Norfolk Health & Wellbeing Board

Date: **Wednesday 11 June 2025**
Time: **09:30 - 12:30**
Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Representing	Membership	Substitute
Borough Council of King's Lynn & West Norfolk	Cllr Jo Rust	Cllr Bal Anota
Breckland District Council	Cllr Tristan Ashby	Cllr Sam Chapman-Allen
Broadland District Council	Cllr Natasha Harpley	Cllr Eleanor Laming
Cambridgeshire Community Services NHS Trust	Anna Gill	Steve Bush
East Coast Community Healthcare CIC	Ian Hutchison	Andy Wood
East of England Ambulance Trust	Kyle Hampshire-Smith	Chris Workman
East Suffolk Council	Cllr David Beavan	Cllr Jan Candy
Great Yarmouth Borough Council	Cllr Emma Flaxman-Taylor	Cllr Donna Hammond
Healthwatch Norfolk	Patrick Peal	Alex Stewart
Norfolk Care Association	Christine Futter	Jon Clemo
Norfolk Community Health & Care NHS Trust	Lynda Thomas	Laura Clear
Norfolk Constabulary	ACC Chris Balmer	DCS David Freeman
Norfolk County Council, Cabinet member for Adult Social Services	Cllr Alison Thomas	Cllr Shelagh Gurney
Norfolk County Council, Cabinet member for Children's Services	Cllr Penny Carpenter	
Norfolk County Council, Cabinet member for Public Health and Wellbeing	Cllr Fran Whymark	
Norfolk County Council, Executive Director Adult Social Services	Ian Wake	Nicholas Clinch
Norfolk County Council, Executive Director Children's Services	Sara Tough	Sarah Jones
Norfolk County Council, Director of Public Health		Suzanne Meredith
Norfolk & Suffolk NHS Foundation Trust	Zoe Billingham	Tricia Fuller
Norfolk and Waveney University Hospitals Group	Lesley Dwyer	
Norfolk and Waveney University Hospitals Group	Mark Friend	
NHS Norfolk and Waveney Integrated Care Board (Chair)	Prof Will Pope	
NHS Norfolk and Waveney Integrated Care Board (Chief Executive)	Ed Garratt	Andrew Palmer
North Norfolk District Council	Cllr Liz Withington	Cllr Wendy Fredericks
Norwich City Council	Cllr Adam Giles	Cllr Claire Kidman
Place Board Chair Great Yarmouth & Waveney	Jonathan Barber	Sheila Oxtoby
Place Board Chair Norwich	Tracy Williams	Claire Leborgne
Place Board Chair North Norfolk	Dr Charlotte Florence	Heather Farley
Place Board Chair South Norfolk	Allan Petchey	Karen Bradley
Place Board Chair West Norfolk	Carly West-Burnham	Oliver Judges
Police and Crime Commissioner	Sarah Taylor	Dr Gavin Thompson
South Norfolk District Council	Cllr Kim Carsok	Cllr Andy Evans
Voluntary Sector Representative	Tim Gardiner	
Voluntary Sector Representative	Dan Mobbs	
Voluntary Sector Representative	Daniel Childerhouse	

Additional members (non-voting)

Norfolk Health Overview and Scrutiny Committee (Chair)	Cllr Brenda Jones
Suffolk County Council, Cabinet Member for Adult Care	Cllr Beccy Hopensperger
Suffolk County Council Representative	Nicholas Pryke
University of East Anglia Representative	Prof Nicole Horwood

For further details and general enquiries about this Agenda please contact the Committee Officer: Maisie Coldman on 01603 638001 or email: committees@norfolk.gov.uk

Norfolk and Waveney Integrated Care Partnership

Date: **Wednesday 11 June 2025**
Time: **on rise of the Health and Wellbeing Board**
Venue: **Council Chamber, County Hall, Martineau Lane, Norwich**

Representing
Borough Council of King's Lynn & West Norfolk
Breckland District Council
Broadland District Council
Cambridgeshire Community Services NHS Trust
Chair of Voluntary Sector Assembly
East Coast Community Healthcare CIC
East of England Ambulance Trust
East Suffolk Council
Great Yarmouth Borough Council
Healthwatch
Norfolk Care Association
Norfolk Community Health & Care NHS Trust
Norfolk Constabulary
Norfolk County Council, Cabinet member for Adult Social Services
Norfolk County Council, Cabinet member for Public Health and Wellbeing
Norfolk County Council, Cabinet member for Children's Services
Norfolk County Council, Director of Public Health
Norfolk County Council, Executive Director Adult Social Services
Norfolk County Council, Executive Director Children's Services
Norfolk County Council, Chief Executive Officer (nominee)
Norfolk & Suffolk NHS Foundation Trust
Norfolk & Waveney Integrated Care Board (Chair)
Norfolk & Waveney Integrated Care Board (Chief Executive)
Norfolk and Waveney University Hospitals Group
Norwich City Council
Police and Crime Commissioner
Place Board Chair Great Yarmouth & Waveney
Place Board Chair Norwich
Place Board Chair North Norfolk
Place Board Chair South Norfolk
Place Board Chair West
Primary Care Representatives TBC
South Norfolk District Council
Suffolk County Council, Cabinet Member for Adult Care
Suffolk County Council, Representative
Voluntary Sector Representative (1)
Voluntary Sector Representative (2)

For further details and general enquiries about this Agenda please contact the Committee Officer:
Maisie Coldman on 01603 638001 or email: committees@norfolk.gov.uk

Norfolk Health & Wellbeing Board and Norfolk and Waveney Integrated Care Partnership

Wednesday 11 June 2025
Agenda
Time: 09:30 - 12:30

08:45 - 09:25: *There will be a networking opportunity available prior to the start of the meeting in the Margaret English Room next to the Council Chamber at County Hall, Norfolk County Council.*

Advice for members of the public:

This meeting will be held in public and in person.

It will be live streamed on YouTube and members of the public may watch remotely by clicking on the following link: Norfolk County Council YouTube

We also welcome attendance in person, but public seating is limited, so if you wish to attend please indicate in advance by emailing committees@norfolk.gov.uk

Current practice for respiratory infections requests that we still ask everyone attending to maintain good hand and respiratory hygiene and, at times of high prevalence and in busy areas, please consider wearing a face covering.

Please stay at home if you are unwell, have tested positive for COVID 19, have symptoms of a respiratory infection or if you are a close contact of a positive COVID 19 case. This will help make the meeting safe for attendees and limit the transmission of respiratory infections including COVID-19.

1.	Apologies	Committee Officer	
2.	Chair's opening remarks	Chair	
	Norfolk Health and Wellbeing Board		
3.	HWB Minutes	Chair	(Page 5)
4.	Actions arising	Chair	
5.	Declarations of interests	Chair	
6.	Public Questions (How to submit a question: HWB) Deadline for questions: **5pm, Thursday 5 June 2025**	Chair	
7.	Urgent arising matters	Chair	
8.	Election of vice chairs	Chair	
9.	Director of Public Health Annual Report for Norfolk 2024/25: Health and Climate Change	Suzanne Meredith / Diane Steiner/ Ben Spratling	(Page 18)
10.	Better Care Fund 2025/26 Plan	Ian Wake / Edward Fraser Ed Garratt / Karin Bryant	(Page 103)
11.	NHS Norfolk and Waveney Integrated Care Board Annual Report 2024/25	Ed Garratt	(Page 147)

	Norfolk and Waveney Integrated Care Partnership		
1.	ICP Minutes	Chair	(Page 8)
2.	Actions arising	Chair	
3.	Declarations of Interest	Chair	
4.	Public Questions (How to submit a question: ICP) Deadline for questions: **5pm, Thursday 5 June 2025**	Chair	
5.	Election of Chair	Committee Officer	
6.	Election of vice chairs	Chair	
7.	Norfolk & Waveney NHS System Capital Distribution for 2025/2026	Ed Garratt / Steven Course	(Page 151)
8.	Health Inequalities Strategic Framework for Action	Suzanne Meredith / Tracy Williams	(Page 157)

Further information about the Health and Wellbeing Board can be found on Norfolk County Councils website at: About the Health and Wellbeing Board

Information regarding the Integrated Care Partnership can be found on the Integrated Care System website at: About the Integrated Care Partnership

Health and Wellbeing Board and Integrated Care Partnership
Minutes of the meeting held on 05 March 2025 at
in the Council Chamber, County Hall.

Present:	**Representing:**
Cllr Bal Anota	Borough Council of King's Lynn & West Norfolk
Cllr Natasha Harpley	Broadland District Council
Ian Hutchison	East Coast Community Healthcare CIC
Chris Workman	East of England Ambulance Trust
Mark Friend	James Paget University Hospital NHS Trust
Christine Futter	Norfolk Care Association
Laura Clear	Norfolk Community Health & Care NHS Trust
DCS David Freeman	Norfolk Constabulary
Cllr Alison Thomas	Norfolk County Council, Cabinet member for Adult Social Services
Cllr Fran Whymark	Norfolk County Council, Cabinet member for Public Health and Wellbeing
Nicholas Clinch	Norfolk County Council, Executive Director Adult Social Services
Sara Tough	Norfolk County Council, Executive Director Children's Services
Stuart Lines	Norfolk County Council, Director of Public Health
Tracey Bleakley	NHS Norfolk and Waveney Integrated Care Board (Chief Executive)
Cllr Liz Withington	North Norfolk District Council
Sheila Oxtoby	Place Board Chair Great Yarmouth & Waveney
Tracy Williams	Place Board Chair Norwich
Allan Petchey	Place Board Chair South Norfolk
Carly West-Burnham	Place Board Chair West Norfolk
Cllr Kim Carsok	South Norfolk District Council
Tim Gardiner	Voluntary Sector Representative
Dan Mobbs	Voluntary Sector Representative
Daniel Childerhouse	Voluntary Sector Representative

Additional members present (non-voting):

Nicholas Pryke	Suffolk County Council Representative

Officers Present:

Stephanie Butcher	Policy Manager Health and Wellbeing Board
Stephanie Guy	Advanced Public Health Officer
Maisie Coldman	Committee Officer

Speakers:

Nicholas Clinch	Director of Communities, Prevention and Partnerships, Adult Social Services, NCC
Stuart Lines	Director of Public Health, NCC
Tracy Williams	Clinical Lead for Health Inequalities & Inclusion Health, ICB
Goeff Connell	Director of Digital Services, NCC
Ian Riley	Executive Director of Digital & Data, ICB
Edward Fraser	Assistant Director Communities and Integration, Adult Social Services, NCC
Liz Joyce	Head of System Transformation, ICB
Nichola Coburn	Public Health Principal - Place and Community, NCC
Jamie Sutterby	Director of People and Communities. South Norfolk and Broadland district Council
Mark Burgis	Executive Director of Patients & Communities, ICB
Lisa Mathieson	Programme Manager, Integrated Health and Social Care, Norfolk County Counc and Norfolk Community Health and Care NHS Trust

Norfolk Health and Wellbeing Board (HWB)

1. Apologies

1.1 Apologies were received from Cllr David Beavan, Andy Wood and their substitute Alice Webster, Cllr Brenda Jones, Cllr Jo Rust (substituted by Cllr Bal Anota), Tom Spink and their substitute Kim Goodby, Ian Wake (substituted by Nick Clinch) and Patricia Hewitt, Lynda Thomas substituted by Laura Clear, Cllr Penny Carpenter, Anna Gill and their substitute Steve Bush, Cllr Flaxman Taylor and their substitute Cllr Donna Hammond, Cllr Adam Giles and their substitute Cllr Claire Kidman, Professor Horwood, Jonathan Barber (substituted by Shelia Oxtoby), Cllr Beccy Hopfensperger and Jason Gillingham (substituted by Chris Workman).

Cllr Tristan Ashby, Patrick Peal, Dr James Gair, and Sarah Taylor were absent.

2. Chair's Opening Remarks

2.1 The Chair welcomed Christine Futter, Norfolk Care Association, and Chris Workman, East of England Ambulance Trust, to the meeting as new attendees. The Chair took the opportunity to express thanks to the previous Chair, Cllr Bill Borrett, for his work in chairing the Norfolk Health and Wellbeing Board and Integrated Care Partnership meetings and for his advocacy for the health and wellbeing of residents. Members heard that Stuart Lines, Director of Public Health, was retiring. The Chair extended his thanks to Stuart for all his work.

2.2 The Chair reminded members that an attendance sheet would be appended to the minutes (Appendix A).

3. Minutes

3.1 The HWB minutes of the meeting held on 4 December 2024 were **agreed** as an accurate record and signed by the Chair.

3.2 The questions that were unable to be answered at the meeting on 4 December 2024 would be appended to the minutes (Appendix B).

4. Actions arising

4.1 The Chair shared with members that Sir Marmot would be attending the King's Lynn Corn Exchange as part of King's Lynn and West Norfolk becoming a Marmot place. He encouraged members to attend.

5. Declarations of Interests

5.1 None.

6. Public Questions

6.1 None.

7. Urgent Matters Arising

7.1 None.

8. Better Care Fund (BCF) 2024/25: Q3 report request for sign off and Better Care Fund 2025/26: proposed plans update

8.1 Nick Clinch, Director of Communities, Prevention and Partnerships, Adult Social Services, NCC introduced the appended (8) report which updated the board on the Quarter 3 (Q3) BCF report and on the proposed plans for the BCF in 2025/26. Members heard that Norfolk Co-chaired the regional BCF Network and that the regional goals reflected the local ambition.

8.2 Edward Fraser, Assistant Director of Communities and Integration, Adult Social Services, NCC provided the board with additional information. It was noted that the Q3 report shows that 3 of the 4 metrics were on target to be achieved and that activity and expenditure were in line with expectations. The BCF schemes were reviewed against the criteria that were agreed upon by the HWB as a result of this review 19 schemes would schemes would be off-boarded. Members were assured that off-boarding schemes were not a reflection of the scheme or a de-commissioning process, but how funding was classified.

The following points were also highlighted:

- The Government had indicated they wanted to move towards a multi-year settlement for the BCF.
- Performance management would be more tightly controlled with the addition of new metrics.
- The consolation of funding schemes would allow more flexibility locally.
- Next year BCF had been uplifted; the additional resources would go to local authorities to use on social care services.
- The team involved in this work was praised.

8.3 The following points and comments were discussed:

- Members were pleased that the value for money, performance and impact of the BCF would be focused on.

- There would be opportunities to on-board schemes, and explore the totality of funding, that met the criteria and priorities of the BCF.

- Whilst the decision to off-board schemes from the BCF was not a decommissioning decision and schemes could utilise other funding sources, the financial position was difficult, and NHS partners were in the process of decommissioning more broadly.

- The Board was reminded that extending and expanding schemes could result in financial savings.

- It was confirmed that plans were in place to support long-term residential placements which was the metric that was not being achieved. This was part of a national conversation, and more work would be carried out to support this metric next year. The plans were detailed in the BCF template; members heard that additional details on the schemes would be added to the template in future reports.

- The long-term residential metric had drivers below it to support evaluation and comparison to determine the best approach.

- The Cabinet Member for Adult Social Care highlighted to members that a Proactive Prevention Pilot report went to Cabinet and was available to read.

- The metrics would help to guide future planning and provide direction as to the areas that the BCF could focus on. It was expected that part of the planning for next year could look into preventative activity and expanding initiatives that had been successful.

- The chair summarised the conversation, noting that the clarity around the BCF off-boarding was appreciated and that a left shift and investments to save, were important steps forward.

8.4 The HWB noted the proposed changes to the BCF plan for 2025/26 arising from the joint BCF review, ahead of formal approval at the next Health and Wellbeing Board in June 2025 and **AGREED** to sign-off the BCF Quarter 3 report and to a presentation of the 2024/25 End of Year report at the Health and Wellbeing Board in September 2025.

9. Norfolk and Waveney Joint Forward Plan update (JFP)

9.1 Tracey Bleakley, Chief Executive, ICB introduced the appended (9) report which updated the board on the progress of the JFP and outlined the process for refreshing the plan. Members heard that the 10-

Year Health Plan for the NHS was expected to be published in spring 2025 and thus, the refresh would be limited.

9.2 Liz Joyce, Head of System Transformation, ICB, provided additional information on the context of the JFP. She highlighted the approach, ambitions, and outcome measures, and noted that JFP had moved into the delivery phase.

9.3 The following points and comments were discussed:

- Following a member's question about productivity, it was noted that productivity was a huge focus for the NHS at the moment. Productivity data packs have been given to organisations from the NHS Regional Team to inform their direction of work. Some areas that would be focused on in our area included updating old estates, digitalisation, workforce, and the 'left shift' moving from Acute to Community.

- A member noted that it would be helpful to link the ambitions of the JFP with the finances available and what trade-offs might need to be taken. There was a commitment from the ICB to look at this.

- Following a member's question, it was noted that the deliverables had an outcome metric and affordability component. The deliverables were monitored every 6 months through the Commissioning and Performance Committee. The JFP refresh included reflections on the progress made to date and areas that required work such as elective recovery, and financial and performance challenges.

The chair shared with the board a statement of opinion on behalf of the HWB for inclusion in the 2025/26-2029/20 JFP.

Having considered the approach being taken to refresh the 2025/26 – 2029/30 JFP for Norfolk & Waveney, and whether it takes proper account of the Integrated Care Strategy for Norfolk and Waveney/Joint Health and Wellbeing Strategy for Norfolk, the HWB **AGREED** a statement of opinion on behalf of the Norfolk Health and Wellbeing Board for inclusion in the 2025/26 – 2029/30 JFP.

The Health and Wellbeing board closed at 10:18

Integrated Care Partnership (ICP)

1. Election of Chair

1.1 The committee Officer invited nominations for the election of Chair of the Integrated Care Partnership. Cllr Fran Whymark was nominated by Cllr Thomas and seconded by Ian Hutchinson. There were no further nominations. All in agreement. Cllr Fran Whymark was elected as Chair for the Integrated Care Partnership for the ensuing year.

2. Nominations to the Integrated Care Board (ICB)

2.1 The Chair invited nominations for the representative for the ICB. Cllr Fran Whymark was nominated by Cllr Alison Thomas and seconded by Cllr Kim Carsok. There were no further nominations. All in agreement. Cllr Fran Whymark was elected as the representative for the ICB.

3. Integrated Care Partnership Minutes

1.1 The minutes of the Integrated Care Partnership (ICP) meeting held on 4 December 2024 were **agreed** as an accurate record and signed by the Chair.

4. Actions arising

4.1 None.

5. Declarations of Interest

5.1 None.

6. Public Questions

6.1 None.

7. Driving Integration Through Digital, Data and Technology

7.1 Nick Clinch introduced the appended (7) report and highlighted that the report focused on artificial intelligence (AI). There was confidence in the approach being implemented to use AI and how it was being governed. The developments in AI across Norfolk and Waveney were felt to be something to be excited and proud about.

7.2 Ian Riley, Executive Director of Digital & Data, ICB updated members with the work that was currently happening across primary care, these included:

- Modern telephony in primary care systems.
- Wi-fi offering in GP practices.
- Robotic process automation.
- Promoting the uptake of the NHS app.
- A digital connect session was scheduled for 7 May 2025. Members could get in touch if they were interested in attending this session.

7.3 Geoff Connell, Director of Digital Services, NCC, provided members with additional information about the use of AI, highlighting that AI tools would require training, process redesign, and cultural change. The risk associated with AI was shared, including data loss, bias, and inadequate data quality. Work was being undertaken to ensure that AI was being used appropriately and balanced against the risks. There was a Governance Board to manage the implementation of AI.

Members heard examples of how AI was being used, some of the uses included reducing the risk of falls through Proactive Intervention pilots, the rollout of co-pilot to 300 NCC staff members, and using AI for passive listening and note writing. The outcomes of the examples had been positive. The partnership was assured that AI would not be responsible for making decisions and that a human would remain the decision-maker.

7.3 The following points and comments were discussed:

- Members acknowledged the positive updates regarding AI and the potential use of the technology.

- NCC was cautious with the implementation of AI and was taking an approach to start small, demonstrate that there was a business case and then look to expand and scale up. As the use for AI was expanded, the amount of data utilised would also expand thus, a measured approach, that has appropriate balance and pace, was important. Local authorities were sharing learnings which helped to balance the risk.

- It was expected that the systems that were already used would offer AI as part of their software and could be procured.

- Members were pleased to hear about the passive listening capabilities of AI, noting the quality that could be added to conversations. Following members' comments, it was noted AI was only advising and helping and that the human would still be required to sign off on what was produced and take ownership of it.

- It was highlighted that before processes became automated, they would need to be reviewed to ensure that poor processes were not being automated. Automated processes would be evaluated.

- Staff would need to be educated on AI. AI drop-in sessions had previously been run, and the mandatory e-learning module includes information on AI. The benefits of AI would require staff understanding and use of the technology. It would not be implemented externally until staff were fully educated.

- The Executive Director of Children Services requested that the next update to the partnership include information on how technology, including AI, was utilised within Children's Services.

- A member questioned if there could be joined-up working, training, and purchasing power across the system.

- The model and analytics would be owned by the vendor and the analyst, and the data would be jointly owned by the participants i.e. NCC and district councils. There would be data sharing agreements, and the data could only be used for the specific purpose that it was agreed for in the contract.

- Transparency was a guiding principle; people needed to be aware of how the technology was being used.

- Following a member's question, it was shared that the cost savings through the implementation of the proactive intervention pilot were monitored and compared against control groups. This would continue to be monitored as it was expanded.

- The Chair requested that information on the Digital Connect event was shared with members. He expressed that a cautious and proactive approach to AI was important, and that safety and risk needed to be considered. He agreed that it would be helpful to look at the work associated with Children and Young People.

Mark Friend left the meeting at 10:56.

7.4 The ICP noted the updates on the progress taken around the collaboration as a system, raised potential gaps or priorities to further inform the plan, and reviewed, commented, and advised on the approach to Artificial Intelligence and the proposed forward plan.

8. Norfolk and Waveney Health and Wellbeing Partnership Event

8.1 Stuart Lines, Director of Public Health, NCC introduced the appended report (8) which provided the partnership with an overview of the Health and Wellbeing Partnership (HWP) event held on 26 November 2024.

8.2 Nichola Coburn, Public Health Principal - Place and Community, NCC, shared with members that the HWP event focused on reflection and sharing success, and looking into the future with consideration to the system priorities. Members heard of examples of key projects that were presented by each of the HWPs.

8.3 Jamie Sutterby, Director of People and Communities. South Norfolk and Broadland District Council added that the HWPs were an important strategic anchor and environment for innovation. The HWP's were at a crossroads and the long-term outlook of the partnerships needed to be developed and understood.

8.4 The following points and comments were discussed:

- Members who attended the event shared that they found it enjoyable and helpful.

- A strong link with the HWPs Chair's was important.

- It was noted that the report would also be shared with all the HWPs and that the comments from the ICP would be incorporated into the report.

- A member felt that it was important to ensure that social care providers are engaged with, and have a voice at, the HWP meetings.

- Working at a micro-locality level, understanding communities and their needs would continue to be important even considering Local Government Reorganisation.

- Officers shared the difficulties of translating the impact locally into the system. The Health Inequalities Framework could offer the opportunity to channel those conversations back to the partnership.

8.5 The ICP **AGREED** to:

a) Acknowledge the HWPs role in bringing partners together as key and strategic anchors to the ICP's shared objectives of addressing health inequality and prioritising prevention based on data-led local priorities since their formation in 2022.
b) Support the HWPs to develop proposed actions from the HWP event to further strengthen their goals via a model of shared leadership and how resource can be distributed to support longer-term locally tailored prevention initiatives.
c) Agree an annual HWP event to bring the HWP partners together to share learning and report progress to the ICP.

9. Norfolk & Waveney Place Board update

9.1 Tracey Bleakley, Chief Executive, ICB introduced the appended (7) report and highlighted the work occurring at Place level. The ICB sought a commitment from the partnership to define and advance the role of Place and harness the potential of place-based working.

9.2 Mark Burgis, Executive Director of Patients & Communities, ICB highlighted to members that Place was about people, partnership, and collaboration. A sample of the Place-based projects were highlighted in the report. A dedicated resource within the ICB facilitates place-based working and change. Members heard that Place Boards have no formal commissioning powers or delegated budgets; an update would be shared with the partnership at a future meeting.

9.3 The following points and comments were discussed:

- Members were supportive of the Place Board update. The work of the Place Boards was making a difference to local communities and the relationships, and collaborative working, were well established. Working at a local neighbourhood level provided the opportunity to deliver the transformation required; recent NHS Guidance supported this.

- Members discussed the need to share resources, information, and teams and to develop timeframes for this work.

- It was felt to be an exciting opportunity to explore Integrated Neighbourhood Teams and how these would work in our communities to bring teams together and use data differently to inform priorities.

- Place-based working provided opportunities for people to be supported within their local community.

- A member reflected on how the system enables proportionate universalism.

9.4 The ICP **AGREED** to:

a) Commit to defining and advancing the role of Place to have a clear strategy with shared coordinated outcomes that will support Place to implement objectives in the NHSE neighbourhood health guidelines 2025/26.
a) Establish shared accountability for resourcing integration and system transformation at all levels.

b) Establish a system-wide framework for investing in Place and neighbourhood health, ensuring resources are allocated equitably based on evidenced need to reduce inequalities and achieve the greatest impact.

10. Section 75 contract for Integrated Community Health and Social Care

10.1 Nick Clinch introduced the appended report (8) which provided an overview of the continued contract between Norfolk County Council (NCC) and Norfolk Community Health & Care (NCHC) to deliver integrated community Health and Social Care. The current agreement ends in March 2025, it was planned to continue this collaboration with a renewed focus on helping people live independently and fully.

10.2 Lisa Mathieson, Programme Manager, Integrated Health and Social Care, Norfolk County Council and Norfolk Community Health and Care NHS Trust, shared with the partnership that renewing the contract would build on existing relationships and focus on prevention, early help, and delivery. The new contract would outline the framework for integration. Members heard of the 8 aims and ambitions noted in the report.

10.3 The following points and comments were discussed:

- The Cabinet Member for Adult Social Care noted the success of the current Section 75 contract and spoke positively of the new ambitions.

10.4 The ICP commented on the plans to renew the section 75 contract for Integrated Community Health and Social Care contract.

11. Health Inequalities update

11.1 Stuart Lines, Director of Public Health, NCC introduced the appended report (11) and highlighted that health inequalities and prevention underpins the work that the system carried out. The governance foundations of the Health Inequalities Steering Group were strong and brought together the work of the working groups.

11.2 Tracy Williams, Clinical Lead for Health Inequalities & Inclusion Health, ICB, provided the partnership with the following additional points:

- The framework had entered the second year of work which was focused on action.
- It was the ambition that the action plans would sit underneath the Place Boards and the HWP's to drive the actions forward.
- Working closely with the community was vital; members heard of Community Voices which connected with communities, provided health literacy, and guidance, and gathered insights.
- Addressing wider determinants of health informed the direction of work.

11.3 The following points and comments were discussed:

- It was felt that areas of deprivation would be unlikely to change during Local Government Reorganisation; work at the neighbourhood level would remain essential.

- A member questioned if the mechanism existed to address equity by pooling funding. It was noted in responses that the system was financially restrained and resources needed to be used most effectively. It was recognised that the mechanism was a key component that would continue to be developed.

- Community connection would have elements of health conversations, health literacy training, insight gathering, and work with community connectors more generally. A framework for this area of work was expected to be developed.

- A range of projects were established to support people in a connector role and the workforce more broadly. Public Health has supported the voluntary sector with bespoke training and

guidance on making every contact count.

- The learning and insight that King's Lynn and West Norfolk gained from becoming a Marmot Place provided an opportunity for the system to learn and implement.

- A member discussed universal and proportionate universalism approaches to thinking about health inequalities.

- The Chair summarised the discussion and highlighted the importance of this work and understanding what communities need.

11.4 The ICP **AGREED** to:

a) Develop an ICS plan to scale up Community Voices across the ICS as a shared framework for engaging our communities.
b) Scope the potential for a Community Connection/Health Creation plan for Norfolk and Waveney
c) Formally agree the role of the place-based structures in the implementation of the Health Inequalities Strategic Framework for Action and support delegation where appropriate to enable local action plans to be developed and delivered.
d) Partner organisations of the ICP are invited to provide progress updates in relation to their commitment to reducing inequalities to the Steering Group, to inform future reports, highlighting learning and good practice and mutual areas of opportunity, challenge and risk.
e) Further our system understanding of 'proportionate universalism*' and implement a framework for equitable investment policies.

Meeting concluded at 12:12

Fran Whymark

Chair Health and Wellbeing Board and Integrated Care Partnership

Health and Wellbeing Board and Integrated Care Partnership Attendance Record
(From the last 3 meetings)

Member Organisation Represented	Named Member	04 Sept 2024	04 Dec 2024	05 Mar 2025
Borough Council of King's Lynn & West Norfolk	**Cllr Jo Rust**	X	X	X*
Breckland District Council	**Cllr Tristan Ashby**		X	
Broadland District Council	**Cllr Natasha Harpley**	X*	X	X
Cambridgeshire Community Services NHS Trust	**Anna Gill**	X	X	
East Coast Community Healthcare CIC	**Ian Hutchison**	X*	X	X
East of England Ambulance Trust	David Allen **Jason Gillingham**		X	X*
East Suffolk Council	**Cllr David Beavan**	X	X	
Great Yarmouth Borough Council	**Cllr Emma Flaxman-Taylor**	X		
Healthwatch Norfolk	**Patrick Peal**	X	X*	
James Paget University Hospital NHS Trust	**Mark Friend**	X	X	X
Norfolk Care Association	Angela Steggles **Christine Futter**		X*	 X
Norfolk Community Health & Care NHS Trust	**Lynda Thomas**	X		X*
Norfolk Constabulary	ACC Nick Davison **ACC Chris Balmer**	X*	 X	 X*
NCC, Cabinet member for Adult Social Services	**Cllr Alison Thomas**	X	X*	X
NCC, Cabinet member for Childrens Services	**Cllr Penny Carpenter**	X	X*	
NCC, Cabinet member for Public Health and Wellbeing	Cllr Bill Borrett **Cllr Fran Whymark**	X	X	 X
NCC, Interim Executive Director Adult Social Services	Debbie Bartlett **Ian Wake**	X	 X	 X*
NCC, Executive Director Children's Services	**Sara Tough**	X		X
NCC, Director of Public Health	**Stuart Lines**	X	X	X
Norfolk & Norwich University Hospital NHS Trust	**Tom Spink**	X	X*	
Norfolk & Suffolk NHS Foundation Trust	**Zoe Billingham**		X*	
NHS Norfolk and Waveney Integrated Care Board (Chair)	**Rt Hon Patricia Hewitt**	X		
NHS Norfolk and Waveney Integrated Care Board (Chief Executive)	**Tracey Bleakley**	X	X	X
North Norfolk District Council	**Cllr Liz Withington**	X	X	X
Norwich City Council	**Cllr Adam Giles**	X	X	
Place Board Chair (Great Yarmouth & Waveney)	**Jonathan Barber**	X	X	X*
Place Board Chair (Norwich)	**Tracy Williams**	X	X	X
Place Board Chair (North Norfolk)	**Dr James Gair**	X*	X*	
Place Board Chair (West)	**Carly West-Burnham**	X	X	X
Place Board Chair (South Norfolk)	**Allan Petchey**			X
Police and Crime Commissioner	**Sarah Taylor**		X	
Queen Elizabeth Hospital NHS Trust	Chris Lawrence **Andy Wood**			
South Norfolk District Council	**Cllr Kim Carsok**	X	X	X
Voluntary Sector Representative	*Emma Ratzer* **Tim Gardiner**	X	 X	 X
Voluntary Sector Representative	**Dan Mobbs**	X	X	X
Voluntary Sector Representative	**Daniel Childerhouse**		X	X
Norfolk Health Overview and Scrutiny Committee (Chair)	**Cllr Brenda Jones**	X	X	
Suffolk County Council, Cabinet member for Adult Care (Guest)	***Cllr Beccy Hopfensperger***	X	X	
Suffolk County Council Representative (ICP)	*Nicola roper* **Nicholas Pryke**		 X	 X
University of East Anglia Representative (Guest)	Prof Nicole Horwood	X	X*	

*X member attended, * Indicates Substitute attended*

Health and Wellbeing Board
4 December 2024

Item 8	Norfolk Drugs and Alcohol Partnership (NDAP) Annual Report	
8.3	Following a member's question, it was shared that the voluntary sector input was important, and that additional information would be shared with members on the voluntary sector members of the NDAP.	**Response from Diane Steiner** The following are currently funded through the grants we receive from government: Change Grow Live Herring House Trust The Matthew Project Norfolk & Waveney Mind St Giles Together Mental Health Emerging Futures St Martins via Together as part of housing related support. Other organisations are also involved in the partnership and its sub-groups, including: Phoenix Futures Forward Trust Herring House Trust Community Action Norfolk.
8.3	Following a member's question, it was noted that information would be provided on whether an assessment had been carried out on the proposed reduction in the housing support funding from NCC and whether this would have an impact.	Proposals to reduce the HRS budget were discussed during the autumn in a series of meetings with local housing authorities, their Housing Benefit colleagues and accommodation providers to better understand partner priorities but also explore what was possible in terms of economies. Outcomes from these discussions include the prioritisation of accommodation-based services, as far as possible, and the

		agreement of Housing Benefit colleagues to unify their approach (there are 7 local authority HB departments) for claims for Intensive Housing Management that could legitimately by claimed by services as part of Housing Benefit entitlement. Intensive Housing Management covers a similar range of housing related support to that currently funded by NCC ,and where the organisation is a Registered landlord, the increased costs can legitimately be claimed back by the local authority from central government. While not a like for like replacement for NCC funding this mechanism does offer a legitimate way of minimising the impact of NCC funding reductions. Our providers have considered how Intensive Housing Management could be utilised in their services and continue to consider how staffing and support could be adjusted to support the budget reduction A full EQiA and public consultation was carried out and considered by Full Council on 18 February. The Housing Team at NCC continue to work with providers and housing authorities to minimise impact where possible. A link to the EQiA is here - NCC Equality Impact Assessment - reduction in funding for housing related support services

16

Item 5		
5.4	Following a member's question regarding the expectations from organisations in the social care sector with respect to self-assessment and the Health Inequalities Lead, officers agreed to take this question away and members would be updated.	**Response from Tracy Williams and Stuart Lines** The Health Inequalities Self-Assessment (which forms part of the 'Equip' Commitment) within the ICS Health Inequality framework for action is open to all organisations across Norfolk and Waveney to complete. There is support is available to organisations should they wish to discuss any aspect of the assessment. We have developed a shorter version of the Self-Assessment which is currently available to our smaller VCSE organisations who may not find some aspects of the full assessment relevant to their work. If any social care organisations feel the shorter version may be more applicable, we can facilitate this and will explore how we might provide this as an option via the smart survey, we encourage our social care sector organisations to take part. If any social care organisations would like to discuss this, please contact: nwicb.healthinequalitiesconversation@nhs.net

Report to Norfolk Health and Wellbeing Board

Item No: 9

Report title: Director of Public Health Annual Report for Norfolk 2024/25: Health and Climate Change

Date of meeting: 11 June 2025

Sponsor (HWB member): Suzanne Meredith, Deputy Director of Public Health, Norfolk County Council

Reason for the Report

The Director of Public Health has a statutory responsibility to produce an annual report that focuses on the health of the local population. This year's report examines how climate change may impact the health and wellbeing of Norfolk's residents, explores the health co-benefits that can result from climate action, and identifies potential individual and system-wide actions to improve health outcomes and enhance climate resilience. The Board is asked to consider the findings, support the report's publication, and engage with its key messages to inform ongoing and future collaborative action across Norfolk.

Report summary

The Director of Public Health's Annual Report for 2024/25 (see Appendix A[1]) explores how changes in the climate may affect the health and wellbeing of Norfolk's population. It sets out key risks linked to climate change, including extreme weather, air quality, coastal change and flooding, agriculture, and the spread of disease and pests. Using national and local data, the report highlights how these risks are likely to impact Norfolk residents, particularly those who are more vulnerable or already experiencing health inequalities.

The report also highlights the potential co-benefits of climate action, which can support both public health and Norfolk's wider economy. Case studies from across the county showcase work that is already taking place to build climate resilience and improve health outcomes.

The report does not make specific recommendations or assign actions, but instead provides a broad overview of opportunities for both individuals and organisations to consider. Its purpose is to raise awareness, encourage reflection, and support system-wide conversation about how Norfolk can respond to the health impacts of climate change.

[1] [A designed draft of the DPH Annual Report is appended to this paper; designers are finalising the design elements of the report to adhere to accessibility requirements, and a final version will be appended to the final paper].

Recommendations

The HWB is asked to:

a) Approve the publication of the Director of Public Health's Annual Report 2024/25 on the Joint Strategic Needs Assessment (JSNA) website.
b) Acknowledge the potential opportunities outlined in the report, and encourage partners to reflect on how these may relate to their own work.
c) Share the Director of Public Health's Annual Report 2024/25 with relevant partners.

1. Background

1.1 Under the Health and Social Care Act 2012, the Director of Public Health has a statutory duty to produce an independent annual report about the health of the local population, with a corresponding duty on the Council to publish this report. Previous annual reports have focused on Covid-19 impacts (2020-2021), health variations across Norfolk (2022), and smoking and vaping (2023). The previous annual reports are accessible via the Joint Strategic Needs Assessment (JSNA) website, go to www.norfolkinsight.org.uk to view them in detail.

1.2 This year's Director of Public Health's Annual Report 2024/25 focuses on health and climate change.

2. Director of Public Health Annual Report 2024/25: Health and Climate Change

2.1 Attached as Appendix A is the Director of Public Health's Annual Report for 2024/25 which focusses on health and climate change, and is structured around 3 key areas:

2.2 **The health impacts of climate change –** This section explores how climate change affects public health, covering risks such as extreme temperatures, flooding, disease transmission, and disruptions to food production.

2.3 **The health co-benefits of climate action –** This section examines how climate action, including both mitigation and adaptation, can simultaneously improve public health and provide economic benefits. Examples include promoting active travel, encouraging sustainable diets, and improving housing quality. This section highlights existing initiatives across Norfolk.

2.4 **What action can we take –** This final section outlines potential system-wide and individual actions to enhance resilience to climate change, setting out how Norfolk can adapt to climate change's anticipated impacts and/or improve public health. It provides a broad overview of opportunities rather than assigning specific responsibilities to the County Council or partner organisations.

2.5 Throughout the report there is an overarching focus on the wider determinants of health, but also an emphasis on how simple individual behaviour changes can strengthen climate resilience whilst improving health outcomes.

2.6 In developing the report, an advisory group of key internal and external stakeholders was established to provide input and guidance. Further consultation with relevant officers has also occurred throughout the report's development. The report draws carefully on nationally recognised sources, such as the UK Health Security Agency, Met Office, and reputable local data, ensuring Norfolk specific context.

2.7 The report aligns with both Norfolk County Council's Climate Policy and Climate Strategy; it focuses on the health aspects of existing priorities, using evidence and local case studies to illustrate how ongoing work can also deliver benefits for public health and wellbeing.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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Telephone No.: 01603 638417
Email: diane.steiner@norfolk.gov.uk

If you need this report in large print, audio, Braille, alternative format or in a different language please contact 0344 800 8020 or 0344 800 8011 (textphone) and we will do our best to help.

Photography: Getty Images

Director of Public Health Annual Report 2024/25

Health and climate change

Norfolk County Council
Public Health

Contents

Foreword

Fran Whymark
Cabinet member for Public Health and Wellbeing

I am pleased to introduce the Director of Public Health's 2024/25 annual report. This year the report focuses on the health impacts of climate change in Norfolk and the significant benefits that certain climate actions can bring to people's health and wellbeing.

Norfolk County Council is committed to delivering a sustainable, greener and more inclusive future for the County as set out in Better Together for Norfolk. The County Council is already undertaking substantial work to combat climate change, introducing a Climate Strategy and Action Plan.

Climate change has the potential to impact the health of Norfolk residents. This report examines these impacts while also showcasing local initiatives that support both public health and climate action. It also highlights what each of us can do – whether organisations or individuals – to contribute to this valuable work. My thanks to all of those who seek to improve the health of our local residents.

Photography:
Coastwise

Introduction

Stuart Lines
Director of Public Health

Welcome to my 2024/25 independent annual report on the health of the people of Norfolk. This report focuses on the health impacts of climate change in Norfolk and aims to increase awareness of the benefits to health that taking positive climate change action can have.

Actions to reduce greenhouse gas emissions have the potential to offer substantial benefits to health and wellbeing. For example, encouraging short journeys to be taken by bike or on foot, rather than by car, gets people moving and improves cardiovascular health as well as cutting carbon emissions. These health co-benefits of climate action cover a wide range of activities such as sustainable and healthy diets; accessible, biodiverse green spaces; and energy efficient, healthy housing.

The health impacts of climate change do not fall equally on all, with at-risk individuals, older adults and those living in deprivation more severely affected and less able to respond. Climate change drives health inequalities and addressing it can provide benefits and a more resilient future for us all.

Photography:
Norfolk Wildlife Trust

Section 1:
Why the focus on climate change?

What is climate change?

Climate change refers to long-term shifts in temperatures and weather patterns. Since the industrial revolution, human activities have been the main driver of climate change, primarily due to the burning of fossil fuels like coal, oil and gas, and aided by deforestation and the changing use of land[1]. Burning these fuels releases greenhouse gases like carbon dioxide (CO_2) into the atmosphere, which trap heat and lead to a warming climate. The contribution made by human activity now means that atmospheric CO_2 levels are the highest they have been for around three million years[2].

At the 2015 Paris UN Climate Change Conference, 196 countries committed to limiting the global average temperature increase to 1.5°C above pre-industrial levels[3]. However, 2024 saw unprecedented global temperatures and marked the first year in which the 1.5°C limit was exceeded[4], while current policies put the world on track for a 3.2°C rise by 2100[5].

Addressing climate change is important in part due to its likely direct and indirect impacts on health. Fortunately, there are actions that can be taken to prevent or reduce these impacts and to build resilience through behaviour changes on the part of individuals, communities and organisations – locally, nationally and globally.

Some terms: mitigation, adaptation, and net zero

Mitigation: actions taken to reduce or prevent the causes of climate change, either by reducing greenhouse gas emissions, or absorbing and storing these gases (e.g. in forests).

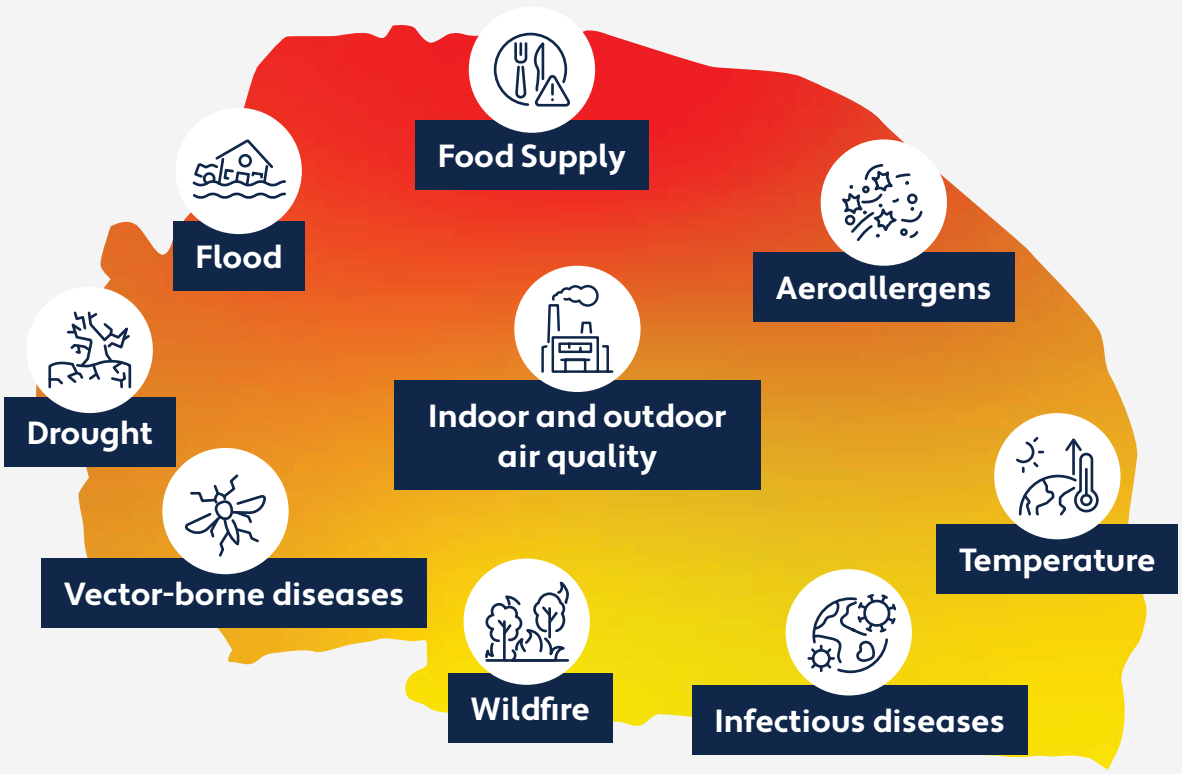
Adaptation: actions taken to adjust to the effects of climate change, such as building flood defences or using drought-resistant crops.

Simply, mitigation tackles the causes of climate change, while adaptation tackles its effects.

Net zero: no longer adding to the total amount of greenhouse gases in the atmosphere.

While efforts to reduce greenhouse gas emissions remain essential to limit climate change, emissions to date mean that a certain level of warming is already inevitable. The climate will change – the question now is by how much and what impact it will have. What is becoming clearer is that climate change will influence Norfolk residents' way of life over the coming years, with few impacts being more profound than those on health and wellbeing. **The UK Health Security Agency's (UKHSA) 2023 report** on the health effects of climate change clearly sets out these direct and indirect risks, highlighting how nearly all determinants of health are affected by climate change. From heatwaves and flooding, to food insecurity and increasing risks of disease, the message from UKHSA is clear: the climate crisis[6].

How could climate change impact health and wellbeing in Norfolk?



Source: Graphic adapted from Health Effects of Climate Change (HECC) in the UK (UKHSA, 2023)

Norfolk's distinctive geography makes the county particularly vulnerable to these changes. The long coastline and low-lying terrain makes Norfolk more susceptible to flooding and coastal erosion, while simultaneously the comparatively warm, dry climate means that risks of drought and heatwaves are higher relative to the rest of the country[7]. Understanding how these risks affect Norfolk will be crucial to enable effective adaptation and preparation for the future.

It is likely that these impacts will not be experienced equally across Norfolk's population; the county's demography and socioeconomic characteristics mean that certain groups may be more impacted by the effects of climate change than others, further worsening existing health inequalities. With pockets of high deprivation in communities across the county[8], as well as an ageing population[9], it is essential that action is taken to minimise the impacts of climate change, particularly upon already vulnerable groups.

However, the need to mitigate and adapt to climate change brings significant opportunities to improve health in Norfolk. Actions that address climate change while at the same time improving health are known as 'co-benefits.' There are numerous ways to bring about positive health co-benefits while reducing greenhouse gas emissions and building climate resilience, particularly in relation to housing, air quality, transport, and green spaces. Individual behaviour changes play an important part. The move towards net zero also creates significant opportunities for Norfolk's economy, with the county particularly well-poised to take advantage of growth in the renewable energy sector, as the county's new Local Growth Plan sets out.

While a lot remains to be done, the UK has already made significant progress. The Climate Change Act 2008 meant that the UK became the first country globally to adopt a law on climate change[10], committing the UK to reach net zero by 2050[11]. In 2022, UK greenhouse gas emissions were 50% lower than 1990 levels[12]. At a local level, **Norfolk County Council's Climate Policy** sets out the Council's commitment to reaching net zero on its estate by 2030, and pledges to use its powers, influence and partnerships to support the UK-wide 2050 net zero target[13]. The accompanying Climate Strategy outlines a series of plans and workstreams to identify how these targets will be achieved through six key themes, including transport, building and planning, and energy. Norfolk's district, city, and borough councils also play an important role in climate action across the county, with all seven having set formal net zero targets.

What strategies and plans are already in place in Norfolk?

- **Norfolk County Council Climate Change Policy and Strategy** – sets out the Council's commitment to reaching net-zero by 2030 and outlines how this will be achieved.
- **Norfolk County Council Environmental Policy** – sets out goals related to issues such as air quality, nature recovery, and land-use management for Norfolk. This is currently being refreshed with a new version expected in 2025.
- **Norfolk's "Together, for our Future" Report** – sets out key changes that Norfolk faces in the future, such as coastal erosion and climate change, and how these can be prepared for.
- **Norfolk's Local Growth Plan** – sets out areas of focus for economic growth, including a vision for Norfolk to become a UK leader in offshore energy production and climate change adaptation.
- **District Authority Climate Commitments and Strategies** – all seven of Norfolk's district, city, and borough councils have set climate commitments for their own estate, with accompanying strategies or action plans.
- **Integrated Care System (ICS) Green Plan** – the Norfolk and Waveney ICS's Green Plan sets out how system partners will work together to cut carbon emissions and enhance resilience. This is currently being refreshed with a new version expected in Summer 2025. The ICS's Green Plan is underpinned by member organisations' own strategies, such as Green Plans for the **East of England Ambulance Service**, **Norfolk and Norwich University Hospital** and **Norfolk Community Health and Care**.
- **Ready to Change ...Ready to Act** – Public Health's Strategic Plan sets out key priorities for improving health outcomes and inequalities in Norfolk and highlights the importance of working with partners towards net zero.

It is important that, as a local system, Norfolk County Council, district councils, the NHS and other partners continue working together to understand and minimise the health impacts of climate change, particularly for Norfolk's most vulnerable residents. This report examines the risks and challenges Norfolk faces, along with the opportunities for improving health outcomes and reducing inequalities through effective climate action. Addressing climate change head-on allows partners to prepare as a system, ensuring that Norfolk is resilient to future impacts and ultimately securing a healthier, more liveable future for all Norfolk residents.

The National Adaptation Programme

The UK Climate Change Act 2008 mandates that a **National Adaptation Programme** is published every five years, setting out the actions that government and other partners will take to adapt to the impacts of climate change[14]. Under the National Adaptation Programme, UKHSA publishes Adverse Weather and Health Plans. The Plans aim to support local and national organisations to prepare and respond to future adverse weather events to protect public health and promote wellbeing. The Plans cover key areas such as heatwaves, cold weather, flooding, and drought, and include strategies for early warning systems, communication, and capacity building[15].

Photography:
Getty Images

Section 2:
The health impacts of climate change

Both at home and across the world, the impact of climate change on health is becoming increasingly visible. These impacts are felt both directly, such as through heat-related illnesses and injuries from extreme weather events, and indirectly, by worsening issues like food insecurity. On a global scale, many of these threats will make certain areas uninhabitable, leading to increased climate-related displacement and migration[16]. The evidence base on climate change's threats to health is growing; the following section sets these out and highlights the potential impact on Norfolk.

Extreme temperatures

The increasing frequency of higher temperatures is a clear sign of the UK's changing climate, with the number of 30°C days tripling in the past decade[17] and 2022 marking England's first 40°C day[18]. This warming trend is evident in East Anglia, where annual temperatures continue to climb above the long-term average (Figure 1). Even if emissions pledges are met, global temperatures will likely still rise 2°C above pre-industrial levels by 2050, increasing the number of summer days in Norfolk above 25°C by a third[19].

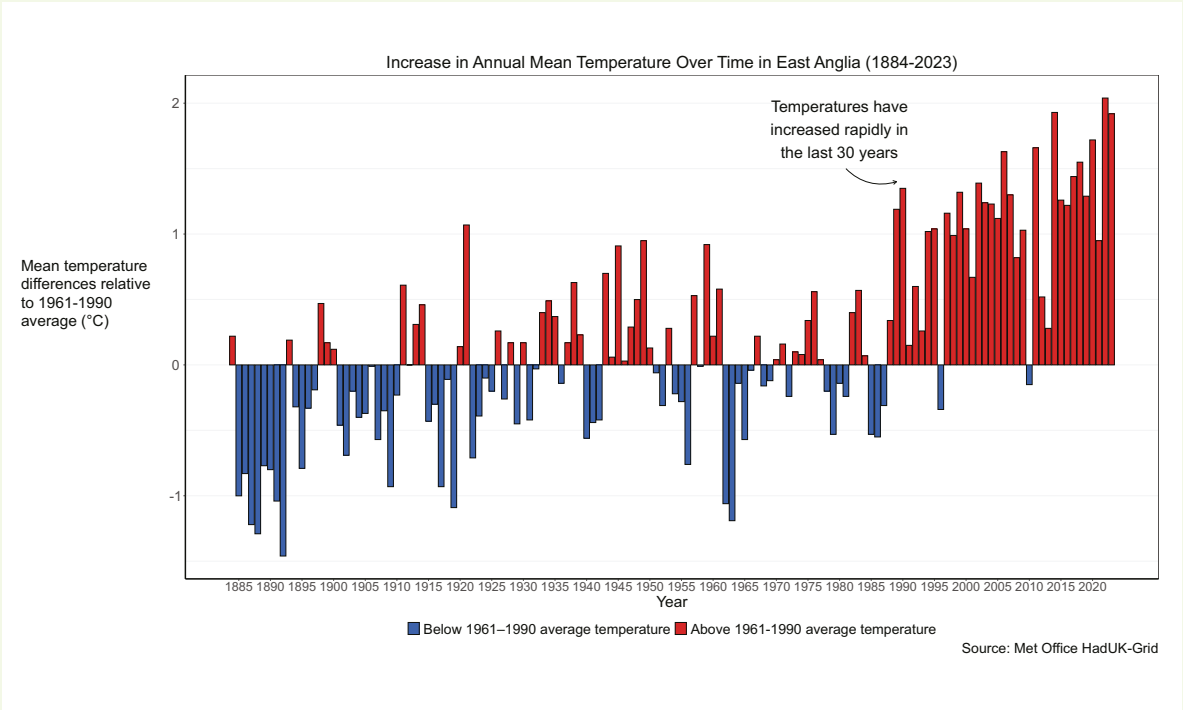


Figure 1. Mean annual temperature anomalies for East Anglia relative to 1961–1990 baseline.

Rising summer temperatures and more frequent heatwaves pose significant health risks. Prolonged exposure to high temperatures can lead to heat-related illnesses such as heat exhaustion and heat stroke and can also worsen existing respiratory and cardiovascular conditions, increasing the risk of heart attacks and symptoms for those with asthma[20]. Hospitals are also likely to become increasingly uncomfortable environments, with 90% of UK hospitals estimated to be at risk of overheating[21]. The 2022 heatwaves highlighted this increasing risk, with 2,985 heat-related excess deaths reported across England, the highest on record[22]. In Norfolk, daily deaths during these heatwaves were 18% higher than the five-year average, with 242 recorded excess deaths (Figure 2)[23].

With climate change projected to increase the frequency and intensity of heatwaves, it is expected that the health risks of extreme heat will worsen without appropriate adaptation[24].

With no adaptations, 2°C of warming, combined with a growing and ageing population, could result in an estimated 3,700 excess deaths annually in the UK by 2030[25].

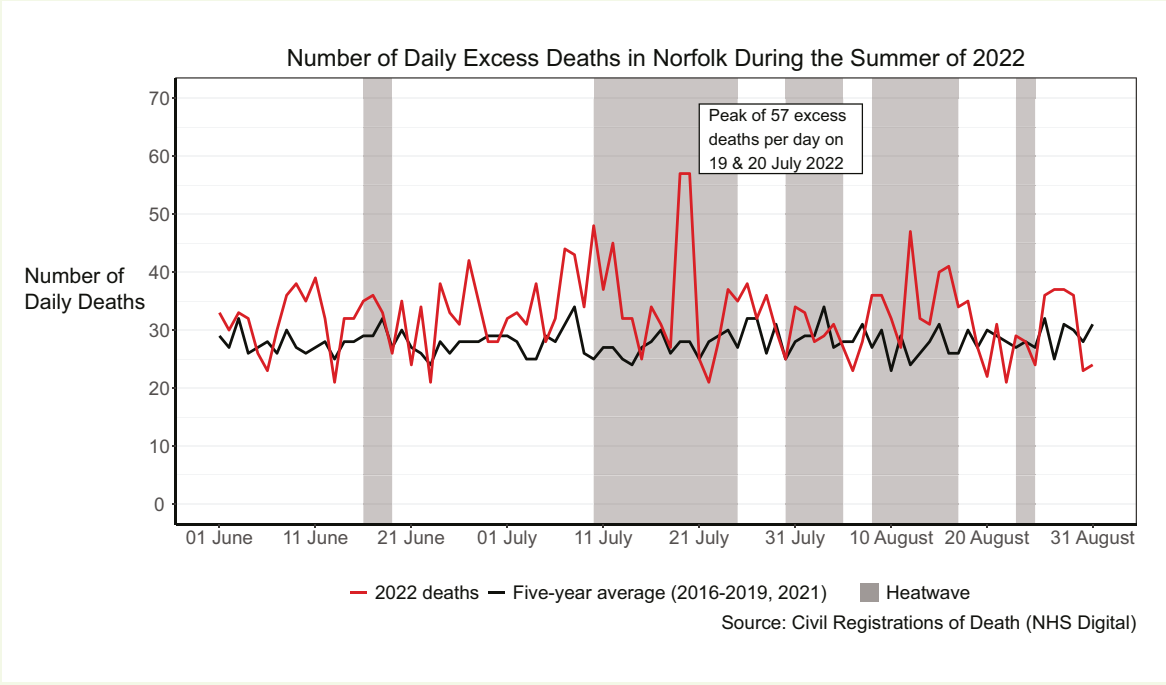


Figure 2. Number of daily death occurrences in Norfolk during the summer of 2022 compared to the five-year average (2016-2019,2021). Grey bars represent periods classified as heatwaves during the summer of 2022 (01 June-31 August).

Rising temperatures and drier summers will also increase wildfire risk. The Met Office's projections indicate that a 2°C increase in global temperatures will double the days in the UK with a very high fire risk and could extend the wildfire season into autumn. In the East of England it's predicted that the number of wildfire risk days will increase by 3-4 times[26]. During the summer of 2022, the joint warmest on record and one of the driest in decades, Norfolk's Fire and Rescue Service responded to 45 wildfires, a 96% increase from 2021 (Figure 3)[27]. Not only are these events a direct risk, but they also contribute to worsened air pollution, aggravating respiratory and cardiovascular issues due to higher levels of particulate matter in the air[28]. As most wildfires are a result of human activity, awareness and changes in behaviour will become increasingly important[29].

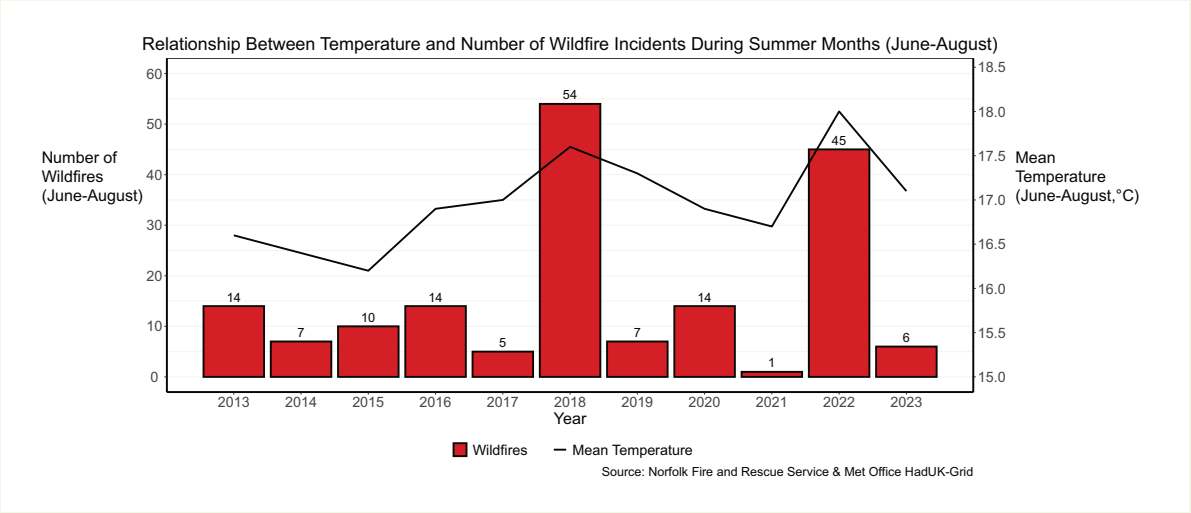


Figure 3. Number of wildfire incident callouts in Norfolk during the summer months from 2012 to 2023 against mean summer temperature. Mean temperature represents the average temperature in East Anglia between June and August of each year.

Photography: Norfolk Fire and Rescue Service

Case Study: Wildfires and Norfolk Fire and Rescue Service

Rising temperatures can lead to prolonged heatwaves, drought and drier conditions, which in turn elevate the risk and extend the duration of wildfire seasons. The summers of 2018 and 2022 were the joint warmest on record and the driest in decades[30], resulting in a significant increase in the frequency and severity of wildfires compared to previous years. In these years, Norfolk Fire and Rescue Service reported 122 wildfires, damaging approximately 133 acres of land and requiring 810 hours to extinguish.

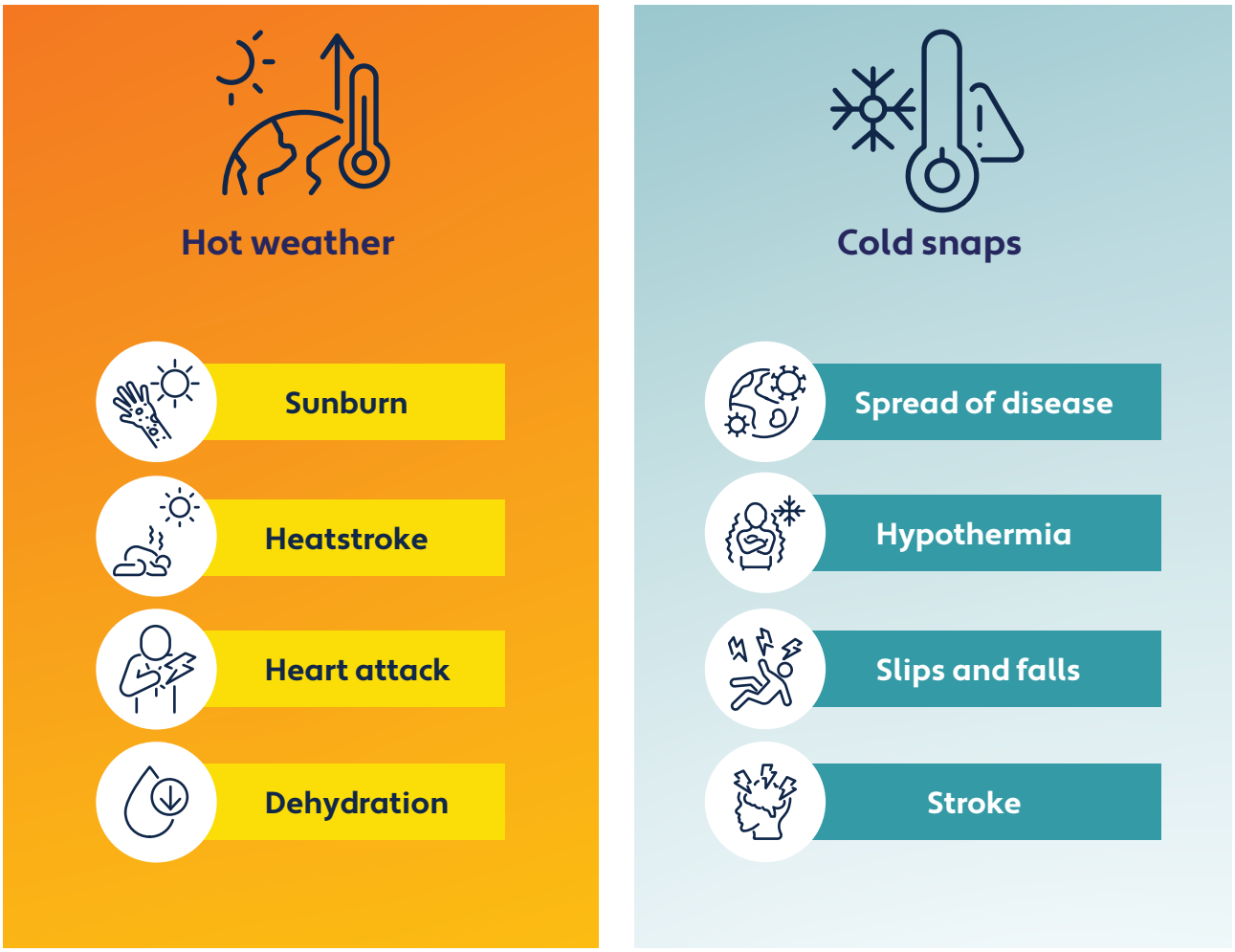
Wildfire smoke poses significant health risks, as it contains various harmful pollutants such as particulate matter. Exposure to this smoke can aggravate respiratory conditions like asthma, increase the risk of cardiovascular problems, and cause irritation to the eyes and throat. Children, pregnant women, and the elderly are particularly vulnerable to smoke exposure.

This growing risk significantly impacts emergency services responding to fires:

"During the unprecedented heat emergency in 2022, our teams at Norfolk Fire and Rescue Service faced a challenge of a scale and intensity we'd never seen before. The extreme heat made already difficult work even harder, putting our crews at serious risk of heat-related illness. We recorded two cases of heat stroke, and numerous staff had to be pulled from operations as they approached exhaustion. The unrelenting demands of continuous work in record-breaking temperatures highlighted just how challenging it is to tackle fires in these conditions and just how much rising temperatures are impacting firefighter safety and wellbeing." – Paul Seaman, Norfolk Fire and Rescue Service Area Manager (Response).

It is also important to consider the effects climate change may have on cold weather and its impacts on health. While winters are projected to be warmer and wetter generally, the incidence of 'cold snaps' will continue, posing significant health risks for vulnerable populations. Cold temperatures increase risks of hypothermia, frostbite, heart attacks, and strokes, while also worsening respiratory conditions and increasing the risk of spreading viral infections. For instance, Norfolk's 2023/24 winter deaths were 10.2% higher than the preceding four months[31]. While overall risk may reduce due to warming winters, projections indicate that the number of cold-related deaths are still set to increase due to our ageing and growing population[32]. As such, cold weather planning remains a priority in Norfolk, working as a system to ensure a coordinated and effective response.

Direct impacts of extreme temperatures on health



The health impacts of extreme temperatures will not be felt equally across the population, with certain groups being more vulnerable. Older adults are particularly at risk due to the likelihood of having pre-existing health conditions and a reduced ability to regulate body temperature, and are consequently the greatest driver of heat- and cold-related deaths[33]. This is particularly relevant to Norfolk given its ageing population, with 24% of the population aged 65+ (compared to 18% nationally)[34], with this projected to rise to 30% by 2043[35]. However, other groups are also vulnerable to extreme temperatures: those with chronic illnesses such as cardiovascular and respiratory diseases and those living in poorer quality housing. Young children are also particularly vulnerable as their bodies are less able to cope with heat. Outdoor workers and those experiencing homelessness are also susceptible due to prolonged exposure. Section 4 explores measures to minimise temperature-related health risks from climate change.

Air quality

Climate change and air pollution are closely intertwined, with Norfolk's increasingly hotter, drier summers having the potential to worsen air quality. Several factors contribute to this. Rising temperatures enhance the formation of ground-level ozone, which not only harms respiratory health but also interacts with other pollutants to amplify their effects[36]. This is not just a concern for urban areas, with ozone concentrations typically being higher in rural areas[37]. Furthermore, prolonged heatwaves make air pollution worse by creating stagnant air conditions which trap pollutants at ground level[38]. As established previously, hotter, drier summers are also expected to increase the frequency of wildfires, which release large amounts of particulate matter (PM_{10} and $PM_{2.5}$) into the air, impacting cardiovascular and respiratory health (PM_{10} and $PM_{2.5}$ refer to two sizes of tiny particles in the air that can be harmful to health).

Climate change is also expected to worsen issues with airborne allergens, with warmer summers increasing pollen production and leading to more frequent and severe allergic reactions[39]. This link between hot weather and worsening air quality is already evident in the UK. Researchers from the National Centre for Atmospheric Science and the University of York observed significant changes in air pollution during the 2022 heatwaves, with levels of ozone reaching twice the World Health Organisation's recommended limit[40]. Among these findings, Weybourne in Norfolk recorded some of the highest ozone levels nationally.

Photography:
Getty Images

Key outdoor air pollutants include fine particulate matter, nitrogen dioxide, and ammonia. The UK has seen a reduction in the emissions of some air pollutants due to tighter regulation (Figure 4). For instance, levels of sulphur dioxide and oxides of nitrogen have declined but decreases in particle emissions from industrial sources have been offset by increases in domestic combustion. Ammonia levels have shown little change and remain high (Figure 4).

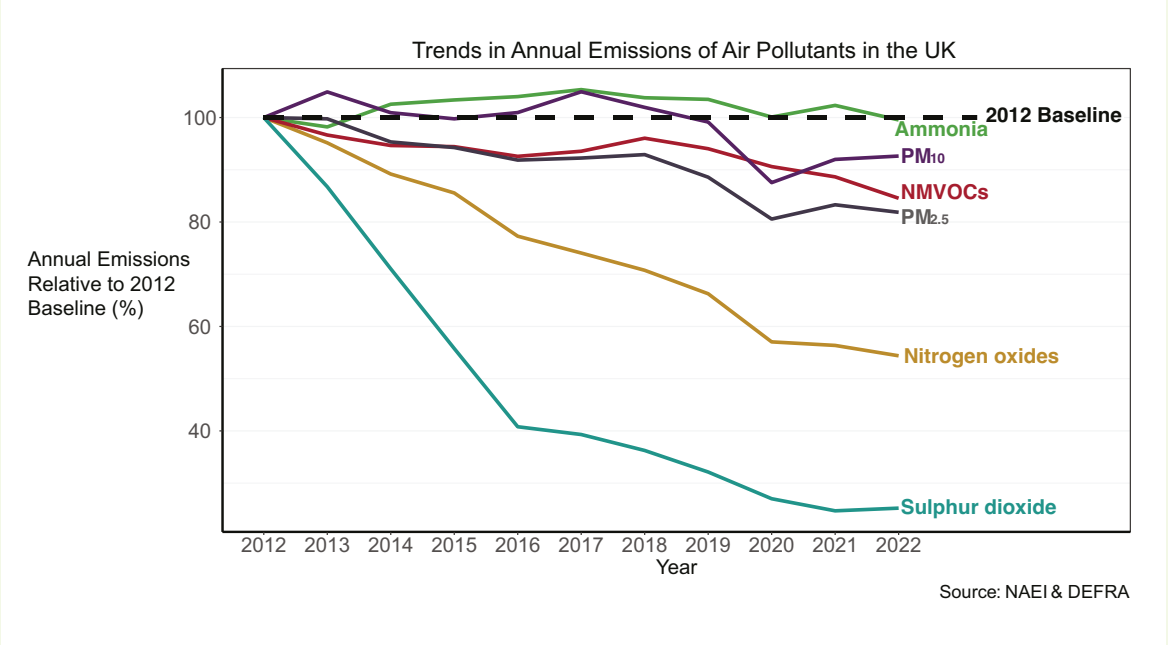


Figure 4. Recent UK trends in annual emissions of air pollutants including PM_{10}, $PM_{2.5}$, nitrogen oxides, ammonia, non-methane volatile organic compounds (NMVOCs), and sulphur dioxide. The dashed line represents the level of annual emissions had they remained constant at 2012 levels[41].

In Norfolk, particulate emissions (both PM_{10}, $PM_{2.5}$) are high in urban areas such as Norwich, King's Lynn and Great Yarmouth, and lower in rural parts of the county (Figure 5, Maps A and B). Similarly, nitrogen dioxide (NO_2) emissions are clearly associated with the county's main urban areas and the network of roads which connect them (Figure 5, Map C). Meanwhile, high ammonia emissions are associated with rural areas where agricultural activity is greater, particularly south and southwest of Norwich (Figure 5, Map D).

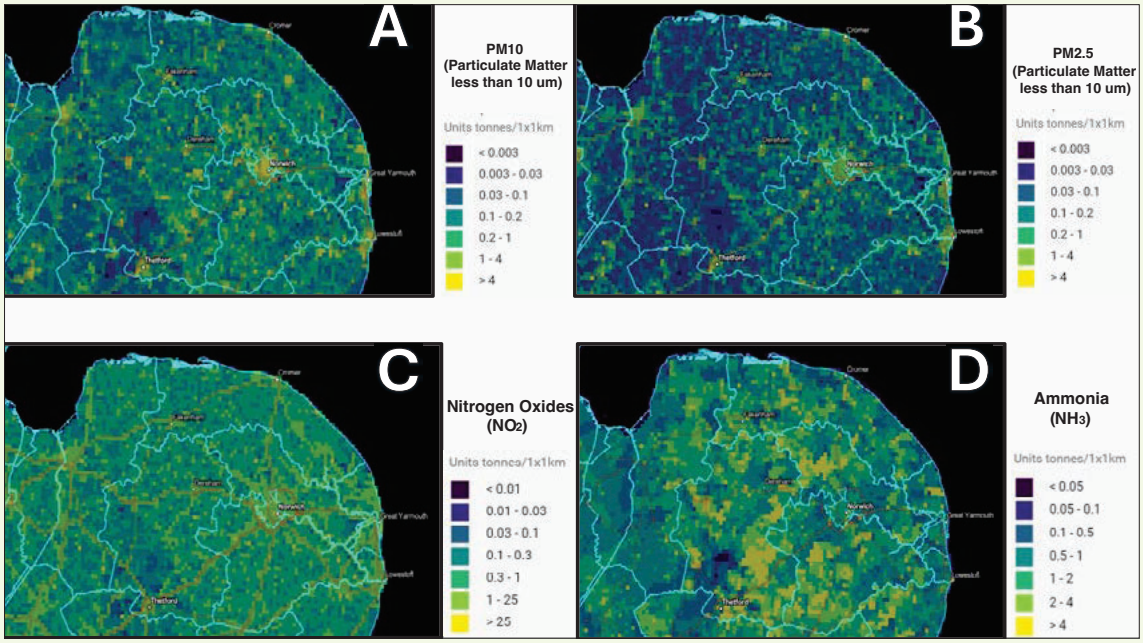
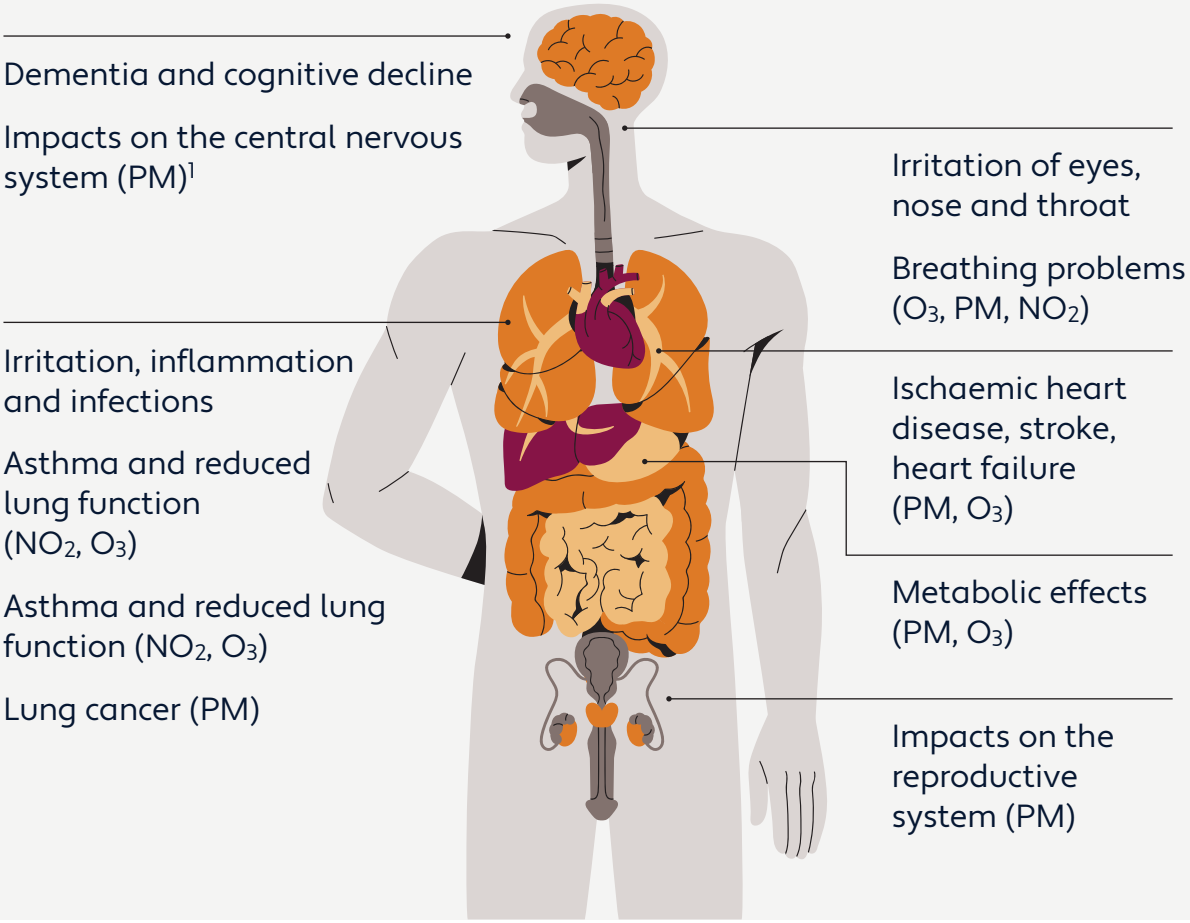


Figure 5. Maps of total emissions from all sectors of PM_{10} (Map A), $PM_{2.5}$ (Map B), nitrogen oxides (NO_2) (Map C) and ammonia (NH_3) (Map D). Data from the **UK National Atmospheric Emissions Inventory for 2021**.

Air pollution is one of the greatest environmental risks to public health in the UK and is associated with an estimated 29,000 to 43,000 deaths per year.[38] Exposure to pollutants such as NO_2 and particulate matter and particulate matter(PM) is known to reduce life expectancy and cause a range of respiratory and cardiovascular health problems such as asthma, chronic obstructive pulmonary disease (COPD), lung cancer, heart disease, and stroke. Long-term exposure has also been linked to an increased risk of cognitive decline, dementia, and other neurodegenerative diseases.[38]

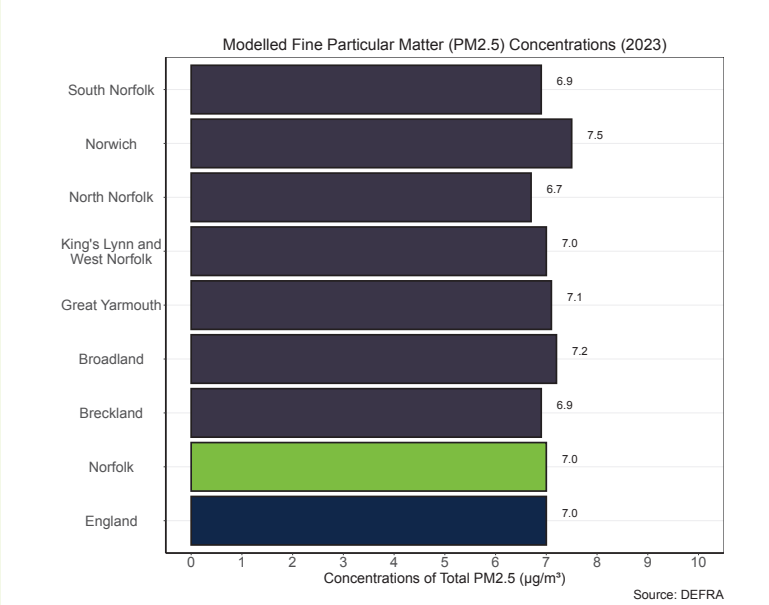
Health effects of air pollutants



Source: **Chief Medical Officer's Annual Report 2022**

In Norfolk, the percentage of early deaths where exposure to fine particulate matter pollution could have been a contributory factor stands at 5.3%. In Norwich the rate is 5.6% (Figure 6B).

A



B

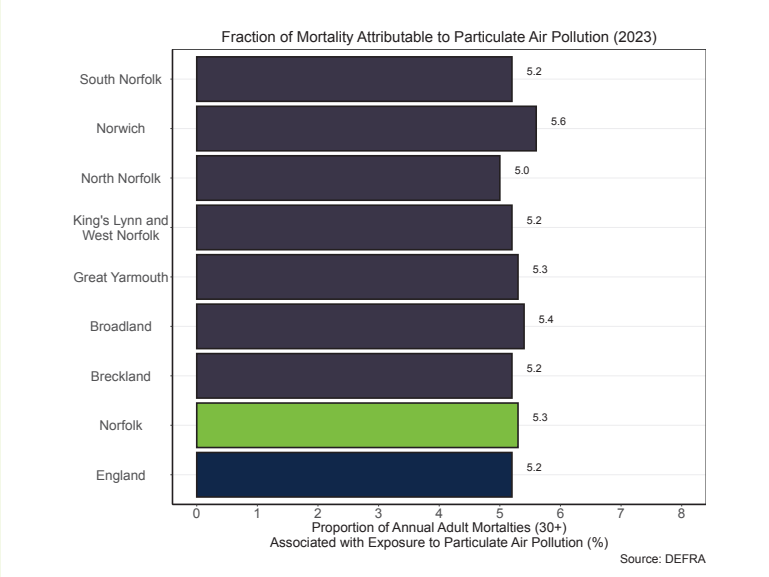


Figure 6. Fine particulate matter ($PM_{2.5}$) concentrations measured in micrograms per cubic meter (µg/m³) (A) and the fraction of annual adult (aged 30+) mortalities attributable to exposure to fine particulate matter (B) in 2023 across Norfolk's local authorities compared to Norfolk and England averages.

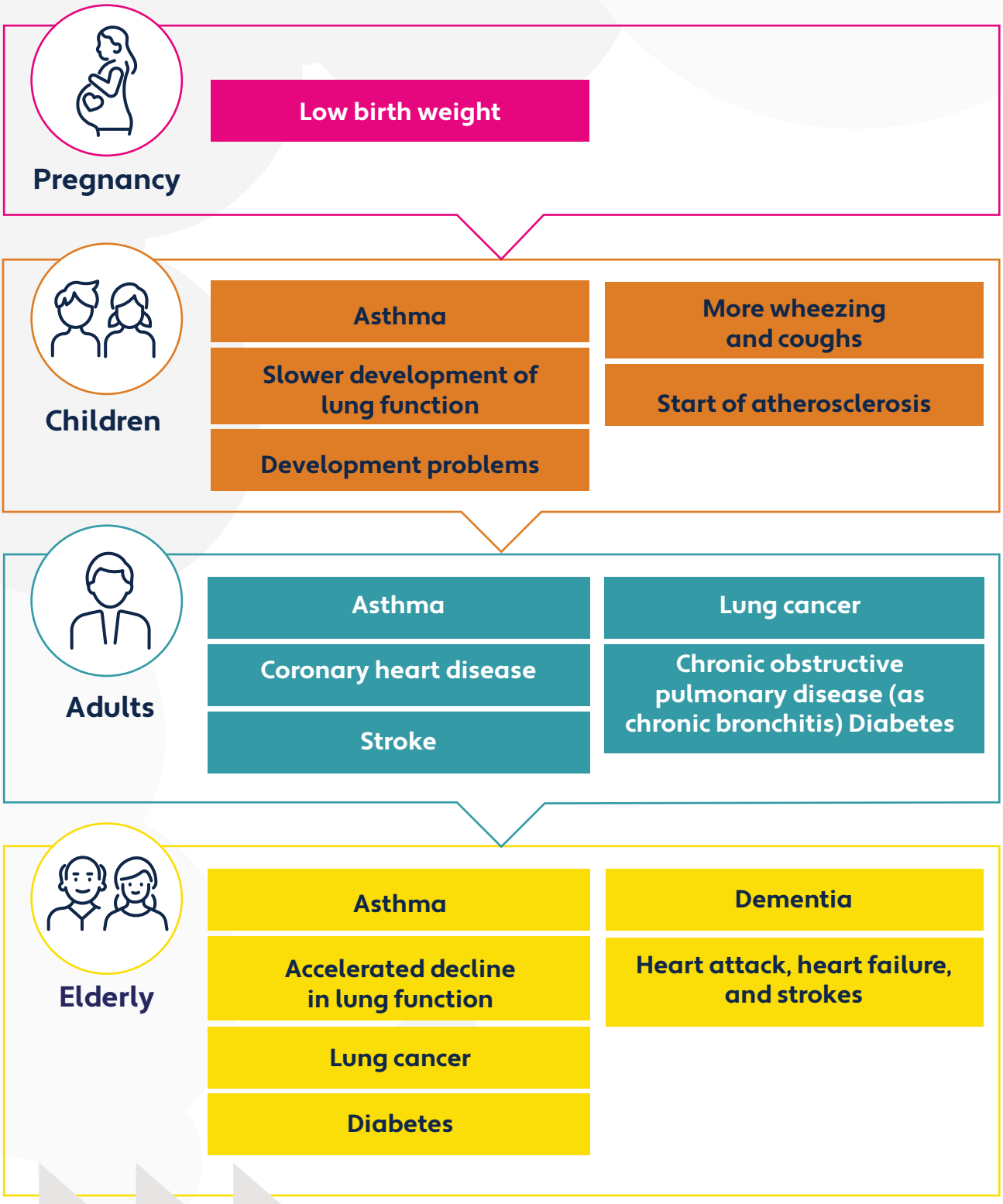
The impact of air pollution is not evenly distributed across the population. Those in more deprived areas are more likely to live near busy roads or industrial sites, where pollution levels are higher. Affordable housing is frequently located in these more polluted areas, increasing exposure to poor air quality[43]. Studies of hospital admissions and mortality show increased health risks associated with exposure to air pollution among those living in areas of higher socio-economic deprivation. A 2023 study by UEA's Health Data Interpretation Group examined healthy life expectancy and prevention opportunities in Norfolk, identifying key avoidable risks that contribute to lower life expectancy in areas such as Great Yarmouth, Norwich, and King's Lynn[44]. One of these factors was air pollution.

The study found that for every 1 mcg/m³ reduction in $PM^{2.5}$ levels, life expectancy at age 65 increased by 6-7 months for both men and women.

Photography:
Getty Images

Air pollution is particularly problematic for young people, pregnant women, older people and those with pre-existing health conditions. Children are particularly susceptible to the health effects of air pollution as their lungs and other organs are still developing, and they inhale more air per body weight than adults[45]. Sections 3 and 4 explores actions to improve air quality and promote public health.

Air pollution affects people throughout their lifetime



Source:
Health matters: air pollution - GOV.UK

A focus on wood burners

In recent years, especially during the cost-of-living crisis, log burners have become increasingly popular for home heating. Even though they might have other pre-existing options for heating, more households are installing wood burners as a secondary heating source[46]. However, they pose significant health risks due to their impact on indoor and outdoor air quality.

The domestic burning of fuels such as wood and coal contributes 29% of the UK's total $PM_{2.5}$ emissions, more than both road transport and industrial combustion[47]. Of this, wood burning accounts for 75%.[47] Breathing air containing $PM_{2.5}$ over a prolonged timeframe can inflame the lining of the lungs and enter the bloodstream, affecting the heart and brain. This exposure is linked to serious health issues, including lung disease, heart disease, dementia, and strokes.

Approximately 2,900 properties in Norfolk are not connected to the gas grid and rely on burning solid fuel for their heating*[48]. However, those who have alternative options for heating may wish to consider the health impacts of burning solid fuels, both for themselves and the wider public.

*Of the 215,000 properties in Norfolk that had an EPC in the last 10 years.

Photography:
Adobe Stock

Flooding and coastal change

Climate change is expected to bring more frequent and intense flooding to Norfolk. Projections suggest that winter rainfall in Norfolk could increase 10-20% by 2100[49], overwhelming rivers and floodplains and leading to flooding across the county. Similarly, whilst summers are expected to be drier overall, the intensity of rain is expected to increase, leading to localised flash flooding[50]. In Norfolk, Suffolk and Essex, climate change, coupled with population growth, could see a 24% increase in people being exposed to flooding by 2050, assuming current levels of adaptation[51]. Given that 106,000 people across Norfolk already live in areas vulnerable to flooding, the increasing risk underscores the importance of continued resilience planning[52]. This risk is not unrealised: over the past 10 years, 1,355 properties in Norfolk have been reported as flooded[53], a number expected to rise. The impacts of flooding were made clear in 2020, the fifth wettest year on record in the UK[54], with Norfolk's Fire and Rescue Service carrying out 537 flood rescues, more than 2019, 2021, and 2022 combined (Figure 7).[27] The annual variation in flood rescue incidents underscores the unpredictable nature of weather events driven by climate change, and has led Norfolk Fire and Rescue Service to recognise flooding as one of six high-impact threats to Norfolk's residents[55].

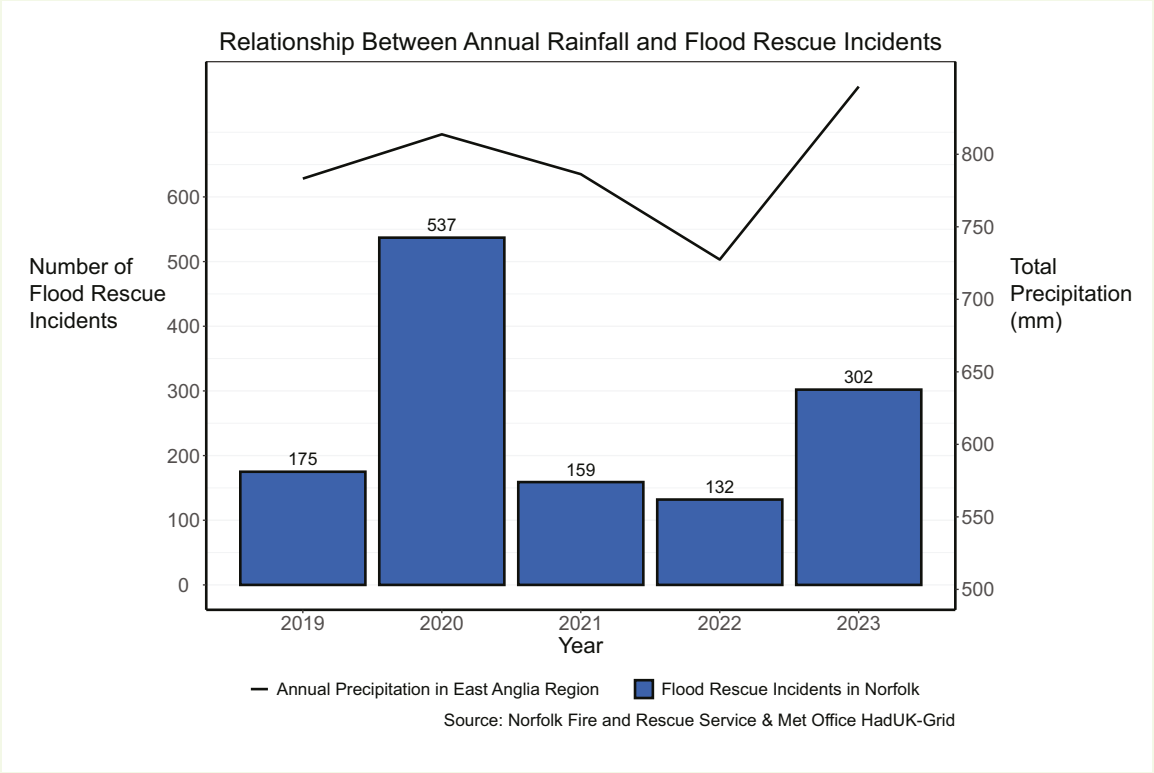


Figure 7. Number of annual flood rescue incident callouts in Norfolk from 2019 to 2023 against annual precipitation in East Anglia.

Current flood risk in Norfolk

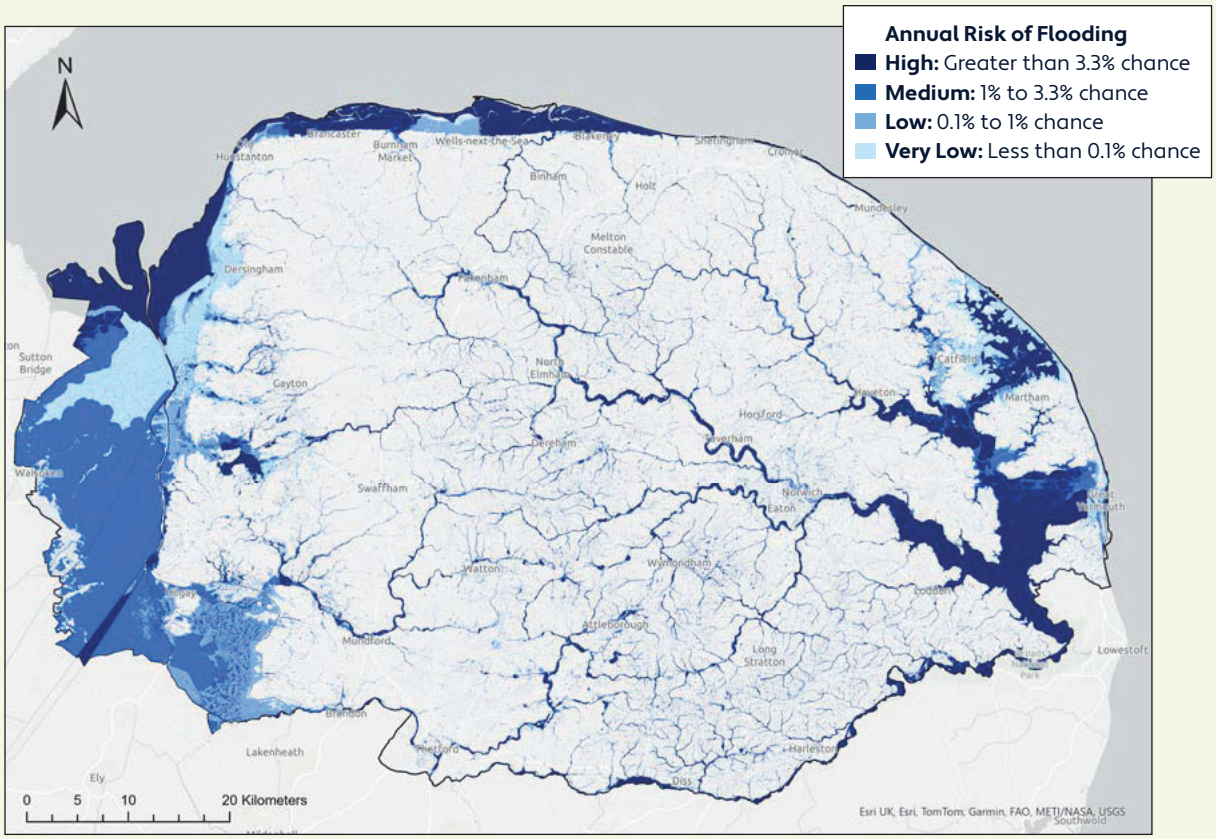


Figure 8. Current flood risk across Norfolk, combining river, sea, and surface water flooding[56]. It is important to note that this map indicates areas at risk based on geographic factors, not areas that experience frequent flooding events.

Other than the immediate risk, there are various indirect impacts of flooding on public health. Flooding can increase disease risk by causing sewage overflows, contaminating water supplies, and leaving stagnant water that can breed mosquitoes, potentially leading to diseases discussed in later sections. Not only does flooding pose a risk to physical health, but those who experience flooding are more likely to suffer from anxiety, depression and post-traumatic stress disorder, as discussed further below. Furthermore, flooding can also impede access to healthcare facilities, heightening risk in emergency situations. In Norfolk, 3 hospitals are in flood risk areas, along with 53 GP surgeries and 28 care homes (see Figure 8 for flood risk areas).[56]

In the UK, low-income households are eight times more likely to live on tidal floodplains[57].

Not only is this exposure to the **risk** of flooding problematic, but low-income households are also less able to cope with and recover from flooding. Only 1 in 3 of the UK's poorest households have contents insurance[58], and with the average cost of flooding reaching £50,000 per home[59], the financial impacts can be significant. This can further deepen economic and health inequalities.

Climate Just's map of flood vulnerability (Figure 9) combines geographical flood risk with social factors like age, health, and income to identify areas where the social impacts of flooding are likely to be most severe. The map suggests that areas around Hunstanton, Great Yarmouth and Norwich are particularly vulnerable and will continue to be so as climate change increases the risk of flooding.

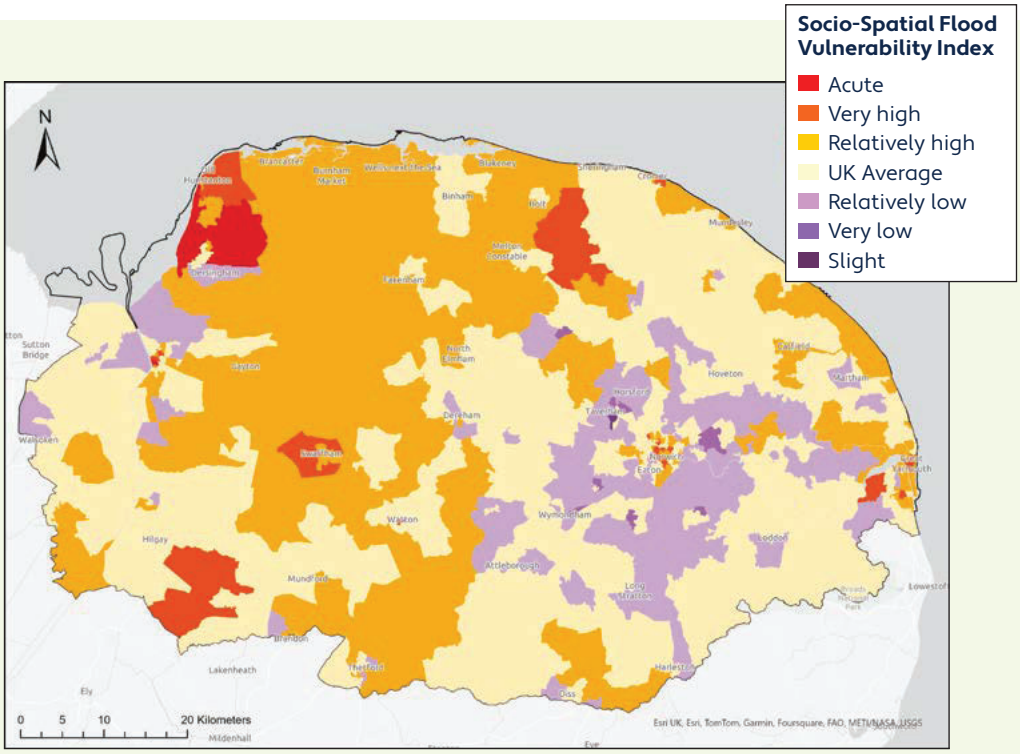


Figure 9. Climate Just's map of social vulnerability in Norfolk with respect to flood-related hazard, highlighting areas where the adverse social impacts of flooding are most pronounced.[52]

Preventing flooding and minimising its impacts could benefit health in Norfolk. In urban areas, Sustainable Drainage Systems (SuDS) offer opportunities to reduce flood risk by using features like rain gardens, permeable pavements, and wetlands to manage rainwater more effectively. Natural flood management measures such as restoring floodplains, installing leaky dams and increasing tree planting also reduce runoff and slow water flow during periods of heavy rainfall, helping to mitigate flooding. Norfolk County Council undertakes a range of flood mitigation work, such as a recent scheme in Besthorpe, near Attleborough, where 16 properties were affected by repeat surface water flooding. The scheme includes an attenuation basin next to the Village Hall that can temporarily store excess rainwater to prevent flooding and which doubles as a parking area in dry weather, and upstream clay bunds (embankments) reduce flows in the adjacent watercourse. The Broadland Futures Initiative is another key scheme in managing long-term flood risk in Norfolk, bringing together key partners such as the Broads Authority, the Environment Agency, and local authorities to develop a framework for flood resilience that accounts for climate change and rising sea levels over the next century.

Climate change will also heighten the risk posed by coastal erosion. While erosion is a natural process, climate change is causing rising sea levels and worsening storms, both of which are increasing erosion rates[60]. It's estimated that over one thousand residential and commercial properties in North Norfolk alone are expected to be lost by 2105[61].

Photography: Coastwise

Coastal erosion poses several direct and indirect health risks to coastal communities. The mental health impacts can be significant, with the threat of losing one's home and livelihood potentially leading to heightened stress, anxiety, and depression. A recent survey undertaken in North Norfolk coastal communities found that 58% of respondents' personal wellbeing is negatively affected by coastal erosion.[61] Erosion can also disrupt transport links along vulnerable parts of the coastline; there are several key roads on the Norfolk coast that are at risk of erosion but are essential links to coastal towns and villages. The loss of these could cut off communities, affecting not only residents' ability to travel themselves, but also hindering emergency services' ability to reach these areas. Potential isolation from healthcare facilities may also worsen non-climate-related health outcomes.

These impacts may also be felt more acutely due to the demography of coastal communities in Norfolk; in some areas 40% of residents are aged 65 or over, compared to only 10% in Norwich and Thetford.[9] Elderly people are particularly vulnerable to coastal erosion due to their reduced mobility and pre-existing health conditions, highlighting the need for effective resilience measures to protect their wellbeing.

Norfolk is likely to face more intense flooding and coastal erosion due to extreme weather conditions, increased winter rainfall, and higher sea levels.

Impact on infrastructure

- Flood damage to properties
- Disrupted health services
- Contaminated water supplies
- Erosion of coastline

Impact on health

- Poor mental health
- Respiratory infections
- Spread of water-borne disease
- Injury

Photography: Coastwise

Case study: Coastwise and Resilient Coasts Projects

Coastwise and Resilient Coasts are two key projects addressing the need to adapt to coastal erosion in Norfolk.

North Norfolk District Council's Coastwise team works with local residents and other stakeholders to co-develop transition plans and practical actions tailored to the needs of communities affected by erosion where defences are not an option. The project, running until March 2027, prioritises community involvement, aiming to prepare coastal communities through practical adaptation actions, planning together and informing national policy development.

Great Yarmouth Borough Council's Resilient Coasts project will create practical tools to help coastal communities plan for their future. The project (in partnership with East Suffolk Council) will involve supporting communities at the highest risk of erosion to discuss and adapt to coastal erosion, while also investigating alternative technology and engineering practices to protect these communities.

These two projects are funded by Defra as part of the £200 million **Flood and Coastal Innovation Programme** which is managed by the Environment Agency. The programme will drive innovation in flood and coastal resilience and adaptation to a changing climate.

Environment Agency

Department for Environment Food & Rural Affairs

Disease and pests

Rising temperatures are altering environmental conditions in ways that both directly and indirectly influence the spread and severity of diseases[62]. Vector-borne diseases are illnesses spread by organisms such as mosquitoes, ticks and fleas which transfer germs from one host to another[63]. Milder winters and longer breeding seasons are allowing these vectors to survive and reproduce more effectively, increasing the risk of disease transmission to humans and animals[64]. The UK Health Security Agency is working with local authorities and environmental agencies to monitor and address these risks[65], with its Human and Animal Infections and Risk Surveillance group playing a key role in identifying and assessing infection risks across the UK[66].

Lyme disease, the most common vector-borne disease in England and Wales[67], is transmitted by ticks, which are becoming more common due to shifting environmental conditions. Lab-diagnosed cases of Lyme disease increased from 1.6 to 2.0 per 100,000 between 2019 and 2023 in England (Figure 10). Norfolk and the East of England have significantly lower Lyme disease rates compared to the national average (Figure 10). However, Norfolk, with its woodlands and changing environmental conditions, offers increasingly suitable habitats for ticks[68].

Nationally, an estimated 2,000 cases of Lyme disease are treated annually, but many may be identified based on symptoms alone, suggesting possible underreporting[69].

Photography:
Getty Images

Most tick bites do not cause Lyme disease, but increased awareness helps with prevention and early diagnosis[70].

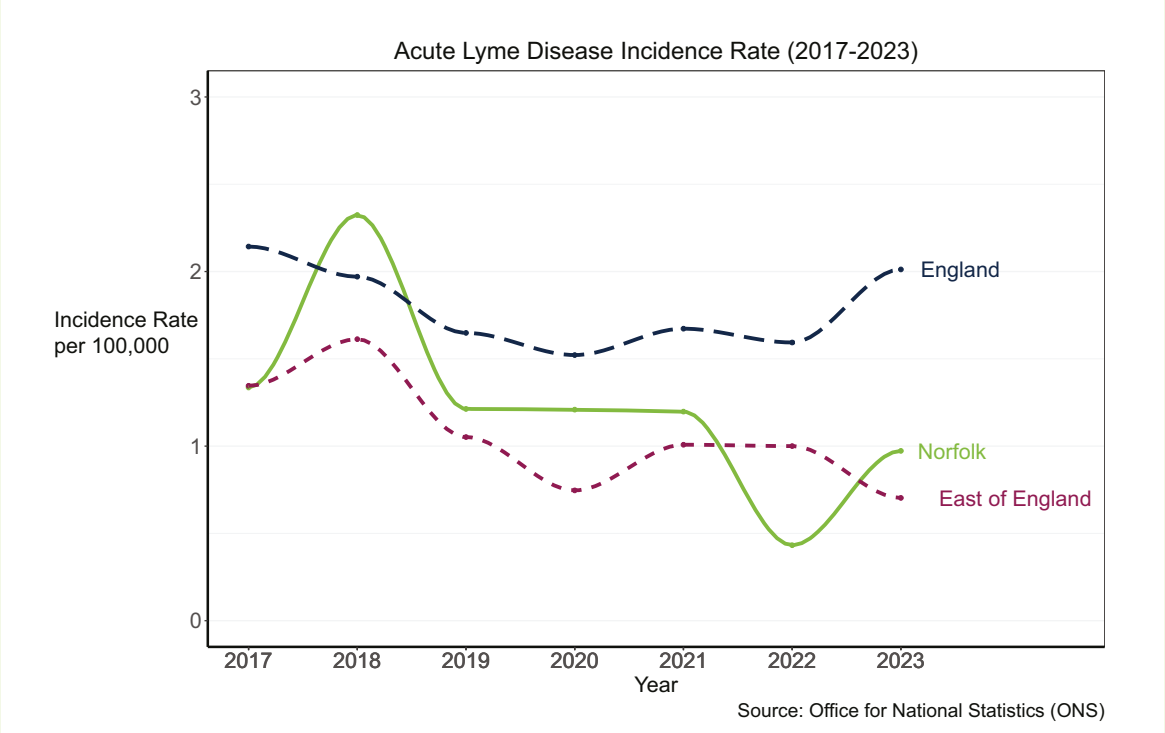
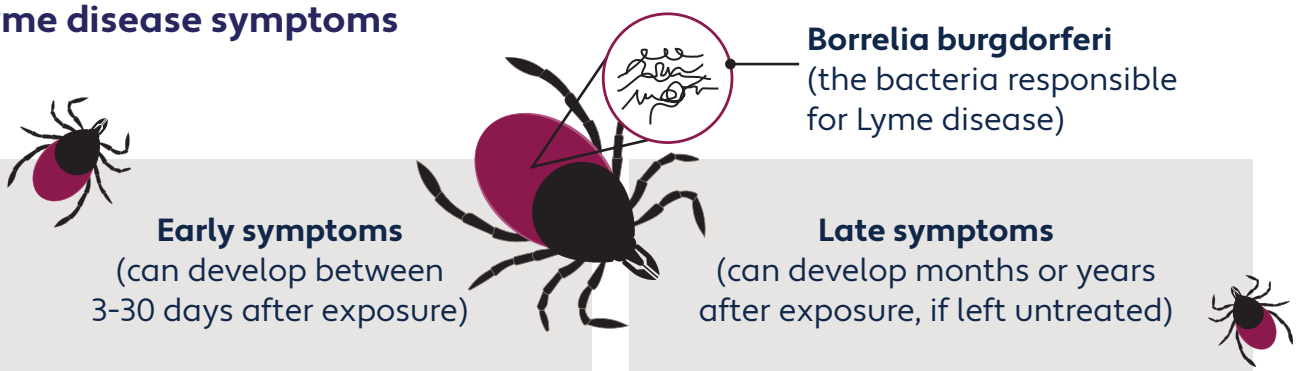


Figure 10. Incidence rates of laboratory-confirmed acute Lyme disease (Borrelia burgdorferi) cases per 100,000 population in Norfolk, East of England and England from 2017 to 2023.

Lyme disease symptoms



Borrelia burgdorferi
(the bacteria responsible for Lyme disease)

Early symptoms
(can develop between 3-30 days after exposure)

- Bull's-eye rash
- Fever and headache
- Fatigue

Late symptoms
(can develop months or years after exposure, if left untreated)

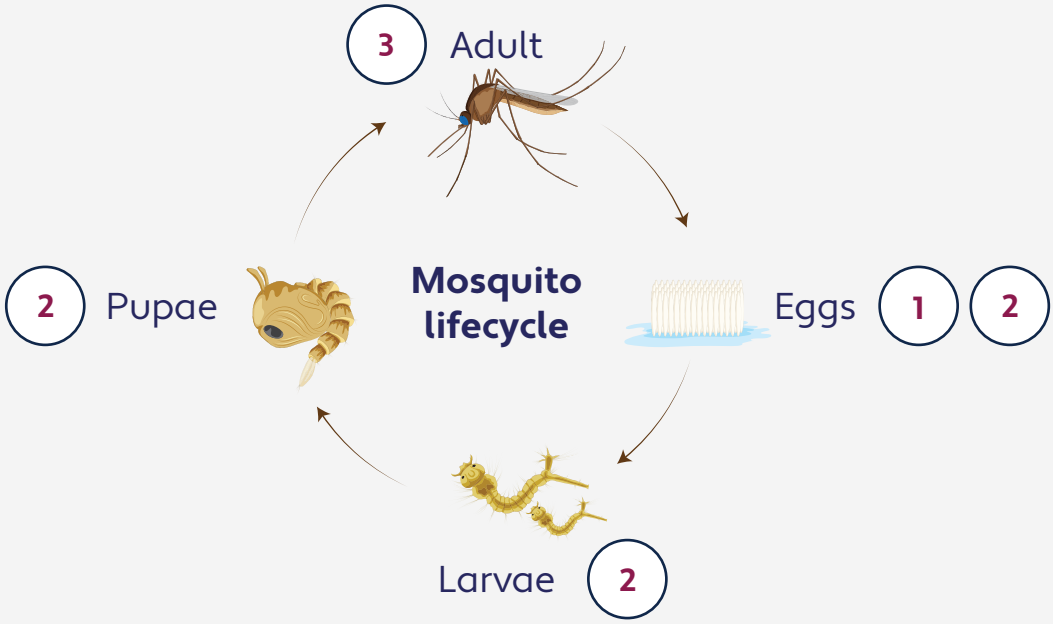
- Facial paralysis
- Irregular heartbeat
- Pain and swelling in joints

Ticks can also spread tick-borne encephalitis (TBE), a disease affecting the nervous system[71]. Between 2019 and 2023, four cases of TBE were identified in England, including in Thetford Forest[72 73]. The UK Health Security Agency monitors ticks through its Tick Surveillance Scheme and reports the risk of infection to be very low.[72 74]

Rising temperatures can enable the emergence of new threats such as mosquitoes carrying diseases like dengue and West Nile Virus.[67 75 76] The Asian tiger mosquito, Aedes albopictus, an invasive species capable of spreading dengue, is potentially an issue due to its ability to thrive in urban environments and bite during the daytime.[75 78] Currently, dengue cases in the UK tend to be linked to international trade and travel.[78] In 2023, 634 dengue cases were reported among returning travellers, highlighting the importance of monitoring.[79] While the UK's climate is not currently suitable for the sustained survival of tiger mosquitoes, rising temperatures due to climate change could make areas of the UK more hospitable to this species in the future. The UK Health Security Agency coordinates national surveillance programmes, including a mosquito surveillance scheme to detect entry of problematic mosquitoes.[78]

The spread of mosquitoes carrying West Nile Virus has been documented across Europe.[80 81 82 83] While the virus, which typically causes mild symptoms, is not currently endemic in the UK, Culex mosquitoes capable of transmitting it are present in some areas, with warming conditions improving their breeding potential.[80 81 84] In Norfolk, the detection of the Aedes vexans mosquito near the River Yare – the first sighting in 90 years – highlights the potential for changes in mosquito populations.[85] The Human and Animal Infection and Risk Surveillance group assesses the risk of these diseases in the UK currently as low to very low and continues to closely monitor emerging threats.[67 80]

Potential impacts of climate change on the lifecycle, distribution and abundance of mosquito species



1

Flooding may produce new mosquito breeding sites in urban areas

Increased flooding may produce stagnant water pools in urban environments, creating ideal breeding sites for certain mosquito species to lay their eggs.

2

Rising temperatures may boost mosquito numbers, elevating the risk of disease transmission

Warmer temperatures may lead to a surge in mosquito populations by accelerating their development stages and enabling adults to reproduce more rapidly. An increase in mosquito numbers would heighten the risk of disease transmission to humans.

3

Warmer temperatures in Norfolk may bring invasive mosquitoes and new infectious diseases

As temperatures rise, Norfolk will likely become a suitable habitat for invasive mosquitoes and the pathogens they carry. This shift could allow new infectious diseases, such as dengue, to emerge in Norfolk, increasing the risk of illnesses transmitted by mosquitoes.

Climate change also increases the risk of waterborne diseases by creating favourable conditions for other pathogens (disease causing microorganisms) like Salmonella and E.coli, especially during warmer months.[86 87 88] Floods and droughts can disrupt ecosystems, creating breeding grounds for vectors and increasing human exposure to pathogens.[81] Indirectly, extreme weather events and rising sea levels contribute to displacement, creating conditions for diseases like leptospirosis, while changes in precipitation and temperature influence the spread of viruses such as influenza and COVID-19.[62]

Workers in outdoor environments, such as forests and agricultural fields, may face increased exposure to disease-carrying vectors.[89] Rising vector-borne diseases could impact productivity in farming and outdoor sectors, with urban areas also at risk from increased standing water due to heavier rainfall.[90 91] These changes may create new inequalities and deepen existing ones due to differences in exposure.

Photography:
Getty Images

Photography:
Getty Images

Case study:

Oak Processionary Moth

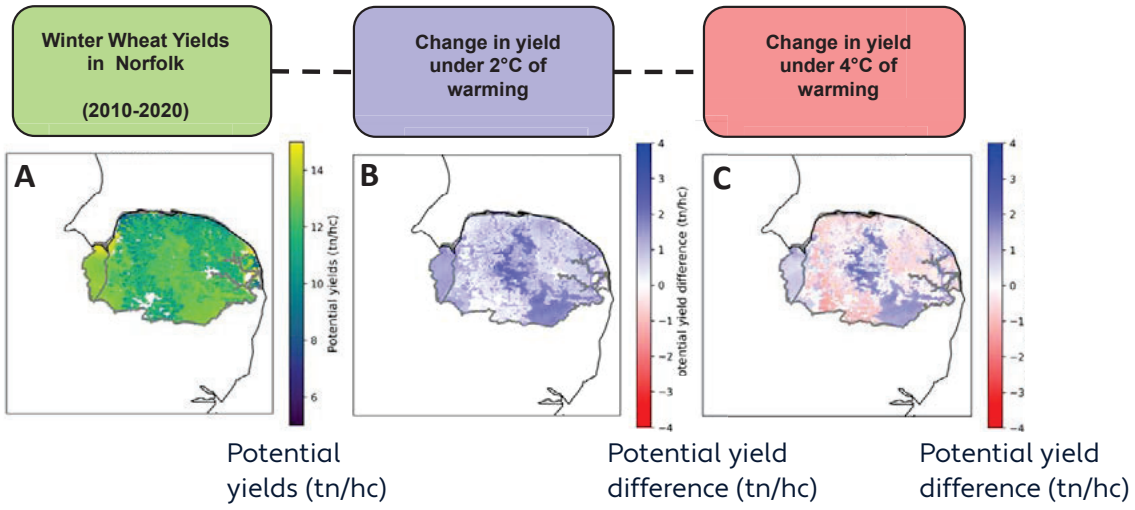
Climate change may increase the presence of various pests within Norfolk. One of particular concern is the Oak Processionary Moth (OPM), (Thaumetopoea processionea), which is native to southern Europe and was accidentally introduced to London in 2006. Since then, populations of the OPM have been gradually migrating northwards.

OPM caterpillars pose a health risk to humans and animals, as their toxic hairs can cause severe allergic reactions including skin rashes, eye irritation, and respiratory issues. As temperatures rise, Norfolk's climate is becoming more hospitable for the species.

Norfolk County Council's arboriculture team are monitoring selected trees along the Norfolk-Suffolk border for the presence of OPM using both visual and pheromone trapping methods. Isolated individual moths have been recorded in Norfolk but no breeding populations have been detected. Given their current northward migration, the team estimates that there will be breeding populations in Norfolk in the next 2-5 years.

Food and agriculture

Climate change is already having significant impacts on the global food system, affecting the availability, quality, and price of food. Whilst these are global issues, Norfolk is not immune from the potential impacts that they may have on health and wellbeing. The increasing frequency of extreme weather events driven by climate change, such as droughts and flooding, will disrupt crop yields and supply chains, and lead to significant price instability and potential food shortages. It is however important to note that some projections suggest that climate change will actually increase yields for certain crops.[92] Figure 11 shows that under a 2°C warming scenario (Map B) wheat yields are projected to increase across Norfolk. However, beyond this, under a 4°C warming scenario (Map C), yields are much more variable with decreases likely. Consequently, while a warming UK climate may benefit some crops, it is likely that more frequent extremely hot summers and changing patterns of rainfall will result in an overall negative impact on crop production,[93] increasingly disrupting Norfolk's agricultural system.



Source: Hayman *et al.* (2024) & Tyndall Centre for Climate Change

Figure 11 Maps of water-limited potential yields of winter wheat modelled for Norfolk for the past decade (2010–2020) in tonnes/hectare (Map A) and of change in potential yield under a 2 °C warming scenario (Map B) and a 4 °C warming scenario (Map C).

Unpredictable and extreme weather is already causing fluctuating and unstable food prices. The 2022 heatwaves had significant impacts on agricultural production across Europe, with estimates suggesting that the heat alone caused food inflation to increase by 0.5-1 percentage points.[94] Similarly, between September 2022 and February 2024, England had its wettest 18 months on record, leaving soils waterlogged and delaying crop planting, with UK vegetable production dropping by 5% as a result.[95] These won't be isolated impacts, with the UK's Climate Change Committee predicting that climate change could lead to a 20% rise in global food prices by 2050.[96] Furthermore, in 2023 the UK imported 84% of its fresh fruit and 47% of its fresh vegetables[97]; reliance on imports from climate-vulnerable countries could impact the availability, cost and therefore consumption in the UK, with potential consequences for diet and health. These rising food prices strain household budgets, particularly for already vulnerable groups who may struggle to afford a healthy diet and do not have the disposable income to absorb rising food costs. Food insecurity can lead to a range of health problems, from malnutrition and stunted growth in children to increased susceptibility to illness and disease in adults. The stress of not knowing where the next meal will come from can also contribute to mental health issues, such as anxiety and depression. While serious food shortages are not expected in the UK, it is important to note that climate change will pose significant food security risks globally.[98]

The importance of agriculture to Norfolk's economy means that climate change impacts will be felt particularly acutely in the county. For the past six years, the East of England has led all English regions in total crop output, producing £2.45 billion worth of crops.[99] However, the region's agricultural sector is already grappling with the effects of climate change; the 2023/24 winter saw areas of Norfolk experience semi-permanent flooding[100], while previous years saw high temperatures and low rainfall threaten water supplies. These unpredictable weather patterns mean that annual yields may become increasingly variable; for instance, total crop output in 2023 declined by 12% compared to 2022.[101] These changes could make Norfolk's agricultural livelihoods increasingly precarious.

In Norfolk, 10,500 people are employed in the agricultural and fisheries industries, representing 2.6% of the county's workforce. This proportion is significantly higher than seen in England as a whole (0.9%).[102] Consequently, the impact of climate change on these industries may be more pronounced in Norfolk compared to other parts of the country.

The potential loss of jobs, particularly in isolated rural communities, could have profound health and wellbeing impacts, leading to increased poverty, social isolation and associated health issues such as depression, anxiety and chronic stress.

Photography:
John Innes Centre

Case study:
John Innes Centre Research

The John Innes Centre (JIC) is an independent, internationally renowned research centre in plant science, genetics and microbiology with a long history of making discoveries that unlock solutions to the world's biggest problems. JIC's research is providing solutions to support sustainable agriculture, both globally but here in Norfolk too.

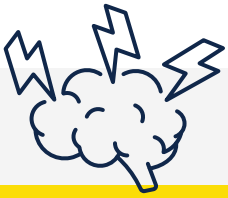
By unlocking the genetic potential of a historic wheat seed collection, researchers are revolutionising crops for the 21st Century, identifying traits to improve heat resilience and slug resistance, helping this crop to thrive in a changing climate and reduce the need for pesticides.

Their research is also unlocking ways to reduce reliance on fertiliser application, which is costly to both farmers and the environment. JIC discoveries are paving the way for more environmentally-friendly farming practices, potentially allowing farmers to use less fertiliser in the future.

Along with their partner The Sainsbury Laboratory, JIC is transforming its existing infrastructure to create a research and innovation hub on the Norwich Research Park at the forefront of tackling climate change, supporting food security and improving human health.

Mental wellbeing

Climate change is increasingly impacting mental wellbeing, with direct and indirect exposure to extreme weather events – such as floods, heatwaves, and wildfires – contributing to mental health issues like post-traumatic stress disorder (PTSD), anxiety and depression.[103]



Trauma
Direct impact of disasters

Flooding
Destruction of homes, displacement, and loss of life

Drought
Water scarcity

Wildfires
Destruction of property and natural habitats

Depression
Feelings of sadness and hopelessness may occur due to loss or trauma

Anxiety
Persistent feelings of fear and worry may be triggered by trauma or loss during disasters

PTSD
Severe mental health challenges such as Post Traumatic Stress Disorder may follow disasters

Eco-anxiety
Worry about the future

Rising temperatures

Extreme weather

Sadness, helplessness, and anger
Among 1,000 young people in the UK, 63% reported sadness, 55% feel helpless and 41% felt despair in relation to climate change

Frightened by the future
Among 1,000 young people in the UK, 49% were found to be very or extremely worried about climate change

Daily life affected
Among 1,000 young people in the UK, 28% said that their worries about climate change affect their daily activities

Frequent and severe extreme weather events can cause damage to homes, personal injuries, and disruptions to livelihoods, often leading to long-term psychological trauma.[104] For example, a study in the south of England (2013-2014) found that individuals whose homes were flooded were 6 times more likely to develop depression, 6.5 times more likely to experience anxiety, and 7 times more likely to suffer from PTSD than those whose homes were not affected.[104] Among affected individuals, 20% developed probable depression, 28% experienced anxiety, and 36% were diagnosed with probable PTSD.[104] Moreover, limited warning before a flood doubled the likelihood of developing depression and PTSD compared to having more than 12 hours' notice.[105] Children are also vulnerable, with post-traumatic stress being the most common consequence of extreme weather events.[106] How individuals perceive climate change responses from authorities plays an important role in shaping their mental wellbeing, trust and resilience.[107]

While extreme weather events pose direct psychological burdens, climate-related mental health issues also affect people who are not directly impacted by such events. Many individuals may experience what has been termed 'eco-anxiety' - a sense of concern, fear, and helplessness about the future, driven by the ongoing and anticipated impacts of climate change.[107] A 2023 study found nearly two-thirds of adults in the UK were worried about climate change, particularly its effect on future generations.[108] A separate study found that among 1,000 young people in the UK, 49% were found to be very or extremely worried, 28% said these concerns affected their lives and many reported sadness (63%), helplessness (55%), and despair (41%).[107]

Eco-anxiety will likely disproportionately impact vulnerable communities, where limited resources heighten climate-related stress.[108] Low income individuals, who have fewer resources to build resilience against climate change, face heightened risks to their mental wellbeing.[110] [111]

Photography:
Getty Images

In Norfolk, local data reflects a rising trend in climate-related anxiety. A 2024 survey of 9,000 Norfolk school children found that approximately 35% of children and young people are worried about climate change either 'A little', 'Quite a lot', or 'A lot' (Figure 12).

This marks a notable increase from 24% in 2015 and highlights growing climate-related worries among young people in the region (Figure 12).[112]

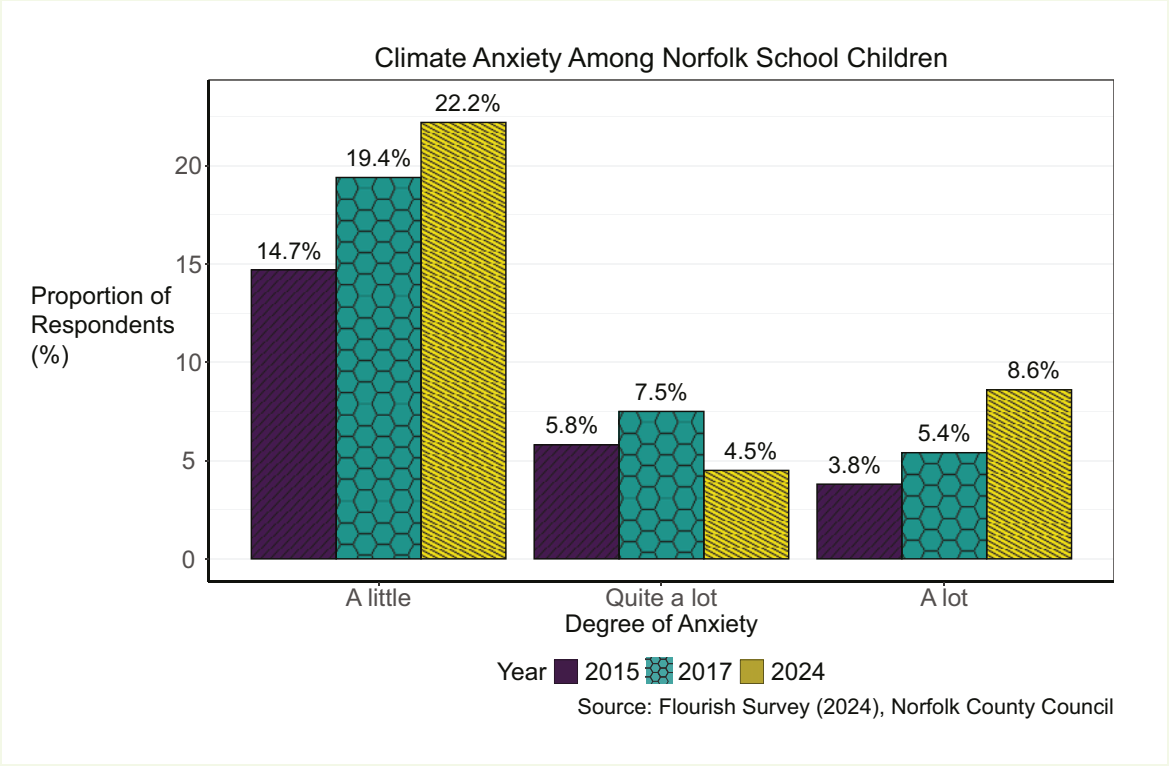


Figure 12. Climate anxiety among Norfolk school children (in school years 7-12) over time. Data obtained from the Norfolk County Council Flourish survey (2024).

Photography:
Getty Images

Case study:
sUStain (Norfolk and Waveney Mind)

Norfolk and Waveney Mind's sUStain project supports individuals dealing with climate anxiety through a range of activities, including workshops, co-designed mindfulness programmes, and "Climate Cafes" assisted by volunteers. These spaces allow people to share their feelings about climate change in a supportive environment.

Participants in the project noted the impact that climate change and environmental degradation had on their wellbeing, with nearly 90% expressing feeling nervous, anxious or on edge about these topics. 88% of participants reported that this improved as a result of engaging with the project.

The sUStain project, in partnership with the UEA and the Climate Psychology Alliance, aims to normalise climate distress and promote mental wellbeing. It currently operates in Norwich and at the UEA and has also developed a specific strand of activity in North Norfolk supporting those directly affected by environmental changes such as coastal erosion.

Section 3: The health co-benefits of climate action

To address the impacts of climate change, both **mitigation measures** (e.g. reducing greenhouse gas emissions) and **adaptation measures** (enhancing preparedness and resilience for future changes) are essential. While these strategies primarily target climate-related goals, many also generate additional health co-benefits due to their impact on the wider determinants of health. **Co-benefits refer to the positive secondary outcomes from climate action, with benefits ranging from improving public health and promoting economic growth.** For example, planting more trees helps absorb carbon dioxide from the atmosphere, but it also provides health benefits by offering shade during heatwaves and improving access to green spaces, which is linked to better mental and physical wellbeing. Similarly, as the county's new Local Growth Plan sets out, Norfolk is particularly well-positioned to take advantage of growth in the renewable energy sector, creating growth and jobs across the county. Likewise, the growing demand for home energy efficiency improvements will create numerous well-paid, local job.

The following section explores some of the key co-benefits of climate action in Norfolk, demonstrating how efforts to tackle climate change can also improve health outcomes and strengthen Norfolk's economy.

Energy efficient, healthy homes and buildings

The UK's housing stock is among Europe's oldest and least efficient, with 3.5 million homes failing to meet the Decent Homes Standard due to poor insulation, inefficient heating systems, and inadequate ventilation.[113] Energy Performance Certificates rate homes from A (very energy efficient) to G (very energy inefficient). In Norfolk, 57% of houses are rated EPC D or below (worse than the national average of 53%)[48], however a significant number do not have recent EPCs, consequently masking the true number of inefficient homes. As such, the energy used to heat and power homes accounts for 21% of Norfolk's total emissions, the second highest of any category behind transport.[114] Reducing the emissions from housing is therefore a key tool to help Norfolk reach net zero targets.

Not only do they contribute to climate change, but cold, damp homes also have significant adverse health impacts on those living in them, either causing or exacerbating a range of circulatory, respiratory, musculoskeletal and mental health conditions.

Consequently, it is estimated that poor housing costs the NHS £1.4 billion each year.[115] Living in cold homes can increase the risk of blood clots, strokes and heart attacks, and can worsen existing respiratory conditions while increasing the risk of developing new ones. Similarly, Norfolk's predicted wetter winters will exacerbate existing issues with damp and mould. Cold homes also impair the body's immune system and increase the risk of poor mental wellbeing.[116]

Photography:
Getty Images

Preventing mould and damp in your home

Improve ventilation by using extractor fans, opening windows, and ensuring air can circulate freely.

Reduce humidity by avoiding drying clothes indoors, using lids while cooking, and opening windows while showering.

Completely dry any damp or wet surfaces as soon as possible and fix the source of any water problems or leaks.

Maintain a consistent indoor temperature, ideally keeping your home heated between 18-21°C to prevent condensation and mould.

Seek medical advice if you have mould problems and experience symptoms such as coughing, wheezing, or throat irritation.

These impacts are not felt equally across the population. For instance, elderly populations are especially impacted, with many conditions associated with ageing, such as rheumatoid arthritis, being aggravated by living in the cold.[116] Older people may be more at risk, with 74% of Norfolk's bungalows, often preferred by this age group, having an EPC rating of D or below.[48] Children and young people are also particularly affected, with evidence suggesting that living in a cold home affects children's brain and lung development, doubles their risk of developing a respiratory illness, and worsens educational attainment.[116]

Arguably, these impacts are felt strongest by the most disadvantaged residents, with England's poorest households five times more likely to live in substandard homes.[117] In terms of energy efficiency in Norfolk, however, it's the middle range of deprivation scales with the least energy efficient housing; 64% of EPCs in the middle deprivation category are D or below, compared to 44% in the most deprived areas (Figure 13).[48] This may reflect the fact that people in deprived areas are more likely to live in flats, which are more likely to be energy efficient and also that in many deprived areas there is a greater share of social housing which is subject to tighter regulation.[118] Those renting in the private sector generally live in poorer performing homes compared to social tenants and owner-occupiers.[119]

Those on low incomes are less likely to have the ability to afford higher energy bills. Consequently, an estimated 50,000 Norfolk households live in fuel poverty.[120]

This struggle to maintain a warm home creates a vicious cycle, where the cost of heating competes with other essential needs, further entrenching poverty and health disparities.

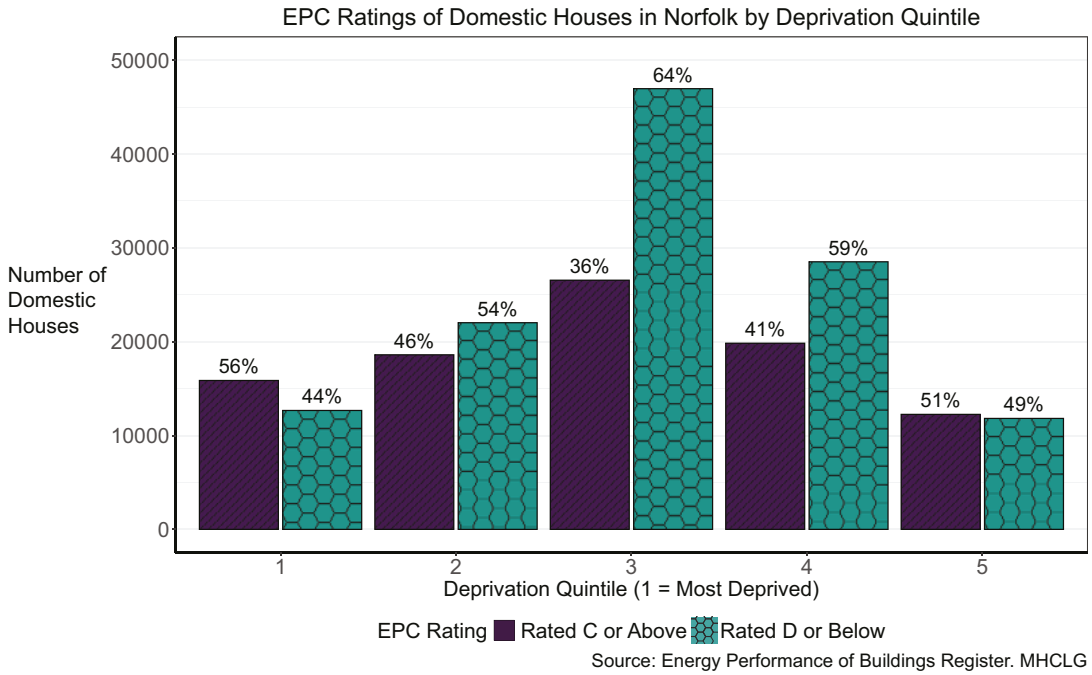


Figure 13. Energy Performance Certificate ratings (EPC) of domestic houses in Norfolk across different deprivation quantiles.

Photography:
Getty Images

Improving the energy efficiency of Norfolk's housing stock clearly has the potential to yield both significant environmental and health benefits. For example, improving insulation helps maintain a warmer, more stable indoor temperature, reducing cold related health issues but also saving money on energy bills. Improved insulation can also help prevent overheating during increasing summer heatwaves[121], which will be especially problematic for dwellings with no ventilation, inadequate shade, or with south-facing windows. Furthermore, stable indoor temperatures and improved ventilation can help reduce damp and mould incidence, which is strongly linked to the development or worsening of asthma and the onset of respiratory infections, particularly in children. However, it is essential that any works are undertaken correctly; insulation without adequate ventilation can potentially worsen damp and mould issues if moist air cannot escape.

What makes a healthy, sustainable home?

Insulation
Effective insulation keeps homes warmer in winter and cooler in summer, reducing energy use and creating a more comfortable and healthier living environment.

Energy
Renewable energy sources like solar panels can cut carbon emissions and lower energy bills.

Shading
External shading such as awnings or tree-cover can keep a home cool during heatwaves.

Appliances
Energy-efficient appliances, such as dishwashers, can reduce electricity use, saving energy and money.

Nature
Trees and greenery can improve air quality, provide shading, support biodiversity, and reduce flooding, fostering climate resilience and well-being.

Lighting
Natural lighting and energy-efficient bulbs can reduce electricity use.

Windows
Double-glazing or energy-efficient windows can minimise heat loss in winter, lowering energy use and maintaining comfort.

Water
Water-saving measures such as rainwater harvesting can conserve water and increase resilience to droughts.

Heating
Sustainable heating systems like air source heat pumps can reduce emissions and maintain a constant comfortable temperature.

Waste
Compost food scraps and reduce waste to reduce emissions, save money, and create nutrient-rich soil for gardening.

Food
Growing fruits, vegetables, or herbs can reduce carbon emissions and encourage healthy eating.

Ventilation
Good airflow with mechanical or natural ventilation can prevent damp, mould, and indoor air pollution, protecting respiratory health.

It should therefore be clear that making homes more energy efficient presents a major opportunity to reduce emissions, improve health, and lower household energy costs. However, community conversations from the Norfolk Climate Change Partnership's Norfolk NetZero Communities project have found that trust in grant schemes and traders to deliver energy efficiency work is low. Residents can find out more about opportunities through **Norfolk Warm Homes**, as well as schemes such as the **Great British Insulation Scheme** and **ECO**. **Norfolk County Council's Trusted Trader website** also provides a directory for home upgrades and energy efficiency work.

Photography:
Norfolk Warm Homes Partnership

Case Study: Norfolk Warm Homes partnership

Norfolk Warm Homes is a consortium led by Broadland District Council, working with five other Norfolk district councils*. Their purpose is to improve the energy efficiency of homes and reduce energy bills and carbon emissions from Norfolk's housing stock.

Since 2018, the Consortium has delivered grant-funded work for energy efficiency improvements and carbon reduction work, including air source heat pumps. The Consortium has invested over £13 million across the county to help improve energy efficiency in more than 1,200 homes, reducing residents' energy consumption and enhancing the thermal comfort of their homes.

Evaluation of the Consortium's work found significant improvements in beneficiaries' health and wellbeing, with 65% reporting improved mental health and 70% feeling safer in their homes. Testimonies from residents living with chronic pain due to conditions such as arthritis also support this, with one beneficiary saying: "I feel healthier, and our pains are not as bad, having heat does so much for us." [122]

*Norwich City Council, South Norfolk District Council, North Norfolk District Council, the Borough Council of King's Lynn and West Norfolk, and Breckland District Council. Residents of Great Yarmouth should contact **Great Yarmouth Borough Council.**

Decarbonising transport and promoting active travel

Changing travel habits offers significant benefits for both climate and health. Transport accounts for 26% of Norfolk's greenhouse gas emissions, more than any other sector[114], while poor air quality and sedentary lifestyles are major contributors to ill health. Decarbonising transport, alongside promoting active travel such as walking, wheeling (using a wheelchair or mobility aid), and cycling therefore presents significant opportunities to improve public health whilst tackling climate change.

Shifting from petrol and diesel vehicles to electric vehicles (EVs), or more sustainable modes of transport altogether, is key to cutting emissions. EVs produce zero exhaust emissions, which not only reduces the carbon emissions associated with transport, but also minimises pollutants such as nitrogen dioxide, which is linked to various respiratory and cardiovascular diseases. However, it is worth noting that EVs do not eliminate pollution, because brake, tyre and road wear also produces particulate matter, highlighting the importance of alternative, more sustainable forms of transport. Accessible and efficient public transport is equally important for providing alternatives to car use, especially in Norfolk's rural areas where reliable services support social connectedness and community wellbeing, particularly among older residents.

Norfolk has recently seen a range of projects and initiatives working to reduce air pollution in the county. One of the most notable is Norfolk County Council's work with bus operators to electrify Norfolk's bus network. This has so far seen First Bus roll out 70 electric buses across Norwich – around half their fleet – with early research suggesting that NO_2 levels have dropped significantly following their introduction. The County Council also works closely with local district and borough councils to support the provision of electric vehicle charge points in Norfolk, securing £7.5 million of central government funding to install chargers in rural and tourist locations, as well as areas with insufficient off-street parking.

One of the most effective ways to reduce environmental impacts whilst also improving health and wellbeing is the promotion of active travel.

Regular physical activity can significantly lower the risk of chronic illnesses such as heart disease, strokes, and type 2 diabetes, with research suggesting that walking for 30 minutes or cycling for 20 minutes daily can reduce mortality risk by 10%.[123] Physical activity can also improve mental wellbeing too, with exercise shown to improve symptoms of depression and anxiety.[124]

This is especially important given that nearly a quarter of Norfolk's resident's exercise less than 30 minutes per week.[42]

In 2021, 25% of those in employment in Norfolk worked from home, but among those who commuted only 11% walked and 4% cycled (Figure 14)[125.] While Norfolk's rural nature means that not all journeys can be walked or cycled, the same survey found of those who do commute to work, 21% of people travel less than 2km and a further 19% travel between 2-5km.[126] These are generally considered walkable and cyclable distances respectively, and so there's significant opportunity to support people to commute actively. Safe and effective infrastructure encourages active travel; even simple measures such as reduced speed limits can improve road safety and help lower particulate emissions.[127]

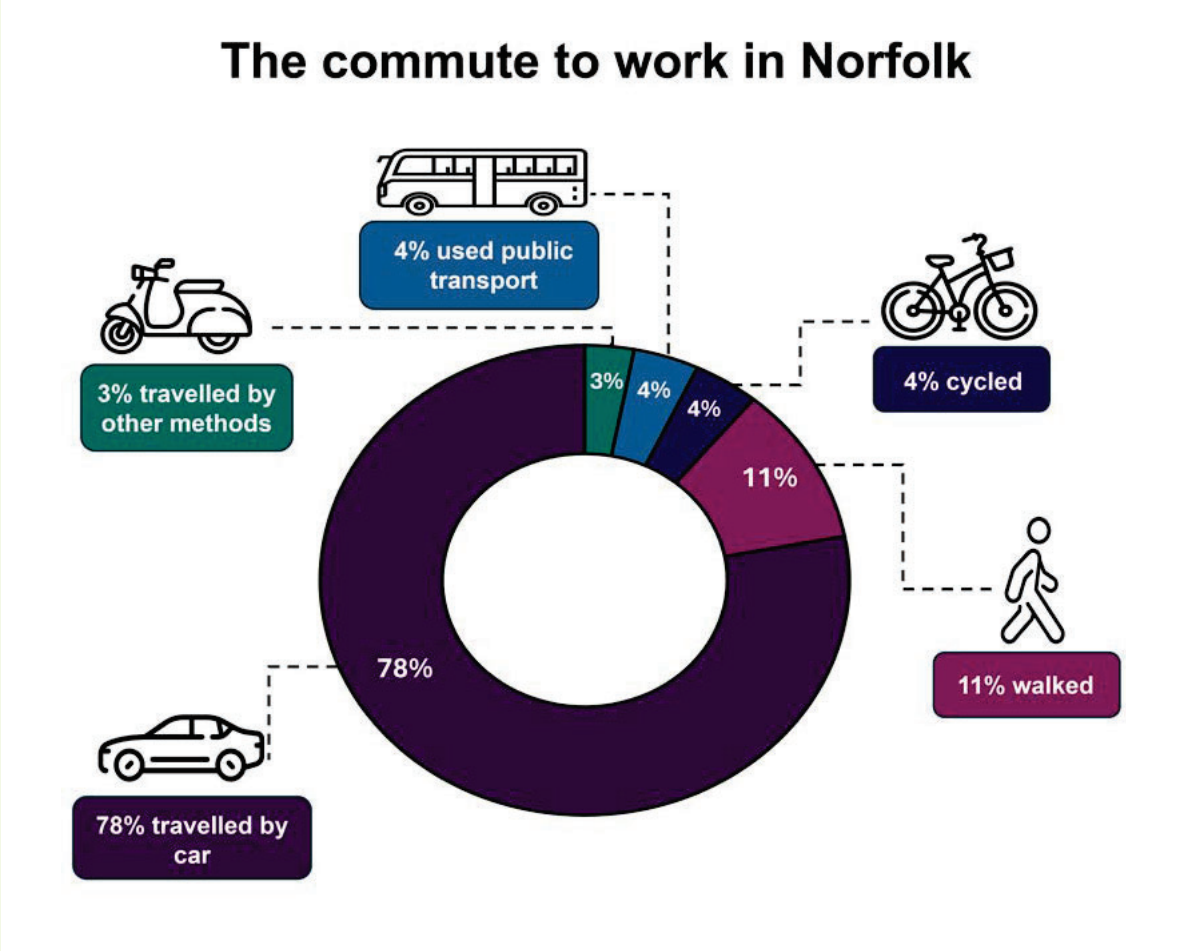


Figure 14. Methods of transport used to travel to work by Norfolk residences in 2021 based on Census 2021 statistical estimates.

Note: Method of transportation in 2021 may have been influenced by the Covid-19 pandemic.

Photography:
Getty Images

Increasing active travel levels is not just good for public health and the environment, but there are also significant economic benefits too. 73% of employees who cycle feel it makes them more productive at work[128], while employees who are also physically active take 27% fewer sick days than their colleagues.[129] Furthermore, people who walk to the high street spend up to 40% more than people who drive[128], and cycle parking delivers five times the retail spend per square metre than the same area of car parking.[130] Evidence also suggests that children who are physically active perform better at school.[131]

Increasing active travel therefore presents a significant opportunity to improve public health and reducing Norfolk's environmental impact. Norfolk County Council's **Walking, wheeling and cycling strategy** sets out the ambitions of the council to create a healthier and greener Norfolk and confirms support for the government's ambition that 50% of journeys in towns and cities are walked, wheeled, and cycled by 2030. The strategy is underpinned by local cycling and walking infrastructure plans which help identify and prioritise infrastructure schemes, such as cycle lanes, to enable increased levels of cycling, walking, and wheeling across the county.

By reducing reliance on fossil-fuel-powered vehicles and encouraging active transport, Norfolk can significantly lower its carbon emissions, improve air quality, and increase the number of physically active residents.

Photography: Beryl

Case study: Beryl

Beryl, in partnership with Norfolk County Council, has been a key player in promoting sustainable travel and shared micromobility* in the Greater Norwich area since its launch in 2020. The scheme offers shared bikes, e-bikes, and e-scooters, providing an accessible, eco-friendly alternative to car travel. Between 2020 and January 2025, over 1.8 million Beryl journeys have been made, covering over 5 million kilometres. User feedback shows that 56% of Beryl users have replaced a private vehicle trip with a Beryl trip, and overall the Norwich scheme has led to over 230 tonnes of CO_2 emissions being saved since the scheme began.

Rider feedback indicates that 44% of people are cycling more often since joining Beryl and 35% have reduced their use of cars. Additionally, 13% of riders identify as having a disability, suggesting that these are potentially enabling increased accessibility for people with mobility issues. One of Beryl's successes has been allowing users to integrate the scheme with other sustainable transport modes; user feedback suggests that 31% of riders used Beryl to connect with public transport. Beryl's success has led to the scheme's expansion with new bays in areas such as Hethersett and Wymondham (figures taken from Beryl's 2023 rider report).

1.8
million journeys made

5.0
million kilometres travelled

230
tonnes of carbon emissions prevented

*Micromobility: the use of lightweight vehicles such as bicycles or scooters, often electric, especially as part of self-service hire schemes

Healthy and sustainable diets

A healthy diet focuses on consuming plant-based foods like fruits, vegetables, legumes and whole grains while limiting red and processed meats and other ultra-processed foods.[132] In 2017, unhealthy diets contributed to 11 million deaths globally, primarily from heart disease, cancer and type 2 diabetes, emphasising the role of diet in preventing chronic diseases.[133] Beyond health benefits, more sustainable diets can also reduce greenhouse gas emissions and natural resource consumption.[134 135] The concept of sustainable diet encompasses how food is managed through its lifecycle, from production to consumption and disposal.[136] Sustainable food practices, including sustainable livestock farming, incorporating a higher proportion of plant-based foods into diets, and reducing food waste can significantly lower dietary emissions across the food lifecycle.[135]

Between 1990 and 2022, greenhouse gas emissions from UK agriculture fell by 12%, though emissions from food have decreased at only half the rate of the wider economy since 2006.[137] If this trend continues, food emissions in 2050 will be four times higher than the level needed to meet net zero targets.[135] While some fruits and vegetables have high emissions due to production and transport, most generate less emissions than meat products.[138 139] For instance, beef generates 25 times the emissions of tofu and over 42 times the emissions of peanuts (Figure 15). As such, it's estimated that plant-based diets emit only a quarter of the greenhouse gas emissions of meat-heavy diets.[140] A survey of 1,900 people aged 16-75 in England, Wales and Northern Ireland found 73% of consumers value food with a low environmental impact.[141] However 71% face barriers preventing them from making more sustainable diet choices, with 29% citing the cost of sustainable foods and 16% reporting a lack of understanding of what constitutes sustainable food.[141]

Photography:
Getty Images

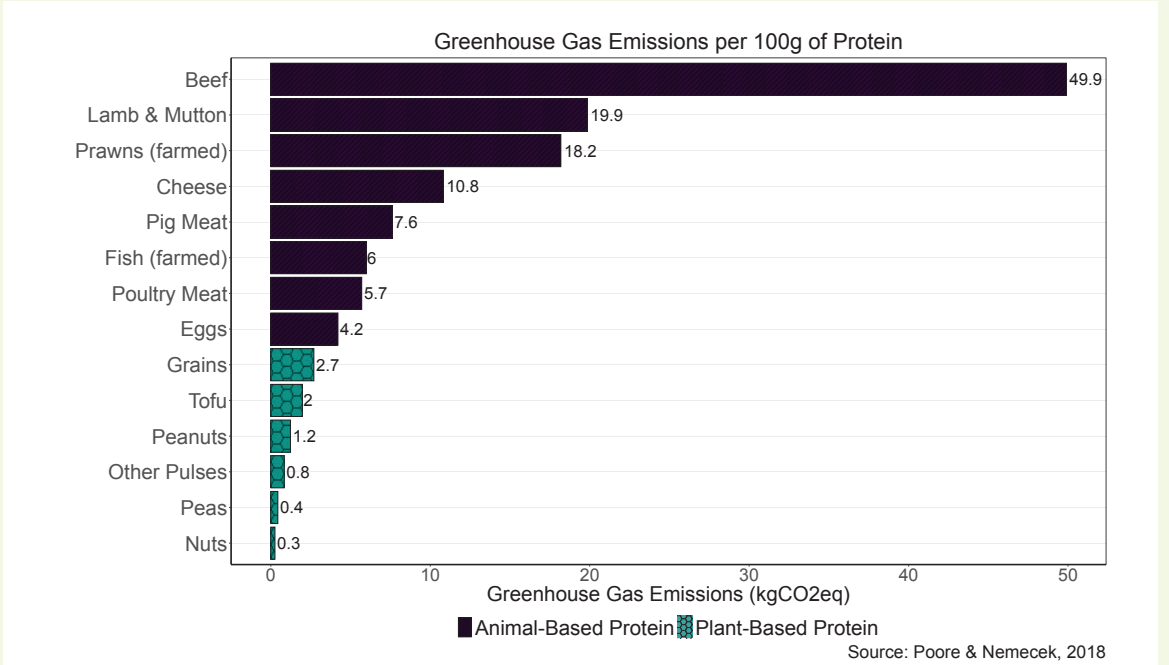


Figure 15. Global average greenhouse gas emissions per 100 grams of protein across different food products. Greenhouse gas emissions are measured in kilograms of carbon dioxide-equivalents (kgCO2eq).

In the UK, meat consumption dropped by 17% between 2008 and 2019.[142] But while reducing meat consumption can lower emissions, livestock farming remains essential to rural economies and national food security.[144] Supporting sustainable livestock practices and supporting farmers transition to lower-emission methods may help to maintain the balance between food production and climate goals.[135] However, more than 84% of farmland in Norfolk grows vegetables and cereals, offering a significant opportunity for Norfolk's agricultural sector to play a key role in promoting sustainable diets and reducing greenhouse gas emissions (Figure 16). Supporting domestic agriculture is especially important given that the UK imports more than two thirds of its food from countries with worse environmental standards.[145]

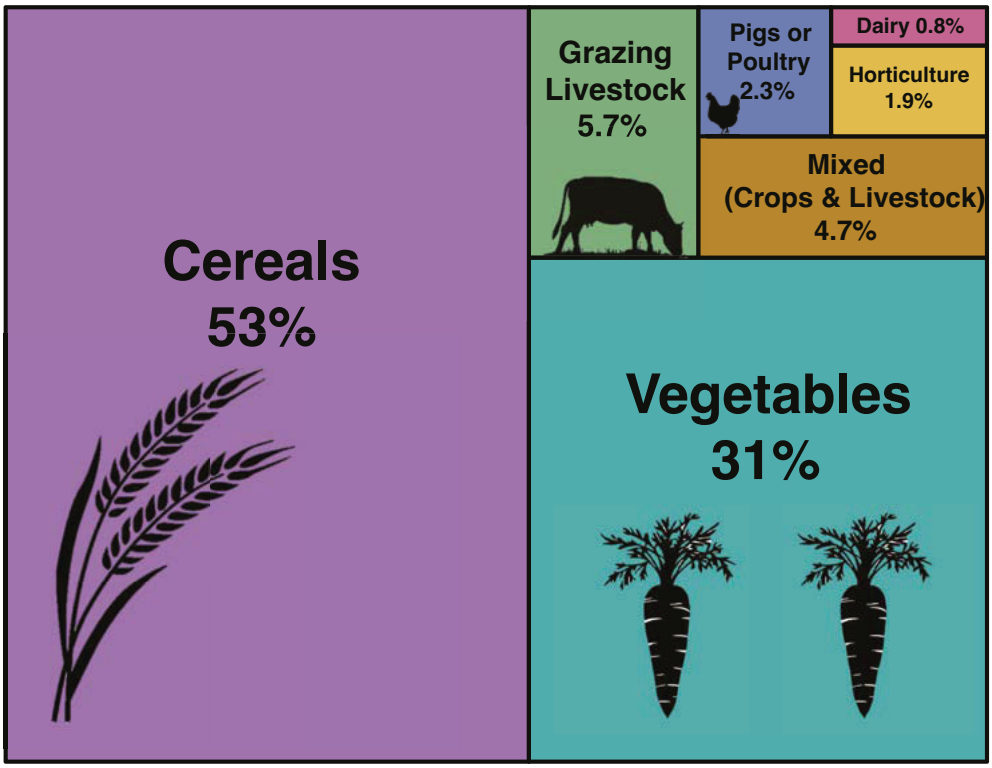


Figure 16. Distribution of farms by type across East of England in 2023. Distribution is based on percentage of farmed area. Agricultural data obtained from DEFRA (2024).

Although low emission diets are affordable in theory, barriers do exist for low-income groups.[135] These barriers can include the higher cost of fresh produce compared to processed foods, lack of knowledge or resources to prepare healthy meals[146], limited time, and limited access to cooking facilities or food shops.[135] In England and Wales approximately 13.8 million people live in areas with low accessibility to food shops[135] and online access to healthy food.[147] This lack of access to sustainable diets can widen health disparities, with low-income and marginalized communities experiencing higher rates of diet-related chronic diseases.[148]

In Norfolk, average annual household CO_2 emissions from food consumption are lower than the national average of 2.72 tonnes. However, 68.2% of annual food emissions from Norfolk relate to the consumption of meat and fish (Figure 17).[149] Transitioning to sustainable diets can therefore help to reduce both emissions and the burden of diet-related chronic diseases in Norfolk. An intermediate to high level adherence with national dietary recommendations is associated with 7% reduced risk of death[150], and eating 5-a-day could increase life expectancy at birth by 7-8 months and reduce greenhouse gas emissions.[151] However, there is still a significant gap in achieving a healthy diet among adults in the UK, with only 31% of adults in England and 36% in Norfolk meeting the recommended five portions of fruit and vegetable a day.[42]

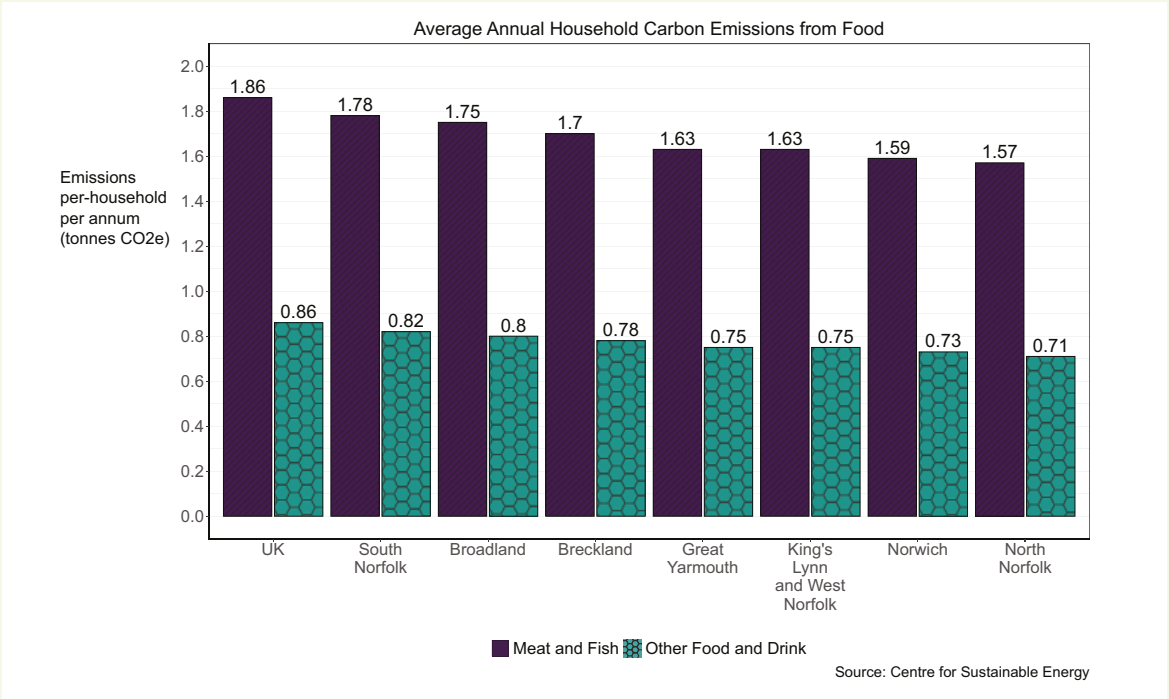


Figure 17. Average annual household carbon emissions from food and drink consumption by residents in the UK and Norfolk districts

Photography:
The Norfolk Master
Composters programme

Case Study:
Master Composter scheme

The Norfolk Master Composters programme, run by Garden Organic and Norfolk County Council, trains volunteers to promote home composting in their communities. Since 2006, the Master Composter scheme has trained 350 volunteers as Master Composters and supports up to 80 active volunteers in the county.

This initiative supports healthy and sustainable diets by promoting the composting of organic waste, reducing the environmental impact of food disposal. By turning food scraps and garden waste into nutrient-rich compost, residents can grow their own fruit and vegetables, promoting plant-based diets and reducing reliance on external food sources. The programme demonstrates how community-led efforts contribute to broader sustainability goals.

Accessible green and blue spaces

Norfolk's abundant green (i.e. parks, forests and gardens) and blue spaces (i.e. rivers, lakes and coastal areas) play an important role in supporting biodiversity, improving residents' health and addressing climate change. With 90 miles of coastline, numerous public parks and the Broads National Park, these spaces absorb carbon dioxide, provide cooling to combat hotter summers, and reduce flood risks by enhancing ground water infiltration and storing rainwater.[152] [153] As climate change intensifies, their importance for mitigation and adaptation will only grow, particularly in urban areas prone to elevated temperatures and flooding.[154]

Recognition is growing regarding the importance of green and blue spaces not only for climate resilience but also for health. Spending time in green and blue spaces has been found to reduce the risk of heart disease, stroke-related death, and low birth weight, while improving mental health and wellbeing.[155] [156] [157] In Wales, a study of over 2.4 million people found that a 10% increase in access to green and blue spaces lowered the likelihood of common mental disorders by 7%.[158] Similarly, a study in London found that a 1% increase in green space coverage was linked to reduced all-cause mortality.[159] Even in urban areas, increased tree canopy cover is associated with improved health outcomes.[160] Green and blue spaces can benefit health by reducing air pollution, aiding stress recovery, promoting physical activity, encouraging social connections and reducing the heat island effect (where urban areas tend to become warmer than rural areas).[161] [162] [163]

Access to green and blue spaces is often unequal, with minority groups and individuals with disabilities facing additional barriers to accessing these spaces.[163] While green spaces are generally accessible year-round, blue spaces tend to attract seasonal visitors, particularly among older populations.[162] Limited access to these spaces can also widen health disparities; communities without them will not experience their benefits and are less likely to engage in physical activity, which helps prevent chronic diseases such as obesity, diabetes, and heart disease.[164] Additionally, these communities may miss out on the mental health benefits provided by regular interaction with nature. Furthermore, limited access also increases vulnerability to climate change impacts such as extreme heat and flooding, as these spaces naturally provide cooling and flood mitigation, compounding existing inequalities. This focus on access is especially important given that studies have found the mental health benefits of green space to be particularly pronounced in deprived areas.[158]

In Norfolk, access to green spaces varies depending on how green space is defined. Under Natural England's 'neighbourhood standard' - which requires a large green area of at least 10 hectares within 1km of home[165] – Norfolk is relatively underserved. While Norwich performs well, with 71% of residents having access to large parks, rural areas often lack public access to nearby private land (Figure 18). Using a broader definition of accessible green space, which includes smaller parks (at least 2 hectares) and footpaths, most of Norfolk's residents are considered to have access.

Under this definition, 79% of residents in Breckland and 94% in Great Yarmouth are estimated to have access, the lowest and highest in Norfolk respectively (Figure 23).

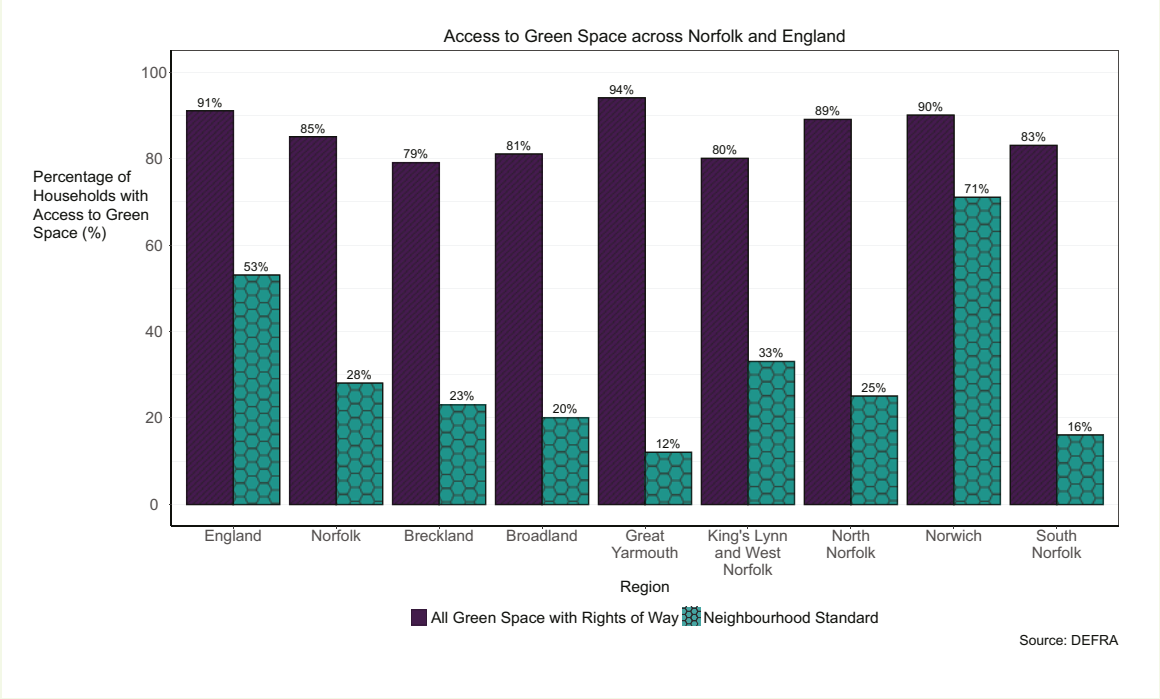


Figure 18: The percentage of households in England and Norfolk with access to green space based on the 'All green space with rights of way' definition and the 'Neighbourhood Standard' definition.

Interestingly, in the most deprived areas of Norfolk, 91% of residents have access to green spaces compared to 80% in the least deprived areas (Figure 19). However, overall access to green spaces in Norfolk remains below the national average. For instance, under the 'all green space' definition, 91% of England has access, compared to 85% in Norfolk. When applying the 'neighbourhood standard' requiring large green spaces within 1km, only 28% of Norfolk residents meet this standard compared to 53% nationally (Figure 18).

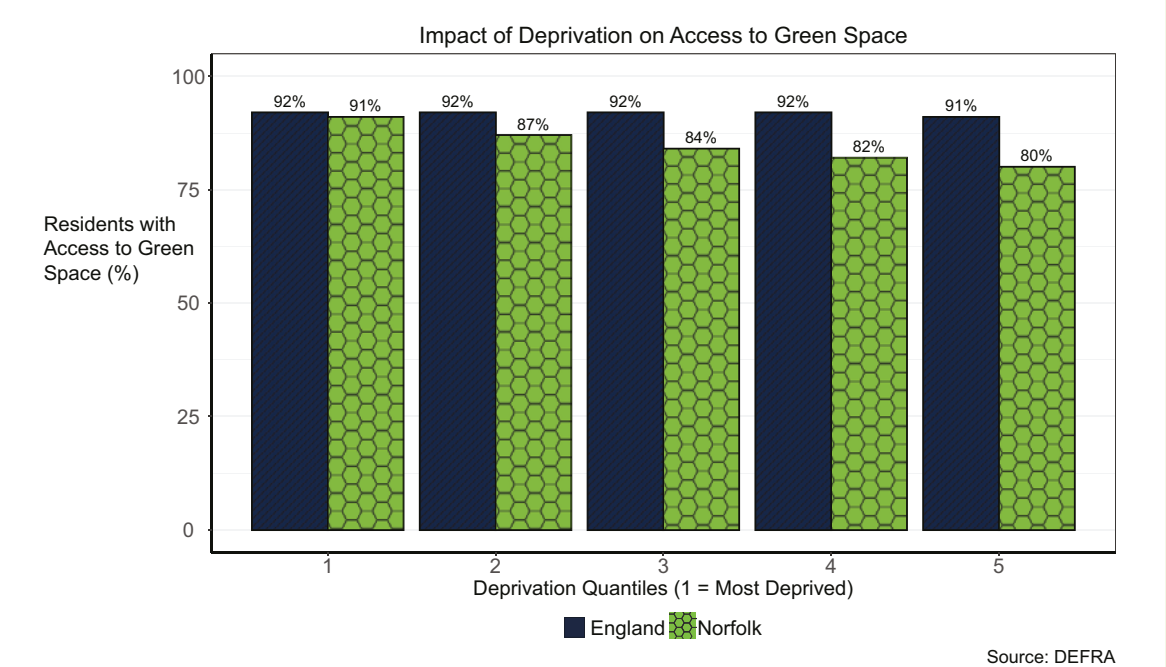


Figure 19: Access to green spaces across deprivation quantiles in Norfolk and England.

Figure 20 illustrates Norfolk's green and blue spaces, with public rights of way shown in purple. These paths create an extensive network across rural Norfolk, however some footpaths, such as those that span only 100 metres without linking to other routes, may offer limited practical use despite being technically accessible. **Norfolk Trails** aims to enhance the connectivity, usability, and accessibility of these paths, making them more enjoyable and accessible to a wider range of people.

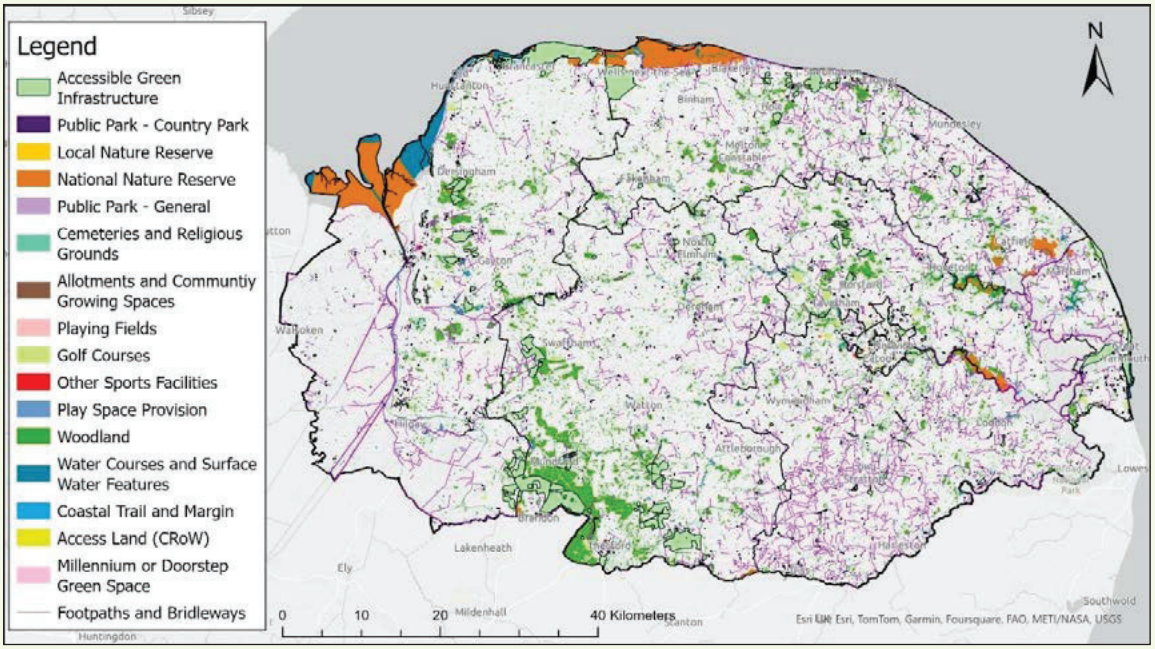


Figure 20. Map showing green infrastructure in Norfolk, highlighting accessible green spaces throughout the region. Map produced by Norfolk Public Health Insight and Analytics using **Natural England data**.

Improving the quantity and quality of Norfolk's green and blue spaces is an opportunity for unlocking the health and environmental benefits discussed throughout this section. Initiatives like Norfolk County Council's 1 Million Trees project are already making significant progress here; having already planted approximately 600,000 trees by the end of the latest planting season, the goal is to plant 150,000 trees per year until the 1 million target is met or exceeded. The County Council has successfully bid for funding through the **Urban Tree Challenge Fund** and the **Local Authority Treescapes Fund** to contribute towards this.

Encouraging and enabling individuals to access green and blue spaces, particularly within disadvantaged communities, could help to improve health. Addressing barriers such as lack of accessibility, transport options, or awareness helps to ensure everyone benefits from the health and wellbeing benefits of time in nature. Norfolk Wildlife Trust's Sweetbriar Marshes project provides an example of how this can be achieved alongside communities. Initiatives like green social prescribing are also particularly important in this regard, where individuals, particularly those with mental health conditions, are encouraged to engage in nature-based activities like gardening, walking, or volunteering in green spaces. There is strong and growing evidence that nature-based social prescribing plays an important, cost-effective role in improving mental and physical health.[166]

Photography:
Norfolk Wildlife Trust

Case study: Sweet Briar Marshes

Sweet Briar Marshes is a unique and significant (90 acre) wild space, located within Norwich's urban boundary and within one of the city's most disadvantaged areas. Norfolk Wildlife Trust (NWT) have a vision to create a place where wildlife is protected and enhanced, while providing opportunities for local communities to connect with nature.

The site plays an important role in providing a cooling effect and alleviating potential flood risk to the city. Planned improvements to the natural functioning of the floodplain will further improve this mitigation and help to make communities more resilient to climate change.

NWT worked with local residents to create a shared vision and design, recognising that a high proportion of people from low-income households spent little time in green and natural spaces and, as a result, missed out on the associated benefits. Over 1,000 people across 50 events provided important insights which influenced the design. This has encouraged many people who traditionally would not have visited to explore, volunteer and enjoy the benefits to physical and mental health and wellbeing from connecting with the natural world.

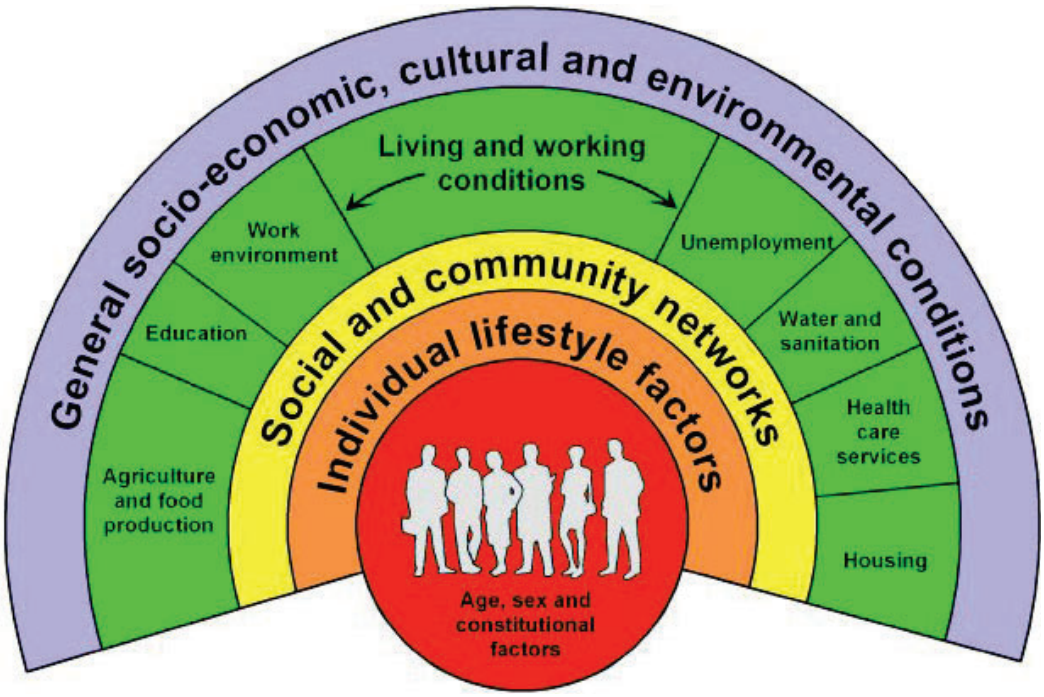
Section 4: What action can we take?

System actions

As climate change continues to pose significant challenges, collaboration across Norfolk's health and care system is vital to enhance resilience against climate change's anticipated public health impacts. Effective climate adaptation – actions that help communities adjust to and prepare for the impacts of a changing climate – is important for reducing risks, building resilience to extreme weather and fostering health and wellbeing in the face of climate-related challenges. Some adaptation actions also double as climate mitigation, meaning they reduce greenhouse gas emissions too, highlighting the multiple benefits of many policies. This section outlines potential actions that could be undertaken collaboratively as a system to improve the health of vulnerable populations and to ensure that Norfolk is well-prepared to meet the ongoing effects of a changing climate.

Many of these actions are underpinned by the wider determinants of health – the various social, economic and environmental factors that influence people's health, such as housing, education, and food – which significantly influence individual and community wellbeing. Addressing these determinants is crucial for building resilience to climate impacts while also fostering healthier, more equitable communities and driving long-term improvements to public health across Norfolk.

Photography:
Getty Images



Source: Dahlgren and Whitehead, 1991

Figure 21. The Dahlgren-Whitehead rainbow, highlighting the relationship between the individual, their environment and health and how this leads to health inequalities.[167]

Below are actions that organisations can take at a system level – some of which are already underway.

Short term actions:

Collaborate with the Norfolk Resilience Forum to ensure that severe weather resilience risk and plans are up to date to reflect the growing climate risk. Effective planning ensures that communities, healthcare facilities, and emergency services can respond quickly and appropriately, preventing avoidable deaths and illnesses.

Plant more trees to provide natural cooling, improve air quality and reduce flooding, while sequestering (capturing and storing) CO_2. Increasing tree canopy cover not only enhances resilience to rising temperatures but also improves residents' quality of life. Norfolk County Council's 1 Million Trees project has already contributed over 600,000 trees towards this.

Integrate climate risk into organisational risk assessments and consider adaptation planning as part of business continuity.

Ensure that organisational staff are aware of climate risks and prevention, mitigation and adaptation measures relevant to their organisations and the people they serve.

Engage with residents to promote resilient and sustainable behaviours, particularly in relation to energy efficiency opportunities in disadvantaged areas. An example is the Norwich Climate Commission's **Our Power** project, which trains trusted community members as 'Neighbourhood Energy Champions', providing energy advice and signposting to their community.

Identify and maintain a register of vulnerable populations to ensure that the most at-risk individuals receive timely support during extreme weather events. Support voluntary, community and social enterprise (VCSE) organisations to ensure that volunteers and staff are ready to provide essential assistance where appropriate.

Implement effective communication strategies to inform residents about climate risks and preventative measures, enabling individuals to take steps to protect themselves during extreme weather events.

Launch public campaigns to raise awareness about the health impacts of climate change and encourage individuals to adopt proactive behaviours that reduce emissions and protect their wellbeing.

Long term actions:

Strategically develop green infrastructure to ensure equitable access across Norfolk. Accessible green infrastructure can improve biodiversity, provide a cooling effect, and reduce flooding, all while providing recreational spaces for residents. Norfolk's forthcoming Local Nature Recovery Strategy and Greater Norwich Green Infrastructure Strategy will play an important role in achieving these objectives.

Ensure that Norfolk has the infrastructure it requires to mitigate and adapt to climate change, working as a system to ensure that the county transitions towards a low-carbon economy and ensuring that local communities benefit.

Ensure that Norfolk's existing core infrastructure is resilient to climate change and that the necessary adaptations for future resilience are clearly identified and understood.

Introduce higher standards for new developments to ensure that communities are more resilient to climate change and extreme weather events, working with planning authorities to include adaptations for both hot and cold weather, such as adequate shade, effective ventilation (e.g. the cross flow of air), and improved insulation.

Ensure that new developments are not located in flood prone areas by utilising available flood risk data, ensuring that communities are resilient and future costs are avoided.

Ensure that new developments are not car dependent by working with planning and highways authorities to create residential areas that encourage walking, cycling and wheeling and are well integrated into existing public transport networks.

Improve existing buildings by implementing a systematic approach to upgrading insulation and incorporating renewable or energy-efficient heating systems, thereby reducing greenhouse gas emissions, lowering energy bills, and improving health and wellbeing.

Prioritise improvements to healthcare and social care facilities to enhance their resilience during extreme weather events, ensuring that they can continue operating effectively.

Integrate sustainability criteria into procurement processes to ensure that goods and services across all sectors have a lower carbon footprint and contribute to enhanced climate resilience.

Promote climate change training for healthcare staff, enhancing their understanding of the health implications of climate change and equipping them to support their patients and communities more effectively.

Work with farmers and the wider agricultural sector to promote sustainable farming practices that enhance climate resilience, improve food security, and benefit public health. Norfolk already boasts numerous examples of sustainable agriculture, such as Wild Ken Hill and the Holkham Estate.

Individual and community actions

While system-level actions are important, individuals also have a powerful role to play. Everyday choices and new habits can collectively make a big difference to support individuals' own health and wellbeing but also to contribute to a more resilient Norfolk. While the actions below might not be suitable for everyone, they offer a variety of ways to make positive changes, helping to build a healthier, more climate-resilient Norfolk for all.

Choose more active, sustainable travel choices such as walking, cycling or wheeling. Public transport and car-sharing also help cut greenhouse gas emissions and reduce air pollution. Becoming more physically active is one of the most powerful ways to improve health.

Eat a healthy and sustainable diet by incorporating more fruit, vegetables and whole grains, while reducing red and processed meats. Growing your own food can reduce your environmental impact and improve your health.

Make your home more climate-resilient by improving energy efficiency, ensuring proper shading and planting trees and greenery in outdoor spaces. Keep your garden as green as possible to reduce flood risk. Energy efficiency upgrades, such as insulation and draught-proofing, help conserve energy, keeping homes warmer in winter and cooler in summer. Larger improvements, like installing solar panels or upgrading heating systems, further reduce energy use, cut carbon emissions, and lower bills. There are various funding options that can make these changes more affordable such as through the **Norfolk Warm Homes** and schemes such as the **Great British Insulation Scheme** and **ECO**. **Norfolk County Council's Trusted Trader website** provides a trusted directory for home upgrades and energy efficiency work.

Maintain diverse gardens or green spaces to support local biodiversity and promote climate resilience. Planting trees and plants provides shade, absorbs CO_2, improves air quality and reduces flooding, making communities more resilient. **Subsidised tree packs** are currently available for Norfolk residents, businesses and community groups.

Support elderly or vulnerable individuals during extreme weather events by ensuring they have adequate heating or cooling, access to essential supplies, and assistance during emergencies.

Understand the risk and prepare for extreme weather if you live in flood-prone or high-risk areas. Being proactive can help minimise damage and ensure the safety of you and your household during floods, storms or heatwaves. For more information visit **Norfolk Prepared.**

Practice water conservation by fixing leaks, using water-saving devices and collecting rainwater. Reducing water use at home helps alleviate pressure on local supplies during droughts.

Look after your mental health by connecting with community support systems, staying informed and getting involved in positive action. Find out more **here**.

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Section 5: Conclusions

Climate change and health are closely linked. Norfolk's unique geography and demographics make it particularly vulnerable to climate impacts such as rising temperatures, flooding, and coastal erosion. These changes bring heightened risks of heat-related illnesses, worsening air quality and displacement due to flooding, all of which can disproportionately affect vulnerable populations such as the elderly, children and those living in substandard housing.

Despite these challenges, there are substantial opportunities to improve public health and enhance resilience to climate change. Improving the energy efficiency of homes not only reduces greenhouse gas emissions but also lowers energy bills and improves living conditions by addressing issues like mould, damp, and cold temperatures. Expanding and improving access to green and blue spaces is equally important, as these areas provide urban cooling, flood mitigation, and numerous health benefits by promoting physical activity, reducing stress and improving air quality.

Norfolk's strong agricultural sector also presents an opportunity to become an exemplar for sustainable food systems. Shifting towards plant-based diets and supporting sustainable farming practices can not only reduce emissions but also improve diets and health outcomes. Meanwhile, initiatives like Norfolk's 1 Million Trees illustrate the potential for local action to enhance the environment and improve wellbeing.

The mental health impacts of climate change are increasingly evident, with eco-anxiety and trauma from extreme weather events increasingly affecting residents. Programmes like Norfolk and Waveney Mind's sUStain project demonstrate the value of community-led initiatives in supporting mental health while addressing climate-related stress.

By integrating health considerations into climate strategies, Norfolk can not only mitigate and adapt to climate change, but also build a healthier and more equitable future for its residents.

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Report to Norfolk Health and Wellbeing Board

Item No: 10

Report title: Norfolk Better Care Fund - 2025/26 Plan

Date of meeting: 11 June 2025

Sponsor
(HWB member): Ian Wake, Executive Director, Adult Social Services, Norfolk County Council
Ed Garratt, Interim Chief Executive, NHS Norfolk and Waveney Integrated Care Board

Reason for the Report
Norfolk Health and Wellbeing Board (HWB) holds the responsibility for overseeing and agreeing the Better Care Fund (BCF) plans each year. This paper provides an overview of the 2025/26 BCF Plan, including changes to the BCF national conditions and metrics.

Report summary
The BCF is a nationally mandated programme, aiming to join up health and care services so people can manage their health and wellbeing and live independently in their communities for as long as possible. For 2025-26 we are asked to submit Norfolk's BCF Plan for a single year. A draft plan has been submitted to NHS England, which we are bringing to HWB for sign off in line with national governance and reporting requirements.

Recommendations
The HWB is asked to:

a) Agree and sign off the Norfolk BCF 2025-26 Plan, for full and final submission to NHS England.

1. Background

1.1 The BCF is a nationally mandated programme, aiming to join up health and care services so people can manage their health and wellbeing and live independently in their communities for as long as possible.

1.2 The BCF is a priority for our HWB and a key element of joint working, focusing on some of the most important integration priorities in our Integrated Care System (ICS). Partners utilise the BCF to fund and develop critical services that support the health and wellbeing of our population, including care from the provider market, key health and care operational teams, and community-based support.

1.3 In line with national timeframes, the Norfolk BCF plan for 2025-26 was submitted (in draft form) to NHS England on 31 March 2025. We are now bringing this plan to HWB for full and final sign off.

2. National Policy Context

2.1 For 2025-26 local HWBs have been asked to submit a BCF plan that covers a single financial year, as opposed to the two-year submission that was made for 2023-25. We understand that future aspirations are to move towards a long-term planning cycle aligned to the NHS 10 Year Plan.

2.2 The four national conditions for the BCF in 2025-26 are:

1. Jointly agreeing a plan; Local authorities and Integrated Care Boards (ICB) must agree a joint plan, signed off by the HWB, to support the policy objectives of the BCF for 2025 to 2026.
2. Implementing the objectives of the BCF; HWBs, through their joint plans, should deliver health and social care services that support improved outcomes against the fund's 2 principal policy objectives:
    - to support the shift from sickness to prevention.
    - to support people living independently and the shift from hospital to home.
3. Complying with grant conditions and BCF funding conditions – including maintaining the NHS minimum contribution to adult social care.
4. Complying with oversight and support processes.

2.3 Several changes have been made to the BCF policy framework at a national level. Funding streams within the BCF have been streamlined as follows:

- Local Authority Better Care Grant – combining what used to be the Improved Better Care Fund (iBCF) and the Local Authority Additional Discharge Fund (ADF) allocation.
- NHS Minimum Contribution – now also including the ICB ADF Allocation.
- Disabled Facilities Grant.

2.4 Overall allocations to the Better Care Fund NHS Minimum Contribution have increased by c1.7%. Following a decision by the Secretary of State, NHS England have stated that this value should be used in full to increase the NHS minimum contribution to Adult Social Care (an uplift of c3.93% against the 2024-25 values).

2.5 The key metrics have also been updated for this year and now include three lead metrics and six supporting indicators. These are:

- Emergency admissions to hospital for people aged 65+.
    - Unplanned hospital admissions for chronic ambulatory care sensitive conditions.

    - Emergency hospital admissions due to falls in people aged 65+.
- Average length of discharge delay for all acute adult patients, derived from a combination of: the proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) and for those adult patients not discharged on DRD, average number of days from DRD to discharge.
    - Patients not discharged on their DRD.
    - Average length of delay by discharge pathway.
- Long term admissions to residential care and nursing homes for people aged 65+.
    - Hospital discharges to usual place of residence.
    - The proportion of people who received reablement during the year, where no further request was made for ongoing support.

2.6 Go to www.gov.uk for further information relating to the national BCF policy direction and planning guidance, where a detailed BCF policy framework 2025 to 2026 can be found.

3. The Norfolk Better Care Fund 2025-26 Return

3.1 The submission deadline of 31 March 2025 was far earlier than we have experienced in previous years, requiring a huge amount of work to be completed in a very short space of time. The positive momentum and partnership working built through the joint BCF review that was completed during 2024-25 provided a strong foundation to enable successful completion of the planning process in line with national timeframes.

3.2 The BCF team has engaged with a range of stakeholders in the development of the Norfolk BCF plan for 2025-26, to ensure that the submission meets both national planning requirements and agreed local priorities.

3.3 Specifically, the Norfolk BCF plan for 2025-26 has been developed based on findings and recommendations from the joint BCF review. The outcomes of this review and early indications of the emerging plan were discussed at the last meeting of the HWB on 5 March 2025.

3.4 The Norfolk BCF return is made up of three documents: a narrative return describing our plans to meet the mandated National Conditions (**Appendix 1**); a Demand and Capacity plan for local Intermediate Care services (**Appendix 2**); and a Planning Template (**Appendix 3**) which details our spending plan and goals for our metrics. Across these documents, the return covers the following elements:

- An overview of our BCF Plan.
- A description of how we will implement the new BCF objectives.

- A description of how our capacity and demand planning has been derived, as well as our forecast demand and capacity for step up and step down services into intermediate care.
- An overview of how we meet our duties with regards to equality, including supporting unpaid carers.
- A summary of our income and detailed account of our planned expenditure.
- Our planned performance against the three key metrics.

3.5 The narrative return outlines how the ICB and Local Authority have jointly agreed to prioritise the uplift to the minimum NHS contribution to adult social care, with a focus on reablement, prevention and integrated working.

3.6 Members have previously expressed an interest in understanding further the BCF metrics and local performance against these. Details are provided as part of the narrative return. It is important to note that two of the three BCF metrics relate to Urgent and Emergency Care (UEC). Work is ongoing within our ICS to ensure alignment to the UEC work programme and appropriate oversight and ownership for performance against these targets through local UEC governance structures.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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Choose an item.

Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1
HWB	Norfolk
ICB	NHS Norfolk and Waveney Integrated Care Board (N&W NHS/NWICB)

Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

System partners for Norfolk continue to work collaboratively with Norfolk County Council (NCC) and NHS Norfolk and Waveney ICB (NWICB) to ensure that all services and schemes, including those funded through the Better Care Fund (BCF), deliver improved outcomes for our population whilst offering value for money. The BCF in Norfolk is acknowledged to be an important tool to support the delivery of shared priorities and is regarded locally as an example of best practice when it comes to integrated working.

We welcome the Government's revised objectives for the BCF to:

1. Support the shift from sickness to prevention

2. Support people living independently and the shift from hospital to home

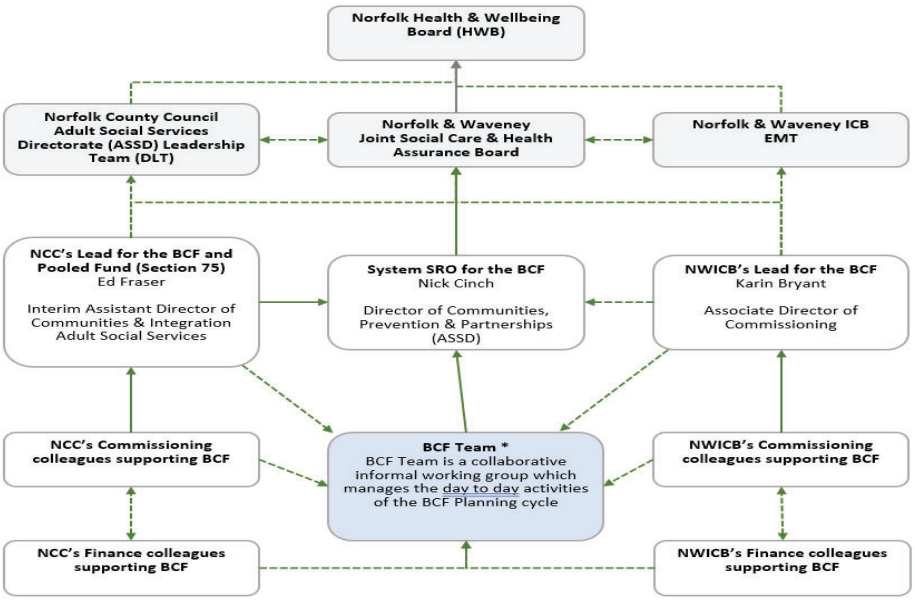
During 2024-25, partners across our Integrated Care System (ICS) have been participating in a review of current BCF expenditure. This process has resulted in six local priority areas that align with the national objectives above. This section summarises the Norfolk BCF plan for 2025-26 and how we are working together to maximise the use of this funding stream for our local residents.

Governance Arrangements

The BCF is administered by a joint team made up of colleagues working across NWICB and NCC. This team is responsible for co-ordinating development and delivery of the BCF plan for Norfolk, based on engagement with a wide range of stakeholders. As per statutory requirements, the BCF is governed by the Norfolk Health and Wellbeing Board (HWB), who agree the approach to the BCF and sign off plans and submissions. NWICB Executive Management Team (EMT) and NCC Adult Social Services Directorate (ASSD) Leadership Team (DLT) form the governance route into the HWB Board. Represented in these groups

are the ICB's Chief Executive Officer, Tracey Bleakley, and the Executive Director of Adult Social Services, Ian Wake.

A Joint Social Care and Health Assurance Board has been established since 2023, which increases the integrated governance for the BCF Plan. Membership from Suffolk County Council on this board ensures that the whole ICS footprint is represented, as the ICS contributes to two separate BCF plans (Norfolk and Suffolk). Colleagues are also included from public health and children's services to ensure areas of shared priority are identified as part of the BCF planning process.



Priorities for 2025-26 and key changes from 2024-25

In 2024-25, the joint BCF team oversee a detailed review of all schemes funded through the NHS Minimum Contribution. The key purpose was to ensure that the schemes are aligned to current system priorities and national BCF metrics.

The review resulted in a series of recommendations, **including six revised local priorities for BCF investment in Norfolk**, which were approved by the HWB in June 2024. One of the agreed next steps was to optimise the BCF by implementing a new 'future state' model as follows:

- Refresh Norfolk's local BCF priorities to ensure they are in line with Norfolk and Waveney ICS ambitions as set out in the ICS strategy published in November 2022. Strategic alignment of BCF schemes with the following six priority areas:
    1. Place based initiatives
    2. Prevention & Community Support
    3. Admission Avoidance
    4. Discharge & Recovery
    5. Enablers for integration
    6. Mental Health, LD and Autism

- Focus the BCF on core integrated services operating at scale within a strategic framework, and requiring joint commissioning and oversight.
- All schemes funded through the BCF must have suitable governance and performance management arrangements so as to tangibly evidence the impact of the scheme on local and national priorities/metrics.

Following this process, 19 schemes have been found to be ineligible against the criteria above and will be offboarded from the BCF plan for 2025-26. Investment from these schemes will be directed to services and teams that are more closely aligned to local and national priorities where there is good evidence of positive outcomes and value for money.

In this way, **the BCF plan for 2025-26 will consist of a smaller number of schemes that are of key significance to our ICS** and are:

- jointly funded, and/or
- would benefit from strong integrated oversight, and/or
- delivering outcomes that will have a positive impact on the provision of health and social care in our system.

All schemes within our BCF are aligned to the national priority areas identified in the BCF planning guidance documentation, as outlined in **Section 2**.

In line with national guidance, the NHS minimum contribution to adult social care has been maintained by the ICB and planned adult social care expenditure for 2025-26 has increased by 3.93% against the minimum requirement. The Local Authority and the ICB have jointly agreed to prioritise this funding as follows:

Allocation	Value	National Policy Objective
Growth/Inflation to meet cost pressures for social care providers	£0.80m	To support people living independently and the shift from hospital to home.
Additional reablement capacity	£0.30m	To support the shift from sickness to prevention. To support people living independently and the shift from hospital to home.
Proactive Intervention – expansion of health provision and capability	£0.25m	
Local Area Coordination / Integrated Neighbourhood Teams	£0.22m	

Development of BCF plan for 2025-26

The 2024-25 review, which involved engagement with a wide range of stakeholders across the ICS, has improved local understanding of the BCF and provided a strong foundation for the development of the plan for 2025-26. In keeping with the local and national ambition to work in partnership with people and communities, we have prioritised engagement through the place-based structures that are established in Norfolk as follows:

- Seven Health and Wellbeing Partnerships, which were established as multi-agency groups and suitably positioned to understand the health and wellbeing needs of their local areas. Partnerships are chaired by district councils and comprise a range of statutory and non-statutory providers working in each of the council footprints.
- Five Place Boards, which bring together system partners to improve integration with a focus on effective operational delivery and improving people's experience of care

Through these networks, the following stakeholders have been involved in the planning process:

- Local Authorities
    - Norfolk County Council (NCC)
    - City, Borough and District Councils
    - Engagement with Suffolk County Council as neighbouring Health and Wellbeing Board in our ICS footprint
- NHS Norfolk and Waveney Integrated Care Board
- Acute hospitals
    - Norfolk and Norwich University Hospitals NHS Foundation Trust
    - Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust
    - James Paget University Hospitals NHS Foundation Trust
- Community healthcare providers
    - Norfolk Community Heath and Care NHS Trust
    - East Coast Community Health CIC
- Mental health provider: Norfolk and Suffolk NHS Foundation Trust
- Primary Care
- VCSE system partners
- Healthwatch Norfolk
- Norfolk Police and the Police and Crime Commissioner (PCC)

This approach has enabled the Norfolk system to use the BCF to involve and empower NHS Trusts, social care providers, voluntary and community service partners and other system partners in the development of the BCF and ensure local priorities are factored into the planning process.

For example, we are looking to expand upon successful delegation of funding to Health and Wellbeing Partnerships, where these Partnerships received funding to deliver prevention programmes in their area, through the BCF in 2023-25 by working with local Partnerships to

shape a new prevention offer that will increase funding to local areas to transform the way in which we identify people at risk and support them to remain safe and well at home. The 'Proactive Intervention' programme has been identified as an example of best practice in national guidance and will form a key part of our system's prevention offer from July 2025. Further details are included in our response to Section 2.

Alignment to Urgent and Emergency Care and Intermediate Care priorities

As noted above, the priorities for the Norfolk BCF include a focus on admission avoidance and discharge and recovery. Many of our key services and teams supporting the Urgent and Emergency care system are already funded through the BCF. This greatly enables joint commissioning and operational planning across our ICS partnership. We have added further contributions to the UEC response into the BCF for 2025-26. This is with a view to developing a systemwide "UEC budget" containing all relevant expenditure within the BCF plan for 2026-27.

UEC schemes funded through the BCF include:

1. Norfolk First Support (NFS) reablement services – an essential service which provides urgent community response including responding to non-injurious fallers, reablement at home as a prevention/admission avoidance response to support individuals in crisis, and reablement at home to support discharge from hospital
2. Caring for Better Outcomes – additional reablement capacity provided by local home support providers alongside NFS
3. Swifts / Night Owls – 24-hour service that provides practical help to adults with an urgent, unplanned need at home. This includes support for people who have fallen over and emergency respite for people whose carers are admitted to hospital
4. Urgent Community Response and Community Nursing and Therapy services supporting hospital discharge and admission avoidance
5. Bed based intermediate care capacity – in addition to c200 community hospital beds, c100 intermediate care beds have been commissioned across Norfolk and Waveney with independent/private providers to support D2A pathway 2. This provision focuses on people with complex needs, including dementia, and include associated wrap around reablement support from primary care, therapy and social work to promote independence
6. Integrated Transfer of Care Hubs – multi-agency, multi-disciplinary teams of health and social care staff, alongside other partners, working together to oversee discharges for people leaving hospital under D2A pathways 1-3. In Central Norfolk this includes dedicated funding for an integrated Escalation Avoidance Team, which plays a vital role in identifying urgent community support options to avoid unnecessary hospital admissions for people in crisis
7. District Direct – dedicated district council resources which identify and overcome housing related barriers to discharge, working as part of our Transfer of Care Hubs. The aim of the service is to enable residents to return home in a timely manner from hospital to an environment that meets their needs, with all necessary support in place
8. Teams and services supporting discharge for working age adults

Norfolk has an established alliance governance structure for Urgent and Emergency Care (UEC), including Intermediate Care, which is aligned to the three acute hospital footprints as set out below. There is a UEC Board, reporting into the ICB's Commissioning & Performance Committee, which has oversight of three UEC Alliances. The BCF team is represented at the Alliances to ensure alignment across BCF and UEC planning returns.

- Central Norfolk – Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH)
- Gt Yarmouth and Waveney – James Paget University Hospital NHS Foundation Trust (JPUH)
- West Norfolk – Queen Elizabeth Hospital (QEH)

During 2024-25, we took a whole system approach to recover Norfolk's UEC position, including ambulance turnaround times at Emergency Departments, flow within both acute and community hospitals and timely discharge. A wide range of initiatives were implemented across our ICS partnership, which has led to significant improvements that have been made and recognised by NHS England (moving from Tier 1 to Tier 2 UEC oversight).

Informed by demand and capacity profiling, we are making creative use of the Additional Discharge Fund (ADF) to increase significantly our capacity within commissioned intermediate care services (both home and bed based). This has included, for example, commissioning a range of intermediate care beds with independent/private providers to provide a recovery focused offer for people with dementia who would benefit from some bed-based reablement and recovery to return home from hospital.

We have expanded the number of dedicated double assist teams within NCC's reablement service, NFS, to increase further the support we can provide to people with complex needs. We have also embedded Occupational Therapists (OTs) within NFS to provide the opportunity for all cases coming through reablement to be discussed with a therapist. This enriches the goal setting and discussions of 'what's next for the person'. Data gathered from monitoring of clients shows a significant change outcomes demonstrating how this intervention is having a positive input in to people's lives.

Similarly, we have used ADF funding to commission a new reablement pathway called Caring for Better Outcomes (CfBO). Through CfBO, select Home Support providers deliver up to six weeks of funded reablement for people leaving acute, community and mental health hospitals on D2A Pathway 1. The service has been designed to enable access to reablement for people where NFS cannot support due to capacity or complexity. A pilot launched in December 2023 and, following a positive evaluation, the pathway was expanded through re-procurement in November 2024. In the year to date, 584 people have been supported. Approximately half of all people supported are fully or partially reabled, experiencing an average reduction of c.5 hours of care per week. Our BCF plan for 2025-26 includes additional funding to enable further expansion of the CfBO pathway to support admission avoidance as well as hospital discharge.

The UEC priority areas for 2025 26 are to improve Accident & Emergency (A&E) waiting times and ambulance response times compared to 2024-25, with a minimum of 78% of patients seen within four hours in March 2026 and Category 2 ambulance response times no more than 30 minutes on average. There are a range of activities underway to deliver these priorities, which are aligned across three portfolio areas:

At a system level, key delivery actions against the identified priorities are outlined below. More detailed delivery planning is underway within each of the three local Alliances.

Optimising UEC demand management initiatives by implementing the Neighbourhood health core components:

- Implementation of recommendations of Strategic Virtual Ward (VW) Review, with increased integration between VW, Urgent Community Response (UCR) and SDECs (Same Day Emergency Care), supported by Unscheduled Care Co-ordination Hub, (UCCH), our Single Point of Access (SPoA) across Norfolk and Waveney, and the 2025 HSJ Partnership Award winner for the 'Best Contribution to the Improvement of Urgent and Emergency Care'
- Increase capacity in UCCH to achieve a consistent 100% review of Category 3-5

Improving access to urgent care outside of hospital:

- VW & UCR - implementing and embedded model, process and operational changes to VW identified through the Q4 24-25 VW Strategic review. Access to same day community services offered at Place footprint, such as UCR and VW will increasingly be made via SPoA
- Address the lack of Urgent Treatment Centre (UTC) provision across the ICS footprint by reviewing the opportunity to implement UTCs utilising the national capital programme

Joining up urgent & emergency care services through a single point of access:

- Continue improvement cycle using to direct and define future developments
- Expand to include consistent trusted assessor access into Acute Emergency Department (ED) alternatives such as SDEC and acute frailty
- Expand access points into SPoA i..e Primary Care, ED and SDEC

Maximise opportunities for hear and treat and ensure clinical validation of 111 outcomes:

- Continued focus and local prioritisation of pre-dispatch reviews via SPoA with local ambition for SPoA to review 100% of clinically appropriate Category 3-5 calls (ED Avoidance)
- Overnight holding of C5 activity in the ambulance service with transfer to SPOA for response upon opening (ED Avoidance)
- Continued promotion of Call Before Convey (CB4C) as the escalation point for Paramedic crews considering conveyance to ED. This will include roadshows, comms messaging, ambulance arrival learning audits and identifying champions within the local ambulance team leader staff pool to embed the use of CB4C. Calls in will support transfer to alternate services including Virtual Ward, SDEC, Acute Frailty Services and coordinating services to avoid hospital admission (Admission Avoidance)

Apply 'discharge to assess' principles aligned to the Better Care Fund objectives and goals:

- Improve the timeliness, volume and quality of discharge for patients on Pathway 1-3, ensuring that the limited resources available are used in the most effective way across each alliance, avoiding duplication, improving efficiencies

Address inequalities within the UEC pathway:

- There is a High Intensity User (HIU) service in place across the ICS, delivering at Place footprint. This meets the national best practice model and has been used as an exemplar model for other ICS areas in the East of England region. Referrals are made via EDs of patients meeting the national definition of HIU attendances. The HIU service works with patients in a health coaching model to address the reasons and lifestyle factors behind the high use of ED. This will continue to be commissioned and contracted recurrently across 2025-26, managing 500 patients over the year across Norfolk and Waveney
- All urgent care services are offered across all areas of the ICS. Through 2025-26 SPoA will identify demand and capacity gaps to allow the system to address areas of inequity in capacity. SPoA covers both physical and mental health.
- Mental health waits in ED

BCF investment for 2025-26 has been aligned to support delivery of these priorities as set out above and within our Planning Template.

Finally, NCC, alongside Hertfordshire and Central Bedfordshire Councils, has played a leading role in the development of a framework for intermediate care. This initiative, which was supported by ADASS and NHS England, provides a set of key principles that can be applied consistently by local health and social care systems across the country.

Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

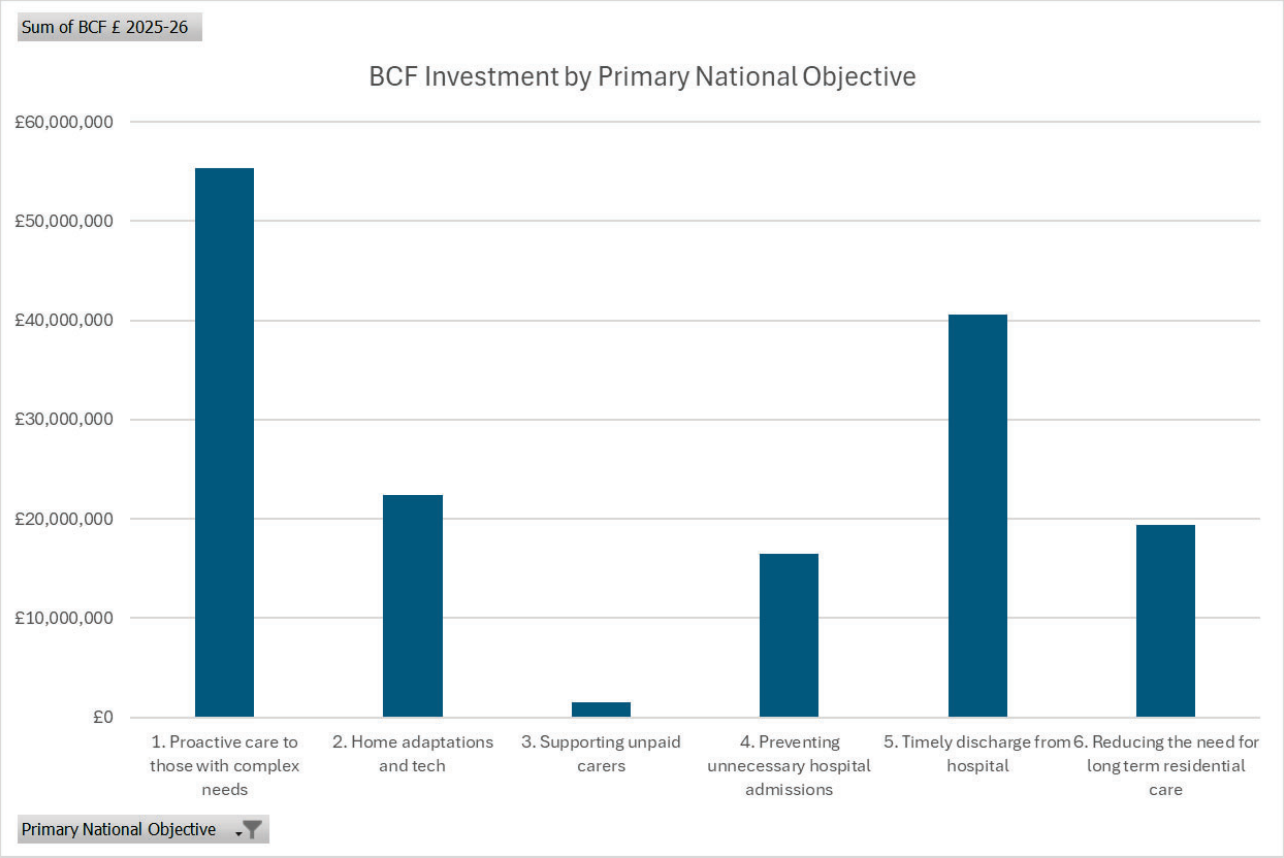
- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

Implementing the objectives of the BCF

The BCF for Norfolk funds some of a most important integrated services and teams, which collectively support the four key goals within our Integrated Care Strategy:

- Driving integration
- Prioritising prevention
- Addressing inequalities
- Enabling resilient communities

These priorities sit comfortably within the Adult Social Services Promoting Independence Strategy, promoting the aim of supporting people to be independent, well, and able to deal with life's challenges. As noted in the previous section, investment is focused on six priority areas, which align closely to the two national priorities.



In addition to services supporting UEC, as outlined in **Section 1**, the Norfolk BCF includes several key schemes providing prevention and community support to enable people to remain independently at home. These include:

- Integrated Community Equipment Service (ICES) – providing community equipment to support service users to remain independent, reducing unnecessary hospital admissions and delayed discharges, as well as avoiding unnecessary admissions to temporary and permanent residential care
- Carers Matter Norfolk – The first social impact bond for carers, Carers Matter Norfolk has provided outcome-focused support to over 11,000 carers since September 2020
- Information, Advice and Advocacy – delivered by a variety of VCSE organisations who work together as part of the “your Norfolk advice network” to deliver free, independent information and advice
- Assistive Technology Service – providing assistive technology to support people to live independently at home and prevent, reduce or delay the requirement for formal care and support
- Specialist support for people with learning difficulties and autism, including Preparing for Adult Life
- Dementia Support Service – a comprehensive support offer for people with dementia and their carers, including a single point of access to information, advice and signposting, bespoke specialist (non-clinical support) and complex clinical support

- Proactive Intervention – place-based community interventions to proactively identify, and support, people at risk of a fall (see below)
- Disabled Facilities Grant (DFG) – we work with our district, borough and city council colleagues work to deliver a DFG programme which supports people to remain independent. The services are further made local, through the use of Regulatory Reform Orders (RROs), to meet residents' needs and work towards our priorities. We are continuing to work with our council partners to improve joint working and integration between our services.

Metrics and Reporting

A joint system approach to planning is taken for the BCF, which includes consideration of local learning and national best practice to ensure schemes within the BCF are meeting objectives whilst delivering value for money. Performance is reviewed regularly by the Joint Social Care and Health Assurance Board, with key issues identified and raised to HWB as required in line with national reporting requirements.

One of the historic challenges for the Norfolk BCF has been the quantity and variety of schemes in scope. By streamlining our BCF plan for 2025-26, we will be able to develop a more coherent and consistent performance management and improvement approach. A dashboard is in development to enable greater oversight of individual scheme performance and value for money for officers and members.

Home First remains a key priority for our ICS. Examples have been given in **Section 1** to illustrate how BCF funding is being used in 2025-26 to expand and enhance existing intermediate care services (both "step up" and "step down"). Both NCC and the ICB welcome the consolidation of the Discharge Fund as a key opportunity to ensure funding across the BCF is prioritised on areas of maximum impact against identified priorities. No significant changes have been made from planned expenditure from 2024-25, but we propose to jointly review investment within UEC across the BCF as part of our work programme for 2025-26.

Emergency admissions to hospital for people aged 65+ per 100,000 population

As a baseline we are profiling a 5.3% increase against this metric over the next 12 months as compared to 2024-25. This has been predicted based on growth observed over the previous 24 months of actual activity data. As noted in **Section 1**, a key part of our system UEC strategy is to reduce ED attendance and hospital admission through deployment of a range of alternatives. We will be reviewing this target on a regular basis to measure the success of our key delivery actions.

Average length of discharge delay for all acute adult patients

Estimates have been based on NHS Operational Planning returns and sense checked against available benchmarking data. We are planning to drive sustained improvement against this metric through successful delivery of the UEC priorities outlined in **Section 1** and further detailed planning work is underway within each of our three UEC alliances to align operational planning assumptions to our transformation programmes. Through profiling we have identified data quality issues that we will be working with local partners to resolve as a key priority.

Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
1.35	1.32	1.41	1.35	1.22	1.29	1.21	1.27	1.25	1.34	1.11	1.15

Admissions to long term residential care homes and nursing homes for people aged 65+ per 100,000 population

Adult Social Care Outcomes Framework (ASCOF) ASCOF performance shows that Norfolk has proportionately more people of all ages supported in residential care settings than other areas. For older people, *new* admissions are broadly in line with the England and peer average and Norfolk has a relatively stable position compared to an increasing trend nationally. Given the older age profile in Norfolk, this demonstrates the effectiveness of our promoting independence strategy in practice. This is further evidenced by our strong performance against the identified supporting indicators:

- Hospital discharges to usual place of residence – **c95%** of all discharges during 2024-25 have been recorded as either Pathway 0 or Pathway 1, with the vast majority of people discharged via Pathway 1 receiving reablement or rehabilitation to enable them to regain their independence following a stay in hospital
- The proportion of people who received reablement during the year, where no further request was made for ongoing support – currently **76%** of people supported by NFS require no formal support on finishing their reablement period. Whilst this proportion has decreased over the last 12 months, this is largely because NFS is now supporting people with more complex needs in keeping with our strategic ambition to enable a Home First approach to local residents.

On this basis, for 2025-26, we have set an ambitious target profile based on benchmarking against national and peer group authorities (median). This target represents a return to 2023-24 levels (1311) following an increase in 2024-25 (est. 1431), which was largely due to movement from short-term to long-term placements as part of a one-off programme of work.

Q1	Q2	Q3	Q4
1396	**1362**	**1327**	**1293**

Ultimately, all three BCF metrics are a measure of our ability to help people to say well, safe and independent at home and in the community for longer. The impact of rehabilitation, reablement and recovery services, community support services and domiciliary care, are all critical to successful delivery. However, we particularly welcome the increased focus on prevention within BCF and NHS operational guidance.

We are nationally recognised in Norfolk for our innovative approach to transforming how we move from a reactive to proactive approach to preventing, reducing and delaying health and care demand. Local 'Proactive Intervention' pilots have tested with 1,250 residents how we can identify people at risk of escalating need using Artificial Intelligence technology, through identifying people at risk of a fall on NCC and District Council records. Interventions have been provided to residents to reduce that risk, and produce an evidence base for the impact on their long-term outcomes and social care demand.

The pilots have evidenced proactively intervening delivers a reduction in falls including associated fractures, improved wellbeing outcomes, and lower social care cost. Proactive Intervention is a partnership endeavour, delivered by NCC (including Adult Social Services, Innovation, Digital Services and Information and Analytics), the NHS, District Councils and other partners across our ICS. The evidence base we have developed is being used nationally as good practice (ADASS Future of Prevention Good Practice Network).

NCC and NWICB have jointly agreed to prioritise funding through the BCF for 2025-26 to enable the expansion of the Proactive Intervention programme across Norfolk by July 2025. In addition to proactively intervening with 12,000 people to reduce the risk of falling, the programme will implement an infrastructure and operating model to underpin the delivery of other prevention initiatives. In keeping with national policy direction, the Proactive Intervention programme will be designed and implemented at place, with bespoke services developed at a local level as part of a wider aspiration to shift towards a neighbourhood health service.

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

Demand and capacity planning is completed jointly by colleagues across our ICS, including BCF and UEC system leads, using a methodology established in 2023 that has proven to be an effective profiling tool. Building on learning from 2023-25, our aim has been to develop an iterative model that meets the following objectives:

- A single plan that projects both “step up” and “step down” demand, capacity to respond to that demand and the impact of actions on both
- Increasingly base decisions (including example commissioning, service design and strategic operational planning) on a greater evidence based provided by demand and capacity planning
- Develop in to a ‘live approach’ – where we build plan accuracy and detail over time, taking an agile approach that does not wait for the perfect model to be developed before we take action
- Monitor against plan and build in other contributing factors including longer term outcomes
- Develop following principles of transparency, trust and collaboration – model is designed to support our collective and individual decision making and insight has been shared between partners explicitly in that spirit

Profiles for 2025-26 have been estimated based on historic reported activity during 2023-24 and 2024-25 captured via NHSE Home First Reporting (previously Sitrep). An estimate has been applied to exclude patients being discharged from the James Paget who live in Waveney (c47.7%). Growth assumptions against 2024-25 levels have been applied across each pathway as per trend analysis of emergency admission data over the last 24 months (see BCF Metric 8.1).

For the purposes of this planning return, we have utilised an average profile for each month. More detailed Demand and Capacity work is currently being undertaken through our UEC alliance structures and we plan to refresh the BCF D&C model once this has been completed. This work will factor in seasonal variation and work to reduce any existing backlogs within our acute hospital settings.

Baseline capacity data has been collated based on historic performance across services within the scope of the given definition of intermediate care, as referenced in the BCF guidance. Further capacity to be delivered as part of a confirmed transformation priority within the UEC work plan for 2025-26 has been added based on estimates from relevant commissioners or operational leads.

Therapy services have been included within the estimates. Further work to explore opportunities to expand our therapy offer and align more closely to our reablement pathway to ensure we are making best use of available resources will be completed as a key priority during 2025-26, building on successful work to pilot a "Therapy First" model over the last year. Where gaps in commissioned capacity have been identified through this process,

detailed planning will be undertaken through our three UEC Alliance structures to identify solutions. The usage of spot care and support arrangements will continue to ensure flow is achieved, although our shared focus as a system is to continue to reduce our usage of spot placements through expansion of specific commissioned intermediate care options for local people. This will include building on our successful initiatives implemented during 2024-25 as outlined previously.

When it comes to Community Step Up, services related to UCR have been removed as per BCF Demand and Capacity guidance. Remaining services focus on social care reablement support at home or via a short-term placement within a local care home environment. Again, Demand and Capacity have been calculated based on the last 12 months of activity data.

Like many systems across the country, it is important to note that there are issues with the quality of available data which make it difficult to reliably profile activity levels. This is particularly true of data from 2023-24 and early 2024-25. Norfolk and Waveney have invested in technological solutions including SHREWD and Optica with the aim of improving data quality and these have had a positive impact.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

We know that people living in our most deprived communities experience more difficulties and poorer health outcomes. Health and Wellbeing Board members told us that this was magnified during the pandemic and gaps between communities widened. We recognise that together, we need to deliver effective interventions, to break the cycle, mobilise communities and ensure the most vulnerable children and adults are protected. To be effective in delivering good population outcomes we need to most help those in most need and intervene by working together at system, place, and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale. Reducing inequalities in health and wellbeing will involve addressing wider issues that affect health, including housing, employment, and crime, with community-based approaches. These need to be driven by partnerships at a place level involving councils, health services, the voluntary sector, police, public sector employers and businesses.

District, City and Borough Councils work closely with partners to identify areas of increasing concern, poverty and inequality across Norfolk and Waveney. Health and Wellbeing Board Members told us that, through the pandemic, local resilience arrangements were key to providing clear messages and communication with communities, partners, and members. Communities have the knowledge, assets, skills, and ability to help their residents flourish. Communities and individuals that are able to meet their own needs have better outcomes. It is important that our services support those living in our communities to look after themselves and live an independent life for as long as possible.

As part of this the Place Boards - which bring together partners across each of the five Places in Norfolk - have been focusing on identifying the specific health inequalities experienced in their area and how the demography, geography and community support available impacts on this. This is as an important factor in the decision to involve the Norfolk Places in the development of the system's BCF priorities.

This Health Inequalities Strategic Framework for Action has been developed following extensive engagement across our Integrated Care System. It is a ten year Framework, and will bring partners together under a common vision and set of priority areas. At the heart of our plan are the residents and communities that experience differences in health outcomes based on where they are born, grow, live and work. These differences are unfair and avoidable and working together we can take action to address them.

As a system we are working to reduce health inequalities by:

- Using population health management techniques as set out below
- Improving access to local community services, for example via the introduction of Health and Care Wellbeing Hubs
- Collaborating through our place boards and local health and wellbeing partnerships to improve access to and the quality of healthcare, as well as to address the wider determinants of health
- Establishing a Patients and Communities Committee, whose remit includes examining how the ICB is reducing health inequalities through the ICS Health Inequalities Strategy

Our collective work as a system is helping us to deliver the measures in the NHS Long Term Plan, the five priority actions to address inequalities that were identified as part of the health service's response to the pandemic and our work to deliver Core20PLUS5. We are using population health management techniques to provide more anticipatory care and early intervention. We are also using technology to empower people to manage their health and wellbeing better, for example by giving people greater visibility and control over their treatment and care journeys – this is a key aim of our new Digital Transformation Strategy.

Carers play a vital role in the health and wellbeing of Norfolk. They are key to maintaining the independence of people with care needs. However, providing care can have a major impact on Carers' lives and all partners within our ICS have a duty to support them. There are around 81,000 people in Norfolk providing essential support to a family member or friend, according to 2021 Census data. They may not think of their role as a 'Carer' or know that support is available to them.

In 2024 our Integrated Care Partnership signed up to a new ICS wide, All Age Carers Strategy, which sets out our ambitions for unpaid Carers in Norfolk. This includes eight key statements which were coproduced by Carers:

1. As a carer, I have rights that will be upheld.

2. As a carer I am identified, recognised, valued and respected as an equal partner in the care of the person I look after which includes clear communication with me.
3. As a carer, I am made aware of, and have access to, good quality information and services including a single and reliable point of contact.
4. As a carer, I have access to good and appropriate support with my mental health, physical health and wellbeing.
5. As a carer, I am an equal partner in the creation, development, monitoring and evaluation of services where my experience is recognised and valued. This will enable carers, and the people we care for, to receive the services we need and want. This is vital to support our health (including mental health) and wellbeing.
6. As a carer, I can access education, employment and training.
7. As a carer, I am able to have time for myself, away from my caring role, including access to peer support and community groups.
8. As a carer, I know the person I care for will be safe and have access to a good quality of life if I am no longer able to care on a temporary or permanent basis

In Norfolk, the BCF funds the Social Impact Bond for Carers. This service, which was launched in September 2020, delivers an enhanced offer for carers in Norfolk. Under the brand name “Carers Matter Norfolk” it provides our carers with a single place to go for any support they need in their caring role. Norfolk has delegated its Carers Assessment function to Carers Matter Norfolk, meaning it can offer support from one-off queries from carers to its advice line all the way up to a full Carers Assessment with ongoing support from a Family Carer Practitioner. The range of support offered by the service allows it to be flexible to meet carers needs, wherever they are in their carers journey. As part of this support, they can also offer carers access to a Health and Wellbeing Fund and Carers Breaks.

In the four years and four months of the service, there have been 12,573 new carers who were not previously known to Carers Matter Norfolk, registered with the service. 6,446 carers have had a Carers Assessment, and 1.965 have received high-level support. This represents a success story for the BCF in funding carers support.

We also deliver support to our carers outside of the BCF funded services through

- A Carers Passport scheme with all three acute hospitals in Norfolk – allowing carers a way to identify themselves as carers when their cared for person is in hospital, and to discuss extended visiting hours to support their cared for person.
- In My Place Emergency Planning – support carers to develop an emergency plan held by NCC which can be enacted in the case they have an emergency to make sure their cared for person still received the necessary care.

Our services (including changes in services) are all developed with Equality Impact Assessments, which aim to understand and mitigate the potential inequalities experienced by people with protected characteristics as a result of new services or service changes.

Many of our services seek to positively target inequalities, for example, by offering additional support to people with protected characteristics.

Currently, we have specific information and advice services within our BCF, targeted at those with protected characteristics and those groups/individuals know experience health inequalities, such as people with disabilities, older people, and unpaid carers. As the Place-based work on health inequalities develops and the system's understanding matures over time, Norfolk can start to use this knowledge to influence a more comprehensive targeting of BCF services to tackle inequalities.

Both NCC and the ICB are committed to service user engagement and co-production in the design and delivery of local services, including those funded through the BCF. For example, we have established an independent user reference group "Making it Real". This board is made up of disabled people and unpaid carers and acts as an advisory and guidance group to:

- Make sure that co-production happens
- Have a shared understanding with adult social services
- Be involved in planning changes and checking to see if the changes are working
- Make sure services provided are personalised

The board advises what good co-production is and how best to co-produce any changes and helps to make sure that the right people are involved in plans early on. The Making it Real board members feedback decisions and plans discussed at board meetings to the groups they represent.

1. Guidance

Overview

This template has been unlocked to allow editing as required. It is optional to submit capacity & demand figures as per this template format and a customised format of this will be accepted.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data can be input into the cell
Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. You should select your HWB from the top of the sheet which will also reveal pre-populated trusts for your area.

2. Once you are satisfied with the information entered the template should be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

3. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority. If your plan has been signed off by the full HWB, or has been signed off through a formal delegation route, select YES. If your plan has not yet been signed off by the HWB, select NO.

3. Capacity and Demand

A full capacity and demand planning document has been shared on the Better Care Exchange, please check this document before submitting any questions on capacity and demand planning to your BCM. Below is the basic guidance for completing this section of the template.

This template follows the same format as last year and so contains all the previously asked for data points including demand (referrals), block and spot capacity, average duration of treatment and time from referral to treat all split by pathway. It is however only required that some form of data points are submitted to show projected demand (disaggregated by step-up and step-down) and capacity for intermediate care and other short term care. The additional data points on average treatment time, time to treat and spot/block capacity split are optional but have remained in case you may find these data points useful.

As with the last capacity and demand update, summary tables have been included at the top of both capacity and demand sheets that will auto-fill as you complete the template, providing and at-a-glance summary of the detail below.

List of data points in template:

3.1 C&D Step-down

Estimates of available capacity for each month of the year for each pathway.
Estimated average time between referral and commencement of service.
Expected discharges per pathway for each month, broken down by referral source.
Estimates of the average length of stay/number of contact hours for individuals on each of the discharge pathways.

3.2 C&D Step-up

Estimated capacity and demand per month for each service type.
Estimated average length of stay/number of contact hours for individuals in each service type for the whole year.

Better Care Fund 2025-26 Capacity & Demand Template

2. Cover

Version 1.1 unlocked

Health and Wellbeing Board:	Norfolk	
Completed by:	Edward Fraser	
E-mail:	edward.fraser@norfolk.gov.uk	
Contact number:	01603 223122	
Date:	Wed 26/03/2025	<< Please enter using the format, DD/MM/YYYY

<< Link to the Guidance sheet

Better Care Fund 2025-26 Capacity & Demand Template

3.1. C&D Step-down

Selected Health and Wellbeing Board: Norfolk

Step-down

Capacity - Demand (positive is Surplus)	Capacity surplus (not including spot purchasing) Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Capacity surplus (including spot puchasing) Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home (pathway 1)	-134	-134	-134	-91	-91	-91	-62	-62	-62	-62	-62	-62	-134	-134	-134	-91	-91	-91	-62	-62	-62	-62	-62	-62
Short term domiciliary care (pathway 1)	0	0	0	0	0	0	0	0	0	0	0	0	134	134	134	91	91	91	62	62	62	62	62	62
Reablement & Rehabilitation in a bedded setting (pathway 2)	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59	-59
Other short term bedded care (pathway 2)	0	0	0	0	0	0	0	0	0	0	0	0	59	59	59	59	59	59	59	59	59	59	59	59
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	-109	-109	-109	-109	-109	-109	-109	-109	-109	-109	-109	-109	0	0	0	0	0	0	0	0	0	0	0	0

Capacity - Step-down		Refreshed planned capacity (not including spot purchased capacity) Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Capacity that you expect to secure through spot purchasing Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Service Area	**Metric**																								
Reablement & Rehabilitation at home (pathway 1)	Monthly capacity. Number of new packages commenced.	579	579	579	622	622	622	651	651	651	651	651	651	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care (pathway 1)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	134	134	134	91	91	91	62	62	62	62	62	62
Reablement & Rehabilitation in a bedded setting (pathway 2)	Monthly capacity. Number of new packages commenced.	237	237	237	237	237	237	237	237	237	237	237	237	0	0	0	0	0	0	0	0	0	0	0	0
Other short term bedded care (pathway 2)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	59	59	59	59	59	59	59	59	59	59	59	59
Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Monthly capacity. Number of new packages commenced.	0	0	0	0	0	0	0	0	0	0	0	0	109	109	109	109	109	109	109	109	109	109	109	109

Demand - Step-down			Please enter refreshed expected no. of referrals:											
	Pathway	**Trust Referral Source**	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Total	**Total Expected Step-down:**	Total Step-down												
Total	Reablement & Rehabilitation at home (pathway 1)	Total	713	713	713	713	713	713	713	713	713	713	713	713
1		JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	75	75	75	75	75	75	75	75	75	75	75	75
2		NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	490	490	490	490	490	490	490	490	490	490	490	490
3		THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	147	147	147	147	147	147	147	147	147	147	147	147
4		OTHER												
5		(blank)												
6		(blank)												
7	Short term domiciliary care (pathway 1)	Total	0	0	0	0	0	0	0	0	0	0	0	0
8		JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
9		NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
10		THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
11		OTHER												
12		(blank)												
13		(blank)												
14	Reablement & Rehabilitation in a bedded setting (pathway 2)	Total	296	296	296	296	296	296	296	296	296	296	296	296
15		JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	21	21	21	21	21	21	21	21	21	21	21	21
16		NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	188	188	188	188	188	188	188	188	188	188	188	188
17		THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	87	87	87	87	87	87	87	87	87	87	87	87
18		OTHER												
19		(blank)												
20		(blank)												
21	Other short term bedded care (pathway 2)	Total	0	0	0	0	0	0	0	0	0	0	0	0
22		JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
23		NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
24		THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	0	0	0	0	0	0	0	0	0	0	0	0
Total		OTHER												
1		(blank)												
2		(blank)												
3	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)	Total	109	109	109	109	109	109	109	109	109	109	109	109
4		JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	19	19	19	19	19	19	19	19	19	19	19	19
5		NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	48	48	48	48	48	48	48	48	48	48	48	48
6		THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	42	42	42	42	42	42	42	42	42	42	42	42
7		OTHER												
8		(blank)												
9		(blank)												
10														
11														
12														
13														
14														
15														
16														
17														

Better Care Fund 2025-26 Capacity & Demand Template

3.2. C&D Step-up

Selected Health and Wellbeing Board: Norfolk

Step-up **Refreshed capacity surplus:**

Capacity - Demand (positive is Surplus)	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Reablement & Rehabilitation at home	-29	-29	-29	-29	-29	-29	-29	-29	-29	-29	-29	-29
Reablement & Rehabilitation in a bedded setting	0	0	0	0	0	0	0	0	0	0	0	0
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

Please enter refreshed expected capacity:

Capacity - Step-up		Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Service Area	**Metric**												
Reablement & Rehabilitation at home	Monthly capacity. Number of new clients.	381	381	381	381	381	381	381	381	381	381	381	381
Reablement & Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	46	46	46	46	50	45	35	37	55	54	44	46
Other short-term social care	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0

Please enter refreshed expected no. of referrals:

Demand - Step-up	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Service Type												
Reablement & Rehabilitation at home	410	410	410	410	410	410	410	410	410	410	410	410
Reablement & Rehabilitation in a bedded setting	46	46	46	46	50	45	35	37	55	54	44	46
Other short-term social care	0	0	0	0	0	0	0	0	0	0	0	0

BCF Capacity & Demand Template 2025-26

Step Down - Demand

Profiles for 2025-26 have been estimated based on historic reported activity during 2023-24 and 2024-25 captured via NHSE Home First Reporting (previously Sitrep). An estimate has been applied to exclude patients being discharged from the James Paget who live in Waveney (c47.7%).

For Norfolk and Norwich and James Paget, data from Apr 24 to Mar 25 have been used (Mar = estimate). For Queen Elizabeth, data from Jul 24 to Jan 25 have been used due to data quality issues.

Growth assumptions against 2024-25 levels have been applied across each pathway as per trend analysis of emergency admission data over the last 24 months (see BCF Metric 8.1).

For the purposes of this planning return, we have utilised an average profile for each month. More detailed Demand and Capacity work is currently being undertaken through our UEC alliance structures and we plan to refresh the BCF D&C model once this has been completed. This work will factor in seasonal variation and work to reduce any existing backlogs within our acute hospital settings.

Step Down - Capacity

Baseline capacity data has been collated based on historic performance (Apr to Dec 24) across services within the scope of the given definition of intermediate care, as referenced in the BCF guidance. Further capacity to be delivered as part of a confirmed transformation priority within the UEC work plan for 2025-26 has been added based on estimates from relevant commissioners or operational leads.

Therapy services have been included within the estimates. Further work to explore opportunities to expand our therapy offer and align more closely to our reablement pathway to ensure we are making best use of available resources will be completed as a key priority during 2025-26, building on successful work to pilot a "Therapy First" model over the last year.

Where gaps in commissioned capacity have been identified through this process, detailed planning will be undertaken through our three UEC Alliance structures to identify solutions. The usage of spot care and support arrangements will continue to ensure flow is achieved, although our shared focus as a system is to continue to reduce our usage of spot placements through expansion of specific commissioned intermediate care options for local people. This will include building on our successful initiatives implemented during 2024-25 as outlined in our narrative submission, which have reduced the usage of spot care over the last 12 months.

Community Step Up

Services related to UCR have been removed as per BCF Demand and Capacity guidance. Remaining services focus on social care reablement support at home or via a short-term placement within a local care home environment. Again, Demand and Capacity have been calculated based on the last 12 months of activity data.

Notes

Like many systems across the country, it is important to note that there are issues with the quality of available data which make it difficult to reliably profile activity levels. This is particularly true of data from 2023-24 and early 2024-25. Norfolk and Waveney have invested in technological solutions including SHREWD and Optica with the aim of improving data quality and these have had a positive impact.

HM Government

NHS England

Better Care Fund 2025-26 Update Template

1. Guidance

Overview

HWBs will need to submit a narrative plan and a planning template which articulates their goals against the BCF objectives and how they will meet the national conditions in line with the requirements and guidance set out in the table on BCF Planning Requirements (published).

Submissions of plans are due on the 31 March 2025 (noon). Submissions should be made to the national Better Care Fund england.bettercarefundteam@nhs.net and regional Better Care Managers.

This guidance provides a summary of the approach for completing the planning template, further guidance is available on the Better Care Exchange.

Functional use of the template

We are using the latest version of Excel in Office 365, an older version may cause an issue.
Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cells

This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.
Within the BCF submission guidance there will be guidance to support collaborating across HWB on the completion of templates.

Data Sharing Statement

This section outlines important information regarding Data Sharing and how the data provided during this collection will be used. This statement covers how NHS England will use the information provided. Advice on local information governance which may be of interest to ICSs can be seen at https://data.england.nhs.uk/sudgt/ - Please provide your submission using the relevant platform as advised in submission and supporting technical guidance.

2. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. To view pre-populated data for your area and begin completing your template, you should select your HWB from the top of the sheet.

Governance and sign-off
National condition one outlines the expectation for the local sign off of plans. Plans must be jointly agreed and be signed off in accordance with organisational governance processes across the relevant ICB and local authorities. Plans must be accompanied by signed confirmation from local authority and ICB chief executives that they have agreed to their BCF plans, including the goals for performance against headline metrics. This accountability must not be delegated.

Data completeness and data quality:
- Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells in this table are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
- The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear red and contain the word 'No' if the information has not been completed. Once completed the checker column will change to green and contain the word 'Yes'.
- The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
- Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'. Please ensure that all boxes on the checklist are green before submission.

3. Summary

The summary sheet brings together the income and expenditure information, pulling through data from the Income and Expenditure tabs and also the headline metrics into a summary sheet. This sheet is automated and does not require any inputting of data.

4. Income

This sheet should be used to specify all funding contributions to the Health and Wellbeing Boards (HWB) Better Care Fund (BCF) plan and pooled budget for 2025-26. The final planning template will be pre-populated with the NHS minimum contributions, Disabled Facilities Grant and Local Authority Better Care Grant. Please note the Local Authority Better Care Grant was previously referred to as the iBCF. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

Additional Contributions
This sheet also allows local areas to add in additional contributions from both the NHS and LA. You will be able to update the value of any Additional Contributions (LA and NHS) income types locally. If you need to make an update to any of the funding streams, select 'yes' in the boxes where this is asked and cells for the income stream below will turn yellow and become editable. Please use the comments boxes to outline reasons for any changes and any other relevant information.

Unallocated funds
Plans should account for full allocations meaning no unallocated funds should remain once the template is complete.

5. Expenditure

For more information please see tab 5a Expenditure guidance.

6. Metrics

Some changes have been made to the BCF metrics for 2025-26; further detail about this is available in the Metrics Handbook on the Better Care Exchange. The avoidable admissions, discharge to usual place of residence and falls metrics/indicators remain the same. Due to the standing down of the SALT data collection, changes have been made to the effectiveness of reablement and permanent admissions metrics/indicators.

For 2025-26 the planning requirements will consist of 3 headline metrics and for the planning template only the 3 headline metrics will be required to have plans entered. HWB areas may wish to also draw on supplementary indicators and there is scope to identify whether HWB areas are using these indiciators in the Metrics tab. The narrative should elaborate on these headline metrics [and may] also take note of the supplementary indicators. The data for headline metrics will be published on a DHSC hosted metrics dashboard but the sources for each are also listed below:

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
- This is a count of non-elective inpatient spells at English hospitals with a length of stay of at least 1 day, for specific acute treatment functions and patients aged 65+
- This requires inputting of both the planned count of emergency admissions as well as the projection 65+ population figure on monthly basis
- This will then auto populate the rate per 100,000 population for each month
https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65
Supplementary indicators:
Unplanned hospital admissions for chronic ambulatory care sensitive conditions.
Emergency hospital admissions due to falls in people aged 65+.

2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
- This requires inputting the % of total spells where the discharge was on the discharge ready date and also the average length of delay in days for spells where there was a delay.
- A composite measure will then auto calculate for each month described as 'Average length of discharge delay for all acute adult patients'
- This is a new SUS-based measure where data for this only started being published at an LA level since September hence the large number of missing months but early thinking about this metric is encouraged despite the lack of available data.
https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/
Supplementary indicators:
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.
Local data on average length of delay by discharge pathway.

3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)
- This section requires inputting the expected numerator (admissions) of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2024-25. Data for this metric is not yet published, but local authorities will collect and submit this data as part of their SALT returns. You should use this data to populate the estimated data in column H.
- The pre-populated cells use the 23-24 SALT data, but you have an option of using this or local data to use as reference to set your goals.
- The pre-populated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) mid-year population estimates. This is changed from last year to standardize the population figure used.
- The annual rate is then calculated and populated based on the entered information.
https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-outcomes-framework-ascof/england-2023-24
Supplementary indicators:
Hospital discharges to usual place of residence.
Proportion of people receiving short-term reablement following hospital discharge and outcomes following short term reablement.

7. National conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund Policy Framework for 2025-26 (link below) will be met through the delivery of your plan. (Post testing phase: add in link of Policy Framework and Planning requirements)

This sheet sets out the four conditions, where they should be completed and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that the HWB meets expectation. Should 'No' be selected, please note the actions in place towards meeting the requirement and outline the timeframe for resolution.
In summary, the four National conditions are as below:

- National condition 1: Plans to be jointly agreed
- National condition 2: Implementing the objectives of the BCF
- National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)
- National condition 4: Complying with oversight and support processes
- How HWB areas should demonstrate this are set out in Planning Requirements

Better Care Fund 2025-26 Planning Template

2. Cover

Version 1.5

Please Note:
- The BCF planning template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

		Complete:
Health and Wellbeing Board:	Norfolk	Yes
Health and Wellbeing Board ahead of submission -	No	Yes
If no indicate the reasons for the delay.	We are taking the paper to the next available HW	Yes
If no please indicate when the HWB is expected to sign off the plan:	Wed 11/06/2025 << Please enter using the format, DD/MM/YYYY	Yes

Submitted by:	Edward Fraser	Yes
Role and organisation:	Assistant Director Communities & Integration (N	Yes
E-mail:	edward.fraser@norfolk.gov.uk	Yes
Contact number:	01603 223122	Yes
Documents Submitted (please select from drop down)	Narrative	Yes
In addition to this template the HWB are submitting the	C&D National Template	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation	
Health and wellbeing board chair(s) sign off	Health and Wellbeing Board Chair	Cllr	Fran	Whymark	fran.whymark.cllr@norfolk.gov.uk		Yes
	Health and Wellbeing Board Chair						
Named Accountable person	Local Authority Chief Executive	Mr	Tom	McCabe	tom.mccabe@norfolk.gov.uk		Yes
	ICB Chief Executive 1	Ms	Tracey	Bleakley	t.bleakley@nhs.net	Norfolk & Waveney ICB	Yes
	ICB Chief Executive 2 (where required)						
	ICB Chief Executive 3 (where required)						
Finance sign off	LA Section 151 Officer	Mr	Harvey	Bullen	harvey.bullen@norfolk.gov.uk		Yes
	ICB Finance Director 1	Mr	Steven	Course	s.course@nhs.net	Norfolk & Waveney ICB	Yes
	ICB Finance Director 2 (where required)						
	ICB Finance Director 3 (where required)						
Area assurance contacts	Local Authority Director of Adult Social Services	Mr	Ian	Wake	ian.wake@norfolk.gov.uk		Yes
	DFG Lead	Mr	Edward	Fraser	edward.fraser@norfolk.gov.uk		Yes
	ICB Place Director 1	Ms	Karin	Bryant	karin.bryant@nhs.net	Norfolk & Waveney ICB	Yes
Please add any additional key contacts who have been responsible for completing the plan	ICB Place Director 2 (where required)						
	ICB Place Director 3 (where required)						
	Commissioning Manager	Ms	Bethany	Small	bethany.small@nhs.net	Norfolk County Council	
	Commissioning Manager	Ms	Fiona	Butcher	f.butcher1@nhs.net	Norfolk & Waveney ICB	

Assurance Statements

National Condition	Assurance Statement	Yes/No	If no please use this section to explain your response	
National Condition One: Plans to be jointly agreed	The HWB is fully assured, ahead of signing off that the BCF plan, that local goals for headline metrics and supporting documentation have been robustly created, with input from all system partners, that the ambitions indicated are based upon realistic assumptions and that plans have been signed off by local authority and ICB chief executives as the named accountable people.	Yes	Over the past year we have been completing a review of our BCF programme, including how it aligns with national and local priorities. Our Health and Wellbeing Board has signed off on the scope and purpose of the review, and has also refreshed our local priorities. HWB received an update on our plans for the 2025-26 submission 5 March and full sign off is expected in June.	Yes
National Condition Two: Implementing the objectives of the BCF	The HWB is fully assured that the BCF plan sets out a joint system approach to support improved outcomes against the two BCF policy objectives, with locally agreed goals against the three headline metrics, which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans and, following the consolidation of the Discharge Fund, that any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.	Yes		Yes
National Condition Three: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to	The HWB is fully assured that the planned use of BCF funding is in line with grant and funding conditions and that funding will be placed into one or more pooled funds under section 75 of the NHS Act 2006 once the plan is approved	Yes		Yes

adult social care (ASC)	The ICB has committed to maintaining the NHS minimum contribution to adult social care in line with the BCF planning requirements.	Yes		Yes
National Condition Four: Complying with oversight and support processes	The HWB is fully assured that there are appropriate mechanisms in place to monitor performance against the local goals for the 3 headline metrics and delivery of the BCF plan and that there is a robust governance to address any variances in a timely and appropriate manner	Yes		Yes

Data Quality Issues - Please outline any data quality issues that have impacted on planning and on the completion of the plan	
Like many systems across the country, we do face issues with the quality of available data relating to acute hospitals. This has made if challenging when it comes to Demand and Capacity planning and Metric 8.2 in particular. Norfolk and Waveney have invested in technological solutions including SHREWD and Optica with the aim	Yes

green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5. Expenditure	Yes
6. Metrics	Yes
7. National Conditions	Yes

<< Link to the Guidance sheet

^^ Link back to top

Selected Health and Wellbeing Board: Norfolk

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£11,363,322	£11,363,322	£0
NHS Minimum Contribution	£91,452,974	£91,452,974	£0
Local Authority Better Care Grant	£48,875,999	£48,875,999	£0
Additional LA Contribution	£4,776,242	£4,776,242	£0
Additional ICB Contribution	£0	£0	£0
Total	**£156,468,537**	**£156,468,537**	**£0**

Expenditure >>

Adult Social Care services spend from the NHS minimum contribution

	2025-26
Minimum required spend	£41,823,320
Planned spend	£44,785,554

Metrics >>

Emergency admissions

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	1,539	1,695	1,552	1,775	1,591	1,576	1,588	1,581	1,585	1,701	1,666	1,612

Delayed Discharge

	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients	1.35	1.32	1.41	1.35	1.22	1.29	1.21	1.27	1.25	1.34	1.11	1.15

Residential Admissions

		2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	620.0	604.9	590.1	575.0	560.2

Better Care Fund 2025-26 Planning Template

4. Income

Selected Health and Wellbeing Board: Norfolk

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Norfolk	£11,363,322
DFG breakdown for two-tier areas only (where applicable)	
Breckland	£1,649,872
Broadland	£1,257,843
Great Yarmouth	£1,672,706
King's Lynn and West Norfolk	£2,212,174
North Norfolk	£1,680,858
Norwich	£1,605,075
South Norfolk	£1,284,794
Total Minimum LA Contribution (exc Local Authority BCF Grant)	**£11,363,322**

Complete:

Local Authority Better Care Grant	Contribution
Norfolk	£48,875,999
Total Local Authority Better Care Grant	**£48,875,999**

Are any additional LA Contributions being made in 2025-26? If yes, please detail below	Yes

Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Norfolk	£4,776,242	LD&A Health Specialist Services
Total Additional Local Authority Contribution	**£4,776,242**	

Yes

NHS Minimum Contribution	Contribution
NHS Norfolk and Waveney ICB	£91,452,974
Total NHS Minimum Contribution	**£91,452,974**

Are any additional NHS Contributions being made in 2025-26? If yes, please detail below	No

Yes

Additional NHS Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£91,452,974**	

Yes

	2025-26
Total BCF Pooled Budget	**£156,468,537**

Funding Contributions Comments Optional for any useful detail
NCC are making an additional contribution, which represents a further pooling of funding to improve integration across a range of our services for people with Learning Disabilities and Autism. This builds on our existing work to improve overall integration of services across the ICS.

Yes

Better Care Fund 2025-26 Planning Template

5. Expenditure

Selected Health and Wellbeing Board: Norfolk

<< Link to summary sheet

Running Balances	2025-26 Income	Expenditure	Balance
DFG	£11,363,322	£11,363,322	£0
NHS Minimum Contribution	£91,452,974	£91,452,974	£0
Local Authority Better Care Grant	£48,875,999	£48,875,999	£0
Additional LA contribution	£4,776,242	£4,776,242	£0
Additional NHS contribution	£0	£0	£0
Total	**£156,468,537**	**£156,468,537**	**£0**

Required Spend

This is in relation to National Conditions 3 only. It does NOT make up the total NHS Minimum Contribution (on row 10 above).

	2025-26 Minimum Required Spend	Planned Spend	Unallocated
Adult Social Care services spend from the NHS minimum allocations	£41,823,320	£44,785,554	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes

Scheme ID	Activity	Description of Scheme	Primary Objective	Area of Spend	Provider	Source of Funding	Expenditure for 2025-26 (£)	Comments (optional)
1	Wider local support to promote prevention and independence	Norfolk Advice Network and Advocacy Partnership	6. Reducing the need for long term residential care	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 280,004	
2	Support to carers, including unpaid carers	A Social Impact Bond for Carers	3. Supporting unpaid carers	Social Care	Private Sector	NHS Minimum Contribution	£ 1,564,150	
4	Wider local support to promote prevention and independence	Dementia / Alzheimer's Support Service (DSS)	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 1,271,615	
8	Urgent community response	West Norfolk Frailty and Community Admissions Avoidance Service	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 2,193,450	
9	Assistive technologies and equipment	ICES (Integrated Community Equipment Service)	2. Home adaptations and tech	Community Health	Private Sector	NHS Minimum Contribution	£ 8,997,882	
10	Long-term home-based community health services	Integrated Care Coordinators	1. Proactive care to those with complex needs	Primary Care	Local Authority	NHS Minimum Contribution	£ 835,146	
11	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Intermediate Spot Purchase Beds	5. Timely discharge from hospital	Community Health	NHS	NHS Minimum Contribution	£ 1,731,178	
13	Discharge support and infrastructure	Community Access Team (CAT)	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 1,152,626	
14	Assistive technologies and equipment	Medical Loans Service	5. Timely discharge from hospital	Community Health	NHS	NHS Minimum Contribution	£ 147,136	
16	Wider local support to promote prevention and independence	Norfolk Medicines Support Service (NMSS)	1. Proactive care to those with complex needs	Community Health	Private Sector	NHS Minimum Contribution	£ 306,888	
17	Wider local support to promote prevention and independence	Equal Lives	1. Proactive care to those with complex needs	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 125,568	
20	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Norfolk First Response	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 11,014,972	
21	Urgent community response	Rapid Response (part of Swifts and Nightowls)	4. Preventing unnecessary hospital admissions	Social Care	Local Authority	NHS Minimum Contribution	£ 1,739,321	
26	Long-term home-based community health services	Neuro Cardiac & Pulmonary Support Services	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 563,124	
27	Long-term home-based community health services	Specialist Nursing Teams	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 568,085	

29	Wider local support to promote prevention and independence	Norfolk and Norwich SEND Association	1. Proactive care to those with complex needs	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 16,640	
32	Wider local support to promote prevention and independence	Together	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 401,367	
33	Wider local support to promote prevention and independence	Central Norfolk NEAT	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 697,395	
34	Discharge support and infrastructure	Discharge Practitioner Services	5. Timely discharge from hospital	Continuing Care	Local Authority	NHS Minimum Contribution	£ 79,843	
38	Wider local support to promote prevention and independence	Eating Matters	1. Proactive care to those with complex needs	Mental Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 156,098	
46	Discharge support and infrastructure	GP / Medical cover - Int Care Beds (West Norfolk)	5. Timely discharge from hospital	Primary Care	NHS	NHS Minimum Contribution	£ 35,295	
51	Long-term home-based community health services	Learning Disability Beds	5. Timely discharge from hospital	Continuing Care	Private Sector	NHS Minimum Contribution	£ 707,771	
56	Housing related schemes	District Direct	5. Timely discharge from hospital	Acute	Local Authority	NHS Minimum Contribution	£ 632,963	
60	Bed-based intermediate care (short-term bed-based rehabilitation, reablement and recovery services)	Out of hospital / Short Term offer	5. Timely discharge from hospital	Social Care	Local Authority	NHS Minimum Contribution	£ 9,154,909	
64	Long-term home-based social care services	LD, MH and Autism Packages of Care (Home Support)	6. Reducing the need for long term residential care	Social Care	Private Sector	NHS Minimum Contribution	£ 3,564,910	
65	Wider local support to promote prevention and independence	Proactive Intervention & Prevention Services	6. Reducing the need for long term residential care	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 1,031,156	
90	Long-term home-based social care services	Independent Mental Health & Capacity Advocacy SLAs	1. Proactive care to those with complex needs	Social Care	Charity / Voluntary Sector	NHS Minimum Contribution	£ 920,032	
91	Discharge support and infrastructure	Norfolk & Waveney Community Support Service	5. Timely discharge from hospital	Acute	Charity / Voluntary Sector	NHS Minimum Contribution	£ 478,917	
92	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Caring for Better Outcomes	5. Timely discharge from hospital	Social Care	Private Sector	NHS Minimum Contribution	£ 864,644	
98	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Discharge P2 Capacity Beds	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 3,835,740	
99	Discharge support and infrastructure	HomeFirst Hubs (West, Central and East) LA	5. Timely discharge from hospital	Community Health	Local Authority	NHS Minimum Contribution	£ 2,277,808	
100	Discharge support and infrastructure	HomeFirst Hubs (West, Central and East) NHS Community	5. Timely discharge from hospital	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 1,307,018	
101	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Bridging the Gap P1 Capacity Beds East	5. Timely discharge from hospital	Community Health	Local Authority	NHS Minimum Contribution	£ 170,000	
102	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Bridging the Gap P1 Capacity Beds Central	5. Timely discharge from hospital	Community Health	Private Sector	NHS Minimum Contribution	£ 348,000	
103	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Bridging the Gap P1 Capacity Beds West	5. Timely discharge from hospital	Community Health	NHS Acute Provider	NHS Minimum Contribution	£ 401,510	
104	Urgent community response	NCHC Urgent community response service (UCR)	1. Proactive care to those with complex needs	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 4,470,308	
301	Long-term home-based community health services	Community Nursing and Therapy (CN&T) - Central Norfolk and West Norfolk	4. Preventing unnecessary hospital admissions	Community Health	NHS Community Provider	NHS Minimum Contribution	£ 8,930,369	
302	Long-term home-based community health services	Community Nursing and Therapy (CN&T) - East Norfolk and Waveney	4. Preventing unnecessary hospital admissions	Community Health	NHS	NHS Minimum Contribution	£ 2,904,327	
1901	End of Life Care	Norfolk Hospice Tapping House (NHTH) - West Norfolk	1. Proactive care to those with complex needs	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 687,886	

1902	End of Life Care	Swaffham & Litcham Home Hospice (social support) - West Norfolk	1. Proactive care to those with complex needs	Community Health	Charity / Voluntary Sector	NHS Minimum Contribution	£ 55,565	
4701	Wider local support to promote prevention and independence	ASD / ADHD / Asperger's Pre-Diagnostic Support Service	1. Proactive care to those with complex needs	Mental Health	NHS	NHS Minimum Contribution	£ 199,600	
4702	Wider local support to promote prevention and independence	Autism Service (Norfolk)	1. Proactive care to those with complex needs	Mental Health	NHS	NHS Minimum Contribution	£ 105,870	
6401	Long-term residential/nursing home care	LD, MH and Autism Packages of Care (Residential Care)	1. Proactive care to those with complex needs	Social Care	Private Sector	NHS Minimum Contribution	£ 14,305,888	
106	Wider local support to promote prevention and independence	Local Area Co-ordination / Integrated Neighbourhood Teams	1. Proactive care to those with complex needs	Social Care	Local Authority	NHS Minimum Contribution	£ 220,000	

5a. Expenditure Guidance

Guidance for completing Expenditure sheet

How do we calcute the ASC spend figure from the NHS minimum contribution total?

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS minimum:

- **Area of spend** selected as 'Social Care' and **Source of funding** selected as 'NHS Minimum Contribution'

The requirement to identify which primary objective scheme types are supporting is intended to provide richer information about the services that the BCF supports. Please select [from the drop-down list] the primary policy objective which the scheme supports. If more than one policy objective is supported, please select the most relevant. Please note The Local Authority Better Care Grant was previously referred to as the iBCF.

On the expenditure sheet, please enter the following information:
1. Scheme ID:
- Please enter an ID to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Activity:
- Please select the Activity from the drop-down list that best represents the type of scheme being planned. These have been revised from last year to try and simplify the number of categories. Please see the table below for more details.
3. Description of Scheme:
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.
4. Primary Objective:
- Sets out what the main objective of the scheme type will be. These reflect the six sub objectives of the two overall BCF objectives for 2025-26. We recognise that scheme may have more than one objective. If so, please choose one which you consider if likely to be most important.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
6. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the NHS or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
8. Expenditure (£)2025-26:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
9. Comments:
Any further information that may help the reader of the plan. You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance.

2025-26 Revised Scheme Types

Number	Activity (2025-26)	Previous scheme types (2023-25)	Description
1	Assistive technologies and equipment	Assistive technologies and equipment Prevention/early intervention	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	Housing related schemes Prevention/early intervention	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.

4	Wider support to promote prevention and independence	Prevention/early intervention	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing
5	Home-based intermediate care (short-term home-based rehabilitation, reablement and recovery services)	Home-based intermediate care services Home care or domiciliary care Personalised care at home Community based schemes	Includes schemes which provide support in your own home to improve your confidence and ability to live as independently as possible Also includes a range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Personalised care at home	Short-term schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period.
7	Long-term home-based social care services	Personalised care at home	Long-term schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient or to deliver support over the longer term to maintain independence.
8	Long-term home-based community health services	Community based schemes	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Bed-based intermediate care services (reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
10	Long-term residential or nursing home care	Residential placements	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	High Impact Change Model for Managing Transfer of Care	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/ Discharge to Assess process support/ core costs.
12	End of life care	Personalised care at home	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home for end of life care.
13	Support to carers, including unpaid carers	Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
14	Evaluation and enabling integration	Care Act implementation and related duties Enablers for integration High Impact Change Model for Managing Transfer of Care Integrated care planning and navigation Workforce recruitment and retention	Schemes that evaluate, build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Schemes may include: - Care Act implementation and related duties - High Impact Change Model for Managing Transfer of Care - where services are not described as "discharge support and infrastructure" - Enablers for integration, including schemes that build and develop the enabling foundations of health, social care and housing integration, and joint commissioning infrastructure. - Integrated care planning and navigation, including supporting people to find their way to appropriate services and to navigate through the complex health and social care systems; may be online or face-to-face. Includes approaches such as Anticipatory Care. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated plans, typically carried out by professionals as part of an MDT. - Workforce recruitment and retention, where funding is used for incentives or activity to recruit and retain staff or incentivise staff to increase the number of hours they work.
15	Urgent Community Response	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2025-26 Planning Template

6. Metrics for 2025-26

Selected Health and Wellbeing Board: Norfolk

8.1 Emergency admissions

		Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	Complete:
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,514	1,568	1,491	1,566	1,504	1,467	1,506	1,527	n/a	n/a	n/a	n/a	As a baseline position we are profiling a 5.3% increase against this metric over the next 12 months as compared to 2024-25. This has been predicted based on growth observed over the previous 24 months of actual activity data. Further work is underway through the UEC alliances to ensure profiling links into operational planning and priorities.	Yes
	Number of Admissions 65+	3495	3,620	3,440	3,615	3,470	3,385	3,475	3,525	n/a	n/a	n/a	n/a		
	Population of 65+*	230,794	230,794	230,794	230,794	230,794	230,794	230,794	230,794	n/a	n/a	n/a	n/a		
		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
	Rate	1,539	1,695	1,552	1,775	1,591	1,576	1,588	1,581	1,585	1,701	1,666	1,612		
	Number of Admissions 65+	3551	3912	3581	4097	3671	3638	3665	3649	3658	3926	3845	3721		Yes
	Population of 65+	230,794	230,794	230,794	230,794	230,794	230,794	230,794	230,794	230,794	230,794	230,794	230,794		

Source: https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Unplanned hospital admissions for chronic ambulatory care sensitive conditions. Per 100,000 population.	Rate	Yes	Yes
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Rate	Yes	Yes

8.2 Discharge Delays

*Dec Actual onwards are not available at time of publication

	Apr 24 Actual	May 24 Actual	Jun 24 Actual	Jul 24 Actual	Aug 24 Actual	Sep 24 Actual	Oct 24 Actual	Nov 24 Actual	Dec 24 Actual	Jan 25 Actual	Feb 25 Actual	Mar 25 Actual	Rationale for how local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	n/a	n/a	n/a	n/a	n/a	0.89	0.91	1.03	n/a	n/a	n/a	n/a	Estimates have been based on NHS Operational Planning returns and sense checked against available benchmarking data. We are planning to drive sustained improvement against this metric through successful delivery of the UEC priorities outlined in our Narrative Plan and further detailed planning work is underway within each of our three UEC alliances to align operational planning assumptions to our transformation programmes. Through profiling we have identified data quality issues that we will be working with local partners to resolve as a key priority.	Yes
Proportion of adult patients discharged from acute hospitals on their discharge ready date	n/a	n/a	n/a	n/a	n/a	83.8%	82.8%	82.5%	n/a	n/a	n/a	n/a		
For those adult patients not discharged on DRD, average number of days from DRD to discharge	n/a	n/a	n/a	n/a	n/a	5.5	5.3	5.9	n/a	n/a	n/a	n/a		
	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan		
Average length of discharge delay for all acute adult patients	1.35	1.32	1.41	1.35	1.22	1.29	1.21	1.27	1.25	1.34	1.11	1.15		
Proportion of adult patients discharged from acute hospitals on their discharge ready date	80.2%	80.9%	80.1%	81.0%	82.7%	82.0%	82.4%	82.2%	82.5%	81.3%	83.3%	83.0%		Yes

For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.84	6.90	7.09	7.09	7.05	7.17	6.83	7.16	7.15	7.16	6.66	6.74		Yes

Source: https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Patients not discharged on their DRD, and discharged within 1 day, 2-3 days, 4-6 days, 7-13 days, 14-20 days and 21 days or more.	Number of patients	Yes	Yes
Local data on average length of delay by discharge pathway.	Number of days	Yes	Yes

8.3 Residential Admissions

		2023-24 Actual	2024-25 Plan	2024-25 Estimated	2025-26 Plan Q1	2025-26 Plan Q2	2025-26 Plan Q3	2025-26 Plan Q4		Rationale for how the local goal for 2025-26 was set. Include how learning and performance to date in 2024-25 has been taken into account, impact of demographic and other demand drivers. Please also describe how the ambition represents a stretching target for the area.	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	568.0	554.2	620.0	604.9	590.1	575.0	560.2		These data are based on previous years performance, taking in to account other local areas achievements to benchmark ourselves against. We are confident that the positive progress we have made to develop our intermediate care options (both home and bed-based) will enable us to meet these plans, as outlined in our Narrative Plan.	Yes
	Number of admissions	1311	1279	1,431	1,396	1,362	1,327	1,293			Yes
	Population of 65+*	230,794	230,794	230,794	230,794	230,794	230,794	230,794			

Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population are based on a calendar year using the latest available mid-year estimates.

Supporting Indicators		Have you used this supporting indicator to inform your goal?	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	Percentage	Yes	Yes
The proportion of people who received reablement during the year, where no further request was made for ongoing support	Rate	Yes	Yes

Better Care Fund 2025-26 Update Template

7: National Condition Planning Requirements

Health and wellbeing board: Norfolk

National Condition	Planning expectation that BCF plan should:	Where should this be completed	HWB submission meets expectation	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution	Complete:
1. Plans to be jointly agreed	Reflect local priorities and service developments that have been developed in partnership across health and care, including local NHS trusts, social care providers, voluntary and community service partners and local housing authorities	Planning Template - Cover sheet Narrative Plan - Overview of Plan	Yes			Yes
	Be signed off in accordance with organisational governance processes across the relevant ICB and local authorities	Planning Template - Cover sheet	Yes			Yes
	Must be signed by the HWB chair, alongside the local authority and ICB chief executives – this accountability must not be delegated	Planning Template - Cover sheet	Yes	HWB sign off in June	30/06/2025	Yes
2. Implementing the objectives of the BCF	Set out a joint system approach for meeting the objectives of the BCF which reflects local learning and national best practice and delivers value for money	Narrative Plan - Section 2	Yes			Yes
	Set goals for performance against the 3-headline metrics which align with NHS operational plans and local authority adult social care plans, including intermediate care capacity and demand plans	Planning Template - Metrics	Yes			Yes
	Demonstrate a 'home first' approach and a shift away from avoidable use of long-term residential and nursing home care	Narrative Plan - Section 2	Yes			Yes
	Following the consolidation of the previously ring-fenced Discharge Fund, specifically explain why any changes to the use of the funds compared to 2024-25 are expected to enhance urgent and emergency care flow (combined impact of admission avoidance and reducing length of stay and improving discharge)	Narrative Plan - Section 2	Yes			Yes
3. Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC)	Set out expenditure against key categories of service provision and the sources of this expenditure from different components of the BCF	Planning Template - Expenditure	Yes			Yes
	Set out how expenditure is in line with funding requirements, including the NHS minimum contribution to adult social care					
4. Complying with oversight and support processes	Confirm that HWBs will engage with the BCF oversight and support process if necessary, including senior officers attending meetings convened by BCF national partners.	Planning Template - Cover	Yes			Yes
	Demonstrate effective joint system governance is in place to: submit required quarterly reporting, review performance against plan objectives and performance, and change focus and resourcing if necessary to bring delivery back on track	Narrative Plan - Executive Summary	Yes			Yes

Report to Norfolk Health and Wellbeing Board

Item No: 11

Report title: NHS Norfolk and Waveney Integrated Care Board Annual Report 2024/25

Date of meeting: 11 June 2025

Sponsor (HWB member): Ed Garratt, Interim Chief Executive, NHS Norfolk and Waveney Integrated Care Board

Reason for the Report

NHS Integrated Care Boards (ICBs) must include a narrative in their annual reports about how they have contributed to the delivery of the priorities of their local Health and Wellbeing Boards (HWBs). HWBs must also be consulted in the preparation of these narratives.

Report summary

NHS Norfolk and Waveney ICB has drafted the narrative set out in this paper for their 2024/25 annual report, outlining how they have supported and contributed to delivering the priorities of the Norfolk and Suffolk Health and Wellbeing Boards (as set out in their respective Joint Health and Wellbeing Strategies).

Recommendations

The HWB is asked to:

a) Comment on the draft narrative and propose any amendments they would like to make.

1. Background

1.1 NHS integrated care boards (ICBs) are required to consult HWBs about the part of their annual report which sets out how they have contributed towards delivering local joint health and wellbeing strategies.

1.2 This paper provides an extract of NHS Norfolk and Waveney Integrated Care Board's (ICB) draft annual report for 2024/25. It outlines how the ICB has contributed towards delivering the Norfolk Joint Health and Wellbeing Strategy, and by default as they are the one and the same document, the Norfolk and Waveney Integrated Care Strategy.

1.3 The ICB is sharing the below extract with the Board for comment. The final version of the ICB's annual report for 2024/25 is not due to be submitted to NHS England until June 2025. The narrative remains draft and subject to minor changes until then.

2. The draft narrative

2.1 **Here is the draft extract from NHS Norfolk and Waveney ICB's annual report for 2024/25:**

2.2 **Joint Health and Wellbeing Strategies**
NHS Norfolk and Waveney ICB is an active member of both the Norfolk and Suffolk Health and Wellbeing Boards. The ICB has worked to support the four priorities in Norfolk's Joint Health and Wellbeing Strategy, as well as the cross-cutting themes in Suffolk's strategy.

2.3 **Norfolk priority: Driving integration**
Suffolk cross-cutting theme: Greater collaboration and system working

2.4 The ICB has continued to work with partners to develop and strengthen our Integrated Care System over the past year. Our Joint Forward Plan sets out how the local NHS and care services will implement our Integrated Care Strategy / the Norfolk Joint Health and Wellbeing Strategy.

2.5 As a system, we have delivered and made progress with a wide range of projects and changes that have and will improve the health, wellbeing and care of local people. The ICB has played an important role as a convenor, bringing together partners from across the system and providing skills and expertise, data and insight to enable us to transform how we care for local people. Examples include:

- **Working as a system to treat people in the community and preventing them from being taken to hospital in an ambulance when they don't need to be:** Our Unscheduled Care Coordination Hub brings together colleagues from different organisations who work together to help people who call 999 that could be better cared for by community services instead of being taken to a hospital by ambulance. The service has had an impressive first year, helping over 10,000 patients and preventing more than 7,500 unnecessary ambulance dispatches.

- **Sharing data better to make it easier for frontline health and care professionals to understand people's conditions and to treat them:** For example, the Norfolk and Waveney Shared Care Record is now used by over 2,000 staff daily, providing access to critical patient information for 12,000 people. This system has streamlined care, ensuring healthcare professionals can make faster and better-informed decisions while reducing the need for patients to repeat their medical history.

2.6 While our Integrated Care System is not fundamentally about structures and governance, to achieve our mission and to deliver more projects and changes like these, it is vital that we have the right foundations and ways of working in place. The ICB concluded an organisational review in 2024/25 and implemented a new structure and operating model that supports greater collaboration and system working.

2.7 As a system, we are strengthening integration at all levels. The ICB has:

- Continued to support the development of our Primary Care Networks (PCNs) and integrating our workforce.
- Worked with partners to continue to develop our five Place Boards, which bring together colleagues from across health and care to integrate services at a more local level.
- Been an active partner in the eight local health and wellbeing partnerships, working with district councils, VCSE organisations and others to address the wider determinants of health.
- Continued to contribute to the development of our Integrated Care Partnership and both Norfolk and Suffolk's Health and Wellbeing Boards.
- Supported greater collaboration between providers, including the development of the Norfolk and Waveney University Hospitals Group and the coming together of Cambridgeshire Community Services NHS Trust and Norfolk Community Health and Care NHS Trust.

2.8 **Norfolk priority: Prioritising prevention**
Suffolk cross-cutting theme: Prevention: stabilising need and demand

2.9 This year we have made significant progress in delivering the priorities set out in our Population Health Management strategy. The strategy focuses on using joined-up data and intelligence to identify and understand the health and care needs of the local population, allowing for targeted interventions that improve health outcomes and reduce inequalities. By prioritising prevention and collaboration, the programme empowers professionals to help people live healthier, more independent lives.

2.10 A major achievement has been the development of the infrastructure needed to support this work, including specialist software, analytical tools, and data dashboards to help colleagues across the Integrated Care System to review population health data and track progress against key priorities.

2.11 We have continued to develop Protect NoW, which is a collaboration between NHS organisations, local authorities, the voluntary sector and independent partners aimed at improving physical and mental health through proactive support. Several targeted projects have been successfully delivered, including improving access to talking therapies for older adults and those at risk of falls, and the Dementia North Norfolk initiative, which connects people affected by dementia with services such as housing support, benefits advice, social activities, and carers' support.

2.12 **Norfolk priority: Addressing inequalities**
Suffolk cross-cutting theme: Reducing inequalities

2.13 As a system, we are committed to working together to tackle unfair and avoidable differences in health outcomes between residents. We do this by listening to communities, prioritising prevention, and taking action together, making health inequalities everybody's business.

2.14 The ICB works with partners to reduce health inequalities by:

- Using population health management techniques.
- Improving access to services.
- Collaborating through our place boards and local health and wellbeing partnerships.
- Having a Patients and Communities Committee, whose remit includes examining how the ICB is reducing health inequalities.

2.15 A key step we have taken this year has been to finalise and start to implement our Norfolk and Waveney Health Inequalities Strategic Framework for Action, which sets out the actions we are going to take as a system to tackle health inequalities.

2.16 **Norfolk priority: Enabling resilient communities**
Suffolk cross-cutting theme: Connected, resilient and thriving communities

2.17 The ICB is committed to supporting people to live independent healthy lives in their community for as long as possible, through promotion of self-care, early intervention and digital technology where appropriate. As set out above, we are using population health management techniques to provide more anticipatory care and early intervention. We are also using technology to empower people to manage their health and wellbeing better, for example by giving people greater visibility and control over their treatment and care journeys.

2.18 Vital to creating more resilient communities is working with the voluntary, community, faith and social enterprise sector. The ICB values the work of the sector and wants to work with the sector as a trusted partner, including through the VCSE Assembly which the ICB has established with both the sector and other partners.

Officer Contact

If you have any questions about matters contained in this paper please get in touch with:

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Report to Norfolk and Waveney Integrated Care Partnership

Item No: 7

Report title: Norfolk & Waveney NHS System Capital Distribution for 2025/2026

Date of meeting: 11 June 2025

Sponsor (ICP member): Ed Garratt, Interim Chief Executive, NHS Norfolk & Waveney Integrated Care Board

Reason for the Report

The purpose of this report is to inform the Integrated Care Partnership (ICP) of the NHS Norfolk and Waveney System Capital Departmental Expenditure Limit (CDEL) proposal to distribute the system resource to the Norfolk and Waveney organisations for capital infrastructure investment.

Report summary

The report highlights the process and progress made by the NHS in distributing £173.5m of available capital resource (System CDEL & "notional" allocations CDEL) for 2025/26. The proposed distribution by organisation is:

- James Paget University Hospital (JPUH) - £30.7m
- Norfolk and Norwich University Hospital (NNUH) - £59.6m
- Queen Elizabeth Hospital (QEH) - £58.9m
- Norfolk and Suffolk Foundation Trust (NSFT) - £13.2m
- Norfolk Community Health and Care (NCHC) - £7.8m
- Norfolk and Waveney Integrated Care Board (ICB) - £3.3m
- Total draft distribution of resource - £173.5m

In addition to system & "notional" allocations CDEL, system partners have a number of schemes and programmes funded from central NHS programmes. These programmes are agreed at national level and are for specific nationally support infrastructure developments. Once these programmes are approved, N&W ICB has no discretion or ability to redistribute these resources as these are managed at a national level. The central programme capital funds for the N&W ICB by programme for 2025/26 are as follows:

- National Hospitals Programme - £81.6m
- Digital/EPR - £27.7m
- Diagnostic (stroke thrombectomy equip.) - £3.7m
- Total central programme resource - £113.0m

The total capital resource for the N&W ICB for 2025/26 is £286.5m (System CDEL of £104.9m, "notional" CDEL allocations of £68.6m & Central Programme CDEL of £113.0m).

Recommendations

The ICP is asked to:

a) Receive and endorse the proposed NHS distribution of the NHS system Capital Departmental Expenditure Limit (CDEL) resource to deliver organisational and system capital plans.
b) Receive and endorse the proposed NHS distribution of the notional CDEL resource for Critical Infrastructure Risk, Return to Constitutional Standards, Primary Care Utilisation and Mental Health out of Area Placements.
c) Receive and note the sums assigned to Norfolk & Waveney NHS organisations for the 2025/26 central NHS programmes.

1. Background

1.1 The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act) sets out that an Integrated Care Board (ICB) and its partner NHS trusts and foundation trusts:

- Must before the start of each financial year, prepare a plan setting out their planned capital resource use.
- Must publish that plan and give a copy to their Integrated Care Partnership, Health and Wellbeing Board and NHS England.
- May revise the published plan – but if they consider the changes significant, they must re-publish the whole plan; if the changes are not significant, they must publish a document setting out the changes.

1.2 To support ICBs in meeting these requirements of the amended 2006 Act, ICB joint capital resource use plan templates will be issued to systems via the Public Financial Management System (PFMS) ICB portal inboxes.

2. The Norfolk and Waveney 2025/26 Distribution of Capital Resource for Capital Infrastructure

2.1 As per the above, the NHS is required to present its 2025/26 capital plan to the ICP. With regard to the identification, prioritisation and distribution process for investment, this report will only consider the system CDEL & “notional” CDEL allocations. The reason for this is because it is only these sums that are for system discretion as to allocation. N&W ICB has no discretion or ability to redistribute the Primary Care Estate & Digital funds, Primary Care Utilisation funding or the provider central programme funded schemes between providers. Once approved nationally, these programmes are managed at a national level.

2.2 Norfolk and Waveney NHS Provider organisations are all members of the Norfolk and Waveney Strategic Capital Board (SCB). This sub-committee of the NHS Finance Committee is where the prioritisation of capital proposals are considered, prioritisations are agreed and capital resource is proposed for distribution to enable the organisational delivery of capital schemes.

2.3 The available capital resources for the Norfolk and Waveney NHS ICB system distribution, as per the NHS planning financial settlements is £56.8m (including funding to support the impact of changes in lease accounting as per to IFRS

16), in addition £46.1m is specifically identified for the RAAC remedial works at JPUH & QEH and £2m is ringfenced for the ICB re: Primary Care Estate & Digital.

2.4 Due to central programme funding constraints, N&W SCB has agreed to contribute system CDEL of £5.6m to the Acute Electronic Patient Record (EPR) programme:

2.5 The consequence of this agreement means that £51.2m of CDEL is available for the remaining capital priorities across N&W organisations.

2.6 For 2025/26 the SCB received the prioritised programmes from each NHS organisation. As per the agreed process of the SCB, for the above requests each organisation prioritised their proposals in the categories of:

1) Prior Commitment/already agreed and commenced.
2) Legal/statutory compliance requirements including Care Quality Commission (CQC) compliance "Must Do".
3) System wide strategic priority schemes.
4) Other "local" schemes.

2.7 Items specifically idented in 1 and 2 are prioritised as first call on the CDEL resource. Items categorised in 3 or 4 are individually assessed and given a score of one to ten (ten high) on three categories with a weighting as per the below:

2.8 **Patient and public safety – 60% Weighting**

- Addressing current high risks relating to one or more of the following areas, which cannot be mitigated through alternative routes at lower cost e.g.
- Clinical safety (not clinical quality), i.e. where there is high risk of patient harm.
- Health and safety of patients, staff and/or visitors.
- Fire safety.
- Cyber security.
- Regulatory instruction in relation to safe patient care, e.g. CQC 'must do'.

2.9 **Maintaining an acceptable level of service quality – 30% Weighting**

- Addressing current high risks, for existing services, relating to one or more of the following areas, which cannot be mitigated through alternative routes at lower cost.
- Clinical quality which adversely impact patient experience but do not carry high risk of patient harm.
- Service continuity.
- Regulatory instruction in relation to quality of patient care, e.g. CQC 'should do'.

2.10 **Business case (strategic and financial case) – 10% Weighting**

- A sound case for investment based on strategic fit and financial case.

2.11 Utilising this process all capital scheme proposals are able to be ranked, prioritised and assessed to ensure key system risks are addressed via the distribution of system capital resource funding.

2.12 Due to the limitations of the resource availability a number of iterations were undertaken by the SCB, reviewing and considering the prioritisation work. Ultimately though to enable the alignment of CDEL to organisational cash balances i.e. that pay for the purchase of capital assets and infrastructure, the resource needs to be considered against the proportional %s of organisational depreciation charges.

2.13 The proportions of depreciation charges (excluding IFRS 16 asset depreciation) for each organisation, are as follows: JPUH 18%, NNUH 30%, QEH 20%, NSFT 18% and NCHC 14%.

2.14 The proportions of depreciation charges associated with IFRS 16 assets for each organisation, are as follows: JPUH 9%, NNUH 73%, QEH 3%, NSFT 12% and NCHC 3%.

2.15 The proposed distribution of System CDEL for each organisation for 2025/26 is shown in the table:

Norfolk and Waveney Capital Plan prioritisation	**JPUH**	**NNUH**	**QEH**	**NSFT**	**NCHC**	**ICB**	**Total Funds**
System CDEL	£7.3m	£12.2m	£8.1m	£7.3m	£5.7m	£0.0	£40.6m
System IFRS 16 CDEL	£0.9m	£7.7m	£0.3m	£1.3m	£0.4m	£0.0	£10.6m
Acute Patient Record (EPR)	£1.2m	£3.2m	£1.2m	£0.0	£0.0	£0.0	£5.6m
System CDEL Sub total	£9.4m	£23.1m	£9.6m	£8.6m	£6.1m	£0.0	£56.8m
RAAC remedial works	£9.9m	£0.0	£36.2m	£0.0	£0.0	£0.0	£46.1m
Primary Care Estate & Digital	£0.0	£0.0	£0.0	£0.0	£0.0	£2.0m	£2.0m
Total cost	£19.3m	£23.1m	£45.8m	£8.6m	£6.1m	£2.0m	£104.9m

3. 2025/26 Notional System CDEL Programme Funding

3.1 In addition to the core system CDEL, IFRS 16 & RAAC funding for 2025/26 the system has been allocated a number of “notional” sums to address specific system issues regarding infra structure risk and developments. These are:

1) Estates Safety (inc. Trusts with reported Maternity/Neonatal Safety Compliance Issues)
2) Constitutional Standards Recovery (Diagnostics, Elective Recovery and UEC)
3) Primary Care – Better Utilisation
4) Mental Health Out of Area Placements

3.2 **Estates Safety (inc. Trusts with reported Maternity/Neonatal Safety Compliance Issues):** The government has allocated £750m nationally for estates safety in 2025/26 to address high-priority estate issues across NHS systems. This funding is intended to mitigate critical infrastructure and safety risks, addressing the poorest quality estates and ensuring a safe, sustainable environment for healthcare delivery. The N&W “notional” share of this funding is

£10.1m and final allocations for systems will be decided centrally, based on the quality and strategic value of proposals received.

3.3 **Constitutional Standards Recovery (Diagnostics, Elective Recovery and UEC):** The 2025/26 national settlement includes £1.35bn for investments aimed at improving NHS performance against constitutional standards. This is split indicatively £0.45bn for **diagnostics**, £0.33bn for **electives** and £0.58bn for **Urgent & Emergency Care** (**UEC)**.

3.3.1 For N&W the "notional" share of the diagnostics funding is £0.750m. The funding is to provide upgraded MRI acceleration software to all eligible machines c. £150k and the balance to be used for physiological sciences to create a targeted increase in acute capacity, especially for echo and audiology to improve 6-week wait performance.

3.3.2 For N&W the "notional" share of the Elective funding is £27.750m. The funding has been allocated to complete the stalled Norfolk & Norwich Orthopaedic Centre II project at NNUH.

3.3.3 For N&W the "notional" share of the UEC funding is £28.750m. The first call on this funding £2.25m is for the completion of the SDEC scheme at JPUH. The balance is to support improvements in UEC performance including MH patients that spend unacceptable lengths of time in acute Emergency Departments.

3.4 **Primary Care – Better Utilisation:** The Primary Care Utilisation & Modernisation Fund provides new capital funding of £102 million to support improvements in the primary care estate. The fund aims to enhance the use of existing infrastructure, create additional capacity for the GP workforce, and increase the number of patient appointments available. For N&W the "notional" share of this funding is £1.9m.

3.5 **Mental Health Out of Area Placements:** N&W have also a notional allocation to support developments in Mental Health out of Area Placements. For N&W the "notional" share of this is £1m. The proposed distribution of "notional" allocations CDEL for each organisation for 2025/26 is shown in the table:

Norfolk and Waveney Capital Plan "notional" allocations	**JPUH**	**NNUH**	**QEH**	**NSFT**	**NCHC**	**ICB**	**Total Funds**
Estate Safety (CIR)	£1.4m	£3.0m	£3.0m	£1.3m	£1.4m	£0.0	£10.1m
Diagnostics (Return Constitutional Standards)	£0.2m	£0.3m	£0.2m	£0.0	£0.0	£0.0	£0.7m
Electives (Return Constitutional Standards)	£0.0	£27.8m	£0.0	£0.0	£0.0	£0.0	£27.8m
Urgent & Emerg. Care (UEC) (Return Constitutional Standards)	£9.8m	£5.4m	£9.9m	£2.3m	£0.3m	£0.0	£27.7m
Primary Care Utilisation	£0.0	£0.0	£0.0	£0.0	£0.0	£1.3m	£ 1.3m
MH Out of Area Placements	£0.0	£0.0	£0.0	£1.0	£0.0	£0.0	£1.0m
Total cost	£11.4m	£36.5m	£13.1m	£4.6m	£1.7m	£1.3m	£68.6m

4. 2025/26 Central Programme Funding

4.1 In addition to system CDEL, system partners are able to bid and obtain funding for specific infrastructure funding from “central programmes”. These programmes are agreed at national level and are for specific nationally supported infrastructure developments. The table below shows these central programme capital funds by organisation for 2025/26.

Central Programme Title	JPUH	NNUH	QEH	NSFT	Total Funds
National Hospitals Programme	£14.9	£0.0	£66.7m	£0.0	£ 81.6m
Digital/EPR	£6.3m	£14.4m	£6.1m	£0.9m	£ 27.7m
Diagnostic (stroke thrombectomy equip.)	£0.0m	£3.7m	£0.0	£0.0	£ 3.7m
Central Programme Total	£21.2m	£18.1m	£72.8m	£0.9m	£113.0m

4.2 Once agreed between organisations and the specific national programme team N&W ICB supports the delivery but doesn’t have any ability to redistribute funding to other priorities. The review and monitoring of these programmes at system level is undertaken at the SCB.

4.3 The highest profile of these central programmes is the New Hospitals Building Programme with James Paget Hospital & Queen Elizabeth Hospitals remaining in the programme post the Labour government review of the NHP.

4.4 The Digital funding across the three acute hospitals is primarily associated with the acute Electronic Programme Record (EPR), which has been developed across acute organisations as an integrated patient records solution. EPR will enhance patient care by empowering clinicians, providing them with the right information at the right time. It will enable integration of acute services across the three trusts and improve the recruitment and retention of skilled healthcare professionals.

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Report to Norfolk and Waveney Integrated Care Partnership

Item No: 8

Report title: Health Inequalities Strategic Framework for Action

Date of meeting: 11 June 2025

Sponsor
(ICP member): Suzanne Meredith, Deputy Director of Public Health, Norfolk County Council

Reason for the Report
To provide assurance on progress in relation the ICS Health Inequalities Strategic Framework for Action and a progress update on the commitments made. To propose recommendations for further progress to be made.

Report summary
Originally endorsed in June 2024, the Health Inequalities Strategic Framework for Action aims to address health disparities across four priority areas: Living and Working Conditions, Lifestyle Factors, Healthcare Inequalities, and Creating the Conditions for Success. During the first year, ten key actions were implemented, guided by principles addressing systemic, organisational, community, and individual levels. Progress to date indicates meaningful advancements in these areas, yet further action is necessary to sustain momentum.

Key recommendations include endorsing the proposed year two actions, with implementation oversight delegated to the Health Inequalities Steering Group. Additionally, the ICP is advised to receive bi-annual progress reports to ensure continued accountability and alignment. These steps aim to build on the foundational work completed in year one and drive measurable improvements in health equity across the region.

The framework underscores a collaborative, multi-level approach to tackling health inequalities and reflects a strong commitment from ICP partners to create sustainable, equitable conditions for all. Continued focus on implementation and monitoring will be pivotal to achieving long-term impact.

Recommendations
The ICP is asked to:

a) Agree the proposed year 2 actions and support implementation, delegating oversight to the Health Inequalities Steering Group.
b) Receive bi-annual progress reports.

1. Background

1.1 The Health Inequalities Strategic Framework for Action for action was endorsed and agreed by the Integrated Care Partnership in June 2024, with partners

committing to supporting it's implementation. Go to improvinglivesnw.org.uk to view the Framework in detail. The Partnership also agreed to provide oversight and receive quarterly progress reports.

1.2 The Health Inequalities Strategic Framework for Action set out four key areas of priority; Living and Working Conditions, Lifestyle Factors, Healthcare Inequalities and Creating the Conditions for Success.

1.3 The image below shows that people are dying much earlier in some parts of Norfolk and Waveney than others for reasons that can be prevented. The difference in average life expectancy between residents in one place compared to another is the kind of gap we want to close. The priority areas as outlined in 1.2, aim to tackle these key inequalities through coordinated and targeted activity.

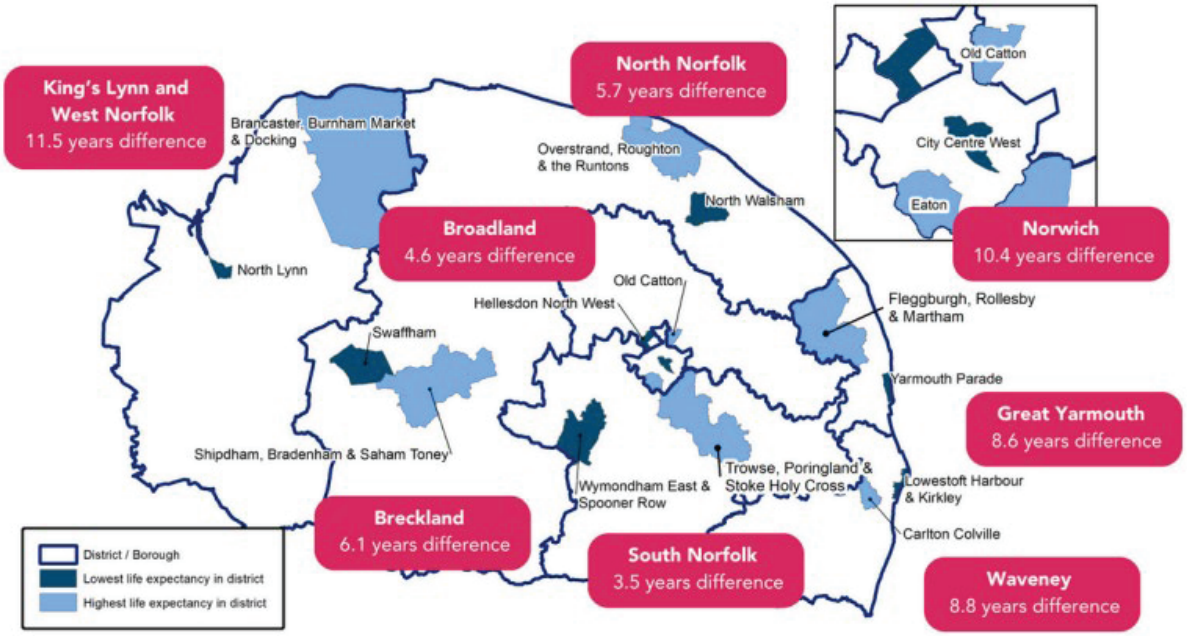


Fig.1 – taken from the 'Health Inequalities Strategic Framework for Action 2024-34'.

1.4 Ten key actions were committed to for the first 12 months of implementation and the Framework details a range of principles that should underpin this activity. In addition, it outlines the commitment to different levels of action required to make a difference at the system, organisational, place, community and individual levels.

2. Health Inequalities Steering Group Report

2.1 **System level action:** The Steering Group and Coordination Group have been driving the implementation of the 10 actions and the previous update to the ICP reported good progress. Some key achievements in the past year include:

- A continued 'Health Inequalities Conversation' with emphasis on creating strong system-leadership, ICP development, and establishing leadership groups that create a foundation on which to further implement the framework and ensure sustained efforts throughout a period of significant change.

- Changing the ICP terms of reference to enable a ‘sub-group’ to lead and oversee the implementation of the Framework – the ICS Health Inequalities Steering Group. This group consists of the Chairs and Vice Chairs of the Living & Working Condition Group, Health Improvement Transformation Group, Healthcare Inequalities Group, VCSE Assembly and Coordination Group.

- Creation of learning and sharing environments, including initial scoping, planning and launch of an ICS Health Inequalities Ambassadors Network, initially bringing together the 35 Core20 Ambassadors participating in the national programme.

- A demonstrable increase in knowledge around the Health Inequalities Framework, development of collaborative relationships and understanding of what the system is doing to tackle inequalities, as demonstrated by our ‘temperature checks’.

- Launch of self-assessment processes that supports organisations to develop organisational improvement plans, undertaken by a range of organisations including the Integrated Care Board, Queen Elizabeth Hospital, James Paget Hospital, Norfolk and Norwich Hospital, Norfolk and Suffolk Foundation Trust, East Coast Community Healthcare, as well as VCSE and local government organisations.

- Developing and launching a primary care Health Inequalities training pilot, launched in February 2025, that can be scaled across the system.

- A health inequalities dashboard which includes the key metrics for each of our ‘building blocks’ for success and will enable our leadership groups and place-based structures to plan and monitor impact.

- Continued development and a system-wide commitment to the Community Voices programme, enabling seldom-heard voices to inform and influence service design and planning, as well as improve health literacy and access to services in our communities.

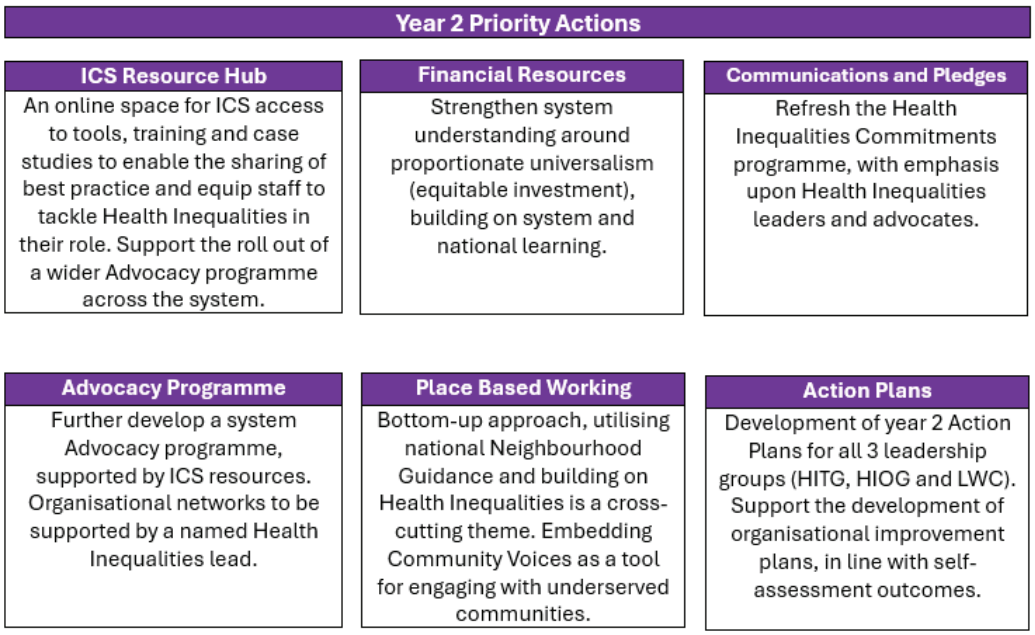
- A review and refresh of Health and Wellbeing Partnership strategies, utilising a Health Inequalities Toolkit to enable alignment with the Health Inequalities Framework.

- Resourcing an integrated, shared post between ICB and NCC Public Health to drive year 2 actions and continued development of leadership structures.

2.2 As we approach one year since the launch of the Health Inequalities Strategic Framework for Action, planning has been underway to determine year 2 priorities, taking into consideration the wider system context including local government reorganisation and NHS reforms. The priority actions of year 2 have been refined to place greater emphasis on solidifying the work to date,

strengthening leadership and advocacy across the system and equipping staff with the tools and resources needed to address structural inequalities.

2.3 The year 2 priorities are set out below:



2.4 A series of task and finish groups are being established to progress this work.

2.5 This work includes the existing Health Inequalities Commitment programme, which organisations from across the ICS have been invited to support. This will be supported by a refreshed communications push.

2.6 Following the commitment to map the flow of health inequalities resources and spend across ICS organisations, an action has been incorporated into Year 2's priority actions aimed at increasing awareness and understanding of proportionate universalism. The Health Inequalities Steering Group will coordinate discussions around resourcing of priorities and how to maximise budgets moving forwards.

2.7 Good progress has been made in the development of governance structures to oversee the action plans to support living and working conditions, lifestyle factors and healthcare access, experience and outcomes. A distributed leadership approach has been agreed, with the groups chaired or vice-chaired by leaders from across health, local government and the VCSE sector.

2.8 The chairs and vice-chairs of the leadership groups come together in an ICP Health Inequalities Steering Group that oversees the implementation of the Framework.

2.9 The **Healthcare Inequalities Oversight Group** is developing and implementing a programme to deliver the Core20plus5 health improvement frameworks for adults, children and young people, as well as creating an NHS Anchors group to drive improvements across our NHS providers and the ICB and maximise our opportunities to support wider social and economic outcomes.

2.10 The **Health Improvement Transformation Group** is developing and implementing an action plan focused on physical activity, smoking cessation, diet and behaviour change. A programme of Behavioural Insights training for public policy makers has been launched, with training running into 2026 for key groups. The Smokefree Social Housing service was launched on National No Smoking Day on 12 March 2025, with over 100 referrals received by 31 March 2025. The Active NoW programme has reached over 8,000 people across Norfolk and Waveney, with almost 4,300 referrals between April 2024 and February 2025, with a 66% uptake rate and 219 referring organisations/departments.

2.11 The **Living and Working Conditions Group** has been supporting the development of the Connect to Work model, along with early discussions around the Get Norfolk Working Local Plan. Discussions are taking place around Healthy Homes and how we can maximise existing assets, with a review of national recommendations to refine the group's focus.

2.12 The **VCSE Assembly** has developed a risk register, mapping key risks to the Assembly itself and the wider VCSE partnering agenda; this risk register is informing the development of a work programme.

2.13 **Organisational level action:** At the ICP conference in October 2024, the **Health Inequalities Commitment** was launched. This commitment asked organisations to undertake several actions to support the implementation of the Framework. These actions include:

a) Nominating/appointing a health inequalities lead.
b) Supporting the development of a Norfolk & Waveney Advocate Network through the identification of organisational advocates.
c) Undertaking a self-assessment to capture existing good practice and areas for improvement to inform an organisational improvement plan.

2.14 Early uptake of the Commitment has been relatively good, with the VCSE sector in particular pledging their commitment to the programme. A refreshed engagement plan is in development to promote wider uptake of the Health Inequalities Commitments and completion of the Self-Assessment.

2.15 NHS England recently launched the third cohort of the **Core20 Ambassador programme**, which brings individuals from across the country together and provides knowledge, learning and networking opportunities. Norfolk and Waveney had among the highest uptake of this cohort compared to other ICSs, with over 35 Ambassadors signed up to the Cohort 3 programme.

2.16 Bi-monthly networking sessions have been established for the Ambassadors of Cohort 3 to support them in the delivery of their projects and facilitate connections. The intention is also to bring previous cohorts together to discuss a Norfolk & Waveney advocate network to drive change in our local system.

2.17 In addition to the local commitments, NHS trusts and the ICB have undertaken a Health Inequalities Board Maturity Assessment, facilitated by NHS Providers.

These assessments offer valuable insights into the current ways of working, elements of good practice and areas of improvement. A Year 2 priority action has been established to focus on supporting the development of organisational improvement plans by utilising these insights, which will in turn contribute to an NHS Anchors system improvement plan that identifies and addresses common areas of action.

2.18 There are examples of where Improvement Plans have already been developed, including with our acute providers and the Norfolk and Waveney ICB. Learnings from this work will be shared across the system and inform the development of further organisational and system Improvement Plans. There will be instances where we can tackle shared challenges, for example, how we can collectively address the gap in understanding around equality vs equity (see image below):

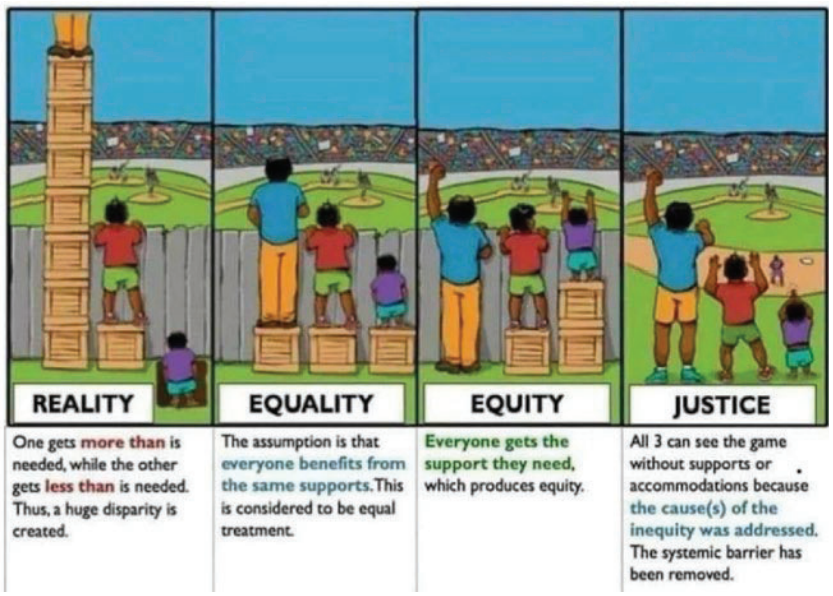


Fig 2. Taken from the 'Norfolk and Waveney Health Inequalities & Equality Diversity & Inclusion Improvement Plan 2025-27'

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communication for all

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