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HEALTH AND WELLBEING BOARD

Thursday 12 March 2026
10.00 am
Council House

Members:
Councillor Aspinall, Chair
Councillor Lugger, Vice Chair
Councillors Laing and P.Nicholson.

Statutory Co-opted Members: Director of Children's Services, Director of Public Health, Strategic Director for Adults, Health and Communities, NHS Devon ICB, and Healthwatch.

Coopted Members: Livewell SW, University Hospitals Plymouth NHS Trust, University of Plymouth and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

This meeting will be webcast and available on-line after the meeting. By entering the Council Chamber, councillors are consenting to being filmed during the meeting and to the use of the recording for the webcast.

Tracey Lee
Chief Executive

Health and Wellbeing Board

1. Apologies

To receive apologies for non-attendance submitted by Health and Wellbeing Board Members.

2. Declarations of Interest

Board members will be asked to make any declarations of interest in respect of items on the agenda.

3. Chairs Urgent Business

To receive reports on business which, in the opinion of the Chair, should be brought forward for urgent consideration.

4. Minutes **(Pages 1 - 18)**

To confirm the minutes of the meeting held on 15 January 2026.

5. Questions from the public

To receive questions from the public in accordance with the Constitution.

Questions, of no longer than 50 words, can be submitted to the Democratic Support Unit, Plymouth City Council, Ballard House, Plymouth, PL1 3BJ, or email to democraticsupport@plymouth.gov.uk. Any questions must be received at least five clear working days before the date of the meeting.

6. Conditions of Success Report: **(To Follow)**

7. Health and Wellbeing Board Priorities 2026/7: **(Pages 19 - 30)**

8. Health Determinants Research Collaboration Update Report: **(Pages 31 - 40)**

9. Suicide Prevention: **(Pages 41 - 110)**

10. Vaccination Update: **(Pages 111 - 120)**

11. Men and Boys' Health: **(Pages 121 - 130)**

12. Action Log: **(Pages 131 - 134)**

13. Work Programme **(Pages 135 - 136)**

Health and Wellbeing Board

Thursday 15 January 2026

PRESENT:

Councillor Aspinall, in the Chair.
Councillor Lugger, Vice Chair.
Councillors Laing, and P.Nicholson.

Statutory Members: Ed Garvey (Senior Locality Commissioning Manager, NHS Devon), Tony Gravett (Healthwatch), David Haley (Director of Children's Services), Professor Steve Maddern (Director of Public Health), and Gary Walbridge (Strategic Director for Adults, Health and Communities).

Co-opted Representatives: Laura Alexander (University of Plymouth), Neil Macdonald (Chief Executive, University Hospitals Plymouth), Rachel O'Connor (Director for Integrated Care Partnerships and Strategy, University Hospitals Plymouth), Karen Pilkington (VCSE Representative), and Rob Smith (Chief Executive, Improving Lives Plymouth; Wellbeing Hubs Representative).

Also in attendance: Ruth Harrell (Consultant in Public Health), Amanda Lumley (Chief Executive, Destination Plymouth), Ellie Pullen (Population Health Intelligence Apprentice), and Elliot Wearne-Gould (Principal Democratic, Governance and Scrutiny Officer).

Apologies for absence: Matt Garrett (Service Director, Community Connections), Michelle Thomas (Livewell Southwest), and Tracey Lee (Chief Executive; LCP Representative).

The meeting started at 10.00 am and finished at 12.23 pm.

Note: At a future meeting, the committee will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

62. **Declarations of Interest**

There were no declarations of interest made in accordance with the code of conduct.

63. **Chairs Urgent Business**

There were no items of Chair's Urgent Business.

64. **Minutes**

The Board agreed the minutes of 03 October 2025 as a correct record.

65. **Questions from the public**

There were no questions from members of the public.

66. **The Director of Public Health Annual Report: The Health and Wellbeing of Women in Plymouth**

Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care) introduced the Director of Public Health Annual Report: The Health and Wellbeing of Women in Plymouth and discussed:

a) That Directors of Public Health had a statutory duty to produce an annual independent report on the health of the communities they served, and that this year's report focused specifically on the health and wellbeing of women and girls in Plymouth;

b) That the report set out clear evidence that, whilst women in Plymouth generally lived longer than men, they spent a significantly greater proportion of those years in poor health, with healthy life expectancy locally being markedly below the England average;

c) That behind the statistics were the lived experiences of real women in the city, many of whom had contributed their voices and insights to the report, and that the report therefore represented both quantitative data and qualitative community insight;

d) That the report highlighted the multiple roles women played in society, often leading them to place their own needs last, and that this had profound implications for their physical and mental health;

e) That the report emphasised the wider determinants of health, including income, education, housing, feelings of safety in public spaces and access to green and blue spaces, and that these factors collectively shaped the health outcomes of women and girls in Plymouth;

f) That the report had been designed to prompt action and progress, showcasing work already under way in the city and setting out a call to action for partners to improve outcomes for women and girls;

g) That the recommendations invited Board members and their organisations to note the content of the report, reflect on how they could support its findings, acknowledge the contribution of women and the organisations supporting them, and commit to considering what more could be done to improve health and wellbeing for women and girls across the city.

Professor Steve Maddern (Director of Public Health) presented the report and discussed:

h) That it was his first statutory report for Plymouth, and that the decision had been taken to focus on women and girls in response to evidence that women

in Plymouth had one of the worst healthy life expectancies compared with similar areas;

i) That, while average life expectancy for women in Plymouth was well into the 80s, healthy life expectancy was 55.7 years, almost six years lower than the England average, meaning women in the city were likely to live for approximately 26–27 years in relatively poor health;

j) That this disparity was not just a health issue but one of equity, dignity and opportunity. Women who faced barriers to basic health care often felt unheard and unsupported, and this undermined their ability to thrive;

k) That the report described how the wider determinants of health, such as income, education, housing, safety, and access to green and blue spaces, shaped women's health, and that these determinants were critical to understanding and addressing inequalities;

l) That the report highlighted positive work already taking place in Plymouth, including the Thrive Plymouth programme with its holistic and trauma-informed framework of 'Healthy Body, Healthy Mind, Healthy Places and Healthy Communities', which sought to ensure lived experience shaped service design and delivery;

m) That examples of targeted initiatives included cancer champions working in communities to improve screening uptake and tackle inequalities, investment by NHS Devon in a dedicated menopause pathway and GP training, and the work of organisations such as Improving Lives Plymouth, Trevi and Gifted Women in providing safe spaces and support for women facing multiple disadvantage;

n) That trauma-informed practice was increasingly being embedded across citywide services, alongside strengthened partnerships to address violence against women and girls, recognised as a national emergency with significant local impact;

o) That, despite progress, major challenges remained, including that around one in five women in Plymouth would be considered disabled under the Equality Act, that approximately 36,000 women were estimated to experience at least one incident of harassment each year, and that HPV vaccination rates among girls were below the national average at around 66%, with concerns about the long-term impact on cancer outcomes;

p) That economic inequality was a key concern, with around 80% of women employed in Plymouth earning below the national median salary, and that access to good education and employment was known to be vital to health and wellbeing;

q) That the report called for a focus on improving access to health care (from contraception through to menopause care and cancer screening), ensuring safer public spaces and tackling online harms, addressing economic inequality,

and supporting women into education and employment in settings that actively supported their wellbeing;

r) That the voices in the report, including women describing difficulties in accessing GP appointments, fear of walking alone at night and the exhaustion of navigating complex systems, underlined that improving outcomes would require concerted and collective action across organisations, not just from public health;

s) That the report should therefore be seen as a citywide call to action to build a Plymouth in which every woman and girl could live not only longer but healthier, safer, more independent and more fulfilling lives.

In response to questions, the Panel discussed:

t) The role of community builders in capturing women's voices, and concern that the report appeared to reference a community builder post for men but not explicitly for women and girls. It was clarified that community builders had been used to bring women's voices into the report and that this would be confirmed;

u) The significantly below-average uptake of HPV vaccination among girls in Plymouth, and concern that young women in the city were missing out on life-long protection against cervical cancer. Members questioned what specific best practice, interventions or campaigns could be pursued to increase uptake;

v) The importance of ensuring HPV vaccination was accessible through the school-based vaccination programme and via primary care recall for girls who had missed their initial opportunity. It was noted that HPV would be a core priority within the wider "Protect Plymouth" vaccination campaign, which aimed to address vaccinations across the life course, and that further communications work would be undertaken to understand why girls were not being vaccinated;

w) Opportunities for collaboration with the University of Plymouth and further education providers, including the potential for vaccination clinics linked to the university's Faculty of Health to communicate with young women, including those not engaged in higher education but in further education. It was confirmed that the Protect Plymouth campaign had historically focused "get ready for university" messaging on meningitis, and that there was an opportunity to broaden this to maximise exposure to HPV vaccination messaging for young women;

x) The need to communicate that HPV vaccination could still be accessed after leaving school and that protection could still be gained, even if the vaccination had not been taken up when first offered;

y) The value of identifying areas of the country with significantly higher-than-average HPV uptake, learning from their best practice and considering how those approaches could be adapted for Plymouth;

z) The high levels of harassment reported in the city and a request for further breakdown of the harassment figures (for example, domestic, external or workplace). It was noted that the figures had been drawn from a Plymouth survey, which captured women who had experienced at least one incident of harassment, and that harassment was often subjective, but further detail would be sought where available and shared with the Board;

aa) The position of women veterans in Plymouth and the reference in the report to a women's veterans "listening circle". It was noted that this aspect of the report had attracted significant interest, reflecting that people often did not automatically think of women when they considered veterans, and that more work was required with military partners to understand and support women veterans' needs;

bb) The potential for the city's major employers to act as a lever for communications, hosting programmes or interventions and amplifying key messages about women's health, vaccines and support services. It was noted that reducing inequalities for women and girls would be of particular interest to the 'anchor' collaboration;

cc) How the findings and themes of the report should be connected into wider strategic work, including developing NHS neighbourhoods and commissioning of services, to ensure that the report's insights informed priority setting and service design rather than sitting in isolation;

dd) The importance of celebrating the value and contribution of women in the city, to avoid the report being framed purely as a deficit narrative. Members emphasised that recognising women's strengths and contributions was essential to shaping positive, asset-based responses;

ee) The need to link the report into forthcoming discussions about Health and Wellbeing Board strategic priorities and the governance arrangements for neighbourhood teams, with an emphasis on using the Board's position to drive and oversee progress on women's health;

ff) Whether the annual report's focus on women meant that there would be reduced visibility of overall population health trends and men's health. It was explained that the broader state of health in Plymouth continued to be monitored through the Joint Strategic Needs Assessment, and that a separate, light-touch piece of work was being planned to respond to the Government's men's health strategy and consider men's health in Plymouth, with an intention to bring this back to a future Health and Wellbeing Board;

gg) The balance between targeting multiple issues and focusing on a smaller number of areas for maximum health gain. It was noted that, at whole-population level, cardiovascular disease remained the primary driver of

mortality and morbidity in Plymouth, and that considering this within future Board priorities could allow the city to align multiple interventions (for example, smoking cessation and lifestyle changes) towards a common goal;

hh) Issues of safety and violence against women and girls, including the experience of women feeling inherently more at risk in public spaces simply by virtue of being female, and the impact this had on decisions such as whether to exercise outside or wear headphones;

ii) A recent local 'Lift the Curfew' event, linked to the 'This Girl Can' campaign and organised by women's running groups, which had highlighted concerns about harassment, catcalling and women's experiences of running and exercising in public, and the intersection between physical activity, health and feeling safe in the city;

jj) The wider question of how well understood it was, particularly by men, that women and girls often perceived a baseline level of risk when moving through public spaces, and that this implicit sense of unsafety was not acceptable. Members noted that while safe, protected spaces for women were important, the longer-term goal must be that all spaces were safe;

kk) The role of schools in shaping safer experiences for girls and young women, and the value of engaging with headteachers and senior leaders, including at primary level, to raise awareness of the report's findings and discuss how schools could contribute to improving safety, confidence and health outcomes for girls;

ll) The existence of current programmes in schools addressing safety, relationships and behaviour, and the need to raise the profile of women and girls' safety issues further, including through presentations of the report at headteacher and senior leader conferences;

mm) The links between domestic abuse, women's safety and public health, and the need to treat domestic abuse as a public health issue as well as a criminal justice matter. Members discussed the recent award of the city's domestic abuse service tender to a new partnership and the importance of ensuring that the partnership engaged effectively with the wider health system;

nn) The need to strengthen the ability of health and voluntary sector services to respond to disclosures of domestic abuse, including building staff competence and confidence to identify and support victims much earlier, rather than after multiple incidents;

oo) The value of aligning domestic abuse work with community-based approaches, including the wellbeing hubs and community connections work, and ensuring that training and support were available across the system;

pp) The opportunity to share the report with Plymouth's Youth Parliament and to develop a more accessible summary version for young people, so that

young people were aware of issues such as HPV vaccination and could make informed choices as they became able to decide for themselves.

Action: The Director of Public Health would clarify the position on community builder arrangements for women and girls;

Action: The University of Plymouth would explore, through the Faculty of Health and the wider anchor collaboration, how the university and further education partners could support HPV vaccination uptake and broader women's health messaging, including options for hosting clinics and joint communications;

Action: The Director of Public Health would seek further breakdown and context for harassment statistics used in the report and share clarifications with Board members (for example, domestic, external or workplace);

Action: The Director of Public Health, working with the Director of Children's Services, would consider presenting the annual report and its key messages to a headteacher and senior leader conference, and explore how schools could further support the safety, health and wellbeing of girls and young women, including reinforcing HPV vaccination messaging;

Action: The Director of Public Health would work with Youth Parliament representatives to develop and share an accessible version of the report, with particular emphasis on HPV vaccination and other preventative measures relevant to young women and girls;

Action: The Director of Public Health would bring an update on Men's Health to a future meeting of the Health and Wellbeing Board, in order to provide visibility of overall population health trends and ensure that the Board maintained oversight of emerging priorities affecting men's health alongside the thematic focus on women and girls.

The Panel agreed:

1. To note the content of the Director of Public Health Annual Report: The Health and Wellbeing of Women in Plymouth;

2. To acknowledge the contribution from women in the city and the organisations that supported them, whose experiences and insights had shaped the report;

3. To commit to considering what more could be done, individually and collectively, to improve the health and wellbeing of women and girls across the city;

4. To recommend that the Director of Public Health collaborates with city partners to ensure HPV vaccine uptake amongst young women in Plymouth increases towards and beyond the national average, and brings an update report to a future meeting of the Health and Wellbeing Board for consideration.

67. **Public Health Intelligence: IMD2025**

Ruth Harrell (Consultant in Public Health) introduced the Index of Multiple Deprivation (IMD) 2025 Update and discussed:

a) That the Index of Multiple Deprivation (IMD) was a core dataset used across the health and wellbeing system, noting that multiple health indicators across Plymouth mapped closely onto deprivation patterns, such as childhood obesity and long-term health conditions;

b) That IMD was periodically reviewed and updated, and although the city's relative position usually remained stable, the 2025 release contained methodological changes which had prompted additional analytical work;

c) That the IMD was composed of seven weighted domains: Income, Employment, Education, Health, Crime, Barriers to Housing and Services, and Living Environment. These domains had changed significantly since 2019, meaning the datasets were not directly comparable;

d) That several indicators had been updated, including the inclusion of persistent school absence post-pandemic, changes to indoor environment metrics (where EPC ratings now constituted 70% of the domain), and removal of central heating access as an indicator due to near-universal coverage;

e) That these changes materially affected Plymouth's apparent level of deprivation, requiring cautious interpretation of the results.

Ellie Pullin (Population Health Intelligence Apprentice) presented the analytical findings and discussed:

f) That Plymouth had moved from 64th most deprived (of 317 authorities) in 2019 to 87th (of 296 authorities) in 2025, appearing to show a significant improvement in ranking;

g) That Plymouth's most deprived Lower Super Output Area (LSOA) remained in St Peter and the Waterfront, which had stayed in the 1% most deprived nationally for over ten years, with a population of 1,843 residents;

h) That Plymouth's least deprived LSOA remained in Plymstock Dunstone and had done so consistently for the past decade;

i) That 11.7% of Plymouth's LSOAs were within the most deprived 10% nationally, representing approximately 32,000 residents, a reduction from 17.4% in 2019;

j) That six LSOAs sat within the most deprived 5%, and 42 LSOAs were within the most deprived 20%, which were areas that could easily shift into more severe deprivation or might improve over time;

k) That Plymouth had made one of the most substantial relative improvements among the Key Cities group, and similar gains were observed when benchmarked against the SIGMA Group of comparable urban authorities;

l) That improvements in the Living Environment domain were strongly influenced by methodological changes, especially the reduced weighting given to access to private outdoor space.

Ruth Harrell (Consultant in Public Health) added:

m) That despite Plymouth's improved ranking, poverty had not reduced, and in some cases had worsened, particularly affecting children;

n) That updated data on absolute and relative child poverty showed increases in both measures over recent years, with Plymouth's rates consistently above the England average;

o) That the Board should remain cautious. While the IMD ranking improved, the lived reality for families did not align with this shift, and it was important not to misinterpret the data as an indication of substantive socioeconomic improvement;

p) That multiple datasets, including ward-level poverty, continued to map onto historical patterns of deprivation, including high deprivation in St Peter and the Waterfront, Ham, Devonport, Honicknowle and St Budeaux.

In response to questions, the Board discussed:

q) That methodological changes in the IMD had contributed to improved rankings, including the national rollout of Universal Credit affecting the Income domain;

r) Concern over the external messaging. If IMD figures were misinterpreted, Plymouth risked appearing less in need of funding and support, despite increasing child poverty and worsening financial hardship;

s) Members sought clarity over what messaging should be shared locally and nationally, noting the potential impact on resource allocation;

t) Members wished to emphasise that any "improvement" was statistical rather than experiential, and should not reduce focus on tackling inequalities;

u) That there was a need to identify genuine areas where improvements had occurred over the last six years, alongside areas where circumstances had worsened;

v) That comparative analysis with Exeter demonstrated clear differences in deprivation trajectories between the two cities;

w) That the 'State of the City' report was currently being prepared and would take a broader look across living conditions, health, and wellbeing, with a draft expected mid-February for future HWB consideration;

x) That wellbeing hubs were working to enhance their data reporting however, data systems varied widely across hubs and agencies, making unified analysis challenging;

y) That councillors required improved access to ward-level deprivation data and maps to support local leadership, and that updated mapping on the council website would support ward-level interpretation;

z) That the potential removal of the two-child limit would positively impact child poverty rates in Plymouth, given the high number of affected families;

aa) Members raised the importance of connecting with relevant academic expertise to explore whether IMD changes aligned with health outcomes or undermined accurate representation of deprivation;

bb) Members noted significant concerns arising from BMI data for children aged 4–11, particularly the high proportion of reception-aged children entering school at unhealthy weight levels, and the importance of continued work with schools to address this;

cc) That despite the concerns, Plymouth performed marginally better than England in flow from healthy to unhealthy weight, though overall levels remained concerning.

Action: The Public Health Intelligence Team would explore mechanisms for improved dissemination of updated ward-level IMD and poverty data to councillors, including through refreshed online mapping tools;

Action: The Public Health Intelligence Team would incorporate IMD 2025 analysis into the forthcoming State of the City report and bring this to a future meeting of the Health and Wellbeing Board.

The Board agreed:

1. To note the IMD 2025 report and, in particular, that the apparent improvement in deprivation ranking reflected methodological changes rather than a reduction in underlying poverty in Plymouth.

68. **City Brand Strategy**

Amanda Lumley (Chief Executive, Destination Plymouth) presented the City Brand Strategy and discussed:

a) That the Brand Strategy work had begun approximately two years earlier following recognition by the Destination Plymouth Board, including representatives from key city organisations, that Plymouth was entering a

major growth trajectory over the next decade and required a clearer, stronger, more competitive city positioning;

b) That the work had been driven by the need to attract people to live, work, study and invest in Plymouth, and to change long-standing external perceptions of the city, noting that many people outside the region knew little about Plymouth or viewed it only as a naval base, a distant location, or a place with limited cultural offer;

c) That early aims of the project included: shifting external perceptions, raising aspirations and civic pride among residents, particularly inspiring young people, increasing awareness of Plymouth's strengths, and creating a narrative rooted in authentic community identity and lived experience;

d) That extensive national perception research had been carried out, including general perception surveys, talent-attraction analysis, sector-specific research (including health, nuclear and defence), and growth-sector insights in collaboration with city partners such as the NHS and University of Plymouth;

e) That the research identified Plymouth's most compelling strengths, including:

   i. The ocean and waterfront as unique and internationally significant assets;

   ii. The UK's first National Marine Park;

   iii. The city's high quality of life when compared to regional competitor cities such as Southampton, Portsmouth, Bristol and Norwich;

   iv. Strong happiness and activity indicators;

   v. A growing cultural offer;

   vi. A friendly, welcoming community;

   vii. Increasing opportunities linked to innovation, marine autonomy, defence, creative industries and health technologies;

f) That talent attraction research revealed people looked for career ecosystems rather than single-job opportunities, meaning Plymouth needed to communicate the breadth of opportunities, progression pathways and family-friendly attributes of the city;

g) That the city's cultural profile remained low nationally despite significant local activity, and that the recent success of Plymouth Culture and the City of Culture announcement created a major opportunity for repositioning the city;

h) That the city possessed over 25,000 anticipated new job opportunities in the coming decade, a substantial investment pipeline now estimated between £8–

9 billion, and a long heritage of innovation stretching back more than 500 years, including modern scientific leadership in areas such as marine microplastics research;

i) That the new overarching narrative, "Make Life an Adventure," reflected the city's unique geography between Dartmoor National Park and the National Marine Park, its emphasis on nature, its environmental credentials and its strengths in community connectedness;

j) That the community-derived city values were:

   i. Go boldly (innovation, doing things first);

   ii. Go together (collaboration and support);

   iii. Go far (global impact and ambition);

k) That the new Brand Toolkit and Media Hub were fully accessible online to all partners, containing narrative statements, facts, case studies, imagery, video content and assets to support recruitment, investment, education engagement and communications across the city;

l) That partners had already begun using the materials, most notably Plymouth Culture for the City of Culture announcement, as well as city centre hoardings, electric bus branding and other public-facing assets;

m) Organisations were encouraged to consistently use the narrative, share the brand across networks and communities, and to "invest in promoting the city," using the brand to support recruitment, outreach and civic pride.

(A video was played at this time - Plymouth, Britain's Ocean City Brand Film)

In response to questions, the Board discussed:

n) That the Strategy had been well-received, with Members commenting that the work was uplifting and long overdue given historic negative perceptions from neighbouring areas in Devon and Cornwall;

o) Members emphasised the importance of the Council and all partners amplifying the Strategy across the UK and internationally, noting the need for a coordinated approach to reach audiences unfamiliar with Plymouth;

p) Opportunities linked to defence recruitment, national defence campaigns, and global talent attraction were highlighted, including discussions around a potential "talent attraction accelerator" and funding avenues such as the Towns Fund;

q) That neighbouring areas, particularly parts of Cornwall and South Hams, often held entrenched negative perceptions of Plymouth despite frequently

using Plymouth's cultural facilities, theatre and retail, signalling the importance of strong regional advocacy;

r) Members reiterated this was a "whole-city" initiative involving partners across all sectors, funded collaboratively and delivered through a highly inclusive process;

s) Members offered personal reflections on how the brand narrative and film captured Plymouth's strengths, noting that even long-term residents often forgot the exceptional environment around them until it was shown through a fresh lens;

t) Members raised that pride in place contributed positively to wellbeing, and that a strong sense of local identity supported the wider health and wellbeing agenda;

u) Newer members of the city workforce, including senior NHS staff recently relocated, described entering the city with limited or outdated perceptions, and commented that the Strategy had the potential to significantly support recruitment and staff retention across the health system;

v) Practical concerns were raised regarding city access during redevelopment, the impact of roadworks on visitor experience, and the importance of minimising disruption during major events. Members also noted that city centre footfall was up by around 6% compared to a national average of 1.8%, and broader data from the city's Data Hub also showed year-on-year increases across the wider central area;

w) That while the visitor economy overall had experienced national declines, Plymouth had performed better than Devon and Cornwall, which reported steeper drops in day-visitor numbers. Collaboration with neighbouring authorities remained essential;

x) Concerns about Christmas trading and temporary disruption were valid, but most city centre works were due to be completed by Christmas 2026, after which benefits to footfall and public space were expected to increase;

y) Members wished to consider showing the brand film at the next Full Council meeting so that all councillors could view and understand the Strategy and its potential benefits.

The Board <u>agreed</u>:

1. To align with the City Brand Strategy and new narratives to position Plymouth as a place to live, work, study and visit;

2. To align with the key components of the branding work, including narratives and visuals, and to mainstream these where appropriate into key delivery programmes requiring citywide messaging;

3. To recognise Destination Plymouth as the citywide marketing organisation with strategic responsibility for leading the brand strategy and implementation, positioning the city's place-brand and continuing to lead the Visitor Plan;

4. To recognise the support of key city partners in funding and driving this work forward.

69. **Neighbourhood Health Plans**

Ed Garvey (Senior Locality Commissioning Manager, NHS Devon ICB) presented a verbal update on the development of the Neighbourhood Health Plan and discussed:

a) That NHS England had published its Operational Planning Guidance late in the previous year, requiring Integrated Care Boards and NHS Trusts to produce and submit a Neighbourhood Health Plan as part of the national planning cycle;

b) That the Neighbourhood Health Plan would need to set out how the NHS, local authority, social care providers and the voluntary and community sector would work together to design and deliver neighbourhood-level health services;

c) That national guidance from the Department of Health and Social Care had not yet been published, and therefore the specific requirements for plan development were still unknown however, guidance was expected imminently;

d) That the purpose of the update was to ensure the Health and Wellbeing Board (HWB) was aware of the upcoming requirement, and that support and approval would be sought once guidance was available;

e) That Plymouth had recently been successful in securing enhanced support from the national Better Care Fund (BCF) Improvement Support Programme, following a bid submitted shortly before Christmas, and that this support would assist in preparing the Neighbourhood Health Plan;

f) That contact from the BCF national team was expected shortly, with a call already scheduled at 1pm on the day of the meeting to confirm next steps, timeframes and expectations;

g) That the ICB and Plymouth City Council intended to develop the plan jointly, and would ensure the Health and Wellbeing Board was fully engaged in its development and sign-off process as required;

h) That previous work across health, social care and the voluntary and community sector, particularly around integrated neighbourhood teams, would sit beneath and feed into the emerging plan, and that national priorities placed significant focus on neighbourhood-based preventative and community care models;

i) That a Local Care Partnership (LCP) meeting had taken place in December where partners had committed to continuing collaborative work. An action agreed at the meeting was to map all relevant workstreams and develop a joined-up strategy and governance framework to drive neighbourhood work forward;

j) That although Plymouth had not been selected for the national Neighbourhood Health Implementation Programme earlier in the year, the bidding process had generated substantial enthusiasm and cross-sector engagement, with a series of workshops continuing to explore co-production and neighbourhood service redesign.

In response to questions, the Board discussed:

k) That Local Government Reorganisation (LGR) would have implications for neighbourhood arrangements and should be considered early in the planning process, even while details remained uncertain;

l) That the HWB may need to convene an extraordinary meeting if required to meet tight national timescales associated with the plan and BCF governance, noting that timely HWB approval was likely to be necessary;

m) That Healthwatch had not yet received significant public interest or awareness around neighbourhood health work. Members noted the importance of public communication and ensuring people understood proposed changes, especially regarding integrated teams and local wellbeing services;

n) That concerns existed regarding potential duplication or postcode inconsistencies unless community involvement, co-production and transparency were built into the planning process from the outset;

o) That Plymouth already had strong community-based models and good practice, and that this should be evidenced clearly in the plan, with the neighbourhood model seen as an opportunity to reinforce existing strengths;

p) That national guidance was needed to shape priorities and provide a framework, but in the meantime local partners should continue preparing foundations through the Local Care Partnership and other integrated governance structures;

q) That children's social care national reforms also emphasised local, multi-disciplinary, co-located models, and that alignment between adults' and children's neighbourhood work would be important to avoid fragmentation;

r) That transitions between children's and adults' services, particularly regarding neurodiversity and mental health, should be considered within the neighbourhood model to improve continuity for young people;

s) Voluntary and community sector partners emphasised the importance of bottom-up, person-centred, trauma-informed service redesign. Members cautioned against top-down rollout that risked embedding system-designed rather than people-designed pathways;

t) That significant cultural change across all organisations would be required to deliver neighbourhood-based care successfully, including challenging long-standing professional silos, organisational protectionism and system-driven metrics that did not reflect people's lived experiences;

u) That the Changing Futures programme had demonstrated strong methodologies for deep community engagement and co-production which could be used to shape the neighbourhood approach;

v) That neighbourhood models may need to develop at different speeds across the city, reflecting the varying needs, strengths and characteristics of individual communities.

The Board agreed:

1. To note the verbal update on the Neighbourhood Health Plan;

2. To note Plymouth H&WB's successful bid for enhanced national BCF support;

3. To review national guidance once published and to consider the development timeline for the Plan at a future meeting.

70. **Revised Terms of Reference**

Elliot Wearne-Gould (Principal Democratic, Governance and Scrutiny Officer) presented the Revised Terms of Reference and discussed:

a) That in Spring 2025 the Board had participated in Development Workshops to review whether the existing Terms of Reference and membership remained fit for purpose;

b) That a subsequent report had been submitted to the Board in April 2025, where Members agreed to explore widening membership to improve representation, particularly by clarifying the distinction between core and co-opted members and how this related to quorum and voting rights;

c) That the revised Terms of Reference included updated partner organisation names, refreshed membership lists, revised role profiles and the incorporation of Neighbourhood Health guidance to reflect emerging national requirements;

d) That a significant proposed change was an amendment to the quorum rules, removing co-opted members from the quorum count to ensure meetings

remained functional as the Board expanded its co-opted membership, noting that co-opted members were not mandated to attend all meetings;

e) That, subject to HWB approval, the revised Terms of Reference would be submitted to City Council for adoption.

Ruth Harrell (Consultant in Public Health) added:

f) That the Plymouth Plan, which also served as the city's statutory Health and Wellbeing Strategy, was in the process of being refreshed and updated;

g) That Public Health requested a workshop be scheduled in late February for HWB Members to review the health and wellbeing elements of the Plymouth Plan and consider any amendments;

h) That the workshop would also include a draft of the new State of the City (health and wellbeing) report to support the Board in identifying priorities for the forthcoming year.

In response to questions, the Board discussed:

i) Members supported setting up a workshop to review the strategy and identify priorities;

j) That further amendments would be made to the Board membership once additional partner organisations had been contacted and confirmed acceptance to Join the Board;

k) That the term "statutory members" had been clarified to remove previous ambiguity around additional/co-opted membership. Statutory members were those required by legislation, while co-opted members were appointed at the Board's discretion.

The Board agreed:

1. To review, comment, and endorse the draft updated Terms of Reference;

2. To submit the revised Terms of Reference to City Council for approval, subject to clarification of additional co-opted partners.

71. **Tracking Decisions Log**

The Board agreed to note the progress of the Tracking Decisions Log.

72. **Work Programme**

Elliot Wearne-Gould provided an update on the Work Programme and discussed:

a) That the agenda for 12 March 2026 was currently clear;

b) That the February workshop would generate draft Board priorities for 2026/27 which would then inform agenda planning for the March meeting and beyond;

c) Substantive items would be scheduled once the Board had agreed its revised focus areas flowing from the Plymouth Plan refresh.

The Board agreed to note the Work Programme.

Health and Wellbeing Board

Date of meeting:	12 March 2026
Title of Report:	**Health and Wellbeing Board Priorities 2026/7**
Lead Member:	Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Professor Steve Maddern (Director of Public Health)
Author:	Teresa Cullip
Contact Email:	Teresa.cullip@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
The purpose of the report is to seek agreement to a list of priorities for the Health and Wellbeing Board for 2026/7, following a recent workshop to discuss potential priorities.

Recommendations and Reasons
We recommend six priorities for the Health and Wellbeing for the 2026/7 period;

1. Oral health, including dental health
2. Cardiovascular disease prevention
3. Plymouth as a Marmot City
4. Integrated Neighbourhood Teams
5. Falls and Frailty prevention
6. Culture for Health

We seek the Boards approval of these priorities, and collective engagement and support in pursuing these priorities across Board members.

Alternative options considered and rejected
The Board discussed the above priorities at a recent workshop and reached collective agreement. During that session, two additional priorities were identified, namely falls and frailty prevention and culture for health.

Relevance to the Corporate Plan and/or the Plymouth Plan
The HWWB priorities directly support the Council's corporate priority to work with the NHS to improve access to healthcare and dentistry. It also aligns with key elements of the Plymouth Plan 'A Healthy City', specifically:

- **HEA1:** Reducing health inequalities
- **HEA2:** Improving outcomes for children and families

- **HEA3:** Supporting adults with health and social care needs
- **HEA5:** Delivering strong and safe communities and good quality neighbourhoods
- **HEA9:** Delivering accessible health services and clinical excellence
- **INT8:** Celebrating diverse communities

Implications for the Medium Term Financial Plan and Resource Implications:
There are no medium-term financial plan and resource implications.

Financial Risks

There are no financial risks.

Legal Implications

There are no legal implications.

Carbon Footprint (Environmental) Implications:
There are no carbon footprint or environmental implications. For information only.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
There are no other implications. For information only.

Appendices
**Add rows as required to box below*

Ref.	Title of Appendix	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7
A	HWBB Priorities Briefing Paper	X						

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Asset s	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Professor Steve Maddern											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 25/02/2026											
Cabinet Member approval: Cllr Mary Aspinall, approved by email Date approved: 02/03/2026											

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HEALTH AND WELLBEING BOARD

2026/7 priority setting

INTRODUCTION

Following a recent Health and Wellbeing Board workshop, several potential priorities were discussed by Board members for 2026/7. Board priorities are intended to guide the work of the Board and provide a focus for health activities across Plymouth in coming years. Whilst these priorities align with the current Plymouth Plan, the Board will also contribute to longer term priority setting as part of the refresh of the Plymouth Plan during 2026.

The priorities discussed by the Board, and proposed for 2026/7 are:

1. Oral health, including dental health
2. Cardiovascular disease prevention
3. Plymouth as a Marmot City
4. Integrated Neighbourhood Teams
5. Falls and Frailty prevention
6. Culture for Health

This paper provides a summary justification for each of these topics as a priority for Plymouth and provides an outline of opportunities for work in this area. A more detailed action plan will be brought for the Board to consider once priorities are formally agreed.

1. ORAL HEALTH

SUMMARY OF ORAL HEALTH CHALLENGES IN PLYMOUTH

- Good oral health is important as it allows us to eat, talk and express emotions. Having poor oral health can significantly impact on self-esteem, as well as physical and mental health.
- Almost 1 in 4 five-year-olds experience dentinal decay in Plymouth
- Over 700 of children are awaiting tooth extraction under general anaesthetic, many of whom have no dental home
- Poor oral health outcomes are notably worse in Plymouth's more deprived communities.
- 51% of children in Plymouth have not accessed dental services in the last 12 months, and 72% of adults have not accessed dental services in the last 24 months.
- Urgent care provision is unable to meet demand, with many calls going unanswered

- Oral Health needs of adults in care homes are not being adequately met. This issue is likely to extend to other adults receiving care.
- Risk factors associated with poor oral health (such as smoking, excess alcohol and poor diet) are high in Plymouth, and greatest in our most vulnerable communities.
- Prevention programmes, funded through high street dental underspend, are currently focused only on our younger children.

ORAL HEALTH OPPORTUNITIES

A. Prevention: Build a stable, life course prevention infrastructure

- Evaluate the impact of current prevention programmes to inform future activity
- Consider expansion of the fluoride varnish scheme for children and vulnerable adults
- Embed oral health promotion consistently across community settings

B. Vulnerable adult groups: Improve oral health outcomes for vulnerable adults

- Develop a programme of work to support adults with their oral health needs, notably adults receiving care and people experiencing multiple disadvantage
- Evaluate the wider impact of poor oral health in vulnerable adult groups
- Strengthening system leadership by engaging with stakeholders

C. Developing the oral health workforce: Grow capacity across professions.

- Continue to support and encourage increased dental training provision locally
- Expand oral health champion training for non-dental professionals to expand the workforce

D. Access to dentistry for children: Reduce the number of children without a dental home

- Collate and analyse data on children who do not have a dentist
- Implement a Dental Therapist-led pilot focused on improving access and routine care for children

The Dental Task Force, a multiagency task force, will lead this work. The task force meets quarterly and will report to the Health and Wellbeing Board on an annual basis.

2. CARDIOVASCULAR DISEASE PREVENTION

SUMMARY OF CARDIOVASCULAR DISEASE CHALLENGES IN PLYMOUTH

Cardiovascular Disease (CVD) is the second leading cause of death in Plymouth, accounting for 24% of all local deaths. This includes significant premature or preventable mortality, especially among men

and residents in our most deprived neighbourhoods. Clinical, environmental and behavioural risk factors, such as smoking, obesity, hypertension, and high cholesterol are high in many communities and frequently cluster in Plymouth's most deprived neighbourhoods. There is a clear need for targeted, place-based early prevention and robust secondary prevention, such as cardiac rehabilitation, to break the cycle of recurring events.

By shifting our system toward prevention and optimising clinical support, there are substantial opportunities to improve outcomes for Plymouth residents. High-level modelling indicates that optimising detection and improving treatment pathways has the potential to avert at least 150 major CVD events per year. The potential financial savings are significant, conservatively estimated at saving at least £750,000 in acute NHS treatment costs alone, alongside significant reductions in long-term social care needs. This is in addition to the individual benefit, preventing long-term ill health and supporting people to maintain healthy lives.

CVD PREVENTION OPPORTUNITIES

A. Improve Equity: increase case finding

- Identify high-risk, low-uptake groups and identify ways to support individuals in their communities, for example establishing Community Appointment Days
- Review the impact of NHS Health Checks on prevention in Plymouth, and work across partners to deliver a model that works for our communities
- Ensure that support for all risk factors, such as smoking cessation and healthy lifestyles, is available to all communities, especially those at greatest risk

B. Improve clinical prevention: Continue to scale 'treat to target'

- Work with primary and secondary care to optimise treatment for CVD clinical risk factors (Atrial Fibrillation, Hypertension, Lipid Control), especially amongst those at highest risk
- Scale patient-led care to enable resident to manage their own cardiovascular health

C. Community led recovery: Manage CVD conditions closer to home

- Embed CVD prevention into Integrated Neighbourhood Teams and extend secondary prevention to meet current needs
- Extend secondary prevention, including Cardiac Rehabilitation, into community settings to meet current needs, using local settings and community assets alongside digital models

D. Work in partnership on CVD and all Long-Term Health Conditions

- Establish a unified approach to CVD prevention across all stakeholders, including clinical providers, NHS Devon, public health and VCSE partners
- Align resources, work collaboratively and drive accountability across our system

We propose to work on this topic within existing frameworks of the Local Care Partnership and Integrated Neighbourhood Teams but maintain the flexibility to adapt to the needs of Plymouth partners and residents.

3. PLYMOUTH AS A MARMOT CITY

SUMMARY OF CURRENT CHALLENGES IN PLYMOUTH

Plymouth continues to experience stark health inequalities. Life expectancy differs significantly across neighbourhoods, with residents in our most deprived neighbourhoods living markedly shorter lives than those in less deprived areas. Healthy life expectancy is particularly concerning for men in Plymouth who live just 57 years of good health, and women 55.7 years, meaning that many Plymouth residents live 20–30 years in poor health.

MARMOT CITY OPPORTUNITIES

The Marmot Principles offer an approach to improve health equity for all our residents. The principles are:

1. Give every child the best start in life.
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination and their outcomes.
8. Pursue environmental sustainability and health equity together.

Becoming a Marmot Place offers Plymouth a strategic, system-wide mechanism to accelerate progress on health equity. Key opportunities include:

A. Embedding health equity in all policies and programmes

By formally adopting the Marmot Principles, Plymouth commits to ensuring that health equity is intentionally considered in policy, programme design, and service delivery. This also aligns strongly with existing work, particularly the *Building Bridges to Opportunity* framework on reducing poverty and enhances coherence across all council activity.

B. Strengthening system-wide collaboration

Thrive Plymouth's existing network of over 300 organisations provides a strong foundation for collaborative working. Marmot Place status offers a way to grow this momentum, aligning wider city systems—public, private, and voluntary sectors—through shared principles and consistent approaches. The Plymouth Charter and Civic Agreement frameworks offer further opportunities to embed health equity across multiple sectors.

C. Expanding community-led and asset-based approaches

A key commitment of becoming a Marmot Place is ensuring that work is *led by communities*. This means empowering residents, recognising and strengthening community assets, and ensuring co-design rather than top-down delivery. The Thriving Communities Framework provides a route for structured engagement with our communities and Marmot status would enhance and formalise this approach.

D. Joining a national network and sharing best practice

Over 60 local authorities have already become Marmot Places. Joining this movement would allow Plymouth to benefit from shared learning, comparative data, and access to expertise from the Institute of Health Equity. Although the South-West is already a Marmot Region, Plymouth becoming a Marmot Place would elevate our leadership role and demonstrate the city's commitment to long-term, system-wide change.

4. INTEGRATED NEIGHBOURHOOD TEAMS

The NHS 10-year plan articulates three shifts:

- from hospital to community with more care to be available on people's doorsteps and in their homes
- from analogue to digital: new technology to liberate staff from admin and allow people to manage their care as easily as they bank or shop online
- from sickness to prevention: to reach patients earlier and make the healthy choice the easy choice

The NHS system sees Integrated Neighbourhood Teams (INTs) as a way to embed and deliver the shift from hospital to community as well as contribution to other shifts. Whilst Neighbourhood Teams guidance is still pending, this delivery approach is key to future NHS organisation and delivery.

NHSE policy (Jan 2025), the most recent guidance on INT working, asked systems to focus on specific areas in preparation for a move to Neighbourhood Health, namely population health management, modern General Practice, standardising community health services, neighbourhood multidisciplinary

teams for adults and children, integrated intermediate care with a 'Home first' approach, and urgent neighbourhood services.

Whilst INT development is still a work in progress in the Plymouth system, there is significant engagement ongoing, with a maturity matrix being delivered to structure work towards INT development. There is a clearly articulated role for the Health and Wellbeing Boards in the oversight and governance frameworks for INTs, and in setting local priorities for neighbourhood working through the Neighbourhood Health Plan. Any priorities for the Health and Wellbeing Board should align directly with those of INTs.

5. FALLS AND FRAILTY PREVENTION

SUMMARY OF FALLS AND FRAILTY CHALLENGES IN PLYMOUTH

- Falls are the number one reason older people attend emergency care, with 5% of falls resulting in fractures and around 1 in 3 adults over 65 falling yearly, rising to 1 in 2 adults over 80.
- Of 29,069 emergency hospital admissions of Plymouth residents in 2022/23, 54% were in adults over 50 years, with falls and fractures the largest cause for admission in older people. Outcomes are worse for those living in more deprived communities
- Frailty is rising with our ageing population, leading to loss of independence, higher hospital use, and increased need for supportive care
- Risk factors such as social isolation, poor strength and balance, and unsafe homes cluster in our most vulnerable groups.
- A shift to prevention could avert admissions, save acute costs and extend healthy years.

OPPORTUNITIES FOR FALLS AND FRAILTY PREVENTION

Key opportunities to support ageing well across Plymouth include:

A. **Strength and balance offer**

- Deliver a citywide offer of evidence-based strength and balance programmes to improve mobility, confidence and independence.
- Focus on embedding accessible programmes in everyday community settings to promote lifelong activity and resilience.

B. **Connecting people and communities**

- Use falls and frailty prevention to build stronger community connections, so older people stay active, valued and independent for longer.
- Support social elements within prevention efforts to combat isolation and foster belonging.

C. **Safer homes and communities**

- Scale up home hazard checks and adaptations so homes and neighbourhoods are safer for older residents.
- Prioritise proactive environmental improvements alongside health checks to create supportive living spaces.

D. **System leadership**

- Establish a unified approach to align Public Health, NHS Devon, primary and secondary care and VCSE efforts.
- Drive coordinated action to ensure equitable prevention at scale.

6. CULTURE AND CREATIVE HEALTH

There is growing international recognition of the value of culture and creativity in improving health outcomes. Studies have shown that people can have health and wellbeing benefits both from engaging in arts and cultural activities as leisure, and from active enrolment in creative activities aimed at achieving specific health outcomes. Examples of artistic interventions that can improve health and wellbeing include music and singing, drama and storytelling, dance and movement, clown interventions, reading and writing, photography and film, visual arts, architecture and design, heritage sites and museums, many of which have a significant role in Plymouth life.

An EU Culture for Health[1] report found that art related cultural activities had a range of health outcomes ranging from health promotion, management and treatment of a range of health conditions, increasing social engagement and individual empowerment, building personal resilience and confidence and improving overall wellbeing.

Plymouth has a strong and growing foundation of creative health activity, developed organically over many years through community, cultural and health-led practice. Plymouth's network of 20 Wellbeing and Family Hubs provides a powerful platform for embedding creative health within community-based prevention. A partnership between Plymouth Culture and Plymouth Wellbeing Hub Network (WBHN) led to the Plymouth Creative Health Network (CHN) set up in 2025 – a network of around 20 different organisations from arts, culture and wellbeing voluntary and health organisations across the city, supported by the national Creative Health Network. National Centre for Creative Health

There is already a wide range of creative health activity taking place across the city, much of it rooted in communities and led by artists, cultural organisations, VCSE partners and informal groups. This includes projects such as Sea for Yourself (a partnership between Plymouth Culture and Plymouth National Marine Park), creative activity embedded within wellbeing hubs, arts-based mental health support, community-led cultural activity, and creative approaches to social connection,

[1] Final_C4H_FullReport_small.pdf

physical activity and environmental engagement. Plymouth's decade-long investment in its cultural sector has positioned the city as a national leader in cultural placemaking, with creativity increasingly recognised as a driver of inclusion, wellbeing and community renewal.

Plymouth's network of 20 Wellbeing and Family Hubs provides a powerful platform for embedding creative health within community-based prevention. Together, the hubs see over 25,000 people every quarter, generating more than 78,000 attendances. This consistent footfall reflects both their reach and the trust residents place in these neighbourhood spaces. The Hubs collectively manage a wide range of commissioned health and care services.

OPPORTUNITIES FOR CULTURE AND CREATIVE HEALTH:

A. Build a Creative Health community

- To establish a formal role in Creative Health to drive this agenda at community level
- Focus on creative health across agencies linking partners into opportunities to improve access to culture and creative health
- To ensure that the focus of creative health is community led and celebrates the best of Plymouth and its communities and residents

B. Improve access to cultural and creative health opportunities

- To develop an understanding of the scope of the creative health and cultural offers in Plymouth and ensure that these are publicised across the system
- To include cultural and creative health opportunities into Integrated Neighbourhood Teams as a key part of the health and wellbeing system
- To build community led access to cultural and creative health opportunities, focussed on our Wellbeing and Family Hubs across Plymouth

CONCLUSION

In summary, we propose 6 priorities for the Health and Wellbeing Board for 2026/7, spanning the breadth and challenges of health and wellbeing in Plymouth.

Health and Wellbeing Board Choose Committee.

Date of meeting:	12 March 2026
Title of Report:	**Health Determinants Research Collaboration Update Report**
Lead Member:	Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Professor Steve Maddern (Director of Public Health)
Author:	Dr Ruth Harrell/Professor Gary Wallace/Elaine Fitzsimmons
Contact Email:	Gary.wallace@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
This report updates the Health and Wellbeing Board of the progress of the Health Determinants Research Collaboration (HDRC). This is a grant funded programme funded by the National Institute of Health Research with the core objectives of:

- Developing the culture and skills to ensure a learning approach informs decision making to impact positively on the wider determinants of health.
- Produce knowledge for use locally and of value nationally, especially for similar coastal communities

Recommendations and Reasons
Members are requested to note the content of the report which is largely for information, but to be aware that the council has been offered extended funding until December 2028 (additional 15 months) to continue its work; but also be aware that in the current challenging financial climate, releasing staff to undertake research projects has meant a number of novel and creative solutions have been necessary to avoid underspending on the budget.

Alternative options considered and rejected
Alternative options are not considered in this paper.

The funding is a welcome contribution to support cultural change in the council, encourage an environment of enquiry which allows teams to explore difficult operational challenges which can sometimes run counter to the need to reduce inequalities.

Relevance to the Corporate Plan and/or the Plymouth Plan
The objectives for the HDRC in terms of areas of focus are very widespread and the HDRC have used the priorities in the Plymouth Plan, combined with the Thrive Strategy to contribute to the focus on key areas of work (these are described in the paper).

Implications for the Medium-Term Financial Plan and Resource Implications:

The HDRC is wholly funded by the NIHR as a grant which initially ran until October 2027 but now extended to December 2028 as a minimum. The council has a formal contract with the NIHR which specifies how the funding can be used. The funding cannot be used for anything other than delivering the core objectives as set out in the grant conditions.

Financial Risks

Despite being wholly grant funded and ring fenced the financial risk around this resource, is of losing the funding if it cannot be spent as required. The HDRC had some initial challenges and delays around recruiting staff (which is like all HDRC's across the country) but is now showing just a small underspend.

The greatest challenges in terms of spend is associated with releasing council staff (we offer backfill to cover the costs). Staffing is tight because of the operational position of the council and the ability to release people but more importantly replace their skills, and knowledge means that several projects take longer than expected to be implemented.

Legal Implications

The project is subject to a formal agreement between the NIHR and Plymouth City Council and then subsequent to this a partnership agreement with the University of Plymouth which is in the process of being updated now the council has a better understanding of governance associated with research.

Carbon Footprint (Environmental) Implications:
The NIHR has a carbon reduction strategy for research which the HDRC must comply with. Some of the aspects are very similar to the council approach but also includes specific issues such as ensuring data from people is only collected where it is essential to do so, and ensuring before any research takes place we have to declare that this is new research (and does not duplicate other research).

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
There are international & national principles of good practice for research that the council is bound to adhere to under the contract signed with the NIHR. These reflect issues around equality, equity, and ensuring diversity in research.

All of the projects reflect wider determinants of health so address a number of the council's responsibilities and particularly focus on issues which are relevant to our population. Projects address specific aspects such as child poverty, debt, food security and consider groups with protected characteristics and/or groups which are particularly sensitive to health inequalities, e.g. unpaid carers, asylum seekers, women and girls and associated violence.

The HDRC has been activelyworking with the Research Specialist Service of the NIHR in understanding ethics and integrity in undertaking research. The HDRC became aware that despite there being comprehensive academic processes, these didn't adequately cover the issues which the council would consider needed to be addressed to ensure that citizens, staff and the reputation of the council were protected. Information governance, safeguarding and the scenario of maintaining a longer-term relation with research participants were some key areas where the council has developed a local process for assurance.

Appendices

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*

		1	2	3	4	5	6	7
A	Briefing Report - HDRC							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Asset s	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Professor Steve Maddern											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 02/03/2026											
Cabinet Member approval: *Councillor Mary Aspinall, agreed via email* Date approved: 03/03/2026											

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ODPH
Health Determinants Research Collaborative Update Report

1. EXECUTIVE SUMMARY

Plymouth City Council, with its partner University of Plymouth, received a grant from the National Institute of Health Research (NIHR) to provide research capacity and capability into the ways in which interventions on the wider determinants of health can support reductions in health inequalities.

The total grant award is for £4,744,469 over the course of 5 years. This funding is ringfenced to that detailed within the grant bid documentation and is essentially a capacity building grant for councils to enable them to become 'research rich' environments.

Plymouth Health Determinants Research Collaborative (HDRC) has been assessed by NIHR as performing well and we have extensive relationships across the council and wider city. We have been very successful in engaging staff and departments and have dozens of short, medium and long-term projects in process. In addition, we have hosted a number of study visits from other councils, devolved governments, NHS organisations and fellow HDRCs.

Over the past year, since out last update to the Board, we have published peer reviewed papers, been co-applicants on several successful bids and presented on work in Plymouth at a number of conferences. In addition, we have continued to work with the UK Cabinet Office on Test Learn Grow, Community Help Partnerships and Social Value and with the Local Government Association on Place Based Budgets and on Adult Safeguarding (the detail of these projects can be found below).

Nationally, the funding of HDRCs by the NIHR, to support councils to be involved in research has been acknowledged as a success. The ability of funders to support wider health inequalities research by exploring many of the contextual issues (housing, debt, community cohesion, education etc) would not have been so successful without the engagement of councils and their staff. The HDRC model is perceived to be an important vehicle for advancing and widening the body of public health knowledge, especially in understanding how to truly target resources and interventions which can have the most impact on improving health and wellbeing and reducing inequality.

Thirty HDRCs are now funded for councils and recognised as infrastructure capability in the same way the NIHR supports the NHS. This recognition is important as it acknowledges that research has a cost which should be supported by research funders, rather than expecting it to be wholly funded by Councils, who, with this financial support can facilitate the increase in knowledge which can be of local and national benefit.

The Council has been notified that the NIHR are planning to extend the life of the collaboration to extend to 2028, and possibly longer. This is excellent news as it recognises that changing culture and capacity needs a long-term investment but also that councils need to benefit in the same way the NHS and other organisations have, in terms of external funding to participate and lead in research.

It is also of note that Plymouth HDRC has been selected by NIHR as an 'Impact Case Study' that will highlight our work across all our objectives.

2. BACKGROUND

The health of the public is fundamentally influenced by the wider determinants of health. The work of local government profoundly impacts on these drivers, and The National Institute for Health Research (NIHR) have recognised that it is vital that local government is better supported to become more research-active and further build this evidence base.

OUR AIMS

Our bid had two components

- Develop the culture and skills to ensure a learning approach informs decision making to impact positively on the wider determinants of health.
- Produce knowledge for use locally and of value nationally, especially for similar coastal communities.

In addition, the Plymouth bid focusses on

- Innovation – really understanding whether some of the interventions and approaches that we are interested in work, why they work, and whether they would work with other groups of people and in other settings. A key piece of local innovation is development of what has become the Human Learning System (HLS) approach to public service and HDRC is both evaluating and spreading this innovation.
- Evidence – how we are developing and using the evidence base to inform decisions, and to influence the decisions of others.
- Intelligence - are we asking the right questions and using all our data sources to provide joined up intelligence to support Council processes and to provide evidence.

2. METHODS

Traditional research in councils is often extractive and driven by academics. Essentially, they want access to our data/people to progress a piece of theory they are interested in testing. We have a different approach in that ALL our research questions must be generated by council staff doing the work – a 'bottom up' approach to ensure any research we do is directly relevant, applicable and useful. To do

this, we are using an innovative embedded researcher approach (which is also being evaluated). There are 3 stages to this approach.

- **Make "friends"** – our researchers are embedded in teams across the council and VCSE to build relationships of empathy and trust and understand the work and its challenges.

- **Be useful** – regardless of whether a topic will become a formal research project we can spend often short amounts of time helping staff solve real life problems through the application of research techniques e.g. helping somebody understand and interrogate a dataset or design a consultation or brokering a literature review on a topic with a UoP academic. This is a gentle way of introducing staff to research techniques. Additionally, we provide many (free to Plymouth) courses on a range of topics – e.g. research skills, evaluation techniques, complexity theory, and appreciative enquiry.

- **Formal Research** – progressing research ideas generated by staff to full formal studies. These ideas are tested against the priorities identified by service directors to ensure they are consistent with corporate needs. The formal research is conducted by the member of staff that identified the research question (we can pay for their time to do this) alongside the embedded researcher or an appropriate academic in the university. By doing it this way we ensure the staff member gains a higher level of knowledge about research that they can take back to their team, thus increasing capacity and capability.

Nationally the HDRCs were set up with some common core objectives but allowed to develop locally. The message that we are being understood as an infrastructure support mechanism for councils has become much stronger as HDRCs have reported back to the NIHR. Each HDRC has highlighted that in the first few years the amount of work necessary to enable the council to be an organisation which can own and lead research has been quite extensive. We are all now closer to being able to understand the core subject matter expertise required but also reaching out to other infrastructure organisations such as the RDN and PENARC as well as neighbouring HDRCs (Cornwall and Somerset) to understand how we can avoid duplication of skills, find some synergy and mutually support each other.

Locally Determined Priority Areas

We have been engaging with strategic and service directors to identify priorities, and these are set out below;

- **Citizen priority group** – children and young people

- **Council cultural drivers** – using information more effectively to target reductions in key inequalities and organisational culture and development. Developing staff to engage with research and evidence in their specialist areas.

- **Personal impact of inequalities** – food security, housing, debt, employment opportunities (trauma informed recruitment).

- **Community wide inequalities** – asylum seeker and refugee services, unpaid carers, violence against women and girls, strong and stable voluntary, and community sector.

Highlighted Examples

Council priorities

We have been mindful that where research opportunities are considered, the topics are driven by council staff and teams so that as well as underpinning our drive to reduce inequalities we can also consider how we support the efficiency and wellbeing of staff (akin to the approach to the roll out of AI), as well as the relationships with our citizens and also the critical council objectives. Some projects have been associated with using evidence to influence how funding is spent (retrofitting priorities), using information to target greatest need (use of One Devon data set), or financial pressures such as research which explored how we can reduce placement breakdown for children or inform how placements can be better made. We have also supported several projects which enable staff to deliver support and services within complex environments, which can be shown to be more cost effective and more bespoke (trusted professionals models/Creative Solutions Forum).

Developing Staff

We are informally supporting numerous staff in the council and VCSE to develop evidence informed and research focused projects, but we also have several planned and funded development opportunities for staff. We have fully funded a Children's Directorate (Education) worker to undertake a PhD researching high-cost placements for Looked After Children with an aim to reduce them. We have fully funded and supported two commissioning team staff on to the First Steps in Research programme to develop evidenced based commissioning skills and fully funded an Occupational Therapist based in The Zone Early Psychosis service to undertake an MSc in Substance Misuse. We also have Peter Kerslake on secondment from HROD who is leading a plan to train 300 council middle managers in research skills and evidence-based practice as part of the corporate staff development plan.

Meaningful Engagement with Communities

Health inequality is socially patterned i.e. it is concentrated in our most deprived areas. To address these persistent inequities, we must engage both with those communities and with the council and VCSE organisations that directly serve them. We aim to build resilience, grow local responses to local problems and support citizens to become active in their areas. Our role is to support the community

to do its own research, and work with them to understand how the information they gather can be used to influence policy, commissioning and service changes**.** We act as a learning partner for the local network of community-based researchers, known as the Learning by Listening network, and we support the broader training needs of community-based colleagues, for example, through a process of co-production we have developed two sets of training for communities and we undertook two projects where we fed back findings from Appreciative Enquiries directly back to those communities as part of the new engagement strategy facilitating meaningful knowledge exchange between the council and communities.

HDRC Grants and Publications

As an NIHR funded project we are expected to publish research findings in peer reviewed journals and to disseminate our work in accessible formats (plain English Summaries, professional magazines etc). We have done this successfully and ensured in doing this we that we have also connected with other councils, and the LGA and are working with the national bodies to influence the development of national offers for council led processes for research, e.g. costing for grants, development of council lead research contracts, and ethical processes. In addition, we have been making bids to various funding bodies to bring more research and development funds into Plymouth. We have submitted 39 bids for funding, 14 successful, 9 awaiting outcome and 16 unsuccessful grant submissions. For example, Rebecca Carter (researcher in residence) successfully bid for funding to develop a project aimed at getting people with health and other difficulties into work. We hope this will lead to a more substantial bid later in 2026. In terms of publication and dissemination we have over 30 publications or public disseminations of findings, ten conference attendances directly including HDRC work and a further eight aligned publications (not directly HDRC) via lead academic researchers.

National Work

Several HDRC staff are engaging with national projects and forums, such as the national embedded researchers forum and the National Expert Safeguarding Group to share learning from a diverse range of Plymouth projects. Some examples are below

- **Test Learn Grow** – national Cabinet Office scheme. Our project based in Whitleigh, involving the VCSE, Primary Care and community in work to reduce high intensity NHS users, led by Ruth Harrell.

- **Community Help Partnerships** – HDRC are acting as a learning partner on the development of this Cabinet Office scheme to improve secondary prevention approaches for people with complex needs.

- **Cabinet Office Social Value** – we have presented on the Plymouth approach to the lead officer for this nationally.

- We are also working with NHS Improvement Scotland and NHS Cymru as a learning partner on Human Learning Systems.
- The Child Health and Weight strategy was presented by Dave Schwartz to the NHS Confederation and is generating significant national interest.
- The LGA National Expert Safeguarding Group have asked us to present the Creative Solutions Forum evaluation at the National Safeguarding Chairs group.

Next Steps

Working with the NIHR to understand the next steps for extension of the HDRC and any future re-procurement.

Through evaluation, we are refining the way we work and prioritise research areas; this will help us to ensure that the energy is aligned with organisational needs in a more structured way.

Developing our ways of working within Council – we are trialling a more formal relationship with the Children's Directorate which involves a Research Champion in the Directorate working with a named Researcher, to help us to develop and prioritise work areas.

Health and Wellbeing Board

Date of meeting:	12 March 2026
Title of Report:	**Suicide Prevention**
Lead Member:	Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Professor Steve Maddern (Director of Public Health)
Author:	Kamal Patel
Contact Email:	Kamal.patel@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
The report provides the Health and Wellbeing Board with an update on local suicide data and the proposed One Devon Suicide Prevention Strategic Plan for 2026-2031

Please be aware that this report and associated papers discuss suicide, which can be an emotional topic. Please look after yourself and seek support if you need: ***Mental health support | PLYMOUTH.GOV.UK***

Recommendations and Reasons

1. It is recommended that the Health and Wellbeing Board reviews and ratifies the One Devon Suicide Prevention Strategic Plan for 2026-2031
   Reason: Suicide Prevention partnerships are accountable to Health and Wellbeing Boards. Therefore, endorsement will enable partners to begin the delivery of the plan, focusing on the highest priority areas in the first year.

Alternative options considered and rejected

1. The alternative is to not agree and endorse the plan. This would risk hindering the collaborative progress made over the past year, delay delivery of suicide prevention activities and require local areas to create a new strategic plan for each area.

Relevance to the Corporate Plan and/or the Plymouth Plan
Contributes to overall mission of the Corporate Plan as well as the following priorities:
- Working with the NHS to provide better access to health, care and dentistry
- Keeping children, adults and communities safe

Contribute to policies in the Plymouth Plan:
- HEA1: Addressing health inequalities, improving health literacy
- HEA2: Developing the best outcomes for children, young people and families
- HEA3: Supporting adults with health and social care needs
- HEA5: Delivering strong and safe communities and good quality neighbourhoods
- HEA9: Delivering accessible health services and clinical excellence

Implications for the Medium Term Financial Plan and Resource Implications:
N/A

Financial Risks

None identified

Legal Implications

There are no identified legal implications

Carbon Footprint (Environmental) Implications:
There are no identified carbon footprint implications

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
N/A

Appendices

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Suicide Prevention Strategic Plan – briefing							
B	One Devon Suicide Prevention Strategic Plan 2026-2031							
C	Plymouth Suicide Audit Summary 2022-2024							
D	HWBB March 2026 Suicide Prevention (presentation)							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Asset s	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Kamal Patel											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 05/02/2026											
Cabinet Member approval: Cllr Mary Aspinall – approved verbally Date approved: 18/02/2026											

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Suicide Prevention Strategic Plan 2026-2031

Partnerships

Contents

INTRODUCTION

Suicide can have a devastating impact on families, friends, neighbours, colleagues and whole communities. The national suicide rate has not fallen since 2018, and there are still over 5,000 deaths by suicide in England each year.

A death by suicide is a tragic and traumatic event. Its most fundamental impact is the loss of the opportunity for that person to experience all that life holds. It is also a devastating bereavement for family and friends, and the pain and grief can be immense and long lasting. The impact also extends into the wider community, workplaces and to all services involved. In addition, people who are bereaved by suicide are at increased risk of suicide and mental health problems themselves. The impacts of suicide are felt most deeply on a human level. However, the economic cost of each death by suicide in England for those of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings and the intangible costs associated with pain, grief and suffering.

Every life lost to suicide is a tragedy. Preventing deaths by suicide needs action from national and local Government, from the NHS and other health & care services, from Voluntary, Community and Social Enterprise sector (VCSE), from education and businesses, communities, and individuals.

Suicide can be preventable. But it is essential that the preventative approach addresses the complexity of the issue. No one organisation is responsible for suicide prevention and there are no simple measures to prevent suicide. Suicide prevention is broad and includes measures to improve emotional wellbeing, support for people with mental health issues (from early intervention through to crisis care) and support for people who are bereaved by suicide.

We all have a role to play in challenging stigma, improving understanding about mental health and wellbeing, and developing the knowledge, skills and confidence to have mental wellbeing conversations. Suicide prevention is everybody’s business. A whole systems approach is required between national and local organisations, communities and individuals so that partners are working in collaboration towards the same priorities.

OFFICIAL

THE NATIONAL CONTEXT

The Suicide prevention in England 5-year cross-sector strategy sets out the national direction and ambition for suicide prevention from 2023 to 2028. The strategy has three key aims, and eight priority areas for action.

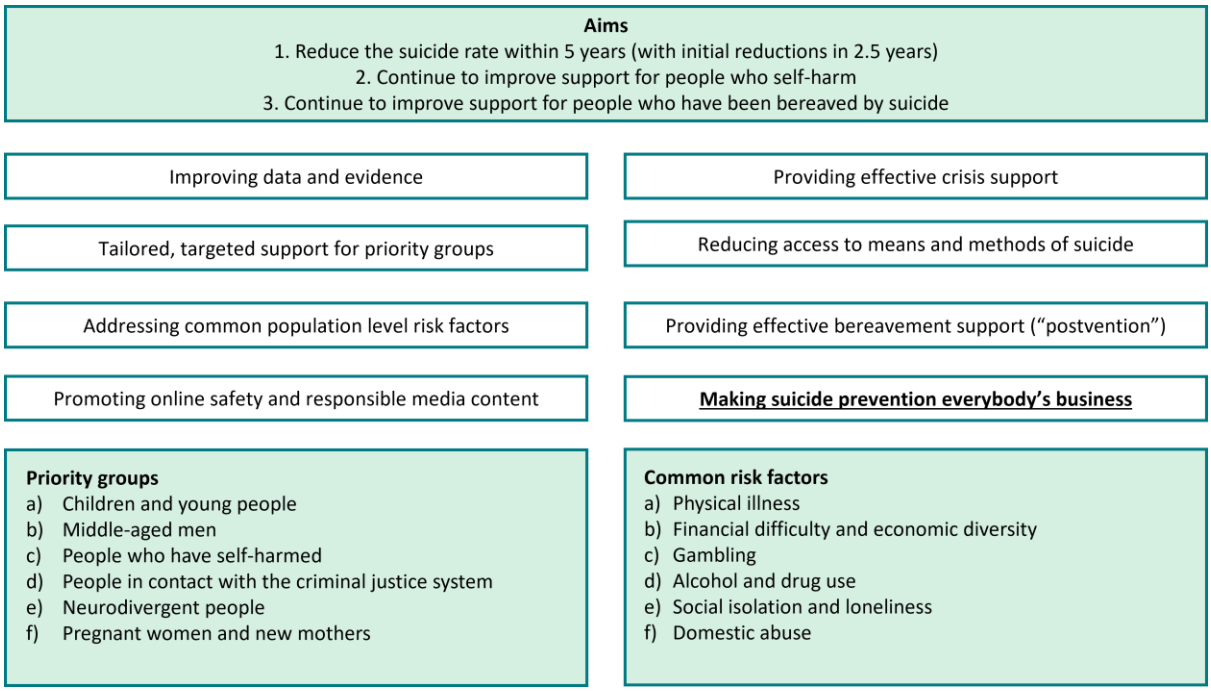

Figure 1 National Suicide Prevention Strategy 2023-2028 aims and priority areas.

Alongside the strategy, an action plan was produced which summarises over 100 actions, and details which government department or organisation will deliver each action, and by when. Both the national strategy and its' supporting action plan have been used to benchmark the local position against those national priority areas and actions, to inform the development of this suicide prevention action plan.

This strategic plan has been organised so that it aligns with the national strategy's aims and priority areas. Each section of the plan reflects these themes, allowing local partners to see how their work contributes to the wider national direction, while responding to local needs and priorities.

THE LOCAL CONTEXT

Multi-agency suicide prevention groups help coordinate action to reduce suicides in local areas. In England, responsibility for local suicide prevention strategies and action plans usually sit with local government through Health and Wellbeing Boards.

Previously the multi-agency suicide prevention groups in Devon, Plymouth and Torbay have aligned around a strategic vision but maintained their own strategic plan. The common vision is:

"Our vision in Devon is for all suicides to be considered preventable and that suicide prevention is everyone's business. The ambition for suicide prevention is to deliver a consistent downward trajectory in the suicide rate for all areas of Devon, Plymouth and Torbay so that they are in line with or below the England average."

While this plan seeks to provide a consistent strategic framework, it recognises that there are existing differences between Devon, Plymouth and Torbay in terms of population size, demography and risk profile, as well as variation in the availability of mental health services and VCSE support. Some areas face additional challenges such as smaller populations that make auditing and evaluation more difficult, or higher concentrations of groups at increased suicide risk. Where such variation exists, the plan aims to make these differences visible, promote equity of access and outcomes, and support partners to adapt or strengthen local provision so that people receive timely, appropriate support wherever they live.

The NHS Devon: Health and Care Strategy sets out the future model of the local care system. Mental health is a clear priority in that plan with the aim of moving towards a more prevention, person-centred, community and neighbourhood approach. This Suicide Prevention Strategic Plan aligns with that approach.

ABOUT THIS STRATEGIC PLAN

The plan has been co-developed by system partners structured around the aims and priority areas of the national suicide prevention strategy. It brings together the three existing local

suicide prevention action plans for Devon, Plymouth and Torbay into one co-ordinated Integrated Care System (ICS) wide plan. It provides a shared framework for suicide prevention across our region, based on the eight priorities of the Suicide prevention strategy for England: 2023 to 2028, ensuring that activity is connected, evidence informed and aligned to national priorities, while retaining the flexibility to respond to local need.

The plan is intended for all partners involved in suicide prevention, including local authorities, NHS organisations, voluntary, community and social enterprise (VCSE) organisations, education providers, emergency services, criminal justice partners, employers and community leaders, as well as for commissioners and system leaders who oversee and resource suicide prevention activity. It is also a reference point for anyone developing, delivering or commissioning services and interventions that may reduce suicide risk.

Governance for this strategic plan is provided through the existing suicide prevention partnerships in Devon, Plymouth and Torbay and accountable to their respective Health and Wellbeing Boards. Oversight, prioritisation of the objectives and development of specific actions to meet the objectives will be held by the Devon ICS Suicide Prevention Oversight Group (SPOG), which provides senior strategic leadership and ensures effective cross-communication and alignment between suicide prevention partnerships and the wider ICS. This governance framework enables consistent priorities across the system while allowing local adaptation based on existing contexts and assets, supports timely sharing of learning and intelligence, and ensures that progress, challenges and successes are fed back to all areas.

This is a suicide prevention strategic plan, not a mental health strategy. There are significant overlaps between work to improve mental health and suicide prevention. The priority areas of the national strategy and therefore this suicide prevention strategy also highlight this crossover, with people who have self-harmed, people in contact with mental health services being a priority group and providing effective crisis support as a priority area. This strategic plan considers these priority areas with a suicide prevention lens and does not cover the whole scope of mental health services, which can be considered as a core service delivery area for the system.

The plan shows:

- **System-level objectives** where a coordinated approach is needed to deliver consistent impact across Devon, Plymouth and Torbay.
- **Shared ownership** identifying leads and partners, and promoting collaboration across NHS, local authorities, VCSE organisations and other system stakeholders.

Objectives within this plan span the full spectrum of suicide prevention work. It builds on existing core delivery while addressing identified gaps, variation and inequity across the system.

OVERARCHING PRINCIPLES

The following principles underpin the development and delivery of this suicide prevention strategic plan. They reflect how we will work together as a system and the values that should guide all activity across Devon, Plymouth and Torbay:

Localised delivery within a system-wide framework	Actions agreed at Integrated Care System (ICS) level should be implemented in ways that respond to the specific needs, assets and contexts of local areas. Where appropriate, actions will be adapted to reflect the priorities and delivery models of locality partnerships while remaining aligned to the overall system plan.
Collaborative system working and strong partnerships	Suicide prevention is everybody's business. Success depends on effective collaboration between local authorities, NHS organisations, voluntary and community sector partners, education, employers, emergency services, criminal justice partners and community leaders. System partners will share learning, resources and expertise to maximise impact.
Meaningful involvement of people with lived experience	People with personal experience of suicide, bereavement and mental health crisis bring essential insight to prevention work. The system will review how they will be engaged and supported in a safe, respectful and impactful way, shaping priorities, informing service design and contributing to evaluation and continuous improvement.
Equity and inclusion	All activity will take account of the unequal distribution of suicide risk, ensuring that prevention approaches are inclusive and responsive to the needs of groups who experience higher risk, due to factors such as deprivation, discrimination, trauma, neurodiversity or other vulnerabilities and to differences in local service provision and capacity.
Evidence-informed and continuously improving practice	Decisions will be based on the best available data, research and real-time intelligence. The system will monitor outcomes, evaluate interventions and adapt approaches in response to emerging evidence and feedback from those affected.

CORE SERVICE DELIVERY

Alongside the new objectives and priorities set out in this plan, there is already a significant programme of suicide prevention activity in place across Devon, Plymouth and Torbay. This

core service delivery forms the foundation on which further work will build. It is delivered collaboratively by local authorities, NHS organisations, the Integrated Care Board (ICB), mental health providers, voluntary and community sector partners, the police, coroner's service and other system stakeholders.

Current system-wide core-delivery includes:

Priority area	Description of core service delivery
1. Improving data and evidence	• Routine use of the Devon Real Time Surveillance System (RTSS) system and national data (Office for Health Improvement and Disparities profiles, ONS data) to monitor trends and novel methods, support early response and inform planning. • Contribution to local suicide audits (Plymouth and Torbay) and sharing of key learning widely. • Coordinated campaigns and communications to raise awareness, reduce stigma, and promote help-seeking. • Insights from audits, reviews (including avoidable deaths reviews, domestic abuse related death reviews and safeguarding processes) and pilots are shared to inform ongoing improvements.
2. Tailored targeted support to priority groups	• Prioritisation of activity to support these priority groups • Existing community and health services providing support to these groups
3. Addressing risk factors	• Prioritisation of activity to support people with these risk factors • Existing community and health services providing support to people with these risk factors
4. Promoting online safety and responsible media content	• Signposting to existing resources
5. Providing effective Crisis support	• A 24/7 local crisis response offer through NHS providers (NHS 111 option 2), supported by clear signposting tools for professionals and the public. • Signposting to appropriate other crisis services such as Shout, Papyrus, and Samaritans.
6. Reducing access to means and methods of suicide	• Work with local authorities, police, and transport partners to address access to high frequency locations, implement safe design principles and share alerts about emerging methods or risks.

7. Providing effective bereavement support to those affected by suicide	• Specialist bereavement services (e.g. Pete's Dragons) are commissioned across the ICS, linked to the RTSS to enable timely support, including support to settings. Police and other partners continue to improve referral processes and promote awareness of available services.
8. Making suicide everyone's business	• Local authority-based suicide prevention partnerships • Training and workforce development: A wide range of suicide prevention, mental health and trauma-informed training is offered across sectors, including universal awareness training (e.g. Making Every Contact Count).

ONE DEVON SUICIDE PREVENTION STRATEGIC PLAN 2026-2031

The strategic objectives described below are framed using the priorities of the Suicide prevention strategy for England: 2023 to 2028, which is sets the overall strategic direction for this plan. Progress of this shared system plan will be overseen and driven by the One Devon Suicide Prevention Oversight Group (SPOG). The objectives under each priority are provided with a rationale and context for that objective, together with the key partners who will support the work to achieve the objective. This includes partners who are members of SPOG (Public Health, NHS Devon, Mental Health providers, Devon and Cornwall Police) as well as partners from the mental health system and beyond.

1. IMPROVING DATA AND EVIDENCE

Timely and high-quality data, evidence and intelligence allow for a better understanding of the drivers of suicide and self-harm, the development of more effective interventions and more rapid responses to prevent suicide. It is an essential part of suicide prevention both to understand what has worked in preventing suicides and where to direct future efforts.

	Objective	Rationale and context	Key partners
1.1	**Create a One Devon Suicide Prevention Dashboard.**	Bringing together data from a range of sources to provide a temporal and spatial view of suicide across the county including risk factors. This includes data from Real Time Surveillance System (RTSS), ONS, Concerns for Welfare and Trust data. This will enable suicide prevention activity to be better targeted to the level of need. Consider how to link to National Real Time Surveillance System.	Public Health, Police, Pete's Dragons, NHS Devon, Highways, BTP
1.2	**Improve local data and use national data on potential or emerging risk factors and priority groups.**	Such as people with chronic pain, people from diverse communities (particularly in the context of the current social and political landscape due to increasing polarisation, discriminatory narratives, and structural inequities), experiencing harmful gambling, people who are homeless and rough sleeping, are neurodiverse, LGBTQIA+, people who are care experienced, farming and fishing communities and the armed forces community.	Public Health, Police, Pete's Dragons, NHS Devon, provider of support services to people in these groups

		Improving understanding of the robust data for certain groups enables more effective prioritisation of resources to where the need is.	
1.3	**Application and sharing of data, evidence and learning from local and national reviews and frameworks related to suicide such as child death reviews, PSIRF, avoidable death reviews, suicide audits to inform support prioritisation and build on this strategic plan.**	There are multiple local and national system reviews that have implications for suicide prevention work. Being able to review these for key learning and trends to share with the wider system is crucial to ensure that these reviews are leading to positive system change and quality improvement.	System-wide. All partners involved in these reviews and services where learning can be applied

2. TAILORED TARGETED SUPPORT TO PRIORITY GROUPS

Suicide prevention is population-wide, and the objectives set out within this plan are designed to support as many groups and individuals as possible. However, there are some groups that could particularly benefit from bespoke support. For some groups, such as people in contact with mental health services, data suggests relatively high numbers of suicide. Others may not have high rates but are of particular concern, such as children and young people, for whom rates have increased in recent years despite being low overall. It is therefore crucial that organisations and individuals tailor and target resources and services to support these groups.

	Objective	Rationale and context	Key partners
2.1	**Raise awareness, challenge stigma, promote training and signposting of resource and support to the priority groups and workforces that support these groups.**	These groups have been identified through national data, evidence and engagement as priority groups for suicide prevention activity.	System-wide

2a. Children and young people

While the suicide rate in under-20s is relatively low compared with older age groups, rates across all age groups under 25 have been increasing over the last decade in England. This increase is particularly apparent among females under 25. This trend in rates is now levelling off – however, we must focus action to reverse this trend.

	Objective	Rationale and context	Key partners
2a.1	**Support young people, parents/carers and non-mental health professionals who work with young people to have a greater awareness of self-harm and suicide prevention**	Improving knowledge of self-harm and suicide reduces stigma and improves help-seeking. Through the general and targeted provision of effective resources and training young people, parents/carers and professionals can have greater confidence to recognise risk factors, the signs of distress, have confidence about having a conversation with somebody, make a safety plan and signpost/refer appropriately.	Public Health, CAMHS services, CYP systems

		Children with additional risk factors, including those not in education employment or training (NEET) and those who have Adverse Childhood Experiences (ACEs) are at a higher risk of suicide – specific prioritisation needs to be given here to ensure awareness of risk factors and to support suicide prevention efforts. Target organisations such as CYP drug and alcohol services, Children's Social Care, children not in mainstream education.	
2a.2	**Support all secondary schools, colleges and FE institutions to have a suicide prevention policy**	This should inform staff of the risks and ways to support young people. The policy should contain up to do ate signposting to support individuals or groups where necessary. It should also include examples of how to communicate information to staff, young people, parents/carers. Policies should have senior leadership ownership and be updated annually.	Educational settings Public Health
2a.3	**Support universities to implement national plans regarding student mental health, wellbeing and suicide prevention.**	Support universities to Suicide-safer universities guidance, which covers both prevention of suicide and compassionate responses to suicide in universities. Guidance developed in partnership with PAPYRUS-UK.	Universities, Public Health
2a.4	**Support young people to be aware of ways to support their own mental health.**	Supporting young people to understand and manage their mental health is a key preventative measure that reduces long-term risk of suicide and improves overall wellbeing. Providing accessible information, tools, and resources empowers young people to build resilience, seek help early, and develop healthy coping strategies. Promotion of resources such as 5 ways to wellbeing. Consider participatory work with young people to develop own resources.	Public Health, CYP systems

2b. Middle-aged men

Men are three times more likely to die by suicide than women, with middle-aged men having the highest rates of suicide of any other group (based on age and sex) since 2010.

There are several factors that have been particularly strongly linked to suicide in this group. Socioeconomic disadvantage is strongly associated with suicide among this demographic, and middle-aged men did not have the highest rates of suicide of any group until after the 2008 recession, suggesting a link between recession and suicides. National evidence on suicide in middle-aged men shows that factors such as living in the most deprived areas and experiencing unemployment or financial difficulties (including debt and housing difficulties) have also been particularly linked to suicide in this group.

A history of alcohol or drug use, contact with the justice system, family or relationship problems, harmful gambling and social isolation and loneliness are also factors that are common in men who died by suicide.

	Objective	Rationale and context	Key partners
2b.1	**Support employers of largely male industries to have adequate and appropriate support in place for employees, including through targeted awareness raising and training.**	Men from more deprived areas have one of the highest suicide rates. Ensuring that suicide awareness and training is targeted to where men are working, particularly in manual and routine workforces, where the suicide rate is higher.	Public Health, training providers, DMHA
2b.2	**Support system-wide Men's Mental Health work across the region, prioritising men in mid-life particularly in deprived areas.**	Raise awareness, challenge stigma, promote training and signposting of resource and support - targeting areas where men may be. Consider engaging with sports clubs, barbers, pubs to normalise conversations about mental health in male-dominated settings. Support development of evidence base including proactive outreach to men who may not traditionally seek help.	Public Health, DMHA, Active Devon

2c. People who have self-harmed

Self-harm does not necessarily mean someone is experiencing suicidal thoughts or feelings. However, as well as being an important issue to address in its own right, we know that self-harm is associated with a significant risk of subsequent suicide. It is therefore important that we focus efforts on prevention and the provision of consistent high-quality care for self-harm (including aftercare and support within community settings).

There are an estimated 200,000 hospital presentations for self-harm per year in England. The occurrence of self-harm in the community is likely to be much higher. Evidence also suggests that the suicide rate is highest in the year following hospital discharge for self-harm, particularly in the first month.

	Objective	Rationale and context	Key partners
2c.1	**Review current service provision for people who self-harm to ensure compliance with NICE standards and pathways.**	NHS quality incentive for at least 80% of eligible patients who have self-harmed and referred to psychiatric liaison teams in emergency departments receive a comprehensive psychosocial assessment. For CYP (< 25s) to achieve NICE-compliant self-harm services each Emergency Department should as a minimum, undertake comprehensive psychosocial assessments for any child or young person presenting with self-harm, conducted by multidisciplinary teams (e.g. medical, CAMHS and social care teams) including child protection and safeguarding considerations. For < 25s who are frequent service users should have multi-professional assessments with the appropriate agencies (social care, education, mental health services and paediatrics).Self-harm Prevention in Children and Young People - South West Population Health Tools - Futures	NHS Devon, MH providers, children's social care, acute hospitals, CYP community services (LWSW and CFHD)
2c.2	**Develop an understanding of local need, system and support for people who self-harm.**	Utilise the self-harm needs assessment, to identify and escalate gaps and further opportunities for improving self-harm care.	Public Health, NHS Devon, MH providers, DMHA
2c.3	**Raise population level awareness of self-harm, tackle stigma, promote training and safety planning.**	Through the provision of resources, such as written, videos and training offers.	Public Health, NHS Devon, MH providers, DMHA

2d. People in contact with mental health services

When individuals are in contact with mental health services, it is crucial that they are offered safe, compassionate and patient-centred care each and every time.

People known to be in contact with mental health services represent around 27% of all deaths by suicide in England – on average around 1,300 people each year. This includes anyone in contact with mental health community services, people in inpatient settings, and anyone that has been in contact with these services within 12 months.

Evidence suggests that history of self-harm, alcohol and drug use, co-morbidity (more than one mental health diagnosis), and living alone may be particular risk factors for suicide for people in contact with mental health services.

Between 2010 and 2020 there was a 25% fall in the number of suicides in inpatient settings in England when taking into account the number of admissions. This fall is likely due to safer physical environments (including the removal of ligature points), staff vigilance, and wider improvements in mental health inpatient settings.

	Objective	Rationale and context	Key partners
2d.1	**Support system wide identification and response to gaps in mental health services.**	The local mental health system has previous identified gaps such as those between talking therapies and secondary mental health services for adults, and school-based Mental Health Support Team and young people's specialist mental health services. Properly characterising these gaps will support the development of appropriate responses.	NHS Devon, MH providers, DMHA, Public Health
2d.2	**Mental health service providers to identify and implement actions to further prevent suicides, including reviewing and implementing evidence-informed recommendations such as those outlined in the NCISH annual reports.**	Implementing evidence-informed recommendations, such as those outlined in NCISH annual reports, ensures best practice, strengthens clinical governance, and supports continuous learning. Example: the NCISH toolkit – 10 ways to improve patient safety.	NHS Devon, MH providers
2d.3	**Take steps to ensure that patients receive good quality (in line with NICE guidance) follow-up support within 72 hours of being discharged from inpatient mental health settings.**	The period immediately following discharge from inpatient mental health care is a high-risk time for suicide. Ensuring timely, high-quality follow-up within 72 hours, in line with NICE guidance, provides continuity of care, supports recovery, and reduces risk of harm. This includes developing effective integrated pathways.	NHS Devon, MH providers

2d.4	**Ensure that mental health providers across the range of services provide support in line with Staying Safe from Suicide guidance and more broadly the Personalised Care Framework.**	This new NHS guidance promotes a shift towards more a holistic, person-centred approach rather than relying on risk prediction which is unreliable.	NHS Devon, MH providers
2d.5	**Using PSIRF framework and mortality reviews to support the development of a culture of system learning and improvement.**	PSIRF (Patient Safety Incident Response Framework) supports the development and maintenance of an effective patient safety incident response system and includes four aims of compassionate engagement, proportionate responses, system based approaches to learning, and supportive oversight, with an overall emphasis on learning and improvement.	MH providers, NHS Devon
2d.6	**Align to established clinical effectiveness oversight processes to ensure compliance with NICE guidance for specific conditions that are associated with higher rates of suicide.**	This includes affective disorders (depression and bipolar), personality disorders, schizophrenia and other delusional disorders and eating disorders. Consider how waiting times, disengagements, transitions and other factors impact on suicide	MH providers, NHS Devon

2e. People in contact with the justice system

People in contact with the justice system have higher rates of suicide and self-harm behaviour than the general population. Action to prevent suicide and self-harm is needed across the justice system – in police custody, in prison services for those on remand or serving a sentence, in probation services and for all people on release.

	Objective	Rationale and context	Key partners
2e.1	**Explore support at specific points in criminal justice pathways, particularly for sensitive offenses.**	RTSS data indicates that there may be a higher rate of suicide in people who are arrested for sensitive offences.	Police, Public Health
2e.2	**Review and support optimisation mental health pathways for people leaving prison**	Utilisation of mental health continuity of care recommendations from the CMO report: The health of people in prison, on probation and in the secure NHS estate in England - GOV.UK	Prisons, mental health services, drug and alcohol services

2f. People with neurodiversity including autism and ADHD

Evidence suggests that people who are neurodiverse (particularly ADHD and autism), including children and young people, may be at a higher risk of dying by suicide compared to those who are not. It is essential that health, mental health, and local authority services and education providers consider the needs of people who are neurodiverse in suicide prevention activity.

	Objective	Rationale and context	Key partners
2f.1	**Support universal mental wellbeing and suicide prevention initiatives to be neurodivergent inclusive.**	Embedding neurodivergent inclusion within universal initiatives ensures equity, improves accessibility, and strengthens the effectiveness of prevention efforts across the whole population.	Public Health, DMHA
2f.2	**Raise awareness of learning opportunities such as the Learning from Lives and Deaths (LeDeR) programme and other review processes.**	Learning from Lives and Deaths (LeDeR) and similar review processes provide critical insights into avoidable factors contributing to premature mortality among people with learning disabilities and autism. Raising awareness of these learning opportunities supports continuous improvement, strengthens safeguarding, and ensures that lessons inform practice across all partners.	Public Health, MH providers, NHS Devon, DMHA
2f.3	**Support system wide work to improve earlier identification and timely access to autism and ADHD assessment services.**	Timely identification and access to autism and ADHD assessment services are essential to reducing unmet need, preventing escalation of mental health issues, and improving life outcomes. Delays in diagnosis can lead to increased distress, social exclusion, and higher risk of crisis.	MH providers, NHS Devon
2f.4	**Support for young autistic adolescents transitioning into adulthood**	This should include support for accepting their diagnosis, exploring their identity, building their independence and navigating social interactions	MH Providers DHMA, NHS Devon, social care, CYP community MH providers

2g. Pregnant women and new mothers/parents

In the UK, suicide is the leading cause of direct death 6 weeks to a year after the end of pregnancy. In 2020, women were three times more likely to die by suicide during or up to six weeks after the end of pregnancy compared with 2017 to 2019. Impacts on affected families are devastating and often have lasting effects, particularly on children from a very early stage in their development.

Overall, the level of risk of suicide after pregnancy is not higher than at other times in a woman's life. However, the high risk compared to other cause of maternal death (most of which are rare) and the potential long-term consequence on children's development mean we must take action to prevent suicides in this group. The increasing numbers of teenage maternal suicide, in particular care leavers, in recent years is a significant concern and particular targeted support is needed for this age group.

	Objective	Rationale and context	Key partners
2g.1	**Provide greater person-centred support for women and parents who have children's social care involvement including child removal**	These women often experience multiple disadvantage including mental health issues, domestic abuse, and substance use, and are at risk of harm from themselves and others. Greater person-centred coordinated support should be provided including through the use of Section 42 enquiries and Multi-Agency Risk Management (MARM) processes.	NHS Devon, Children's social care, midwifery, health visitors, adult safeguarding and social care, Mental health services

3. ADDRESSING RISK FACTORS

Addressing risk factors linked to suicide is a central part of effective suicide prevention. This provides an opportunity for effective early intervention, as well as providing appropriate, tailored support for those experiencing suicidal thoughts or feelings.

Many risk factors are common across different individuals, groups and communities. Therefore, actions to address these risk factors are likely to prevent suicides at a population level with potential benefits for some groups.

Links have been evidenced between suicide and social determinants of health such as housing, poverty, employment and education. Therefore, the impacts of the core determinants of health need to be considered in suicide prevention work.

There are some specific factors (many of which are linked to the core determinants of health) that, through data, evidence and engagement, have been identified as priority areas to address in the national strategy.

	Objective	Rationale and context	Key partners
3.1	**Raise awareness, challenge stigma, promote training and signposting of resource and support people with these risk factors and workforces that support them.**	These risk factors have been identified through national data, evidence and engagement as priority areas for suicide prevention activity.	Whole system

3a. Physical illness

Evidence suggests that a diagnosis of a severe physical health condition may be linked to higher suicide rates. Evidence from NCISH suggests that over half of men aged 40 to 54 who died by suicide had a physical health condition.

And, while 2 or 3 people who die by suicide have not been in contact with mental health services in the previous year, evidence suggests that many (49 to 92%) make contact with primary healthcare services in this time. Over 40% of middle-aged men have been in contact with primary care services for either physical or mental health needs within 3 months before taking their own life. It is essential that we support those seeking help for physical illness to meet both their physical and mental health needs.

Objective	Rationale and context	Key partners

3a.1	**Support the General Practice workforce with suicide prevention through exploration of training offers and resource provision.**	Evaluation results of the primary care suicide prevention training pilot indicate that training was well received by primary care and improved capacity and capability to have conversations around suicide in a compassionate way. There was high demand for the course. This outcome should be used to advocate for a regular training offer to people working in primary care.	NHS Devon, Primary Care. Public Health
3a.2	**Raising awareness of suicide risk to workforces supporting people with chronic conditions, especially life-altering conditions and chronic pain.**	Chronic conditions, life-altering conditions, chronic pain, degenerative, terminal, conditions that affect mobility can all increase isolation and affect mental health including leading to suicidal ideation.	Primary care. Secondary care. NHS Devon, Public health

3b. Financial difficulty, economic adversity and unemployment

Financial difficulty and adversity can result in suicidal thoughts or action. Evidence shows an increased risk of suicide for people with debt, and economic recession has been consistently linked to suicide. More recently, evidence from charities has suggested that rises in the cost of living have been linked to some people feeling unable to cope, with some feeling suicidal.

	Objective	Rationale and context	Key partners
3b.1	**Explore how suicide prevention system can support, align to and influence employment programmes such as Connect to Work.**	Connect to Work provides support to help individuals with whatever challenges they face that prevent them from engaging with work, including mental health.	Public Health, DWP, Citizen's advice
3b.2	**Explore opportunities to influence local economic strategies to ensure that there is sufficient focus on local residents living with or at risk of financial difficulty.**	Influencing local growth agenda to be inclusive of local residents living in more deprived communities.	
3b.3	**Embed suicide prevention awareness in housing, employment and debt advice services.**	Embedding suicide prevention awareness within these services enables early identification and signposting for individuals in distress. This approach strengthens frontline capacity, promotes holistic support, and ensures that key partners contribute to reducing risk factors.	Public Health, housing, employment and financial services

3c. Harmful gambling

There is increasing evidence of the relationship between harmful gambling and suicide, including in younger people. Although reasons for suicide can be complex, we do know that gambling can be a dominant factor without which the suicide may not have occurred. Action therefore needs to be taken to address the harms of gambling, including suicide, and reach people at risk.

	Objective	Rationale and context	Key partners
3c.1	**Support relevant partners to improve identification of harmful gambling through routine inquiry and promote and raise awareness of gambling support available.**	Supporting partners to include routine inquiry and raise awareness of available support ensures earlier identification and intervention. Signposting to free training available.	Public Health, gambling support organisations

3d. Drug and alcohol use

Consistent links have been evidenced between alcohol and drug use and suicide. Acute intoxication, as well as dependence on alcohol and/or drugs, has been associated with a substantial increase in the risk of suicide and self-harm.

Addressing alcohol and drug use may be especially important for supporting particular groups. In a study of middle-aged men that died by suicide in 2017, 49% had experienced harmful alcohol and/or drug use, particularly where individuals were unemployed, bereaved or had a history of self-harm or violence. Among people in mental health services in England who died by suicide between 2010 and 2020, there were high proportions of both harmful alcohol (45%) and drug (35%) use.

	Objective	Rationale and context	Key partners
3d.1	**Take an avoidable death approach to deaths including by suicide where drugs and alcohol, homelessness and domestic abuse were factors to share intelligence, raise awareness of suicide risk and learning and drive system improvements.**	Deaths involving suicide, drugs, alcohol, homelessness and domestic abuse often share common risk factors and system gaps. This may also include co-existing mental health issues and contact with the criminal justice system (section 2e). Taking an avoidable death approach enables intelligence sharing, learning and coordinated action across agencies. This strengthens awareness of suicide risk, drives improvements in safeguarding and service pathways, and supports a whole-system prevention response.	Public Health, substance use providers, DASVVAWG, housing system, Police
3d.2	**Ensure those with severe mental illness and co-existing alcohol or drug use are receiving treatment for their mental health needs.**	People with severe mental illness and co-existing substance use face significantly higher suicide risk and poorer health outcomes. Ensuring access to appropriate mental health treatment alongside drug and alcohol support promotes integrated care and helps to addresses complex needs. This approach aligns with national guidance on dual diagnosis and supports equity in service provision.	Substance use providers, MH providers, Public Health

3e. Social isolation and loneliness

Social isolation (having few people to interact with regularly) and loneliness (not having the quality or quantity of social interactions we want, regardless of social contacts) have been closely linked to suicidal ideation and behaviour.

This includes for particular groups – one study suggested that social isolation was experienced by 15% of under 20-year-olds and 11% of 20-24 year-olds who died by suicide, and qualitative research undertaken by Samaritans found loneliness played a significant role in young people's suicidal thoughts or feelings. A further national study suggested that, of men aged 40 to 54 who died by suicide, 11% reported recent social isolation.

We know that loneliness is one of the primary reasons that individuals access crisis services, and that actions to reduce social isolation and loneliness are therefore likely to be key to suicide prevention.

	Objective	Rationale and context	Key partners
3e.1	**Promote suicide prevention training for staff who may be in contact with people who are socially isolated.**	Including but not limited to, befriending services, community builders, community hubs, wellbeing hubs.	Public Health, DMHA, social care
3e.2	**Explore further ways to signpost people to social prescribing and other loneliness support.**	Strengthening signposting to social prescribing and community-based support will help individuals build connections, access practical help, and improve wellbeing.	Public Health, Primary Care, DMHA
3e.3	**Increase awareness of the impact of bereavement on suicide risk and organisations that can support people.**	Bereavement is a known risk factor for suicide. Raising awareness of this impact and promoting organisations that provide specialist support ensures timely intervention and reduces isolation.	Public Health, DMHA, Pete's Dragons
3e.4	**Increase awareness of the impact of relationship breakdown on suicide risk and organisations that can support people.**	Relationship breakdown can result in acute crises that increases the risk of suicide. This is often linked to emotional distress, social isolation, access to family (e.g. children) and housing challenges.	Public Health, DMHA

3f. Domestic abuse

Since the 2012 strategy, more evidence on a link between domestic abuse and suicide has emerged. Research on intimate partners violence, suicidality and self-harm showed that past-year suicide attempts were 2 to 3 times more common in victims of intimate partner violence than non-victims. It highlighted deaths in male and female victims, children and young people in households impacted by domestic abuse and among perpetrators. Research by the Kent and Medway Suicide Prevention Programme and Kent Police found around 30% of all suspected suicides in that area between 2019 and 2021 were impacted by domestic abuse.

Tackling domestic abuse and identifying victims, including children who witness abuse, is key to preventing related suicides.

Objective		Rationale and context	Key partners
3f.1	**Suicide prevention and VAWG/DASV colleague should work together with partners across multiple disadvantage to ensure that there is a tiered, pragmatic workforce development model for recognising and responding to suicide risk in situations of domestic abuse.**	This should include: Raising awareness of the link between domestic abuse and suicide through the suicide timeline helps professionals understand the mechanisms involved and identify opportunities for early intervention. Particular effort should be targeted to the multiple disadvantage system and situations where children are removed. Ensuring appropriate agencies, such as domestic abuse services have appropriate suicide prevention policies so there is a structured approach to identifying and managing risk. The challenge of implementing safety plans when under coercive control needs to be considered in the response. Understanding and responding to the suicide and homicide-suicide risk of perpetrators of harm, including the use of safety plans.	DASVVAWG system, substance use system, Public Health
3f.2	**Explicitly embed suicide prevention within MARAC, MATAC and Safeguarding processes**	Suicide risk must become a routine and explicit part of MARAC discussion. This includes updating MARAC Operating Protocols and referral forms requiring direct questions to be asked about suicide ideation for both victims and perpetrators. MATACs should also adopt a similar approach. These processes should also be clear on the next steps required if suicide risk is identified.	DASVVAWG system, NHS Devon MARAC/MATAP, Police,
3f.3	**Build suicide prevention awareness in DASH training offers.**	Domestic Abuse, Stalking and Harassment (DASH) assessments often identify individuals at high risk of harm, including suicide. Building suicide	DASVVAWG system, Public Health

		prevention awareness into DASH training equips practitioners to recognise warning signs and respond appropriately. However, not all agencies use DASH, and so wider workforce development is required to ensure all frontline practitioners can identify and respond appropriately to suicide risk.	

4. PROMOTING ONLINE SAFETY AND RESPONSIBLE MEDIA CONTENT

Recent decades have propelled us forward in advances of the internet, technology and the availability of media resources. This has been invaluable in raising awareness and improving access to support for suicide and self-harm. However, the online world also poses new harms that need to be addressed.

There has been emerging evidence of the link between the online environment and suicide across different age groups. Internet use for suicide-related purposes has been linked to children and young people who have presented to hospital for self-harm or a suicide attempt and middle-aged men who have died by suicide.

	Objective	Rationale and context	Key partners
4.1	**Work with local media to build a positive relationship to continuously improve responsible reporting and relevant signposting within articles and promote positive mental health reporting.**	Building strong relationships with local media supports responsible reporting in line with national guidelines and ensures inclusion of signposting to support services. Promoting positive and accurate reporting helps reduce stigma, encourages help-seeking, and supports community resilience.	Public Health, local media
4.2	**Raise awareness and promote good practice guidance and resources around online safety and reducing online harms.**	Raising awareness and promoting good practice guidance supports safer online environments and empowers professionals, parents and communities to reduce risk.	Public Health
4.3	**Review effectiveness of moderation skills training for social media group administrators and consider ongoing opportunities.**	Social media groups can influence community attitudes and provide support, but poor moderation may allow harmful content that increases suicide risk. Cornwall, Plymouth and Somerset Public Health Teams have collaborated to provide training sessions for social media forum moderators to support them to manage content on their pages.	Public Health

5. PROVIDING EFFECTIVE CRISIS SUPPORT

Research by NCISH suggests that, of all deaths by suicide by people in contact with mental health services in England between 2010 and 2020, 15% were under the care of crisis resolution and home treatment teams (CRHTs). This is equivalent to 180 suicides per year on average. NHS 24/7 mental health crisis lines currently receive around 200,000 calls each month. And many more people are in contact with crisis services provided by other organisations, including those from the voluntary sector.

It is therefore essential that timely and effective crisis support is available to those who need it.

	Objective	Rationale and context	Key partners
5.1	**Improve system awareness of mental health crisis support provision, including options available and what the service can and cannot provide.**	Improving system awareness of available local and national options, including service capabilities and limitations ensures individuals in crisis receive the most effective support. This may include face to face, digital and telephone offers as different people have different preferences.	NHS Devon, MH providers, DMHA, Public Health
5.2	**Explore how to seek assurances on NHS crisis responses, identify areas of missed opportunities and unmet need and escalate appropriately.**	Exploring mechanisms to identify missed opportunities and unmet need enables system-wide learning and improvement. Escalating concerns appropriately strengthens supports continuous quality improvement across crisis pathways.	NHS Devon, MH providers
5.3	**Joint working with ICBs to explore VCSE alternatives to crisis support such as crisis cafes, sanctuaries and safe havens.**	Community-based alternatives such as crisis cafés, sanctuaries and safe havens provide accessible, non-clinical support for individuals in distress and can reduce pressure on statutory crisis services. Supporting ICBs to explore VCSE-led models promotes innovation, improves choice, and strengthens local capacity for early intervention.	NHS Devon, DMHA, Public Health
5.4	**Build capacity and resilience in communities by providing appropriate intervention training, such as Mental Health First Aid or ASIST.**	Building capacity within communities through training such as Mental Health First Aid or ASIST equips individuals to recognise signs of distress and respond effectively. This approach promotes early intervention, strengthens local resilience, and reduces reliance on statutory services.	Public Health, training providers

6. REDUCING ACCESS TO MEANS AND METHODS OF SUICIDE

We must work together to reduce access to the means and methods of suicide and limit the awareness of these methods.

Our plans to improve early intervention and tackle the drivers of self-harm and suicidality are vital, but only part of the overall picture, because we know there will still be individuals who may be contemplating and planning suicide. For people at this point, one of the most impactful practical interventions is to reduce access and limit awareness of the means and methods of suicide, providing more time to intervene with effective longer-term actions and preventative support.

	Objective	Rationale and context	Key partners
6.1	**Develop a suicide cluster response plan for Devon**	Suicide clusters can have a profound impact on communities and increase contagion risk. Developing a Devon-wide cluster response plan ensures a coordinated, timely approach to prevention and postvention, enabling rapid mobilisation of support and intelligence sharing.	Public Health
6.2	**Working with partners such as highways, bridges, railways and the coast guard to identify and implement appropriate suicide prevention measures.**	Locations such as highways, bridges, railways and coastal areas are associated with higher suicide risk. Working collaboratively with partners to identify and implement prevention measures—such as physical barriers, signage and surveillance—reduces access to means and supports early intervention.	Public Health, Highways, National Rail, Coast Guard
6.3	**Review and strengthen the role of Public Health in assessing planning applications to support 'designing out' risk factors for suicide**	The built environment can influence suicide risk through access to means and lack of protective design features. Reviewing the role of public health in planning applications supports a proactive approach to 'designing out' risk, ensuring developments incorporate safety measures and promote wellbeing. This strengthens upstream prevention and embeds suicide awareness into local planning processes.	Public Health, Planning teams
6.4	**Explore measures to improve medication safety particularly in situations where suicide risk may be higher.**	People who are bereaved and people who have a terminal or life-altering diagnosis may be at increased risk of suicidal ideation. They may also have access to strong (e.g. opioid, benzodiazepines, gabapentin etc.) medication through leftover prescriptions or because they are prescribed for their condition.	

7. PROVIDING EFFECTIVE BEREAVEMENT SUPPORT TO THOSE AFFECTED BY SUICIDE

Evidence suggests family, friends and acquaintances who are bereaved by suicide may have a risk of dying by suicide that is up to three times higher than the general population. Compassionate, effective and timely support for people bereaved by suicide is essential.

	Objective	Rationale and context	Key partners
7.1	**Adopt a 'Public Task' legal basis for referrals from the Police to suicide bereavement support services, rather than relying on individual consent.**	Using a 'Public Task' legal basis for referrals from the Police to suicide bereavement support ensures timely and appropriate information sharing without relying on individual consent, which can be challenging during periods of acute distress.	Police, Pete's Dragons, NHS Devon
7.2	**Develop a consistent approach across Devon to support education settings affected by a suicide.**	Suicide within an education setting can have a profound and lasting impact on students, staff and the wider community. Developing a consistent approach across Devon ensures timely, coordinated postvention support, reduces the risk of contagion, and promotes emotional wellbeing.	Public Health, CYP system
7.3	**Work with organisations to ensure appropriate plans are in place to enable an effective response that supports the wellbeing of staff members (and clients) following a suicide in a client or staff member.**	Suicide within an organisation can have profound emotional and operational impacts on staff and clients, increasing risk of trauma and further harm. Ensuring organisations have clear postvention plans promotes timely, compassionate support, reduces stigma, and helps maintain workforce wellbeing.	Public Health

8. MAKING SUICIDE EVERYONE'S BUSINESS

Suicide prevention is everyone's business. Every person, organisation and service play a role. In recent years, good progress has been made to tackle the stigma around suicide and mental health. However, there is more we can all do to ensure we are all equipped with the skills necessary to potentially save lives.

	Objective	Rationale and context	Key partners
8.1	**Develop a shared online space for Devon-wide suicide prevention.**	A shared online space will enable consistent communication, resource sharing, and coordination across Devon partners. This improves accessibility to guidance, training, and data, reducing duplication and ensuring alignment with regional priorities. It supports collaborative working and strengthens the collective impact of suicide prevention efforts.	SPOG
8.2	**Improve system ability to access funding for suicide prevention activity.**	Securing funding is critical to deliver and scale effective suicide prevention interventions. Improving system capability to identify, apply for, and manage funding opportunities will support innovation and continuous improvement of suicide prevention efforts. To achieve this, we need a clear understanding of need and a cohesive and shared strategy with clear system-wide direction.	SPOG
8.3	**Raise awareness, challenge stigma, promote training and signposting of resource and support to the whole population with a particular focus on the priority groups and risk factors identified in the strategy.**	Promoting training, signposting, and accessible resources across the population, while prioritising high-risk groups identified in the strategy (including people who support people in these groups in a formal or informal capacity), will build protective factors, improve community resilience, and ensure equitable access to support.	SPOG
8.4	**Increase the general awareness of safety plans and their use.**	Safety plans are an evidence-based tool that help individuals manage suicidal thoughts and reduce risk during crisis. Increasing awareness of their purpose and use among professionals, communities, and those at risk will promote early intervention and empower individuals to access support.	SPOG
8.5	**Share progress, learning and key updates from the One Devon Suicide**	Transparent reporting and shared learning are essential to maintain accountability, drive improvement, and strengthen collaboration across the system. Disseminating progress and key updates—such as through an annual	SPOG

	Prevention group widely, e.g. through an annual report.	report—ensures partners remain informed, promotes best practice, and supports continuous development of suicide prevention activity across One Devon.	
8.6	**Review as a system how people with lived experience of suicide bereavement and mental health crisis will be engaged and supported in a safe, respectful and impactful way to help shape priorities and inform service design.**	Engaging people with lived experience of suicide bereavement and mental health crisis is critical to ensuring services are relevant, compassionate, and effective. A system-wide review will help establish safe and respectful mechanisms for involvement, reduce risk of harm, and ensure contributions are impactful. The system should also highlight where this is being done currently and share good practice.	SPOG
8.7	**Support the whole system to embed trauma informed approaches, ensuring service are able to recognise and respond to the impact of Adverse Childhood Experiences (ACEs) and other forms of trauma.**	Embedding trauma-informed approaches across the system acknowledges the impact of Adverse Childhood Experiences (ACEs) and other traumatic events on mental health and suicide risk. This ensures services respond with empathy, reduce re-traumatisation, and promote recovery.	SPOG

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SUICIDE PREVENTION STRATEGIC PLAN

Health and Wellbeing Board, 12 March 2026

1. BACKGROUND

A death by suicide is a tragic and traumatic event. Its most fundamental impact is the loss of the opportunity for that person to experience all that life holds. It is also a devastating bereavement for family and friends, and the pain and grief can be immense and long lasting. The impact also extends into the wider community, workplaces and to all services involved.

Suicide can be preventable. But it is essential that the preventative approach addresses the complexity of the issue. No one organisation is responsible for suicide prevention and there are no simple measures to prevent suicide. Suicide prevention is broad and includes measures to improve emotional wellbeing, support for people with mental health issues (from early intervention through to crisis care), and support for people who are bereaved by suicide.

Multi-agency suicide prevention actions help coordinate action to reduce suicides in local areas. In England, responsibility for local suicide prevention strategies and action plans usually sit with local government through Health and Wellbeing Boards. Previously, the multi-agency suicide prevention groups in Devon, Plymouth and Torbay have aligned around a strategic vision but maintained their own plans.

In March 2025, Plymouth, Devon and Torbay Health and Wellbeing Boards each supported the proposal to develop a One Devon Suicide Prevention Plan to replace the individual suicide prevention plans in each area. This would enable more effective oversight of the plan, facilitate clearer engagement with organisations that work across multiple local authority areas, improve partnership working across the county, and maximise capacity, whilst maintaining accountability to each local Health and Wellbeing Board.

2. DEVELOPMENT OF THE SUICIDE PREVENTION STRATEGIC PLAN

The plan has been co-developed by system partners and is structured around the aims and priority areas of the national Suicide prevention strategy for England: 2023 to 2028. Since March 2025 extensive collaborative work has been undertaken, this has involved:

2025/26 Q1: Mapping of existing suicide prevention plans

2025/26 Quarter 1: A mapping exercise of the existing plans in Plymouth, Devon and Torbay against the national strategy. This indicated that the three plans were all well aligned to the national strategy and that there was significant duplication across the plans.

2025/26 Q2: Engagement workshops

Through the summer of 2025 a series of face-to-face workshops were held with partners across the system to develop the new One Devon Suicide Prevention Strategic Plan. The workshops were themed against the priorities of the national strategy and partners from relevant organisations/departments were invited to attend.

2025/26 Q3: Developing the draft strategic plan

The outputs from the workshops were used to develop a draft plan. This plan was reviewed and edited by the Devon ICS Suicide Prevention Oversight Group. This group, chaired by Public

Health, consists of colleagues from across Plymouth, Devon and Torbay in Public Health, NHS Devon ICB, NHS Mental Health Providers (Livewell Southwest and Devon Partnership Trust) and the Police.

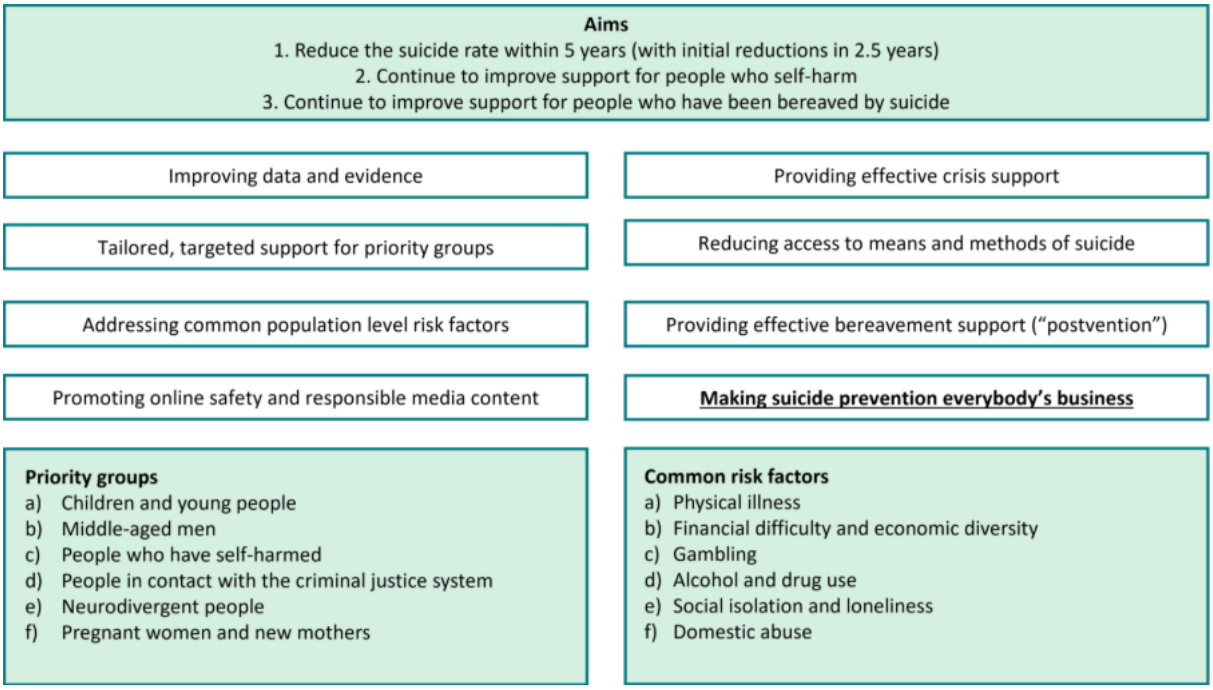
Following this, partners across the system were further consulted to provide feedback on the developing plan. This consultation occurred via email and themed meetings, for example on suicide risk in the context of domestic abuse.

2025/26 Q4: Finalising the draft plan for Health and Wellbeing Boards

Final pieces of feedback from partners reviewed and relevant changes made to create the strategy presented to HWBB. Starting of prioritisation exercise for the delivery of the objectives in the plan.

3. ONE DEVON SUICIDE PREVENTION STRATEGIC PLAN

This strategic plan has been organised so that it aligns with the national strategy's aims and priority areas. Each section of the plan reflects these themes, allowing local partners to see how their work contributes to the wider national direction, while responding to local needs and priorities.



In total there are 64 objectives in the One Devon Suicide Prevention Strategic Plan. The plan is intended for all partners involved in suicide prevention, including local authorities, NHS organisations, voluntary, community and social enterprise (VCSE) organisations, education providers, emergency services, criminal justice partners, employers and community leaders, as well as for commissioners and system leaders who oversee and resource suicide prevention activity. It is also a reference point for anyone developing, delivering or commissioning services and interventions that may reduce suicide risk.

Governance for this action plan is provided through the existing suicide prevention partnerships in Devon, Plymouth and Torbay and accountable to their respective Health and Wellbeing Boards. Oversight, prioritisation of the objectives and development of specific actions to meet the objectives will be held by the Devon ICS Suicide Prevention Oversight Group (SPOG), which provides senior strategic leadership and ensures effective cross-communication and alignment between suicide prevention partnerships and the wider ICS. This governance framework enables consistent priorities across the system while allowing local adaptation based on existing contexts

and assets, supports timely sharing of learning and intelligence, and ensures that progress, challenges and successes are fed back to all areas.

Overarching principles

The following principles underpin the development and delivery of this suicide prevention strategic plan. They reflect how we will work together as a system and the values that should guide all activity across Devon, Plymouth and Torbay:

Localised delivery within a system-wide framework	Actions agreed at Integrated Care System (ICS) level should be implemented in ways that respond to the specific needs, assets and contexts of local areas. Where appropriate, actions will be adapted to reflect the priorities and delivery models of locality partnerships while remaining aligned to the overall system plan.
Collaborative system working and strong partnerships	Suicide prevention is everybody's business. Success depends on effective collaboration between local authorities, NHS organisations, voluntary and community sector partners, education, employers, emergency services, criminal justice partners and community leaders. System partners will share learning, resources and expertise to maximise impact.
Meaningful involvement of people with lived experience	People with personal experience of suicide, bereavement and mental health crisis bring essential insight to prevention work. The system will review how they will be engaged and supported in a safe, respectful and impactful way, shaping priorities, informing service design and contributing to evaluation and continuous improvement.
Equity and inclusion	All activity will take account of the unequal distribution of suicide risk, ensuring that prevention approaches are inclusive and responsive to the needs of groups who experience higher risk, due to factors such as deprivation, discrimination, trauma, neurodiversity or other vulnerabilities and to differences in local service provision and capacity.
Evidence-informed and continuously improving practice	Decisions will be based on the best available data, research and real-time intelligence. The system will monitor outcomes, evaluate interventions and adapt approaches in response to emerging evidence and feedback from those affected.

4. RECOMMENDATIONS

It is recommended that the Health and Wellbeing Board reviews and ratifies the One Devon Suicide Prevention Strategic Plan for 2026-2031

Reason for recommendation:

Suicide Prevention partnerships are accountable to Health and Wellbeing Boards. Therefore endorsement will enable partners to begin the delivery of the plan, focusing on the highest priority areas in the first year.

5. ALTERNATIVE OPTIONS

The alternative is to not agree and endorse the plan. This would risk hindering the collaborative progress made over the past year, delay delivery of suicide prevention activities and require local areas to create a new strategic plan for each area.

6. FINANCIAL IMPLICATIONS AND RISK

There are no financial implications to this decision

7. NEXT STEPS

Following Health and Wellbeing Board approvals of this plan, partners in the Devon ICS Suicide Prevention Oversight Group will undertake a prioritisation exercise so that a phased approach to delivering the objectives of the plan can be agreed.

Health and Wellbeing Boards will receive an update on the progress against the plan annually.

PLYMOUTH SUICIDE AUDIT – SUMMARY

Deaths registered 2022 to 2024

Author: Office of the Director of Public Health, Plymouth City Council

Date: January 2026 (v1.0)

This document is produced as part of Plymouth's Joint Strategic Needs Assessment.

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Plymouth Suicide Audit – Summary

Based on deaths registered in 2022, 2023 and 2024

Deaths by suicide and undetermined intent

Purpose and focus

This report provides a city-wide overview of the deaths of Plymouth residents by suicide and undetermined intent. It updates the information provided in our previous report covering 2021 to 2023.[1] Local suicide audits are undertaken to monitor local trends and to compare these with national data, and also to support suicide prevention initiatives. The Plymouth Suicide Prevention Strategic Partnership, a multi-agency group led by Plymouth City Council, has responsibility for suicide prevention in the city.

Deaths of Plymouth residents are included in this audit whether they died in Plymouth or elsewhere in the UK. The information presented refers to the deaths of residents (aged 10 years and older) registered during calendar years 2022, 2023 and 2024. However, not all of these deaths will have occurred during these three years as deaths by suicide and undetermined intent are registered only after an inquest has taken place.

Definition of suicide

A death is officially considered a suicide only when a coroner at an inquest has concluded that the person intentionally took their own life (using a lower civil standard of proof,[2] from mid-2018). Deaths that are 'undetermined' are where the coroner at inquest reaches an open or narrative verdict because the intention of the person is uncertain. The Office for National Statistics currently defines as suicide 'all deaths from intentional self-harm for persons aged 10 years and over and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 years and over'.[3]

Audit process and data sources

Our local suicide audit process involves monitoring all deaths where the coroner has given a conclusion of suicide, or an open or a narrative conclusion. During the year information is collected from weekly death registrations, from the Primary Care Mortality Database, and from HM Coroners Office.

Deaths included in this audit have been checked and verified using mortality data for Plymouth residents provided by NHS Digital. Deaths from suicide are confirmed using the International Classification of Diseases (ICD10) codes X60-X84 ('intentional self-harm') and deaths from undetermined intent are identified using ICD10 codes Y10-Y34, excluding Y33.9 ('event of undetermined intent').[4]

Information on the trend in mortality rates is drawn from the Public Health Outcomes Framework and the Health Profiles produced by the Office for Health Improvement & Disparities.

Number of deaths 2022, 2023 & 2024

- 49 deaths in total: 44 Plymouth residents died by suicide and 5 residents died by undetermined intent (UI)
- More deaths were registered in 2022 than in 2023 or in 2024 (20 deaths in 2022 compared to 17 deaths in 2024 and 12 deaths in 2023)

Average number & rates

- The average number of deaths per year from 2004 to 2024 is 23
- The directly age-standardised mortality rate for the period 2022 to 2024 for persons is 6.8 deaths per 100,000 population aged 10+ (lower than the England rate of 10.9)
- for males it is 10.9 deaths per 100,000 population aged 10+ (lower than the England rate of 16.8)
- for females it is 2.9 deaths per 100,000 population aged 10+ (lower than the England rate of 5.5)
- Trends in mortality rates from 2003 to 2024 are shown in the chart (below)

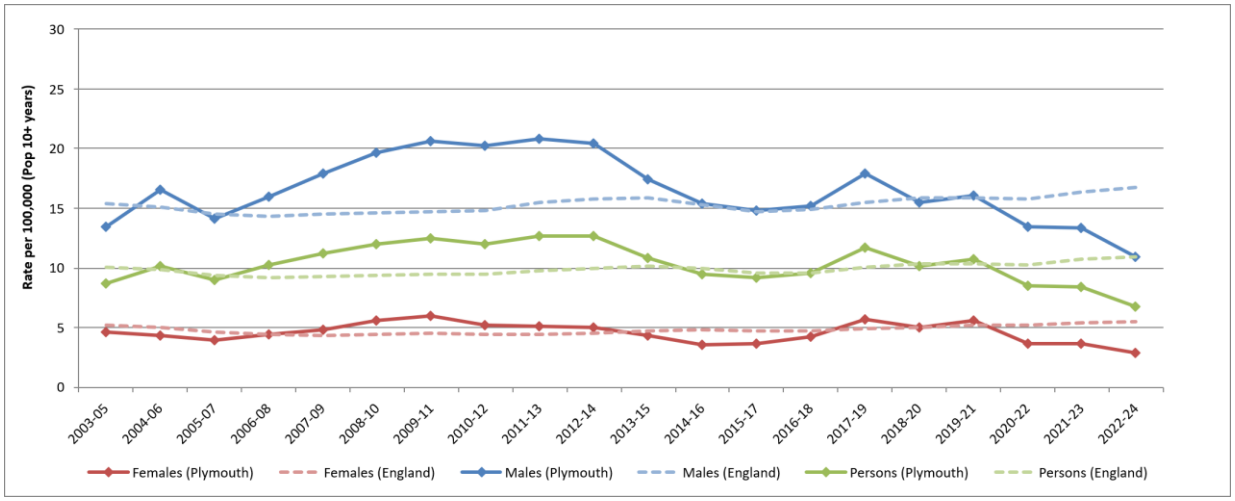
Sex differences

- 38 males and 11 females died (just over three times as many males than females)
- 11 females died by suicide
- 33 males died by suicide and 5 by UI

Place of birth

- 19 people who died were born in Plymouth, 21 were born elsewhere in the UK, and 8 were born outside the UK.

Trends in mortality from suicide/ UI, England & Plymouth, 2003-05 to 2022-24



Source: Suicide Prevention Profile (January 2026)

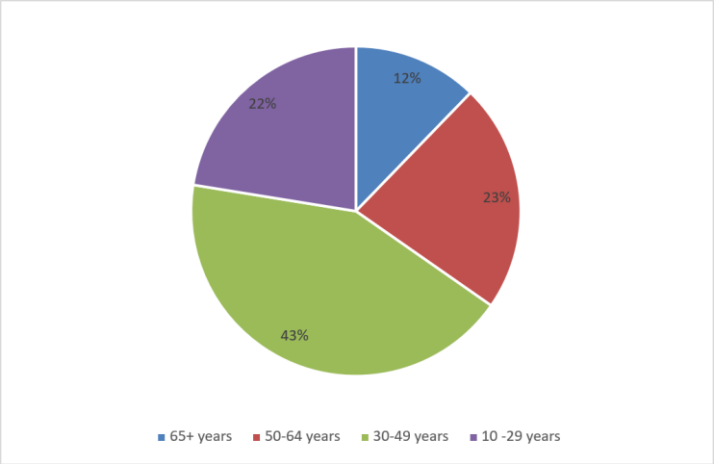
Delay in registration for suicide

- Across the last few years in Plymouth the delay in coroner registration has increased i.e. the time between date of death and a suicide conclusion at the coroner's inquest. For suicide deaths that were registered in 2024 Plymouth has one the longest delays in the country with a median delay of 698 days compared to 199 for England.[5]

- The increasing coroner registration delay is likely to artificially be reducing the official suicide statistics for Plymouth
- They delay has been due to an inherited backlog by the Coronial Service. The Coroner services for Plymouth, Torbay and Devon merged into a single County of Devon Coroner area as of April 1, 2024.

Age groups

- 11 people who died were younger than 29
- 6 people who died were older than 65
- The majority of those who died were below the age of 50



Source: NHS Digital

Place of death

- 27 people died at home and 11 died elsewhere in the city
- 4 people had their place of death noted as Derriford Hospital
- 7 Plymouth residents died outside the city

Plymouth Suicide Audit summary reports present data for deaths registered in particular calendar years combined for three-year periods. This enables comparisons to be made with national mortality data which is also presented by year of registration. Death by suicide/ UI is a rare event in Plymouth and the numbers of deaths fluctuate from year to year.

Where they lived

Death by suicide and undetermined intent is a concern across the city:

- **18 of the 20 wards in the city had at least one resident die by suicide/ UI**

Four wards had the highest number of residents die by suicide/ UI: 'St Peter & the Waterfront' (8 deaths) followed by 'Stoke (5 deaths), and 'Drake (5 deaths). There were no deaths by suicide/ UI in two wards.

Note: For information one undetermined intent death is not included in this report as their age is below ONS definition of 15+.

References

1. Hoad, S. (2024) Plymouth Suicide Audit Summary (2020-2022). Plymouth City Council: ODPH.
2. Office for National Statistics (2019): Suicides in the UK: 2018 registrations.
3. Office for National Statistics (2020): Suicides in England and Wales: 2019 registrations.
4. World Health Organisation (2010) International Statistical Classification of Diseases and Related Health Problems, 10th Revision. Geneva: WHO.
5. Office for National Statistics (2024): Suicides in England and Wales by local authority.

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Suicide Prevention in Plymouth

Plymouth Health and Wellbeing Board,

12 March 2026

Kamal Patel

Public Health Consultant, Plymouth City Council

Overview

- Background
- Local suicide data
- Coroner registration delays
- Suicide Prevention – key information
- One Devon Suicide Prevention Strategic Plan
- Key activities and resources

Background

- Please look after yourself and take time if you need. **Mental health support | PLYMOUTH.GOV.UK**
- Suicide is the act or instance of intentionally killing oneself.
- Only a Coroner can determine a suicide, after an inquest.
- We may talk about data and numbers, but we are always aware that these figures relate to real people.
- Every suicide is a tragic loss and has devasting and long-lasting impact upon families, friends, neighbours, colleagues and whole communities.

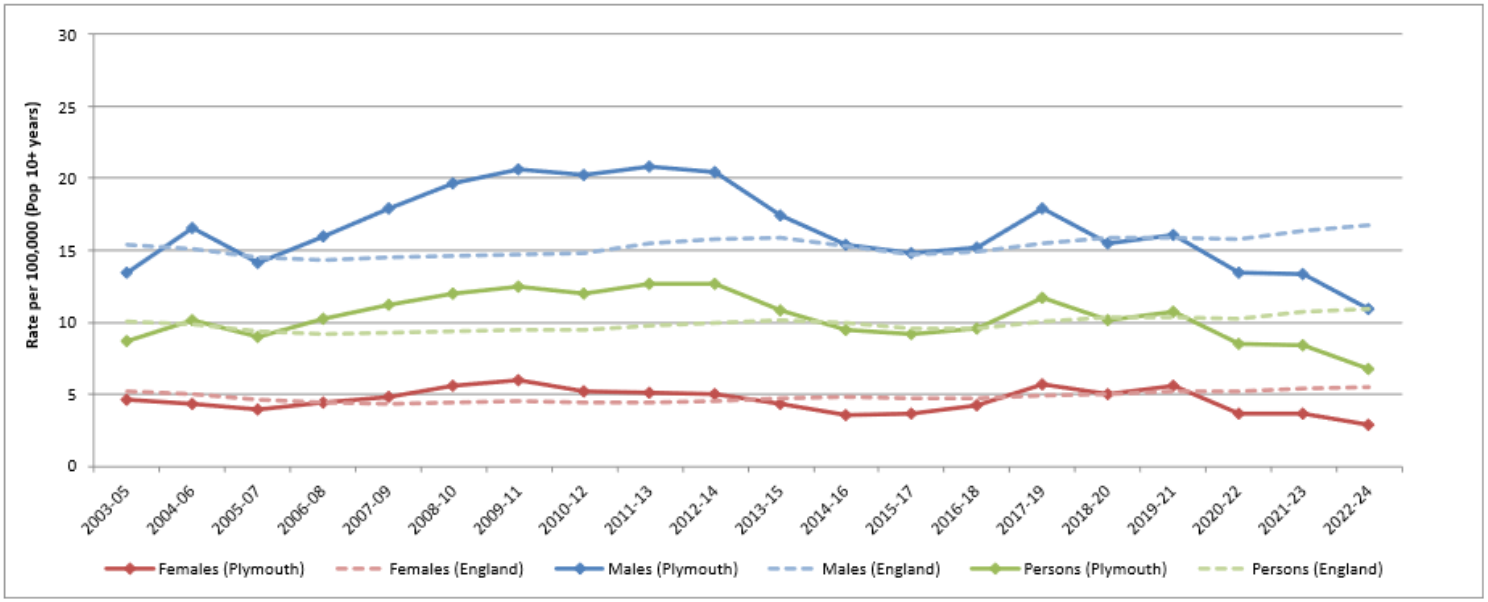
Background

- The causes of suicide are complex and individual. There is rarely a single cause.
- Risk factors often reflect wider inequalities and economic factors.
- The impact is felt most deeply at a personal and human level. The average cost to society of each death is £1,67 million.
- 70% of people who die by suicide are not known to mental health services in the year before their death.
- Suicide can be preventable.

Plymouth Suicide Audit – Summary 2022-2024

PLYMOUTH CITY COUNCIL

Trends in mortality from suicide/ UI, England & Plymouth, 2003-05 to 2022-24

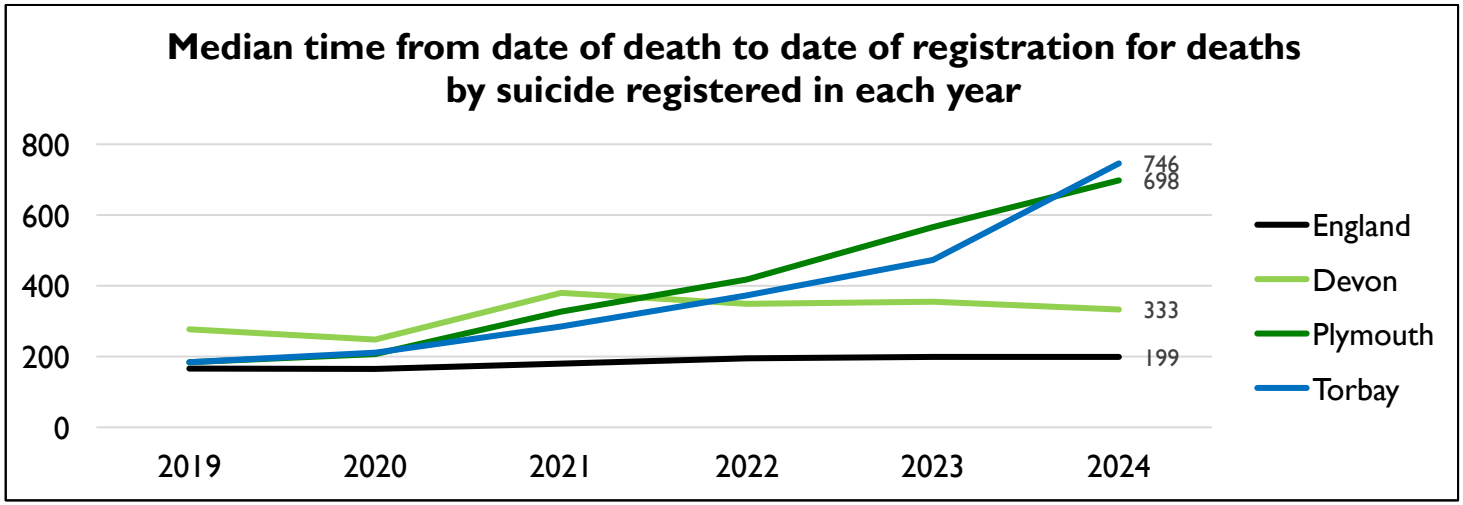


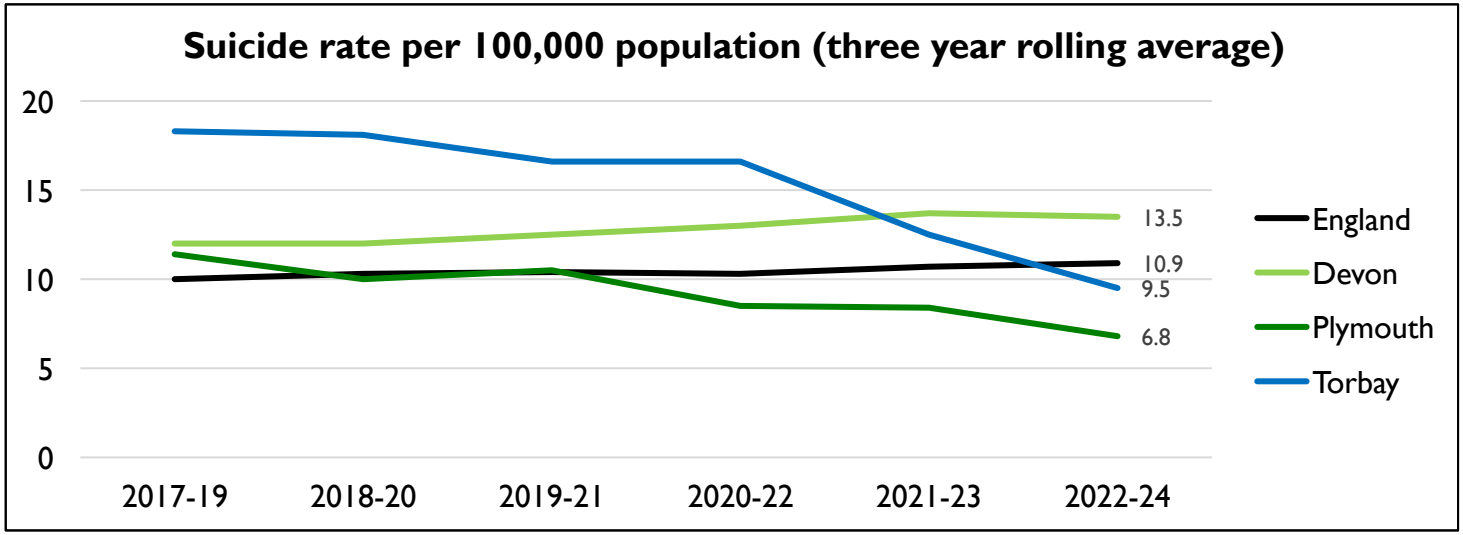
Source: Suicide Prevention Profile (January 2026)

Coroner registration delays

- Time between a death and when a death is registered
- A death that is registered in 2024 will be within the 2022-24 dataset regardless of when the death actually occurred
- The official suicide statistics are dependent on the time between death occurring and being registered as a suicide.
- Long delays can artificially reduce the suicide rate

Coroner registration delays





What is suicide prevention?

- Suicide prevention is broad and includes everything from:
  - Measures to improve population level emotional health and wellbeing (including through the wider determinants of health).
  - Support for people with mental health issues (from early intervention through to crisis care).
  - Support for people who are bereaved by suicide.
- It is essential that the preventative approach addresses the complexity of the issue.
- No single organisation is responsible for suicide prevention and there are no simple measures to prevent suicide.
- Suicide prevention is everyone's business. A whole systems approach is required so that partners are working in collaboration towards the same priorities.

Talking about suicide

- Talking about suicide is hard.
- Asking about suicide can relieve the person of the internal burden if approached sensitively and compassionately.
- Worry about language shouldn't stop us talking about suicide…however,
- There is stigma associated with suicide and thoughts of suicide, Stigma reduces help-seeking behaviour.

Preferred language	Try to avoid
Die by/ death by suicide	Commit suicide (it is not a crime) Completed/successful suicide
Suicide attempt	A 'successful', 'unsuccessful', or 'failed' suicide attempt
Thoughts of suicide	'Just', 'only', 'threat', 'attention seeking'

Suicide bereavement service

- People bereaved by suicide are at higher risk themselves
- Bereavement support - NHS Devon commissioned service
- Provide support for anybody (adults and children) affected by suicide for as long as they need
- Historical and recent suicide deaths
- No waiting lists – support starts within 48 hours of contact.

Suicide Prevention Training

[Wellbeing at Work (Livewell Southwest) Events | Eventbrite]

One Devon Suicide Prevention Strategic Plan

- In March 2025, Plymouth, Devon and Torbay Health and Wellbeing Boards each supported the proposal to Develop a One Devon Suicide Prevention Plan to replace the individual plans across each area.
- The reasons for the proposal were:
  - Improve partnership working across the county
  - To enable more effective oversight of the plans
  - Maximise capacity and reduce duplication
- Accountability to local Health and Wellbeing Boards would be maintained.

Development of the Strategic Plan

- The plan has been co-developed by system partners from across Plymouth, Devon and Torbay
  - 2025/26 Q1: Mapping of existing plans against the national strategy
  - 2025/26 Q2: Series of engagement workshops held
  - 2025/26 Q3: Development of the draft strategy using workshop outputs and further consultation
  - 2025/26 Q4: Final feedback and start of prioritisation

The Strategic Plan

- The plan is organised to align with the priorities of the national strategy:

Aims
1. Reduce the suicide rate within 5 years (with initial reductions in 2.5 years)
2. Continue to improve support for people who self-harm
3. Continue to improve support for people who have been bereaved by suicide

Improving data and evidence	Providing effective crisis support
Tailored, targeted support for priority groups	Reducing access to means and methods of suicide
Addressing common population level risk factors	Providing effective bereavement support ("postvention")
Promoting online safety and responsible media content	**Making suicide prevention everybody's business**

Priority groups
a) Children and young people
b) Middle-aged men
c) People who have self-harmed
d) People in contact with the criminal justice system
e) Neurodivergent people
f) Pregnant women and new mothers

Common risk factors
a) Physical illness
b) Financial difficulty and economic diversity
c) Gambling
d) Alcohol and drug use
e) Social isolation and loneliness
f) Domestic abuse

Governance

- Governance through existing suicide prevention partnerships in Plymouth, Devon and Torbay – accountable to their respective Health and Wellbeing Boards
- Prioritisation and oversight will be held by the Devon ICS Suicide Prevention Oversight Group (SPOG)
- Enables consistent priorities across the system, while allowing for local adaption

Overarching principles

- Localised delivery within a system-wide framework, informed by national strategy
- Collaborative system working and strong partnerships
- Meaningful involvement of people with lived experience
- Equity and inclusion
- Evidence-informed and continuously improving practice

2025/26 Key activities

- Reviewed Livewell training package
- Launch of key 'suicide prevention toolkit' items – SOS Leaflet, CYP Guide, Safety Plan template
- City bridge reviews for prevention work – lighting, foliage, fence and access reviews
- Developing working relationships with Reach Plc
- Widened suicide prevention messaging:
  - Community suicide prevention drop in events
  - Speaking at networking events
  - Bespoke engagement with local organisations
  - Development and delivery of social media training
  - Positioning of wellbeing benches / plaques


COME SIT WITH US

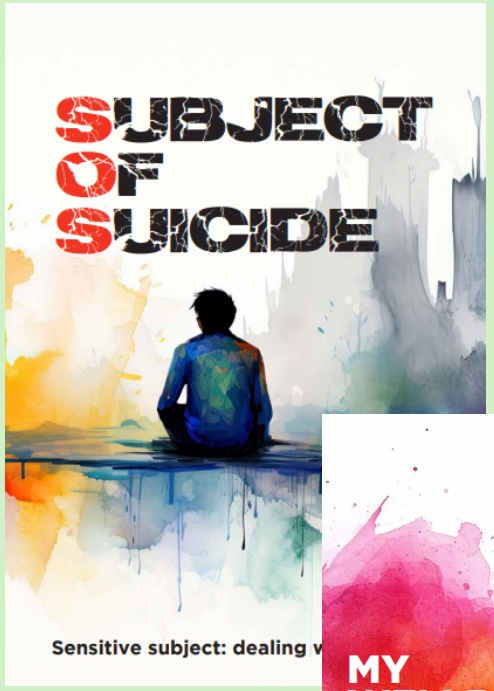

My mental health safety plan
safety plan

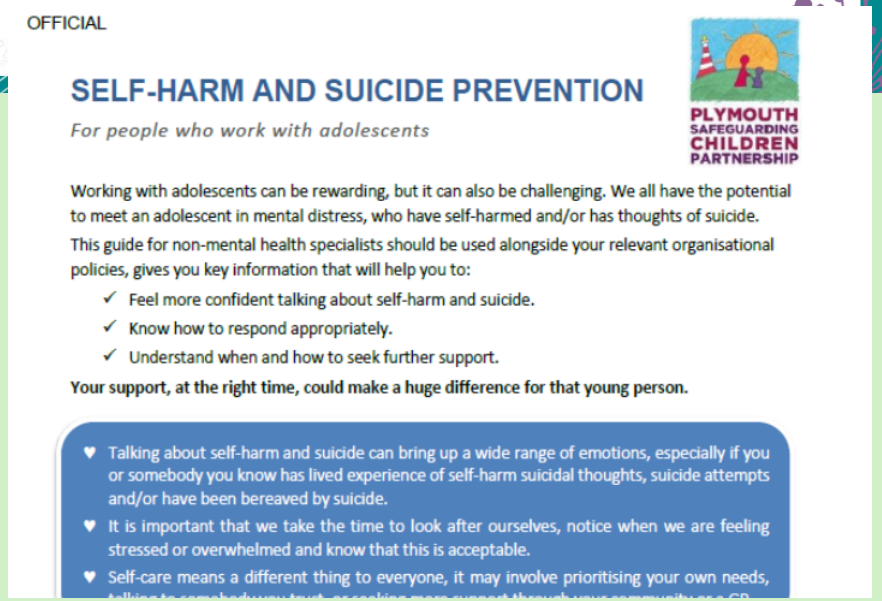

Plymouth Support
Find the support you need now
I want to talk
Livewell Southwest First Response
24/7 Crisis Line - Call 111, free
Samaritans - Call 116 123, free 24/7
Papyrus UK - Call 0800 068 41 41, free 24/7
I want to text
SHOUT - text 'SHOUT' to 85258, free 24/7
I want to read
Letter of Hope
I want information about support


SUICIDE
PREVENTION
DAY

Suicide Prevention Toolkit

PLYMOUTH CITY COUNCIL




OFFICIAL

SELF-HARM AND SUICIDE PREVENTION

For people who work with adolescents

PLYMOUTH SAFEGUARDING CHILDREN PARTNERSHIP

Working with adolescents can be rewarding, but it can also be challenging. We all have the potential to meet an adolescent in mental distress, who have self-harmed and/or has thoughts of suicide.

This guide for non-mental health specialists should be used alongside your relevant organisational policies, gives you key information that will help you to:

- ✓ Feel more confident talking about self-harm and suicide.
- ✓ Know how to respond appropriately.
- ✓ Understand when and how to seek further support.

Your support, at the right time, could make a huge difference for that young person.

- ♥ Talking about self-harm and suicide can bring up a wide range of emotions, especially if you or somebody you know has lived experience of self-harm suicidal thoughts, suicide attempts and/or have been bereaved by suicide.
- ♥ It is important that we take the time to look after ourselves, notice when we are feeling stressed or overwhelmed and know that this is acceptable.
- ♥ Self-care means a different thing to everyone, it may involve prioritising your own needs,

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Health and Wellbeing Board

Date of meeting:	12 March 2026
Title of Report:	**Vaccination Update**
Lead Member:	Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Professor Steve Maddern (Director of Public Health)
Author:	Jacob Hyams
Contact Email:	jacob.hyams@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
The purpose of the report is to provide an update on the activities undertaken to improve vaccine uptake, provide insights into their effectiveness and outline future actions.

Recommendations and Reasons
1. That the Health and Wellbeing Board note the vaccination update.

Alternative options considered and rejected
1. Not relevant. For information only.

Relevance to the Corporate Plan and/or the Plymouth Plan
The report directly addresses the Plymouth Plan strategic objective of 'delivering a healthy city' by detailing the progress of work to increase vaccination uptake across the city.

Vaccinations are considered the mainstay of preventive health, and an area where health inequalities persist, so work on this topic directly speaks to Plymouth Plan policies HEA1: addressing health inequalities, HEA2: delivering the best outcomes for children, young people and families, and HEA9: delivering accessible health services and clinical excellence.

This vaccination paper also direct addresses the Corporate Plan priority of "Working with the NHS to provider better access to health, care and dentistry"

Implications for the Medium Term Financial Plan and Resource Implications:
There are no medium-term financial plan and resource implications. For information only.

Financial Risks

There are no financial risks. For information only.

Legal Implications

There are no legal implications. For information only.

Carbon Footprint (Environmental) Implications:
There are no carbon footprint or environmental implications. For information only.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
There are no other implications. For information only.

Appendices

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must i why it is not for publication by virtue of Part 1of Schedu of the Local Government Act 1972 by ticking the releva*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Vaccination Update	X						

Background papers

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**
See appendices							

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Asset s	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Professor Steve Maddern											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 25/02/2026											
Cabinet Member approval: Cllr Mary Aspinall – signed by email Date approved: 02/03/2026											

VACCINATION UPDATE

Health and Wellbeing Board

Office of the Director of Public Health

Introduction

The UK routine vaccination schedule consists of 15 vaccines protecting against 21 diseases. In England, vaccine services are commissioned by the NHS England Vaccination and Screening Team (VaST) with input from the Integrated Care Board (ICB). This commissioning role will move in coming years, so the ICB are currently shadowing to prepare for the transition. The provision of vaccination services is undertaken by NHS providers, including the vaccine outreach team.

Roles and responsibilities

Whilst Plymouth City Council does not commission or deliver vaccination programmes, we provide insight into the Plymouth population and support commissioners and providers to engage with our communities. A summary of stakeholder organisations and their roles are shown in the table below.

Organisation	Role	Description
NHS England Vaccination and Screening Team (VaST)	Commissioning	Commissions vaccination services
Integrated Care Board (ICB) NHS Devon	Commissioning	Supports commissioning at a regional level and is shadowing for future commissioning role. NHS Devon also commission a Vaccination Optimisation team
GP Practices	Delivery partner	Deliver much of routine vaccination schedule, maintaining patient records, managing invites and clinical oversight
Vaccine Outreach Team	Delivery partner	Provide additional, flexible community-based delivery of seasonal and maternity vaccinations for harder-to-reach groups

School-Aged Immunisation Service (Kernow Health)	Delivery partner	Contracted to deliver school-aged vaccination programmes, including educational sessions in schools
Community Pharmacies	Delivery partner	NHS commissioned pharmacies provide influenza and Covid vaccines
Plymouth City Council	Facilitation and support	Liaison with commissioners and delivery partners to provide community insight and wraparound support to vaccination providers
VCSE Organisations	Facilitator	Charities, community groups and other partner organisations support vaccination providers through vaccination messaging, hosting community provision, and instilling trust in NHS-led services

Seasonal Vaccination

In 2025, Plymouth City Council launched 'Plymouth Protects', a multi-media communications campaign to improve vaccination uptake across the city. This campaign aim was to improve uptake of vaccinations, including seasonal vaccines, such as influenza, particularly amongst vulnerable groups.

Branded posters and digital assets were produced (see Annex), carrying key messaging to encourage vaccination, including materials for specific vaccines. Digital media assets were promoted across PCC social media channels, including Facebook, X, and LinkedIn. Posters and leaflets were provided in libraries, wellbeing hubs, family hubs and welcome spaces, and provided to stakeholder organisations. Posters were also displayed on bus shelters and in the Drakes Circus shopping mall on digital boards.

All information materials linked users, via a QR code or URL, to a PCC hosted webpage with information. This information page attracted over 5,300 views between October and February and accounted for over 30% of views to PCC webpages.

A Plymouth Chronicle article, featuring the Director of Public Health reinforced vaccine messaging for residents and was distributed to 92,000 homes. (See Annex).

The Public Health team also amplified vaccination messaging for carers through targeted advertising for anyone in the Plymouth area who searched online for information relating to carers. This targeted advertising ran throughout November 2025 and generated 12,983 interactions and 9,537 clicks to access further information on vaccinations.

To support PCC staff, four clinics were provided by the vaccine outreach team across PCC locations, with 135 employees vaccinated against influenza.

As of 18th January 2026, the city-wide uptake amongst eligible individuals was 59% for flu (England: 53%) and 64% for Covid (England: 57%).

Health and social care staff

To increase uptake amongst Adult Social Care staff, Plymouth City Council worked with care home managers forum, using the Vaccine Outreach Team to provide tailored education sessions to care home managers. A similar offer was delivered to domiciliary care workers.

University Hospital Plymouth (UHP) conducted staff vaccination activities with an aim of increasing uptake for flu vaccines across their staff group. As of January 2026, staff uptake for the influenza vaccine was 57%, a considerable improvement on 46% in the previous year.

Childhood Vaccinations

From 1st January 2026, the childhood immunisation schedule changed to combine a new Varicella (chickenpox) vaccine with the MMR vaccine; the new MMRV. The timings for this vaccination schedule were also updated to 12 months for the first dose with a follow-up at 18 months. This schedule change may mean that the vaccination record, "red book", may not be accurate, with parents advised to respond to invitations from the child's GP surgery if they are unsure.

Information on the childhood vaccination schedule has been shared on PCC social media channels and shared with Family hubs, and through the Early Years and Childcare Bulletin. Infographics and other resources from the UKHSA advising of the changes were also distributed to the Family hubs.

Human Papillomavirus (HPV)

HPV is the cause of a range of cancers, affecting both males and females, and increasing vaccine uptake is critical to ensure cervical cancer elimination for Plymouth residents. Data for 2025 shows a disparity in uptake for children in Year 10 with 72.8% for boys (England: 71.2%) and 79.5% for girls (England: 76.7%). Uptake is also lower in schools in areas with higher levels of deprivation and amongst children who are electively home educated.

The public health team have engaged with the school-aged immunisation provider to explore options to improve information provision to schools, parents and pupils, including plans to co-produce suitable digital communications with the Youth Parliament.

Work has also begun to improve data sharing between schools and the immunisation provider to identify unvaccinated children so that they can be followed up. We are also identifying links to improve support for children who are electively home educated.

Vaccines for Older Adults

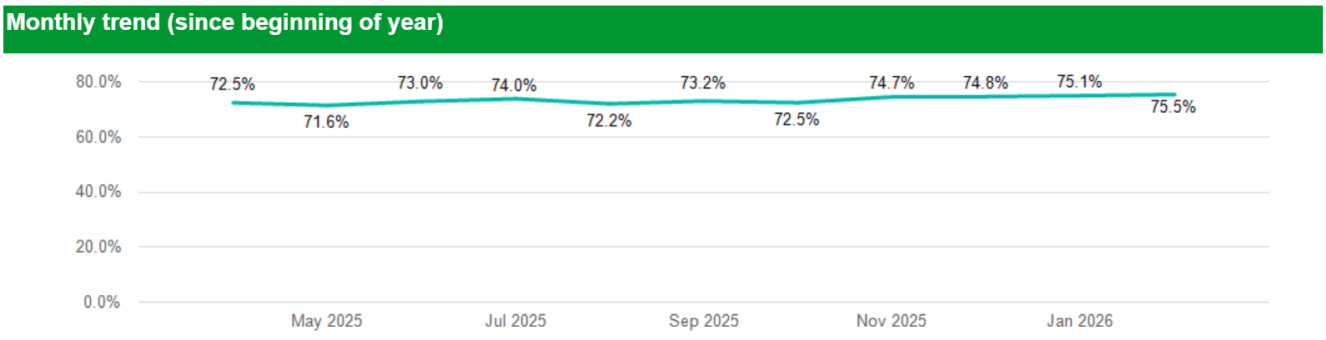
Three key vaccines are offered to older adults: shingles, Respiratory Syncytial Virus (RSV) and PPV (pneumococcal). These vaccines are offered year-round to older adults but each vaccine has different eligibility criteria.

Plymouth Protects communications materials promoting vaccine uptake for these three vaccines are being expanded to include new posters and digital assets, emphasising year-round eligibility and highlighting complications such as pneumonia to improve understanding around the importance of the vaccines.

This plan has been presented to stakeholders at the Ageing Well Collective to engage them in targeting communications materials and gain their support to amplify vaccine messaging for older adults. Posters will be distributed to wellbeing hubs, libraries, care settings, religious spaces and VCSE organisations, while the digital assets will be promoted via PCC social media channels.

Children in Care

A specialist NHS team collects data for children who have a current looked after period of care, based on the child's last immunisation check during their regular health assessment. This indicates that looked after children show relatively high rates of vaccine uptake of 71.6% to 75.5%, likely due to their structured engagement in regular health checks. This overall figure may, however, mask lower uptake for specific vaccines, and looked after children are also likely to experience some of the vaccine inequalities noted elsewhere.



Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Now
72.5% (of 375) (103 not)	71.6% (of 373) (106 not)	73.0% (of 367) (99 not)	74.0% (of 373) (97 not)	72.2% (of 535) (149 not)	73.2% (of 529) (142 not)	72.5% (of 528) (145 not)	74.7% (of 521) (132 not)	74.8% (of 523) (132 not)	75.1% (of 522) (130 not)	75.5% (of 523) (128 not)

We continue to engage with specialist services to ensure access and support for all looked after children with regard to vaccination.

Other Vaccines

Pregnant individuals are offered vaccines for pertussis, RSV and the seasonal influenza virus. PCC has met with UHP midwifery teams and other stakeholders to explore opportunities to support increased uptake of maternity vaccines.

Conclusion

In summary, PCC have undertaken a range of activities throughout the winter to promote the uptake of seasonal vaccines with data suggesting that this has had a positive impact. The focus of this work will now shift to the year-round vaccine offers for older adults and improving the uptake of the HPV vaccine in school-aged children.

Annexes

1. Selection of Plymouth Protects materials

2. The Plymouth Chronicle article

Vaccines: your questions answered

Vaccines are one of the most important ways to protect ourselves and others from serious diseases. But with so much information out there, it's easy to feel confused.
Plymouth's Director of Public Health, Professor Steve Maddern, answers some common questions here.

What is a vaccine?
A vaccine is a medicine that helps your body build protection against diseases. It trains your immune system to recognise and fight off harmful viruses or bacteria without making you seriously ill. This means if you come into contact with the disease later, your body is ready to defend itself.

Why are vaccines important?
Vaccines save lives. They've helped reduce and even eliminate deadly diseases like polio, measles, and smallpox. When enough people are vaccinated, it also protects those who can't have vaccines – like babies or people with certain health conditions – by stopping diseases from spreading. This is called 'herd immunity'.

Are vaccines safe?
Yes. All vaccines used in the UK go through strict testing before they are approved. They are checked for safety, quality, and effectiveness. Once a vaccine is in use, it is constantly monitored by health experts. Like any medicine, vaccines can have side effects, but these are usually mild, like a sore arm or feeling tired for a day or two.

What vaccines can pregnant women have?
Pregnant women are offered vaccines which protect themselves and their babies – these are safe to have during pregnancy. The whooping cough (pertussis) vaccine is especially important as whooping cough can cause very serious illness in babies. Flu and Respiratory Syncytial Virus (RSV) vaccines are also recommended to help prevent babies becoming severely unwell in their first months of life.


Plymouth's Director of Public Health Professor Steve Maddern gets his flu jab

What vaccines do children and teenagers need?
Children and teenagers in the UK are offered vaccines to protect them from serious diseases like measles, mumps, rubella (MMR), whooping cough, and meningitis. The MMR vaccine is especially important, with measles cases on the rise in the UK – uptake in Plymouth is slightly below the 95% level needed to stop outbreaks.
An important vaccine for teenagers is the HPV vaccine, which helps prevent cervical and other cancers. Keeping up to date with these vaccines is the best way to keep young people protected as they grow.

Why is the flu vaccine important every year?
The flu virus changes each year, so the vaccine is updated to match the most common types expected to spread. Getting the flu jab every year is the best way to protect yourself and those around you from serious illness.

Who should get winter vaccines?
Winter vaccines include the flu jab and, for some people, the COVID-19 booster. These are offered for free to those most at risk from serious illness, including older adults, people with certain health conditions, children and pregnant women.

Why should health and care workers get vaccinated?
People working in health and social care frequently encounter people who are unwell or vulnerable. Getting the flu vaccine helps protect both the worker and those they work with from becoming seriously ill. If you care for a friend or relative, you are also eligible for a flu vaccine, to protect you both.

How do I get the vaccines that I am eligible for?
If you're unsure about which vaccines you or your family need, check the NHS website or speak to a health professional – many vaccines will be available from your GP practice.
Flu jabs are also available from many pharmacies across the city, at drop-in clinics run by the NHS, or sometimes through your workplace.

Why should I get vaccinated?
Vaccines are a simple but powerful way to protect you and your loved ones. Staying up to date with vaccinations helps protect everyone in Plymouth, keeping us all safe and healthy.

For more information about vaccines, visit www.plymouth.gov.uk/vaccinations.

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Health and Wellbeing Board

Date of meeting:	12 March 2026
Title of Report:	**Men and Boys' Health**
Lead Member:	Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Professor Steve Maddern (Director of Public Health)
Author:	Sian Reece
Contact Email:	sian.reece@plymouth.gov.uk
Your Reference:	N/A
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
The purpose of the report is to provide a briefing on England's new Men and Boys' Health Strategy, show how Plymouth's current work and outcomes compare to its aims, and propose focused next steps for local action on men and boys health and inequalities.

Recommendations and Reasons

1. That the Heath and Wellbeing Board review and comment on the Men and Boys' Health Paper.

2. That the Health and Wellbeing Board endorse the proposed next steps for local action on men and boys health and inequalities.

Alternative options considered and rejected

1. Not Consider the report – Rejected: This report stems from a request from the Board.

Relevance to the Corporate Plan and/or the Plymouth Plan
The Men and Boys' Health Strategy directly supports the Council's corporate priority to work with the NHS to improve access to healthcare and dentistry. It also aligns with key elements of the Plymouth Plan 'A Healthy City', specifically:

- **HEA1:** Reducing health inequalities
- **HEA2:** Improving outcomes for children and families
- **HEA3:** Supporting adults with health and social care needs
- **HEA9:** Ensuring accessible, high quality health services

Implications for the Medium Term Financial Plan and Resource Implications:
There are no medium-term financial plan and resource implications. For information only.

Financial Risks

There are no financial risks. For information only.

Legal Implications

There are no legal implications. For information only.

Carbon Footprint (Environmental) Implications:
There are no carbon footprint or environmental implications. For information only.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
There are no other implications. For information only.

Appendices

Ref.	Title of Appendix	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must i why it is not for publication by virtue of Part 1of Schedu of the Local Government Act 1972 by ticking the releva*						
		1	2	3	4	5	6	7
A	Men and Boys' Health Briefing	X						

Background papers:

Title of any background paper(s)	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Asset s	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Professor Steve Maddern											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 25/02/2026											
Cabinet Member approval: Cllr Mary Aspinall, signed by email Date approved: 02/03/2026											

MEN AND BOYS' HEALTH

Office of the Director of Public Health

1. EXECUTIVE SUMMARY

This paper introduces the new Men and Boys' Health Strategy for England[1] and considers its implications for Plymouth. It summarises the national direction, reflects on how Plymouth currently aligns, and proposes next steps for the Health and Wellbeing Board.

Nationally, the Men and Boys Health Strategy sets a 10-year vision to improve the health and wellbeing of men and boys, with a strong focus on prevention, earlier diagnosis of major conditions, improved mental health and suicide prevention, and reducing inequalities affecting disadvantaged groups, aligning itself strongly with the NHS 10-year plan. It emphasises meeting men and boys where they are, making services more accessible and acceptable to men, strengthening sex disaggregated data, and working with employers and community partners to reach men who are less likely to engage with traditional health services.

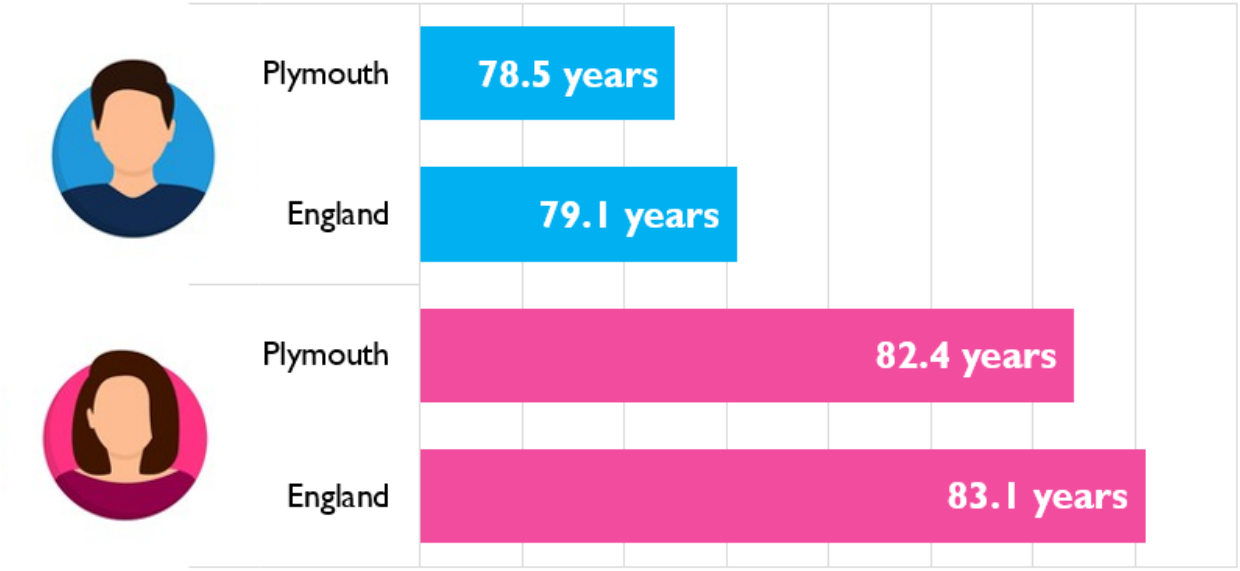
Plymouth has strong foundations that support this agenda. Existing work on tackling health inequalities, including Thrive Plymouth and the city's long-term approach to reducing gaps in health, already contributes to efforts to improve healthy life expectancy for men.

2. BACKGROUND

Across England, men continue to experience significantly poorer health outcomes than women, with 36% of men dying before their 75th birthday and male life expectancy now lower than in many other Organisation for Economic Co-operation and Development (OECD) countries.

[1] Department of Health and Social Care. *Men's Health Strategy for England.* London: DHSC; 2025. Available at: https://www.gov.uk/government/publications/mens-health-strategy-for-england.

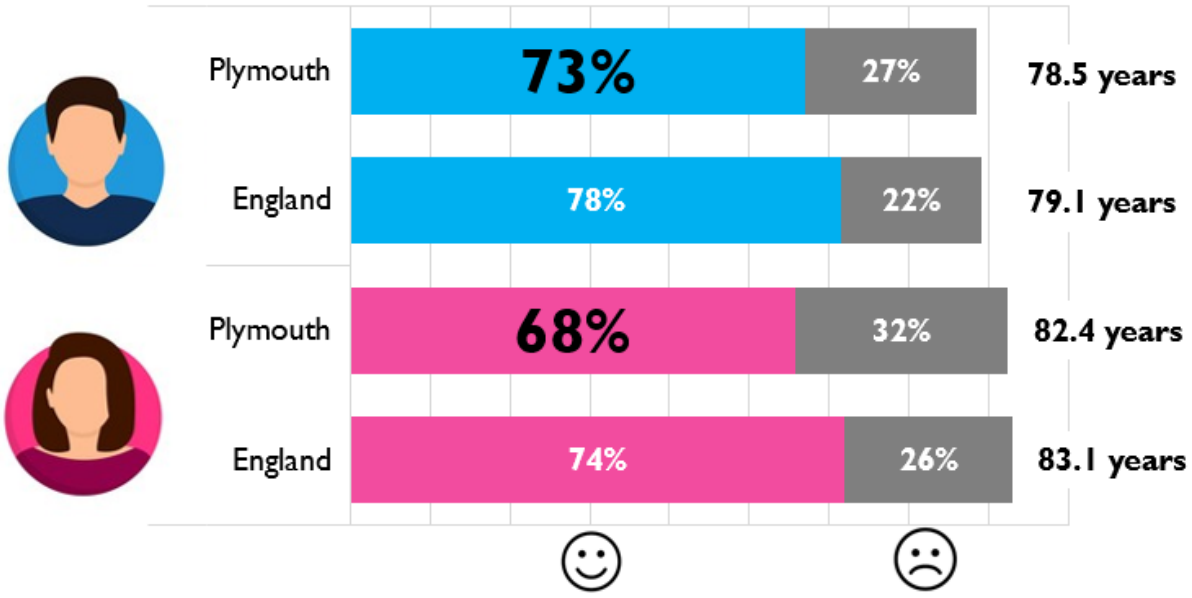
Male and female life expectancy in Plymouth and England (2021-23)



Source: Fingertips, Department of Health and Social Care, accessed 19 Jan 2026

Healthy life expectancy for men has fallen to an average of just 61.5 years, dropping by around one and a half years over the last decade, meaning men typically spend more than a fifth of their lives in poor health. Overall, men live nearly four years fewer than women, highlighting a persistent and widening gender gap in both life expectancy and years lived in good health.[2]

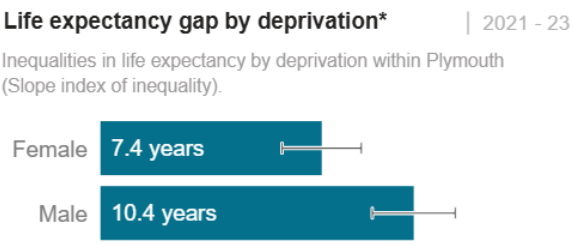
Proportions of life spent in good and poor health, for males and females, in Plymouth and England

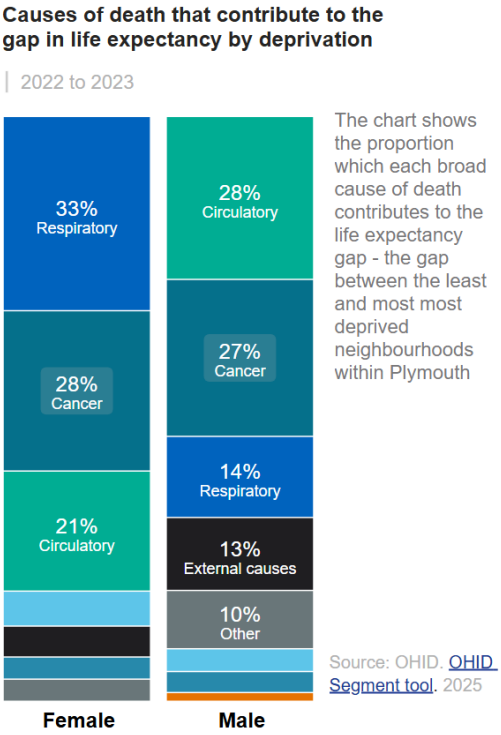


Source: Fingertips, Department of Health and Social Care, accessed 19 Jan 2026.

[2] Office for Health Improvement and Disparities. Segment tool: life expectancy and inequality in Plymouth [Internet]. London: OHID; 2025. Available from: https://fingertips.phe.org.uk/segment

Deprivation has a particularly strong effect on men's health in Plymouth. The life expectancy gap between the least and most deprived neighbourhoods is 10.4 years for men, substantially larger than for women. Among men, circulatory diseases and cancer are the biggest contributors to this gap, with additional impact from respiratory disease and external causes such as injuries or violence.





3. THE MEN'S HEALTH STRATEGY FOR ENGLAND

The Men's Health Strategy for England sets out a 10-year plan to improve health outcomes for all men and boys, with particular attention to those experiencing the poorest health. It responds to persistent evidence that men are more likely than women to die prematurely from preventable causes, less likely to access services early, and are more likely to engage in harmful behaviours.

The strategy has three broad aims:

1. Ensuring health services engage men and boys and are more responsive to their needs.
2. Building structures which support men and boys to maximise their own health and wellbeing.
3. Creating the conditions on which men and boys' health and wellbeing can thrive.

The strategy aligns with the NHS 10-year strategy and promotes the shift from hospital to community, analogue to digital and treatment to prevention.

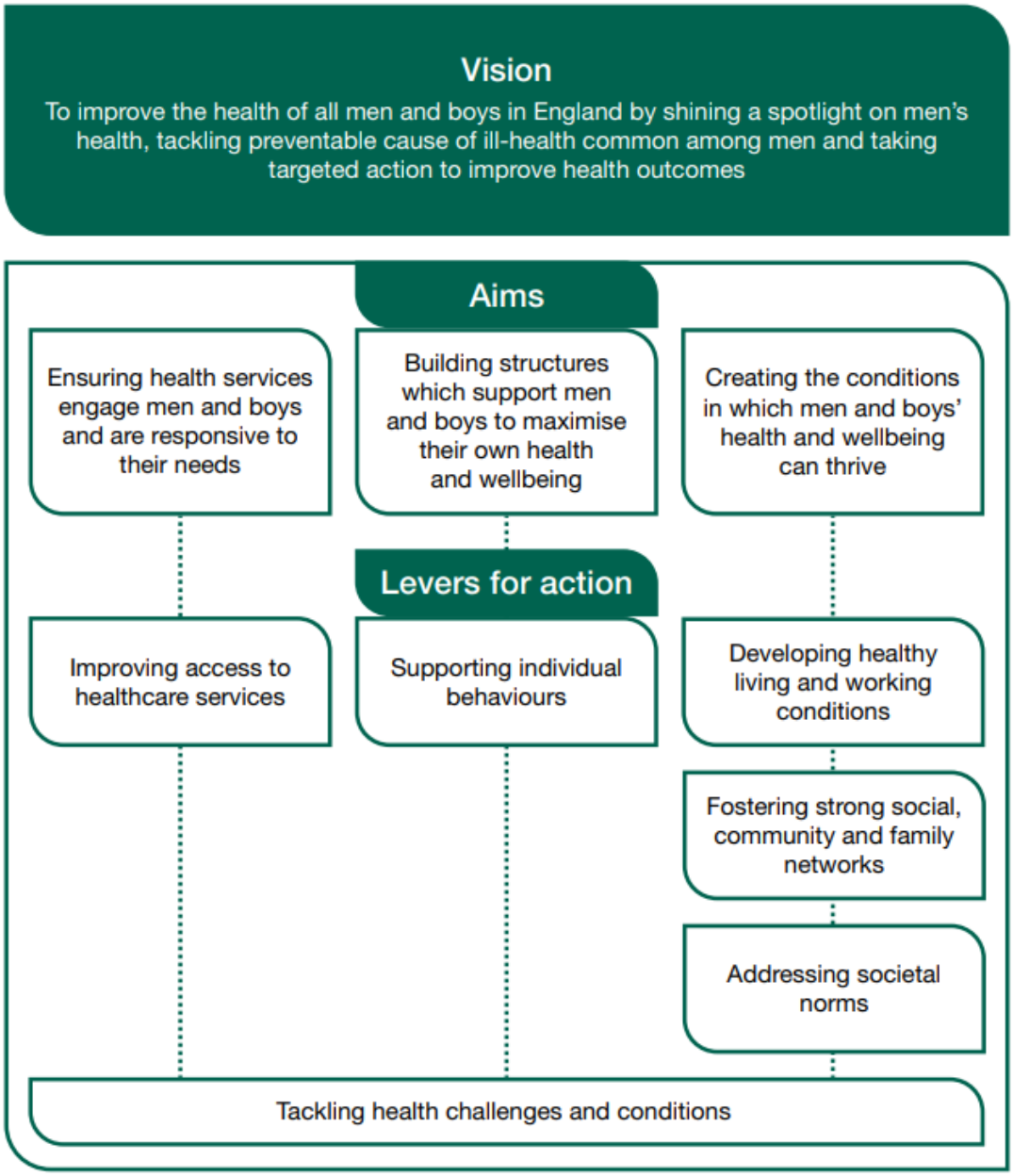
It proposes six levers to achieve its aims:

1. Improving access to healthcare
2. Supporting individual behaviours

3. Developing healthy living and working conditions
4. Fostering strong social, community and family networks
5. Addressing societal norms
6. Tackling health challenges and conditions

Vulnerable groups identified through the strategy include:

- Coastal areas
- Ethic minority backgrounds
- Gypsy, Roma and Traveller communities
- Gay, bisexual and men who have sex with men
- Men with disabilities
- Boys with special educational needs (SEN) and autistic men
- Men who are homeless and rough sleeping
- Men who are in contact with the criminal justice system
- Care leavers



4. PLYMOUTH ALIGNMENT

Plymouth City Council's current activity aligns strongly with the Men and Boys' Health Strategy, with a particular emphasis on prevention, early intervention and community-based support. Suicide prevention remains a core priority, with targeted initiatives for men and boys and training for employers and frontline staff across the spectrum of suicide prevention activity directly aligning with the strategy.

Early intervention for high-risk behaviours is embedded across services, including alcohol liaison teams in the emergency department and cardiovascular disease secondary prevention for men admitted via urgent care, aiming to meet men where they are and directly supporting the individual behaviours contributing to men's ill health.

Support for boys and young men is strengthened through relationship and sex education in schools, alongside the SEND local offer for those with additional needs, helping to support action to develop healthy living and working conditions and addressing societal norms.

A wide network of community-based provision, including family hubs, wellbeing hubs, youth clubs, sports and activity groups, and diverse men's groups, provides accessible, place-based support for men, boys, fathers and male carers, supported by a digital map to help residents and professionals navigate local offers. These efforts strengthen social community and family connections and creating the conditions for boys and young men to thrive.

Work to improve male health also extends into organisational culture through programmes such as 'Man Culture - It's Time for Change', and through safeguarding and employer training linked to violence against women and girls. This is exemplified through the offer by Plymouth City Council to council employees.

These strengths mean that men and boys' health can be seen as an extension and refinement of existing public health priorities.

5. OPPORTUNITIES FOR DEVELOPMENT

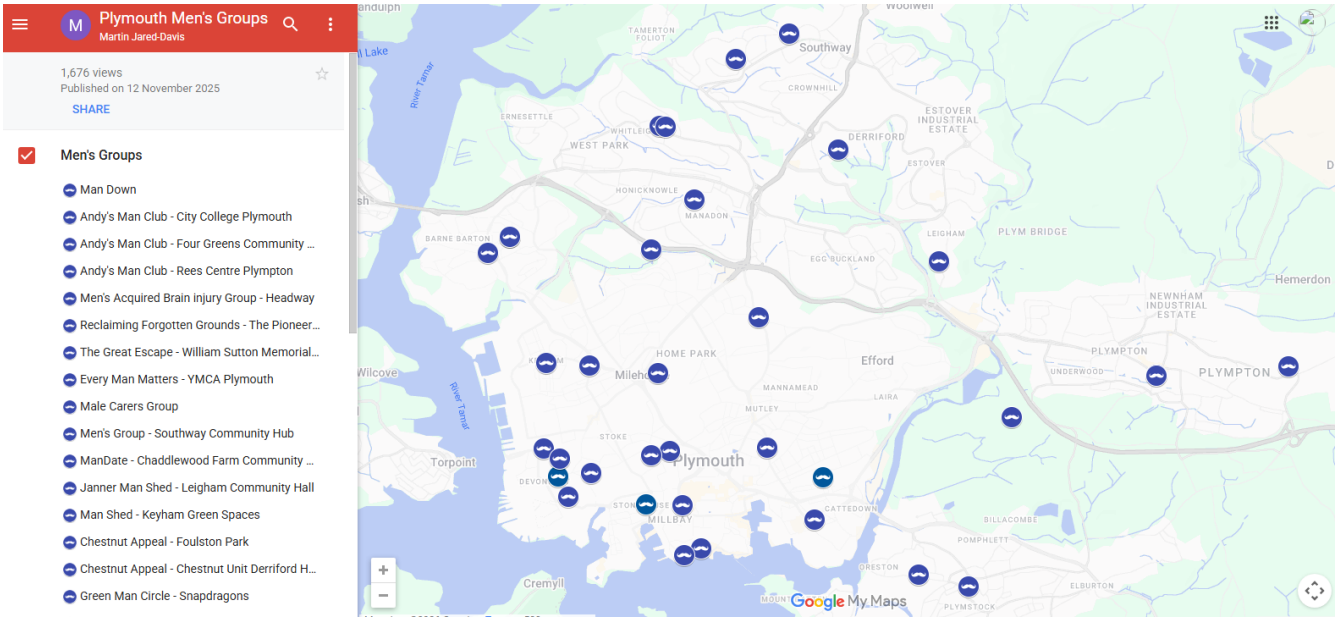
Plymouth has a strong set of opportunities to further embed the Men and Boys Health Strategy across the system. Strengthening the visibility of sex-disaggregated public health intelligence will enable better benchmarking, gap analysis and progress monitoring. While data on life expectancy and some outcomes are available by sex, there is less systematic visibility of indicators that are particularly relevant to men (e.g. cardiovascular risk, screening and vaccination uptake, NHS Health Checks, occupational injuries) to inform planning and performance reporting. Further insight could be achieved through building on existing analytical work by routinely disaggregating key indicators by sex and deprivation.

A proportionate universalism approach can help ensure that vulnerable groups are targeted effectively, addressing the historically low uptake among boys, young men, fathers and men in or out of work. As major employers, Plymouth City Council and partners, including the military, also have a clear role in modelling good practice and improving male health outcomes.

There is significant potential to 'meet men and boys where they are' by engaging through workplaces, welfare and advice services, libraries, family and wellbeing hubs, sports clubs, and criminal justice settings. Stronger links with local sports clubs and community ambassadors offer further avenues for engagement, while expanding work on gambling-harm prevention and online safety, through the prevention arm of the Statutory Gambling Levy, provides an important opportunity to intervene early and reduce long-term risks.

The public health team will implement the recommendations arising from these opportunities. This will ensure all public health work routinely analyses outcomes using a sex-disaggregated lens and maximises opportunities to engage men and boys, particularly where they have been less likely to access services, to improve their health and wellbeing.

Appendix One: Men's support groups



HEALTH AND WELLBEING BOARD

Tracking Decisions Log 2025 – 26

Please note that the Tracking Decisions Log is a 'live' document and subject to change at short notice.

For enquiries relating to this committee's work programme and tracking decisions, please contact Elliot Wearne-Gould, Democratic Support, on 01752 398261

Date	Resolution	Responsible	Progress
15 January 2026 Minute 66 **The Director of Public Health Annual Report: The Health and Wellbeing of Women in Plymouth**	1. Action: The Director of Public Health would clarify the position on community builder arrangements for women and girls; 2. Action: The University of Plymouth would explore, through the Faculty of Health and the wider anchor collaboration, how the university and further education partners could support HPV vaccination uptake and broader women's health messaging, including options for hosting clinics and joint communications; 3. Action: The Director of Public Health would seek further breakdown and context for harassment statistics used in the report and share clarifications with Board members (for example, domestic, external or workplace); 4. Action: The Director of Public Health, working with the Director of Children's Services, would consider presenting the annual report and its key messages to a headteacher and senior leader conference, and explore how schools	Professor Steve Maddern (DOPH) Laura Alexander (University of Plymouth) Professor Steve Maddern (DOPH) Professor Steve Maddern (DOPH)	In Progress: 1. We have a Women's Economic Equality Community Builder on a 1-year FTC that we fund through NHS funding. She is employed by Action for Children and her focus is on Devonport and Stonehouse in particular, whilst also working with women across the city. The role has been going for 6 months and attached is a summary of the work to date. Womens economic community builders le 2. Work ongoing. A verbal update will be provided. 3. Work ongoing. A verbal update will be provided 4. Work ongoing. A verbal update will be provided

	could further support the safety, health and wellbeing of girls and young women, including reinforcing HPV vaccination messaging; 5. Action: The Director of Public Health would work with Youth Parliament representatives to develop and share an accessible version of the report, with particular emphasis on HPV vaccination and other preventative measures relevant to young women and girls; 6. Action: The Director of Public Health would bring an update on Men's Health to a future meeting of the Health and Wellbeing Board, in order to provide visibility of overall population health trends and ensure that the Board maintained oversight of emerging priorities affecting men's health alongside the thematic focus on women and girls.	Professor Steve Maddern (DOPH) Professor Steve Maddern (DOPH)	5. Work ongoing. A verbal update will be provided 6. Complete. A paper is scheduled for H&WB in March 2026
15 January 2026 Minute 67 **Public Health Intelligence: IMD2025**	7. Action: The Public Health Intelligence Team would explore mechanisms for improved dissemination of updated ward-level IMD and poverty data to councillors, including through refreshed online mapping tools; 8. Action: The Public Health Intelligence Team would incorporate IMD 2025 analysis into the forthcoming State of the City report and bring this to a future meeting of the Health and Wellbeing Board.	Ruth Harrell (Consultant, Public Health)	7. Work ongoing. A verbal update will be provided 8. Work ongoing. A verbal update will be provided

15 January 2026 Minute 70 **Revised Terms of Reference**	9. Agreed to hold a workshop with H&WB members to agree priorities for the Board for 2026/27 work programming.	Professor Steve Maddern (Director of Public Health)	9. Complete: A workshop was held on 20 February 2026.. Board members have identified 6 priorities for consideration, which will be discussed at the March H&WB meeting.
03 October 2025 Minute 55 **Winter Planning 2025–26**	10. Requested that Public Health analyse data on health & social care staff vaccination including across care markets, and report back to a future meeting. 11. Requested that future reports include analysis of vaccination uptake and availability for the City's 'looked after children'. 12. Requested that vaccination access/eligibility for voluntary sector workers (e.g., wellbeing hubs) is considered and reported to a future meeting.	Chris Morley (NHS Devon ICB), Lousie Ford (Head of Commissioning, PCC) and Michael Whitcombe (UHP	In Progress: A vaccination update will be provided at the March H&WB meeting.
03 October 2025 Minute 56 **NHS 10-Year Plan & Integrated Neighbourhood Teams**	13. Requested clarification on how young people would be consulted and engaged throughout the development of the Plan. 14. Requested that consultation was shared with all councillors in addition to the relevant committees to ensure that wholistic community views were captured.	Chris Morley (NHS Devon	In Progress: An interim update was provided by Ed Garvey (NHS Devon ICB) at H&WB in January 2026. A further update will be provided at the next meeting.

12/06/2025	Requested that an update on the implications of the Comprehensive Spending Review are brought to a future Board meeting, when appropriate.	Gary Walbridge (Strategic Director for Adults, Health and Communities)	On Hold: Added to the work programme for scheduling at the appropriate time. Implications are not yet clear.

HEALTH AND WELLBEING BOARD

Work Programme 2025 - 26

Please note that the work programme is a 'live' document and subject to change at short notice. This is currently a draft document, under consideration with the Chair and council officers.

For general enquiries relating to this committee's work programme, please contact Elliot Wearne-Gould, Democratic Advisor, on 01752 398261.

Meeting Date	Agenda item	Responsible Officer
12 June 2025	Vaping Motion on Notice - Strengthening Measures to Combat Youth Vaping.pdf	Dan Preece & Dave Schwartz (Public Health)
	Pharmaceutical Needs Assessment	Rob Nelder (Public Health)
	H&WB Development Workshop Report	Professor Steve Maddern (Director of Public Health)
	END OF FORMAL BOARD MEETING	
	H&WB Development Workshop 2	Professor Steve Maddern (Director of Public Health)
03 October 2025	NHS Devon Dental Services Update. (To include dental contract consultation and new Government proposals)	Melissa Redmayne (NHS Devon ICB)
	Plymouth Drugs Strategic Partnership update.	Kamal Patel
	NHS 10 Year Plan & Neighbourhood planning model.	Chris Morley (NHS Devon ICB)
	Winter Planning	Chris Morley (NHS Devon ICB) + PCC + UHP
	Partner Updates	All partners invited
15 January 2026	Revised H&WB Terms of Reference (draft) and Board Strategic Plan discussion.	Professor Steve Maddern (DOPH)
	PNA Update	Theresa Cullip / Ruth Harrell
	DOPH Annual Report	Professor Steve Maddern (DOPH)
	Public health intelligence update (IMD2025)	Ruth Harrell
	Neighbourhood Health Plans (Verbal Update)	Chris Morley (NHS Devon)
	City Brand Story	Amanda Lumley - PCC
	Trauma Informed Network	Nancy Hardwick

Meeting Date	Agenda item	Responsible Officer
12 March 2026	BCF Board Development	BCF Team
	HDRC	Ruth Harrell
	Suicide Partnership Annual Report	Kamal Patel
	Vaccination Paper	Teresa Cullip
	Men's Health Paper	Teresa Cullip + Team
	H&WB Priorities	Professor Steve Maddern
Standing Yearly Items		
2025/26	Suicide Prevention	Kamal Patel
2025/26	Director of Public Health Annual Report	Professor Steve Maddern
Items to be scheduled		
2026/27	Avoidable Death Review	Jenny Coombs
	Cervical Cancer Elimination Strategy	Prof. Steve Maddern
	Local Care Partnership Priorities	LCP + PCC
	Joint Strategic Needs Assessment (2026/27)	Professor Steve Maddern
	Domestic Abuse and Sexual Violence being briefing	Matt Garrett
	Vaccination Programme Update	NHS Devon
	Culture, Wellbeing and Development Hubs	PCC, VCSE