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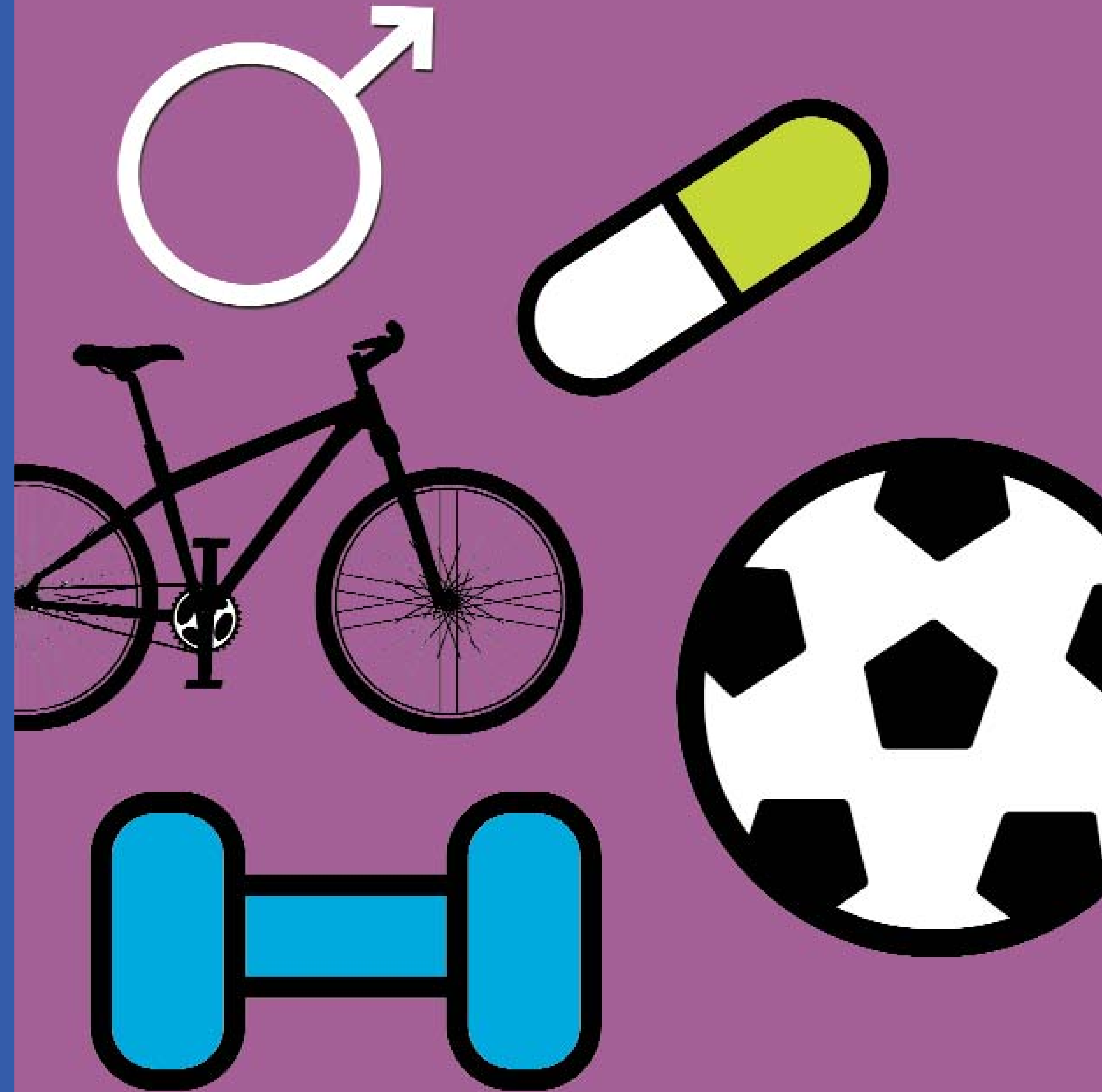
men's health in Lewisham

a scrutiny review



Men's health in Lewisham, a scrutiny review

July 2007

Membership of the Men's Health Scrutiny Review Working Group:

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Councillor Chris Flood
Councillor Chris Maines
Councillor Andrew Milton
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Foreword

We would like to thank all the contributors, especially members of the local community, who have been an integral part of the Men's Health Review. Our task is formidable, to make an impact on improving the health of Lewisham's male population, and we wish to pay tribute to the dedication of the PCT staff and the improvements they are achieving.

As a review team we all gained valuable experience in the important task of scrutinising our local health services and we are keen to share our experience both in Lewisham and more widely. Engaging positively with Lewisham Council and the whole NHS in Lewisham has been crucial to making this process work.

We would like to draw attention to some common themes that developed during the year: the need for men to have better access to services and to visit their GP when 'things start to go wrong' and not to delay, and the importance of gender when considering service improvements or changes.

This report offers both observations and recommendations on additional measures for improving the health of men in Lewisham, which should improve the quality of health for many of our residents.

We were impressed by the amount of time and careful consideration given to the production of this work by so many. We would also like to thank the Men's Health Forum for its expertise and excellent independent advice and its views on tackling the issues affecting health and well-being. Thanks, too, to the officers of the Council, University Hospital Lewisham, South London and Maudsley NHS Foundation Trust, the officers of Lewisham PCT, in particular the Public Health Directorate Team, and finally the members and advisers of the Healthier Communities Select Committee for all their contributions.

We commend the Men's Health Review in Lewisham to Lewisham Council and all our partners across the NHS and look forward to a lively debate and improvements to men's health in Lewisham.

Councillor Alan Hall
Chair, Men's Health Review

Councillor Sylvia Scott
Chair, Healthier Communities Select Committee

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Executive summary

The objectives of the Men's Health Scrutiny Review were:

a) to explore how existing service provision and advice helps to meet the strategic aims, objectives and priorities for Lewisham

b) to identify what services are specifically targeted for men's health in the borough, including mental health services

c) to understand the nature of men's health issues, including sexual health, and in particular if there are any inequalities that exist between different groups of men (for example according to age, sexuality, ethnicity, religion or disability) and what actions could be taken to address these

d) to consider what would make it easier for men to access health services

e) to examine the communication and targeted health awareness-raising campaigns in the borough

f) to identify specific action that the local authority and/or its health partners might take to promote and improve men's health service provision and men's health awareness in general.

A number of qualitative and quantitative methods of information collection were used and baseline information was provided by the council services as well as local health services. Interviews took place with a number of Lewisham council officers, NHS staff and voluntary sector staff. Meetings were held across the borough in different community settings to attract contributions from people and groups who may not have traditionally engaged with the Council and the scrutiny function.

An analysis of the emerging themes was undertaken as a piece of desk research by the scrutiny officer and discussed with members of the Men's Health Scrutiny Review Working Group of the Healthier Communities Select Committee. From the analysis a number of conclusions were drawn as detailed below.

Conclusions

Listed below is a summary of the recommendations resulting from the review of men's health in Lewisham. The full analysis and comprehensive recommendations are provided in Section 4 of this report at page 106.

Overview of men's health

1. The Review Group recommends that information included in residents' surveys needs to be better integrated and shared among the statutory organisations as there is currently very little information available on men from new and emerging communities within Lewisham accessing health services, for example the proportion of Chinese and Vietnamese men accessing health services is unknown.

2. Further consideration needs to be given to the promotion of well men clinics. In particular, the vast majority of men attending well men clinics are older men. Further consideration should be given to developing a social marketing approach to enable Lewisham PCT to target services better and to encourage younger men to access services.

Circulatory diseases

3. It is recommended that Lewisham PCT's Strategy for Stroke is reviewed and that an integrated disease management approach is needed for stroke, coronary heart disease and hypertension, which will benefit both men and women. The current strategies were developed over 10 years ago and were based upon the Lambeth, Southwark and Lewisham Partnership arrangements, which are now outdated. Hypertension is particularly prevalent in the African-Caribbean community in Lewisham, and this needs to be addressed by Lewisham health partners, including the London Ambulance Service, through a comprehensive hypertension strategy.

Smoking cessation

4. It is recommended that a question on smoking is included in the next survey of residents to record smoking prevalence and to better target stop smoking services on an ongoing basis.

5. It is recommended that the Council strengthens its role and responsibility in terms of general well-being and promotes the benefits of smoke-free environments and stop smoking services to staff, service users, clients and contractors. In particular, both the Council and local NHS bodies should use their contractual powers to the fullest to influence other organisations to implement a no smoking policy on all Council and NHS sites to reinforce good practice and raise public awareness.

6. With the stop smoking services expanding their work, there is a need to raise the profile and visibility of these services in Lewisham and to focus on tackling the discrepancy in the number of men to women who are quitting via the smoking cessation services. It is recommended that targeted promotion to men and social marketing of smoking cessation services are developed and implemented. Examples of good practice included Lambeth smoking cessation as being particularly innovative and successful through using social marketing tools, along with Tower Hamlets for raising awareness and promoting health services to hard-to-reach groups. Both Southwark and Lambeth have used a popular DJ from Choice FM to reach people with positive health messages through role modelling.

Physical exercise

7 It is recommended that further work is carried out to assess the appropriateness of the choice and image of the exercise sessions on offer via referral from GPs so that they appeal more to men, to ensure men are being offered the services and that the benefits of taking part are promoted.

8 It is recommended that when follow-up scrutiny is carried out, council officers are asked to report back to the scrutiny body on the outcomes of visits to pubs and workplaces in Lewisham to promote physical activity and the benefits of taking part in exercise for men in relation to health promotion.

9 Only 55% of boys and 39% of girls were reaching the recommended level of physical activity, and the Council needs to do more to increase the numbers of boys and girls reaching the recommended level.

10 The Review Group welcomes the proposed establishment of a Lewisham Sports Council and recommends that the Council and PCT give their support to its successful formation.

11 It is recommended that the Council and PCT, when marketing physical activity, highlight the benefits of everyday activities such as walking and cleaning as identified in the promotion leaflet 'A bit of what you fancy'.

Diet and nutrition

12 It is recommended that, as part of the implementation of the government white paper, the promotion of healthy eating should be considered through local planning and licensing decisions. When responding to consultation on the enhanced role of the councillor and corporate councillor as part of the new government white paper, the Council could include the requirement that local authorities should have a greater influence over planning and licensing policy and that decisions should include consideration of health implications, for example in relation to planning and licensing applications for food outlets to encourage healthy foods.

13 It is recommended that choice in school dinners should be directed at helping to encourage children and young people to eat healthily. The Review Group welcomed schools becoming more active in their involvement with the food choices that pupils bring to school as part of their lunch boxes.

14 In terms of the Healthier schools initiative, greater efforts need to be made to help encourage all schools in Lewisham to participate in the Healthy Schools initiative.

Cancers

15 The Review Group acknowledges the pilot programme for prostate cancer screening, in particular the positive work carried out by Guy's and St Thomas's NHS Foundation Trust, and that the PSA test has some limitations in terms of its accuracy in detecting prostate cancer. To this end, it is recommended that careful counselling is provided alongside PSA tests.

16 It is recommended that Lewisham PCT researches the most appropriate ways in which health promotion can be targeted at men who are at risk of prostate cancer and that a community development approach could be used to promote early detection.

17 The Review Group wishes to highlight good practice identified by the cancer awareness pilot initiative in two Lambeth pharmacies carried out by Lambeth PCT, Health First and South East London Cancer Network. The pilot recognised that whilst there is some resistance to consulting GPs, men especially are more likely to visit their pharmacist and seek advice and over-the-counter treatments for symptoms typically associated with some cancers, e.g. indigestion, rectal bleeding, persistent coughs. The cancer awareness pilot scheme encouraged people with such symptoms who are most at risk of developing cancer to seek advice from their GP sooner than they may otherwise have done. Leaflets providing information on the symptoms and risk factors were handed out to middle-aged and older customers in pharmacies when they purchased over-the-counter medication for these symptoms. It is recommended that Lewisham PCT and pharmacies adopt the approach of the cancer awareness pilot initiative in two Lambeth pharmacies.

Mental health and well-being

18 It is recommended that all healthcare services need to include mental health in prevention strategies, with clear robust actions to take into account the serious and profound impact of racism, to improve cultural awareness and to reduce discrimination. There is also a need to develop training specifically for GPs to help them fully assess whether young men are suffering from early mental health problems in order to avoid their dismissal as 'difficult' or 'adolescent' young men.

19 The Men's Health Review recommends improved and robust systematic monitoring systems to collate better evidence to improve equity of access to services and treatment outcomes for black men and BME communities. This is to ensure that health partners are able to clearly see the evidence of groups at risk of serious diseases. This needs to be taken seriously as otherwise health services will continue to be delivered in the same way and health inequalities will remain for some groups.

Sexual health

20 It is recommended that it is made a priority that all children and young people have access to sex and relationship education (SRE) in Lewisham, as young men's health is vitally important for this borough. On an individual level people would be free to opt out of SRE should they wish to, but there is a need for SRE to be politically driven. It is felt that this message needs to be politically driven as well as managerially driven to ensure that all young people are offered the opportunity to receive evidence-based, age-appropriate sex and relationship education.

21 It is recommended that the PCT and Council carry out focus group work with young black men to ascertain the causes, and come up with solutions for reducing the rates, of the sexual health and mental health problems that currently exist in Lewisham.

Men's access to health services

22 The Review Group recommends that Lewisham NHS bodies and the Council consider the following factors to help encourage men to access health services:

- providing more early morning, evening and weekend opening of health centres
- the use of male receptionists where possible and practicable
- holding getting-to-know-you evenings hosted by GPs and nurses
- greater use of male practitioners within health-promotion work with boys and men
- greater use of occupational health services, which should be extended from screening to the providing of primary healthcare services
- greater linking of health services to sport
- extension of walk-in GP services
- raising parents' awareness of the need to encourage within boys the responsibility for managing their own health and the skills to do so
- training staff in health centres to help them understand young people and their health needs and health-seeking behaviours
- increasing the number of healthy living centres and stimulating more initiatives that are proving popular with men
- promoting the work of the Men's Health Forum by creating local portals to the Men's Health Forum website from the Council and local NHS websites so that visitors can have direct access to the substantial amount of information available
- looking to develop men-only sessions in walk-in health centres and other pilot services such as 'MOT' health checks at pharmacists and mobile units.

23 It is recommended that any plans to target young people where they congregate should make reference to and use good practice developed from joint work carried out by SLaM and Lewisham PCT, as well as looking to utilise links with famous and well-known people, using them as role models to galvanise and publicise the work in relation to men's health.

In conclusion, the Review Group recognises there is a need to get as many men as possible to use the existing health services in the way they are there to be used, but trying to persuade as many men as possible to use the services may mean that the services will have to change.

Quality of life issues

24 It is recommended that the Council with the PCT consider ways in which health impact assessments of Council services can be carried out, and that the results be reported back to the health scrutiny body.

Concluding remarks

There are a number of common themes emerging from this review relating to access to health services and the fact that men do not perceive health services to be for them, with a need for more outreach work. This is recognised through partnership working in Lewisham between the health providers and the Council; the partnerships are well established and are to be commended, but there is a requirement for greater integration in the future to provide a stronger shift in focus towards health promotion.

A central lead to help coordinate activity around men's health is required. In the past it was rare to actually state the need for focused work around men's health, and although this is now changing, there is still a need for further policy formation that is informed of the men's health agenda. It is hoped that this review will go some way to highlighting this and identifying actions to be taken to improve the health outcomes for men in Lewisham.

25 It is recommended that the scrutiny review into men's health in Lewisham is revisited in two years' time to ascertain the changes and developments against the findings and recommendations made in this report.

26 It is further recommended that the innovations and learning points gained by conducting the review into men's health in Lewisham and detailed in Appendix 1 of this report are adopted by the Overview and Scrutiny Business Panel as good practice in scrutiny.

Section 1 – Introduction

> 'Men's health is a relatively new area of concern and there is a feeling that what is missing is a lead to help coordinate activity around men's health. In the past it was rare to actually state the need for focused work around men's health, and although this is now changing, there is still a need for further focus on the men's health agenda.' (White, 2001)

The Men's Health Review is the first to be undertaken by a working group of the Healthier Communities Select Committee, using funds provided by the Centre for Public Scrutiny (CfPS) to undertake and develop action learning for overview and scrutiny. Action learning was carried out by the councillors undertaking the review with support from independent consultants Shared Intelligence. Action learning is a process used to provide a broad perspective on the development of scrutiny and its long-term effectiveness in terms of the project processes, partnership arrangements and engagement with local decision makers and the community. The action learning from the Men's Health Review has included good practice developed by involving the community, using community venues and handling different types of witnesses; further details are available at Appendix 1 – Innovations and learning points as reported to the CfPS.

The overall aim of this review was to explore men's health issues in Lewisham and to establish whether there are any inequalities that exist between different groups of men and what actions could be taken to address these.

This report is split into three main sections, plus this introduction (which comprises Section 1). Section 2 deals with the methodology for the scrutiny review, including the scope and rationale for choosing to focus on men's health issues. The third section details the evidence and information gathered during the review, and this includes the national picture for men's health and the local context for the London Borough of Lewisham. Following on are the specific health conditions of importance locally: circulatory diseases, including hypertension, heart disease and stroke, cancers affecting men, sexual health, and mental health and well-being. Evidence was also gathered on lifestyle issues affecting men's health, including smoking prevalence, diet and physical exercise, men's attitudes to health and well-being and the health services available.

The final section of the report presents the Review Group's consideration of the overall findings from the review with recommendations for policy development and specific actions by Lewisham Primary Care Trust, Lewisham Council and other local health service providers.

Section 2 – Methodology

Scope

In scoping this scrutiny review, the Healthier Communities Select Committee set up a working group to carry out the review and report to the select committee. The working group comprised five committee members and recruited two representatives from Lewisham Primary Care Trust as advisers to the working group: a senior director from the Public Health Team and a senior director for communications with expertise in patient and public involvement in health.

The working group was established specifically to carry out the terms of reference agreed by the Healthier Communities Select Committee:

a) to explore how existing service provision and advice helps to meet the strategic aims, objectives and priorities for Lewisham

b) to identify what services are specifically targeted for men's health in the borough, including mental health services

c) to understand the nature of men's health issues, including sexual health, and in particular if there are any inequalities that exist between different groups of men (for example according to age, sexuality, ethnicity, religion or disability) and what actions could be taken to address these

d) to consider what would make it easier for men to access health services

e) to examine the communication and targeted health awareness-raising campaigns in the borough

f) to identify specific action that the local authority and/or its health partners might take to promote and improve men's health service provision and men's health awareness in general.

Rationale

The rationale for this review was simple and was chosen by councillors following discussions on the health indicators of men in Lewisham, including gender differences in mortality, the main causes of death in men and the decision of Lewisham Primary Care Trust (PCT) to delay building capacity in areas of significance to men's health until the following financial year. Councillors were concerned with the existing health inequalities for men in Lewisham and with this review were seeking to address these imbalances by investigating the issues with the PCT in order to make recommendations for change to improve the health outcomes of men in Lewisham.

Lewisham's health economy is typical of the national picture for health, with considerable pressure on both Lewisham Primary Care Trust and University Hospital Lewisham, which are facing compounded deficits and need to establish recovery plans to achieve financial balance. A strategic rethink of local health services is essential to achieving a local health service that is fit for purpose and in financial balance. The results of this review will inform a local review of men's health services in 2007–8, and it is hoped that it will have a direct influence on the shape of men's health services locally.

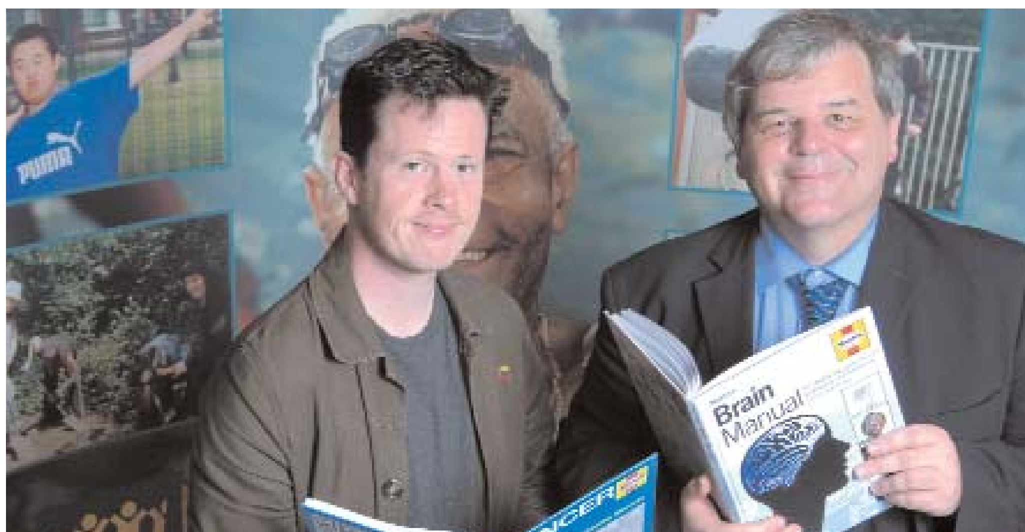
Methodology

The working group held two planning meetings in June and July 2006 to scope the review and determine the guest speakers, reports to be commissioned and approaches to engaging the local community.

The review engaged with patients and the public by involving the local Patients' Forums, established local organisations concerned with health issues and men's issues, widespread publicity using the media, website promotion and publicity targeted directly at men's groups and general consultations. This included using the Gender Equality Scheme Consultation on 2 December 2006 with a specific workshop on men's health in Lewisham and the local Mental Health Stakeholder Event held on 31 October 2006, which provided a workshop on mental health for young black men in Lewisham.

A public launch event for the review into men's health was held on 26 September 2006, which was very well attended by voluntary and community groups. The launch event provided presentations on the national context for men's health and men's health in Lewisham, followed by a question and answer session.

From the launch event, the working group agreed a programme of six further meetings. Crucially, the meetings were held in various public and community venues across the borough to attract attendance and involvement from as many people as possible; they included meetings at a local health and fitness centre and at a voluntary sector organisation that offers support for people of African and African-Caribbean descent experiencing mental health difficulties. The meetings focused on the following topics:



Mental Health

- circulatory diseases (including hypertension, heart disease and stroke), the benefits of participating in physical activity, healthy diet and stop smoking services
- cancers
- mental health and well-being
- sexual health
- access to health services
- quality of life issues linked to the national Choosing Health agenda.

Section 3 – Information and evidence

The purpose of this section is to outline the information gathered about men's health generally for Lewisham and specifically about the six topics listed in the methodology in section 2.

The following information was submitted and reviewed:

A: **The national context for men's health** including life expectancy and mortality, an overview of circulatory diseases, cancer, sexual health, mental health and national initiatives for improving public health as included in the government white paper Choosing Health: Making Healthy Choices Easier.

B: **Men's health in Lewisham** including life expectancy and mortality, an overview of circulatory diseases and cancer prevalence locally, sexual health and mental health.

C: **Circulatory diseases** including the background and the national service framework for coronary heart disease, primary prevention, opportunities for working in partnership on smoking cessation, obesity, food nutrition and health, secondary prevention including acute myocardial infarction, angina, revascularisation, coronary angiography activity, electrophysiology procedures, heart failure, cardiac rehabilitation, stroke services, hypertension and support services for physical activity.

D: **Trends in cancer amongst men in Lewisham** including lung cancer, prostate cancer, stomach cancer, colon and rectal cancers, bladder cancer, all skin cancers and throat cancer, mortality rates from cancer and prevention measures.

E: **Men's mental health and well-being** with a focus on young black men aged 16–24 in Lewisham, including epidemiology of mental illness in Lewisham, treatments for severe mental illness, explanation and academic research for higher than expected numbers of young black men in the psychiatric system and reported racially aggravated crime.

F: **Men's sexual health** including HIV, chlamydia, gonorrhoea, syphilis, teenage pregnancy rates, the national sexual health strategy, sexual health services available to Lewisham residents, screening programmes, testing and treatments, sexual health promotion including voluntary sector prevention services and the role of Health First in Lewisham.

G: **Men's access to health services** including attitudes towards health, health concerns, help to keep healthy, health improvement priorities, public involvement and community health work, the hypertension community health programme for men in Lewisham and the Health Bus.

H: **Quality of life issues affecting men's health** including information on demographics, health, income and welfare dependency, housing, GCSE results, adult education, carers and employment.

A: The national context for men's health

1. Introduction

Over the past 20 years, men's health has emerged as a concern in the UK and other developed countries. The interest in women's health, which developed as part of the feminist movement, highlighted the fact that, despite their dominance in most other areas, men fare less well than women in relation to health and life expectancy.

Men's health in England and Wales is poor according to a range of measures. It also varies depending on race, class and other differences.

- During the period 2002 to 2004, life expectancy at birth for males in England and Wales was 76.5 years. In this same period, the corresponding figure for females was 80.8 years.
- Men in higher-level managerial jobs can expect to live about three and a half years longer than men in manual work.
- The main causes of death in men in England and Wales are circulatory diseases (including heart disease and stroke) and cancer.
- Suicide is the most common cause of death in young men, and although there has been a sustained downward trend in the last five years, last year almost 1,000 men took their own lives.
- Men take risks. Two in five drink too much. More than one in four smoke and one in three younger men use illegal drugs.
- Diagnoses of both prostate and testicular cancer have increased since the early 1990s.
- More and more men are catching sexually transmitted infections.
- Men are less likely than women to consult a doctor and are much less likely to visit a dentist for a check-up.
- Compared to the wider population, Indian, Bangladeshi, Black Caribbean and Irish men are at greater risk of heart disease and stroke.
- Men in routine and manual jobs are more likely to smoke and have chronic health problems than other men.

2. Life expectancy and mortality

The most striking men's health problem is lower life expectancy. Tackling this life expectancy gap will require tackling the causes of death that underpin it.
With the notable exception of cancers in the 30 to 44 year age group, mortality rates in England and Wales are higher for males than females for all the major causes of death and in almost all age groups (Table 1).

England & Wales						Rates per 100,000 population
	0-14	15-29	30-44	45-64	65-84	85 & over
Males						
Infectious diseases	2	1	3	6	30	142
Cancers	4	6	23	245	1,403	3,422
Circulatory diseases	1	4	27	232	1,861	7,982
Respiratory diseases	2	2	5	41	566	3,610
Injury and poisoning	4	41	45	36	59	299
All causes	28	71	139	654	4,427	18,806
Females						
Infectious diseases	1	1	1	4	24	115
Cancers	3	5	32	218	921	1,858
Circulatory diseases	1	3	11	88	1,269	7,016
Respiratory diseases	1	1	4	30	403	2,654
Injury and poisoning	3	10	12	15	45	294
All causes	21	28	80	416	3,115	15,983

3, Circulatory diseases

Circulatory diseases (which include coronary heart disease – CHD – and stroke) have remained the most common cause of death in England and Wales over the last 90 years among both males and females. Male death rates from circulatory disease are higher than those for females: 300 per 100,000 males and 190 per 100,000 females in 2003. Within these, death rates from CHD were higher than from stroke among both males and females.

Key lifestyle risk factors for CHD include smoking, poor diet and lack of exercise. About ten million people in England smoke – over one in four people. Approximately 20% of CHD-related deaths in men are attributable to smoking. The incidence of CHD is highest amongst people who are obese. Overall, 22% of men in England are now obese. Regular physical activity reduces the risk of cardiovascular disease mortality in general and of coronary heart disease mortality in particular. Physically inactive people have about double the risk of CHD.

The National Service Framework (NSF) for Coronary Heart Disease (CHD), published in March 2000, sets out a strategy to modernise CHD services over 10 years. It details 12 standards for improved prevention, diagnosis, treatment and rehabilitation and goals to secure fair access to high-quality services.

4. Cancer

Lung cancer is the most common cause of death from cancer for both men and women, responsible for 24% of all male cancer deaths. Since 1950 lung cancer mortality rates in men have declined for all age groups. During the same period, mortality has increased for most age groups in women. Despite this trend, mortality in all age groups is still considerably higher for men than for women, and there is no doubt that lung cancer remains the most important cancer in terms of mortality in men.

More than 10,000 men a year die from prostate cancer in the UK, which makes it the second most common cause of cancer mortality in men after lung cancer.

Today one man in 12 is diagnosed with prostate cancer, almost 32,000 every year, and it has now overtaken lung cancer to become the most common cancer in men. This increasing incidence is largely due to a higher number of cases being diagnosed (through the greater use of PSA tests) and the influence of an ageing population.

The majority of men with prostate cancer are aged over 60 years. Although this cancer can also occur in younger individuals, it is very rare under the age of 50.

The PSA test can be used to screen for early prostate cancer. The PSA Blood Test tests the level of 'prostate specific antigen' in the blood. A high reading suggests prostate cancer but could also be caused by other conditions, which means the PSA test is not a foolproof test for prostate cancer.

- Two out of three men with a raised PSA level will not have any cancer cells in their prostate biopsy.
- Up to one in five men with prostate cancer will have a normal PSA result.

A positive biopsy is needed to confirm cancer. If prostate cancer is diagnosed, it is not necessarily life threatening and curative treatment may not be required – most men diagnosed with early prostate cancer following a positive PSA test would be expected to have slowly growing cancer which should not cause any problems during their natural lifespan.
There is controversy over whether PSA testing should be used in routine screening for prostate cancer. Many feel it would be wrong to introduce national screening in this country because the effectiveness of screening is unproven and the side effects of treatment can be significant. As a result, there is no NHS PSA testing programme because it has not been demonstrated that it leads to an improvement in mortality.

Testicular cancer primarily affects younger men and is the most common form of cancer in men aged between 15 and 45. Testicular cancer is still quite rare, with about 2,000 cases a year in the UK, but its incidence is increasing dramatically – by almost fourfold in the last 50 years – and the reasons for this are not yet known.

Thanks to advances in treatment, testicular cancer has an overall cure rate of 95%. The cure rate can be as high as 99% if caught at an early stage. Regular testicular examination by men themselves is a recognised means of ensuring early diagnosis.

5. Sexual health

The number of people living with HIV in the UK is now around 58,300. This latest figure includes both those who have been diagnosed and also an estimated 19,700 who remain unaware of their infection and therefore undiagnosed.

During 2004, 7,275 new HIV diagnoses were reported in the UK – this compares with 7,217 diagnoses in 2003. The majority of cases (4,287) were diagnosed in heterosexual men and women, 73% of which were likely to have been acquired in Africa.

Of all cases of HIV infection thought to have been acquired in the UK, three-quarters were in gay and bisexual men and the total number of all new diagnoses in this group in 2004 – 2,185 – was the highest since 1990. This figure is a combination of both those who have been infected for some time who have come forward as a result of increased HIV testing and those tested as a result of recent risk. Separate laboratory testing has also shown that the rate of new infections in gay and bisexual men has remained constant.

While there has been a levelling off in the number of diagnoses likely to have been acquired through heterosexual sex in Africa between 2003 and 2004 (from 3,457 to 3,138), there has been a slow but steady rise in the number of heterosexual infections acquired in the UK in recent years, from 227 diagnoses in 2000 to 498 in 2004.

In addition to this information on HIV, the following are national sexual health challenges:

- There has been a steep rise in the number of syphilis infections between 2003 and 2004, from 1,641 to 2,254, against a backdrop of several localised outbreaks amongst gay men and heterosexuals in areas such as London and Manchester.
- There have been 215 cases of Lymphogranuloma venereum (LGV) in an outbreak amongst gay men since 2004. This has mainly affected London and Brighton.
- In 2004 the rates of people accessing HIV-related treatment and care services were much higher in England (91 per 100,000 population) than in the rest of the UK (17 to 46 per 100,000 population).
- The London region cares for the largest number of diagnosed HIV individuals, with 22,642 accessing HIV-related care in the capital during 2004.
- Gonorrhoea diagnoses in England (42/100,000) were more than double those in Wales (18/100,000) and Scotland (15/100,000), and five times higher than those in Northern Ireland (7.3/100,000) in 2004.

The Department of Health published its National Strategy for Sexual Health and HIV in 2001.

A plan to begin implementing a national screening programme for chlamydia was included in the national strategy. Ten opportunistic screening programmes were implemented in 2002, with a further 16 programmes announced in January 2004, currently covering over 25% of PCTs in England, including Lewisham where screening for gonorrhoea is included in the programme. The overall programme aim is to implement and monitor opportunistic screening for genital chlamydia trachomatis infection for young women and men in selected programmes in England.

6. Mental health

A new drive to reduce the suicide rates in young men was launched in June by Health Minister Rosie Winterton, when she published a report outlining the findings of three pilots which have been looking at ways to reduce suicide rates in young men.

The three government-funded projects were set up in 2004 to help identify the barriers that may discourage young men from seeking help and to look at ways of reaching out to this particularly vulnerable group. The results of the pilots will be used to spread best practice and learning across the NHS.

The pilots – based in Camden, Bedfordshire and Manchester – found that:

- Community-based locations such as youth centres and youth-oriented services offered a more successful means of engaging with young men than more formal settings such as GP surgeries.
- Front-line staff, when given appropriate training, are better able to engage with young men.
- Alternative terms to 'mental health' – such as 'dealing with stress' or 'well-being' – need to be adopted to encourage young men to engage with future projects and to ensure that mental health issues are discussed in a non-stigmatising way.
- Proactive and community-based outreach programmes should be established, as these approaches were perceived by young men as more acceptable, less threatening to their self-esteem and less risky, since staff were perceived as less likely to share information with other agencies, such as the police.
- Accessible information and advice need to be available for family members and friends of young men, since they are likely to provide a more immediate and trusted source of support.

7. Other national initiatives

In November 2004 the Department of Health published *Choosing Health: Making Healthy Choices Easier*, a white paper describing its approach to improving public health in England and Wales. The document outlined six priority areas:

- tackling health inequalities
- reducing the numbers of people who smoke
- reducing obesity
- improving sexual health
- improving mental health and well-being
- reducing harm and encouraging sensible drinking.

Subsequently the Department published *Delivering Choosing Health*, in which it outlined how the commitments identified in Choosing Health were to be delivered at the national, regional and local level, across all sectors.

Children, young people and older adults were identified as population groups requiring a particular focus in the white paper and in *Delivering Choosing Health*, and although men were not identified in the same way, all the priority areas have an importance for men. Any review of men's health should be undertaken in the context of *Choosing Health*, particularly in relation to prevention.

Prior to the publication of *Choosing Health*, an important development in the UK was the establishment in 2001 of an All Party Group on Men's Health. This group aims to raise awareness of men's health issues and has focused on the following topics:

- male health policy
- heart disease
- depression
- sexually transmitted infections (STIs)
- erectile dysfunction and underlying conditions
- PSA testing.

The secretariat to this All Party Group is provided by the Men's Health Forum. The forum, founded in 1994 and a registered charity since 2001, works for the development of health services that meet men's needs and to enable men to change their risk-taking behaviours. The Department of Health has provided funding to the Men's Health Forum, assisting the provision of health information and advice via a range of media, including a free website (www.malehealth.co.uk). These two bodies are the main advocates for men's health in England and Wales.

Donal O'Sullivan, 17 August 2006

UHL & PCT

B: Men's health in Lewisham

1. Introduction

As is the case in the country as a whole, the health experience of men in Lewisham is of concern.

- Male life expectancy at birth is about 74 years, compared with 75.7 in London and 76 years in England.
- The main causes of death in men in Lewisham are circulatory diseases (including heart disease and stroke) and cancer.
- The proportion of premature deaths due to circulatory diseases in Lewisham residents is about 20% higher than is the case in the country as a whole. The excess deaths are mainly due to stroke, which is more common in men than in women.
- Mortality due to cancer in the under 75s is considerably higher amongst men than amongst women in Lewisham.
- Men are more likely to smoke than women and are less likely to access stop smoking services.
- In comparison with the country as a whole, very high rates of HIV and other sexually transmitted infections occur in men in Lewisham, many of whom are not accessing relevant services.
- There are significantly greater mental health problems in Lewisham than in the country as a whole.
- Men are much less likely than women to contact their family doctor with a mental health problem, no matter how severe.
- Mortality due to alcohol and levels of problem drug use are high amongst men locally. Both alcohol and drug use have a significant impact on criminal behaviour locally.

Many of these concerns are being addressed, and members of the Overview and Scrutiny Committee may require further information on the action being taken. But it is not clear how best to address others; high rates of sexual and mental health problems (including suicide, drug use and problem alcohol use) in young men are of particular concern, especially in young black men. It is important that members of these groups are aware of, and act on, appropriate health promotion messages. It is also important that they access relevant services as necessary. How best to achieve these ends remains a challenge.

2. Life expectancy and mortality

Male life expectancy at birth is about 74 years in Lewisham, compared with 75.7 years in London and 76 years in England. Although life expectancy has improved for men in Lewisham over recent years, it has remained consistently lower, by two years or so, than male life expectancy in the country as a whole.

Locally, men also fare badly compared to women; life expectancy at birth for women in Lewisham is 79 years, five years higher than that for men.

Within Lewisham there is wide variation in male life expectancy (Figure 1). The ward with the lowest life expectancy for men (New Cross) has an average life expectancy of 5.9 years less than the ward with the highest (Blackheath).

New Cross, Lewisham Central, Evelyn, Rushey Green, Sydenham and Telegraph Hill are the wards with the lowest life expectancy for males in Lewisham.

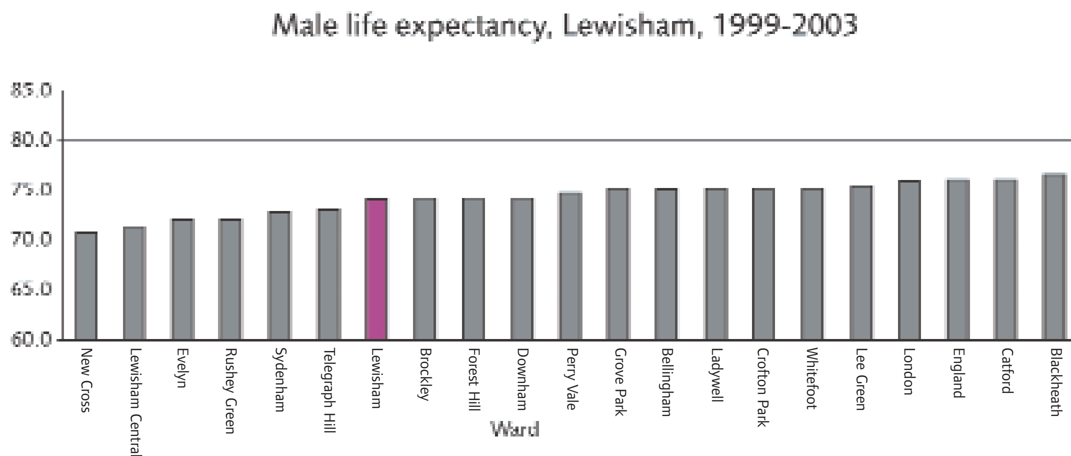
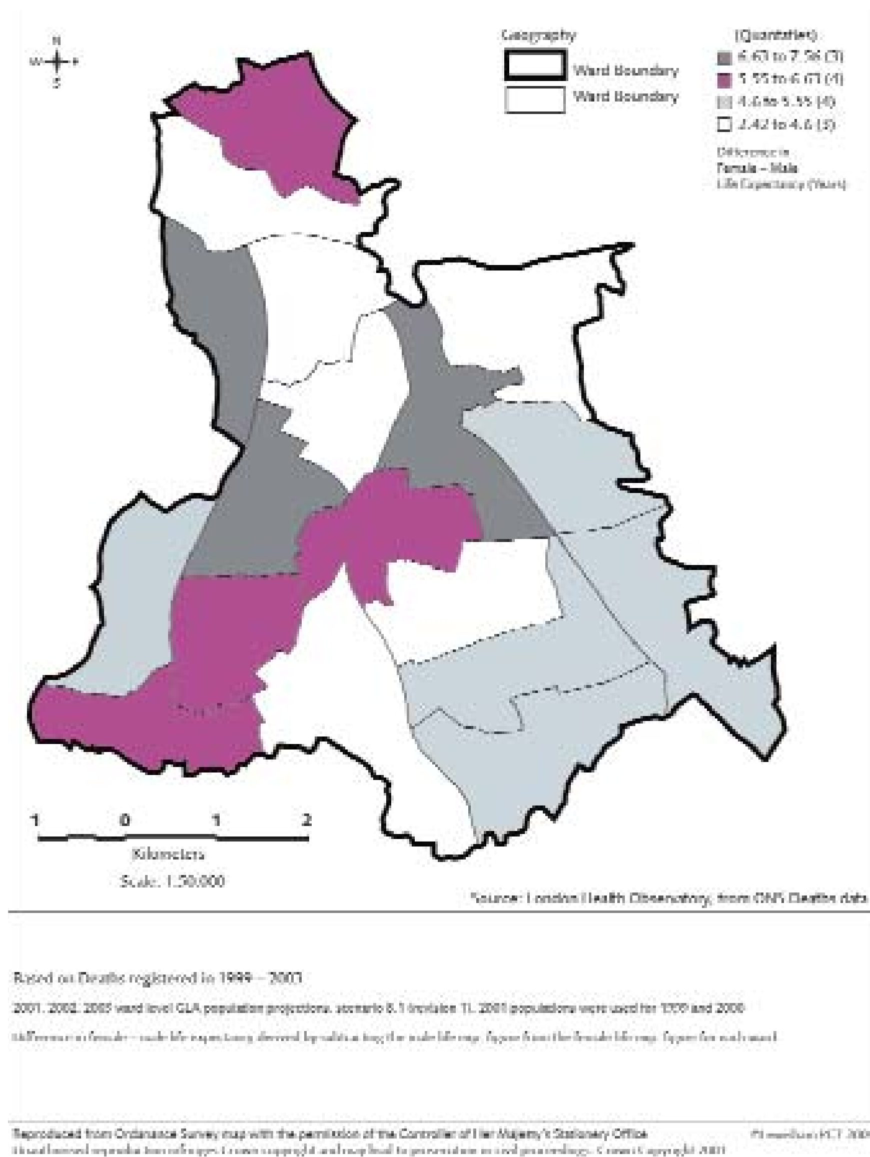


Fig 2 Difference in Female - Male life expectancy at birth, Lewisham 1999-2003



3. Circulatory diseases

Circulatory diseases, which include coronary heart disease (CHD) and stroke, have remained the most common cause of death in England and Wales over the last 90 years among both males and females.

The proportion of premature deaths due to circulatory diseases in Lewisham residents is about 20% higher than is the case in the country as a whole. The excess deaths are mainly due to stroke, which accounts for about 10% of mortality in Lewisham. Although mortality due to stroke is declining, there is a preponderance of deaths amongst males at all ages (Figures 3 and 4). The primary care team is the key to the prevention of stroke and to the long-term management of disability and handicap resulting from stroke.

Figure 3

Deaths from stroke in people aged under 65 years, Lewisham, 1993-2004

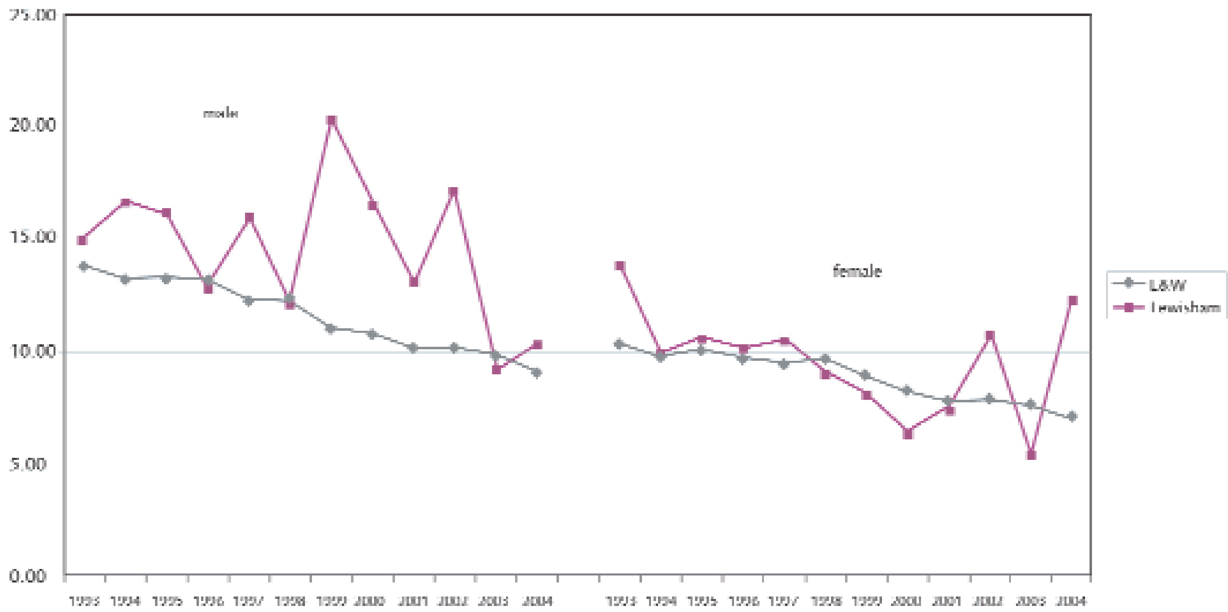


Figure 4

Deaths from stroke in people aged 65-74 years, Lewisham, 1993-2004

CHD mortality rates have declined considerably since the early 1980s. Within England in 1990, the directly age standardised rate in the under 75s was 114 deaths per 100,000, and this declined to 62 per 100,000 in 2000, representing a fall of 52 per 100,000. The Lewisham rate also fell from 120 per 100,000 to 65 per 100,000, an appreciable drop of 55 per 100,000. Despite these encouraging trends, premature deaths in Lewisham residents from coronary heart disease are still about 10% higher than nationally, and deaths from CHD for all ages are about 2% higher than nationally. Lewisham ranks 10th in London for deaths from coronary heart disease

Key lifestyle risk factors for CHD include smoking, poor diet and lack of exercise.

Smoking prevalence locally has been estimated at approximately 33%, but with considerable variation between wards; estimates of smoking prevalence in Bellingham, Brockley, Downham, Evelyn, New Cross and Telegraph Hill are all higher than the Lewisham average, with Evelyn ward being the highest at 42%.

The Lewisham stop smoking service is a treatment programme operating at three levels:

- Level 1 – provision of information about smoking and health and services available to help smokers to quit (provided by any professional)
- Level 2 – provision of one-to-one support and advice (provided by trained community stop smoking advisers)
- Level 3 – provision of specialist, intensive support for smokers by the specialist smokers' clinic.

Local Level 2 and Level 3 services have reached approximately 11% of smokers in the past six years. A quit date is the pre-set date on which a client of Level 2 or 3 plans to give up smoking. A recent health equity audit has demonstrated that more women than men set quit dates in both Level 2 (62% compared with 38%) and Level 3 services (59% compared with 41%), indicating that far fewer men than women are accessing these services. More positively, having set a date to quit, equal proportions of men and women (39%) are not smoking four weeks after their quit date. It is hoped that expansion of Level 2 services in pharmacies and workplaces, and increased outreach services, will increase access by men to these services.

It has been estimated that over 63% of Lewisham men aged 16 or over are overweight or obese.

The Lewisham Physical Activity, Sport and Leisure Strategy (available separately) is a five-year plan which aims to develop and sustain sport and physical activity in Lewisham through effective partnerships between local organisations led by London Borough of Lewisham.

Lewisham's Food Strategy was published in June 2006 by a multi-agency partnership (this time led by Lewisham PCT) and aims to increase the health and welfare of Lewisham people through improved access to nutritious and safe food from a more sustainable food chain.

Hypertension is an important risk factor in relation to both stroke and CHD and is an important focus of various initiatives locally.

The National Service Framework (NSF) for Coronary Heart Disease (CHD), published in March 2000, set out a plan as to how heart disease prevention and cardiac services were to be developed and modernised over a ten-year period. This plan focused on 12 standards for improved prevention, faster

diagnosis, more rapid treatment, and more effective rehabilitation. A copy of Lewisham PCT's CHD Commissioning Strategy, which includes an analysis of how services in Lewisham match against these standards, is available on request, but in summary the strategy aims to address problems in achieving targets related to primary prevention (smoking cessation, reducing obesity and increasing physical activity), acute coronary syndromes and heart failure.

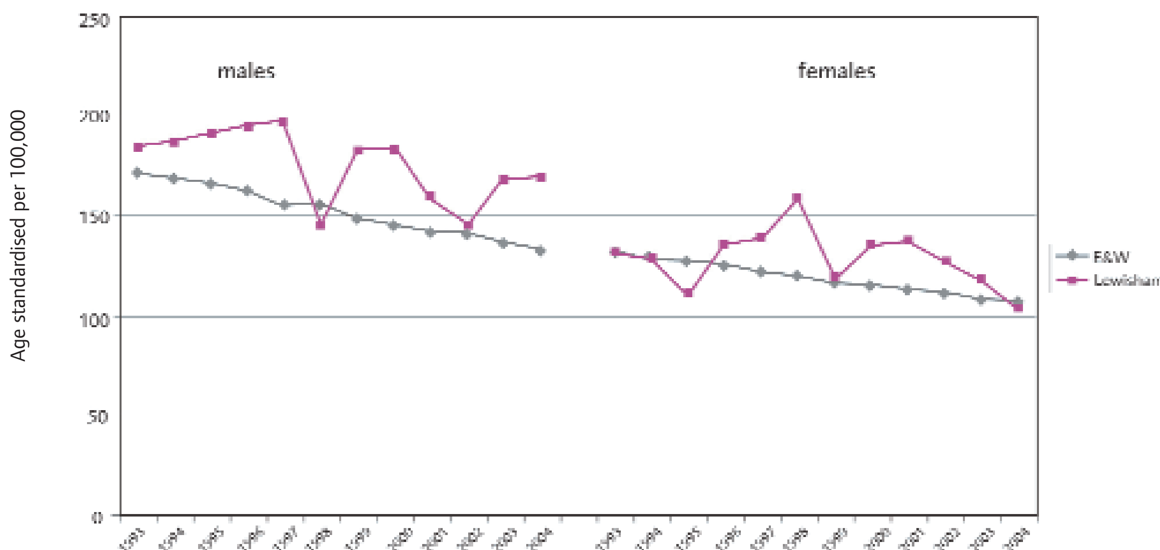
4. Cancer

Cancer remains a leading cause of death in Lewisham, as it does nationally. Lewisham ranked fourth in London for deaths from cancer in people aged under 75 years in 2003. The standardised mortality ratio (SMR) in Lewisham from all cancers for all ages is 112.4 and for those aged under 75 years is 111.3. Thus deaths from cancer are more than 10% higher in Lewisham than nationally.

There has been a steady downward trend in deaths from cancer in males and females in England between 1993 and 2004. Locally, death rates are variable year on year but there has been generally a downward trend in both sexes (Figure 5).

Mortality due to cancer in the under 75s is, however, considerably higher amongst men than amongst women in Lewisham (Figure 5). Again, this is comparable to the national picture.

Figure 5, Trends in mortality from all cancers, men ad women under 75yrs



A similar trend is also seen in mortality due to specific types of cancer.

- Lung cancer mortality in men is considerably higher than amongst females in Lewisham (Figure 6), but follows the downward national trend.
- Prostate cancer mortality was declining in Lewisham in line with national rates up to the year 2000. More recently, there appears to have been an increase locally (Figure 7).

Figure 6

Trends in mortality from lung cancer in men and women <75 years

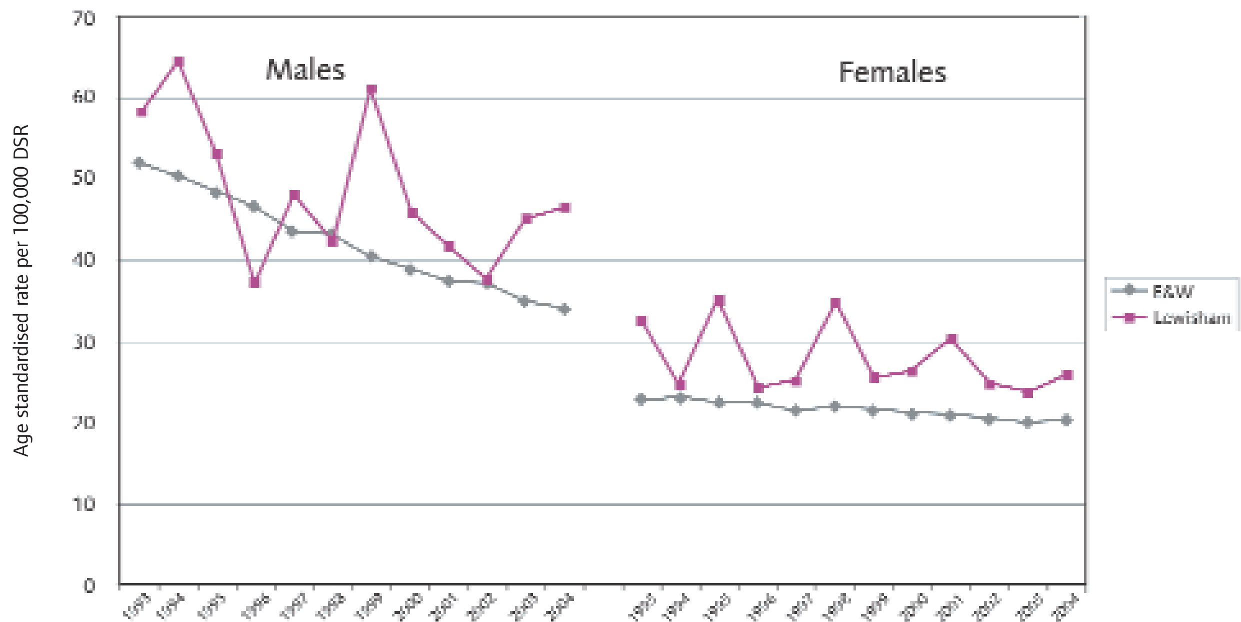
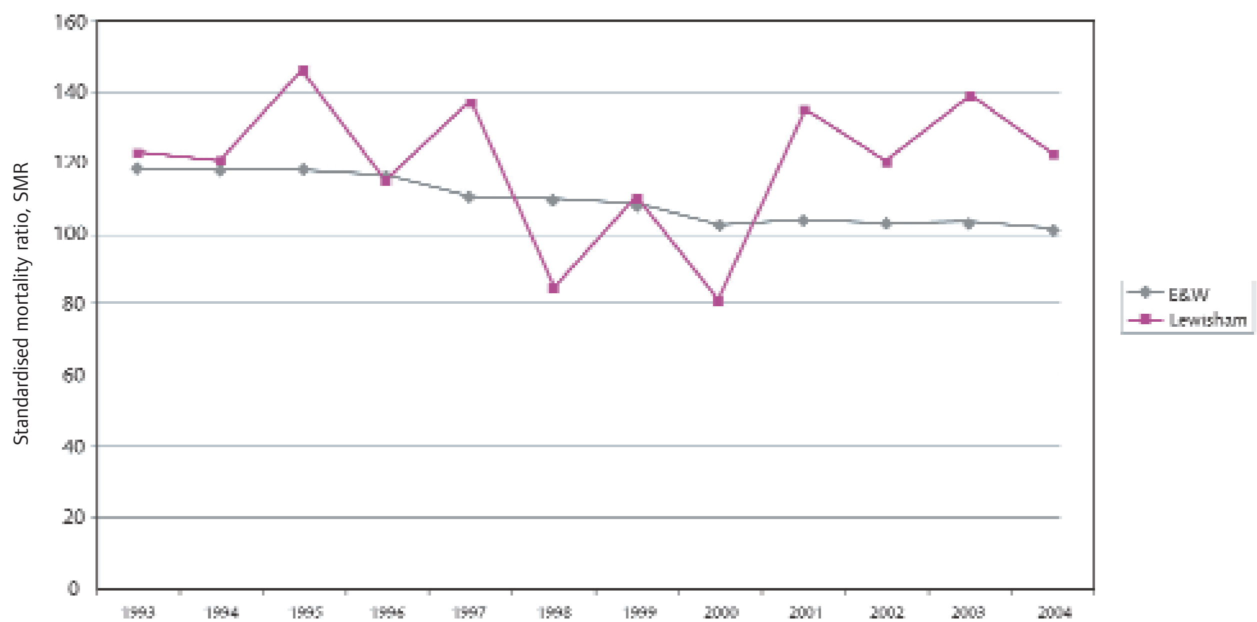


Figure 7

Trends in mortality from prostate cancer, all ages



The National Cancer Plan, which was published in 2000, provides a detailed account of the government's comprehensive national programme for investment in and reform of cancer services in England. The plan aims to reduce death rates and improve prospects of survival and quality of life for cancer sufferers by improving prevention, promoting early detection and effective screening practice, and guaranteeing high-quality treatment and care throughout the country. The Cancer Plan is particularly committed to addressing health inequalities through setting new national and local targets for the reduction of smoking rates, the setting of new targets for the reduction of waiting times, the establishment of national standards for cancer services, and investment in specialist palliative care, the expansion and development of the cancer workforce, cancer facilities, and cancer research. Locally, health services are currently achieving all targets and are in line to achieve the target on reduction of cancer-related mortality.

Action on smoking and diet, key factors in relation to cancer, have already been discussed in relation to circulatory diseases.

5. Sexual health

Key issues in men's sexual health in Lewisham include Human Immuno-deficiency Virus (HIV), other sexually transmitted infections (STIs), and the contribution of men to the well-being of their sexual partners and of their children.

In 2004, the most recent year for which data are available, a total of 895 residents of Lewisham, or almost four in every thousand, were known to be living with HIV. The preceding years had seen a relentless rise in the numbers of people living with HIV in South East (SE) London(Figure 8), partly due to increasing numbers of new cases of infection (Figure 9) but also due in part to better treatment and therefore increasing survival of people with HIV.

Figure 8 Prevalence of HIV infection in SE London from 1996 to 2004

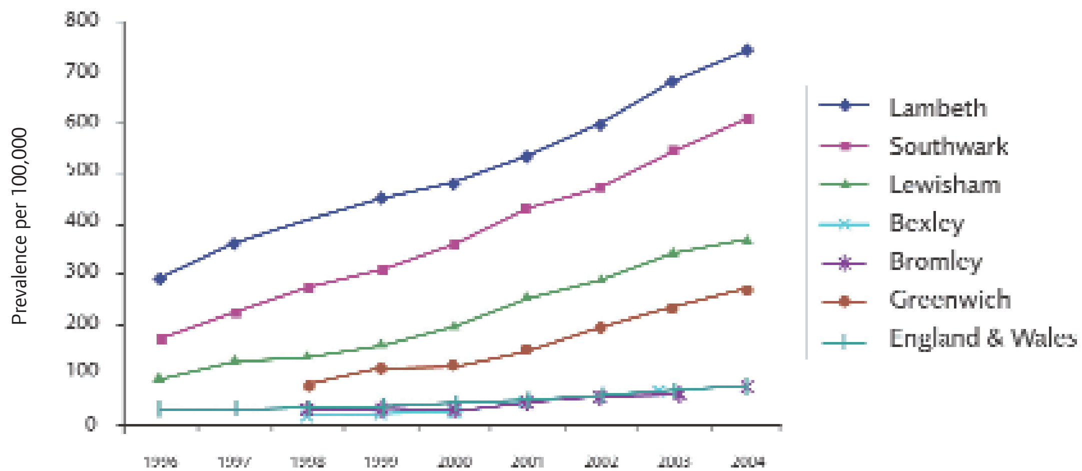
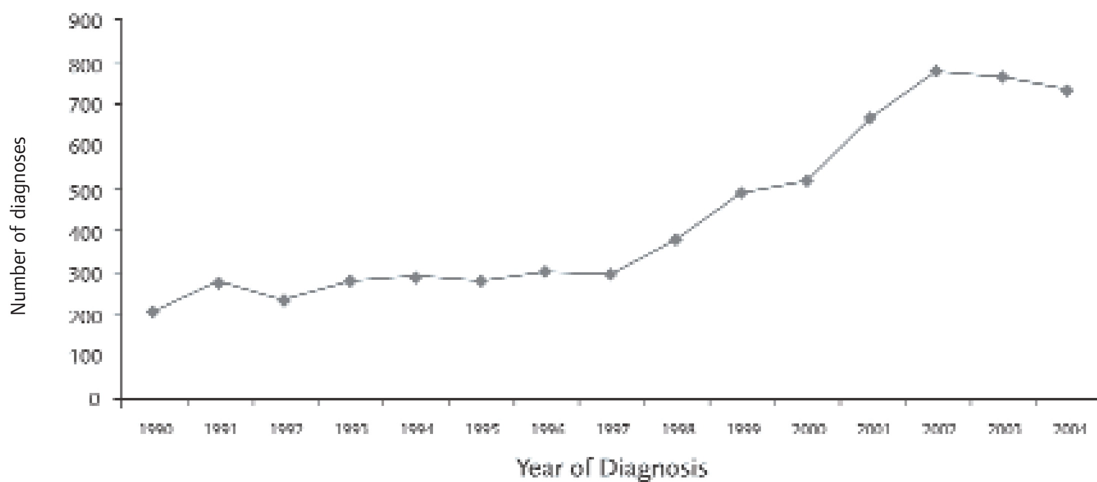
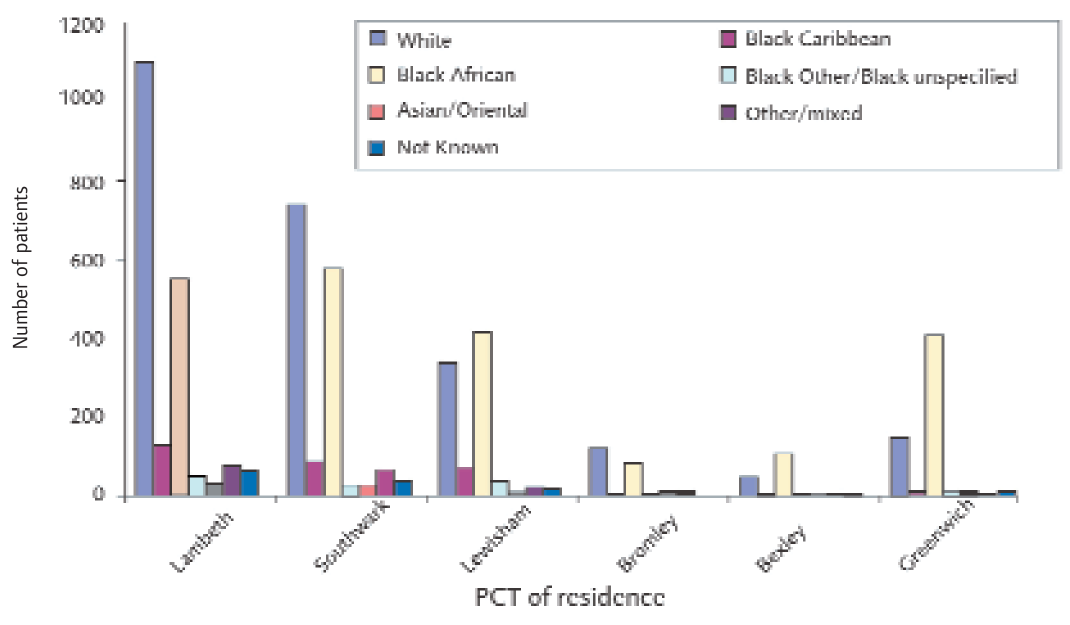


Figure 9 New diagnoses of HIV/AIDS in SE London from 1990 to 2004



Almost half of those living with HIV in Lewisham in 2004 were Black Africans, white people accounting for a slightly smaller percentage (Figure 10). Overall, 60% of those living with HIV in Lewisham are men, but almost twice as many Black African women as Black African men were known to be living with HIV, indicating considerable under-ascertainment of cases in men in this ethnic group.

Figure 10. Number of diagnosed HIV-infected patients in SE London in 2004 by ethnic group and PCT of residence



The number of Black Caribbeans living with HIV, although relatively low in Lewisham, is nevertheless significant. Infection in this group is an important phenomenon when considered in the context of the endemic levels of other sexually transmitted infections in this same group locally. These levels of sexually transmitted infections indicate high levels of unsafe sex, which, together with the potential for chlamydia and gonorrhoea to act as co-factors in the transmission of HIV, must cause concern about the possibility of a rapid rise in the incidence of HIV in this population.

Overall, in terms of numbers of people living with HIV, the most commonly reported means of acquisition of HIV is sex between men and women, accounting for infection in 494 or 55% of Lewisham residents living with HIV in 2004. Most heterosexual transmission, however, occurs abroad, and sex between men remains the most important means of acquisition of infection locally, accounting for 36% of all cases and for 61% of men known to be infected.

Data on sexually transmitted infections (STIs) in Lewisham are limited. Most data come from genito-urinary medicine (GUM) clinics and are not available by borough of residence. As there is no GUM clinic at University Hospital Lewisham (UHL), data for the whole of SE London are presented here.

Recent years have seen an increase in the numbers of cases of chlamydial infection in SE London (Figure 11), partly due to improved diagnosis but also probably to increased incidence. Similar increases have been seen in the incidence of gonorrhoea, but with a reduction in 2003 and 2004 (Figure 12). Gonorrhoea continues to be an increasing problem in men who have sex with men (MSM), but numbers of cases of chlamydial infection remain low in this group.

Figure 11 Diagnoses of chlamydia reported from GUM clinics in SE London

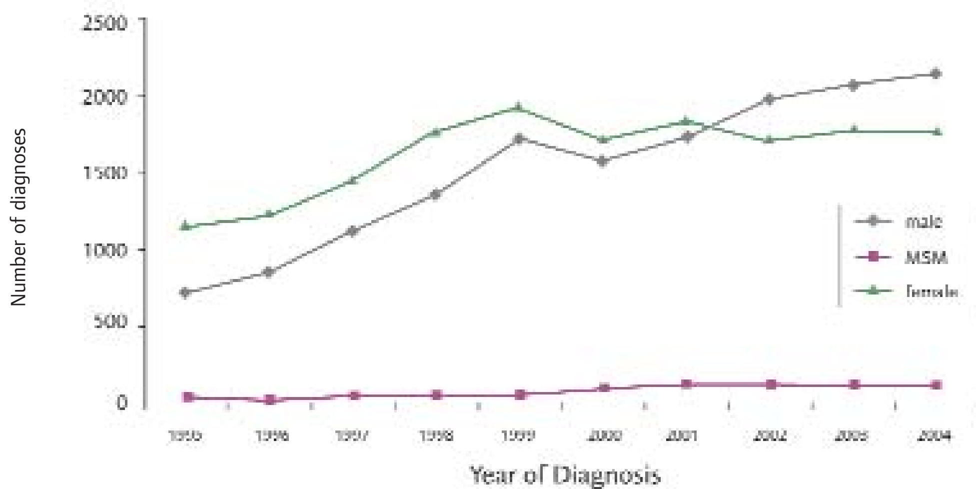
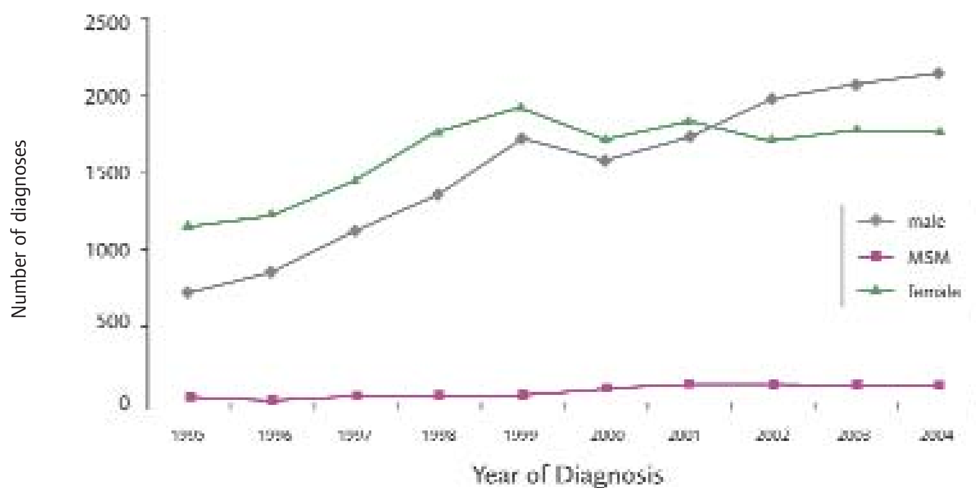
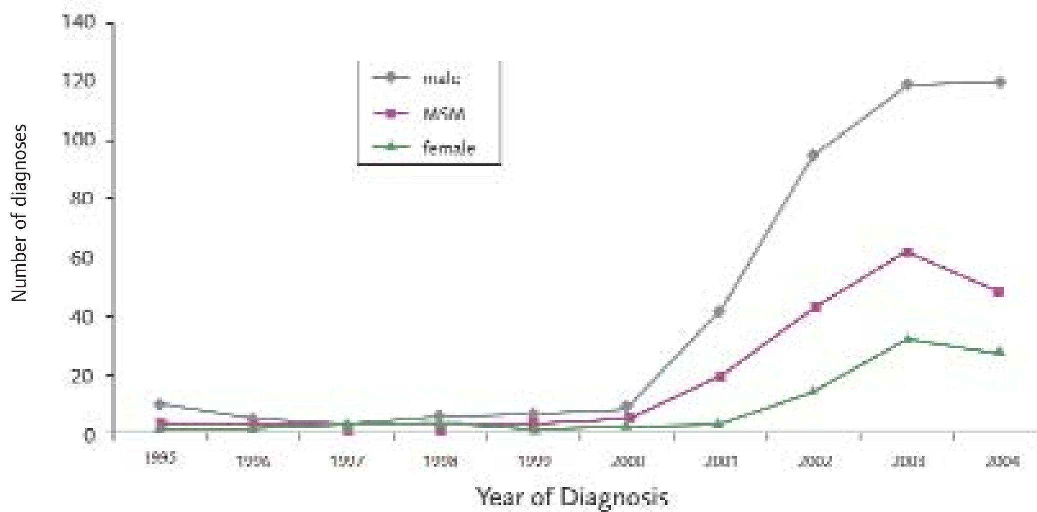


Figure 12 Diagnoses of gonorrhoea reported from GUM clinics in SE London



Diagnoses of syphilis seen in GUM clinics in SE London have increased dramatically in recent years (Figure 13). Many of these cases occurred as part of an outbreak amongst heterosexual men and women associated with commercial sex workers, but a significant proportion of cases occurred in men who have sex with men (MSM). 2004 saw a slight downturn in the number of cases; this was sustained in 2005, when a total of 112 cases were reported (compared to 147 in 2004 and 150 in 2003).

Fig 13. Diagnoses of syphilis reported from GUM clinics in SE London



Some of the best information on sexual health in Lewisham comes from data provided by Lewisham PCT's sexual health service. These data are quite separate from those collected in GUM clinics. Clinics operated by this service performed over 10,000 screening tests for chlamydia and gonorrhoea in the period between April 2005 and March 2006. Almost 10% of these tests were positive for chlamydia, and 3% were positive for gonorrhoea. In the same period, over 2,500 people were treated by the service either because they had an STI or because they had sexual contact with somebody else who had.

A recent health equity audit identified that although increasing numbers of young men were accessing the PCT's sexual health service (15% of clients in 2005/6 were men), there remains a gap in services for men and for young men in particular.

Health First, the specialist health promotion agency for Lambeth, Southwark and Lewisham, has an extensive HIV and sexual health programme. As part of this programme, Health First provides sexual health training and resources for staff from a wide variety of organisations, works together with others to ensure appropriate support for communities most affected by HIV and STIs (including people living with HIV), and supports the Healthy Schools programme across Lewisham. Further information can be obtained from Health First.

Lewisham PCT's Sexual Health Outreach Team focuses on the key issues around public health which impact directly on the sexual health of young people in Lewisham, in particular reducing the rates of unplanned teenage conceptions, STIs and issues around safeguarding vulnerable young people. The team also addresses issues such as smoking, alcohol, drug use and other risk-taking behaviours. The Outreach Team aims to provide a universal service for young people as well as to target the priority groups identified in the Lewisham Teenage Pregnancy Strategy: looked after children, refugees and asylum seekers, boys and young men, and black, minority and ethnic (BME) groups. They work in partnership across the education, voluntary and statutory sectors.

6. Mental health

The general conclusion of the WHO is that although there is a similarity of incidence of major mental illness internationally, there are some significant areas with a different pattern of incidence. Also, recent reports have highlighted higher risk ratios for men getting schizophrenia than women. There are indications that urban settings have a higher incidence of schizophrenia. A recent systematic review of the incidence of schizophrenia found a statistically significant effect of migration (both in first and second generation migrants) on the incidence of schizophrenia. Overall, migrant groups displayed an elevated incidence of schizophrenia compared to their native-born populations.

Lewisham has significantly higher rates of mental illness than England as a whole. The Mental Health Needs Index 2000 (MINI 2K) score for Lewisham for schizophrenia and other psychoses is 1.55 (the score for England is 1.00), indicating that Lewisham has significantly greater mental health needs than the country as a whole.

Applying the findings of a number of studies suggests that the incidence of major mental illness locally is very high in Black Caribbean people and Black African people. The rate of incidence among Caribbean people in Lewisham is estimated to be 21 people in every 100,000, compared with only three in every 100,000 white people. This is a far higher incidence than is found in the Caribbean.

Suicide is often associated with mental illness, particularly with schizophrenia and depression. The directly standardised mortality rate for suicide in Lewisham during the period 2002 to 2004 is 13.94 per 100,000, which though lower than the corresponding rates for London (15.52) and England (16.63) is not significantly so. During the same period, directly standardised rates of years of life lost were greater among men (38.7/10,000) than among women (21.6/10,000) in Lewisham.

At the primary care level, there may be problems identifying men with mental health problems. There is evidence that women are 70% more likely than men to contact their family doctor with a mental health problem, regardless of the severity of illness.

During the period 2001 to 2003, the alcohol-related mortality rate for Lewisham was 16.8/100,000. The corresponding rate for Lewisham men is 25.0/100,000, the fifth highest such rate in London (Table 1), significantly worse than the mortality rate among men in London as whole and very much worse than that for England as a whole.

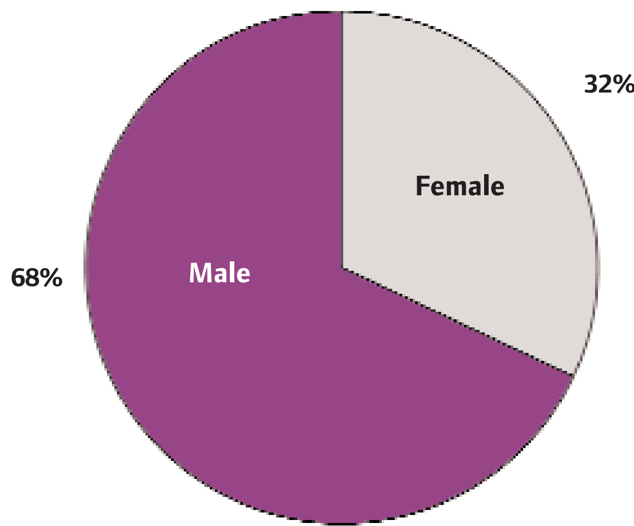
Table 1 Alcohol-related mortality, deaths by 100,000 (2001–3 pooled)

	Males	95% confidence interval	Females	95% confidence interval
England and Wales	14.7	(14.7–14.9)	7.4	(7.2–7.6)
London	17.6	(16.8–18.5)	7.4	(6.9–7.9)
Lewisham	25.0	(19.8–31.7)	9.3	(6.3–13.4)

Source: Office for National Statistics (ONS)

In the period January 2004 to July 2006, 1,450 individuals were seen by the Drug Treatment Services in Lewisham, accounting for 2,729 referrals. Of these, slightly more than two thirds were male (Figure 14).

Figure 16, Drug users in treatment, Jan 2004 - July 2006, Lewisham



Two thirds of drug users are white (Figure 15); the same proportion of the general Lewisham population identified themselves as white at the most recent census. However, Africans accounted for under 10% (28/308) of drug users categorised as black, compared with about 40% of black people in Lewisham at the census, while 'Other Black' made up about 40% compared with 10% at the census.

Figure 17, Drug users in criminal justice system, Lewisham

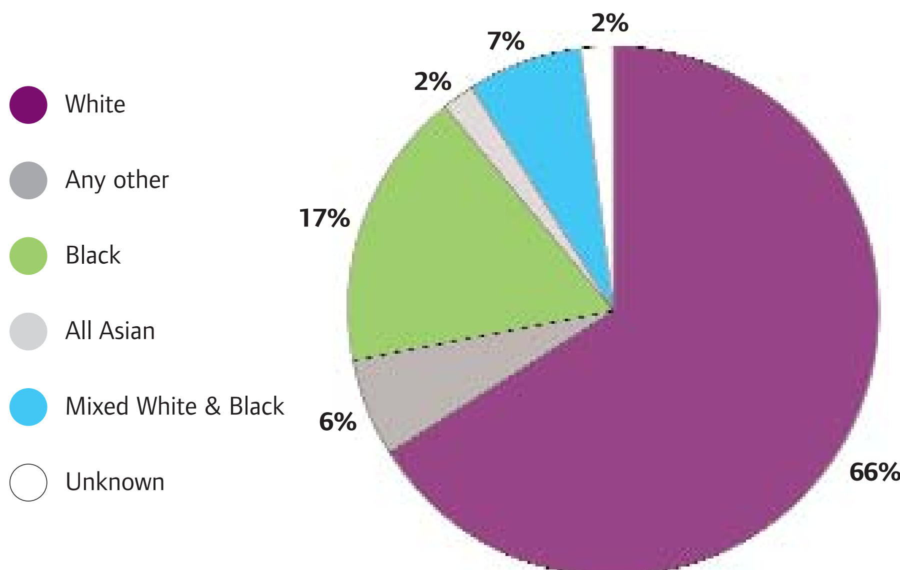
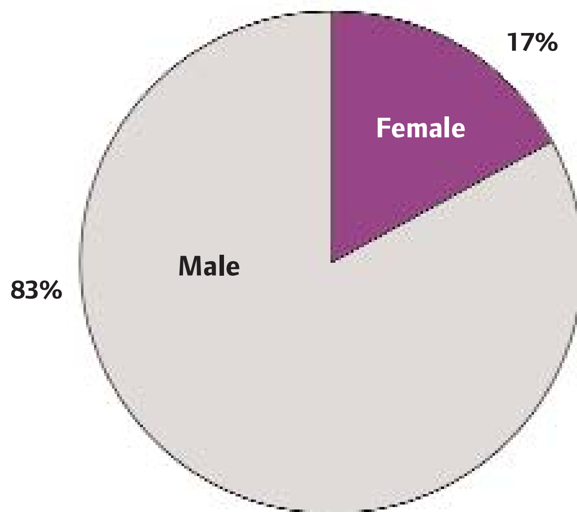


Figure 16, Drug users in treatment, Jan 2004 - July 2006, Lewisham

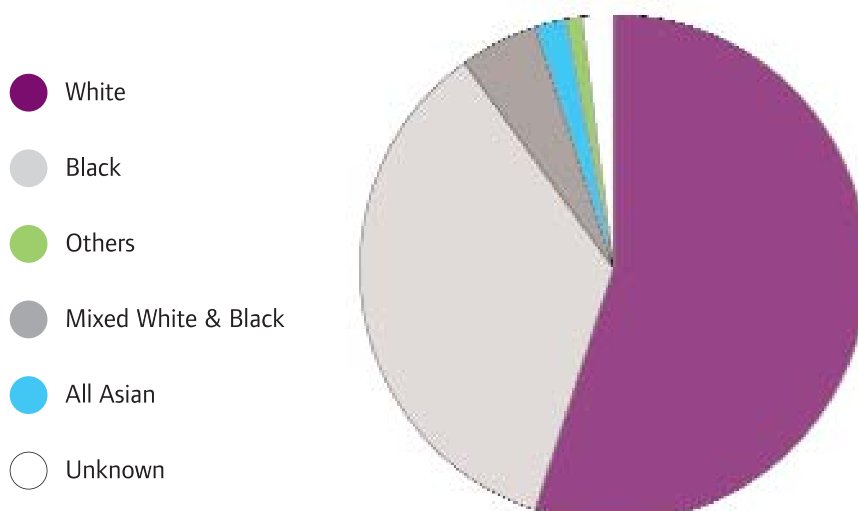


7. Conclusion

The health experience of men in Lewisham is not as good as that of women in Lewisham, or men in the country as a whole. Specific concerns exist in relation to points identified in the introduction to this paper. Many of these concerns are being addressed but it is not clear how best to address others; high rates of sexual and mental health problems (including suicide, drug use and problem alcohol use) in young men are of particular concern, especially in young black men. It is important that members of these groups are aware of, and act on, appropriate health promotion messages. It is also important that they access relevant services as necessary. How best to achieve these ends remains a challenge.

Donal O'Sullivan, 25 September 2006

Figure 17, Drug users in criminal justice system, Lewisham



C: Circulatory diseases

1. Background

Circulatory diseases, which include coronary heart disease (CHD) and stroke, have remained the most common cause of death in England and Wales over the last 90 years among both males and females.

The proportion of premature deaths due to circulatory diseases in Lewisham residents is about 20% higher than is the case in the country as a whole. The excess deaths are mainly due to stroke, which accounts for about 10% of mortality in Lewisham. Although mortality due to stroke is declining, there is a preponderance of deaths amongst males at all ages (Figures 1 and 2). The primary care team is the key to the prevention of stroke and to the long-term management of disability and handicap resulting from stroke.

Fig 1 Deaths from stroke in people aged under 65 years, Lewisham, 1993-2004

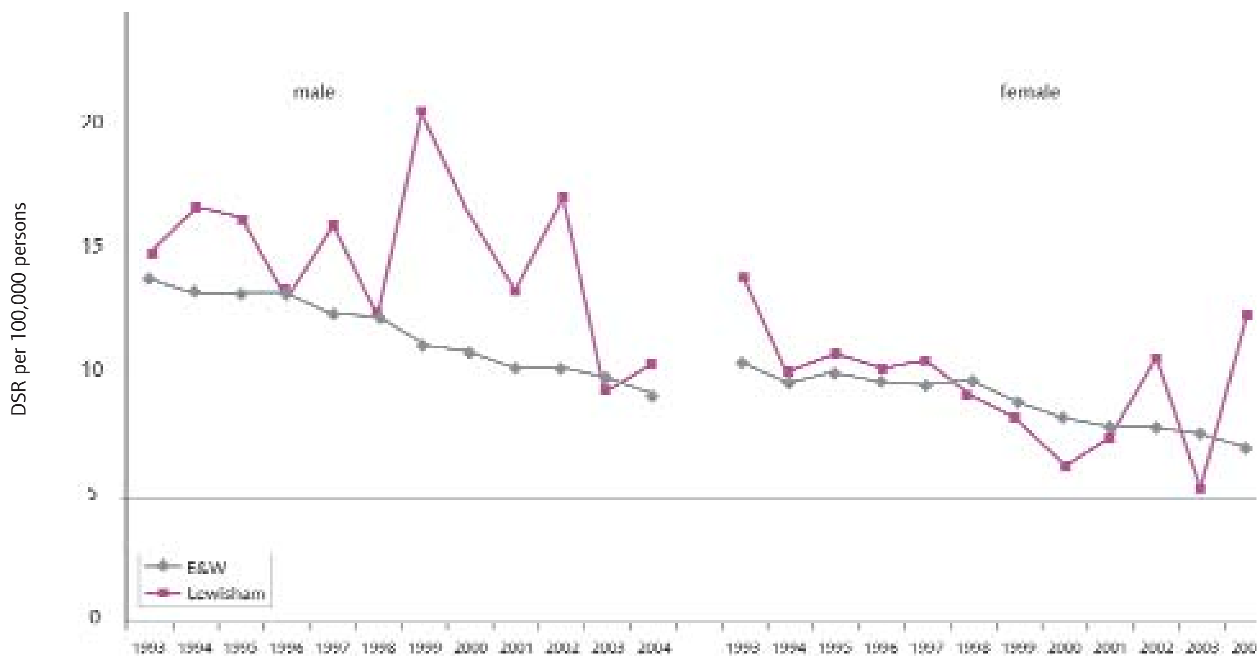


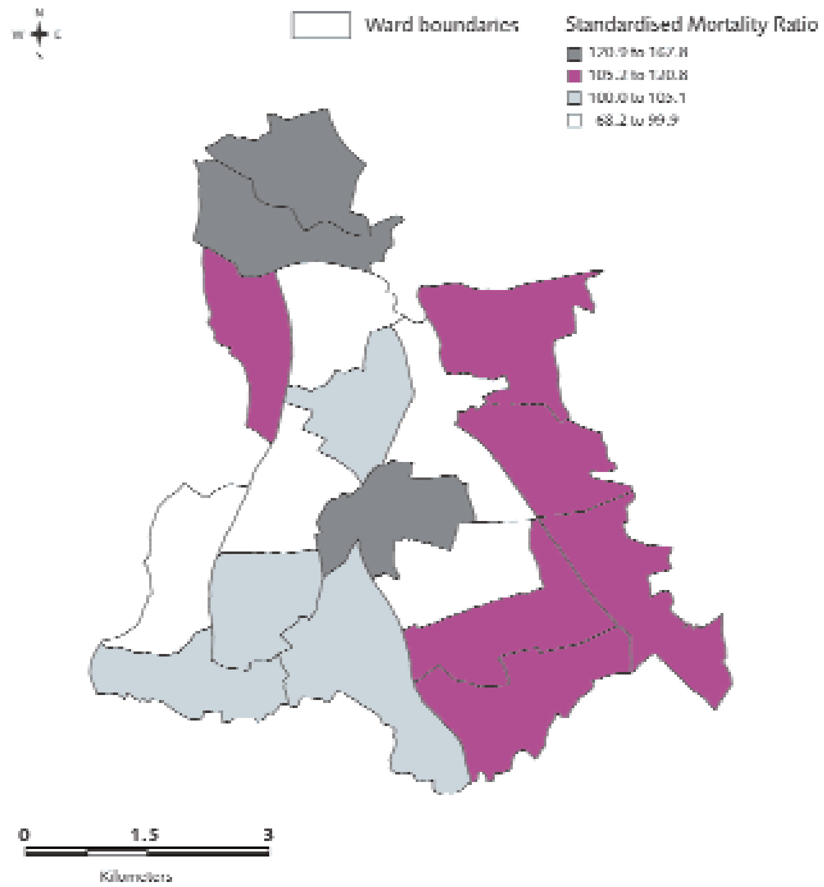
Fig 2 Deaths from stroke in people aged 65-74 years, Lewisham, 1993-2004

source: Compendium

CHD mortality rates have declined considerably since the early 1980s. Within England in 1990, the directly age standardised rate in the under 75s was 114 deaths per 100,000, and this declined to 62 per 100,000 in 2000, representing a fall of 52 per 100,000. The Lewisham rate also fell from 120 per 100,000 to 65 per 100,000, an appreciable drop of 55 per 100,000. Despite these encouraging trends, premature deaths in Lewisham residents from coronary heart disease are still about 10% higher than nationally, and deaths from CHD for all ages are about 2% higher than nationally. Lewisham ranks 10th in London for deaths from coronary heart disease.

There are significant differences in mortality at ward level; during the period 1998–2002, standardised mortality rates (SMRs) for CHD varied from 64 in Forest Hill to 164 in Evelyn (Figure 3).

Figure 3 Mortality from CHD, by ward, all persons under 75 years in Lewisham (2002)



The National Service Framework (NSF) for Coronary Heart Disease (CHD), published in March 2000, set out a plan as to how heart disease prevention and cardiac services were to be developed and modernised over a ten-year period. This plan focused on 12 standards for improved prevention, faster diagnosis, more rapid treatment, and more effective rehabilitation. The plan covered the following six clinical areas, as well as heart health promotion in the community:

- primary and secondary prevention
- acute myocardial infarction
- angina
- revascularisation
- cardiac rehabilitation
- heart failure.

The subsequent NHS Plan, published in July 2002, identified CHD as one of the clinical priority areas. This investment plan set clear targets and milestones for the delivery of the CHD NSF in each of the six clinical areas, further endorsed by the Priorities and Planning Framework 2003–6.

Within Lewisham, the CHD NSF implementation programme is led by the Public Health Directorate with broad directorate and managerial representation and includes consultant cardiologists, general practitioners and nurses.

In terms of the CHD NSF, the greatest areas of risk are the achievement of the targets in primary prevention (smoking cessation, reducing obesity and increasing physical activity), acute coronary syndromes and heart failure. An area of recent concern is cardiac rehabilitation.

2.1 Primary prevention

NSF standards

Standard 1: The NHS and partner agencies should develop, implement and monitor policies to reduce the prevalence of coronary risk factors in the population and reduce inequalities in risks of developing heart disease.

Standard 2: The NHS and partner agencies should contribute to a reduction in the prevalence of smoking in the local population.

2.1.2 Smoking

Smoking prevalence locally has been estimated at approximately 33%; approximately 30,000 men living in Lewisham aged 20 and above are smokers. This compares with 27% of men nationally. There is considerable variation between wards; estimates of smoking prevalence in Bellingham, Brockley, Downham, Evelyn, New Cross and Telegraph Hill are all higher than the Lewisham average, with Evelyn ward being the highest at 42%. It is important to note, however, that no locally collected data on smoking in individuals are available. It has been recommended that questions on smoking be included in the upcoming residents' survey.

Smoking prevalence increases as household income decreases. In 1997 the age-standardised proportion of the population who were smokers rises consistently from 21% for men and 18% for women in the highest income quintile to 42% for men and 37% for women in the lowest income quintile.

In 1996 smoking accounted for over half of the difference in the risk of premature death among men between social classes, while between 1991 and 1993 premature deaths from lung cancer were five times higher among men in unskilled manual work compared to those in professional occupations (**Acheson**,1998a).

The Lewisham stop smoking service is a treatment programme operating at three levels:

- Level 1 – provision of information about smoking and health and services available to help smokers to quit (provided by any professional)

- Level 2 – provision of one-to-one support and advice (provided by trained community stop smoking advisers)

- Level 3 – provision of specialist, intensive support for smokers by the specialist smokers' clinic.

The budget for the service is £302,900 for 2006/7. The majority of the service provision is commissioned from a range of providers, including general practice, pharmacy, the Maudsley Specialist Smoking Clinic and the voluntary sector.

The key elements of the stop smoking strategy locally are:

- to increase the number of trained advisers in primary care – in practices and pharmacies
- to engage GPs, who have a key role in advising and referring smokers
- to extend the number and range of advisers in the community – in community nursing and community groups
- to reach specific groups of smokers by training advisers in specialist services, e.g. mental health, leisure, youth service, midwives
- to use experienced advisers on a sessional basis to add capacity, flexibility and ease of access for smokers
- to go into workplaces to reach staff and community settings and those not using mainstream services.

The recent Healthcare Commission Health Improvement Review on Tobacco Control rated the PCT as good (Level 3) – *'Performance that goes beyond minimum requirements and the reasonable expectations of patients and the public'*.

Local Level 2 and Level 3 services have reached approximately 11% of smokers in the past six years. A quit date is the pre-set date on which a client of Level 2 or 3 plans to give up smoking. A recent health equity audit has demonstrated that more women than men set quit dates in both Level 2 (62% compared with 38%) and Level 3 services (59% compared with 41%), indicating that far fewer men than women are accessing these services. More positively, having set a date to quit, equal

proportions of men and women (39%) are not smoking four weeks after their quit date. It is hoped that expansion of Level 2 services in pharmacies and workplaces, and increased outreach services, will increase access by men to these services.

The findings of the review and the health equity profile have been considered and have informed the planned action to continue improving the service.

2.1.3 Stop smoking targets

This service made a huge leap last year with a 67% increase in the number of quits in 2005/6 compared with 2004/5. The service has turned itself around and expects to continue to improve in 2006/7. The targets for the period 2003/6 were very challenging and not met. One of the reasons for this was the turnover in the number of coordinators during this period. Successful PCTs have had continuity in core staff teams.

There are stop smoking targets in both the local PSA and the Local Area Agreement (LAA), including the number of four-week quitters (1,604 for 2006/7 and 2,149 for 2007/8) and those remaining abstinent at 52 weeks (481 for 2006/7 and 645 for 2007/8).

2.1.4 Opportunities for working in partnership on smoking cessation

The smoke free legislation was introduced in the summer of 2007, and the experience of Scotland and Ireland was that large numbers of smokers quit in the period before the legislation was introduced in preparation for the ban.

This is a major development in public health and one of the most important interventions to improve the health of the population. The legislation requires virtually all workplaces in England to become smoke free.

There is a need to start planning now for the introduction of the legislation. Many directorates from Lewisham Council would need to be involved, not just the environmental health department. At a recent meeting of the multi-agency Tobacco Control Strategy Group this was addressed.

This legislation and the LAA targets provide an opportunity to strengthen partnership working in Lewisham to reduce smoking, including among males.

2.1.5 Obesity

It has been estimated that over 63% of Lewisham men aged 16 or over are overweight or obese.

The Lewisham Physical Activity, Sport and Leisure Strategy (available separately) is a five-year plan which aims to develop and sustain sport and physical activity in Lewisham through effective partnerships between local organisations led by London Borough of Lewisham.

Lewisham's Food Strategy was published in June 2006 by a multi-agency partnership (this time led by Lewisham PCT) and aims to increase the health and welfare of Lewisham people through improved access to nutritious and safe food from a more sustainable food chain. The strategy has five main elements.

Food access

This element aims to reduce physical, economic, social, cultural and educational barriers which prevent people in Lewisham from accessing food which will improve their health and well-being. Work being undertaken includes the development of food cooperatives, work with local supermarkets, food trails in local markets, targeted work with different community groups and the development of a community food workers training programme.

Food in schools

The aim here is to increase the health and welfare of children in Lewisham schools through improved access to and awareness of a healthy diet, food safety and sustainable food. Work includes the monitoring of new menus, actions to increase the uptake of free school meals and supporting the implementation of the Food in Schools Toolkit (devised by the Department for Education and Science) by Healthier schools.

Food nutrition and health

This element should contribute to long-term improvements in the diet and nutrition of people in Lewisham and the reduction of nutrition-related ill health in the borough. Work includes initiatives to increase breastfeeding, the development of cooking skills in the community and the provision of programmes such as MEND – a programme for the prevention and treatment of obesity in children.

Food sustainability

The aim of this element is to achieve a more sustainable food chain in Lewisham by improving the sustainability of food production, transport, sale and consumption in the borough.

Food safety

Ensuring the safety of, and the reliability of information about, foods produced, imported, sold or consumed in Lewisham and a reduction in the incidence of food poisoning are the aims of this element of the Food Strategy.

2.2 Secondary prevention

NSF standards

Standard 3: GPs and primary care teams should identify all people with established cardiovascular disease and offer them comprehensive advice and appropriate treatment to reduce their risks.

Standard 4: GPs and primary healthcare teams should identify all people at significant risk of cardiovascular disease but who have not developed symptoms and offer them appropriate advice and treatment to reduce their risks.

The main way of achieving these targets is through the Quality and Outcomes Framework (QoF) of the new GMS contract, which is heavily weighted towards CHD, with the largest number of points (120) being awarded for this disease category. There are less formal arrangements in place for 'at risk' patients. This is an area that needs attention, particularly with the increase in obesity and diabetes. The lower than expected incidence and prevalence of heart failure and cardiac arrhythmias probably indicate inadequate recording rather than lower levels of disease locally; this also needs to be addressed.

Table 1 CHD disease registers in primary care

CHD registers	Target 100%	Actual performance (March 2005) 98%	Actual performance (March 2004) 84%
Number of practices with electronic CHD registers		50	
Number of practices with manual registers		1	
Number of patients identified electronically with diagnosed CHD		5,964	
Number of practices with registers for those with high risk CHD		7	
Number of patients on high risk CHD registers		Not known	

Table 2 Quality and Outcomes Framework

Monitoring and managing patients with CHD diagnosis (March 2005)	% of patients monitored or treated across the PCT
Smoking cessation advice offered in the last 15 months to patients with CHD	84.48
% of patients with CHD who have a record of blood pressure in the last 15 months	94.72
% of patients with CHD in whom last BP reading in the last 15 months is less than 150/90	80.32
% of patients with CHD whose notes have a record of total cholesterol in the last 15 months	83.29
% of patients with CHD whose last measured total cholesterol (measured in the last 15 months) is 5 mmol/l or less	62.91
% of patients with CHD with a record of treatment with aspirin, other anti-platelet therapy, or anticoagulant is being taken	85.82
% of patients with CHD who are currently treated with a beta blocker	57.94
% of patients with a history of myocardial infarction (diagnosed after 1/4/03) who are currently treated with SCE inhibitor	86.42

2.3 Acute myocardial infarction

NSF standards

Standard 5: People with symptoms of a possible heart attack should receive help from an individual equipped with and appropriately trained in the use of a defibrillator within 8 mins of calling for help, to maximise the benefits of resuscitation.

Standard 6: People thought to be suffering from a heart attack should be assessed professionally and, if indicated, receive aspirin. Thrombolysis should be given within 60 mins of calling for professional help.

Standard 7: NHS trusts should put in place agreed protocols/systems of care so that people admitted to hospital with proven heart attacks are appropriately assessed and offered treatments of proven clinical and cost effectiveness to reduce their risk of disability and death.

Monthly data show London Ambulance Service (LAS) 8-minute response rates averaging 65–70% (target 75%). A new sector commissioning group is being established for the LAS and a key objective is to ensure progress in the improvement of ambulance response times for Category A calls.

Achieving national thrombolysis targets has been a particular challenge at Lewisham Hospital. However, the primary angioplasty programme, whereby patients are taken directly to a tertiary centre for coronary intervention has obviated the necessity for thrombolysis in a significant proportion of patients (over 90% of those with ST elevation MI).

2.4 Angina

NSF Standard 8: People with symptoms of angina or suspected angina should receive appropriate investigation and treatment to relieve their pain and reduce the risk of coronary events.

A rapid-access chest pain clinic was established in Lewisham Hospital in 2002 and currently meets the target of 100% of patients being offered an appointment within two weeks. There are about 375 admissions for angina with attendant costs of £750k and 305 admissions for chest pain with attendant costs of £220k. These conditions could be managed in primary care.

2.5 Revascularisation

NSF standards

Standard 9: People with angina that is increasing in frequency or severity should be referred to a cardiologist urgently or, for those at greatest risk, as an emergency.

Standard 10: NHS trusts should put in place hospital-wide systems of care so that patients with suspected or confirmed CHD receive timely and appropriate investigation and treatment to relieve their symptoms and reduce their risk of subsequent coronary events.

Diagnostic angiography remains the single largest cause of cardiac bed blockages at the tertiary centres and consequent delayed transfers, leading to increased lengths of stay at Lewisham Hospital. Implementation of the NSF for CHD has also increased the number of suspected cases of angina with attendant higher levels of diagnostic intervention, e.g. angiography.

Based on predicted future need and the current provision of about 585 angiographies each year, a further 85 angiographies per year will be needed by 2010.

The projected additional level of activity and investment is set out below.

Table 3 Coronary angiography activity and cost

	2005-6	Cost	2010 projected	Cost
Guy's and St Thomas's (elective) tariff £809	172	£139k	198	£160k
Guy's and St Thomas (emergency) tariff £3,672	44	£162k	50	£184k
King's (elective) tariff £809	306	£274k	350	£283k
King's (emergency) tariff £3,672	63	£230k	72	£264k
Total	**585**	**£778k**	**670**	**£890k**

Assessment of future demand for revascularisation suggests a requirement of 550 revascularisations by 2015, an increase of 185 procedures per year over current activity levels, an increase of 50% in revascularisations over a period of 10 years. Using the national tariff of approximately £ 9,430 for a CABG and £ 4,900 for a PTCA, the additional 185 procedures, based on a ratio of 6 PCI:1 CABG, would cost about £1.1 million, effectively about £108,000 each year for 10 years assuming an even distribution of activity.

The introduction of the new NSF chapter 8 on cardiac arrhythmias will lead to a significant increase in the costs of implantable cardio-defibrillators (ICD), pacemakers and ablation (Table 4).

Table 4 Projected increase in electrophysiology procedures

Electrophysiology Procedures	Assumption in model	Current activity 2005–6	Projected activity by 2015	Cost	Incremental increase in cost
ICD (average £30,000	100 pmp (7% pa)	5	25	£750k	£75,000
Pacing (£4,427)	550 pmp (5% pa)	105	140	£610k	£61,000
EP/Ablation (£4,633)	250 pmp (7% pa)	12	60	£280k	£28,000
Total		**122**	**225**	**£1.64m**	**£164,000**

This represents the additional level of funding that the PCT needs to make provision for in its commissioning arrangements to meet the expected increase in electrophysiology activity. This is not a matter of choice, as it is driven by advances in clinical practice and necessity. The majority of these patients will be admitted as emergencies and consequently, under payment by results, these procedures would attract the full national tariff.

2.6 Heart failure

NSF Standard 11: Doctors should arrange for people with suspected heart failure to be offered appropriate investigation (e.g. electrocardiography, echocardiography) that will confirm or refute the diagnosis. For those in whom heart failure is confirmed, its cause should be identified – treatments most likely to both relieve their symptoms and reduce their risk of death should be offered.

The NICE guidance on the management of patients with chronic heart failure was published in July 2003 and covers:

- tests to be used in diagnosis
- pharmacological interventions for appropriate management
- non-pharmacological interventions
- invasive procedures
- the role of patient/care support groups.

Chronic heart failure is largely undiagnosed and poorly managed in primary care, leading to significant levels of emergency admissions and re-admissions at an average cost of over £1.5 million per year.

The implementation of a Heart Failure Integrated Disease Management (IDM) programme in Lewisham has been the principal driver for change and includes the following key elements:

- a model of care which describes the care pathway and sets out medical management, including criteria for referral and discharge (copy available separately)
- clinical guidelines disseminated through an education and training programme
- the appointment of a consultant cardiologist with a special interest in heart failure
- implementation of a nurse-led community heart failure service
- development of a patient self-management programme (e.g. self-care diary, access to information, supported discharge).

A key component of the Heart Failure IDM programme has been the development of a Community Heart Failure Service, supported by a patient self-management programme.

The Heart Failure IDM programme has had a significant impact in reducing admissions for heart failure, with an actual reduction in admissions of around 40%.

2.7 Cardiac rehabilitation

NSF Standard 12: NHS trusts should put in place agreed protocols/systems of care so that, prior to leaving hospital, people admitted to hospital suffering from coronary heart disease have been invited to participate in a multidisciplinary programme of secondary prevention and cardiac rehabilitation. The aim of the programme will be to reduce their risk of subsequent cardiac problems and to promote their return to a full and normal life.

South East London PCTs are working together to draw up a sector strategy for cardiac rehabilitation. Although there is a well-developed rehabilitation service for patients post-myocardial infarction, there is a pressing need to develop cardiac rehabilitation services for patients with angina and heart failure.

There is a minimal community cardiac rehabilitation service in Lewisham at present. The angina and angioplasty plans are guided self-help rehabilitation programmes designed to facilitate cardiac rehabilitation. They are essentially based on cognitive behaviour therapy.

The lack of community cardiac rehabilitation has been recently highlighted because of proposed changes to rehabilitation services at Lewisham Hospital that mean certain elements of cardiac rehabilitation will no longer be provided at the hospital. These elements are not covered by Payment by Results, the current tariff-based system for paying trusts, which means that hospitals do not get paid for this work. No change will occur before the end of March 2007, and discussions are already under way as to how these services might be provided in the community, or how hospital services can be maintained.

3 Stroke services

The National Service Framework (NSF) for Older People was published in March 2001 and has stroke as one of its core standards. Aspects of the prevention and management of stroke are also addressed in the other standards of the NSF.

The Stroke Health Improvement Framework and Action Plan for Lambeth, Southwark and Lewisham (LSL) was published in 2000 and had as its key aims and objectives:

- to contribute significantly to a decrease in premature death and disability from stroke among the population of LSL
- to maximise the functional potential of those who have suffered a stroke through the combined and coordinated efforts of the NHS, other local partners and carers
- to reduce inequalities, particularly in terms of health opportunities and access to services for stroke prevention and treatment
- to reduce the death rate from stroke and related illnesses in people under 75 years by at least two fifths by 2010.

Delivery of the plan required work in a number of areas:

Promoting healthy lifestyles in the community:

- Cost-effective initiatives targeted at those groups in the community most likely to develop risk factors for stroke

General Practice-based primary prevention aimed at higher-risk individuals:

- Evidence-based lifestyle advice and drug treatment targeted at individuals found to be at higher risk of stroke

Case finding:

- Early identification of symptomatic cases of TIA or minor stroke through improved over-75 checks and education regarding the significance of symptoms
- Clear and effective referral channels from primary care to a specialist multidisciplinary management team

Acute treatment of stroke:

- The public, GPs, ambulance service, A&E department, wards and outpatient clinics, and other healthcare settings, should understand that stroke is a medical emergency and be equipped to provide immediate care if required
- Lead named clinicians responsible for stroke services for the local population, covering services both in the community and in secondary care settings
- Rapid and ready access to A&E department and hospital beds staffed by, or with input from, clinicians in all disciplines specialising in stroke
- Ready access to a multidisciplinary team specialising in stroke care (the make-up of such a team will be discussed later in this document)
- Ready access to investigatory facilities both inpatient and outpatient
- Rapid evaluation and management of patients with TIA or minor stroke

Rehabilitation and support:

- A coordinated specialist multidisciplinary service provided which spans the continuum between hospital and community, and which provides a structured and individually focused programme aimed at achieving specific goals agreed between the rehabilitation team, the patient and the main carer
- Carer support provided from diagnosis
- Seamless multidisciplinary communication and care provision between hospital-based and community-based services and other agencies
- Effective multidisciplinary discharge planning, involving patient and carer
- Effective arrangements for multidisciplinary re-evaluation at an agreed time after stroke
- Where rehabilitation takes place mainly in the community, or where there is potential for further functional improvement after hospital discharge, specialist multidisciplinary rehabilitation must be continued at home
- Access to day hospital or other day care services, and specialist services in the community

Continuing access to tertiary and other specialist services:

- Outpatient consultation, outpatient or inpatient diagnostic and treatment services, access to services in other specialities (neurology, neurosurgery, vascular surgery, psychology, therapy services)

Secondary prevention:

- The secondary prevention strategy is evidence-based, built upon specialist expertise, is multidisciplinary in nature and is applied equally across primary and secondary care settings

Communication between disciplines, services and care settings:

- Coordination and care planning between multidisciplinary teams in hospital and in the community
- Effective liaison between primary and secondary care physicians
- Effective interdisciplinary and inter-agency communication, care planning and care delivery

Education, training and support:

- Evidence-based guidelines for prevention and management of stroke both in primary and in secondary care
- Regular audit
- In-service training for all staff caring for those with stroke and their carers
- Information provision and support to those with stroke and their carers
- Appropriate training for those with stroke and their carers.

Services for stroke patients are developing slowly and unevenly as a result of conflicting service pressures. It is imperative to utilise the standards of the Older People's NSF to press for substantial improvements in stroke services, and to ensure that equity of access to the best service is available to all regardless of age or locality. Considerable impetus has been lost in developing stroke services in recent years. It is especially important that the issue of stroke is reviewed in Lewisham PCT.

There are significant opportunities for health promotion to reduce the incidence of stroke in the long term.

There is good evidence that coordinated specialist multidisciplinary stroke care, from acute care to rehabilitation, reduces disability and saves lives. A dedicated stroke unit will be included in the new wing at Lewisham Hospital.

It is probable that significant advances in the management of stroke will become more widely available in the next few years – it is important that health partnerships are positioned to take advantage of these developments.

The potential reduction in inappropriate hospital-bed usage through Intermediate Care needs to be realised for stroke patients, provided that the benefits of specialist multidisciplinary care are not lost. This will only be achieved if Intermediate Care services are developed with the proper specialist expertise and focused, through robust specialist assessment, on those patients who are most likely to benefit.

4. Hypertension

Hypertension is an important risk factor for both CHD and stroke.

At present there is no comprehensive hypertension programme or strategy in Lewisham. Although guidelines have been produced by the British Hypertension Society (commonly known as the ABCD guidelines), these have not been disseminated or supported through an education programme.

Lewisham has almost four times the national rate of admissions for hypertension. Although this can be partly explained by the higher prevalence of hypertension in African-Caribbeans, the rate of admissions is still unacceptably high.

It is estimated that there are about 46,000 people with hypertension in Lewisham (25,000 men and 21,000 women). Of these, it is estimated that only about 40% (19,000) are receiving some form of treatment.

To address this situation would require an Integrated Disease Management (IDM) programme, the key components of which would be:

- increased level of detection and control in primary care
- improved clinical management in primary care
- more effective management of referrals
- reduction in admissions
- increased effectiveness of prevention programmes in smoking cessation, physical activity and schools
- increase awareness of the risk of hypertension in the community, particularly within the African-Caribbean group
- increase self-care management and compliance with medical therapy.

Such an approach, however, will require investment.

One element of the IDM in which there has been investment is ambulatory blood pressure monitoring. Blood pressure varies significantly over a 24-hour period and single, elevated measurements do not necessarily reflect the true position. Ambulatory monitoring during routine daily activities provides several readings throughout the day and night and offers a profile of blood pressure during rest as well as activities. It is especially important in differentiating spuriously high readings (white coat effect) from true sustained hypertension. A community based ambulatory blood pressure monitoring service operating from four sites was established in 2005. The cost of the service is about £8,000 per annum, covering an estimated 400 patients per year who would otherwise have been referred to a hospital for assessment. Present uptake of ambulatory testing is low; this needs to be addressed if improvements in outcomes are to be achieved.

5. Summary

Circulatory disease is the most important cause of death of men in Lewisham. It is also a leading cause of disability. Although significant improvements have occurred, considerable challenges remain, particularly in ensuring more effective services relating to hypertension and stroke, conditions which disproportionately affect men from some black and minority ethnic communities. A major review of strategy in relation to hypertension and stroke is now overdue.

Much of the information contained in this report was provided by Conrad De Sousa, Jane Miller and Katrina McCormick (respectively – Lewisham Public Health Leads on CHD, Tobacco Control and Obesity). Any errors are mine.

Donal O'Sullivan, 20 October 2006

Men's Health Scrutiny Review Working Group item no 2
Men's Health – Circulatory Diseases and Physical Activity
Executive Director, Community Services
date 25 October 2006

1. Summary

1.1 This report will outline the health benefits of participating in physical activity for people with circulatory diseases – stroke, hypertension and heart disease – and in particular what is provided specifically for men and other more general provision that men currently attend to improve health.

2 . The health case for physical activity and circulatory diseases

2.1 The uptake of regular physical activity decreases the risk of cardiovascular disease mortality in general and of CHD mortality in particular. Inactive people can double the risk of CHD.

2.2 The National Service Framework for Coronary Heart Disease (standard 12) states that a multidisciplinary programme of secondary prevention should be recommended for people with heart disease (and stroke) to participate in, and this should include physical activity. The aim is to reduce the risk of further cardiac problems and to promote a return to a full and normal life for both men and women.

2.3 The benefits of exercise to heart and stroke patients, after an event, have enabled people to make a quicker recovery, improve their quality of life and return to daily activities and living. However, exercise must be maintained by groups of people with circulatory diseases in order to sustain longer-term cardiovascular benefits. These include improved blood flow to major muscle groups and vital organs, leading to an improved cardiovascular system through regular training, as well as improved coordination, muscle strength and mobility, especially for people who have experienced a stroke.

2.4 The benefits of participating generally in exercise and specifically in a structured programme of rehabilitation for people with circulatory diseases have been documented by the World Health Organisation, 1993 and Horgan et al. Evidence has shown that the benefits are:

- improved survival
- improved functional capacity
- reduced angina
- lower blood pressure
- reduced anxiety and depression
- increased confidence and well-being
- improved return to work and leisure
- improved compliance with lifestyle modification.

The benefits of exercise and specifically endurance training for people with circulatory diseases can reduce the ischaemic/anginal threshold in both men and women.

2.5 Regular physical activity prevents or delays the development of high blood pressure and reduces blood pressure in people with hypertension. Both men and women who are at risk of hypertension, or currently suffer with it, can benefit from participating in the recommended 5 x 30 minutes of physical activity a week. Taking aerobic exercise (brisk walking, cycling, etc.) can have an effect on reducing systolic and diastolic blood pressure (in trials) (NICE Guidelines). The benefits are maintained as long as the exercise is sustained on a regular basis and combined with support from a multi-health professional team.

3 Current support services

3.1 Current support services in terms of physical activity and people with circulatory diseases include a range of physical activity programmes across the borough. The Exercise Referral Scheme is a primary prevention programme which also has pathways to exercise for specialist groups, such as stroke patients, and people with existing coronary heart disease. The scheme works in partnership with a range of health professionals to provide a variety of lifestyle changes, support and advice.

3.2 Currently on the Exercise Referral Scheme, men are under-represented, with 66% women and 26% men attending for the last quarter of the scheme (April–June 2006).

3.3 The community Active Heart Programme and CHD referral scheme are two programmes which aid rehabilitation. The former programme is for people who have completed cardiac rehabilitation and want to continue exercising in the community. The latter scheme is for people post-CHD who need to have an assessment before taking up exercise after a period of inactivity. Both schemes are predominantly attended by men, supported by their partners, although there has been a recent increase in women being referred.

3.4 The Lewisham Healthy Walks programme is on offer for people with circulatory diseases and has a good attendance by men.

4 Future campaigns to promote exercise to men with circulatory diseases

4.1 Men are currently under-represented on some of the current exercise programmes available in Lewisham – in particular the Exercise Referral Scheme, whereby GPs and nurses can refer men for exercise. Men may not be accessing the service for a number of reasons:

- not being offered the service
- don't feel it will benefit them
- the image and choice of exercise sessions on offer.

4.2 The Exercise Referral Scheme will be looking at ways to target men through a series of health awareness campaigns in the future. This will involve introductory sessions for men into leisure centre activities, taking blood pressures, and attending gym sessions. It will also look at visiting a range of non-traditional places for exercise, such as pubs and male-orientated workplaces, to promote physical activity and the benefits of participating in exercise.

4.3 Lifestyle sports will also be explored, looking at pathways for people who have played sport competitively but who, as they age, may wish to take up other less physically demanding sports on a recreational basis. Equally, many may wish to try less physically demanding/less time reliant, but still competitive, sports.

D: Trends in cancer amongst men in Lewisham

1. National policy context

Cancer causes a quarter of all deaths in England and Wales. Survival rates from cancer compare poorly with survival rates in other Western countries. The National Cancer Plan was published in 2000 with a central target to reduce mortality from cancer in people under 75 years by 20% by 2010 (from baseline in 1995/7).

2. Cancer in Lewisham

Death rates from cancer are 25% both nationally and in Lewisham. In 2003, 803 people were diagnosed with cancer and 536 people died of cancer in Lewisham.

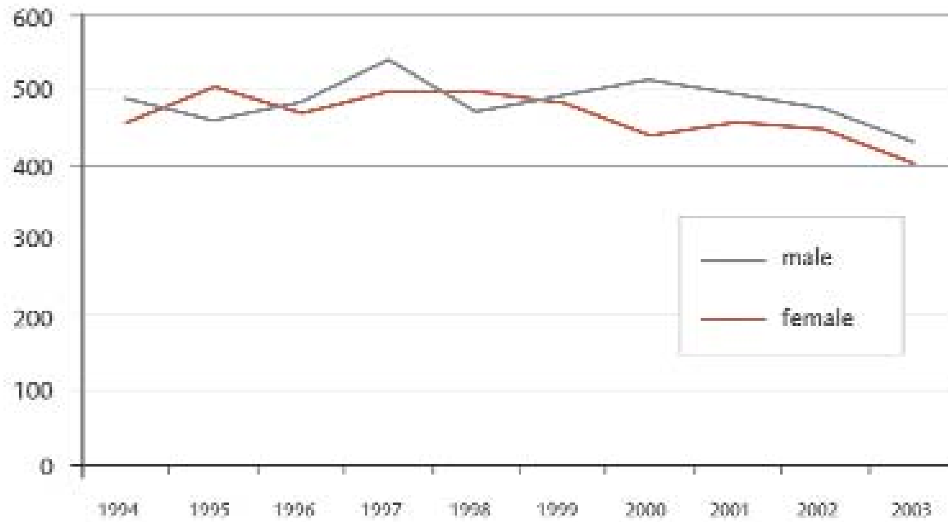
3. Incidence of cancer

About 1,000 people are diagnosed with cancer every year in Lewisham; this figure varies year on year but has shown a decrease since 1997 (Table 1) and (Chart 1). The percentage decrease since 1997 is 20%.

Table 1 Numbers of patients diagnosed with cancer in Lewisham 1994 –2003

Year of diagnosis	Males	Females	Total
1994	487	457	944
1995	461	505	966
1996	483	469	952
1997	539	498	1,037
1998	473	497	970
1999	488	482	970
2000	511	442	953
2001	498	456	954
2002	474	446	920
2003	429	401	830
Total	**4,843**	**4,653**	**9,496**

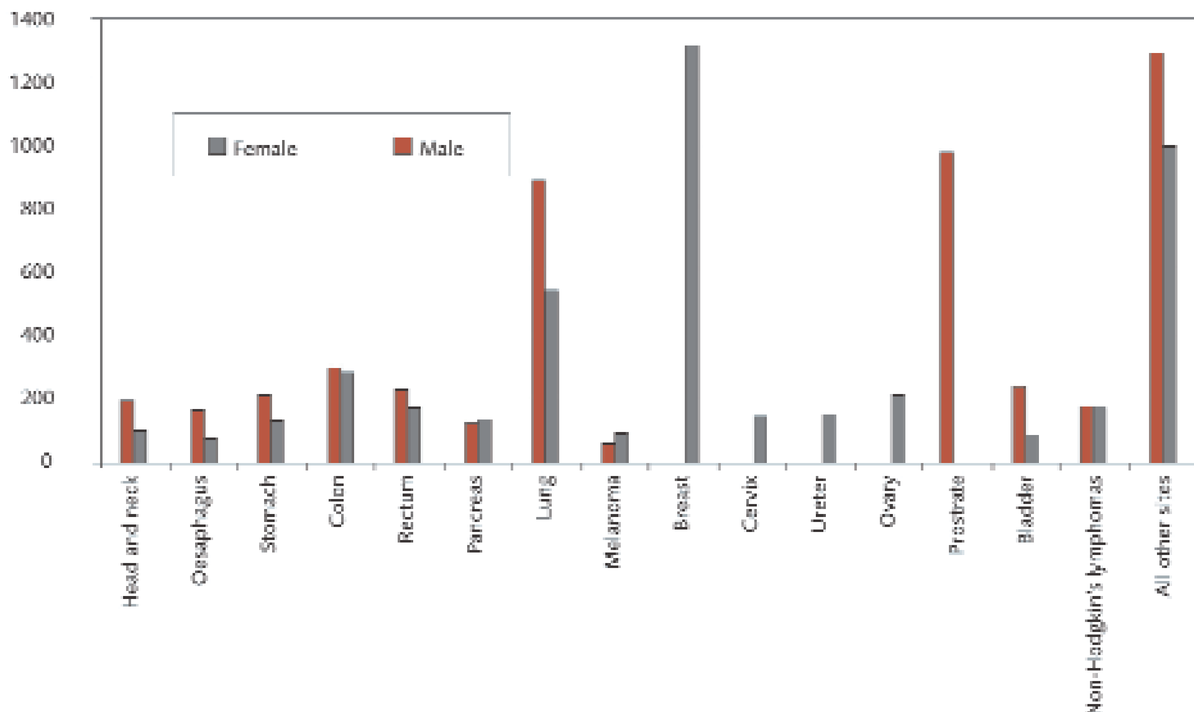
Chart 1 – Number of cancer cases diagnosed (1994–2003)



source: Thames Cancer Registry

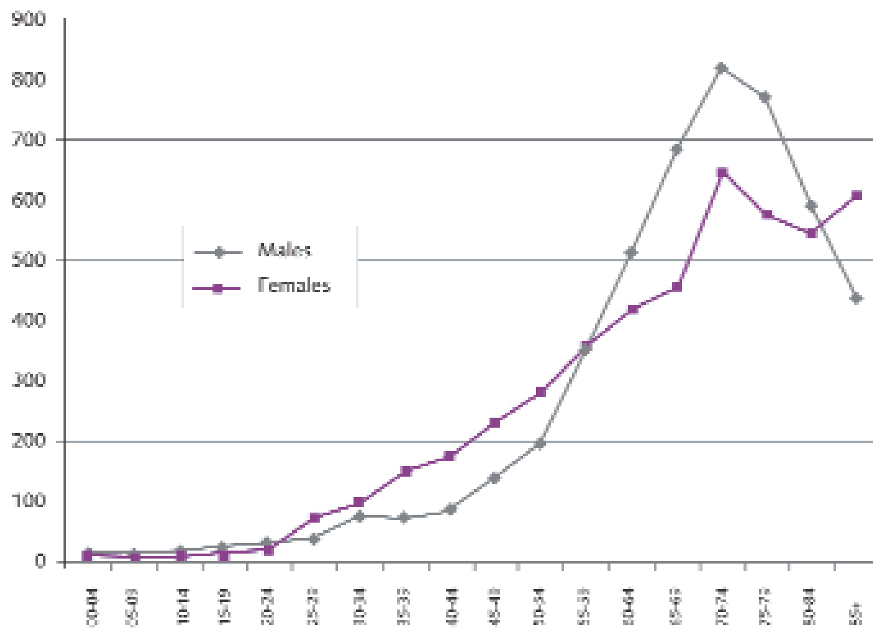
Prostate cancer is now the most common cancer in men (Chart 2). Breast, lung, colorectal and prostate cancers account for half (49.2%) of cancer in Lewisham (Table 1). Seventy-five per cent of cancers occur in people aged over 60 years (Chart 3), but some cancers can affect people at younger ages.

Chart 2 – Number of cancer cases registered in Lewisham, 1994–2003



source: Thames Cancer Registry report 'Cancer in Lewisham PCT, 1994–2003'

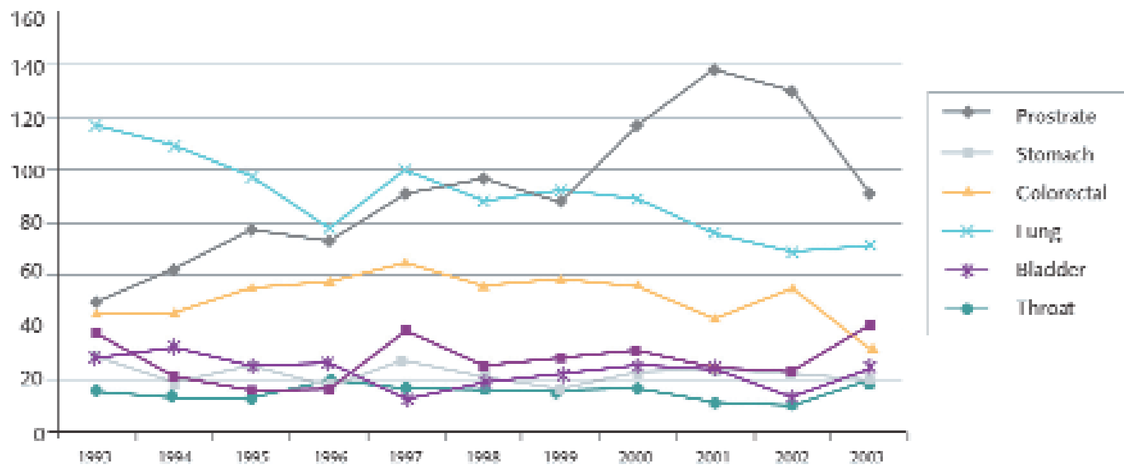
Chart 3 – Number of registrations by sex and five-year age group (1994–2003)



source: Thames Cancer Registry

2.2 Trends in cancers in Lewisham

2.2.1 Incidence of cancer in Lewisham



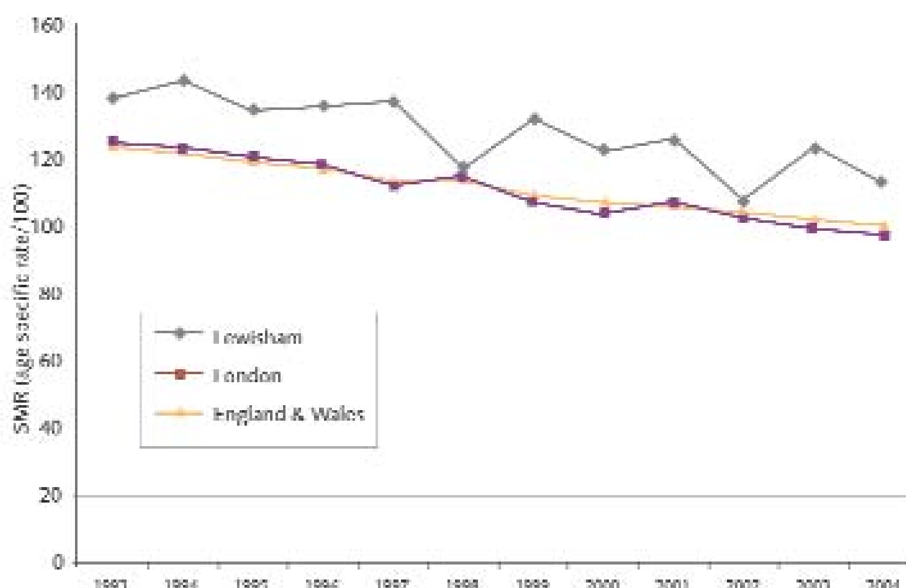
Source: Compendium of health indicators, 2006

4. Mortality from cancer in Lewisham

4.1 All cancers

Mortality rates from cancer overall are consistently higher in Lewisham than in England and Wales, particularly for males. For males, although rates have declined in the decade 1994–2003, the decline has been in line with national reduction so that mortality still remains higher than the national average. The National Cancer Plan target is to reduce mortality from cancer in people under 75 years by 20% by 2010. Nationally there was a 20% reduction in mortality between 1990 and 2000; however, in Lewisham it was only 14%. If the current trends continue, Lewisham is unlikely to meet the target at the local level, which will further widen the differential rates that currently exist.

Chart 5 – Trends in mortality from all cancers in people under 75 years

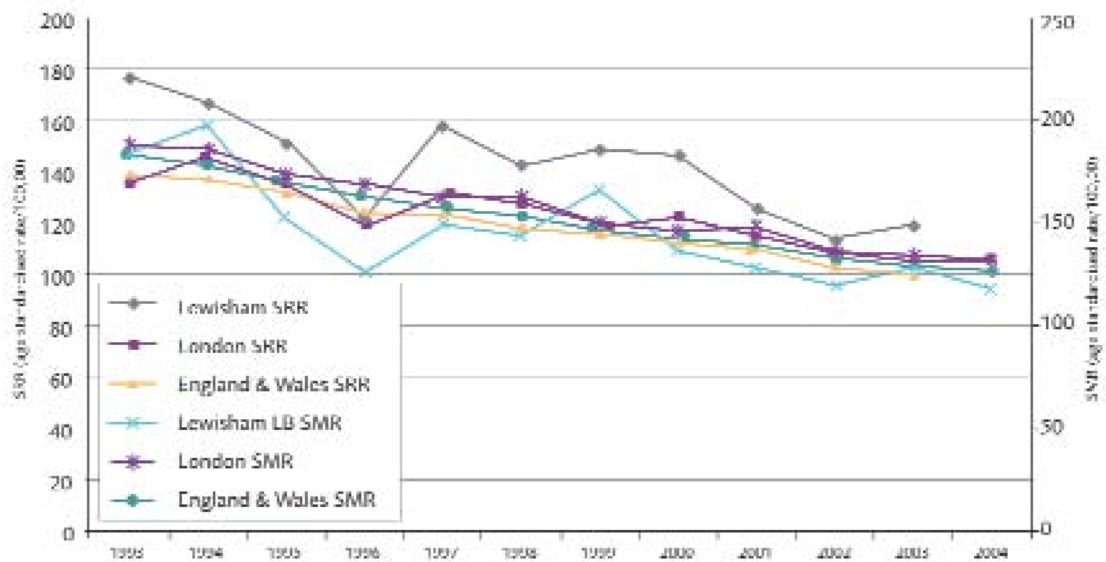


4.2 Lung cancer incidence and mortality

Lung cancer was the most common cancer in males but has now been overtaken by prostate cancer (Chart 4). The incidence of lung cancer in males has declined substantially and consistently in the last decade and in 2003 was over 40% lower than in 1993. Although there has been a significant decline, the burden of ill health caused by lung cancer is still large.

Lung cancer accounts for 17% of cancer cases but 22% of deaths, as survival rates from lung cancer are poor – on average only 8% of people will survive 5 years after diagnosis. Lung cancer mortality has been consistently higher in Lewisham than in London or England and Wales. In males mortality has declined, on average faster than the national decline (Chart 6).

Chart 6 – Lung cancer incidence and mortality (1993-2004)

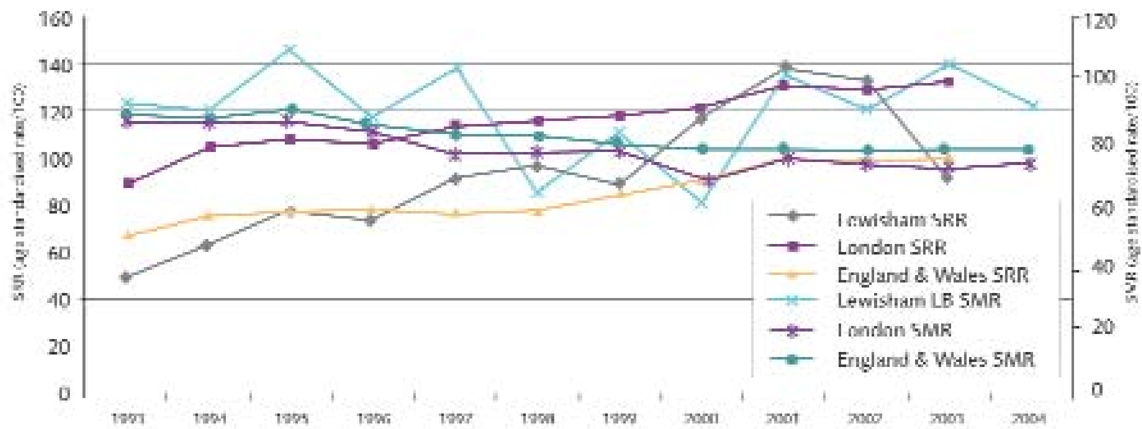


4.3 Prostate cancer incidence and mortality

There has been a very substantial increase in the number of people diagnosed with prostate cancer in Lewisham (Chart 7). This is similar to national trends and is likely to be due to the increase in early diagnosis through the use of the prostate specific antigen (PSA) test. This results in far more prostate cancers being detected when they are extremely small. Data from Thames Cancer Registry for SE London indicate that the rates of metastatic cancer have remained stable. However, the increase in the numbers of people diagnosed will result in an increase in the numbers of people treated for this disease.

Trends in mortality from prostate cancer are similar to national and London trends. The increase in deaths in the early 1990s levelled off, and mortality appears to have declined more rapidly in Lewisham than in London or England and Wales (Chart 7).

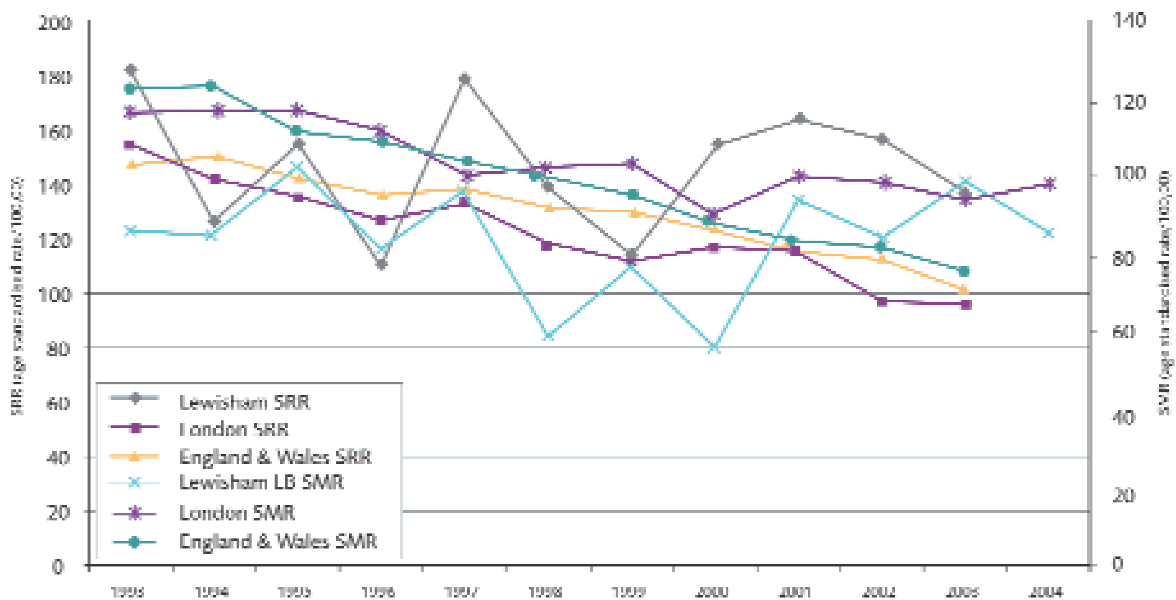
Chart 7 – Prostate cancer (1993-2004)



4.4 Stomach cancer incidence and mortality

There are no clear trends over the period for stomach cancer and numbers are quite small. However, the incidence of stomach cancer in Lewisham is higher than in London as well as England and Wales. Mortality from stomach cancer is higher in Lewisham than in London or England and Wales (Chart 8).

Chart 8 – Incidence and mortality from stomach cancer

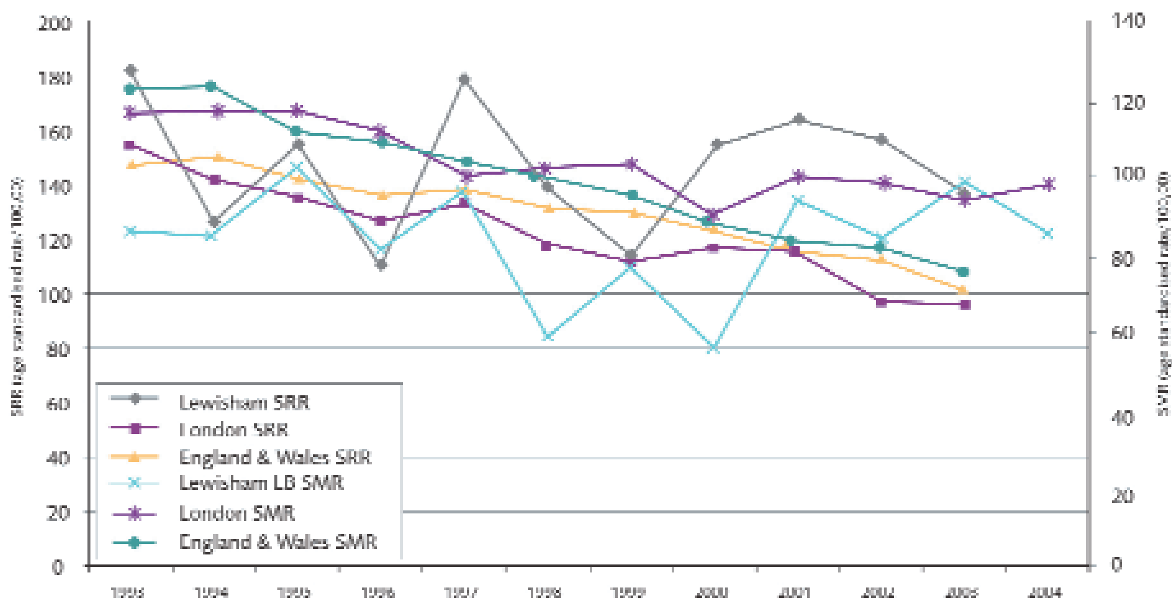


4.5 Colon and rectal cancers incidence and mortality

In males there was an increase in colon cancer in the late 1990s, but in 2003 rates were lower than in 1993 (Chart 4).

Bowel cancer mortality is generally much lower in London than in England and Wales and has shown a steady decline. However, Lewisham reverses this trend, and bowel cancer mortality is higher in males and on average has declined little (Chart 9).

Chart 9 – Incidence and mortality from colorectal cancer



4.6 Bladder cancer incidence and mortality

There are no clear trends for incidence over the period for bladder cancer and numbers are quite small. However, data for 2003 appear to show an increase in diagnoses over the preceding years (Chart 10). There are no clear trends over the period for mortality.

4.7 All skin cancer incidence and mortality

There are no clear trends over the period for all skin cancer and numbers are quite small. However, data for 2003 appear to show an increase in diagnoses over the preceding years (Chart 11). The numbers of people dying from skin cancer are small and therefore the rates vary significantly from year to year. Mortality from skin cancer appeared to be high in 2003 before returning to a less dramatic level.

Chart 10 – Bladder cancer incidence and mortality (1993-2004)

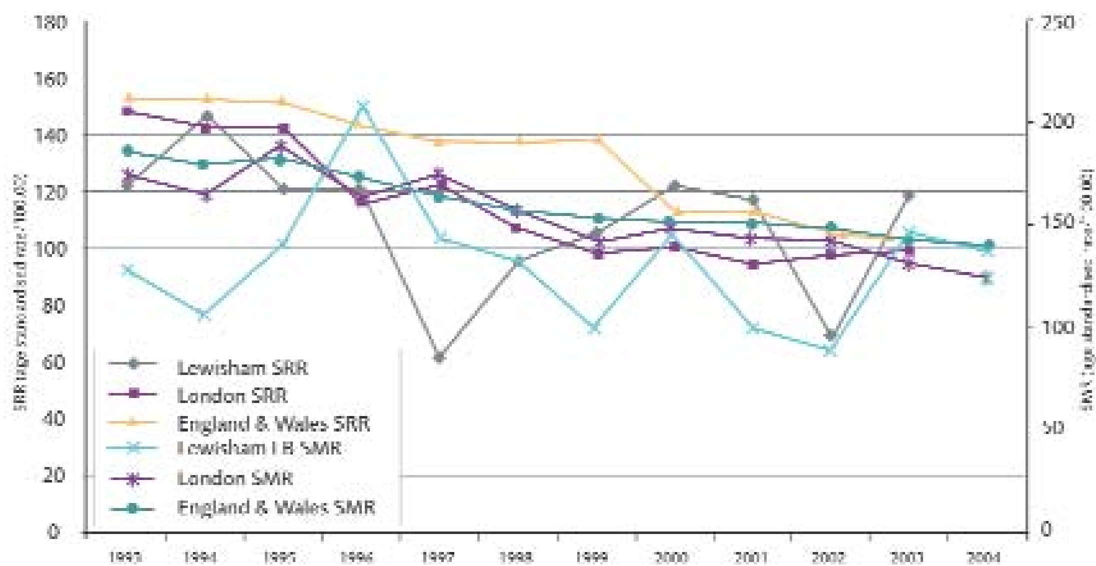
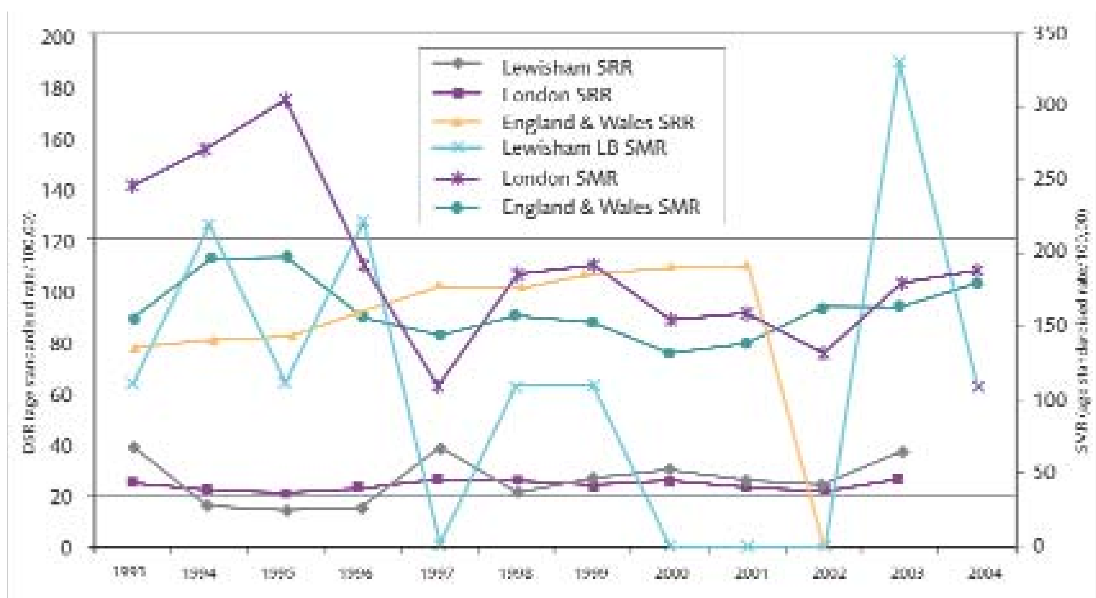


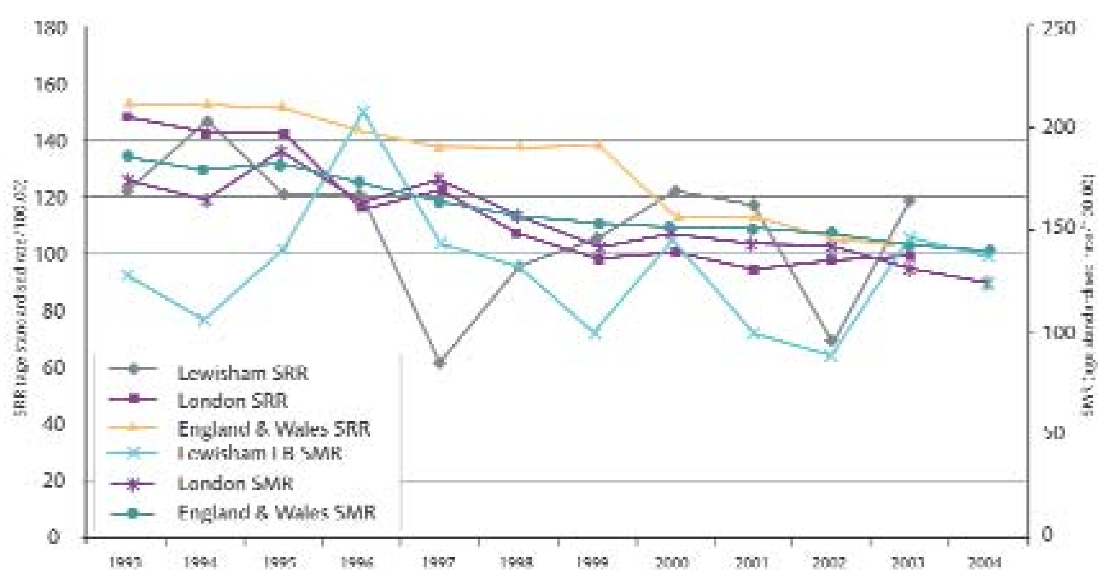
Chart 11 – Skin cancer mortality and incidence (1993-2004)



4.8 Throat cancer incidence and mortality

There are no clear trends over the period for throat cancer and numbers are quite small. Nationally, the number of diagnoses is fairly static (Chart 12). There are no clear trends over the period for mortality from throat cancer in Lewisham. Nationally the mortality from throat cancer is stable (Chart 12).

Chart 12 – Incidence and mortality from throat cancer (1993-2004)



2.3 Death rates by ward and neighbourhood

There are considerable variations in cancer mortality between wards for people under 75 years. Rates were significantly higher than national rates in New Cross, Evelyn, Brockley, Telegraph Hill, Sydenham and Bellingham for men, and New Cross, Forest Hill and Bellingham for women.

Table 2 Mortality from cancer in people <75 yrs 2002–4, by ward

Neighbourhood	Ward	Males	Females
1	New Cross	175.3*	136.2*
1	Evelyn	140.5*	117.3
1	Brockley	132.1*	82.4
1	Telegraph Hill	125.0*	116.4
2	Blackheath	72.4	104.1
2	Ladywell	103.5	115.2
2	Lee Green	103.9	113.9
2	Lewisham Central	92.7	114.2
3	Grove Park	101.6	98.1
3	Whitefoot	119.1	112.8
3	Catford South	95.7	106.0
3	Downham	112.3	121.0
3	Rushey Green	116.5	89.8
4	Forest Hill	119.0	129.1*
4	Perry Vale	116.5	89.8
4	Crofton Park	116.0	101.5
4	Sydenham	128.5*	120.9
4	Bellingham	154.5*	155.6*

Standardised Mortality Ratio. Local rates presented as a ratio to national rates where England = 100.
* Rates are significantly higher than national rates.

When cancer mortality rates are looked at separately for males and females, all ages, a varied picture emerges. New Cross, Grove Park, Downham, Rushey Green, Bellingham and Sydenham wards have significantly higher cancer mortality rates for men, whilst for women death rates are significantly higher in New Cross, Forest Hill, Bellingham and Sydenham. Because of low numbers at ward level it is not robust to look at specific cancers at ward level.

Table 3 Mortality from cancer, males and females, all ages, 2002–4, by ward

Neighbourhood	Ward	SMR Males	SMR Females
1	Evelyn	110.3	122.1
1	New Cross	175.0*	145.1
1	Brockley	117.7	75.3
1	Telegraph Hill	119.3	93.2
2	Blackheath	95.3	120.5
2	Ladywell	80.0	112.4
2	Lee Green	99.8	118.7
2	Lewisham Central	90.8	119.7
3	Catford South	100.7	101.7
3	Whitefoot	119.9	103.0
3	Grove Park	126.5*	109.3
3	Downham	123.8*	122.0
3	Rushey Green	128.8*	94.5
4	Forest Hill	119.2	127.6*
4	Crofton Park	103.6	91.8
4	Perry Vale	99.5	81.7
4	Bellingham	138.2*	142.5*
4	Sydenham	139.3*	125.9*

Source: LHO
Standardised Mortality Ratio (SMR). Local rates presented as a ratio to national rates where England = 100.
* Rates are significantly higher than national rates.

5 Cancer prevention

5.1 Smoking causes 30% of all cancers, in particular it is the major cause of cancers of the lung, mouth, oesophagus, bladder, kidney and pancreas and contributes to cancer of the stomach, liver, nose and leukaemia. Differential smoking habits account for between half and two thirds of the difference in health outcomes (including cancer mortality) between the upper and lower social groups. Smoking is thus one of the most important factors in health inequalities. Historically high rates of smoking in Lewisham explain the high incidence of lung cancer, and the continued high rates of smoking in women (and increasing rates in some age groups) explain why the incidence of lung cancer is not decreasing much in women.

5.2 Diet is related to 30% of cancers, in particular colon, rectum, stomach, liver and prostate. Diets high in fat and/or low in fibre can contribute to the development of several cancers, and consumption of smoked or cured foods contributes to stomach cancer. High consumption of fruit and vegetables is known to protect from cancer.

5.3 Obesity is implicated in 5–10% of cancer, particularly colon for men. Increasing physical activity helps reduce the risk of obesity.

5.4 Occupational exposure to carcinogens accounts for 4–6% of cancers; exposure to certain infective agents (e.g. helicobacter pylori and stomach cancer) and genetic factors are also risk factors for some cancers.

5.5 Cancer screening for men

Prostate screening. Currently there is a pilot programme taking place for screening for prostate cancer; however, all GPs have received information about the availability of prostate specific antigen (PSA) testing. The PSA test can detect an increased risk of prostate cancer but it is insufficiently specific to predict likely outcomes. There are some limitations to the test as:

- the PSA test is not a foolproof test for prostate cancer
- two out of three men with raised PSA will not have any cancer cells in their cancer biopsy
- up to one in five men with prostate cancer will have a normal PSA result.

Bowel (colorectal) screening. The national pilot of bowel screening is now complete. The bowel cancer screening programme is being rolled out across the country. It has been operational since October 2006 in London.

6. Quality of care – patient views

- A national survey of cancer patients was done in 2001. The survey only reported results for trusts where there were more than 50 respondents. Results are available for UHL for colorectal cancer patients.

For colorectal cancer patients, UHL was among the worst performing trusts for:

- cancelled appointments
- time to receiving diagnosis
- confidence in doctors and nurses
- understanding of information given
- being treated with dignity and respect
- involving the family
- information about primary care involvement post-discharge.

UHL was amongst the best performing trusts for:

- amount of time spent with the patient.

7. Place of death

Data from Thames Cancer Registry show that in 1994–2003 just over half (53%) of all cancer deaths occurred in hospital and nearly a quarter at home. This compares well with other parts of London, e.g. in NE London only 17% of cancer deaths occurred at home. Sixteen per cent were in a hospice.

E: Men's mental health and well-being

The mental health of young black men (aged 16–24) in Lewisham.

Disproportionately high rates of young black men from Lewisham in secure mental hospitals and held under mental health section.

1. Introduction

There is evidence of a higher rate of psychosis and manic depression (severe mental health problems) in young black men compared to young white men. Young Black Caribbean men are more likely than other ethnic groups to be diagnosed as schizophrenic. They are also more likely to be admitted to hospital, and their admission is more likely to be compulsory than other groups. Clearly, there is a complex relationship between ethnicity, social disadvantage and service provider attitudes.

2. Demography

There are an estimated[1] 16,658 young men aged 16–24 in Lewisham and 28%[2] of them are from black and other minority ethnic (BME) groups. The largest BME group in Lewisham is Black Caribbean, followed by Black Africans and the fastest growing ethnic group is the black/mixed race group. At the younger ages of 5–15 year olds, the proportion of black and black/mixed race boys is greater (32%). The wards with the highest ratio of Black Caribbean people are Deptford, New Cross, Evelyn and Lewisham Central. The BME population is younger than the white population in Lewisham.[3]

3. Epidemiology of mental illness in Lewisham

In 2000 a national psychiatric morbidity survey was conducted by the Office of National Statistics.[4] The study team interviewed 8,800 people aged 16 to 74 years old in the UK.[5] This survey found that over the course of one year, 173 people in every 1,000 had some type of neurotic (or common) mental health problem, 4 people in every 1,000 had some form of psychotic (or severe) mental illness, and 47 people per 1,000 had some form of severe alcohol dependence. A similar survey, but focusing on the differences between ethnic groups'[6] experiences of common mental illness, showed that there were slightly higher rates of mental illness in minority groups compared to white groups (Table 1). Data from a children's psychiatric morbidity survey (1999) only show a slightly higher than expected prevalence of mental health problems in black boys compared to white boys (Table 2).

[1] Greater London Authority population projection (2003): 8.1.
[2] Roughly 4,664 young men (ibid.).
[3] Lewisham Health Profile 2004, 2005, Lewisham PCT.
[4] Meltzer, H. et al. 2000, Psychiatric Morbidity Survey for England and Wales, ONS.
[5] People with severe mental illness were identified from a random sample of GP records.
[6] Nazroo, J. 2000, Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) Survey, ONS.

Table 1
Prevalence of common mental illness in the UK, by ethnicity

	White (%)	Irish (%)	Black Caribbean (%)	Bangladeshi (%)	Indian (%)	Pakistani (%)
Men	**11.6**	18.4	**13.8**	12.9	12.1	12.6
Women	19.0	18.6	19.8	12.3	23.8	26.0

Source: ONS EMPIRIC Survey, 2002

Table 2

Comparisons of rates of mental disorder for specific characteristics in children aged 5–15 in the UK			
Boys	11%	Girls	8%
Boys 5–10	10%	Boys 10–15	13%
Girls 5–10	6%	Girls 10–15	10%
White	**10%**	Black	**12%**
Pakistani/Bangladeshi	8%	Indian	4%

Source: ONS, 1999

Psychosis has severe and disabling consequences. The standardised mortality ratios (likelihood of dying) for schizophrenia are 2.5 times those of the rest of the UK population. It is likely that 15% of those with long-term illness will die from suicide. Fifty per cent of all acute admissions to psychiatric wards are for schizophrenia, which clearly demonstrates the importance of the condition for the health service.[7]

The aetiology (nature and cause) of schizophrenia is much debated, but there is likely to be a complex interaction between genes, life circumstances and upbringing. Current theories are moving away from gene-focused explanations to more social and family process-oriented theories.[8]

[7] Brown, S., Inskip, H. and Barraclough, B. (2000) Causes of the excess mortality of schizophrenia. *British Journal of Psychiatry*, 177: 212–17.

[8] Fearon, P., Kirkbride, J.B., Dazzan, P., Morgan, C., Morgan, K., Lloyd, T., Hutchinson, G., Tarrant, J., Fung, W.L.A., Holloway, J., Mallett, R., Harrison, G., Leff, J., Jones, P.B. and Murray, R.M. (2006) Incidence of schizophrenia and other psychoses in ethnic minority groups: results from the MRC AESOP Study. Psychological Medicine, 26: 1–10.

The annual incidence (new cases) of schizophrenia has been estimated at 0.1 cases per 1,000 population per year (range 0.07–0.14) and, as stated before, the prevalence (or the amount of people with the illness) is about 3–4 per 1,000 population and appears to be stable across countries, cultures and time.[9] If the national prevalence figures for schizophrenia are applied to the Lewisham population, we should expect 527 males (around 158 black men) with the disease in Lewisham. The average age of getting psychosis is around 24 years old for men. The data from SLAM services show black men are entering in-patient services at much higher rates at the ages of 16–24 than white boys (Figure 2).

Findings from the Fourth National Survey of Ethnic Minorities (FNS),[10] based on illness and symptoms rather than treatment, found that Caribbeans did have a raised prevalence of psychotic symptoms in comparison with the white group. For Caribbean people the annual prevalence of mental disorder was 14 per thousand, in comparison with the rate of eight per thousand for the white group (that is 75 per cent higher in the Caribbean group). However, this is still less than the difference found in treatment rates.

There is a strong body of evidence to show that social deprivation increases the likelihood of severe mental illness (SMI). As the Adult Psychiatric Morbidity Study (2000) did not account for deprivation, an index was developed to predict admission rates for SMI based on several deprivation factors (e.g. number of people on welfare benefits).[11] Lewisham is a relatively deprived borough and the index predicts a higher mental health burden in the north of the borough.

There should be little difference in the rates of illness between black and white people in Lewisham (after adjusting for deprivation). However, the incidence of new people with psychosis being treated in hospital is six times greater in black people then it is in white people, far higher than expected even when adjusting for deprivation. There are also more black men than black women in in-patient services. It also appears that white people are under-represented in services.

4. Treatment for severe mental illness

The mental health think tank the Sainsbury Centre for Mental Health conducted a London-wide study to investigate the disproportionate treatment rates of mental illness in black people. They used two main sources of data: the mental health minimum data set (used by mental health trusts) and the 'Count Me In' survey of psychiatric in-patients (2005). The study area covered four mental health trusts (including SLAM) and 60% of the total black population of London. They found that a black person is 1.6 times more likely to come into contact with mental health services than a white person (Figure 1). The SLAM in-patient data for the month of October 2006 shows that although only 28% of young men in Lewisham are black, they account for almost 70% of all in-patients compared to only 30% for white young men (Figure 2). Young black men are also more likely to be sectioned than white people in London (Figure 3). Echoing the London report, data from the SLAM

[9] Jablensky, A., Sartorius, N., Ernberg, G., Anker, M., Korten, A., Cooper, J.E., Day, R. and Bertelsen, A. (1992) Schizophrenia: manifestations, incidence and course in different cultures. A World Health Organization ten-country study. *Psychol. Med. Monogr. Suppl., 20*: 1–97.

[10] ONS, 2005.

[11] Glover, G. (1999). How much English health authorities are allocated for mental health care [editorial]. British Journal of Psychiatry, 175: 402–6.

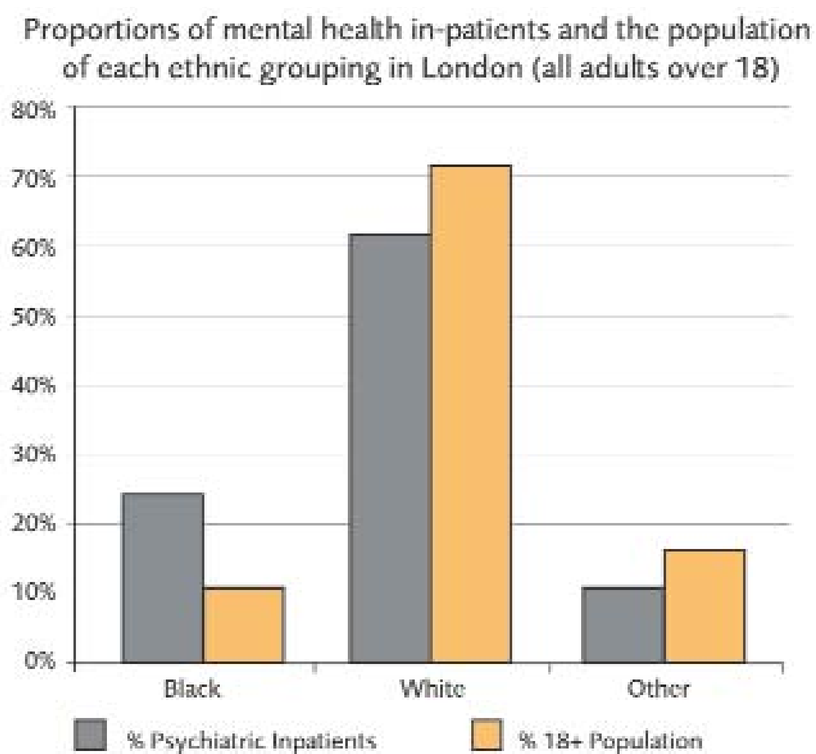
[12]The Costs of Race Inequality: Policy no. 6. Sainsbury Centre for Mental Health, October 2006.

trust also show that black people from Lewisham are more likely than white people to be in acute services than in community services or rehabilitation (Figure 4).

Figure 1

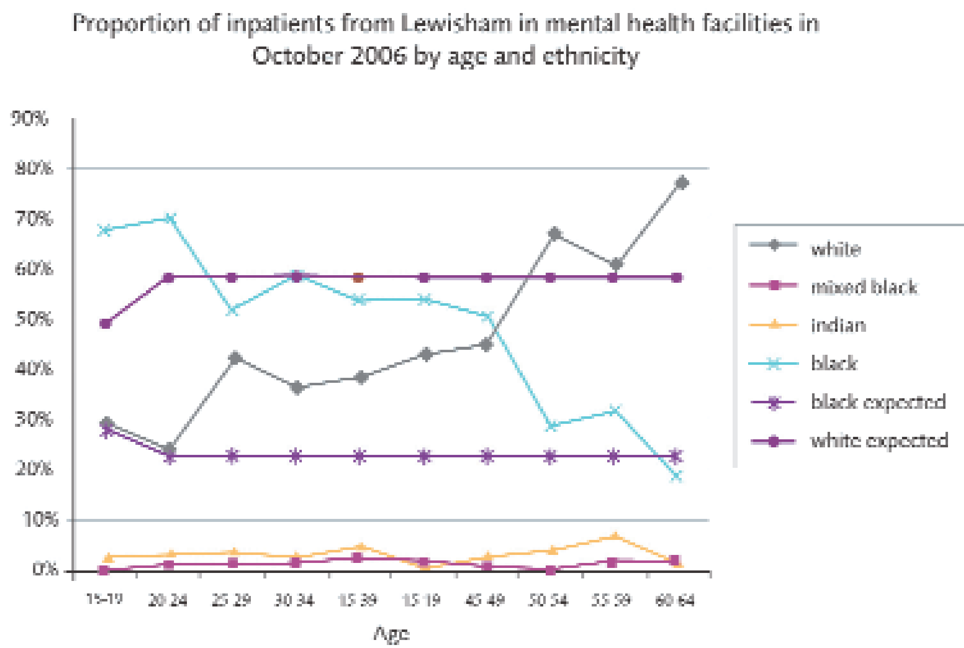
Proportions of mental health in-patients and the population of each ethnic grouping in London (all adults over 18)

Chart 1 – Number of cancer cases diagnosed (1994–2003)



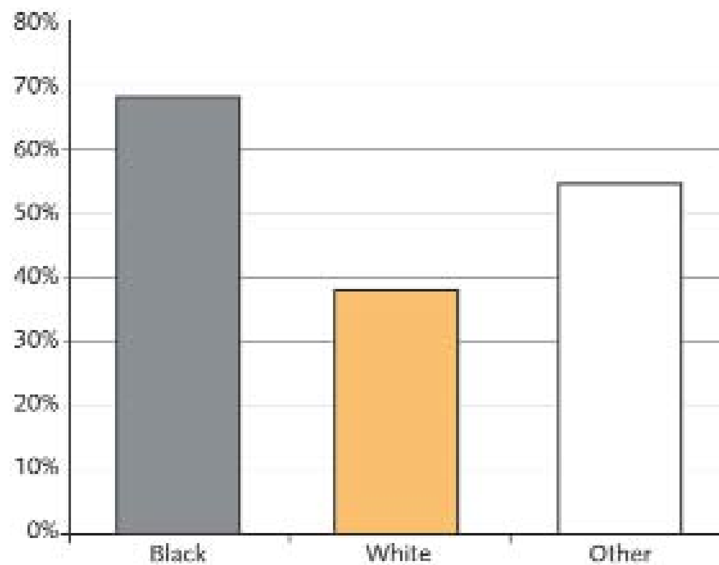
source: Sainsbury's Centre for Mental Health, 2006

Figure 2



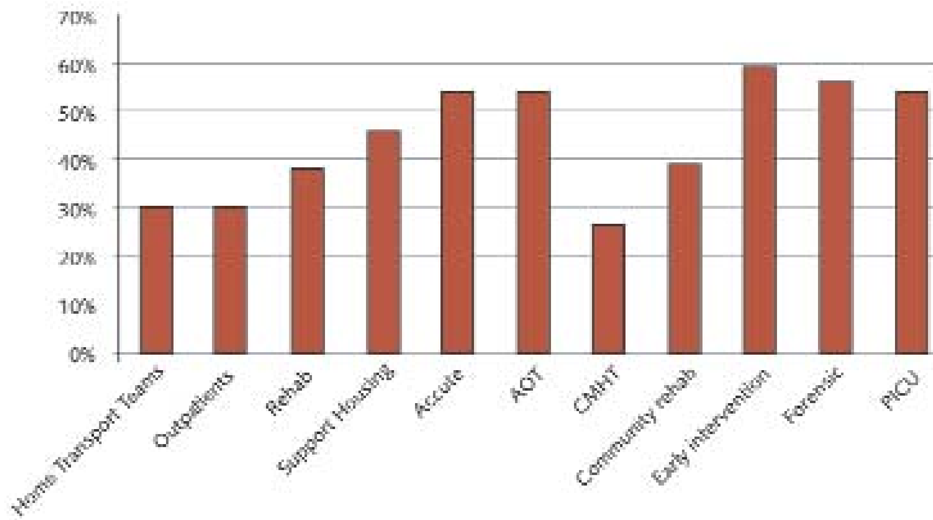
source: SLAM in-patient data snapshot, October 2006

Figure 3 – Admissions under the Mental Health Act in London 2005



source: Sainsbury's Centre for Mental Health, 2006

Figure 4 – Proportion of Lewisham Black people in SLAM services October 2006



source: SLAM in-patient data snapshot, October 2006

5. Why these differences? Explanations from research

There are five main reasons why there might be higher than expected numbers of young black men in the psychiatric system in Lewisham (and nationally):

- misdiagnosis by clinicians (no evidence)[13]
- biological (no evidence)[14]
- social forces (good evidence)[15]
- family process[16] (good evidence)
- psychological (little evidence).[17]

[13] Sharpley, M.S., Hutchinson, G., Murray, R.M. and McKenzie, K. (2001) Understanding the excess of psychosis among the African Caribbean population in England: review of current hypotheses. *British Journal of Psychiatry*, **178** (40): 60–8.

[14] Hickling, F.W. and Rodgers-Johnson, P. (1995) The incidence of first contact schizophrenia in Jamaica. *British Journal of Psychiatry*, **167**: 193-196

[15] Sharpley, M.S., Hutchinson, G., Murray, R.M. and McKenzie, K. (2001) Understanding the excess of psychosis among the African Caribbean population in England: review of current hypotheses. *British Journal of Psychiatry*, **178** (40): 60–8.

[16] Morgan, C., Kirkbride, J., Leff, J., Craig, T., Hutchinson, G., McKenzie, K., Morgan, K., Dazzan, P., Doody, G., Jones, P., Murray, R. and Fearon, P. (2006) Parental separation, loss and psychosis in different ethnic groups: a case-control study. *Psychological Medicine*, [vol/pp].

[17] Sharpley, M.S., Hutchinson, G., Murray, R.M. and McKenzie, K. (2001) Understanding the excess of psychosis among the African Caribbean population in England: review of current hypotheses. *British Journal of Psychiatry*, **178** (40): 60–8.

Much of the current research and data conclude that ethnicity is not independently associated with prevalence of mental disorders but is more clearly linked to lower social status and adverse economic conditions such as unemployment and lone parenting and the experience of being black.[18] These conditions can increase the risks of family and community disruption and lead to feelings of being unsafe, all of which increase the chances of suffering a mental disorder.

The data from the Health Survey for England (1999)[19] shows that people from BME communities are poorer than white people. The inequalities in reported poor health (including mental health) between different ethnic groups begin to widen (particularly between the Black Caribbean and White English) after the ages of 16–20 (Figure 5). Before that time, reported health is similar for all ethnic groups. By the ages of 30–40 the gap is marked. This illustrates the existence of certain social forces that begin to operate when young people reach adolescence, an understanding of which may be helpful to local mental health services.

Putting these social forces in context might be helpful. Recent statistics from the fourth national ONS survey show that 65% of employers have discriminated against ethnic minorities, 14% of the BME population in England and Wales have experienced serious racial abuse and attacks in the past year and, when asked, 20–40% of white people admitted to discriminating against BME groups (Figure 6). Recent research has shown that the experience of stress as a result of the harassment, loss of aspiration and fear that arises from racism is a contributing factor in the pathway to developing psychosis in young black men.[20] This is further compounded by the adverse family processes and attachment problems that occur in childhood for this group of men.

[18] Thornicroft, G. (1991) Social deprivation and rates of treated mental disorder: developing statistical models to predict psychiatric service utilisation. *British Journal of Psychiatry*, 158: 475–84.

[19] Department of Health (1999) Health Survey for England: The health of minority ethnic groups. London : The Stationery Office.

[20] Karlsen, S., Nazroo, J., Mckenzie, K, Bhui, K. and Weich, S. (2005) Racism, Psychosis and Common Mental Disorder among Ethnic Minority Groups in England. *Psychological Medicine*, 35: 1795-1803.

Figure 5 – Reported fair or bad health by ethnic group and age

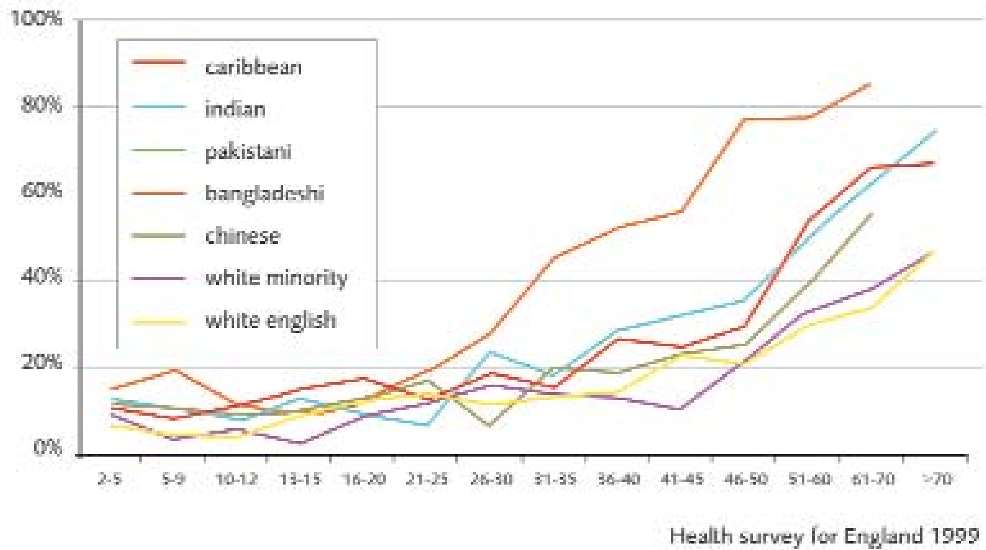
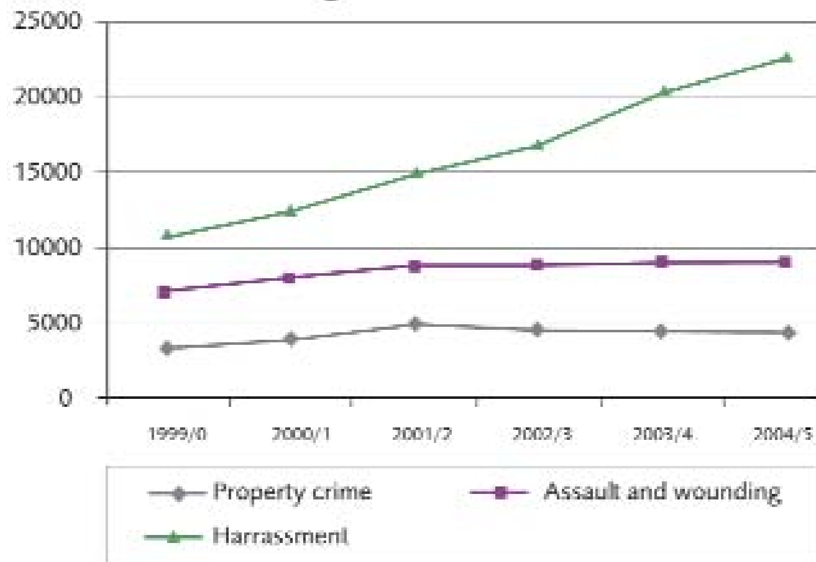


Figure 6 – Reported racially aggravated crime in England and Wales



source: Home Office, 205

6. Conclusion

There should be little difference in rates of psychosis between young black men and white men after adjusting for deprivation, and yet the treatment data continue to show higher proportions of black men compulsorily detained under the Mental Health Act. The Sainsbury's Centre research clearly shows that there is a huge economic cost to these inequalities. If the numbers of young black men seen as mental health in-patients, and throughout the mental health service, could be brought in line with the rates for white people, then across London cost savings of £18,000,000 could be made. This amounts to one extra community mental health team per borough across London.

The current position on this issue from the Sainsbury's Centre for Mental Health concludes that there are three linked factors that need to be tackled in order to reduce the numbers of black young men in mental health services:

- lack of trust and engagement in statutory services by the black community
- inappropriate escalation of risk by clinicians (perceiving greater threat)
- the experience of being black (socially, economically and within the family).

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F: Men's sexual health

1. Background

Sexual health has been a Lewisham priority for some time on account of the epidemic in sexually transmitted infections and the high rates of teenage pregnancies. The first national sexual health strategy (2001) was developed in response to the scale of the sexual health problem in the UK. It placed an increased focus on sexual health as a major public health issue and tasked PCTs to develop local structures to ensure its implementation. Lewisham has established a multi-agency, multidisciplinary group that encompasses the NHS, local authority and voluntary sector to develop a local Sexual Health and HIV Strategy.

2. Burden of sexual ill health in Lewisham

Lewisham has high rates of HIV, sexually transmitted infections, terminations and teenage conceptions.

2.1 HIV

HIV continues to be one of the most important communicable diseases in the UK, and each year many thousands of individuals are diagnosed with HIV for the first time. The infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed.

The increasing incidence of the disease and improved survival rates because of highly effective anti-retroviral therapies are the two most important factors underlying the increase in prevalence of this infection, which in turn has had a dramatic impact on local services.

Data for the Survey of Prevalent Diagnosed HIV Infections (SOPHID) are collected on an annual basis and relate to individuals known to be HIV positive who attend for HIV-related treatment and care in acute sector NHS hospital settings. In interpreting these data, it is important to remember that an estimated 27% of individuals infected with HIV are undiagnosed and cannot, therefore, be included in the data.

In 2005 the number of diagnosed HIV-infected patients seen for care, and resident in Lewisham, was 985. Of these, 328 were seen at Lewisham Hospital, of whom 126 were male. A more detailed analysis of the 2005 data is currently being undertaken. In 2004 the prevalence rate in Lewisham was slightly higher than that in London, which has four times the prevalence rate of infection in England as a whole. Of the 528 Lewisham men living with HIV in 2004 (out of a total of 895), 303 (57%) were white. Overall, in terms of numbers of people living with HIV in Lewisham, the most commonly reported means of acquisition of HIV was sex between men and women, accounting for infection in 494 or 55% of Lewisham residents living with HIV in 2004. However, sex between men remains the most important means of acquisition of infection for men, accounting for 324 cases or 61% of infected men.

2.2 Chlamydia

Genital chlamydial infection is the most common sexually transmitted infection in South East London. As most people are asymptomatic, a large proportion of cases remain undiagnosed.

Data about Chlamydia are collected by GUM clinics and from the screening programme outside GUM clinics. The number of diagnoses of uncomplicated genital chlamydia infection in GUM clinics has risen steadily since the mid-1990s. Chlamydia diagnoses in South East London in GUM clinics increased by 1.4%, from 3,840 cases in 2003 to 3,894 in 2004. However, this rate of increase appears to have slowed compared with the previous year (a 4.2% increase from 2002 to 2003). The 1.4% increase compares with a 2.5% increase across London and 8.4% for the UK.

The prevalence is highest in sexually active adults, especially women aged 16 to 24 and men aged 18 to 29.

As there are currently no data available about the prevalence of chlamydia within the 16 to 24-year-old Lewisham population, the percentage of positive results is being used as a proxy indicator of the prevalence of chlamydia in this age group. The positive test rate in the screening population for chlamydia was approximately 13.5% in the first year of the programme, which is slightly higher than the 11% positivity nationally.

However, there are limitations to these data. It is likely that the users of the sexual and reproductive health clinics are not representative of the Lewisham population.

2.3 Gonorrhoea

Overall, there was a 15% increase in the number of cases of gonorrhoea diagnosed in South East London GUM clinics from 1998 to 2003. Gonorrhoea diagnoses decreased by 19.7%, from 2,172 cases in 2003 to 1,745 in 2004. The decrease in the number of diagnoses of gonorrhoea at GUM clinics continues the trend observed the previous year (17.0% decrease from 2002 to 2003). The 19.7% decrease observed in South East London was greater than that seen across London (12.7%) and the UK (10%).

The high positivity rate for gonorrhoea in Lewisham of 3.5% in the first year of the screening programme demonstrates the value of screening for both gonorrhoea and chlamydia at the same time.

2.4 Syphilis

In GUM clinics the syphilis diagnoses decreased by 2.0%, from 150 cases in 2003 to 147 in 2004. The decrease in diagnoses of syphilis in 2004 reversed the trend observed the previous year (40.2% increase 2002 to 2003) and is in contrast with the increase seen across London (17%) and the UK (37.2%).

2.5 Teenage pregnancy

Table 1 Under 18s conceptions

Under 18 conception rates in Lewisham									Trajectory			
Year	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
LB Lewisham	79.0	80.0	75.4	67.3	65.4	75.2	74.0	70.2	61.65	53.1	44.55	36
% change in rate from baseline		0.0	-5.8	-15.9	-18.2	-6.0	-7.5	-12.2	-23	-33.7	-43.1	-55%

Source: Teenage Pregnancy Unit, 2006

3. Policy context

The policy context for sexual health promotion is set out in a range of strategies including the National Strategy for Sexual Health (DH, 2001), the public health white paper *Choosing Health* (DH, 2004), the Teenage Pregnancy Strategy (Social Exclusion Unit , 1999), and *Every Child Matters: Change for Children*.

3.1 National Strategy for Sexual Health

The first National Strategy for Sexual Health of 2001, developed in response to the scale of the sexual health problem in the UK, has placed an increased focus on sexual health as a major public health issue. It defines sexual health as follows:

'Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human right to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment, with access to information and services to avoid the risk of unintended pregnancy, illness or disease.'

The strategy addresses the growing prevalence of sexually transmitted infections and HIV and aims to modernise sexual health and HIV services. It aims to improve services, information and support, reduce inequalities and improve health. It provides a framework for improving access to sexual health services, with three elements to facilitate a more systematic approach to service provision. Level one provision will be provided by the majority of general practices and sexual health services where patients self-refer. Level two requires specific extra training, support and infrastructure, and it is not envisaged that these services will be provided at all sites. Level three requires specialist skills and facilities and a more substantial infrastructure.

3.2 Implementation of national policy in Lewisham

The Lewisham Sexual Health Strategy places high importance on health promotion, prevention and outreach and the development of local sexual health services.

The Sexual Health Strategy Group links with the Lewisham Teenage Pregnancy Programme Board, and the Teenage Pregnancy Programme Action Plan dovetails with the Sexual Health Implementation Plan. Positive feedback was received from the Regional Teenage Pregnancy Coordinator about the Annual Report on the Teenage Pregnancy Programme for 2003/4:

'Excellent progress in service provision, clearly linked into the PCT's sexual health strategy, shows successful targeting of vulnerable young people.'

Health equity audits in sexual health and teenage pregnancy have been carried out during the past year.

4. Sexual health services

Lewisham PCT aims to provide and purchase services to meet the full range of requirements for an appropriate network of sexual health provision. Services have been developed within the framework of the national sexual health strategy, working towards a coherent provision of services, including health promotion and outreach services and services at levels one, two and three. Sometimes organisations provide services at more than one level.

Level one services

A range of easy-access level one services are provided, including the diagnosis and referral of people with sexually transmitted diseases (chlamydia, gonorrhoea, HIV, warts, etc.), contraception, smear tests and pregnancy tests, treatment and advice. There is a range of providers, including community pharmacy, sexual and reproductive health services and primary care.

The PCT Sexual and Reproductive Health Service has recently established an HIV rapid testing clinic. Some GPs also carry out HIV testing.

Level two services

A decision was taken in 2001/2 to invest in the Lewisham Family Planning Service, to begin to offer a comprehensive Sexual and Reproductive Health Service and to enable some GP practices to provide a 'level 2' service. In investing in a holistic community sexual health service (i.e. STI testing and treatment, contraception advice and provision, pregnancy testing and advice), Lewisham PCT aims to provide a one-stop service for sexual health. The 'sexually transmitted infection' (STI) work of the PCT in-house department and partners in primary care now makes a considerable contribution to STI work for Lewisham residents in a very accessible and diverse manner.

Level three services

HIV treatment and care are provided by acute hospital and community services and the voluntary sector. In 2004 the majority of Lewisham residents with HIV (64%) were receiving triple or quadruple anti-retroviral therapy.

4.1 Sexual and Reproductive Health Service

There is no GUM provision within the borough of Lewisham. In order to address this gap, services have been developed over the past two years with limited resources in both the Sexual and Reproductive Health Service and primary care, providing a holistic and one-stop approach (contraceptives, pregnancy advice and management of sexually transmitted infections). An increasing and significant proportion of people with genital chlamydial infection are diagnosed and treated by the Sexual and Reproductive Health Service.

In 2004/5 the PCT Sexual and Reproductive Health Service saw over 25,000 clients, held nearly 52,000 consultations (of which 48% were with people aged under 25, including over 1,000 young men), took over 10,000 tests for chlamydia (15% of them from men and 58% from people aged under 25) and treated over 2,500 people with sexually transmitted infections (or as contacts of these infections). Approximately one in three male visits resulted in a chlamydia/gonorrhoea test being performed. Approximately one in seven male visits involved STI treatment. Only 218 referrals were made to the local GUM clinics, and while this number does not include those people (chiefly men with acute urethral discharge) who were advised to go straight to a GUM clinic, it is a very low number for a service of this size (Annual Report 2004/5).

5.4% of the contacts with the PCT Sexual and Reproductive Health service were made by men, compared with 3.9% nationally (NHS Contraceptive Services 2005/6, England).

The Sexual and Reproductive Health Service operates extended-hours clinics and weekend clinics. It also coordinates an outreach programme to local schools and colleges. These have been extremely successful in attracting new clients, in particular young men.

4.2 Chlamydia screening programme

The chlamydia screening programme offers opportunities for the public to get screened for chlamydia and gonorrhoea in a range of settings in the borough, not just the traditional clinical settings.

In the calendar year 2005, 4,289 people under 25 years of age were screened for chlamydia and gonorrhoea in Lewisham. Since the screening programme commenced, 17.5% of the population under 25 had been screened by September 2006.

4.3 HIV testing and treatment

An increasing number of Lewisham's residents with HIV are treated at UHL (which now treats more than 25% of Lewisham's residents with HIV). Lewisham's residents attend services across London.

The main providers of HIV care for Lewisham residents were:

University Hospital Lewisham	227 cases
St Thomas's Hospital	197 cases
King's College Hospital	162 cases
Chelsea and Westminster	66 cases
Mortimer Market	51 cases
St Mary's Hospital	39 cases
Queen Elizabeth's Hospital, Woolwich	36 cases
Royal Free Hospital	27 cases.

This distribution is not what might be expected. A possible explanation is that many gay men prefer to attend clinics elsewhere for a variety of reasons. For example, some clinics are well known as being gay friendly and more attuned to their needs.

Most Lewisham residents still continue to access HIV testing at GUM services. Lewisham has recently developed a new rapid HIV testing centre, the RIVAH Clinic operated by Lewisham Sexual and Reproductive Health Service. This and other rapid HIV testing clinics in other parts of London have proved popular with the public. This is because results are back in less than an hour, which compares with the traditional one-week wait for the standard HIV test.

4.4 Genito-urinary medicine (GUM) clinics

GUM is an important component of the network of sexual health provision open to Lewisham residents. GUM provision is not commissioned directly by the PCT. There are five GUM services on Lewisham's borders (Caldecot at King's, Lydia and Lloyd clinics at Guy's and St Thomas's, Trafalgar at Queen Elizabeth's Hospital and Beckenham Hospital).

Approximately 5,000 Lewisham residents are seen at GUM clinics every year (Health Protection Agency's one-week sample survey carried out every quarter).

5. Sexual health promotion

Sexual health promotion is an integral part of both Lewisham Sexual Health and HIV Strategy and Lewisham Teenage Pregnancy Strategy.

The 1986 World Health Organisation Ottawa Charter provides a clear and cogent framework for the design and delivery of best practice in terms of promoting sexual health and preventing HIV. Sexual health promotion encompasses a wide range of settings and methodologies, both direct with communities, groups and individuals, and indirect with professionals, agencies and service providers; it also encompasses the wider social, economic and political factors that impact on and shape sexual health.

- Sexual health has been described as ‘an important part of physical and mental health … essential elements of good sexual health are equitable relationships and sexual fulfilment, with access to information and services to avoid the risk of unintended pregnancy, illness or disease’ (DH, 2001). [rep: quoted p. 82 (sec. 3.1, para 2)]

- Sexual health promotion aims to improve the positive sexual health of the general population and reduce inequalities in sexual health. It has been defined as ‘any activity which proactively and positively supports the sexual and emotional health and well-being of individuals, groups, communities and the wider public and reduces the risk of HIV transmission’ (DH, 2003).

5.1 Sexual health promotion in Lewisham

In a recent mapping of sexual health promotion by Health First, the borough’s specialist health promotion service, 51 organisations reported that they undertook sexual health promotion in Lewisham.

These agencies perform a range of activities across the borough supported through both mainstream and short-term targeted funding. Short-term funding is provided through the Teenage Pregnancy Programme, New Deal for Communities and the Local Area Agreement.

There are outreach projects, a young people’s health project, sexual and relationship education initiatives and community and voluntary organisations providing information and advice to a range of communities, in addition to the service provided by Health First. A number of community organisations are funded to provide health promotion to communities most at risk of HIV across Lambeth, Southwark and Lewisham, across South London or at a pan-London level. Some of the same organisations also provide treatment and care to members of those communities who are HIV positive.

A range of sexual health and relationship education is provided in schools and informal youth settings. The Healthier Schools partnership, the PCT sexual health and reproductive outreach service and others support this. The Lewisham Teenage Pregnancy Programme supports a range of programmes that target young men in Lewisham.

Full details of reported sexual health promotion activity in Lewisham is available from Health First (www.healthfirst.nhs.uk).

5.2 Health First

Health First has the specific role of supporting the agencies in Lewisham to deliver their sexual health promotion. Health First works in partnership with the local health and social care providers, including the acute sector, the local authority, regeneration initiatives, the voluntary and charitable sector as well as community-based organisations. National, sectoral and local targets and priorities determine the work of Health First.

Health First's sexual health and HIV programme is based on epidemiology and therefore targets the following populations: African communities, men who have sex with men (MSM), young people, Caribbean communities, HIV-positive people and users of sexual health services.

Health First works to support and facilitate interventions undertaken by health professionals and staff and volunteers in community-based organisations, including:

- advice and consultancy: to increase the awareness, accessing and usage of sexual health promotion and HIV prevention services
- training and professional development: to increase the skills base of those delivering health promotion
- community development: to empower community organisations to engage with local NHS services on issues around sexual health and HIV
- health promotion capacity building: to enable staff and volunteers to deliver their own health promotion interventions
- coordination/partnership development: to ensure joined-up working and avoid duplication
- consistency: to improve sexual health promotion practice in local sexual health services
- resources development: informing and empowering people to improve their sexual health choices
- research and evaluation: to ensure evidence-based practice
- policy development: to contribute to the development of and to influence local (and national) sexual health policy
- quality assurance: to improve sexual health promotion practice in local sexual health services.

6. Summary

Sexual ill health continues to be a concern in Lewisham. However, the investment in transforming and modernising services has had a marked effect. There has been an increase in access to local sexual and reproductive health services. This is a result of longer opening hours and targeted outreach activity. The increase in attendees means that there is more diagnosis and treatment of a large volume of sexually transmitted infections, especially chlamydia.

Sexual health is a complex issue, and the needs of residents need to be taken on board when devising programmes to support positive health choices. The Lewisham Sexual Health Strategy provides a framework to enable this to happen and to ensure that Lewisham continues to develop innovative and award-winning services that are relevant to patients' needs.

This report only provides a snapshot of service provision and the burden of sexual ill health in the borough. It does not address the complex reasons why people make sexual behavioural choices that may result in sexual ill health.

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28 December 2006

HIV prevention – voluntary sector HIV prevention services 2006/7

Organisation	Services provided	Target population	Comments
1. African work			
AAF (African Advocacy Foundation)	Peer education and volunteer training outreach and workshops, newsletter, African Parents Project	African communities	Across Lambeth, Southwark and Lewisham (LSL)
SHAKA	Condom distribution scheme via black business and social venues, 1 event (YP)	African-Caribbean and African communities	Across LSL
UAAF (Ugandan AIDS Action Fund)	Outreach, advocacy, workshops, local media campaign (buses), young people's group, visits to sexual health services	African communities	Across LSL
LEAT/ACHF (London Ecumenical AIDS Trust/ African and Caribbean Health Foundation) CHIP (Christian Health Improvement Partnership)	HIV/STI work with African-led churches, including mapping of independent African-led churches, training for pastors, etc. Small resource development	African communities	Across LSL
African Men's Involvement Project/AAF/ARCHRO /TAIFA	Partnership targeting African men, workshops, volunteer training, peer education, work with minicab drivers, sports groups, small media; uptake of HIV testing services; use of sexual health services, etc.	African communities	Across LSL

Organisation	Services provided	Target population	Comments
1. African work			
West African initiative, WANI (West African Networking Initiative) Neovenator	Partnership targeting outreach to West African communities via African businesses, social networks, house parties, workshops	West African communities	Across LSL
African OD Project	Organisational development and capacity building, 1 to 1 and group	African-led community groups	Across LSL
African Muslim Communities Campaign against HIV AAF/ARCHRO, Dayreel, Woman Being Concerned	Resource development/mosque involvement/training; young people's drama/nasheed group; Muslim positive people group; women's group	African Muslim communities	Across LSL; new links with new X Mosque and Lewisham and North Kent Islamic Centre; Dayreel to target Somali Muslims
THT (Terrance Higgins Trust)	Small/mass media campaign and resources	African communities	Pan-London
African Health Forum, small grants scheme	11 organisations funded for range of projects	African communities	Managed by Health First, Across LSL
NAZ	Needs assessment of sexual health k.a.p. of young Somali men	African communities	Across LSL
South London African Women's Organisation (SLAWO) and WoManBeing Concern	Needs assessment of primary and secondary HIV, prevention needs of African women	African communities	

Organisation	Services provided	Target population	Comments
2. Gay men's work			
Pan-London Gay Men's HIV Prevention Partnership (GMFA, HGLC, PACE, THT, Health First, C&I Health Promotion Unit	Outreach to gay venues PSEs, group work, counselling, mass and small media and condom distribution scheme to gay commercial venues	Gay men	Pan-London
THT NRGY Youth Group	Targeted work with young gay men	Gay men	Across LSL
Streetwise	Outreach and prevention with male sex workers	Male sex workers	Pan-London
LLGS	Helpline	Gay men	Pan-London
3. Work with IDUs and female sex workers			
Mainliners	Information, outreach working women's project	IDUs and female sex workers	Across LSL
4. Other vulnerable			
THT	Small and mass media resources for HIV-positive people	HIV-positive people	Pan-London
THT	Small and mass media resources for HIV-positive people	HIV-positive people	Pan-London

Organisation	Services provided	Target population	Comments
5. Pan-London treatment information provision			
THT, NAM/UKC, African HIV Policy Network	Information, adherence support including targeted work with African communities	HIV-positive people	Pan-London
6. Non- voluntary sector			
Healthy Schools Partnership	Contribution to HIV/STI element of work	Young people	Across LSL
Infant Feeding Scheme	Provision of formula feed and sterilising equipment to HIV-positive mothers to support avoidance of breastfeeding	HIV-positive mothers without recourse to public funds	Across LSL

Additional information about sexually transmitted infections in men

Chlamydia screening programme

The Lewisham screening programme, which includes tests for both chlamydia and gonorrhoea, began in 2004. The PCT Sexual and Reproductive Health Service carried out more than 90% of the screens in 2005/6. Other providers include GPs, the colposcopy clinic and the maternity services. The data below does not include those tested for chlamydia and gonorrhoea at GUM clinics.

Table 1 Chlamydia screening test results in men, Lewisham chlamydia screening programme for 2004/5 and 2005/6

	Total tests 2005/2006	Total tests 2004/2005	Screening tests among men 2005/6		Screening tests among men 2004/5	
	No (%)	No (%)	No. (positives)	Percentage positive	No. (positives)	Percentage positive
Total	7,328		1,251 (238)	19.02%		21.93%
Ethnicity						
White	2,518 (34.36)	1,927 (32.79)	312 (44)	14.10%	203 (38)	18.72%
Black Caribbean	1,441 (19.66)	1,220 (20.76)	315 (69)	21.90%	247 (63)	25.51%
Black African	769 (10.49)	565 (9.61)	158 (17)	10.76%	111 (18)	16.22%
Black British/Other Black	1,425 (19.44)	1,268 (21.58)	325 (76)	23.38%	263 (65)	24.71%
Asian subcontinent	65 (0.89)	63 (1.07)	6 (1)		15 (2)	13.33%
Chinese/ Other Asian	112 (1.53)	98 (1.67)	6 (3)		10 (1)	10.00%
Other Ethnic Group	139 (1.90)	100 (1.70)	13 (4)		15 (3)	20.00%
Mixed	642 (8.76)	495 (8.42)	81 (19)	23.46%	56 (14)	25.00%
Unknown/not specified	217 (2.96)	141 (2.40)	35 (5)	14.29%	19 (2)	10.53%

Source: Lewisham chlamydia screening programme breakdowns, 1 April 2004 to 31 March 2005, SE London Health Protection Unit, Jan. 2007

The positivity rates of all men screened were high at 19% in 2005/6 and 22% in 2004/5. It is important to be aware of the fact that 255 (28%) of the 899 Lewisham male residents tested were contacts of people previously tested positive. They were even higher in the Black Caribbean (22% in 2005/6, 26% in 2004/5), Black British/Black Other (23% in 2005/6, 25% in 2004/5) and Mixed (24% in 2005/6, 25% in 2004/5) ethnic groups.

The high positivity rates are of concern. However, it is encouraging that the positivity rate is decreasing in all ethnic groups, with the highest decrease among the Black Caribbean and Black African populations.

Table 2 April 2005/6 results by provider

	Total tests	Screening tests among men	
	No. (%)	No. (positives)	Percentage positive
Clinic type			
CRSH	6,671 (91.03)	1,150 (225)	19.57%
GP	578 (7.89)	101 (13)	12.87%

Source: Lewisham chlamydia screening programme breakdowns, 1 April 2004 to 31 March 2005, SE London Health Protection Unit, Jan. 2007

The majority of screening tests (91.03%) were undertaken by the Sexual and Reproductive Health Services (CRSH). The positivity rate in men is higher in those tests carried out by the CRSH than in those tested by GPs.

Table 3 April 2005/6 comparison of gonorrhoea results with chlamydia results

GC (gonorrhoea) test results	Chlamydia test results	
	Positive	Negative
Positive	40	32
Negative	191	942

Source: Lewisham chlamydia screening programme breakdowns, 1 April 2004 to 31 March 2005, SE London Health Protection Unit, Jan. 2007

The majority of results for men were negative for both chlamydia and gonorrhoea. 44% of the positive gonorrhoea results were negative for chlamydia. 82% of the positive chlamydia results were negative for gonorrhoea.

Jane Miller, Assistant Director Public Health, 24 January 2007

Men's Health Scrutiny Review Sexual Health

Additional information from Deptartment of Sexual and Reproductive Health

Men attending S&RH clinics are offered an initial holistic health assessment which includes general health, smoking, alcohol and drugs, sexual health, advice on safer sex, condom teach, including use and availability of lubricants, post-coital contraception, testicular self-examination, Fraser competency for under 16s, discussion of legal issues/age of consent, STI testing and treatment information, and addresses any risks of abuse.

Men are encouraged to attend on their own and/or with their partners.

Main areas of provision for men in S&RH service are:

- provision of condoms, teaching and demonstration; an extensive range of condoms is on offer
- asymptomatic STI screening and testing (chlamydia and gonorrhoea)
- treatment for chlamydia and gonorrhoea infections and as contacts
- diagnosis and treatment for warts and herpes
- lumps and bumps, am I normal?
- testicular self-examination advice
- preconceptual health advice including sickle-cell testing
- psychosexual problems and anxieties
- sub-fertility
- rapid HIV testing by appointment
- vasectomy counselling and referral.

The Sexual Health Outreach Team provides comprehensive sex and relationships education in schools, sixth forms and colleges in Lewisham, i.e. Crossways and Lewisham College. Work in schools includes pupil referral unit and schools with special educational needs.

Out of school the Outreach Team provides sex and relationships education to different groups of young people, for example within the youth offending team, Springboard (those excluded from pupil referral units), young refugees and asylum seekers accessing education. The team have worked and link with staff from Metro and have worked with young people in children's homes (direct referrals).

Outreach chlamydia and gonorrhoea has taken place at Lewisham College and this term is happening in Goldsmiths College, Crossways Sixth Form Academy and Lewisham College.

Our department provides weekly sessions for young adults with learning disabilities around sex and relationship education in conjunction with Lewisham Education.

Training and education around sexual health and relationships are provided for those who work with young men, e.g. teachers, foster carers, youth workers, Connexions advisers.

Outreach work is targeted to ensure provision to boys and young men.

The team works to improve knowledge and dispel myths, enabling informed choices.
Key messages are:

- knowledge is power – accurate information to give informed choice
- respect yourself and others
- protect yourself, safer sex
- empower and support to access mainstream sexual health services
- delay sexual activity even if already had sex.

The numbers of young men using our service continue to increase:

2002/2003	1,410
2004/5	2,231 (2,197 were young men aged under 25)
2005/6	2,808 (a rise of 26% in the last year).

(Numbers of consultations by young men are higher than numbers of clients.)

Almost 11% of consultations with young people under 25 were with young men, which is significantly above the national average of men accessing contraception and sexual health services.

A high proportion of men accessing our service are from black and minority ethnic groups. General service data are attached; we are unable to provide more specific ethnicity data.

G: Men's access to health services

1. Introduction

The health experience of men in Lewisham is not as good as that of women in Lewisham, nor of men in the country as a whole. There are specific concerns regarding, for example, differences in life expectancy, mortality due to circulatory diseases and cancer, and the prevalence of mental health problems and sexually transmitted infections. Although men's life expectancy at birth has improved in Lewisham (which is not the case for women), it has remained consistently lower, by about two years or so, than male life expectancy in England.

The differences in health outcomes between men and women are often reflected in men's access to health services and participation in community health promotion activities. In 2004/5 females were more likely than males to consult a GP. Females had an average of five NHS GP consultations per year, whereas males had three (General Household survey).

This paper provides an overview of some of the access and participation issues that have emerged as a result of:

a) the Men's Health Workshop conducted in partnership with the London Borough of Lewisham as part of the Gender Equality Consultation in December 2006
b) public involvement and community work undertaken by the PCT.

2. The men's health workshop

As part of the Gender Equality Consultation organised by the London Borough of Lewisham, the PCT helped facilitate a number of workshops, one of which was on men's health. A number of issues that affect health service access, such as attitudes towards health, major health concerns and suggestions for health improvement, were explored from men's perspectives.

2.1. Attitudes towards health

When asked what being healthy meant to them, the participants talked about being healthy in terms of:

- happiness
- being physically active
- living life to the full
- a sense of well-being.

2.2. Health concerns

When asked what their major concerns about health were, the participants talked about:

- the need for a centre for health check-ups, e.g. prostate cancer
- concerns about sexually transmitted diseases, e.g. chlamydia and gonorrhoea
- lack of genito-urinary medicine (GUM) clinics in Lewisham
- lack of convenient opening hours to allow people to see the doctor during the working day (e.g. lunchtime)
- once at the doctor's, the problem of having to wait often for up to 30 minutes past the appointment time

- the problem of having to change GP even if you have made only a small move out of an area
- a feeling that doctors are dismissive of men's health and don't take it seriously. One participant said:

'I feel that I am imposing if I go to the doctor's. I feel that I must first be ill to go to the doctor's. I don't want to be a nuisance or annoy the doctor.'

2.3. Help to keep healthy

When asked what could be done to help them keep healthy, the participants talked about:

- free or cheaper gym membership
- free or cheaper fruit and vegetables
- affordable swimming facilities
- dancing opportunities, especially for older people
- more clubs for sports activities, including contact sports, e.g. martial arts
- more tennis clubs – current facilities in Lewisham dominated by young people.

2.4. Improving mental health

On what could be done to improve mental health, the participants talked about the importance of social activities and gave examples of:

- dancing
- painting and drawing
- snooker.

2.5. Health improvement priorities

Overall, the participants were of the view that in order to improve men's health in Lewisham there is a need for well-publicised services targeting men, as well as facilities and opportunities for exercise and physical activities. They gave the following as their three most important health priorities:

1. exercise – availability of opportunities and affordable facilities
2. specialist clinics or centres for men's health – this should be well advertised
3. opportunities to improve nutrition.

3. Public involvement and community health work

Through the Public Patient User Involvement Plan, the Community Development Strategy and the Health Inequalities Strategy, the PCT is committed to working in partnership with voluntary and statutory agencies to tackle health inequalities and improve health.

3.1. Public involvement in health

The problem of men's access to and engagement with health services is reflected in the low numbers of men in contact with the PCT's Public Patient Involvement (PPI) team, including the Patient and Advice Liaison Service. The PPI team works with PCT staff and local people to encourage more opportunities for local people to look after their health, e.g. through the Expert Patient Programme, and to get involved and give their views on health and health services. The majority of people who

have been involved in these activities have been women. Presently, as part of implementing the Community Development Strategy, one of the actions being pursued is exploring ways of incorporating an introduction to community development into the internal staff training on Public Patient Involvement. This is with a view to improving the skills of staff in including the often excluded groups in work that they undertake with the public. This includes working with men.

3.2. Participation in community health programmes: the Health Trainers Scheme

A similar pattern of more women than men has emerged in relation to community participation in health promotion initiatives. For example, as part of implementing the government's Choosing Health white paper on improving health and addressing health inequalities, the PCT and its community sector partners have developed the Health Trainers Scheme. Health Trainers are local people recruited and trained as volunteers to help the public to take better care of their health. This is achieved through identifying and involving individuals in health-promoting group activities, and helping people to find and use the right health and other related services (e.g. stop smoking services, healthy eating advice, physical activity, alcohol services, mental health support). In the two rounds of recruitment undertaken in 2005/6 and 2006/7 very few men have volunteered. Of the 18 volunteers currently training to become Health Trainers, only one is a man. As part of the review of the scheme, an approach targeted at recruiting men, e.g. through coordinators of Sunday league football, has been proposed. By recruiting and training more men as Health Trainers, it is hoped that they will help support other men to use services, such as the stop smoking service, which currently is accessed by more women than men.

3.3. Hypertension community health programme for men

Alongside tobacco use, unhealthy diet and physical inactivity, hypertension is an important risk factor in relation to circulatory diseases. Circulatory diseases, which include coronary heart disease (CHD) and stroke, are the most common cause of death in England and Wales. The proportion of deaths due to circulatory diseases is 10% higher in Lewisham than in the rest of the country. Most of these deaths are due to stroke, which accounts for 10% of mortality in Lewisham. Black African and Black Caribbean are among the groups with the highest prevalence of hypertension. Below the age of 65, hypertension tends to affect more men than women. Men visit GPs less often than women, which compounds the problem of hypertensionand means that early detection is less likely.

3.4. The Health Bus

Some outreach work is being developed as part of mental health promotion. A Health Bus providing health information and blood pressure checks has been to some neighbourhoods in Lewisham (e.g. Bellingham and Downham). More visits are planned to other areas, such as the Heathside and Lethbridge estates in March. Although the Health Bus seeks to reach all members of the public, men are particularly targeted for blood pressure measurement and referral if necessary to the GP. The initiative is being coordinated by the health promotion officer at South London and Maudsley NHS Trust (SLAM) in partnership with workers from the PCT, local authority and voluntary sector.

3.5. Improving the prevention, detection and management of hypertension

More targeted work on hypertension is planned with men. As part of tackling health inequalities, the Lewisham PCT Public Health Department is planning a hypertension health improvement programme. This will initially focus on the north of the borough (New Cross and Evelyn wards). The aim will be to improve the prevention, detection, treatment and management of hypertension in men from black and minority ethnic groups. This will be a community-based initiative involving the recruitment and training of volunteers to work alongside health professionals, including the local GPs, to reach BME men through faith groups, barbers, pubs, etc. An example of a similar approach is that from the neighbouring London Borough of Southwark. Men's health is a focus of their Neighbourhood Renewal Health Improvement Plan. One of the activities they undertake is a series of men's MOT health checks at various venues where men can be found, e.g. pubs (Appendix 1 of Southwark Health Improvement Programme).

4. Conclusion

Many of the concerns regarding the poorer health outcomes of men, e.g. life expectancy, mortality due to circulatory diseases and cancer, and the prevalence of mental health problems and sexually transmitted infections, are being addressed within the context of strategies for improving health and addressing health inequalities. There is, however, no community health programme as yet in Lewisham that specifically targets men. In the neighbouring London Borough of Southwark, the Health Improvement Plan has men's health as one of its work areas. Through Neighbourhood Renewal support, the PCT and local authority are taking forward this plan. One of the actions that the London Borough of Lewisham and the PCT may wish to consider is facilitating the drawing together of more detailed information on such examples of practice in other boroughs and PCTs. This should be addressed with a view to developing a men's health programme in Lewisham with a clearly identified community development for health work stream.

Alfred Banya
Community Development Coordinator
Lewisham PCT
January 2007

H: Quality of life issues affecting men's health

1. Summary

The attached data represent a sample of the range of information available that is pertinent to men's well-being and their health in the wider sense.

2. Further information

The data presented highlight a range of factors and contextual information that members may wish to feed into their discussions and final review recommendations. The information has not been analysed, nor have any potential conclusions been drawn.

Information has been gathered on a range of subjects including:

- demographics, health, income and welfare dependency
- housing
- GCSE results
- adult education
- carers
- employment.

A summary of information from the Gender Equality Scheme consultation event has also been included for information.

3. Recommendation

It is recommended that members note the information provided and draw on it for use in their discussions.

4. Key gender statistics in Lewisham

Demographics

- There are 124,900 females and 122,500 males in Lewisham.

- 81,100 females (16–59 years) and 86,500 males (16–64 years) are of working age in Lewisham.

Health

- Females live four years longer than males (females 79.5 years, males 75.1 years), though the gap has narrowed in recent years.

Employment

- Overall, 75% of all jobs are full time. The employment rate for the non-white population is significantly lower at 59% than for the white population and is lower still for disabled people of working age (45%).

- Though the white population of Lewisham (including White Irish and White Other) makes up 66% of the total population, it makes up only 45.6% of the unemployment-related claimant rate. In Lewisham just over 54% of claimants are non-white (ranked 13th in London) – this compares to a non-white population of 34% in the borough.

- The male employment rate is 11% higher than the female employment rate (male 75%, females 64%).

- 11,000 males and 4,300 females are self-employed in Lewisham.

- 5,213 males and 2,078 females claim Jobseeker's Allowance in Lewisham (November 2006).

Income

- Males earn 20% more than females in Lewisham, which is partly due to the greater amount of part-time work that females do (males £510 per week, females £415 per week). 88% of males in work are in full-time employment and 12% are in part-time employment. 59% of females in work are in full-time employment and 41% are in part-time employment.

- The gap between male and female weekly earnings in Lewisham is higher when comparing residence-based incomes (males £563, females £412) to workplace-based incomes (males £510, females £415).

- However, earnings for female full-time workers (£533) are higher than for male full-time workers (£518).

Welfare dependency[21]

- Welfare dependency affecting females of working age is twice as high in Downham (27.6%) as in Catford South (13.3%).

- Welfare dependency affecting males of working age is generally lower than for females, ranging from 11.9% in Blackheath to 21.0% in Evelyn.

5. Highlights from the Gender Equality Scheme consultation

Whilst broad quantitative conclusions should not be drawn from this event, it does provide the Council with a greater insight into what local women and men feel about their quality of life, and why they think as they do.

[21] Dept for Work and Pensions, February 2006.

From the discussions at this event, the attitudes of men and women towards learning and working were most different. They can be summarised as follows.

- Women enjoy learning and see it as very important for personal development, building confidence and meeting new people.
- Men see learning as primarily for personal advancement and acquiring the essential skills needed for work.
- Men regard work and progression at work as important for their self-esteem and feeling part of a community, as well as earning money.
- Women approach work from a more pragmatic point of view and see it as primarily for earning money.

With regard to health, both men and women felt that they did not do enough to look after their health. However, they had different perspectives:

- Women felt they did not have enough time to look after themselves.
- Men felt that there was an insufficient focus on men's health by professionals.

The attitudes of women and men towards safety and living in Lewisham were more similar, with the same issues being key for both men and women. Key themes were:

- antisocial behaviour
- community cohesion, particularly between people of different ages rather than across different ethnic groups
- a need for better recreational and leisure facilities for both adults and young people.

6. Other information about the local context

At the local level, men's health in Lewisham is not as good as women's health or as good as men's health generally in the UK. Men in Lewisham are more likely to die at an earlier age from cancer and cardiovascular disease. There are high rates of sexual and mental health problems as well as suicide, drug use and problem alcohol use. The prominence of these issues amongst young men is particularly concerning, especially in young black men.[22]

Safety is the highest priority for Lewisham residents, with significantly more women than men feeling unsafe in their local area at night (49% for women compared to 29% for men).[23] The overall level of crime in Lewisham has increased by 7 per cent since 2003/4 and violent crime by 27 per cent.

Whilst men are the majority perpetrators of crime in Lewisham, men are also more likely to be victims of crime. We know that, in relation to safety, 85% of all domestic violence is experienced by women. Equally, young black men are over-represented in the criminal justice system in Lewisham.[24]

[22] Lewisham PCT, presentation to Lewisham Council, Select Committee on Men's Health, September 2006.
[23] Annual Residents Survey 2005/6.
[24] Safer Lewisham Strategy, 2005–2008.

Lewisham is becoming more prosperous. In 2004 Lewisham was ranked as 57th for deprivation, placing the borough in the 20% most deprived boroughs in England.[25] This is a significant improvement from being amongst the 10% most deprived boroughs in England in 2000. Most people seek employment outside the borough. The rate of unemployment in Lewisham is above both London and national averages. The unemployment rate for men is double that for women.[26]

In education, the number of pupils achieving 5 or more GCSEs at grades A*–C in Lewisham secondary schools in 2005/6 was 54.8%. This represents a 19% improvement from 2003/4. There remains a significant gap in attainment between black pupils and white British pupils.[27] When comparing the achievement of girls and boys, girls generally outperform boys.

6.1 Housing

The Best Value review of housing options in 2006 highlighted a specific problem in relation to single fathers.

It was determined that full consideration needed to be given to the circumstances of single fathers and children in the housing assessment process.

It was agreed to provide training for staff across the service to include full consideration of the rights of men in the assessment and delivery of services.

Lettings equalities impact assessment

This equalities impact assessment (EIA) systematically analysed the Lewisham Homesearch choice-based lettings scheme to identify its effect on different groups in the community.

The EIA noted that men were less likely to engage with its services than women. It concluded that it must ensure that all general services are accessible to all members of the community.

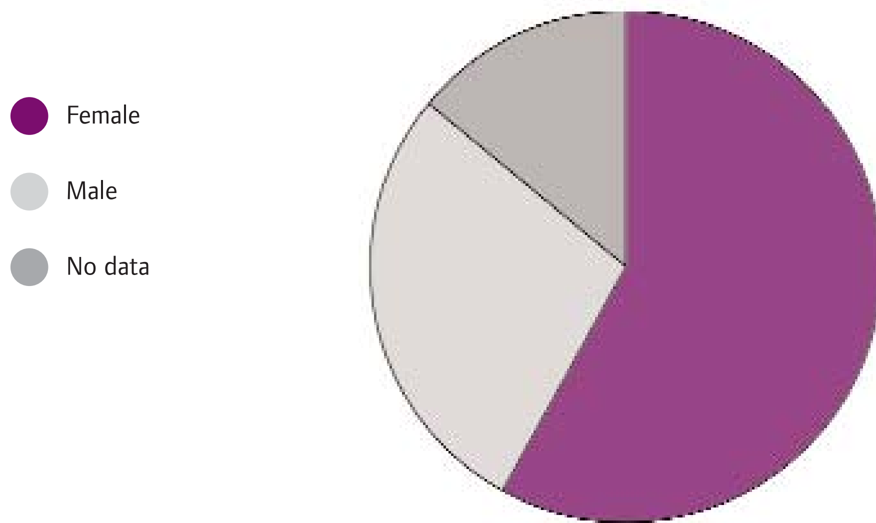
Stock Options Appraisal equalities impact assessment

Lone parents in Lewisham make up 49% of those in unsuitable housing (LHNS), and 56.5% of all households living in unsuitable housing are in council accommodation. The two key reasons for unsuitability are mobility/health problems and overcrowding.

[25] Indices of Multiple Deprivation, 2004.
[26] Lewisham's Local Area Agreement, 2006.
[27] Lewisham's Local Area Agreement, 2006.

Housing equalities monitoring report 2006/7

Of the 168 housing improvement grants allocated, 47 (28%) were to men.



Further information on gender breakdown of tenancies and acceptance as to having homeless and priority needs is currently being collated by Housing.

6.2 GCSE results

Roll figures			
2005		2006	
Boys	Girls	**Boys**	**Girls**
1,118	1,086	**1,123**	**1,104**

5 or more A*–C grades

Boys					Girls				
2005		**2006**		Diff.	2005		**2006**		Diff.
#	%	#	%		#	%	#	%	
509	45.5	**509**	**48.1**	2.6	583	53.7	**680**	**61.6**	7.9

5 or more A*–-G grades

Boys					Girls				
2005		**2006**		Diff.	2005		**2006**		Diff.
#	%	#	%		#	%	#	%	
963	86.1	**989**	**88.1**	1.9	??	93.2	**1,026**	**92.9**	-0.3

1 or more A*–C grades

Boys					Girls				
2005		**2006**		Diff.	2005		**2006**		Diff.
#	%	#	%		#	%	#	%	
776	69.4	**829**	**73.8**	4.4	854	78.6	**911**	**82.5**	3.9

1 or more A*–G grades

Boys					Girls				
2005		**2006**		Diff.	2005		**2006**		Diff.
#	%	#	%		#	%	#	%	
	95.8	**1,078**	**96.0**	0.2	1,065	98.1	**1,081**	**97.9**	-0.1

6.3 Adult education

	Numbers	Enrolments	Achievements
Males	**1,623**	**2,530**	**655**
Females	5,683	9,770	2,718
All learners	7,306	12,300	3,373
Male % of total	**22.2**%	**20.6**%	**19.4%**
Female % of total	77.8%	79.4%	80.6%

In common with most other adult and community learning providers, the majority of CEL's learners are female, though work is being undertaken to engage more male learners. Some courses are run specifically for men to encourage participation in learning, e.g. as part of the Family Learning programme: Dads and Kids Outdoor Pursuits, Dads Matter, and Dads and Dinghies.

The classes with the highest participation by male learners are as follows, and mostly in Learning Support, Music, Media, Drama, Languages, Basic Skills, Design and IT.

Dept	F	M	Total	% Male
LS (Learning Support) Basic Skills	18	44	62	71.0%
Computer Project	29	46	75	61.3%
Learning Support	236	203	439	46.2%
Music	120	102	222	45.9%
LS Mental Health	63	51	114	44.7%
Media	69	45	114	39.5%
Drama	69	33	102	32.4%
LS Sensory Disabilities	45	21	66	31.8%
Languages	598	219	817	26.8%
Community Studies	113	41	154	26.6%
Basic Skills	921	329	1,250	26.3%
Design	433	152	585	26.0%
Info Technology	795	259	1,054	24.6%
Art	883	263	1,146	22.9%

Many of the courses lead to accreditation. On accredited courses, male learners did best on IT, Woodwork and Gardening, as per the sample courses overleaf.

AOS	Title	F	M	Total
B939	Lip-reading	9	8	17
G3269	Woodwork OCNLR		8	8
G3202	Gardening RHS Year 1	11	6	17
B145	Basic Skills – Reading and Writing	2	15	17
H2044	European Computer Driving Licence (ECDL)	13	6	19
M767	Spanish-Begs Acc** Brockley Rise	14	7	21

7. Carers

There are approximately 2 million men in the UK caring for relatives.

More men are taking on this role because of social changes and the reduction of traditional support networks.

Male carers in Lewisham

The 2001 census shows that around 41.5% of carers in the borough are male (8,171). This is the same as the national percentage.

Current statistics indicate that 20% of carers registered with Carers Lewisham are male, which equates to 742 men.

In April 2004 male carers in Lewisham were invited to express their feelings about their caring role. The following comments are examples of what was said:

'I feel outnumbered', 'I feel uncomfortable in this role', 'I feel a social outcast amongst my own gender', 'I don't feel heard or recognised as a male carer' and **'it's been a traumatic learning curve for me'.**

As a result, a Male Carers Group was set up and takes place once a month (for two hours on the last Thursday in the month).

Over two years later there are now 21 members, whose ages range from 40 to 86 years old and represent the following user groups: 43% Frail Elderly (including Dementia), 19% Physical/Sensory, 19% Parent Carers, 10% Mental Health, and 9% Learning Difficulties. Of the group, 30% are black and ethnic carers.

The group's members have discussed a number of topics such as looking after your health, benefits, and issues over providing personal care to a wife or mother. Information sharing between members has helped to build people's self-esteem and confidence, and also acted as a link to other Lewisham services for carers. For example, counselling was seen by some men almost as taboo, but, with the

encouragement of others who have tried it, it is now more widely accepted. Respite care, reflexology, first aid, computer classes, benefits, the learning for living course, digital photography and art classes – these have all helped to raise the quality of male carers' lives.

The men's carers group is helping to break down barriers for some male carers who have been plunged into caring and feel lost and overwhelmed. Through talking to each other and feeling more confident about getting help and support, it is hoped that perhaps the male attitude of 'coping alone' and 'holding it all in' is being gently eased. There is a sense of change in the group, with men being able to manage their caring situations better, perhaps in the comfort of knowing that they've also got each other to talk to. It's been a big step.

Comments on being a male carer:

- caring perceived as a female role
- men in a caring role do not get respect from the wider society, especially from other men who are not carers
- serious impact on self-esteem
- prone to depression
- discrimination experienced as male carer
- stigma – being viewed as a 'sponger'
- learning curve greater because many women already have experience of a caring role
- big changes – caring role is often very different from anything done before

Changes that occurred when we became carers

- life plans
- had to give up work
- loss of concentration
- became depressed
- found it difficult coping on my own
- social life out the window
- lack of support
- lack of help
- loss of freedom
- loss of income
- strain on the marriage in the case of parent carers
- not being able to get help to look after my health

The hardest thing about being a carer and male

- understanding female personal needs, e.g. personal clothing
- female medical issues
- dealing with people's perceptions
- feeling useless
- isolation (even within a family in a parent carer role)
- female nurses/care workers can lead to experiences of carer exclusion
- having patience

- tend to isolate to relax/destress, not sit and talk
- poor support, especially from the PCT and Social Services

What would help me cope better with my caring role?

- more support from family and friends
- knowing my own health was OK, and that I was getting more support from the health professionals
- more social contact
- knowing where to go for help
- respite (however, sometimes the cared for doesn't like/can't deal with strangers which makes getting respite a problem).

The Lewisham Carers Working Group has developed the following action point.

Objective: Improve the health outcomes for men and boys with caring responsibilities in Lewisham.

Action: With partners and community-based organisations, increase the numbers of men and boys accessing Carers Lewisham support services.

Directorate/lead responsibility: Community Services/Adult Social Care/Brian Scouler

Measuring success: More men and boys accessing services.

Timescale: 2007–10.

A significantly larger proportion of males (17.1%) work as senior managers or officials, compared to females (12.1%). This difference is reflected in the figures for both corporate managers and for managers and proprietors in agriculture and services.

There is a slight gap in professional occupations in favour of males (14.8%), compared to females (13.5%). There is a very large difference between the proportion of males in science and technology professions (4.9%), compared to females (1.2%). However, females are much more likely to work in teaching and as research professionals (7.9%) compared to males (4.4%), though the scale of the gap is smaller. Amongst the associate professional and technical occupations, females are much more likely to work in health and social welfare (7.2% of females compared to 1.9% of males).

Females have a much higher representation amongst administrative and secretarial occupations than males, with 25.0% of females in this sector compared to 8.8% of males. In particular, there are very few males working in secretarial occupations (0.45%) compared to females (8.8%).

There are even greater gaps in skilled trades occupations (14.1% of males to 1.7% of females). Females are virtually non-existent in skilled agricultural trades, skilled metal and electrical trades, and skilled construction and building trades (0.1% of occupied females in each case), though they do have a presence in textiles, printing and other skilled trades (1.4% of occupied females compared to 2.9% of occupied males), and in fact this sub-sector makes up almost all of female employment in skilled trades occupations.

Females are much more likely to work in personal service occupations, compared to males (11.1% of occupied females to 3.2% of occupied males). Almost all of this difference is in caring personal service occupations, with little difference in the sub-sector of leisure and other personal service occupations (though this is a much smaller sub-sector than caring personal services). Females are also more likely to be employed in sales and customer services occupations than males (8.9% of occupied females compared to 5.1% of males).

Males are much more likely to work as process, plant and machine operatives or transport and mobile machine drivers and operatives (7.9% of occupied males to 1.2% of occupied females). Males are also more likely to work in elementary occupations (12.1% of occupied males to 7.5% of occupied females), particularly in elementary trades. The gender differences in employment in elementary administration and service occupations are relatively small (8.9% of occupied males to 7.0% of occupied females).

Overall, seven of the nine major occupational groupings have significant and sometimes very large differences in their gender profile (only professional occupations and associate professional and technical occupations have relatively small differences). These variations across occupational groupings may be a factor in the gap between male and female pay for both part-time and full-time workers and whether earnings are based on residence or workplace (please see tables above).

Females have a significantly higher representation in personal service occupations and customer service occupations, which tend to be lower paid than other occupations, whilst males have a much higher representation in skilled trades, which tend to be higher paid even compared to many professional occupations. Females have higher representations in teaching, research, health and social welfare professional occupations (or associate professional and technical occupations), and these industry areas tend to have lower pay compared to some other professional occupations.

Section 4 – Analysis and conclusions

This section provides the analysis, commentary and conclusions determined by the Men's Health Scrutiny Review Group.

Overview of men's health

The Council addresses young men's health issues via the school curriculum, but older men's health needs tended to appear not to be specifically addressed by the Council or by Lewisham Primary Care Trust.

The statistical information suggests that men living in the most deprived council wards in Lewisham are the most reliant on welfare benefits and their life expectancy is considerably lower than that in more affluent wards.

Limited information was found to be available on the health of men in ethnic minorities. However, what information there is suggests that there may be particular health issues faced by young people from black and ethnic minority groups.

1. **The Review Group recommends that information included in residents' surveys needs to be better integrated and shared among the statutory organisations, as there is currently very little information available on men from new and emerging communities within Lewisham accessing health services; for example, the proportion of Chinese and Vietnamese men accessing health services is unknown.**

In considering the provision of well men clinics, it was acknowledged that health clinics for men tend to be less widely known about than well women clinics in Lewisham.

2. **Further consideration needs to be given to promoting well men clinics. In particular, the vast majority of men attending well men clinics are older men. Further consideration should be given to developing a social marketing approach to enable Lewisham PCT to target services better and to encourage younger men to access services.**

What is social marketing?

1 Its primary aim is to achieve a particular 'social good' (rather than commercial benefit) with specific behavioural goals clearly identified and targeted.
2 It is a systematic process phased to address short, medium and long-term issues.
3 It utilises a range of marketing techniques and approaches (a marketing mix). In the case of health-related social marketing, the social good can be articulated in terms of achieving specific, achievable and manageable behaviour goals, relevant to improving health and reducing health inequalities.

What are the key features of social marketing?

- Customer or consumer orientation
  A strong customer orientation with importance attached to understanding where the customer is starting from, their knowledge, attitudes and beliefs, along with the social context in which they live and work.
- Behaviour and behavioural goals
  Clear focus on understanding existing behaviour and key influences on it, alongside developing clear behavioural goals, which can be divided into actionable and measurable steps or stages, phased over time.
- 'Intervention mix' and 'marketing mix'
  Using a range (or 'mix') of different interventions or methods to achieve a particular behavioural goal. When used at the strategic level this is commonly referred to as the 'intervention mix', and when used operationally it is described as the 'marketing mix' or 'social marketing mix'.
- Audience segmentation
  Clarity of audience focus using audience segmentation to target effectively.
- Exchange
  Use and application of the exchange concept understanding what is being expected of the customer, the real cost to them.
- Competition
  Use and application of the competition concept understanding factors that impact on the customer and that compete for their attention and time.

Circulatory diseases

The Review Group concluded that the statistics for coronary heart disease (CHD) in Lewisham are improving. Since 1990 the CHD mortality rate has fallen from 120 per 100,000 residents to 65 per 100,000 residents, an appreciable drop of 55 per 100,000 residents. However, circulatory diseases remain the most common cause of death in England, and in Lewisham the number of premature deaths is approximately 20% higher than is the case nationally, with Lewisham ranking 10th highest in London for deaths from coronary heart disease.

Stroke, hypertension and CHD were highlighted as the three main causes of circulatory diseases, and gaps in services were identified by Lewisham PCT for these three causes. Stroke is a particular problem in Lewisham. It is recognised that improvements are occurring but not in a strategically planned way, as one would hope to be the case.

3. It is recommended that Lewisham PCT's Strategy for Stroke is reviewed; an integrated disease management approach is needed for stroke, coronary heart disease and hypertension, which will benefit both men and women. The current strategies were developed over 10 years ago and were based upon the Lambeth, Southwark and Lewisham Partnership arrangements which are now outdated. Hypertension is particularly prevalent in the African-Caribbean community in Lewisham, and this needs to be addressed by

Lewisham health partners including the London Ambulance Service through a comprehensive hypertension strategy.

Lifestyle choices that can be taken to reduce the risk of circulatory diseases for men are to stop smoking, to take regular physical exercise and to adopt a healthy, nutritional diet.

Smoking cessation

Smoking prevalence locally has been estimated at 33%; approximately 30,000 men living in Lewisham aged 20 and above are smokers, with considerable variations by ward areas. The Stop Smoking Strategy for Lewisham includes increasing the number of trained stop smoking advisers, including GP practices, pharmacies, community nurses and workers in the voluntary and community sector.

Statistical trends identify that smoking prevalence increases as household income decreases. However, there is currently no localised accurate data on smoking prevalence in Lewisham.

4. It is recommended that a question on smoking is included in the next survey of residents to record smoking prevalence and to better target stop smoking services on an ongoing basis.

The Review Group wishes to stress the importance of the need to work in partnership on tobacco control, whereby trading standards and enforcement are linked more closely with stop smoking services and prevention services.

5. It is recommended that the Council strengthens its role and responsibility in terms of general well-being and promotes the benefits of smoke-free environments and stop smoking services to staff, service users, clients and contractors. In particular, both the Council and local NHS bodies should use their contractual powers to the fullest to influence other organisations to implement a no smoking policy on all Council and NHS sites to reinforce good practice and raise public awareness.

More women than men are currently accessing stop smoking services, as demonstrated in a recent health equity audit. The Review Group acknowledges the planned expansion of the provision of one-to-one support services in pharmacies and workplaces and increased outreach services that will hopefully increase the number of men accessing these services, along with the national ban on smoking that came into force in July 2007.

6. With the stop smoking services expanding their work, there is a need to raise the profile and visibility of this service in Lewisham and to focus on tackling the discrepancy between the number of men and the number of women who are quitting via the smoking cessation service. It is recommended that targeted promotion to men and social marketing of smoking cessation services are developed and implemented. Examples of good practice include Lambeth smoking cessation, which is particularly innovative and successful through using social marketing tools, along with Tower Hamlets for raising awareness and promoting health services to hard-to-reach groups. Both Southwark and Lambeth have used a popular DJ from Choice FM to reach people with positive health messages through role modelling.

Physical exercise

Lewisham has a number of multi-agency strategies, including the Food Strategy and Physical Activity, Sport and Leisure Strategy, which are tackling obesity in the borough. The recommendation by the Department of Health to achieve health benefits is for adults to do at least 30 minutes of moderately intense physical activity on five or more days per week. Lewisham has 18.9% participation at the recommended physical activity rate, lower than the national average of 21% participation.

Current support services for encouraging and maintaining physical activity in Lewisham include exercise on referral schemes as a primary prevention programme and for specialist groups such as people with existing coronary heart disease. Other support services include the Community Active Heart Programme, which aids rehabilitation for people who have completed cardiac rehabilitation and want to continue exercising. In addition, the Lewisham Healthy Walks Programme is offered to people with circulatory diseases and is well attended by men.

However, men are under-represented in the current exercise on referral schemes. The possible reasons for men not accessing these services are because they are not being offered exercise on referral, they don't feel they would benefit from the exercise, and/or the image and choice of exercise sessions on offer does not appeal to men.

7. It is recommended that further work is carried out to assess the appropriateness of the choice and image of exercise sessions on offer via referral from GPs so that they appeal more to men and to ensure men are being offered the services and that the benefits of taking part are promoted.

The Review Group commends local initiatives such as offering blood pressure readings at leisure centres and at workplaces and promoting physical activity and the benefits of taking part in exercise in pubs and male-orientated workplaces.

8. It is recommended that when follow-up scrutiny is carried out, council officers are asked to report back to the scrutiny body on the outcomes of visits to pubs and workplaces in Lewisham to promote physical activity and the benefits of taking part in exercise for men in relation to health promotion.

In terms of the role of the Council, the Review Group endorsed the work happening with schools to ensure that at least two hours per week of physical activity are provided, including by after-school clubs, and that the positive achievements from the Healthy Schools projects are disseminated across the borough. However, concern was expressed that:

9. Only 55% of boys and 39% of girls were reaching the recommended level of physical activity; the Council needs to do more to increase the numbers of boys and girls reaching the recommended level.

The affordability of gym sessions and leisure centres, particularly for people on low incomes, was raised as a concern by the Review Group. Council officers responded that they would be willing to work with other agencies to provide services that more people can access and that the current Lewisham Plus Card for discounted services was being promoted and a new Plus Card offering discounted prices for children and young people was being developed.

10. The Review Group welcomes the proposed establishment of a Lewisham Sports Council and recommends that the Council and PCT give their support to its successful formation.

Following on, it was recognised that physical activity does not necessarily need to involve costs such as gym membership; it could be as simple as recognising the physical activity involved in day-to-day activities such as walking, climbing stairs and cleaning.

11. It is recommended that the Council and PCT when marketing physical activity highlight the benefits of everyday activities such as walking and cleaning as identified in the promotion leaflet 'A bit of what you fancy'.

Evidence suggested that physical activity classes run by men attract more men to attend. And for certain health conditions, such as diabetes, it was often family and personal connections that encouraged more men to attend physical activity classes, and therefore it was important to promote physical activity as widely as possible. The Review Group also recommends that the Council and PCT look to engage with and involve Saturday and Sunday football clubs to promote general health and well-being, as well as physical activity.

The issue of opening up schools' facilities for use by the general public was raised, as many schools in Lewisham have excellent gym and exercise facilities. Council officers reported that the Council is committed to the 'Extending Schools Programme' and building contracts for new schools stipulate the requirement for schools' facilities to be available to the general public in a managed way.

Diet and nutrition

The Review Group discussed ways in which to promote healthy eating in relation to the benefits for improved health outcomes.

12. It is recommended, with respect to the implementation of the government white paper, that the promotion of healthy eating should be considered through local planning and licensing decisions. When responding to consultation on the enhanced role of the councillor and corporate councillor as part of the new government white paper, the Council could include that local authorities should have a greater influence over planning and licensing policy and decisions to include consideration of health implications, for example in relation to planning and licensing applications for food outlets to encourage healthy foods.

Improving the diets of young people through healthier school dinners, nutritional classes and more physical exercise in schools would help to start the process of improving diets and lifestyles over a generation.

13. It is recommended that choice in school dinners should be directed at helping to encourage children and young people to eat healthily. And the Review Group welcomed schools becoming more active in their involvement with the food choices that pupils bring to school as part of their lunch boxes.

14. In terms of the Healthier Schools initiative, greater efforts need to be made to help encourage all schools in Lewisham to participate in the Healthy Schools initiative.

Cancers

Mortality rates from cancers are consistently higher in Lewisham than in England and Wales, particularly for males, although rates have declined in the decade 1994–2003. The National Cancer Plan target is to reduce mortality from cancer in people under 75 years by 20% by 2010. Lewisham is unlikely to meet this target at a local level, which will further widen the differential rates that currently exist.

Prostate cancer is the most common cancer in males, overtaking lung cancer. There has been a very substantial increase in the number of people diagnosed with prostate cancer in Lewisham, and it is important to stress that this is likely to be due to the increase in early diagnosis through the use of the prostate specific antigen (PSA) test.

15. The Review Group acknowledges the pilot programme for prostate cancer screening, in particular the positive work carried out by Guy's and St Thomas's NHS Foundation Trust, and that the PSA test has some limitations in terms of its accuracy in detecting prostate cancer. To this end, it is recommended that careful counselling is provided with PSA tests.

There is a much higher chance of effective treatment for prostate cancer if men go to their GPs early on with symptoms such as frequent urination, especially at night, inability to urinate, blood in the urine or semen, and frequent pain in the lower back, hips or thighs.

16. It is recommended that Lewisham PCT researches the most appropriate ways in which health promotion can be targeted at men who are at risk of prostate cancer, and that a community development approach could be used to promote early detection.

Bowel cancer mortality is generally much lower in London than in England and Wales and has shown a steady decline. However, Lewisham reverses this trend, and bowel cancer mortality is higher in males and on average has declined little. The Review Group commends the national bowel screening programme being rolled out across the country, which has been in operation in London since October 2006.

In terms of prevention of cancers, smoking causes 30% of all cancers. Smoking is one of the most important factors in health inequalities, and historically high rates of smoking in Lewisham explain the high incidence of lung cancer.

Diet is related to 30% of cancers, including prostate cancer. Diets high in fat and/or low in fibre can contribute to the development of several cancers. The consumption of high levels of fruit and vegetables is known to offer some protection from cancer.

17. The Review Group wishes to highlight good practice identified by the cancer awareness pilot initiative in two Lambeth pharmacies carried out by Lambeth PCT, Health First and South East London Cancer Network. The pilot recognised that whilst there is some resistance to consulting GPs, men especially are more likely to visit their pharmacist to

seek advice and over-the-counter treatments for symptoms typically associated with some cancers, e.g. indigestion, rectal bleeding, persistent coughs. The cancer awareness pilot scheme encouraged people with such symptoms who are most at risk of developing cancer to seek advice from their GP sooner than they might otherwise have done. Leaflets providing information on the symptoms and risk factors were handed out to middle-aged and older customers in pharmacies when they purchased over-the-counter medication for these symptoms. It is recommended that Lewisham PCT and pharmacies adopt the approach of the cancer awareness pilot initiative in two Lambeth pharmacies.

Lastly, the Review Group wishes to praise the work of the South East London Cancer Network in helping to improve the care of cancer patients in Lewisham. Their work, alongside that of the NHS, has led to coordinated cancer care provision in the South East area, with specialised cancer teams in Guy's and St Thomas's for prostate cancer and King's College Hospital for bladder cancer; both are beneficial for Lewisham residents.

Mental health and well-being

The Review Group chose to focus on the mental health of young black men aged 16–24 in Lewisham as there are disproportionately high rates of young black men from Lewisham in secure mental hospitals and held under mental health section. The complex relationship between ethnicity, social disadvantage and service provider attitudes was explored at a meeting held at the ISIS, a voluntary-sector organisation that offers support for people of African and African-Caribbean descent experiencing mental health difficulties. The meeting was well attended by health professionals, members of the public and the Men's Health Forum chief executive.

The Review Group learned that young black men are over-represented in the mental health services in Lewisham. The South London and Maudsley Mental Health Trust in-patient data for October 2006 show that although only 28% of young men in Lewisham are black, they account for almost 70% of all in-patients for mental illness, compared to only 30% young white men.

Lewisham has significantly higher rates of mental illness than England as a whole. According to the findings of a number of studies, the incidence of major mental illness locally is very high in Black Caribbean people and Black African people. The rate of incidence among Caribbean people living in Lewisham is far higher than is found in the Caribbean.

It was recognised that, at the primary care level, there is a struggle to identify men with mental health problems. There is evidence that women are 70% more likely than men to contact their family doctor with a mental health problem, regardless of the severity of the illness.

In order to reduce the number of young black men in mental health services there is a need to build trust and engagement in statutory services by the black community. The Review Group wishes to highlight the good work happening in Lewisham in terms of the schools programme at Forest Hill Boys School. The programme offered boys the opportunity to talk about the health of their minds, to explore language and to demystify myths and negative language like 'psycho'.

18. It is recommended that all healthcare services need to include mental health in prevention strategies, with clear robust actions to take into account the serious and profound impact of racism, to improve cultural awareness and to reduce discrimination. There is also a need to develop training specifically for GPs to help them fully assess whether young men are suffering from early mental health problems in order to avoid their dismissal as 'difficult' or 'adolescent' young men.

19. The Men's Health Review recommends improved, robust systematic monitoring systems to collate better evidence to improve equity of access to services and treatment outcomes for black men and BME communities. This is to ensure that health partners are able to clearly see the evidence of groups at risk of serious diseases. The issue needs to be taken seriously, for otherwise health services will continue to be delivered in the same way and health inequalities will remain for some groups.

Sexual health

Sexual health has been a priority in Lewisham for some time because of the high rates of sexually transmitted infections and teenage pregnancies. Lewisham has a multi-agency, multidisciplinary group that includes the NHS, the Council and the voluntary sector to develop a local Sexual Health and HIV Strategy.

There are high rates of HIV in Lewisham – 985 cases in 2005, of which 328 were seen at Lewisham Hospital and of whom only 126 were male. It was highlighted that the majority of HIV cases were male and yet the majority of those with HIV treated at Lewisham Hospital were female. In 2004 there were 895 cases of HIV; 535 were men and 57% of them were white. The health professionals commented that the majority of people diagnosed with HIV seek health services in north London, most likely to reduce the chances of people they know finding out and so they feel safer.

With regard to chlamydia and gonorrhoea, 70% of black African Caribbean men in Lewisham are testing positive. The numbers accessing sexual health services are steadily increasing and there are several services that are commissioned to target black men.

The Review Group also heard that black gay men are more likely to test positive for HIV. The Lewisham population is very mobile and the HIV epidemic in Africa impacted upon the African population in Lewisham. Other changes include new gay populations in Manchester, Brighton and London, where new strains of chlamydia have been diagnosed.

In order for men to manage their sexual health they need confidence and self-worth, the ability to talk about sex, awareness and accurate information on sexual health, and appropriate and consistent services.

The councillors acknowledged the comprehensive sexual health promotion happening in Lewisham, which includes the sexual health strategy, clinical service provision, outreach work, one-to-one and group work, sex and relationships education, condom provision and training and coaching.

A recent health equity audit identified that although an increasing number of young men were accessing Lewisham PCT's sexual health services (15% of clients in 2005–6 were men), there remains a gap in services for men and young men in particular.

Sex and relationships education (SRE) is not mandatory for schools in England and Wales, and yet accurate information is crucial; misinformation about sexual health is worse than no information at all. Council officers commented that two years ago all secondary schools in Lewisham were offered the opportunity to provide sex education. There is a need for more intensive work with St Joseph's Academy, which opted out of providing sex education, and the Healthy Schools partnership was working on this.

The Review Group was supportive of the schools that are fully participating in SRE. However, it was felt that for one of the schools in Lewisham not to provide SRE was to deny young people the right to basic health information, and that the option to opt out of SRE should be given on an individual basis only and not taken by whole institutions, particularly within Lewisham, a borough with high rates of STIs and teenage pregnancies. Therefore:

20. It is recommended that it is made a priority to make sure all children and young people have access to sex and relationship education (SRE) in Lewisham, as young men's health is vitally important for this borough. On an individual level, people would be free to opt out of SRE should they wish to, but there is a need for SRE to be politically driven as well as managerially driven to ensure all young people are offered the opportunity to receive evidence-based, age-appropriate sex and relationship education.

It remains unclear how best to address the high rates of sexual and mental health problems in young men, which are of particular concern, especially in young black men. It is important that members of these groups are aware of and act on appropriate health promotion messages. It is also important that they access relevant services as necessary. How best to achieve these ends remains a challenge, and it is recommended that further work is carried out to explore what actions should be taken.

The Review Group had requested that officers carry out research with young black men in Lewisham to establish recommendations for change. However, it was not possible in terms of the time and resources available for the scrutiny support team to recruit and carry out this research.

21. Therefore it is recommended that the PCT and Council carry out focus group work with young black men to ascertain the causes of, and come up with solutions for reducing the rates of, sexual health and mental health problems that currently exist in Lewisham.

Men’s access to health services

Alan White, chair of the Men’s Health Forum, identifies the main issue facing men as the reluctance to access health services.

In conducting a scoping study on men’s health in 2001, Alan White highlighted the data on men’s usage of the health service, suggesting that up to the age of 16 boys have very similar attendance patterns at primary care to girls because their mothers take them there. However, after that point there are different patterns of health service contact both between young men and women and between the differing social classes. This issue of access is not restricted to any one group of men and is seen as a problem for all areas of the male population. This is not to suggest that men do not access health services at all. Even young men from the lower socio-economic groups, which are assumed to be poor users, were found to have visited the doctor on average 2.21 times per year. However, it appears that they are attending just for treatment and missing out on preventative healthcare. There are also large numbers of men who do not visit the doctor at all.

The Review Group examined the outcomes of the Men’s Health Workshop, which was held as part of the Lewisham Gender Equalities Scheme consultation hosted jointly by Lewisham PCT and the Council in December 2006. Attitudes towards health, health concerns and suggestions for health improvement were explored from men’s perspectives. Some of the areas discussed in the workshop were attitudes towards health, health concerns, keeping healthy, improving mental health and identifying improvement priorities.

Some of the key issues identified locally in respect of men accessing health services are:

- Men access health services and participate in community health promotion activities less than women. In 2004–5 females were more likely than males to consult a GP. Females had an average of five NHS GP consultations per year, whereas males had three consultations (General Household Survey, 2005).

- Men’s access to and engagement with health services was reflected in the low numbers of men in contact with the PCT Patient and Public Involvement Team, including the Patient Advice and Liaison Service.

- Lewisham has a developed expert patients programme; however, the majority of people participating have been women.

- The Health Trainers Scheme, developed by Lewisham PCT and community-sector partners, recruits and trains local people as volunteers to help the public take better care of their health. Out of the 18 volunteers currently training to become health trainers, just one is male. As part of the review of the scheme, a targeted approach to recruiting men as volunteer health trainers through Sunday league football has been proposed.

- Both men and women felt they did not do enough to look after their health, but they had different perspectives. Women felt they did not have enough time to look after themselves, whereas men felt that there was an insufficient focus on men’s health by professionals.

Reasons for men's general reluctance to contact their GP were given as:

- a lack of understanding of the processes of making appointments and negotiating with female receptionists
- inappropriate opening times, which tend to coincide with work commitments
- an unwillingness to wait for appointments
- a feeling that the service is primarily for women and children and sitting in the waiting room is uncomfortable for them
- the negative response many men feel they get when presenting with difficulties that are not quickly dealt with
- great fears relating to the shame of having to admit to another person that they may have a problem, and one that can't be solved
- lacking the vocabulary they feel they need to discuss issues of a sensitive nature, with the result that it is easier to go to the doctor with a non-embarrassing physical illness than when depressed or faced with the symptoms of, say, prostate cancer or erectile dysfunction.

There is a great deal of interest in increasing the use of man-friendly approaches such as the NHS Direct website and telephone helpline. There have been novel ways identified to gain access to men, such as the Health Bus initiative to provide health information and blood pressure checks to Lewisham residents. Although the Health Bus outreach is for all members of the public, men are particularly targeted for blood pressure checks and are referred to the GP if necessary. However, there is a realisation that this must be seen as an addition to the existing services, with the prime intention being to get men to use the primary care system more effectively.

22. The Review Group recommends that Lewisham NHS bodies and the Council consider the following factors to help increase the numbers of men accessing health services:

- **providing more early morning, evening and weekend opening of health centres**
- **the use of male receptionists where possible and practicable**
- **holding getting to know you evenings hosted by GPs and nurses**
- **greater use of male practitioners within health promotion work with boys and men**
- **greater use of occupational health services, which should be extended from screening to the providing of primary healthcare services**
- **greater linking of health services to sport**
- **extension of walk-in GP services**
- **raising parents' awareness of the need to encourage within boys the responsibility for, and the skills to manage, their own health**
- **training staff in health centres to help them understand young people and their health needs and health-seeking behaviours**
- **increasing the number of healthy living centres and stimulating more initiatives that are proving popular with men**
- **promoting the work of the Men's Health Forum by creating local portals to the Men's Health Forum website from the Council and local NHS websites, so visitors can have direct access to the substantial amount of information available**
- **looking to develop men-only sessions in walk-in health centres and other pilot services such as 'MOT' health checks at pharmacists and mobile units.**

Health promotion and information needs to be targeted to the places where young men congregate. Work is being undertaken by South London and Maudsley Mental Health Trust (SLaM) in partnership with the PCT to look to engage with men by going to such places as barber shops, gyms and snooker halls. Also, 'Under Pressure', a voluntary sector organisation that focuses on black people and African and Caribbean people to prevent stroke and raise awareness, worked in Lambeth on targeting men to help improve their health, and this was successful.

23. It is recommended that any plans to target young people where they congregate should make reference to and use good practice developed in joint work carried out by SLaM and Lewisham PCT, as well as look to utilise links with famous and well-known people, using them as role models to galvanise and publicise the work in relation to men's health.

In conclusion, the Review Group recognises there is a need to get as many men as possible to use the existing health services in the way they are there to be used, but trying to persuade as many men as possible to use the services may mean that the services will have to change.

Quality of life issues

There are many issues that affect men's well-being and their health in the wider sense. These include housing, education, employment, welfare dependency and the environment, along with social networks and a sense of community.

The Review Group examined information on quality of life indicators for Lewisham. It was recognised that the issues that have the biggest impact on health are not the health services themselves, which deal with people when they are ill, but the wider determinants that the Council and other bodies have a direct influence over.

The Review Group asked council officers for further information on potential opportunities for highlighting how the Council can act to improve health outcomes in Lewisham, in particular for men. Councillors requested a paper setting out how the Council's services could be graded in terms of the health impacts on men's health by listing the magnitude of the health impacts, for example education compared with housing, trading standards, etc., in order to explore how much the Council understands the impacts on men's health and health inequalities. They were advised that a comprehensive statement of the health impact of council services was not readily available.

24. It is recommended that the Council with the PCT consider ways in which health impact assessments of council services can be carried out, and that these be reported back to the health scrutiny body.

Concluding remarks

There are a number of common themes emerging from this review relating to access to health services and the fact that men do not perceive health services to be male orientated enough, with a need for more outreach work. This is recognised through good partnership working in Lewisham between the health providers and the Council; the partnerships are well established and are to be commended, but there is a need for greater integration in the future to provide a stronger shift in focus towards health promotion.

A central lead to help coordinate activity around men's health is needed. In the past it was rare to actually state the need for focused work around men's health, and although this is now changing, there is still a requirement for further policy formation that is informed of the men's health agenda. It is hoped that this review will go some way towards highlighting this and identifying actions to be taken to improve the health outcomes for men in Lewisham.

25. It is recommended that the scrutiny review into men's health in Lewisham is revisited in two years' time to ascertain the changes and developments against the findings and recommendations made in this report.

26. It is further recommended that the innovations and learning points gained by conducting the review into men's health in Lewisham, and detailed in Appendix 1 of this report, are adopted by the Overview and Scrutiny Business Panel as good practice in scrutiny.

Lewisham men's health scrutiny review innovations and learning points final report

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1. Introduction

1.1. Shared Intelligence used an action learning approach with councillor members of the review team to identify key *innovations and learning points* from LB Lewisham's Men's Health Scrutiny Review, which took place in 2006 and 2007. Through discussions with councillors after scrutiny sessions, facilitated using action learning principles, different aspects of the Men's Health Review process were examined. Eight innovations and learning points were discussed in detail, and the main purpose of this report is to record them in order that they can be disseminated and made use of in subsequent scrutiny reviews. The eight points are:

Scrutiny Review Group membership
Looking beyond the PCT and Council for witnesses
The initial stakeholder event
Having a dedicated review webpage
Involving members of the public
Getting the best information from witnesses
Reaching conclusions at the end of the review
Where the Review Group could have gone further.

2. Background to the project

2.2. Lewisham Council was able to support this project because of a successful funding proposal to the Centre for Public Scrutiny (CfPS). The CfPS is running a Department of Health-funded support programme for the 150 health overview and scrutiny committees of social services authorities as they develop their power to promote the well-being of local communities through effective scrutiny of health and healthcare issues.

2.3. The support programme, which includes nine action learning projects, is designed to help non-executive councillors and their NHS and public health partners learn together about the experience of health scrutiny. Through this, it is hoped that health scrutiny becomes an informed joint enterprise between partners.

2.4. Lewisham's bid to become one of the CfPS-supported action learning projects explained the rationale for the men's health scrutiny. The decision to examine men's health in Lewisham reflected members' concerns about health inequalities for men in the borough. The review, the bid explained, would seek to address these imbalances by investigating the issues with the PCT to achieve change and improve health outcomes for men in Lewisham.

2.5. Along with the scrutiny review's ultimate aim of bringing about an improvement in the health and well-being of men in Lewisham, the bid set out why the review met the CfPS's criteria for funding support:

The action *learning element* would add value through showing how to engage with men on health issues which directly affect them, broadening the scope of the health scrutiny to the voluntary and community sectors and using scrutiny within the Local Area Agreement framework.

The review would secure *patient and public engagement* through involving the PPI forum, men's groups, a citizens' panel and widespread publicity through the media.

The review would work *collaboratively* with partner authorities, local NHS bodies and other agencies through a representative review group, joint working on the report and a virtual consultation group.

2.6. The CfPS bid also explained that the review would focus thematically on services specifically targeted at men's health, men's sexual health, health inequalities between men and women and according to geographic areas, and mental health issues for men.

3. A desire to try something new

3.7. It is important to understand in reading this learning points report that while our action learning discussions themselves only began part way through the review, the members of the Scrutiny Review Group were well aware of the CfPS support from the outset and were keen to see the review as a testbed for innovation and new approaches. So the knowledge that this review would be *different*, coupled with a subject matter – men's health – which was also seen as requiring different approaches from public agencies, brought about a buy-in from all the Review Group members to try new things and seek out new ideas.

3.8. The results of this could be seen in the decisions taken at the first planning meeting around the meeting schedule, media strategy and witnesses to call.

3.9. As we hope readers will agree, there was real innovation in this review as well as the adoption of existing best practice around community engagement and democratic processes. In seeking to understand why this happened more than in other scrutiny reviews, we believe it likely that knowing this project had been selected by CfPS for special treatment, and the idea of action learning, encouraged the desire to try something new.

4. Our method and objectives

4.10. When we began our project in January 2007 the Men's Health Scrutiny had already been running since August 2006 and had held four public meetings. Action learning had been intended to start earlier in the course of the review, but contracting and organisational factors delayed us.

4.11. Given the relatively late stage at which we introduced action learning sessions to the Men's Health Review, we agreed with the scrutiny manager and the chair of the review panel that our objective would be to identify and document learning about what had already taken place during the review, and to capture anything new that came up in the latter part.

4.12. With a focus on what had been done differently, we set out to use reflective discussion, with strong facilitation, to capture high quality information about what had been learnt from this review, in a way which would enable innovations to be disseminated and replicated in upcoming reviews.

4.13. With this objective agreed, Shared Intelligence facilitated four action learning sessions with the elected members taking part in the Men's Health Scrutiny Review Group – the co-opted non-councillor members did not attend the action learning discussions.

4.14. The four sessions were:

Introduction to action learning principles at a private meeting of the Review Group in January 2007.
One 45-minute session held immediately before the committee's public meeting on 31 January 2007.
Two 45-minute sessions held immediately after the final two meetings of the Men's Health Review in February and June 2007.

(NB We had already attended the 10 January public meeting as observers and to meet the Scrutiny Review Group for the first time.)

4.15. To make best use of the short amount of time available (45 minutes) we set the same simple starting question at the beginning of each discussion – *'what have we done differently, and what with hindsight would we have liked to take further?'* Each member of the Review Group was asked to suggest ideas in turn, and several minutes were spent by the group and facilitator attempting to draw out practical examples to support general assertions and also to tease out *why* this approach had been taken. Some of the discussion focused on the public scrutiny meeting that evening, and some on the meetings which had already taken place. At each action learning session the group identified three or four examples which were documented. At some points the discussion switched into problem-solving mode, and these segments of the discussion were handled in a structured action learning format of problem, suggestions, responses.

4.16. In addition to the project with members of the Men's Health Scrutiny Review Group, Shared Intelligence also ran a learning set to support Overview and Scrutiny officers, which met four times between February and May 2007. This set followed a fairly orthodox action learning method of action-orientated, facilitated discussion to address set members' problems or issues affecting them.

5. Innovations and learning points

5.17. The main purpose of this report is to document the answers we received to our central question of 'what have we done that was different and why was it good?'. In identifying the things that were done that were different, we pushed members to cite specific practical examples which would enable these to be replicated – and these too are documented.

5.18. The eight innovations and learning points are set out below.

5.19. There is one theme running through many of these but which we have not documented as a separate item. That is the idea of *informality* in the atmosphere of the meetings, the style of chairing, in the layout of the meeting rooms, and so on, which the Review Group believes was a good thing. We did not test why informality was thought to be better than formality, but all members of the Review Group seemed in agreement that informal was better and was something which scrutiny should aim for in all in-depth reviews.

1 - A more inclusive Review Group membership

5.20. In a departure from the usual councillor-only scrutiny committees, the Men's Health Review Group included three officers from the PCT and Council alongside the five councillors. The officers were the PCT's assistant directors for public health, and communications and public involvement, and the Council's policy manager for community services. Apart from bridging the officer–councillor divide, this was also felt to have contributed to the panel's informal atmosphere. Panel members felt that because of this they were seen by witnesses as more of an informal group than a formal committee, and that this might have influenced witnesses' willingness to contribute more freely. Coupled with the decision to have witnesses and other attendees sitting at the same table, intermingled with the panel members, this created an atmosphere that was different, in a good way, from other council meetings.

5.21. Councillors also felt that the presence of non-councillors on the panel had encouraged them as councillors to 'stick together', which broke down the usual partisan distinctions.

5.22. The combination of informal atmosphere and being less self-conscious of partisan politics led, the group felt, to an absence of political point-scoring and more neutral questioning designed simply to get the best information.

5.23. Key learning point: continue to experiment with non-councillors on scrutiny review panels.

5.24. Key learning point: room layout and where people sit make a big difference and having others sitting at the table does not necessarily make it harder to have an effective meeting.

2 - Looking beyond the PCT and council senior managers for witnesses

5.25. One area where the Review Panel felt they had made a bigger difference was in calling witnesses from beyond the ranks of the Council's and PCT's service managers, to a greater extent than was usual in Lewisham scrutiny. This wider range included representatives from national organisations like the Stroke Association, local groups connected with national bodies like the local branch of Diabetes UK, as well as front-line healthcare clinicians from the local hospital trusts, and PCT.

5.26. Having such diverse witness evidence from national and local experts represented a departure from usual practice at scrutiny review sessions of focusing on service managers.

5.27. The panel believed the key to obtaining a better mix of witnesses had been in giving clear instructions to the supporting officers at the first review planning meeting. They had specifically asked to hear evidence from a mix of witnesses – from the Council and the PCT, but also from people who could give a national or London-wide perspective, and in particular clinicians and front-line practitioners. The panel's aim was to get two presentations per session from this wider set of witnesses.

5.28. The Review Panel believed this had brought several benefits.

5.29. They had found more witnesses who were eager to take part in the scrutiny process and give evidence. This contrasted with some officers from the Council who did not speak with as much enthusiasm or conviction and sometimes appeared to see scrutiny as an obligation they had to fulfil.

5.30. Presentations were overall more relevant and more effective in stimulating fluid, helpful discussion. The director of the South East London Cancer Network, based at Guys and St Thomas's hospitals, who appeared at the review's November 2006 meeting, was seen as a prime example of this. Not only was his contribution informative, but he was particularly good at engaging people and his enthusiasm and presentation style energised the session. The evidence from the chief executive of the Men's Health Forum to the December meeting was also seen as adding significant value, as it left the Review Group with a huge amount of new information, in particular around the most effective channels for health promotion information aimed at men.

5.31. It is clear these two witnesses left strong impressions as their evidence can be seen feeding through into the review's recommendations – in particular the Men's Health Forum messages about health promotion to men.

5.32. The type of witnesses also added to the informal atmosphere which was fostered in different ways, as mentioned elsewhere. This was attributed to the nature of the relationship between members of the Review Panel and witnesses. Unlike service manager witnesses who are directly responsible to councillors or reliant on the Council for funding (e.g. PCT service directors), these witnesses were independent of the Council, appeared to give less guarded answers in evidence and were more willing to volunteer information.

5.33. Key learning point: seek a wide range of witnesses from organisations beyond the Council and its immediate service delivery partners to obtain a wider perspective.

3 - Beginning the scrutiny with a stakeholder event

5.34. The first full evidence session for the review was held in September 2006 and was conceived of as a 'stakeholder event' to give the review a high profile launch and hear a range of views at the outset.

5.35. Although the formal notice and agenda did not bill the meeting as anything different, several changes were made to the usual meeting format to make the 'stakeholder event' quite different. The meeting format included break-out discussion groups involving all attendees, not just Review Panel members. The physical layout was planned to include everyone present in the discussion rather than having a distinction between 'committee table' and 'public gallery'. In fact, the decision to allow everyone in attendance to participate in the discussion was a feature which the Chair and his Review Group tried to maintain throughout the review. At several subsequent meetings, people who in other reviews would have been expected to sit in the public gallery were invited to sit around the main meeting table.

5.36. In addition to the Review Panel members themselves and support staff, around 20 core stakeholders representing health services and community groups attended, along with a number of other local people. While the total of 23 attendees fell well short of the 150 invitations sent out, this was good in comparison to other scrutiny meetings. Moreover, attendees represented a broad cross-section of the voluntary and community sector and statutory heath sector in Lewisham, all able to feed their views into shaping the review:

- Carers Lewisham
- Mount Zion Foundation
- the Stroke Association
- Diabetes UK – Lewisham Support Group
- Health First
- Victim Support
- Under Pressure
- Lewisham PCT – Public Health Team
- South London and Maudsley Mental Health NHS Trust
- University Hospital Lewisham.

5.37. Among the stakeholders invited to the September meeting were journalists from the local newspapers. This had been decided at the initial project planning session and press liaison was led by the press teams at the Council and the PCT. The September meeting began with a planned presentation on the significant health problems of men in the borough, and used

that to explain to stakeholders why a review was needed. The press coverage was very positive, repeating the poor health statistics and going on to report matter-of-factly that the review would explore what more could be done – as well as highlighting some of the actions already being taken. This achieved a full page of coverage in the South London Press, and half a page in the Greenwich Mercury. By repeating several of the PCT's health awareness messages – such as the effects of smoking, poor diet, and low male take-up of GP services – the coverage also yielded free health promotion as well as encouraging local people to contribute to the review.

5.38. Key learning point: a proactive media strategy from the start can produce significant positive coverage for scrutiny, as can inviting the press to attend inaugural meetings.

4 - Having a dedicated Men's Health Review webpage

5.39. At the start of the Men's Health Review, the Overview and Scrutiny team arranged for it to have its own webpage (by creating a page in the e-consultation area of the Council's website) on which agendas, minutes, reports and meeting dates would be accessible in one place.

5.40. The papers and agendas for other Lewisham committees and scrutiny panels are all available online but can only be found by browsing the full list of all council meetings. In practical terms the dedicated webpage made it much easier for members of the Review Group, partners, witnesses and other interested citizens to find the papers easily. It would also have been seen by anyone researching any of the Council's other consultation exercises. However, aside from the practical advantages, the Review Group also said it gave them a stronger sense of identity, being able to see all their work in one place and perhaps being aware too that their work was slightly more visible and open to public scrutiny than that of other committees.

5.41. Key learning point: having a webpage on the Council's consultation pages enables scrutiny to be seen as part of public engagement, as well as making reviews more transparent and easier to see in their entirety.

5 - Involving and including members of the public

5.42. The Men's Health Review aimed to increase the number of local people attending its public meetings. There is an understandable pessimism about the ability of council meetings generally to attract local people to attend – 'if only one member of the public turns up, it's a gain' is a common sentiment. Considerable thought was, therefore, given to bringing more local people into the process. In addition to the press strategy already mentioned, and the general aim of being more informal, this also included a strategy of holding meetings in different locations.

5.43. Two meetings were held outside the civic suite; the November meeting took place at the Bridge Leisure Centre in the south of the borough several miles from the civic centre, and the December meeting was held at the ISIS family health centre near to the civic centre.

5.44. The ISIS centre meeting in December attracted around 40–45 people, meaning there was standing room only. Not only did people attend but those who did clearly wanted to join in the debate – 'it could have gone on all night' recalled one panel member in relation to the number of hands going up to speak. On reflection the Review Panel felt that this needed a bit of qualification, as people were unsure at the beginning about what the rules were for speaking from the floor. The people who spoke first seemed to be professionally involved in health, and while many others did eventually join in, more could have been done to make the rules clear at the outset.

5.45. The high turnout is clearly something the Review Panel would like to replicate and the main factors seem to have been: the scrutiny team publicising the meeting well in advance, the location of the venue, and the fact that it was regularly used by members of the local community for health services. The meeting began with a presentation from the Men's Health Forum, which was very much a non-bureaucratic view of health improvement and talked about the realities of encouraging men to take their health more seriously. After this there was an open questions session, which started slowly but soon took off as described. Many men spoke of their personal experiences and gave first-hand testimony of real-life examples. This evidence of individual experience was seen by the panel as an invaluable balance to the formal data and statistics they had seen and helped bring the issues to life for the Review Panel members.

5.46. Key learning point: it would help to announce at the start of meetings how and when questions from the floor will be taken and perhaps also produce a leaflet to give out.

5.47. Key learning point: holding sessions in well-chosen venues other than the Town Hall, backed up with strong publicity, can result in much greater public attendance.

6 - Getting the best information from witnesses

5.48. Eliciting strong relevant evidence to enable the review to produce a well-informed report with new insights was a priority for the Review Group.

5.49. An issue common to many scrutiny reviews in the Review Group's opinion was that a lot of precious meeting time was taken up by witnesses making long presentations. To make matters worse, witnesses would often simply read from the reports which the group had already seen in advance and add no new information or even draw out key points. Given that most meetings are two hours long and that the evidence typically has to be gathered in around three or four sessions, it is essential to get the most out of the time available – and this means focusing on obtaining new information and allowing enough time to ask questions and cross-examine the answers. The Review Group therefore became concerned as the review progressed about two linked issues:

5.50. Firstly, that from council witnesses they were not getting much new information that was not already in the pre-circulated submissions – though this was not true of many of the witnesses who were further removed from the Council.

5.51. Secondly, that papers were not always circulated far enough in advance of meetings to be read thoroughly (or at all in some cases), which added to the difficulty of getting the most out of witnesses and building up each member's knowledge of the subject matter.

5.52. They felt this risked generating a cycle in which they were discouraged from reading in detail the papers sent out before a meeting since they knew they would be read out in the meeting anyway.

5.53. Key learning point: delays to dispatching scrutiny committee papers hinder the decision-making process – and perhaps papers not circulated within this time frame could be deferred to the following meeting.

5.54. Key learning point: limiting witnesses to a short presentation (say 10 minutes max.) would leave more time for questioning.

7 - Reaching conclusions at the end of the review

5.55. As part of the action learning session which took place at the end of the 28 February evidence session, the scrutiny officers and action learning facilitators ran an exercise to help the Review Group form its conclusions.

5.56. A draft report structure and set of recommendations had been produced by the Overview and Scrutiny officers based on the evidence and discussions which had constituted the review.

5.57. After officers had summarised the draft structure and recommendations to the Review Group, the group was divided into two small discussion groups and asked to decide whether the draft covered the issues they felt had come across most strongly during the review. This led to some issues in the draft being downgraded, and others which were low down, or absent, being marked up as priorities or 'added back in'. The panel were then asked to say how they would like to see the priority issues presented in the final report.

5.58. Overall, the Review Group felt that this was a useful exercise, offering a stage for steering conclusions and recommendations that had been absent in previous reviews. Having a draft report from officers at this stage was also felt to be a good innovation, since councillors would probably not go back and re-read all the minutes and papers from the entire review. Some group members went even further and said they would like even more control over the report content next time and that this 'reaching conclusions' stage should come before officers had put pen to paper. So while they thought there was use in having a specific stage in the process for reaching conclusions, they were keen for it to be timed so that the report from the outset reflected a clear councillor perspective on the review.

5.59. Key learning point: a group working session at the end of a review helps ensure strong councillor input to the review's conclusions and recommendations.

8 - Where we could have gone further …

5.60. In the final action learning discussion the Review Panel members were asked to consider the areas where they felt they had done things differently, and then to say how they would like to go further next time.

5.61. They found this difficult, not just because it was at the end of a long meeting late in the evening but also because they genuinely felt the review had gone further than they had hoped in finding new ways of working. However, they did suggest the following areas where future reviews could go even further:

5.62. Having **witnesses from beyond the Council and PCT** was a good thing but this could have been used even more during the review. For instance, an external perspective would have been helpful on sexual health, especially from another London borough with similar demographics to Lewisham.

5.63. **Getting more local people to attend meetings** was a major achievement, but the Review Panel didn't really engage anyone outside the actual meetings. Members could have taken informal soundings from members of the public on a one-to-one basis or in a focus group.

5.64. Building on the **webpage and e-consultation**, another option could have been to set up an internet discussion group or provide other means for people to contribute through ICT and web communication.

6. What impact did this have on the final scrutiny product?

6.65. At the time of writing this learning points report, the report of the Scrutiny Review Group itself is not yet complete. It is therefore impossible to say with certainty what tangible impact the action learning approach had. To be more precise, what was the impact of a scrutiny review group commencing their review with the intention of doing something different, and knowing there was an expectation to do so? However, we can see from the 'different approaches' taken throughout the course of the review and identified through the action learning discussion that there were several changes in approach which are likely to impact directly on the end product. We see these as being the following:

6.66. Having the 'reaching conclusions' stage when only the report outline and draft recommendations had been written meant the Review Group members were able to put their stamp on the draft report before officers completed the main drafting.

6.67. In terms of sheer numbers, the review reached more people, including Lewisham residents, than other reviews, both in the meetings themselves and through the comprehensive (and mainly factual and/or supportive) press coverage.

6.68. The relatively wide-scale engagement and press coverage have raised the profile of scrutiny in a positive way, including with health stakeholders.

6.69. The inclusion of evidence from national organisations meant the issues were placed in a wider context, which can be particularly difficult in London.

6.70. New ways of working were tested, and many of these earned the confidence both of Review Group members and officers and so should be used again or experimented with further.

7. Our own learning from this project

7.71. As we have made clear in this learning points report, Shared Intelligence only attended the final three of a series of eight Scrutiny Review Group meetings – and it was at these that the action learning discussion took place. In originally planning the project with Lewisham's scrutiny manager, we had envisaged having a formative impact on the review. But it quickly became clear that the real value was in documenting learning which in most cases had come from Men's Health Review Group meetings which had already taken place and which we had not attended.

7.72. The formative impact on the Men's Health Review of the action learning discussions themselves is therefore quite limited. But as a means of identifying and documenting the learning about 'what we did differently' we believe the highly structured action learning discussions, which pushed the Review Group to provide specific examples and explain their personal roles, were very effective. Had these not taken place, this learning is unlikely to have been documented and quite possibly would have faded over time.

7.73. While we only began our sessions late in the Review Group's programme, we believe the desire from the group and supporting officers at their first project planning meeting in August 2006 to 'do something different' did have a formative impact on the approach they then took. At that first meeting the Review Group already knew about the CfPS funding which would support the review, and understood that this was intended to stimulate new approaches. There also seems to have been buy-in to action learning as a principle, even if Review Group members understood to differing degrees what this meant in detail. So the 'idea' of action learning did, we believe, have a formative impact.

7.74. We were also aware of the time pressures involved. Scrutiny meetings in Lewisham take place in the evening, and most Review Group members will already have had a full day of other demanding commitments. Nonetheless, the Review Group members taking part all stayed on late, or arrived early, in order to participate in the action learning discussions – and did so with tangible enthusiasm. Holding a larger number of action learning sessions would have proved very demanding on the Review Group and we are unable to say what the limit might have been – perhaps around four or five would have been the realistic maximum.

7.75. Our final assessment is that while we were unable to test action learning discussions as a formative tool in scrutiny, they were effective in capturing learning even when only used sparingly. We also saw that the idea of action learning, even if only partially informed, contributed to different approaches being taken to scrutiny – many of which are viewed by the Review Group as having had a positive and desirable impact.

7.76. Key learning point: action learning can be used to draw out learning from a scrutiny process and tease out the specific practical examples from general observations, which is essential for transferring the learning.

7.77. Key learning point: if action learning was introduced to support the initial project planning meeting of a new review, it could be strongly formative in the scrutiny process.

8. Additional information about the review

Review webpage
http://www.lewisham.gov.uk/CouncilAndDemocracy/HavingYourSay/MensHealthReview/
Chronology of the Men's Health Scrutiny Review Group

23 Aug. 2006	Project planning meeting
26 Sept. 2006	Stakeholder event
25 Oct. 2006	Evidence session
15 Nov. 2006	Evidence session (Bridge Leisure Centre)
13 Dec. 2006	Public engagement session (ISIS centre)
10 Jan. 2007	Evidence session (action learning introduced)
31 Jan. 2007	Evidence session (first action learning session)
28 Feb. 2007	Reaching conclusions (second action learning session)
6 June 2007	Agreeing report (third action learning session)

The final report of the Men's Health Scrutiny Review Group is planned to be launched at a public event in September 2007.

Members of the Men's Health Scrutiny Review Group
Councillor Alan Hall (Chair)
Councillor Chris Flood
Councillor Sylvia Scott (Chair of the Healthier Communities Select Committee)
Councillor Andrew Milton
Councillor Chris Maines
William Godwin, Policy Manager , Community Services, Lewisham Council
Donal O'Sullivan, Assistant Director of Public Health, Lewisham PCT
Oliver Lake, Associate Director of Communications and PPI, Lewisham PCT
Eleanor Rees, Policy and Research Officer, Overview and Scrutiny, Lewisham Council

The terms of reference for the Men's Health Review

How existing service provision and advice help to meet the strategic aims, objectives and priorities for Lewisham.

What services are specifically targeted for men's health in the borough, including mental health services.

Understand the nature of men's health issues, including sexual health, and in particular if there are any inequalities that exist between different groups of men (for example according to age, sexuality, ethnicity, religion or disability) and what actions could be taken to address this.

Consider what would make it easier for men to access health services.

Examine the communication and targeted health awareness raising campaigns in the borough.

Identify specific action that the local authority and/or its health partners might take to promote and improve men's health service provision and men's health awareness in general.

Anti-retroviral therapies – medications for the treatment of infection by retroviruses, primarily HIV. Different classes of antiretroviral drugs act at different stages of the HIV life cycle. Combination of several (typically three or four) antiretroviral drugs is known as Anti-Retroviral Therapy.

CABG (Coronary artery bypass graft) – surgery to treat coronary artery disease. The surgery uses a blood vessel (called a graft) taken from the chest, leg or arm to bypass a narrowed or blocked coronary artery. This can improve blood flow to the heart and reduce the chance of a heart attack.

FORVIL – Federation of Refugees from Vietnam in Lewisham

The Health Bus – provides health information and blood pressure checks and will make referrals if necessary to local GPs. The initiative is co-ordinated by South London and Maudesley Mental Health Foundation NHS Trust in partnership with Lewisham PCT, Lewisham Council and the voluntary sector.

Health First – is the specialist NHS health promotion agency for Lambeth, Southwark and Lewisham in South East London. It is hosted by Lewisham Primary Care Trust.

Healthy Schools Initiative – national scheme that encourages schools to develop a whole school approach to health promotion. It focuses on relationships, curriculum development, liaison with the wider community and above all, the well-being and care of individuals in the school.

Health scrutiny body – each local authority with social care responsibilities has a health scrutiny body (or committee) made up of locally elected councillors. The health scrutiny body has a statutory responsibility regarding reviewing, scrutinising and reporting on NHS services and organisations.

Men's Health Forum – is an independent body working for the development of health services that meet men's needs and enable men to change their risk-taking behaviours
www.menshealthforum.org.uk

Overview and Scrutiny Business Panel – is responsible for the co-ordination and approval of the scrutiny work carried out by the overview and scrutiny select committees in Lewisham. The Overview and Scrutiny Business Panel also holds the Council's executive to account for performance in the delivery of plans and strategies.

PCT – Primary Care Trust

PSA – a protein produced by prostate cancer cells. Any condition that irritates or damages the prostate gland can lead to a leakage of PSA into the blood.

PSA test -– prostate-specific antigen (PSA) test is a blood test which measures the level of PSA.

PTCA – percutaneous transluminal coronary angioplasty. PTCA – often called angioplasty – is a procedure to treat coronary artery disease. It involves flattening the fatty material (atheroma) that can build up inside the walls of the main blood vessels (arteries) to the heart causing them to narrow. Angioplasty does not involve open heart surgery; a catheter is threaded through an artery in the groin or arm to reach the coronary arteries of the heart.

SLaM – South London and Maudsley NHS Foundation Trust

S&RH clinics – Sexual and Reproductive Health Clinics

TIA – a transient ischaemic attack (TIA) causes symptoms similar to a stroke, but symptoms last less than 24 hours. The most common cause is due to a tiny blood clot. Treatment after a TIA aims to reduce the risk of having a stroke, further TIAs, or a heart attack. Treatments include medicines to reduce the risk of blood clotting, and tackling any risk factors such as high blood pressure, diabetes, a high cholesterol level, and smoking. Surgery is advised in some cases.

Well men clinics – each clinic offers its own selection of tests, depending on its resources and the age and key health risk areas of the men attending. In Lewisham, 'Open for Men – Health Check', is provided free of charge on the NHS. Telephone: 020 7635 1111.

Appendix 3 – Bibliography

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Appendix 4 – Acknowledgements

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