

Health and Social Care Committee

Oral evidence: Men's Health, HC 139

Tuesday 5 March 2024

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Members present: Steve Brine (Chair); Paul Blomfield; Paul Bristow; Mrs Paulette Hamilton; Dr Caroline Johnson; Rachael Maskell; James Morris.

Questions 92 - 133

Witnesses

I: Ceri Durham, Chief Executive Officer, Social Action for Health; Dr Veena Raleigh, Senior Fellow, The King's Fund; and Dr Justin Varney, Director of Public Health, Birmingham City Council.

II: Dr Jeremy Davies, Head of Impact and Communications, Fatherhood Institute; Karla Capstick, Programme Director, Small Steps Big Changes; and Simon Yates, Director of Operations, Place2Be.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

Examination of witnesses

Witnesses: Ceri Durham, Dr Veena Raleigh and Dr Justin Varney.

Q92 **Chair:** Good morning. This is the Health and Social Care Select Committee, for the second day in a row. Yesterday, we were talking about pandemic preparedness, but today we are talking about men's health, as part of our ongoing inquiry into that subject. This is the third evidence session of that inquiry and it is an opportunity for us and our guests to explore health inequalities between groups of men, as well as their health across the whole life course, which I am, I suppose, potentially halfway through, having just turned 50. Anyway, I digress.

We have two panels of guests, and the first is in place, primed and ready to go. Ceri Durham is the chief executive officer at Social Action for Health, Dr Veena Raleigh is a senior fellow at the King's Fund, and Dr Justin Varney is director of public health at Birmingham City Council. Nice to see you all; thank you very much for coming in. It is a cross-party Committee and we will whizz round the table. We will probably run the first panel until about 10.40 am and then change over, because we have health oral questions downstairs in the Chamber today.

Let me start with you, Dr Raleigh. Health inequalities was the thread that ran through pretty much all the submissions to our major prevention inquiry, another inquiry that we are doing. Many of our inquiries overlap, and there are common threads to them. Which areas of health inequality do you think have the biggest impact on men's health, and on outcomes for men?

Dr Raleigh: Some of the areas that have the biggest impact are cardiovascular disease, and some cancers—lung cancer. I am talking about conditions that have a big impact both on the health of men and on inequalities in men's health. Overall, at the population level, CVD accounts for about 25% of the difference in life expectancy between the most and least deprived deciles.

It is important to remember that a very high proportion of those conditions are preventable. About 80% of CVD deaths are considered preventable. Lung cancer and COPD are associated with smoking. Of course, their impact is much greater in more deprived areas. CVD mortality rates are three times higher in the most deprived decile of areas, compared with the least deprived. There is a big impact on both men's health and inequalities in men's health. Although the impact is less in terms of the number of deaths, none the less in what we call deaths of despair, three quarters of suicides and about two thirds of drug misuse deaths are in men.

Q93 **Chair:** Dr Varney, may I ask you the same question? Which areas of health inequality among the guys have the biggest impact on our health outcomes?

Dr Varney: I agree very much with Dr Raleigh. The other thing to highlight to the Committee is that there are inequalities between men as



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a group. We talk about men as a homogeneous group, but particularly if we look at mental health, over 51% of young gay and bisexual men have self-harmed before reaching the age of 18. Prostate cancer occurs at a much younger age in the African and Caribbean population. There are differences within men as a homogeneous group, but I agree with the point that the majority of deaths from cardiovascular disease, and particularly metabolic conditions like diabetes, linked to obesity, could be prevented if we had much more upstream intervention and considered men's health across the life course in a much more holistic way.

Q94 Chair: How has that changed over time? In the last five, 10 or 20 years, how would you say that has developed?

Dr Varney: In general, and certainly in my part of the world in Birmingham, we are not going in the right direction. We have not seen the gains in life expectancy that more affluent parts of the country have. We are getting better at understanding the granularity of inequalities—looking at the differences between men and not just saying, “Well, this is all about poverty.” Poverty plays a really important part, and we must not ignore the fact that white British poor men do extremely badly when it comes to health outcomes, but looking beyond single identity strands and delving beyond that simple socioeconomic gap is probably where we are making some gains.

As a system we are doing piecemeal interventions—small projects that are funded in non-recurrent ways and do not get mainstreamed. That is a challenge for anyone working in the system at the moment. Whether you are in the public sector or the voluntary and community sector, you are lurching from one non-recurrent intervention to another.

Q95 Chair: Between you and Dr Raleigh—Dr Raleigh, you look at the global picture, through the King's Fund, and Dr Varney, you are dealing with it at the coalface as a DPH—what has gone wrong and, to put it in a positive context, what should the Committee recommend, as part of our men's health inquiry, to address what Justin says?

Dr Raleigh: Over the past 10 years, health inequality has been widening, and that has been amplified by the pandemic. We see increasingly that the deprivation and geographical divide is widening. In the last two or three years deaths from heart disease have been rising, consequent to covid. Where we have perhaps failed over the last 10 years is in taking our foot off the prevention pedal, and in terms of seriously targeting inequalities and their causes. I agree with Dr Varney that obesity, for example, is the new threat to health and inequalities, in the way that smoking was. Of course, smoking remains one of the biggest killers, with a 25% prevalence in the most deprived decile.

Q96 Chair: Why is the foot off the pedal? Is it want, or is it means?

Dr Raleigh: I think it is a bit of both. Budgets for public health have been cut significantly during the austerity period and the focus has been much more towards delivering care—dealing with waiting lists and so on—and that is pretty much where we are now. At the same time, to



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address inequalities, obviously healthcare and public health have a big role to play, but there are wider determinants. If we are serious about tackling the ever-widening inequalities, which are much bigger in this country than in many high-income countries, we need a cross-Government strategy for tackling health inequalities. We need to address child poverty and fuel poverty. Now, for both childhood and adulthood, population health is appalling; it is in a bad state in this country.

Q97 Chair: You have mentioned smoking twice. The smoking and vaping Bill will, we are led to believe, come forward at some point in all our futures. What would you say to those who say it is unnecessary and that it is nanny state to ban those things?

Dr Raleigh: With respect to both smoking and the obesity issue, and the nanny state argument, we need to be firefighting on those fronts, now. Trends in childhood and adult obesity are truly alarming. As for just saying that it is nanny-statism to intervene to influence food additives, fat, sugar, salt and so on—we really need to be doing this and tackling it hard. The reports on this are absolutely alarming. We are building in a generation that is going to have poor health.

Chair: Well, Dr Raleigh, you've cheered us up to kick off the session. Excellent—thank you for that. And they say I'm half-empty! Let's bring in James Morris, who is very half-full.

Q98 James Morris: We have heard in evidence and in previous sessions about barriers to men's access to healthcare. What do you think are some of the prime barriers to men's access to healthcare, Dr Varney?

Dr Varney: I am sure Ceri will want to come in on this. There are common barriers to access, particularly for men, because we build services around staff rather than around the people who use them. I trained as a GP before I specialised in public health. GP practices run until 6 pm or 7 pm. Extended hours go to 7.30 pm. Even if you can get an appointment, if you are working it is very hard to get to it. Hospital appointments are scheduled during Monday to Friday. Men are being asked to make a choice between the money that they earn and getting to an appointment.

I am very grateful to see the new taskforce on occupational health, established under Dame Carol Black. We have not addressed the issue of workplace health systematically or consistently in this country. In Birmingham, 99% of businesses are small or medium-sized enterprises. This is not about FTSE 500 occupational health, but about how we help corner shops, fast food takeaways—small employers—to prioritise the health of their employees. As with children in schools, if we do not get workplace health right, we will not be able to support men to get their health right.

James Morris: Ceri.

Ceri Durham: Good morning. I work at Social Action for Health, a community-based health charity in Tower Hamlets in east London, a



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borough where, as most people know, there are high levels of poverty and deprivation. We recently ran a community health day and most of the people who came were men who work as refuse collectors, market traders or similar, who were not able to get access to a GP during normal working hours. We sent three people, on different days, straight to A&E, because their blood pressure readings were so high. These were people who had absolutely no idea that their health was in that state. There is definitely something about access in terms of time and working hours.

Another thing that was key on that day, and makes it a good example, was language. Most of the men were Bangladeshi, which reflects our local population. Because of their level of written and spoken English, and level of confidence in using English to navigate very complicated systems at the GP, which now often require you to book online, they often do not access healthcare in that way. We had bilingual staff there, and they were able to explain the tests and their importance, and signpost people appropriately. That demonstrates some of the key factors for the Committee to be aware of.

Q99 James Morris: Do you think, practically speaking, that we might be able to address some of the access issues if employers take more responsibility for their employees' health, and what sort of practical recommendations would you make?

Dr Varney: There is a very strong evidence base that access to occupational health in employment settings has a good impact and is cost-effective. What we haven't cracked is how to make it accessible to small and medium-sized enterprise. There are lots of things you can do, but in essence you can't yoga your way out of bad line management. It is important to recognise that workplace health is not just about getting people physically active, eating healthily and access to smoking cessation at work. It is fundamentally about the environment in which you work. We have seen a significant increase in mental health-related distress and anxiety in the workplace as people juggle portfolio careers and all of that. But it is an area where there is an evidence base to pull on. Going back to the previous question, we have seen the appetite for work and health go up and down in terms of policy and commitment, and sustainability of investment.

Q100 James Morris: Dr Varney, you said that there are issues in different communities and that when we talk about inequality affecting men we are not talking about a homogeneous group. What are the distinctive challenges with groups who would feel reluctant about accessing health services? What can we do to get rid of those barriers?

Dr Varney: Certainly in Birmingham we have spent a lot of time working with communities and engaging directly with them. Particularly with you, Paulette, if I may say so, when you were there as a cabinet member, we worked with the community during the pandemic to engage them. That has to be the first step. On the other side, we have to work with healthcare professionals so that they recognise the inequality and can



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talk in ways that people understand, and can connect with those communities.

The final element is in policy: we have to talk about it. Disabled men experience higher rates of domestic abuse than non-disabled women. That has been evident for over a decade, yet we do not see it reflected in a single bit of policy action. We need the triumvirate of working with communities, educating professionals and having a policy landscape that recognises that you cannot have a homogenised approach to inequality.

Ceri Durham: I want to pick up on that in terms of funding. I know that it is a factor that community-based organisations like mine go on about, but I had discussions this morning with Dr Varney and Dr Raleigh, and we know from covid and other interventions that the community-based approach—working with communities—works, but at the moment the funding is so sporadic that you cannot plan any long-term community interventions. That came up with the health day that I mentioned: “Can you do it next month?” We can do that, but if we want sustainable interventions that actually meet the communities that need them, funding needs to be looked at in a sustainable and long-term way.

Q101 **James Morris:** Dr Raleigh, do you have anything to add?

Dr Raleigh: I would highlight Dr Varney’s point about the heterogeneity of different groups. We assume that all ethnic minorities have a similar profile. They don’t. They are very diverse and the differences between different minority groups are often greater than their differences relative to white British. If you look at socioeconomic differences, the Indians and Chinese are now doing relatively well, even compared with the white British, on some parameters. At the other end are very deprived communities—black, Pakistani and Bangladeshi. I agree that there is a lot to be learned from the covid pandemic—how you brought reluctant groups forward to get the covid vac, for example—about how you induce behaviour change in communities. The same approaches can be used for public health messaging. One other thing is the gender difference. Of course, women very often go to see the GP because they have children, and men won’t do that.

Q102 **Rachael Maskell:** Thank you ever so much. We have known about the inequalities that exist for a substantial time—I think back to the Marmot report; it is over 14 years since its publication—yet we still seem to be in a bind around addressing them. I want to start by asking how we improve the literacy and understanding that are required. I am particularly thinking about making policy around this, not just across the health system and with health professionals, but with the public and also, for instance, employers.

Dr Varney: It is important when we talk about health literacy to unpack what it is. The experience that we had, particularly in Birmingham through the pandemic, was that we assumed a level of basic biology understanding, up to primary school level, but when we talked about vaccines we quickly realised that people did not understand what their



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immune system was. So there is a kind of health education: “What is your body, and how does it work?” Then there is: “Can I navigate the health service and understand what a GP or pharmacy does?” That is how the NHS talks about health literacy. Then, when you sit in front of a healthcare professional, how do you describe your pain? As a doctor I am trained to recognise certain words. If it is crushing in your chest, that is your heart. If it is sharp and stabbing in your chest, that is infection or muscular; it is unlikely to be your heart.

Those three elements of health literacy need to be brought together and we need to do that through a systematic approach in education. It is as important as teaching people maths and English. It should be embedded from the start of life, through; and there should be retrofitting of it, through adult education, and help for healthcare professionals to understand that the person in front of them probably doesn’t have even a GCSE in biology, so that a lot of what you are saying just goes over their head. That is not fair and it is not patient-led healthcare, which is what we have committed to deliver.

Q103 Rachael Maskell: What policy interventions would you want to see in that arena?

Dr Raleigh: It is a very good question. You referred to the Marmot review, and before that there was the Black review, and so on. In this country, we have a long and very good track record. Compared with most high-income countries we have had a longer period of trying to tackle health inequalities. We know more about it than most countries do. That is why it is really sad to see that we are in the position we are.

In terms of policy interventions, we should be learning from what we have done before that has worked. One of the things that worked—this is not a party political point—is a cross-Government approach. That is what you need; that is the key Marmot message, and it remains. The inequalities start in childhood and infancy. You have to build from there.

We have very short organisational memories. We need to revisit some of what we have done that worked, and learn from that. We do not need more research. We have done it before and we need to be doing it, and much more aggressively. In the wake of covid not only are health inequalities widening, but with long covid and the impact on the long-term sick, and so on, we are going to see a widening chasm. That chasm is worse for men than for women. The gender difference in life expectancy is worse in deprived areas than in the more affluent, by one year. That is a lot. Many of those deaths are preventable.

Very quickly, as a last point, in terms of population health literacy we need to do much more awareness-raising. One in four adults has hypertension. ONS statistics of just two weeks ago show that one in five adults either is prediabetic or is at risk of being prediabetic. That is a really scary statistic because it is a lifelong killer. People need to be aware of that, but, again, there is research that shows that these conditions go undiagnosed in the least at-risk groups. The GP may see an



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overweight or older person and advise them, but if you are young and not seemingly in a high-risk group, you are not aware, especially if you are male. We need to be doing much more aggressive information and awareness-raising, at both the community level and the national level.

Q104 **Rachael Maskell:** Thank you. Ceri, you are out in the community; what would you add that you want to see in the policy arena?

Ceri Durham: In terms of policy I reflect what Dr Raleigh said about the Marmot principles. We are very familiar with the social determinants of health and I think we need to go back to that. It is about the life course, starting at the youngest age, and having universal services for everybody is the best way to get those messages out.

On mental health, in our recent survey of 1,000 minoritised ethnic men in east London, about 20% did not recognise that they were living with what would be medically described as mental health conditions—depression, anxiety, high levels of stress and so on. It was not even on the agenda, so they would never go and access services. There have to be community interventions, and social determinant factors. We need such a broadbrush approach. We need to keep going with the awareness-raising from the earliest possible stage.

Q105 **Paul Blomfield:** That segues neatly into my question, which is about raising awareness. You talked about the Bangladeshi community in Tower Hamlets and I obviously recognise the need for niche targeting there, but, between men and women across communities, are there particular issues that make men less or more susceptible to, or willing to engage with, awareness-raising?

Ceri Durham: Definitely, in our experience, there is very much a stigma. Being the strong man is very prevalent, particularly among some minoritised ethnic communities. It came out very strongly in the survey that men felt they had to be strong and be the provider. They did not want to go and ask for help. The social prescriber work that we did reflected the same thing. When women go to the GP, they are much more likely to be open to what is called social prescribing—non-medical interventions—than men, who, if they got as far as going to the GP, were much more likely to want a tablet, or something like that. That probably speaks to lots of things about our society and culture. Where I am, there is definitely a gender divide as to who is willing to access those other services.

Q106 **Paul Blomfield:** Are you able to respond to that in the awareness campaigns that you run, so that you recognise it? What has worked?

Ceri Durham: Absolutely. We try to respond as best we can. For example, we do a lot of our men's work in mosques. That is common for lots of men's groups in communities such as ours, where many men access the mosque. Initially we had trouble recruiting men to our health prevention courses. As soon as we did them in the mosque at times that were appropriate and fitted around people working in gig economy jobs, the uptake was suddenly fantastic. People were very engaged and there



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was a 100% retention rate. People were really grateful, but we obviously had to go there and make it language appropriate and culturally appropriate to ensure that accessibility.

Q107 Paul Blomfield: Justin, you talked about the heterogeneity of men and the fact that we should not see them as a single group. On the issue of how we get through to people so that they understand the health risks they face, how effective do you think awareness can be, and how do you think it could be developed for different groups, recognising their heterogeneity?

Dr Varney: It is important to say, when we talk about health awareness, that the evidence base about the impact of posters and leaflets is that it is pretty poor. When I talk about health awareness I am talking more about conversations, which are much more effective, using things like community radio, peer-to-peer advocacy, health champions and that kind of engagement. We have some great national campaigns. Things like Movember are brilliant at raising awareness. There is some disease-specific charity-led work on things like prostate cancer, and we have seen increasingly the large national charities starting to get more nuanced in the way they tailor their messages, in the same way that private commercial companies tailor to a target. It is not new; it is just applying commercial marketing to a different demographic in the context of trying to achieve behaviour change.

I think there is a fundamental difference, though, between men and women, in relation to their access and awareness. Because of the way society positions parenting, women tend to have much greater contact with public sector professionals, not just in health but in education. Each of those "making every contact count" moments can highlight something, such as noticing if someone is limping, or if they are in pain or distress. Men have far fewer of those because of the way in which we, societally, raise our children. We have to think about how we reach them, and whether it is through the mosque or, where people still have them, through working men's clubs or sports clubs. It is about finding vehicles to talk to men where they are, rather than expecting them to come to us. This is not about hard-to-reach communities. No community is hard to reach. It is about making the effort to go and find them, and talk to them in language they understand.

Q108 Paul Blomfield: What about Ceri's point that there is a sort of male self-image that is resistant to that sort of messaging? How do you deal with that?

Dr Varney: Over the last two to three decades we have seen significant social repositioning of men's body image and societal image, and that contributes to the narrative of invincibility. The caring aspect makes a difference. Women are often triggered to do something if it is impairing their childcare: "It is going to threaten my child if I'm not looking after my health." There is the idea that the carer needs to care for themselves first. That doesn't seem to work in quite the same way in relation to the narrative around men.



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We are seeing increasing numbers of eating disorders in men, which speaks to societal trends in social stigma and social imagery. We are only just starting to understand the impact of social media on self-harm, particularly on young people. Purely looking at my Instagram feed, if I believed what men did on my Instagram feed, I would be quite depressed about my own life. It creates a narrative that is unachievable. I think men still feel that more, or in a different way, because of the way our society is constructed.

Q109 Paul Blomfield: Dr Raleigh, you talked about the obesity crisis and, clearly, we are all aware of it. There are shocking figures on the number of obese children going into primary school compared with those coming out, so we are clearly not tackling it. What is the balance between awareness and other interventions? We knew, for example, that cigarettes were toxic to our health for many years. We ran public awareness campaigns and big tobacco ran counter-campaigns, but it wasn't until we actually intervened that we began to see real behavioural change. What is the balance there?

Dr Raleigh: That is an interesting point, because a lot of the evidence shows that if you have information and awareness-raising campaigns about behaviour changes that are good for you and so on, the uptake is more in more affluent groups. The groups that most need to change their behaviours either do not get those messages or are not responsive to them, which is the reason for things like the ban on smoking in public places and the tax on cigarettes. The sugar tax reduced sugar consumption quite significantly.

The role of fiscal and regulatory means is a powerful lever. It goes back to the point about the nanny state. It is a very powerful lever and it has been shown to work, most graphically in the case of cigarettes. Those are some of the things we need to be doing. The risk factors tend to cluster in those groups of people who are most at risk of health inequalities. They will be the groups who smoke more and have bad diets, and have no green spaces to exercise in, even if they had the will to do so, or the energy left after a hard day's work.

Q110 Paul Blomfield: And you are saying that they are the least susceptible to awareness campaigns.

Dr Raleigh: They are, yes, less receptive. It is your middle and upper-middle classes where, if you look at the uptake of jogging and gym membership and so on, there is a selective uptake and responsiveness. That is not to say that we shouldn't have them, but they are not a sufficient tool on their own. We need other means of reaching people. The power of commercial companies is immense, as we know from cigarettes.

Paul Blomfield: Thank you.

Chair: We have about 10 minutes left in this session. I will bring in Paulette and then Paul.

Q111 Mrs Hamilton: I have one quick point for you to answer, Ceri. What



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support do community groups need from Government to carry out their work helping men who are experiencing health inequalities? I know that funding is a major issue because Justin is my man—I'll say it—and we have this discussion all the time. If you take away the funding element of all of this, can you answer?

Ceri Durham: It is very difficult to take away the funding but, yes, I will. It is about sustained commitment to that particular issue. As we have been talking about, not all men are the same and not all groups are the same. Working within the local context, it is identifying the men who need particular interventions, awareness or whatever, and then running the campaign or intervention sustainably over a long time, with joint commitment from local authorities and across Parliament and so on, at all levels. It has to be identifying the groups most at need and then targeting them.

Q112 **Mrs Hamilton:** Justin, I am going to move on to a subject that we have talked about quite a lot: integrated care boards. How do you believe, through a big system like Birmingham, that integrated care boards can help us to link not just with what is going on locally but with other parts of the health service, and others?

Dr Varney: Integrated care boards give us an opportunity to really think as a system. There are some real advantages to that. As long as there is stability for a period of time, so that we can allow them to mature enough to make strategic decisions, there will be huge gains.

It starts with the data. The first thing is that we have to start looking at the data we have within the system and report it in a transparent and accountable way. In our own ICS, we have started to create dashboards that are publicly accessible, where you can cut cardiovascular disease by gender, for example. We haven't done that before. If you don't look at the data, to look at what the inequality is, you are not going to design your services in a way that meets the inequality, so the first step is ICSs and ICBs looking at their data in a way that actually goes beyond the population level.

The second thing is truly living up to the commitment to patient-centred care. The idea that we co-design patient services with the patients who use them has been around for decades, but if you don't know who your patients are, and you don't know who is not coming through the door, that is quite hard to do.

The ICBs give us huge opportunity if we are strategic in using the data. That is driving service design, which looks across the totality of a care pathway and looks at the way that different communities, and men from different communities, interact with that pathway. There are some emerging good signs of that, particularly in the mental health collaboratives. We are bringing the voluntary sector alongside NHS providers, alongside private providers and with primary, secondary and tertiary care all together. You start having a much more sophisticated conversation, rather than, "Please can you see this patient in your clinic,



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and then send them back to me and I'll send them somewhere else?" It is still very early days. They need time to mature and the space and the bandwidth to be able to develop that.

Q113 Mrs Hamilton: Finally, Dr Raleigh, what can be done nationally to help them, both locally and with local organisations, to make it more joined up? At the moment it seems very disjointed. Some systems are doing quite well, but some systems are struggling and really need to do better.

Dr Raleigh: We have talked about the constraints around funding. A lot of it comes back to that.

Q114 Mrs Hamilton: If you had the funding, do you feel that would sort out the problem?

Dr Raleigh: Not entirely. I think what you are talking about is also good practice. There is something about learning from areas that are making it work, whether it is at ICB level or working effectively with local community groups. There is something about learning from good quality and good practice examples and disseminating those more widely.

Mrs Hamilton: And for that you need the funding.

Dr Raleigh: Funding always helps.

Q115 Paul Bristow: Dr Varney, I was very taken by what you said about health literacy among the public. Of course, that doesn't just mean knowledge about one's own health. It means understanding the system and the NHS. I think you hit the nail on the head. There is a shockingly low understanding of access points in our NHS. That is not the public's fault. A lot of the time the old traditional models—the family doctor and all that sort of stuff—have gone with the population explosion, and all sorts of other factors.

Obviously, the entrance to the system can now be a pharmacy, A&E, 111 or the traditional GP model. To what extent are we looking at this the wrong way round? Rather than trying to re-educate the public about the points in the system where they can enter, shouldn't we be asking them about how they wish to access health services?

Dr Varney: Yes, absolutely. What we will see is a bit of cohort effect. We know that younger men are much happier to use digital booking systems. They are much more digitally fluent and digitally native. Expecting an 80-year-old to accommodate going online and navigating the NHS app to do their repeat prescription is not fair. How do we shift a system to be customer-focused, recognising that you cannot have a one size fits all? That is very hard to do at national level. At national level it is easier to have one size fits all. That is where I think the partnership between local government and the NHS, through the ICBs, is quite important.

What local government does really well is understand its local people. Therefore, you build that connection. I would say it because I am a director of public health. My bridge between—

Paul Bristow: You don't know Peterborough City Council very well.



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Dr Varney: One of the great privileges of having moved from the NHS to local government is that you start to be able to influence the wider determinates. You operate in a very different environment. It is an extremely different environment from being in the NHS, but both need to come together. Both need to work with patients and citizens and understand that citizens will always be there; they will be patients for bits of their life, but they won't describe themselves as patients for all of their life. Therefore, thinking about universal services that are accessible in many different ways is a better solution.

Q116 **Paul Bristow:** Dr Raleigh, do you have any comments on that? Very specifically, do you feel that the NHS is well equipped to do what has just been described? Can it reform and change the way it allows people to enter the system in the way Dr Varney said?

Dr Raleigh: To some extent the NHS is trying to do that, but perhaps not enough. Yes, it needs more of a commercial approach to selling the product, but there are good examples. The NHS health check is a good one. We should increase access to that. At my gym there was a sign-up saying that you could get your NHS health check done there. It is targeting adults in their prime, when they are at the greatest risk of developing chronic disease. You know what I am talking about?

Paul Bristow: I do, yes.

Dr Raleigh: Taking it out through avenues that are the natural places that men inhabit, and not necessarily the GP clinic, is one way of doing it. Through employers, occupationally, it should be standard employment practice to look after the health of your workforce.

Q117 **Paul Bristow:** How do we make individual pinch points like GP surgeries and pharmacies, which are often locally led, do this? For example, I feel very sorry for GPs in many ways because they are GPs, but we expect them in many ways to run mini businesses. Some do it brilliantly. Thistlemoor surgery in Peterborough is a brilliant example of how they reach out to their population, but others, quite frankly, are brilliant GPs but hopeless because they don't have that skillset. They want to cure the sick and see their patients. They do not necessarily want to run small, mini businesses. How do we change that?

Dr Raleigh: It is a very difficult call. Primary care—general practice—is under so much pressure now. Some of these things perhaps need to be organised through central and other routes rather than everything needing to go through a general practice. I don't think we can add a whole lot more there. In fact, with the NHS health check—having said what I did—if you diagnose more illness, it goes back to the GP. I think we need to think of imaginatively approaching, delivering and reaching people through other routes. Men do not like to make GP appointments.

Q118 **Paul Bristow:** Finally, Ceri, I was interested in what you said about mosques. Peterborough is a multicultural city. We have six main mosques in our city now. I think one of the great virtues of the covid vaccine programme was that they went into places like mosques and shopping



centres to do it. It showed that the NHS can do things in an accessible way. In your experience, the NHS showed it could do it, but in your mind will it do it? In peacetime, beyond a covid emergency, does it have the bandwidth to think that imaginatively?

Ceri Durham: The potential is there, but the systems need to be developed and grown. I will talk about the funding again: that needs to be there sustainably to do it. We showed we could do it in covid. We can do it again. I think that is what most community groups and religious institutions would want to do. They are very willing to help their populations have the best possible health. They would absolutely be very keen to do that.

Chair: Thank you. That concludes the first panel. Ceri Durham, Dr Raleigh and Dr Varney, thank you very much for being here.

Examination of witnesses

Witnesses: Dr Jeremy Davies, Karla Capstick and Simon Yates.

Q119 **Chair:** For our second panel we have Dr Jeremy Davies, the head of impact and communications at the Fatherhood Institute—perhaps you could say a little bit about that, Jeremy, and what it does—Karla Capstick, the programme director at Small Steps Big Changes, and Simon Yates, the director of operations at Place2Be.

Jeremy, would you say a quick word—60 seconds or so—about the Fatherhood Institute, just for those watching to know the work that you do?

Dr Davies: We are a small research policy and practice organisation. You might call us a think-tank. We do research about fatherhood and develop interventions.

Chair: Okay. Small Steps Big Changes?

Karla Capstick: Thank you, Chair. We are a national lottery community-funded project. We are one of five Better Start sites working in Nottingham. We are very focused on supporting babies, pregnancy and child development outcomes from pregnancy through to four. Our input today will be very much focused on early years, pregnancy, the transition of men into fatherhood and the parenting space and their experiences of that.

Chair: Simon, tell us about Place2Be.

Simon Yates: Place2Be is a leading children's mental health charity. We deliver mental health support to children in schools, both primary and secondary. We have been delivering the service for about 30 years.

Q120 **Chair:** Dr Davies, let's start with you. What is the biggest barrier to poorer health outcomes for boys, and the role that fathers can play in that?



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Dr Davies: The issue from our perspective is lack of engagement with fathers by services, which then feeds into a lack of impact on their children's outcomes. It is not just boys; it is also girls.

We have done successive evidence reviews looking at the antenatal period and the postnatal period and, most recently, we have done one that looks right through to adolescence. What we have found through our work and consistently in the evidence is that services do not see men as fathers, even when they are in the room, which they mostly are. If you think about maternity services, for example, well over 90% of men attend antenatal appointments. Well over 90% of men attend their children's birth. The evidence is that, even when they are in the room, those men are not being talked to as fathers. They are often not engaged with at all.

I heard the evidence in the previous panel. There are issues around fathers' own attitudes and availability to services, if you want to see it in that way. At the same time, there is an issue with services themselves both failing to reach out to men—going to men and fathers where they are—and, when fathers are presenting, failing to see them and respond to them in that crucial role. Of course, that has a knock-on effect on those fathers' abilities to be great parents for their children and to understand the impact that they themselves can have, and the mother can have, on looking after the children's health.

Q121 **Chair:** Karla, how would you respond to that?

Karla Capstick: I absolutely agree and concur with Dr Davies. We commissioned a city-wide fathers' consultation in Nottingham back in 2020. It was obviously slightly hampered by what was happening nationally at that time, but a large number of fathers—just under 100—took part in that for us. We looked at various things, like what fathers wanted and what their current experiences were of services, particularly in the pregnancy and postnatal period. We asked questions specifically around mental health and how they wanted to receive information.

What fathers told us was that they wanted to be recognised as an active if not equal parent when engaging with services. Exactly as Dr Davies described, they are often viewed as invisible—not deliberately, I think, but health services during the perinatal period are predominantly aimed at women and babies. Far fewer provisions are there for men. There are no dedicated statutory services for males in the perinatal period at all, yet quite obviously fathers can also feel vulnerable, anxious, concerned and potentially even traumatised if it is a challenging birth. There is nothing potentially to support them in that space.

This is a system issue. Fathers told us that the pregnancy and early years workforce is predominantly female. Some men do not feel comfortable raising issues and concerns that they might have with a predominantly female workforce. Similarly, that female workforce did not necessarily always feel best placed or well equipped to support men with the



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questions that they might have. There is a bit about workforce training, understanding and wider peer support.

This will be my final point. The timing bit came up in the previous panel. There is a real golden moment at this point in a father's life. Fathers told us that they would be most proactive in seeking advice and support in the first weeks and months directly after their child is born. In fact, 45% said that in the six-week period after the baby is born they would welcome advice and support about their health and around the health of their child. There is a real golden moment to engage with fathers, alongside its being potentially an area where they might need more support as well.

Chair: James Morris is going to talk about mental health and boys.

Q122 **James Morris:** Yes, I am interested in boys' mental health. Obviously, boys face distinctive issues sometimes in the school environment, where behaviour gets interpreted in a certain way. What do you think are the distinctive challenges around boys' mental health, Simon?

Simon Yates: We work across both primary and secondary. In the primary age setting we seem to see about 50:50 representation in our services for young boys. In our self-referral in primary, only about 30% are boys. Already, at an early age, boys are not self-referring to health services. When you get to secondary school, only 30% of boys are represented in any of our interventions. As you go through the age range, it becomes less and less accessible for boys. Something is going on for boys at school.

Q123 **James Morris:** Any idea what is going on there?

Simon Yates: Stigma is probably one of the contributing factors. Boys are still expected to be tougher and not show emotions at all. I think that is reinforced sometimes through role modelling and sometimes through social media. It is a barrier to boys seeking access.

To build on the workforce element, three quarters of mental health professionals are female. The majority of the workforce in the teaching profession is female as well. Access to people who are like you to discuss issues with is more constrained for boys than it is for girls in an area where they spend most of their time, which is school, up to the age of 18.

Q124 **James Morris:** Karla, do you share the view that there is still stigma associated with boys talking about mental health or issues of that nature? Is that one of the barriers you see, or are there others?

Karla Capstick: We've not done any work directly. Obviously, we work with very young boys and with babies, but what we see with young fathers is that there is still stigma. They are still thinking about how they present in a very masculine way. It was interesting that it came up through Ceri and some of the other colleagues in the previous panel. One of the things that we have done in Nottingham is to focus on some of our community support groups to break down barriers. They have been



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particularly successful with some of our black and Asian minority ethnic fathers.

We have a fabulous project called Shifting Your Mindset that works in the city, predominantly focused on that particular community. Working in a very positive-masculinity way, they have run extensive parenting programmes. These are often fathers who are separated from the mother and have very limited access, but they still engage with parenting programmes. They still engage with positive fathers' work. The organisation itself saw over 1,000 fathers last year and worked with over 300 dads on those particular programmes. They are certainly looking at how they break down some of the barriers that are linked to the stigma of, "I must be the provider. I must be strong." The work that they have done has been quite powerful.

Q125 James Morris: Dr Davies, do you think there is still stigma around?

Dr Davies: Our work is not especially focused on boys and masculinity. In general, the way that fathers are thought about, talked about and planned for in policy is that they are providers and that is fundamentally what they are there for. There is very little focus, I would say, in our society on supporting men's caregiving roles. Of course, it is through those active caregiving roles, as anybody in the room who is a father themselves will have worked out, that men are most likely to access the soft skills and the things that are not traditionally thought of as masculine in themselves.

Of course, that then feeds through to their male children. We are setting up men to be a certain thing: "You need to be like this, not like this." That is both a cause and an effect.

Q126 James Morris: I want to pick up on a point you made about the early years nature of the interventions. You say there is a lack of statutory perinatal services for men and a lack of a role for fathers. Do you think we need to be thinking about some adjustments or a redesign of how we think about early intervention, to cater for the particular issues that boys in certain groups have?

Karla Capstick: It would be a fabulous development nationally if we were to really think about universal services also supporting fathers in the same way that they support mothers. We need to think about the equity, though. I am not advocating that we should start not concerning ourselves with mum and baby in this period. Obviously, they are of paramount importance. I think that most services need to recognise that fathers want to be good dads. They want to support their child's health and development. They also have their own health needs. At the moment, a better joined-up approach to men's health in the early child and family service period, and policy around that, would massively support and help.

Q127 James Morris: Simon, in the educational setting, do you think there need to be any adjustments or additional thinking around particular issues that boys face at certain ages in the development cycle, in the way



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that the CAMHS are organised or the trend of having mental health counsellors in schools? Do you think there is anything in there that needs to be examined?

Simon Yates: I think the mental health support teams have been really welcomed. Place2Be is the mental health support team in primary schools in Manchester. We think that a further roll-out of that would be really beneficial. The embedded nature of those teams breaks down one barrier already by having somebody familiar to go and talk to. It is somebody who is there in the setting, week in, week out.

One of the issues that we find when children are referred to CAMHS is that there is an immediate barrier in that they do not know who they are going to see. This is anecdotal because there are so few male mental health practitioners, but boys and men are more likely to access and be more open with a male practitioner than they would be with a female practitioner. There is something about making those caregiving roles even more acceptable and more encouraging for men to take them up.

It goes alongside working across organisations. We work closely with people like Football Beyond Borders and Greenhouse Sports, which obviously work through the medium of sport, and we try to find different pathways for men and boys to talk about their health. Seeing a therapist might not be the first thing that an adolescent boy might choose to do, but they might talk to their sports coach in the first instance. That might open up doors for them to talk more widely about some of the emotions or feelings that they have.

Q128 **Mrs Hamilton:** I will ask this question of Dr Davies. In my day—I always say to the panel that I am only 21 and a half—when I had babies, men did not come in the room. They did not come near. If they did, it was frowned upon and they did not get involved. Things have changed a lot now. What do you believe we need to do now, for young dads especially, to include them more at this really important time of their life? Historically, it has not been the man thing to do.

Dr Davies: You are right, and I absolutely recognise what you are saying. What is interesting is that the cultural shift has been massive. It has happened despite policy rather than instead of it. For example, nobody told fathers that they needed to start being at their children's birth, yet we have well over 90% doing that. There has been a massive cultural shift.

The problem is that our services have not caught up with the reality of how both men and women want to live their lives. My sense is that fathers want to be actively involved as caregivers. They are not very demanding of services. You won't find men knocking on the door demanding, "I need help," or, "I need this." They tend to hold back from doing that, but that does not mean that they do not need it. There are lots of ways. As I was saying before, they are often in the room already. Maybe change the conversation you are having with him. Look him in the eye, call him by his name, shake his hand and show that you value him



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as a parent in his own right. Some of it is quite basic stuff. It is about respect. That then changes the dynamic and opens the door for those men so that if they feel they need some help they are much more likely to ask for it.

We did a survey called "How was it for you?" about five years ago on about 2,000 men who had become fathers in the previous five years. About two thirds of them said that at no point in the entire perinatal system had anybody talked to them as a father. Well over half said that they had rarely or never been addressed by name. These men are absolutely in the system, but wandering around as if they are invisible.

There is a lot that we can do to adjust our thinking. How are the professionals being trained to make sure that they see the men and have the right conversations with them? Of course, when you start to do that, you need to be able to do something with those fathers sometimes. If you identify a problem, they have to be referred somewhere and so on. Sometimes the problem is that even when you are good at engaging with a dad, "Then what am I going to do with him?" Where is there mental health support for fathers that is available and that they can get to?

Q129 Mrs Hamilton: This will be my final question—I don't have one for you today, Simon. The natural thing to ask is, what about the employer? How are we engaging? You have made all the right points, in my humble opinion, Karla, but how would you suggest we start involving the employer, where most of our men spend at least 40% to 50% of their time? They have paternity leave and access to services, but how can the employer be more effective in this area?

Karla Capstick: There are opportunities for employers to think about how they can support fathers in the period when they transition to being a parent. As you said, there are opportunities through paternity leave. Some of the fathers that we spoke to through the consultation that we did said that that was still a barrier. Although it is there, it is not as flexible. The time is still limited as to how much they can access services. As an employer or as services—you could flip it either way—what do we do to make sure about it? We talk about fathers engaging, but are we making our services accessible and allowing fathers opportunities to access things during their working time? That might be a challenge, depending on the employer, but I think there is far more that we could do.

Certainly, in Nottingham, as a commissioner of services, we have not necessarily engaged as much with employers, but we have asked some of our services to think about offering evening appointments so that fathers can be involved. That is one of our speech and language interventions. We have done work in the community. We have done drop-ins and weekends. We have also commissioned some very specific offers that far more speak to dads. It is interesting what Simon was saying around the kinds of therapies that boys want to access. We also found that men are less likely to want to access talking therapies. They are far happier to access things that are action-based, doing things and making things.



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I think conversation with employers is important. There is the opportunity to think about flexibility and dad's role as a co-parent and the benefits that that would have for him, and therefore potentially his productivity, his satisfaction at work, sickness and all those kinds of things. That is a bigger question. There is a bigger discussion to be had.

Chair: We had the Men's Sheds Association in at the start of this inquiry. They talked about being shoulder to shoulder instead of face to face, and how that encouraged better conversation. It was very interesting.

Q130 **Rachael Maskell:** I want to turn to physical health, particularly intergenerational health. In the first session today, we heard from Dr Veena Raleigh about the health outcomes in adult men. Clearly, we know that many of those trajectories start in early years.

Dr Davies, what opportunities are there for intergenerational interaction to ensure that we get our boys focused on their wellbeing for the future? That is particularly for physical health, but we know that it has implications for mental health as well. Many schools only offer something like an hour a week PE, so they are not getting a lot of opportunity for physical wellbeing. What are the policy interventions that we need to improve young people's physical health? Of course, that will have ramifications for improving the health of fathers as well.

Dr Davies: Again, obviously, I am going to give you an answer that is about fathers. Karla used the term "golden moment" earlier about the perinatal period. We know that fathers' obesity, for example, is associated with their children's obesity. At the moment we are doing nothing to look at men in the antenatal or perinatal period and to assess their physical exercise to provide them with even basic advice about healthy eating and so on.

If you were looking for an intervention that would feed through to children, you might look at getting the fathers thinking about their own health. What is crucial when you are engaging with fathers is to find the most effective method for explaining the benefits to their children. When you are talking to a man who is about to become a father, you are not just talking to him about his own health. You are doing it in the context of, "Think about the effects of this on your child once it arrives." I would say that would be an excellent starting point if one was developing a strategy for engaging with children's health. To address some of the challenges, you need to start with strategies that meaningfully and directly engage with both parents.

Q131 **Rachael Maskell:** Karla, I will turn to you with a similar question about how parental health, and physical health, can have a bearing on little ones' wellbeing and the early start.

Karla Capstick: I absolutely echo what Dr Davies said. We have seen in the work we have done that there is a definite correlation. When we have looked at doing projects in Nottingham focused on fathers, we have not done as many that have been father specific mainly because, as my colleague said, fathers do not necessarily want father-specific services.



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That is sometimes helpful, and there is definitely a correlation with more physical activity. We have done work with two local football clubs. We have done work with various community groups very much targeted at fathers and getting them involved with their small child in the more physical benefits. We have supported them with that.

We have done work around healthy eating, diet and nutrition, with cook and play sessions. Again, it depends on when those are run as to whether father can access them and see the benefits. As we have already mentioned, there is that golden moment or that opportunity to talk positively about behaviour change in terms of men's health and wider outcomes. If you talk about it through the lens of their child, they are far more receptive to hearing about it. They want to be there for their children. They want to be a positive role model. We have seen more fathers making changes and supporting smoking cessation, thinking about their weight and exercising more because they link it to activities that they can do with their children.

Q132 Rachael Maskell: Simon, clearly you see the correlation between what happens in the home and what happens with people who use your services. What recommendations would you provide the Committee with as to how that can be improved, particularly around things like adverse childhood experiences?

Simon Yates: Definitely. What we increasingly see in school communities now is that schools are creating an environment that may formerly have been available in the broader community. It is having community settings on the school premises, where they engage family teams like ours, counselling and NHS services and bring the whole family into that setting to get them more engaged. As my colleagues said, engaging parents in early years is exceptionally important for positive mental health in children. Half of mental health issues develop before the age of 14, so we are talking about primary school and the very bottom end of secondary school.

Those community settings are important because they increase the diversity of people who will access health services. We definitely see that in some of our projects in more diverse communities. It is one of the barriers that is broken down. A school is a natural place where people go, to either drop off or pick up their children. It is not like going to a statutory service where sometimes there might be a perceived barrier to entry because of what the implications might be of coming to that setting with an issue about their child. The informality of the setting is really encouraging.

It also allows the school, local community groups and third sector organisations to come together to provide a range of different options for people to talk about. We have seen cookery classes, as we just talked about, going on in community settings, facilitated by the third sector so that people can get involved at their community level. From my perspective, bringing fathers into that is really important. We see more mothers attending our parental services.



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Going back to the previous point about engaging employers, making some of the parenting services accessible through employment schemes is something that we are really interested in looking at. It is another route to trying to engage parents where they spend a lot of their time.

Q133 **Rachael Maskell:** Should some of the services be available at weekends so that fathers can attend as well?

Simon Yates: Yes. Some of the more successful ones that we have seen are run on a Saturday morning. Fathers are more engaged in the workplace from Monday to Friday, so running those things on a Saturday morning and making it a family-friendly activity—often they run clothes banks or food banks at the same time—in a non-stigmatised place for people to come is really good. There is also the opportunity to access healthcare services, which people might not consider if they were just going to a statutory provider to do that.

Chair: That's great. Job done. Dr Jeremy Davies, Simon Yates and Karla Capstick, thank you very much for giving evidence to us and for being succinct in your answers. We have got a lot from the session, as well as from the previous panel. That concludes today's session in our men's health inquiry. To be continued.