# Health and Social Care Committee

## Oral evidence: Men's Health, HC 139

Tuesday 7 May 2024

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Watch the meeting

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

Questions 134 - 180

### Witnesses

I: Maria Caulfield MP, Minister for Mental Health and Women's Health Strategy, Department of Health and Social Care; Jason Yiannikkou, Director of System, Oversight and Integration, Department of Health and Social Care.

Written evidence from witnesses:

– [Add names of witnesses and hyperlink to submissions]

HOUSE OF COMMONS

# Examination of witnesses

Witnesses: Maria Caulfield and Jason Yiannikkou.

Q134 **Chair:** Good morning. This is the Health and Social Care Select Committee, back after the bank holiday mini-recess. It is Tuesday 7 May and we are in the Thatcher room in Portcullis House. We are concluding our inquiry into men's health, a subject that Select Committees in the House have not looked at for a very long time. It has been a very illuminating inquiry—short but focused.

Today is an opportunity for our cross-party Committee of MPs to question our guests, who I will introduce in just a second, about the inquiry that we have heard and the themes that we have drawn out, with a view to us writing our report, which we do at the end of every inquiry. We are very pleased to have the Minister with us. Maria Caulfield MP is the Minister for Health and Women's Health Strategy—we will come on to that—at the Department of Health and Social Care. Jason Yiannikkou is the director of system, oversight and integration at the Department. It is nice to see you again, Jason. We knew each other when I was a Health Minister back in the day.

Thanks for coming in. I am going to kick off with you, Minister., We have heard evidence from organisations such as the Men & Boys Coalition, the ManKind Initiative, the UK Men's Sheds Association, Global Action on Men's Health, Men's Health Unlocked and the all-party group. As you would imagine, we have heard lots of talk about a men's health strategy from the Government. Are the Government considering a specific men's health strategy? If not, why not and how does that then fit with your strategy and health agenda?

***Maria Caulfield:*** To answer your question, we do not have specific plans for a men's health strategy if you compare it to the women's health strategy, which is a couple of years old now. We have set up a men's health task force to bring together experts in the field of men's health.

Q135 **Chair:** Is this the task and finish group, as it is called?

***Maria Caulfield:*** Yes. We have groups such as men's sheds, Andy's Man Club and Movember all taking part in that. We are looking to drive forward the work that is happening in men's health, but also to raise the profile of some of this work, for example the TRANSFORM prostate cancer trial that is taking off. We need the help and support of those groups to get the word out to men of how important it is, when they receive their invitations, to go to those.

We are also appointing a men's health ambassador. We should be able to update you fairly soon on that. We have some interviews going ahead. There will not be a specific strategy, but there are specific strands of work that we are working on, using the task and finish group to try to pull it all together, but particularly raise awareness about that work, whether it is on digital health checks, prostate cancer or suicide

prevention, so that men are more aware of the health offers that are open to them.

Q136 **Chair:** I remember the women’s health strategy being devised and consulted on when I was in the Department. Presumably that then went through its statutory consultation and so on. Martin Tod from the Men’s Health Forum said to us that men’s health issues are “hiding in plain sight”. Reading between the lines, are you telling me that the task and finish group is a way of taking a lot of those issues that we know are there and getting on with it?

***Maria Caulfield:*** That would be fair to say. The women’s health strategy is amazing. It is the first ever strategy in England. We got over 100,000 responses to our call for evidence, but it took, as you said, years to get to where we are actually delivering on those priority areas. We have some low-hanging fruit in men’s health that we can deal with now, particularly in the prevention work.

There are three key areas. One is around suicide prevention, because middle-aged men are a high-risk group in our suicide prevention strategy. We have the work that we are doing on prostate cancer and lung cancer, which men are disproportionately, obviously with prostate cancer, affected by. There is also the cardiovascular disease element. Some of the work that we are doing there to try to improve on that, particularly around smoking, will make a big difference to men fairly quickly. There may be room for a men’s health strategy after that but, with the resources we have, we would prefer to crack on, get on and try to drive forward those changes. We need to do that, whether we have a men’s health strategy or not.

Q137 **Chair:** If I remember rightly, there were things that the women’s health strategy needed in a more legal, properly consulted on way because legislative changes were required around women’s health. Is that why that had the strategy and this does not need one at the moment?

***Maria Caulfield:*** Women’s health issues are slightly different, in that women were saying to us that, when they were trying to access healthcare, it was often the culture around women’s health. Women would often go, say, for endometriosis, eight or nine times to a GP before getting tests done. It often takes eight to nine years to get a diagnosis of endometriosis. Menopause is pretty similar. We are going with various symptoms maybe years before finding out that we are going through the menopause and maybe never being offered HRT.

With men’s health, it is slightly different. I do not want to generalise or stereotype men, but men are often not engaging with health at all. They do not come forward for tests when they are offered them. If they are feeling low in mood, they will not go and see their GP to talk about it. Women come forward for healthcare, but their experience of healthcare is not necessarily a positive one historically, whereas for men it is getting

them engaged in healthcare in the first place. It is a slightly different element.

The women's health strategy is about changing the culture of how we look at the life course of a woman, in that being pregnant, periods and menopause are not just something that happens—"Get on with it"; there are specific health interventions that can improve the outcomes for those. With men, we know that they have specific health needs that they are not coming forward for or where we are not really focusing our resources into getting better outcomes for them.

Q138 **Chair:** That is interesting. Jason, to bring you in, if I may, the Minister mentioned the men's health ambassador. Where are we specifically on that? You are one of the officials at the Department who work full time on these issues. Why have we not heard of that person yet?

***Jason Yiannikkou:*** I am afraid that I am going to say that these processes take time, which I know is a slightly depressing thing to say, but it is true. They do. We are definitely in the thick of it and seeing people. People are going through the process.

Q139 **Chair:** You have advertised and you have candidates.

***Jason Yiannikkou:*** Yes.

Q140 **Chair:** You are now interviewing those candidates, or you are sifting? Which stage are you at?

***Jason Yiannikkou:*** We are interviewing.

Q141 **Chair:** What is the key question you ask them? Are they all men?

***Jason Yiannikkou:*** No.

**Chair:** They are not all men.

***Jason Yiannikkou:*** No. The key question we ask is a broad one: "How would you tackle the role? What would you do to raise the profile of this agenda and advance the cause of men's health?"

Q142 **Chair:** If you appoint a woman as the men's health ambassador, how do you think that is going to go down?

***Jason Yiannikkou:*** As you know, we have to run an open and fair process.

Q143 **Chair:** I know that it is the law. I am asking you about the presentation of that.

***Jason Yiannikkou:*** I am reluctant to get too drawn when we are in the middle of a process, as you will understand. We have to find the right person for the job and we will see how the process works out.

Q144 **Chair:** Could I then ask briefly about the national clinical director for men's health role, which does not exist? In April, NHS England appointed

a national clinical director for women's health. I think it was the first one, was it not, Minister? Why do we not have an NCD for men's health at NHS England?

***Maria Caulfield:*** That is probably something that we need to look at for the future, but it was quite a struggle to get one for women. That was with a women's health strategy in place and with a women's health ambassador who is a clinician and very supportive of having that. That will probably come with time, but it is not something that we have a definite step platform for. It was a bit of a struggle to get one for women.

Q145 **Chair:** Why was it a struggle?

***Maria Caulfield:*** I think that there is a reluctance to pigeonhole people into women's health and men's health. I quite understand that as well, because a lot of the issues that are important to both men and women cross all divides. You should be treating people as a whole rather than asking, "Are they a man? Are they a woman?" I can understand that there is a bit of reluctance to try to pigeonhole it into men's health and women's health, because we should be treating people across the board.

There are some specific elements in both where it would be helpful to have that kind of medical specialty to try to pull things together. Let us see how the women's director goes and whether that is successful, which I am very confident it will be. The fact that we had a women's health ambassador, and seeing the difference Lesley Regan has made to driving forward women's health, has made the case for why we need a men's health ambassador. We do not want to make health male/female and so black and white as that, but they bring a lot to the table.

Q146 **Chair:** No, you have given a pretty clear steer there for them. Is the national clinical director for women's health a woman?

***Maria Caulfield:*** No.

**Chair:** I am just getting some facts out there on the record. Thank you for those opening remarks.

Q147 **Rachael Maskell:** We are expecting a major conditions strategy at some point. I want to know how much men's health will feature within that and particularly address the specific inequalities that men face. Can you give us some indication of when that strategy is likely to emerge as well?

***Maria Caulfield:*** I do not lead on the major conditions strategy. It is Minister Stephenson who leads on that. It is going to be looking at five key elements of the major conditions that have the biggest impact on mortality and morbidity. We have things such as cardiovascular disease, cancer and mental health. I think that there will be a maternity element there too. Those conditions are some of the leading causes of death in men.

Again, I do not want to stereotype men or pigeonhole men and women, but we know that women live longer than men but in poorer health. We

know that men have a shorter life expectancy and there are some groups of men that have shorter life expectancy than others. These are the major conditions that dictate those outcomes more generally.

It is a piece of work that will make a big difference, but it will also replicate the work that NHS England is already doing in Core20PLUS5, which is looking at five major conditions and the 20% of the population that has the poorest outcomes. Within that, there are big groups of men across the country where that targeted work is making a difference.

On lung cancer for example, the targeted lung health checks are making a huge difference to men. There are the screening tests for those, which are often scans, as well as smoking advice and that sort of thing. It is not just specifically for men, but men make up a higher proportion because more men smoke than women. I know that there is a formal review in 2025, but we are already seeing that, when the lung cancer is detected on those checks, 80% of those have been detected at stage 1 or 2, where traditionally it would be 30% if you went to your GP and had an X-ray or CT scan.

That sort of work is already happening. The major conditions strategy will build on that work so that we have a strategy going forward. I know that there was some controversy—you may pick up on this—about putting mental health in the major conditions strategy. We have decided to put mental health in there because we do not want to separate people out into having a mental or a physical health issue. We know that people who have mental illness have poorer physical health. Likewise, people who have poor physical health suffer with their mental health as well. Bringing that all together and trying to target those who are most likely to have the poorest outcomes is really important. My understanding from my colleagues is that that is likely to be published this summer. We can update the Committee when we have some more firm dates on that.

***Jason Yiannikkou:*** Can I add to that? I should probably confess that I am the co-SRO for the major conditions strategy in the Department as well. One thing to draw out, having read through the transcripts of your previous sessions and some of the other evidence, is that there is quite a good alignment between what you are thinking about here and what we are thinking about with regard to men’s health and the major conditions strategy work.

The thing I would particularly point to, and it has come up time and again in your Committee, is the importance of services and things that support healthcare, so meeting people where they are and meeting people in the lives that they lead, whether that is men as men or different groups in different ways. That is going to be a fundamentally important strategic need for developed health economies, including ours, in the years to come because of the way demography is changing. There will be some references to men’s health and issues that relate to men’s health in the

strategy but there is a more fundamental alignment between the two that is probably worth drawing out as well.

Q148 **Rachael Maskell:** In particular, there is the socioeconomic disadvantage, which is very prevalent. I would like to move on to talking a little bit about the research base in this area. You mentioned your task and finish group, which has a lot of organisations with a lot of experience in delivering those frontline interventions. Understanding the psychology of what is happening behind men's health, needs a level of in-depth experience. We have very few academics in the country who are focused on men's health. What consideration have you made to create a national centre for men's health, which can be a solid base for research development, and ensure that we get ahead of the curve with addressing these inequalities?

***Maria Caulfield:*** I don't think that we have looked at creating a centre, but our very first topic in our task and finish group was around what research evidence and what research gaps there are in men's health. We had some academics come along and talk us through some of the work that they are doing. There is some funding that is supporting their work. I don't know, Jason, whether you wanted to touch on the research that is happening in this space.

***Jason Yiannikkou:*** This encapsulates one of the dilemmas in this space, because, yes, we want there to be a focus on men's health, but we also want men's health and other issues to be embedded in other forms of research as well. I know that NIHR is doing some work on mental health and men. We can draw together for you some of the other things that are going on. It is a both/and sort of approach that we probably need, where we are thinking about this in all aspects of what we do, rather than just bringing it into a particular centre.

Q149 **Rachael Maskell:** We know that there are specific issues. If we are able to drive those issues we will start achieving significant changes in health outcomes, which is really important. That takes me on to my next question. From the work that we have done, we recognise that interventions need to be made very early on in life, particularly with boys, and certainly looking at issues around healthy masculinity and the gender stereotypes that are so dominant in our society. How do we ensure that we have a cross-departmental strategy so that, for instance, the education system is aligned, and other Departments, to reinforce key messages about boys' health, which will then translate into men's health?

***Maria Caulfield:*** We are doing this in one way with the suicide prevention strategy, because we know that middle-aged men are a third more likely to take their own life than women at that age. Our suicide prevention work is doing a lot of work with young boys in schools. We have over 400 mental health teams now in our schools. That will be towards 50% of schools towards the end of the year. That is teaching young boys what good mental health looks like but also coping mechanisms, how to ask for help and how to support each other so that,

if you know someone who is struggling, you are able to know what to do in terms of asking people whether they are okay and signposting them to help.

We are not doing that quite so much on a physical health level. The suicide prevention stuff is cross-Government, so we hold regular meetings with Ministers, because we want suicide prevention to be everyone's business. We have education in there, the Minister for Sport, DWP and DEFRA. All those Government Departments are on there so that everyone is joined up in working on that.

We have not done it for physical health and maybe that is something that we need to look at. Again, this is why it is so important to have that ambassador. Lesley Regan has been working with DfE on teaching around young women's health, which would include boys and girls, so that boys know about the menopause, periods, pregnancy and that sort of thing. We don't have that same focus on teaching about men's health. Maybe that is something we need to look at, but it is Lesley Regan, the women's health ambassador, who is working with DfE on the curriculum to make sure that women's health is embedded through the education system as well. We are doing it for mental health for young men, but not so much for physical health, so that may be a gap in the market.

**Rachael Maskell:** I certainly would recommend that, in the light of the evidence that we have taken in this inquiry, which showed that the inequalities start very early in life. Therefore, ensuring that we have that joined-up strategy across Departments could address that.

Q150 **Mrs Hamilton:** Good morning, both. I want to concentrate on the issues of cancer, which, Maria, you focused on quite a bit at the beginning. Let me start by giving my context because that is how I do it. As we all know, men drink more—perhaps I am being naive here—smoke more and tend to be more overweight. Especially within the constituencies, if people are going to be homeless, it tends to be men.

You then find they come into the system late. The issues relating to prostate cancer affect the African and Caribbean community—I think it is one in four—more than other communities, because, in my humble opinion, they associate it with their sexuality, don't like talking about things and find it very difficult to open up. The question I want to ask is about what you are doing, Maria, to ensure that, within this strategy or within the bigger strategy, you can encourage people to come to us a lot earlier, but, more than that, once they come to the system to say, "There is something wrong" and we start to diagnose, that things like MRI scans are available. In some parts of the country it is far more available than in other parts.

How can you ensure within the strategy that, when you are diagnosing cancers, it can be done at an earlier stage? It is not so much about prevention, because somebody else will raise that here, but about early

intervention before we get to the stage 4 prostate cancer, straight into the bone and the issues that are there, and it becomes terminal.

***Maria Caulfield:*** In our task and finish group, the people there from groups like Andy's Man Club and men's sheds make that point. It is about encouraging men to come forward but, when they come forward, making it as easy as possible to engage in healthcare. The lung health check is a good example of that. It is available for women as well, but, for those men who are called forward, they are targeting it to those most at risk of developing lung cancer, so that they are really making sure that they are getting to the right people, rather than the worried well who will come forward whenever a test is offered.

For prostate cancer, you are right and there is a really good example of that. Black men have double the risk of white men of developing prostate cancer. The work that Prostate Cancer UK is doing on the TRANSFORM trial, which the Government have, I think, put £16 million into, is proactively targeting black men. It will be open for recruitment in the next few months and it will be by invitation, so you cannot just volunteer to be on the trial.

It will be doing things such as MRIs to see whether there is a good test that can be rolled out as a screening programme for prostate cancer. Knowing that black men are much more likely to get prostate cancer, they are proactively recruiting black men. I think that they want one in 10 of the recruits to be black men, so that it much better reflects the real group of people who get prostate cancer. This is about being a bit more proactive in targeting those who are suffering from certain conditions and then making it much more applicable to them.

Our NHS health checks were a bit curtailed during Covid, but in the last year we have really ramped them up so that people are coming forward in much greater numbers than pre-Covid. One thing that we have had feedback on is that men don't want to just hear, "Come and get your blood pressure checked because it might prevent a heart attack." They then want to know, "What are you going to do about that?" If they know that, if they come and their blood pressure is slightly high, there is medication that can help, there is dietary advice, and it may not be medication for life and might be for a short period, they are much more willing to engage, rather than just sending out a bland invitation.

Again, I don't want to stereotype but that is the difference between men and women. If you send a woman out an invitation for a smear test or a mammogram, they will go. Men want to have a bit more information and want to know what the outcomes are before they will engage so well. Because we are doing the work on who is more likely to suffer from cardiovascular disease, prostate cancer or lung cancer, we are targeting those groups and being a bit more supportive to them in terms of providing that information and encouraging them to come forward.

For example, in our health checks, because we are hearing about how you might be sent an appointment when you are working or you might have a kind of nervousness about coming forward to get a health check, we are rolling out the digital health check from September, so that that makes it easier for men to engage. We are also going to the workplace, because we are recognising that men, particularly those in construction, who may be self-employed, will not want to take time off work that they are not getting paid for. There is a pilot in the workplace for cardiovascular disease, which has got £10 million from the shared outcomes fund.

We have a number of initiatives to make it as easy as possible for men to come forward. What we need the men's health ambassador to do when they are appointed, but also the various groups within men's health and the various charitable organisations, is to work together to give those reassuring messages to men that it is worth coming forward because, if you have high blood pressure, we can do something about it, which means you probably will not, or are less likely to, get a stroke, heart attack, respiratory, COPD, or whatever it is, so that they feel that there is a benefit in coming forward. I am told by the experts that the messaging is very different for men as opposed to women, in terms of getting them to come forward.

Q151 **Mrs Hamilton:** My final point is in the same vein. It is relating to cancers and the major conditions strategy that you are talking about. Maria, you have highlighted some excellent things that you are doing. What keeps coming into my head is what keeps being said to us as a Committee, which is the single point of leadership. Things that you are talking about seem to be coming from everywhere. If I was a thumping bag it would be "thump, thump, thump", but I cannot see where the source is.

How can we make sure that it is embedded within the major conditions strategy, that what you are saying does not get lost before it gets to where it needs to get to, and that we can roll it out and make it part of the bigger strategy that you are talking about? What are you doing to ensure that happens?

***Maria Caulfield:*** In my first answer we touched on the three main areas around the low-hanging fruit—suicide prevention, work around prostate cancer, which kills around 12,000 men a year, and all the cardiovascular work. That is the low-hanging fruit, but it can easily get lost in all the work that is happening across the board. The men's health ambassador will no doubt help with that. There are two things we are really looking for from them. One is to get the message out to men to engage in healthcare and promote all the various strands of work that are happening. Two is to pull those strands of work together so it is more cohesive and we can measure the difference it is making for outcomes for men.

Q152 **Mrs Hamilton:** Where do you finally see it sitting within that top tier of Government so it does not get lost?

***Maria Caulfield:*** That comes back to the point that Steve was making at the beginning. Do we need a national clinical director? Do we need a men's health strategy? That is probably a work in progress. We are keen to get on and make some changes quite quickly, but there probably needs to be a strategic place for that to fit in.

You, or maybe Rachael, asked around physical health and young people. The HPV vaccination programme is a good example of that. It was initially set up to try to prevent cervical cancer, which it does. Boys were not initially included in that. They are now. The message is that it is not just about preventing future partners of yours getting cervical cancer. It can reduce penile cancer, cancer of the anus and throat cancer. There is a benefit for boys and young men in getting that vaccination, but that has got completely lost in the messaging. There probably needs to be a bit of a strategic view of the men's health angle, so that young boys are feeling, "There is a personal benefit for me from taking part in that vaccination programme". That is a missing link at the moment.

**Mrs Hamilton:** I will leave it there. That is a good place to leave it.

Q153 **Dr Johnson:** I have a few questions, Minister. Which individual modifiable risk factor do you think contributes the most to the most men dying early?

***Maria Caulfield:*** I am not a clinician in the same way as you are, but I would say that it is the cardiovascular disease element, and then the prostate and lung cancers would be the two elements. That is why we have had for a long time now the NHS health checks to try to get people with high blood pressure, with high cholesterol or who are smoking into the system. We have had some success with that. That is why, also, there is the real drive to get the prostate cancer trial off the ground because there is not a screening test for men in the same way that there is for cervical cancer or breast screening for women. They would be my two elements.

Q154 **Dr Johnson:** The Government have a great strategy at the moment on tobacco and that Bill is going through Committee at the moment. I should say that I am on that Committee. The other factor that I think contributes to a lot of men's deaths is obesity. Looking at the figures, we can see that 68% of young men aged 16 to 24 are of normal weight, but that drops to 39% by 25 to 34. Although the figures are poor across the board, there is a massive jump downwards in men of normal weight between the teenagers and early 20s to the late 20s and early 30s. Without being unduly nanny state, what can the Government do to reduce the number of men who become obese or overweight?

***Maria Caulfield:*** There are a number of things. The health checks that are done for the over-40s by the NHS are done by local government and they target them to their local population, so they are not a standard set of tests across the board. Weight is one of those that they would be measuring when someone comes along to get their blood pressure,

cholesterol, weight and smoking history done. They can target those who may be in the bracket of being overweight, but I think your question is about how we prevent it in the first place.

The Government are doing a number of things across the board, not just for men and boys. They now have the hour's worth of sport that has to be done in schools to try to get young people more active. We have put in measures such as the sugar tax in sugar drinks. We have the calories that are now on menus to try to subtly make people more aware of what they are taking in. There is not a programme that I am aware of that is specifically for men in relation to weight.

***Jason Yiannikkou:*** The NHS is very keen on making every contact count, which I am sure you have heard of, and so trying to use whatever encounter that health professionals might have with someone as a doorway into a wider conversation about those modifiable risk factors and what they might do about it. This comes back to the earlier discussion about different channels, different things working for different people and subgroups of people who might find one form of engagement helpful but another not terribly helpful.

Some of this is in the marketing and in the different modes of engagement. Peer-to-peer seems to be quite helpful from some of the things we have seen, and I think some of the things you have heard as well. We are often more influenced by people we know and trust, as distinct from people from outside our social circle. That is something that might well have some potential as well, particularly for men.

Q155 **Dr Johnson:** That leads quite nicely into my next question, which is about the contact counts. Minister, you said earlier that men are less likely to have that contact and that opportunity with the NHS. Looking through the figures, men are more likely to be in employment than women and much more likely to be in full-time employment relative to women. To what extent do you think that contributes to a reduction in contact with health services—the fact that you need to take that time off work and perhaps have a reduction in income in order to attend those appointments? What can the Government do to ensure that health services are available to men at times they are able to access them?

***Maria Caulfield:*** You are absolutely right and that is the feedback we are getting from some of the stakeholders: that a lot of men are self-employed, for example, so taking time off work costs them money. Unless they can see a real benefit right now of doing that—you can tell them that they may have a heart attack or a stroke in 10 years—they are trying to pay their bills today and that is their priority.

That is why we have those cardiovascular disease health checks happening in the workplace. My understanding is that they are being slightly directed towards more male-dominated places, such as construction sites, because the uptake in men is lower. The aim is for

150,000 people in their place of work to get those health checks done—bringing healthcare to them, rather than the other way round.

There are also things we are doing around opening up pharmacies for blood pressure. We had—I cannot remember the name of the campaign—the million checks campaign, or something, to try to get more people to get their blood pressure checked in pharmacies quite recently, so that men in particular are not having to phone at 8 am to get through to their GP, then take time off to go to an appointment. If they are out on the high street on a Saturday morning, they can go and get their blood pressure checked. Making it easy and accessible is certainly something that we are hearing from the stakeholders. If you miss that opportunity—if you are not there when the men are there—they won't think, "I will go back and do that later." They just won't do it.

One area that I am quite keen on, and there is a bit of work happening in this space, is around sport. In the mental health space, Trevor Steven, who is the ex-Everton player, is doing a lot around mental health work at football grounds, because that is where a lot of men go on a Saturday afternoon. Again, it is about trusting relationships. They are much more likely to listen to a footballer saying to them, "Go and get your blood pressure checked" as opposed to a Minister. There is some really exciting work happening in this space, but in the workplace in particular we will be looking at the outcomes of those workplace checks. If they are successful, it is certainly the way forward.

Q156 **Dr Johnson:** The Pharmacy First thing is great. I actually went to visit the Pharmacy First service in Sleaford Boots last week and they did my blood pressure too while I was there. It is a great service that expands the availability, but we need to look a bit more broadly than that and look at how men get access to GP services as well.

***Maria Caulfield:*** Like you say, Pharmacy First is brilliant if you are motivated to go and get that done. It is about making it as easy as possible. You might be nervous about going to get your blood pressure checked because you have been told, "If you have high blood pressure you have risk of a stroke and heart disease." We have heard from men's groups that that message puts men off coming forward. They want a much more positive, "Don't worry if you have high blood pressure. There is something we can do about it." Having that in the workplace, seeing your mate getting his blood pressure checked, and then he is on antihypertensives and doing well, is much more reassuring than saying, "There is a pharmacy down the road. If you have 10 minutes, go and get your blood pressure checked." We have to be as accessible as possible.

Q157 **Dr Johnson:** That is right. Of course, if you are nervous that puts your blood pressure up, which makes it more difficult. I have two further questions, if the Chair will allow me. The first one is that the Secretary of State talked about intimate care and the right to have intimate care provided by someone of the same sex, should you wish that to be the case. I know that this has gone out to consultation. With 11% of nurses

being male, how does this apply to men?

***Maria Caulfield:*** It is a really good question. I don't want to speak on behalf of men, but I presume that, if you are having something like a prostate examination, that is quite an intimate procedure, so it would apply to men. In the consultation, it would equally apply to men. You make a good point in terms of the makeup of some of those clinical staffing groups. It is often, particularly in nursing, harder to get a male nurse than a female nurse. I guess that that is something we could look at.

***Jason Yiannikkou:*** The principle that applies here and is in the consultation is really about trying to accommodate the wishes of patients as far as we can. As you will know, the material circumstances that present themselves in some situations can make that a challenge. There is always an element of having to adapt to those circumstances. The presumption is that it would be equally applicable to all people and based on their preferences.

Q158 **Dr Johnson:** My final question comes from an article by Catherine Carr in yesterday's *Guardian*. She talks about a BBC Radio 4 programme she made about the boys and how she has interviewed lots of boys, young men and their mothers about various aspects. She comes up with some discussion of doom scrolling, the use of pornography, unrealistic expectations and a fear of sex and intimacy, to the point where young men say that they are not initiating such contact or that they are recording verbal consent to contact before it starts, or even all the way through, because they are so frightened of being accused at a later date of not having obtained consent. The MeToo programme and the consent that has been taught in schools is really good stuff to protect women. That is great. How do we ensure that men are not frightened in this way? How do we encourage them to have normal sexual relationships?

***Maria Caulfield:*** It really starts at school. That is why the work that we are doing with DfE in terms of relationship and sex advice is so important so that, at school, young people, boys and girls, are getting that kind of education about what a good, healthy relationship is.

Your point on pornography is well made. I was in the debate—I think that it was one of the International Men's Day debates—where Miriam Cates raised the issue of pornography, how that is affecting relationships between young men and young women and the expectation about what a normal relationship is. The availability now online of all that sort of material and it being shared so freely is very difficult. When I was young, which is a long time ago, you had a few magazines on a top shelf that you could not reach. It is just so available for youngsters now.

Miriam made the point that, even if you do not allow your children access to that, they will be seeing it on someone's phone or tablet. It is having an effect on relationships in terms of domestic abuse and even fertility as well, because it is really changing some of the relationship expectations

that men have of women. I don't know what we do about that, other than the work that is happening with the online safety work. How do you reset that balance, because there is only so much you can do in schools? If people are having other input in terms of what a good, healthy relationship should be like, it is quite difficult to overcome that.

Q159 **Dr Johnson:** It is a difficult balance, is it not? You have young men looking at sometimes very violent pornography and having odd expectations of what sex might be like, but then at the same time being too frightened to engage in it in case an accusation is made later.

***Maria Caulfield:*** It is a very difficult time to be a young man or a young woman because you have so much input of information coming from multiple sources. Schools and families have a huge role, but there is only so much that they can do when there is so much information coming from elsewhere. It is about all of us speaking freely about things such as pornography and maybe making it clear that that is not a normal, healthy relationship.

Q160 **Chair:** I never thought that Sleaford Boots would get an airing at the Health and Social Care Committee, but good for them. They will be pleased to hear that, will they not? Thank you, Caroline. That is interesting. Picking up on Caroline's excellent article that she spotted there and raising that with you, often people talk about the Andrew Tate manosphere and all that work. How much of a problem do you think that is? Young boys are quite capable of distinguishing between the sensible and the Andrew Tate, are they not?

***Maria Caulfield:*** They are, but it is about making sure that they have that information coming to them at an early stage. That is why the curriculum, and relationships and sex education, is so important, so you are setting at an early stage what good, healthy relationships look like. There is also an element of not knowing what to do. It is very difficult for young boys in particular at the moment. It goes from one extreme of pornography—"This is what a relationship could look like"—to how far you go in terms of checking in a relationship what is acceptable and what is not. It is very difficult for them to navigate. I guess that that is why we need to ensure that they are getting as much access to good information about what a good, healthy relationship looks like as possible.

Q161 **Chair:** You mentioned the health checks with all three of my colleagues just now. You raised it a few times, did you not? The NHS health checks are from 40. FYI, when I turned 40, 10 or so years ago, I was never actually called for an NHS health check for five years.

***Maria Caulfield:*** It is every five years.

Q162 **Chair:** Rachael is saying that she has never been called for one.

***Maria Caulfield:*** I challenged this, because it is local government that does this. Some councils do it to everyone, so anyone who is over 40 will get one. Some of them do it to the targeted groups that are more likely

to have poorer outcomes. I think I said that at the beginning. There is not a standard approach across all local authorities.

Q163 **Chair:** That is fine, because that is what health devolution is about. We wrote a report on ICSs called *Integrated Care Systems: Autonomy and Accountability* for that very reason, because different areas will have different health needs. I am fascinated to hear about going to workplaces, by the way. That is really interesting. It would be really interesting if you felt the desire to write to us with some more details about that, or maybe Jason. We would be really interested to see that.

What does the NHS health check actually do, though? When you go out into these workplaces or when people go into the NHS health check, what would a man expect to happen at that health check? How does it interact with the vast amounts of data that the NHS holds on each of us in terms of calling people in for that?

***Maria Caulfield:*** My understanding is that, if you have an existing condition, so if you have already had a stroke or a heart attack, or if you have COPD, you will not be called forward because you are in the system already.

**Chair:** You are on a pathway, yes.

***Maria Caulfield:*** It is for people who are generally healthy at 40 and may not have been engaging in getting their blood pressure checked. In my understanding, in most of the health checks, you will get your blood pressure checked, your cholesterol checked, your weight checked and your smoking history. They are the four main checks that you would expect to have.

**Chair:** Would your waist be measured?

***Jason Yiannikkou:*** I am trying to remember what they did at mine.

Q164 **Chair:** As men get older into middle age, that is where weight collects and that, of course, can be very dangerous on lots of different levels. I am just wondering. Did they stick a tape measure around your waist, Jason? That is the level of detail that we are getting into here.

***Jason Yiannikkou:*** I did not know that I would be discussing this on a Tuesday morning.

**Chair:** From Sleaford Boots to your waist.

***Jason Yiannikkou:*** It has been a few years since I had mine. I cannot remember whether I was weighed or measured. I was certainly given a talking to and my blood pressure was then managed afterwards. It is basically those risk factors that they look at.

**Dr Johnson:** You said that you were given a talking to.

***Jason Yiannikkou:*** Yes. It was a very nice talking to, actually.

Q165 **Dr Johnson:** I am sure that it was. I am wondering whether you have any evidence about the sort of people who turn up for these checks. Are these the slimmer, fitter, healthier people who are going to have that reinforced in their own minds? Are the people who know that they should not smoke and they should not be a bit fat not going when we need them to, because they do not want to be lectured or given a talking to, they know it already and they do not realise there is something that can be done?

***Jason Yiannikkou:*** I think that it is a mix. If we are staying on my personal experience, I had a sense that I probably needed a bit of a talking to at that point and was happy to get one.

**Dr Johnson:** I mean in general, as a population.

***Jason Yiannikkou:*** There is clearly some evidence, and you have heard some of it in previous sessions, that some people who it would be really great to have had come forward don't come forward. That is exactly the motivation for trying to go into workplaces, to use digital and to find other channels and ways of engaging with people.

***Maria Caulfield:*** If you look at the lung health checks—I know a few constituents who have had those—although they are looking for lung cancer in the main and I think that it is an MRI that they do to see if there is lung cancer, they do then check blood pressure, weight and smoking cessation. Every contact matters and they use it to get people into their GPs for those routine checks. They are predominantly people who have poorer health outcomes because they have a history of smoking, are in a geographical area that has poorer health outcomes or have demographic indicators that would suggest that they have poorer health outcomes. Some of the newer programmes are much more sophisticated in who they are calling forward than perhaps the rollout of a health check for all.

Q166 **Rachael Maskell:** On this issue as well, I am wondering whether there is a missed opportunity to talk around the mental and social wellbeing of individuals in those health checks, because we know the correlation between the two.

***Maria Caulfield:*** There is. Some of the work that we are doing around the men's suicide prevention is looking at this and looking at the workplace in particular as well. I was at a big construction site at King's Cross, the new Google HQ, where they have mental health first aiders in the workplace. People will often say, "They are the big construction firms," but actually it was available to anyone. The small subcontractors, the self-employed plumber, whoever, could all access that. Good employers are recognising that you have a captive audience in the workplace, and that it is a place where they can do both physical and mental health checks.

Q167 **Chair:** I love it. We were in Singapore with another inquiry that we were doing and there is quite a lot of nudge policy being used there where

there are rewards for involvement in certain weight management programmes, for instance. Yes, you can call people to health check through good use of data, but do not underestimate the ability of us men to deny challenges. Therefore, is there a nudge and a reward system that you could consider to bring certain groups of men in for these health checks?

***Maria Caulfield:*** Yes, and the digital health check is an opportunity as well.

Q168 **Chair:** What is a digital health check? Just tell me in nuts and bolts what happens.

***Maria Caulfield:*** It is being rolled out as we speak. It will go live from September. You can check your weight at home. You put it in and it will give you advice. It might point you to the Couch to 5K app or something else. You can put in your blood pressure if you do your blood pressure at home or go to the pharmacy and get it done. You can put it in and it will guide you to healthy eating: "This is what you could do." It is a much less daunting experience. You could use nudge tactics with that as well: "Come back in six months and put your weight in. Have you reached your goal?"

Q169 **Chair:** I am going to bring in James Morris in a minute, who is despairing of my questions here. Do you ever reach out? I was at Winchester Parkrun on Saturday. I hasten to add that I was watching—bad knees. Anyway, I was watching. What a wonderful health opportunity that is each weekend. The number of people doing it is incredible and the energy they find in that last 100 yards is amazing. I wondered whether that is an opportunity, given how prevalent Parkrun is across pretty much, I would guess, all of our constituencies, to reach out and find people for your health checks.

***Maria Caulfield:*** That is the sort of avenue that we are going down. I think that I mentioned sporting events as well, where you have a kind of captive audience. Football clubs are doing a lot of work, say putting messages on the big screens at halftime. They could be good venues. Some local football clubs are hosting health check areas. In my own patch, our new community diagnostic centre is based at the Amex Stadium in Brighton. If you are invited for an X-ray or a CT, you get to go to the Amex to have a little look round. It is being innovative in that way to try to make healthcare more appealing.

**Chair:** If you are a fan of my team—people can google which it is—you could probably do that during the game. It would certainly be better for your health. FYI it is Spurs.

Q170 **James Morris:** Maria, you mentioned how, when it comes to maternity, we have made huge strides in perinatal mental health care across the country. Yet the role of fathers, fathers' mental health and early relationships within the family have not got so much attention. What more do we need to do in that area of involvement of fathers, fathers'

mental health and the relationship in that very early attachment phase?

***Maria Caulfield:*** It is something we have not really looked at. We are doing a huge piece of work with the maternity disparities group on pre-conception, because we often wait for women to be pregnant and having babies before we recognise that there is some work that we could be doing to have better outcomes. That is probably solely focused on the mum, rather than parents as a whole. Again, Lesley Regan is doing some work with schools on that, which would include boys and girls.

I guess that the biggest piece of work we are doing around that is around bereavement, so baby loss, where we are really trying to make sure it is mum and dad, not just mums. We quite recently rolled out the baby loss certificate. When we initially did it, it was going to be that mums register the birth of the baby. We pretty quickly came to the conclusion that it had to be both parents, or there had to be the option for both parents, to recognise the loss that exists for dads as well as mums. It was not just about registering the baby. It was for both parents to register their loss, really. We are rolling out bereavement suites in our maternity units, which are very family-focused and not just looking at mum. We are really taking that very seriously. We are not at the other end, I would say.

Q171 **James Morris:** I was thinking more—I do not think that it is directly in your area—of the Start for Life programme that is being rolled out. Does that give some opportunities to focus more on the issues in relation to fathers? I am not quite sure whether anything has been initiated in that area.

***Jason Yiannikkou:*** There is a strand of work around perinatal mental health for fathers within that programme, more or less precisely as you have described there. There is a recognition of the importance of that issue as part of a wider programme of work to improve bonding between parents and children in those early months and years.

Q172 **James Morris:** The second question I have is around interrelationship with education, maybe in the early years or even as a boy progresses through education. Part of this discussion has been about the fact that boys and men do not necessarily interact in a conventional way with the structures that are in place, particularly in a school environment or whatever. Some years ago, there was work done around peer support within the school environment. It was a joint thing between DH and the Department for Education. I am wondering whether there is potential for investment in that peer support for young boys in school, so that they can talk together without necessarily having to interact with authority figures. Is there something in there that might improve some outcomes?

***Maria Caulfield:*** That is something that we can certainly look at. In the older men's bracket, the peer-to-peer support of things like men's sheds and Andy's Man Club are transforming men's health. If you go to one of your men's sheds and someone has been for their blood pressure check, it was not too bad, they survived it, they are on tablets and that has gone

quite well, it really encourages others to go for their tests. That has been transformational in terms of men's health. I cannot speak highly enough of the work that they do. It would make absolute sense that that peer-to-peer support would be equally relevant for young men as well.

Q173 **James Morris:** Particularly in relation to mental health conversations, if you go back a long time to when I was at school, if you felt as though you were suffering from something like mild depression, there was no way of labelling it because we just did not have that conversation. These days, there is a lot more mental health literacy but there still needs to be some way of that not interacting with the conventional hierarchical structure within a school, so a young boy can say, "I am feeling like this," and another kid who has had a similar experience can say, "That is normal," and then they can take the conversation on.

***Maria Caulfield:*** There are some mental health apps that do that peer-to-peer support for young people. They are really popular. There is even Shout, where you can text and get support that way, so you don't have to speak to someone. They are really taking off. It is probably the digital aspect of peer-to-peer support in mental health for young men that is quite appealing at the moment.

Q174 **Chair:** I am going to ask you about the ambassador role. What are Lesley's terms? She is not full time on that, is she? Would it be the same that is replicated across?

***Maria Caulfield:*** I think that we have put it based on the women's health ambassador role. Lesley was initially for, I think, two years, but she has just had her term extended.

Q175 **Chair:** Is it a couple of days a month?

***Jason Yiannikkou:*** It is about that.

Q176 **Chair:** The men's one would be the same.

***Jason Yiannikkou:*** Yes, the men's one would be about that.

Q177 **Chair:** You are basing it on that contract, I presume, are you? Okay, that is that. Then we are going to touch on ICBs and accountability for men's health in their different areas. What are the outputs that we are expecting from the task and finish group on how you will hold ICBs to account for their work on this?

***Maria Caulfield:*** We have only had, I think, a couple of meetings so far. The first one was around the research and what gaps there are in men's health. The second one was focusing on the men's health checks. Because it is local government that commissions those health checks in each of those areas, it did feel like there was a bit of a disconnect between the ICB and its relevant local authority. When we were drilling down into the data, there did not seem to be a national collection of data so that you could compare Sussex with Manchester and that sort of thing. That is something that we have identified. As a task and finish group, we

want to be able to drill down so that we can better see those outcomes. It is one of those rare health screening programmes that are actually run by local councils rather than the ICB, so that is a piece of work that we are taking up.

***Jason Yiannikkou:*** I am mindful of your previous work on ICSs, the Hewitt review and so on. We need to be a bit careful about gathering together a set of metrics and then adding that to a whole other panoply of things that we pursue people for.

I am quite taken by the idea, perhaps influenced a bit by the last question, of peer to peer here as well if we can get some ICSs to take a bit of a lead around this. You have heard from Leeds, I think, in this forum, which has clearly gone ahead of some others, and I think we can find some more around the country. There might be something there about them teaching their peers, rather than us defining it all from the centre, but perhaps with some encouragement from us to bring it along the way. That is the balance we need to strike.

Q178 **Chair:** That would be good if you could do that because, yes, it is not about mandating them to do it, because they are under a lot of pressure, are they not? They are under fire. They have a million and one things they have to do. They have challenging budgets and you can see how this could easily get forgotten.

That is it from us, unless any Members have had anything burning that has come to them. Was there anything else in particular that you wanted to add in this space, knowing how we have looked at this? The fact that we are looking at men's health again after a long time has created a huge amount of interest out there.

***Maria Caulfield:*** I would point to the website as well. One good thing that we had from the women's health strategy was that we put a dedicated portal on the NHS England website, so women could go there, knowing it is reliable information about a range of women's health issues. We are starting to do that with men's health. There are things about testicular cancer and low sperm count that men can refer to. We probably need to build that up so that, if men are a little bit nervous about talking to their mates or going to see the GP, they can go to the NHS website and know that there is some reliable information there as well. That is something that we want to build on too.

***Jason Yiannikkou:*** This agenda is essentially about optimising health gain. Seeing it all through that lens, which this process has done really well, takes you a long way. I would go back to the point I made earlier. There is a really useful alignment between looking at the things that you have looked at in the way that you have looked at them and the wider agenda for health and care for the next 20 or so years. This is part of a bigger shift in the way we do healthcare and health policy. It potentially is really positive.

***Maria Caulfield:*** Can I plug the TRANSFORM trial as well? Those invitations will be going out later this year. It is for men aged 50 to 75. They will be invited by their GP. It is not a volunteer scheme. For black men, it will drop down to age 45, because of their particularly high risk, for screening. In my understanding, it is going to be an MRI scan to check for prostate cancer, but we need thousands of men to come forward so that we can try to build a national screening programme if the evidence supports that.

Q179 **Chair:** You do not volunteer for it. You are invited to it.

***Maria Caulfield:*** Yes, so your GP will send you a letter. If you get that letter, take part in that trial. We need as many men as possible to take part.

Q180 **Chair:** Equally, it would not hurt, if you were having a conversation with your GP, to suggest that you might be interested.

***Maria Caulfield:*** I am not quite sure which criteria they use, but yes, it would definitely be worth having that conversation.

**Chair:** The TRANSFORM trial is very positive. That is it. Thank you very much for your time. Thanks to everyone who has contributed to this inquiry. Thanks to everyone who has given us written evidence. It is all published on our website. All the evidence that we have accepted and published is there on the Health and Social Care Select Committee website. You can see it all. We will write our report in due course, which I know you always, very kindly, take seriously and respond to, so thank you for that. That is it for today.