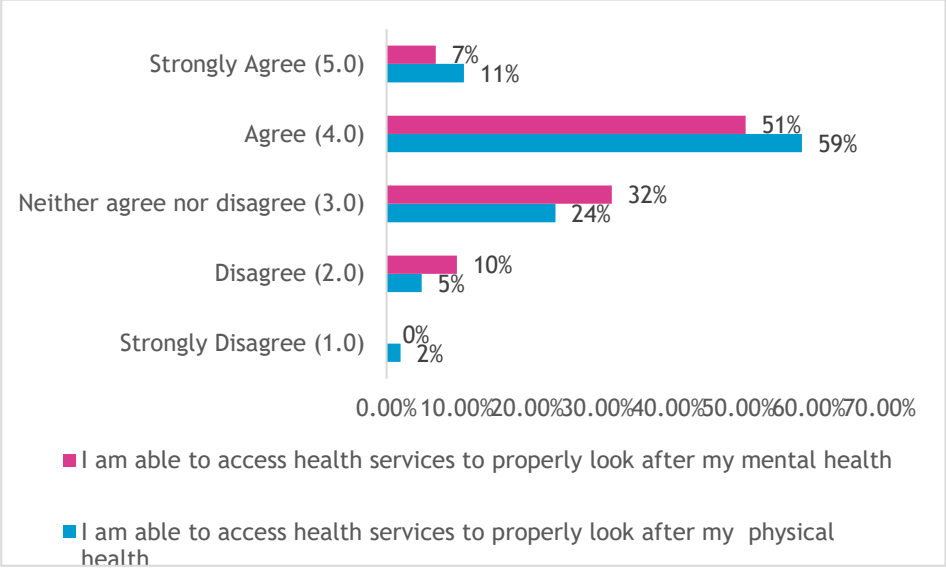


Base* - All Using Information: GP = 110, Pharmacist = 80, NHS Websites = 138, Other Websites = 68, Health Apps = 58, Workplace = 39, Family and Friends = 90. *Only reporting on sources of information where base of respondents scoring is over 30.

4 Accessing Services

We asked respondents to consider the extent to which they agreed or disagreed with statements regarding access to services, for both their physical and mental health.

Fig 16. Access to Services



Base - Total Sample = 251

It would appear that the majority of men feel able to access the services they think they need. Having said that, 1 in 10 disagreed with the statement in relation to physical health, which equates to many thousands of men in the Borough.

When we examine these attitudinal statements across self-reported health issues, nearly 31% disagreed with the statement in relation to mental health services, if they had reported having mental health issues themselves. This would support the earlier insight that there is a mental health need in men that is not being addressed.

There is a theme across the qualitative enquiry where men were not visiting GPs because they did not want to bother them or felt unable to have a proper conversation about their medical situation - '*I just want to have a talk about the statins, it just feels like you get more drugs but no-one explains why*'. Others simply considered the service to be a 'joke'.

There is evidence in our work, as is the case elsewhere, that for some men health matters are mediated and prompted by their spouse (largely female). For others, accessing health services was a motivation inspired by friends and family. An example of this was a widowed elderly individual at a community group, who felt able to divulge his concerns over potential dementia to the group and was encouraged to attend a memory clinic. What is worrying about this case is that despite having been recently widowed, over 80 and worried about his cognitive abilities he '*did not want to bother the GP*'.

The NHS Health Check

Just over a third (35%) of respondents were aware of the NHS Health Check. The question posed was as follows:

Q10. Have you heard of NHS Health Checks?

The NHS Health Check is a health check-up for adults in England aged 40 to 74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia.

Though not intended for men under 40, just under a third had heard of it (30%). This figure increased with age; 38% for those 35 - 54 and 36% for those over 55. This suggests a fairly low level of awareness, given that they were prompted on their awareness with a description.

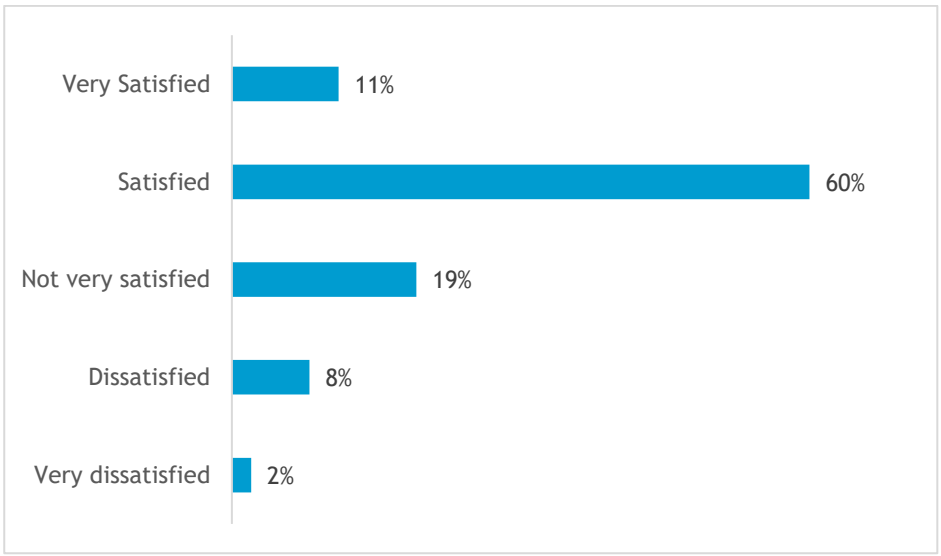
Only 16% of men recalled being invited and attending an NHS Health Check, and nearly a third of those were men between 18 and 34. Given the opportunity for confusion as to what constitutes an NHS Health Check it is likely that actual NHS Health Checks for the target group – certainly in this sample – are particularly low.

It will be worth examining NHS statistics on this in the borough of Barnet, and it is suggested that this element of our understanding can be further developed.

Satisfaction with Health Services

This survey was not intended to gather satisfaction with specific health services, given the multiplicity of encounters that men will have experienced with these and their interpretation of them. However, we did ask a broad question on whether individuals were satisfied with their last encounter (if it had been within the preceding 6 months) with health services.

Fig 17. How has your experience been accessing health services in the last 6 months?



Base All Having Experience within last 6 months: 199.

Most individuals stated that their last encounter with health services was satisfactory. However, nearly a third of respondents (29%) were not satisfied. When considering the population of Barnet this is a significant number of people, and we can with some confidence, generalise to the entire population.

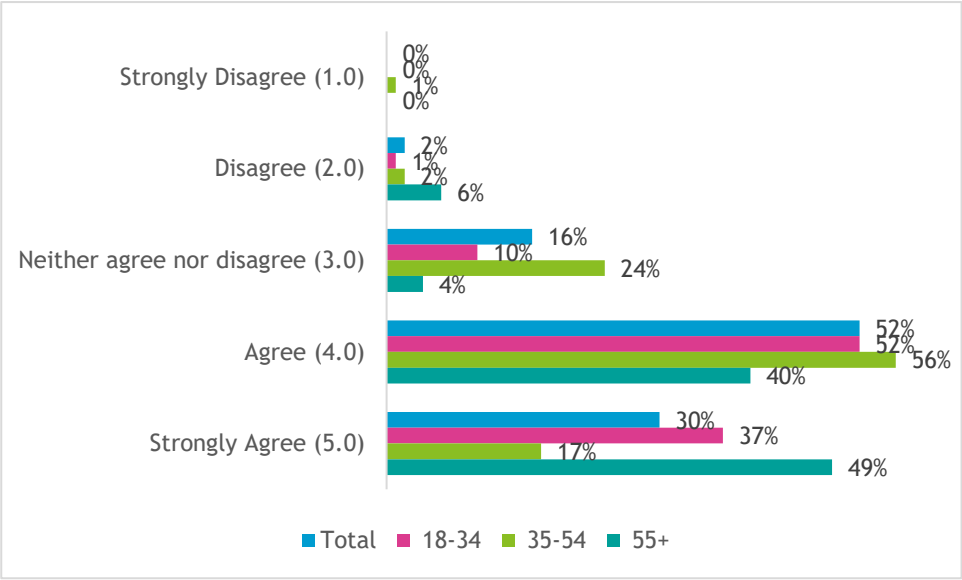
As well as this, nearly half (45%) of those over 55 who had accessed services in the last 6 months expressed some level of dissatisfaction with the service they received. Whilst we are unable to benchmark these levels and attribute them to specific services, it should be sober reading that older men feel so let down by health services.

The evidence suggests that there is something problematic about the experience of men with local health services that needs examining in greater detail. This is borne out in the qualitative research carried out, where time spent, continuity of care, and communication with Primary Care services in particular, were considered inherently problematic.

5 Mental Health

We asked respondents to consider the extent to which they agreed or disagreed with the statement *'My mental health is as important as my physical health'*.

Fig 18. My Mental Health is as important as my physical health. (By Age).

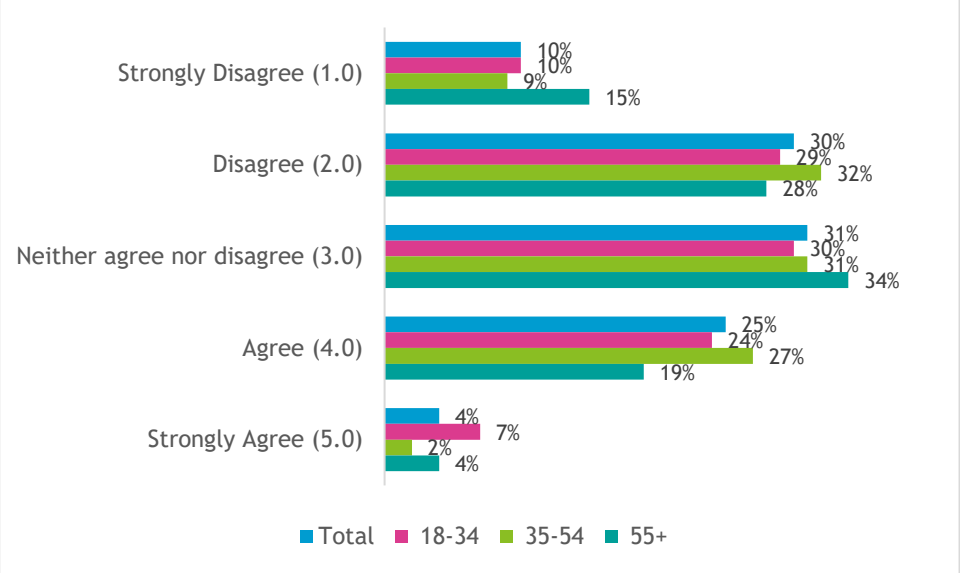


Base Total - 251, 18-34 = 87, 35-54 = 117, 55+ = 47

It is perhaps surprising to see that over 80% of men surveyed believed that mental and physical health were equally important. This may be due to a combination of generational attitude shifts and a more considered assessment of mental and physical balance as one gets older. On the other hand, there was less (though very tangible) acceptance of parity amongst those between 35 and 54.

Despite this, as was clear in the qualitative research, many men were able to talk openly about mental health. They were able to address it as something that could affect them and those they know and demonstrated an emerging openness to discussing depression and anxiety. However, when we examine how prepared men are to talk about their mental health with family and friends, we find a more worrying picture.

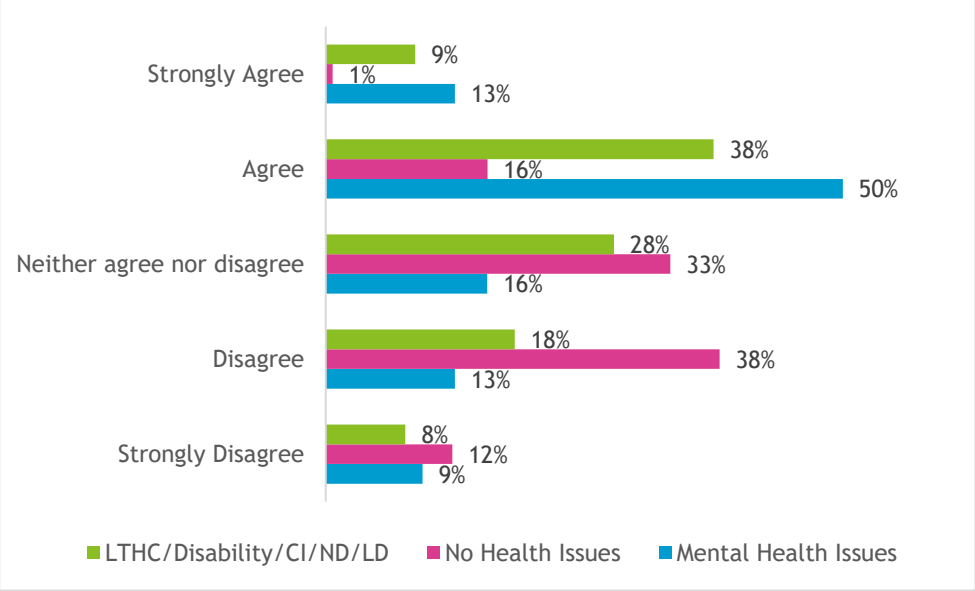
Fig. 19. I find it difficult to talk about my mental health with family and friends. (By Age).



Base Total - 251, 18-34 = 87, 35-54 = 117, 55+ = 47

Despite evidence that mental health is becoming less stigmatised amongst men, almost a third of respondents (29%) said it was something they don't feel able to share with family and friends. Responses were also similar across all age groups.

Fig. 20. I find it difficult to talk about my mental health with family and friends. (By self-reported health).



Base – No Health Condition = 147, LTHC/Disability/Chronic Illness/ND/LD* = 107, Mental Health Issue = 32

It is concerning, that almost two thirds (64%) of those with a mental health issue and nearly half (47%) of those with other conditions felt unable to discuss their mental health with family and friends. This is a further indication of where mental health needs do not appear to be satisfied for those with issues. Whilst there is movement on stigma in general, there perhaps remains a lack of opportunity or willingness for men to open up and seek help for mental distress from those around them.

What the qualitative research mediated by organisations with existing groups showed, was that in groups designed to support men (or at least include men in community activities), they do open up.

Conclusions

Healthwatch Barnet undertook this work to better understand the male perspective on health. As has been outlined in the introduction, male health outcomes are problematic and given that we are experiencing a cost-of-living crisis and serious NHS capacity issues, this is not likely to improve soon. The call is for a men's health strategy in recognition of the evidence that as a group they have poor health outcomes and patchy access to health services.

This work gathered a broad and largely representative view from men in the borough. Our qualitative work exposed us to a range of organisations that were able to connect us with men through the community activities they were providing. This research and engagement activity provided the insights for the development of the online survey, to best capture the broad brush of male attitudes and behaviours with regards to their health.

For the most part, men feel able to take care of their health. Exercising and a good diet are high in their consciousness as predictors of good or bad health, along with smoking cessation and the limiting of alcohol consumption. There is some evidence to suggest that men with lower incomes are not quite as confident about managing their physical and mental health as those in higher brackets.

A pattern that emerges throughout the data relates to those with self-reported mental or physical health issues. The number of men with mental health issues who felt unable to take good care of their health was significantly higher than those with no condition or indeed with a physical health issue. It would therefore be safe to conclude that having a mental health issue is a barrier to agency in maintaining wellbeing. This conclusion is reinforced by the extent to which those with mental health issues feel too unwell to look after their health.

Further examination of the behaviours of those with mental health issues shows that only a small proportion indicate access to therapy or counselling. This paints a worrying picture for the support available to men in mental distress.

For most men, finding and understanding information presented few problems but the sample may not have reflected groups for whom English is not a first language. This was another unfortunate bias in conducting an online survey, due to the modest resources available.

What was clear was that as men get older, they utilise more channels of information and feel better equipped to understand it. This perhaps does mitigate against some notions that older men are unable to access information via a multiplicity of channels. Also, with age comes better understanding.

What is particularly revealing in the survey is the extent to which pharmacists play a key role in providing information and that it is with his source that levels of trust are at their highest. Similar can be said for the extent to which workplace health information is trusted. This evidence, coupled with the interactions that men have in community spaces, highlights the importance of making opportunities available to men to meet others or to offer them somewhere to go where physical and mental health can be discussed openly.

Another point of interest is the extent to which income affects views on the GP as a key source of information. As incomes rise, the GP becomes less of a focus. Higher reliance and trust in a

GP by respondents on lower incomes may speak to a greater need for professional confirmation, as well as less confidence in finding and digesting information for themselves.

Most men feel they are able to access the services they need, in order to take care of their physical and mental health. However, the picture is very different for those with mental health issues where a significant proportion do not feel able to access services for either their physical or mental health.

Having said that, the proportion of men who are aware and have attended an NHS Health Check appears to be very low. It is possible that the NHS Health Check per se may not be distinguished from other medical or routine checks received. There may be some work to be done in promoting and targeting the NHS Health Check more effectively.

Whether men feel they are able to access health services or not, their experience of them suggests a significant level of dissatisfaction, particularly among older men. We are unable to disentangle which services specifically, but the figures suggest a general issue with health services as a whole.

Healthwatch Barnet and Mental Health Services

Healthwatch Barnet will be examining mental health services in the borough over the next year in collaboration with the Local Authority. The findings from this report suggest that support for men around mental health is patchy and whilst there is a growing de-stigmatisation of mental health amongst men, there is still much work to be done. This needs to focus around providing services men feel are relevant to them, as well as spaces and activities that enable them to come together and, with some prompting, have the conversations we have seen they are able to have.

Recommendations and/or next steps

Healthwatch Barnet would concur with the growing sentiment that a men's health strategy is long overdue. The likelihood of a men's health strategy being established at a national level is impossible to predict but we would offer this research as a catalyst for further investigation.

The findings also call for a more focused consideration of health outcomes of men at a public health level. It is particularly crucial to address how support is targeted for what is clearly a gap in provision, in order to address male mental health concerns.

Our tactical recommendations are as follows:

1. Promote this report at system, place and neighbourhood level.
2. Leverage the findings from this work to inform the approach to reviewing mental health services by Healthwatch Barnet in 2023/2024.
3. Consider promoting and sustaining men's clubs and associations that seek to draw men together in activity, or which socially focus on more deprived areas (Local Authority).
4. Harness the workplace as a vehicle for messaging. This is starting to happen in relation to mental health and the findings of this report reinforce how effective a development of that could be.
5. Address the gaps in provision, particularly in regard to groups which are traditionally excluded, through language or culture, and have not had their perspectives properly examined. It is likely that further qualitative work to serve recommendation 1 would focus on some of these groups.

Appendices

Appendix A

Discussion Guide – Men's Health

Healthwatch Barnet, September 2022

OBJECTIVES

- *Find out some initial key themes:*
  - *What participants associate with 'health'.*
  - *How much of a priority 'health' is to them.*
  - *The extent to which they engage with health services + why.*
  - *The extent to which this is related to gender.*

INTRODUCTION

- Welcome: introduce selves
- About the project: your experience of looking after your health, accessing health and support, any barriers, any things that would make it better.
- What will happen with what they tell us:
  - Results will inform our recommendations to health services/council.
  - Contextualise where this discussion/focus group sits in the project; may wish to speak with them 121 in the future for a more detailed conversation if they are interested – will ask for contact details at the end (voluntary basis).
- Guidelines/housekeeping:
  - Should last about an hour
  - Confidentiality
  - Understand health can be a very personal issue – no pressure to share anything they don't want to
  - Ask for consent to make notes.
- Opening question: names, circumstances and icebreaker

QUESTIONSS

Personal priorities:

- How much do you talk about your health/whether anyone has ever asked you anything like this before?
- 'Health' can mean different things to different people. How would you define 'looking after your health' for you?
- Is looking after your health important to you?
- What are some things you do because you think they contribute to your health?
- Are there any things that are difficult for you to look after your health?
- Question about perceptions of men and health (extent to which it's a gendered issue)?

Access to information

- Where do you get information on how to look after your health?
- What kind of information do you access?
- Do you feel the health information available for men is easy to understand?
- What health information would you find useful to help look after your health?
- Where would you prefer to receive information about looking after your health?

Experience of accessing services

- Have you accessed, or tried to access, any health services in the last 12 months? How was that experience for you?

Health Checks

- Have you heard of NHS Health Checks? Where?
- Have you been invited to have an NHS Health Check in the last 12 months? Did you attend? Was it helpful? Would you go again?
- What would encourage you to attend an NHS Health Check?
- Where would you find it most convenient to have a Health Check?

CONCLUDING

- Summarise key points and thank everyone for coming.
- Reiterate what will happen with the information:
    - Ask for contact details for interviews (optional).
    - Offer to share final report.
- Ask about other people/groups we could speak with?

Appendix B

Survey Questionnaire

Thank you for taking the time to complete this survey by Healthwatch Barnet. We are an independent health and social care patient advocacy organisation serving Barnet.

In this survey we would like to ask some questions that may be perceived as sensitive, being related to health, gender identity, religion, ethnicity, sexual orientation. Providing information in response to these questions is entirely voluntary and you may withdraw your consent at any time. The answers that you provide will be used only for market research analysis purposes.

Do you consent to the collection of this information?

1. Yes, I consent [CONTINUE]

2. No, I do not consent [SCREEN OUT]

OPTION 1 [CLIENT HAS GDPR COMPLIANT PRIVACY POLICY]:

For more information on how your information will be processed and protected, please review Inclusion Barnet's (the organisation that runs Healthwatch Barnet) privacy policy here: https://www.inclusionbarnet.org.uk/privacy-policy/

This survey is about men's attitudes and experiences about health and health services. We will also ask you some details about your own health situation to provide important context for the information.

All responses will remain anonymous.

Q1 How would you describe 'good' health?

Please write in_____

Q2 And, how would you describe 'bad' health?

Please write in_____

Q3 To what extent do you agree or disagree with the following statements about your health?

Strongly Disagree	1
Disagree	2
Neither agree nor disagree	3

Agree	4
Strongly Agree	5

ROTATE STATEMENTS

A I am able to take good care of my physical health.

B I am able to take good care of my mental health.

C I have access to the information I need to look after my health.

D I am able to understand the health information I receive.

E My mental health is as important as my physical health.

F I am able to access health services to properly look after my physical health.

G I am able to access health services to properly look after my mental health.

H I know what health services are available to me in my local area.

I I don't have the time to look after my health.

J I don't have the money to look after my health.

K I am too unwell to look after my health.

L I find it difficult talking about my mental health with friends and family.

M I am supported in my overall health by my community (this could be a community centre, sports centre, a place of worship or your local pub).

N I find it difficult talking about my physical health with friends and family.

For all statements where respondent 'agrees' or 'disagrees', show text box to appear on the same screen to the side/bottom for any supporting comments -

Q3a Could you very briefly explain why you (Q3 response +'d') to that statement?

Write In_____

INFORMATION

Q4 Where do you currently get information from on how to look after your health?

Q5 Which sources of information do you most prefer?

For all checked at Q4 or Q5 ask Q6(x)

Q6(x) To what extent do you trust the information you receive from 'insert response code from Q4/5':

	Q4	Q5	Q6		
			1 Do not trust at all		10 Trust completely
GP	1	1	1	Slider	10
Pharmacist	2	2	etc…		
NHS Websites	3	3			
Other Websites		4	4		
Health Apps	5	5			
Workplace	6	6			
Family & Friends	7	7			
Community Centres	8	8			
Places of Worship	9	8			
Food Banks	10	10			
Other (please write in)	11	11			

Q6 Which of the following areas of health information would you currently find most useful in helping you look after your health?

Rotate Responses

Mental Health	1
Addiction	2
Diabetes	3
Heart Health/Stroke	4
Respiratory Health/COPD	5
Dementia or Alzheimer's	6
Physical Exercise	7
Cancer	8
Sexual Health	9
Diet	10

Erectile Dysfunction	11
Rheumatism/Arthritis	12
Pain management	13
Other (Please write in)	14

Q7 Which of the following things do you currently do in order to look after your mental or physical health?

Please tick all that apply.

Rotate Responses

Regular Medical Check-Ups	1
Exercise	2
Meditation	3
Healthy eating	4
Minimising stress	5
Spending time with friends and family	6
Reducing/Stopping smoking	7
Managing alcohol use	8
Therapy/Counselling	9
Religious practice	10
Managing weight	11
Practicing safe sex	12
Other (Please write in)	_____

Q8 How has your experience been accessing health services in the last 6 months?

Very Satisfied	1
Satisfied	2
Not very satisfied	3
Dissatisfied	4
Very dissatisfied	5
I have not accessed health services in the last 6 months	6

Q9 Why do you say this?

Please write in_____

Q10 Have you heard of NHS Health Checks?

The NHS Health Check is a health check-up for adults in England aged 40 to 74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia.

Yes	1
No	2
Don't Know	3

IF Q10 = 1 ASK Q11 ELSE GO TO Q17

Q11 Where did you hear about NHS Health Checks

My GP	1
My Pharmacy	2
Workshop	3
Family & Friends	4
Advertisement	5
Local Authority	6
Can't recall	7
Other (Please Specify)_____	

Q12 Have you:

Been invited to an NHS Health Check and attended?	1
Been invited to an NHS Health Check and not attended?	2
Never been invited to an NHS Health Check ?	3
Don't Know.	4

IF Q12 = 1 ASK Q13 ELSE GO TO Q15

Q13 To what extent did you find the NHS Health Check helpful?

Very helpful	1
Quite helpful	2
Not very helpful	3
Very unhelpful	4
Unable to say/Don't Know	5

Q14 Would you go again if invited?

Yes, definitely	1
Maybe	2
Unlikely	3
Definitely not	4

IF Q12 = 2 ASK Q15 ELSE GO TO Q17

Q15 Why did you not attend your NHS Health Check?

Inconvenient time of appointment	1
Could not get time off work	2
Too worried about the state of my health	3
Too unwell to attend	4
Unable to get to the location	5
Did not think it was important	6
Other (Please Specify)	7

IF Q15 = 6 ASK Q16 ELSE GO TO Q17

Q16 Can you briefly explain why you did not think it was important?

Write in_____

Q17 Where would you find it **most** convenient to have an NHS Health Check?

Please tick all that apply:

GP practice	1
Community pharmacy	2
Community centre	3
Place of worship	4
Pubs/bars	5
Sports clubs	6
Other (Please Specify)_____	

YOUR HEALTH

Q18 Please tick any of the following that best describes your health situation.

I have a long-term health condition	1
I am disabled	2
I have mental health issues	3
I am neuro-divergent	4
I have a learning difficulty	5
I am overweight	6
I have a chronic illness	7
None of the above	8

DEMOGRAPHICS

In order for us to understand better men's experience of health it is important we know a little bit more about you and your circumstances. All responses are entirely anonymous and Healthwatch Barnet will not have access to any of your personal details, unless you agree to being contacted again for future research we may conduct – you will be able to do this at the end of the survey.

[Quote variable – so place wherever is convenient]

D1 What is your age?

Under 18	SCREEN OUT
18 – 24	1
25 – 34	2
35 – 44	3
45 – 54	4
55 – 64	5
65 – 74	6
75 +	7

D2 Are you:

Working full-time?	1
Working part-time?	2
Unemployed?	4
A full-time student?	5
Retired?	6
Prefer not to say.	7
Other (please write in____)	8

D3 How would you describe your gender?

Male	1
Non-Binary	2
Trans Male	3
Prefer not to say	4
Other (please specify)_____	

D4 What band is you overall household income in?

Under £15,000	1
£15,000 to £30,000	2
£30,000 to £45,000	3
£45,000 to £60,000	4
£60,000 to £75,000	5
£75,000 to £90,000	6
Above £90,000	7
Prefer not to say	8

D5 Do you have any dependants under the age of 18 that you are a primary carer for?

Yes	1
No	2

D6 Are you a carer for an adult friend or family member?

Yes	1
No	2

IF D6 = 1 ASK D7 ELSE GO TO D8

D7 Do you get carer's allowance for the care you provide?

Yes	1
No	2

D8 How would you describe your sexuality?

Straight	1
Gay	2
Bi-sexual	3
Something else (please specify)_____	
Prefer not to say	4

D9 How would you best describe your ethnic background?

WHITE – DROP DOWN	
English	1
Scottish	2
Northern Irish	3
Irish	4
Romanian	5
Hungarian	6
Greek	7
Greek Cypriot	8
Turkish	9
Turkish Cypriot	10
Kurdish	11
Traveller	12
Other	13
MIXED ETHNIC GROUPS – DROP DOWN	
White and Black Caribbean	14
White and Black African	15
White and Asian	16
Other mixed background	17
BLACK/BLACK BRITISH – DROP DOWN	
Somalian	18
Nigerian	19
Kenyan	20
Other African	21
Afro Caribbean	22
ASIAN/ASIAN BRITISH – DROP DOWN	
Indian	23
Pakistani	24

Bangladeshi	25
Chinese	26
Korean	27
Japanese	28
Other	29

MIDDLE EASTERN/MIDDLE EASTERN BRITISH – DROP DOWN

Iranian/Persian	30
Saudi Arabian	31
Other	32

KEEP ON PAGE WITH DROP DOWN BOXES

Prefer not to say	33

D10 Would you describe yourself as:

Christian	1
Jewish	2
Muslim	3
Hindu	4
Sikh	5
Buddhist	6
Spiritual	7
Atheist	8
Other (please specify)	9
Prefer not to say	10

Thank you for your responses to this survey.