Norfolk and Suffolk Integrated Needs Assessment

An overview of health and wellbeing

December 2025

This slide deck is a joint product by:

Suffolk Public Health and Communities

Norfolk I&A Public Health

NHS Norfolk and Waveney Integrated Care Board

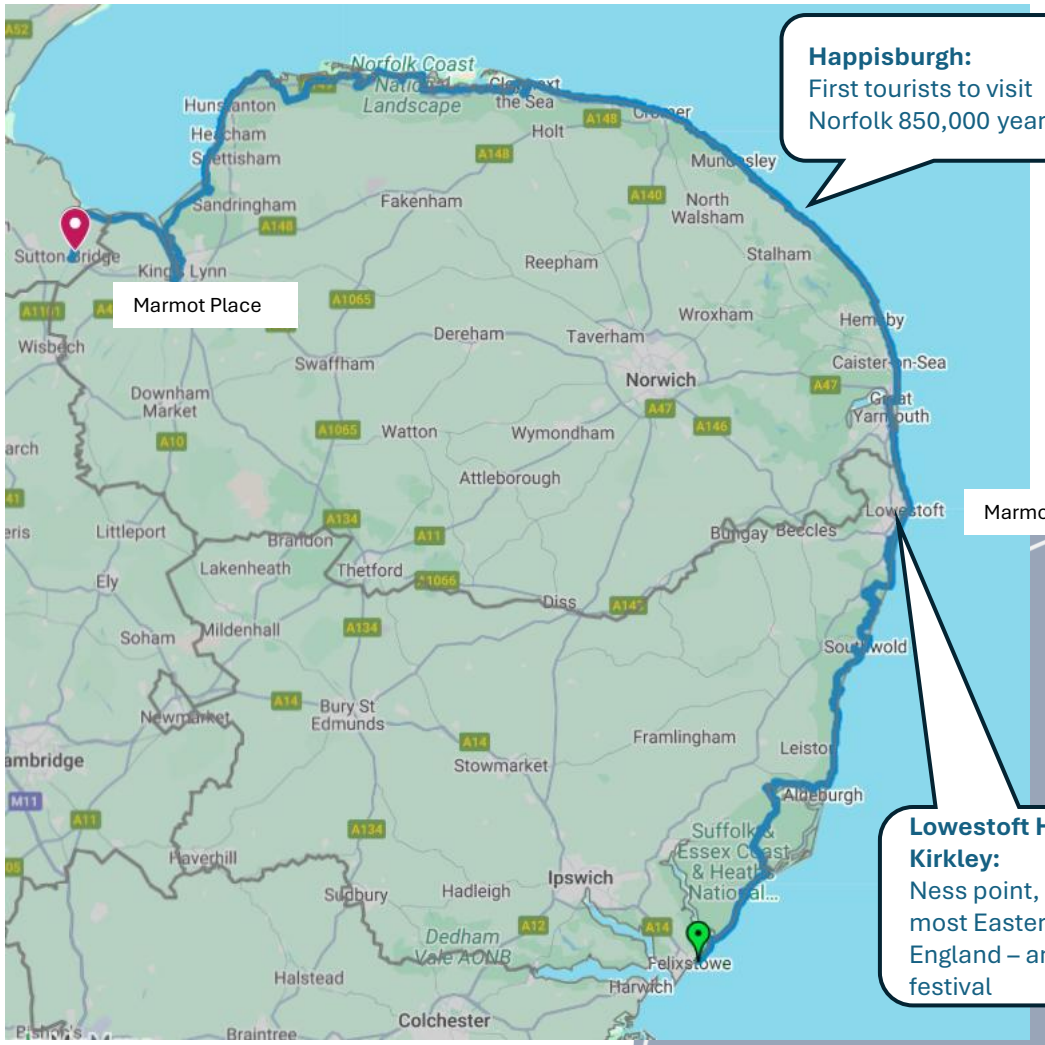
NHS Suffolk and North East Essex Integrated Care Board (ICB)

From coastlines to countryside, the geography of Norfolk and Suffolk shapes the lives and health of our residents…

- Suffolk and Norfolk Coastal path about 240km around the coast from Felixstowe round to Sutton Bridge.
- One side of a combined area of about 9,180 km^2.

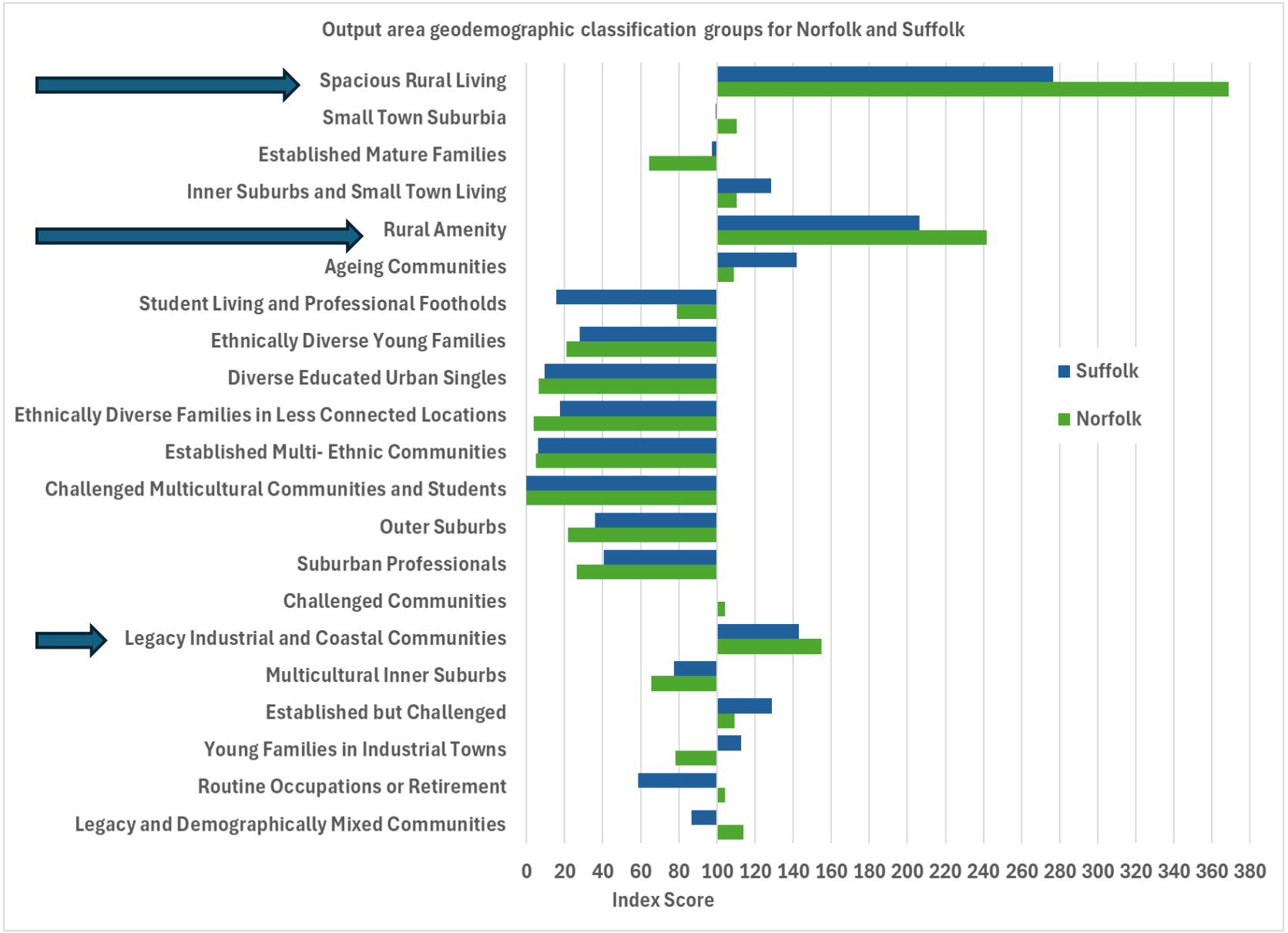
Just under half the size of Wales

- Includes areas of outstanding natural beauty from Dedham Vale and Suffolk Coast and Health to the North Norfolk Coast, passing by the Norfolk Broads.
- Industries across Norfolk and Suffolk include; Clean energy, Agritech, digital and Fintech, nuclear and tourism.
- A combined population of about 1,700,000 people that is generally older than England with some of the highest prevalence of long-term conditions (mostly due to older population).
- Older, rural and coastal populations increases complexity in ensuring access to, and delivery of services.
- Population projections indicate that older people are likely to make up a greater proportion of population in future.
- Less ethnically diverse than England, Suffolk is more ethnically diverse compared to Norfolk. The proportion who consider their ethnicity as White: England 81.0%, Norfolk 94.7% and Suffolk 93.1%.



Norfolk GPX file here: https://www.norfolk.gov.uk/article/42911/About-the-Norfolk-Coast-Path-and-points-of-interest

As well as similar landscapes and industry Norfolk and Suffolk share similar types of communities...



The ONS 2021 Classification for Output Areas (2021 OAC) is a hierarchical geodemographic classification across the UK which identifies areas of the country with similar characteristics.

Spacious Rural Living, Rural Amenity and Legacy Industrial and Coastal make up about 50% of the population.

The total populations in the groups are similar for several groups but there are some differences in the proportions e.g.

- established mature families
- student living and professional footholds

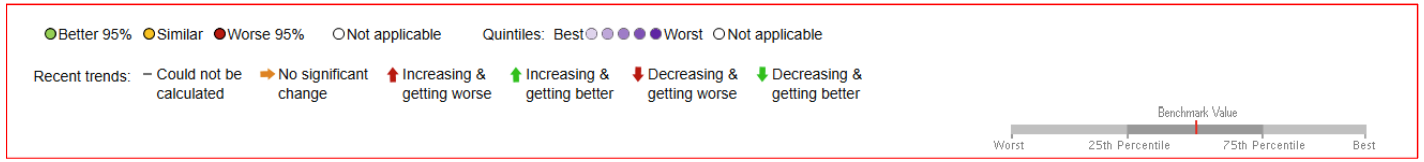
https://data.geods.ac.uk/dataset/output-area-classification-2021

Life Expectancy in Norfolk and Suffolk is generally better than England, but inequality remains. Trends in Healthy Life Expectancy indicate people are spending more time in declining health…

- **Life Expectancy**: The average number of years a person is expected to live based on current mortality rates.
- **Healthy Life Expectancy**: The average number of years a person is expected to live in good health, without disability or major illness.
- **Inequality in Life Expectancy**: A measure of the social gradient in life expectancy, that is how much life expectancy varies with deprivation

Indicator	Period	Norfolk			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Life expectancy at birth (Male, All ages)	2021 - 23	–	-	79.6	79.1	73.1		82.5
Life expectancy at birth (Female, All ages)	2021 - 23	–	-	83.5	83.1	78.9		86.5
Healthy life expectancy at birth (Male, All ages)	2021 - 23	–	-	62.5	61.5	51.8		69.7
Healthy life expectancy at birth (Female, All ages)	2021 - 23	–	-	62.9	61.9	52.6		70.8
Inequality in life expectancy at birth (Male, All ages)	2021 - 23	–	-	7.5*	10.5*	17.2		3.6
Inequality in life expectancy at birth (Female, All ages)	2021 - 23	–	-	4.9*	8.3*	14.9		1.3
Life expectancy at 65 (Male, 65)	2021 - 23	–	-	19.1	18.7	16.1		20.5
Life expectancy at 65 (Female, 65)	2021 - 23	–	-	21.5	21.1	18.7		23.2
Healthy life expectancy at 65 (Male, 65)	2021 - 23	–	-	10.7	10.1	6.9		13.4
Healthy life expectancy at 65 (Female, 65)	2021 - 23	–	-	12.0	11.2	7.8		14.9

Indicator	Period	Suffolk			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Life expectancy at birth (Male, All ages)	2021 - 23	–	-	80.5	79.1	73.1		82.5
Life expectancy at birth (Female, All ages)	2021 - 23	–	-	84.0	83.1	78.9		86.5
Healthy life expectancy at birth (Male, All ages)	2021 - 23	–	-	63.3	61.5	51.8		69.7
Healthy life expectancy at birth (Female, All ages)	2021 - 23	–	-	63.6	61.9	52.6		70.8
Inequality in life expectancy at birth (Male, All ages)	2021 - 23	–	-	7.2*	10.5*	17.2		3.6
Inequality in life expectancy at birth (Female, All ages)	2021 - 23	–	-	6.0*	8.3*	14.9		1.3
Life expectancy at 65 (Male, 65)	2021 - 23	–	-	19.5	18.7	16.1		20.5
Life expectancy at 65 (Female, 65)	2021 - 23	–	-	22.0	21.1	18.7		23.2
Healthy life expectancy at 65 (Male, 65)	2021 - 23	–	-	11.0	10.1	6.9		13.4
Healthy life expectancy at 65 (Female, 65)	2021 - 23	–	-	12.3	11.2	7.8		14.9



Compared to England:

Life Expectancy significantly higher.

Healthy Life Expectancy is about the same.

- Males spend about 17 years in declining health
- Females spend about 20 years in declining health
- Biggest drivers of poor self-reported health are musculoskeletal, CVD, dementia, respiratory and mental health

Inequality in Life Expectancy is lower, but:

- Males in least deprived areas live more than 7 years longer than those in most deprived
- Females in least deprived live about 5 to 6 years longer than those in the most deprived

Source: Fingertips (2025)

*https://www.gov.uk/government/publications/understanding-the-drivers-of-healthy-life-expectancy/understanding-the-drivers-of-healthy-life-expectancy-report

Despite their many similarities, Norfolk and Suffolk are not identical and they differ in certain health and wellbeing outcomes…

Legend:

Better 95% | Similar | Worse 95% | Not compared

Quintiles: Best | | | | Worst | Not applicable

Benchmark comparison = England

Source: Fingertips (December 2025)

Norfolk slightly more deprived and has slightly higher fuel poverty (*Note* 2019 deprivation data here as not updated on this platform yet)

Compared to England:

Norfolk performs **statistically worse (lower)** in relation to **school readiness** for children with free school meal status and **child development** at 2-2.5 yrs. **Suffolk** is **statistically similar**.

Norfolk worse **for sickness absence**

Indicator	Period	England	Suffolk	2 - Norfolk
Infant mortality rate (Persons, <1 yr)	2022 - 24	4.2	3.8	4.6
Life expectancy at birth (Male, All ages)	2021 - 23	79.1	80.5	79.6
Life expectancy at birth (Female, All ages)	2021 - 23	83.1	84.0	83.5
Healthy life expectancy at birth (Male, All ages)	2021 - 23	61.5	63.3	62.5
Healthy life expectancy at birth (Female, All ages)	2021 - 23	61.9	63.6	62.9
Children in absolute low income families (under 16s) (Persons, <16 yrs)	2023/24	19.1	17.2	18.9
Deprivation score (IMD 2019) (Persons, All ages)	2019	21.7	18.5	21.2
Homelessness: households owed a duty under the Homelessness Reduction Act	2023/24	13.4	11.9*	10.5*
Fuel poverty (low income, low energy efficiency methodology)	2023	11.4	11.1	11.7
School readiness: percentage of children achieving a good level of development at the end of Reception (Persons, 5 yrs)	2023/24	67.7	67.5	67.3
School readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception (Persons, 5 yrs)	2023/24	51.5	49.4	46.7
Child development: percentage of children achieving a good level of development at 2 to 2 and a half years (Persons, 2-2.5 yrs)	2024/25	81.4*	83.7	79.8*
Population vaccination coverage: DTaP and IPV booster (5 years) (Persons, 5 yrs) <90% 90% to 95% ≥95%	2024/25	81.3*	90.4	88.8
Pupil absence (Persons, 5-15 yrs)	2023/24	7.1	7.5	7.6
Percentage of people in employment (Persons, 16-64 yrs)	2024/25	75.7	78.1	76.9
Sickness absence: the percentage of working days lost due to sickness absence (Persons, 16+ yrs)	2021 - 23	1.2	1.3	2.0

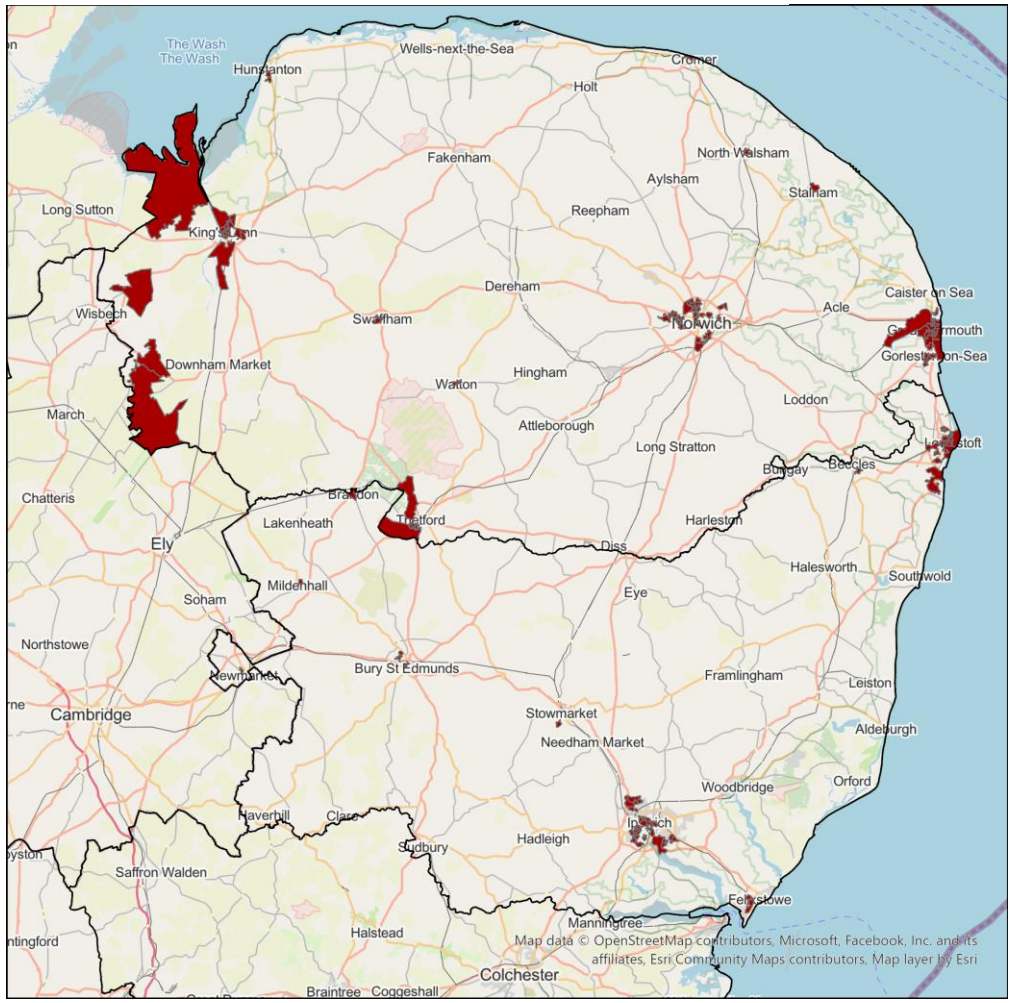
Indicator	Period	England	Suffolk	2 - Norfolk
Reception prevalence of overweight (including obesity) (Persons, 4-5 yrs)	2024/25	23.5	23.5	24.4
Year 6 prevalence of overweight (including obesity) (Persons, 10-11 yrs)	2024/25	36.2	33.6	34.9
Overweight (including obesity) prevalence in adults, (using adjusted self-reported height and weight) (Persons, 18+ yrs)	2023/24	64.5	67.2	66.5
Percentage of physically inactive adults (Persons, 19+ yrs)	2023/24	22.0	18.9	21.0
Smoking status at time of delivery (Female, All ages)	2024/25	6.1	4.9	8.7
Smoking Prevalence in adults (aged 18 and over) - current smokers (APS) (Persons, 18+ yrs) New data	2024	10.4	10.5	8.7
Emergency Hospital Admissions for Intentional Self-Harm (Persons, All ages)	2023/24	117.0	154.2	129.9
Admission episodes for alcohol-related conditions (Narrow) (Persons, All ages)	2023/24	504	523	526
Population vaccination coverage: Flu (at risk individuals) (Persons, 6 months-64 yrs) <55% ≥55%	2024/25	40.0*	44.9	45.6
Population vaccination coverage: Flu (aged 65 and over) (Persons, 65+ yrs) <75% ≥75%	2024/25	74.9*	80.2	79.0
Hip fractures in people aged 65 and over (Persons, 65+ yrs)	2023/24	547	437*	498*
Emergency hospital admissions due to falls in people aged 65 and over (Persons, 65+ yrs)	2023/24	1984	1586	1555
Percentage of cancers diagnosed at stages 1 and 2 (Persons, All ages)	2022	56.8	58.8	56.2
Cancer screening coverage: bowel cancer (Persons, 60-74 yrs)	2024	71.8*	75.9*	74.4*
Cancer screening coverage: breast cancer (Female, 53-70 yrs)	2024	69.9*	78.0*	74.4*
Cancer screening coverage: cervical cancer (aged 25 to 49 years old) (Female, 25-49 yrs)	2024	66.1*	73.3*	71.9*

Norfolk has a **statistically higher (worse)** percentage of mothers smoking at time of delivery. Suffolk is **statistically lower**.

Indicator	Period	England	Suffolk	2 - Norfolk
Cancer screening coverage: cervical cancer (aged 50 to 64 years old) (Female, 50-64 yrs)	2024	74.3*	77.5*	76.8*
Under 75 mortality rate from causes considered preventable (Persons, <75 yrs)	2022 - 24	151.2	123.9	135.2
Under 75 mortality rate from cardiovascular disease considered preventable (Persons, <75 yrs)	2022 - 24	30.2	25.9	25.1
Under 75 mortality rate from respiratory disease considered preventable (Persons, <75 yrs)	2022 - 24	19.3	12.7	15.1
Suicide rate (Persons, 10+ yrs)	2022 - 24	10.9	10.7	11.9

Across Norfolk and Suffolk almost 210,000 people live in the 20% most deprived communities in England (the dark red areas in the map). About 13% of Norfolk population live in these areas compared to about 11% of Suffolk population…

Core20 most deprived 20% of communities nationally



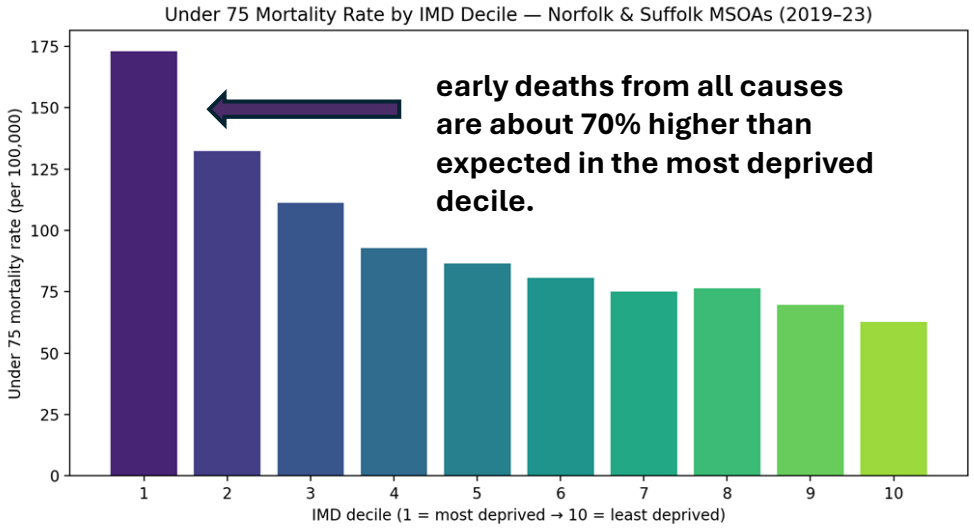
Deprivation data used: Index of Multiple Deprivation 2025. Lower Super Output Area used for map and Middle Super Output Area Score (MSOA) used for mortality analysis from Local Insight (December 2025)

Deprivation is concentrated in the urban areas of Great Yarmouth, Ipswich, King's Lynn, Lowestoft, Norwich and Thetford.

With other pockets of deprivation in some of the coastal and market towns e.g. Beccles, Bury St Edmunds, Cromer, Dereham, Needham Market, North Walsham, Swaffham and Watton.

And some small hidden deprived communities in rural areas.

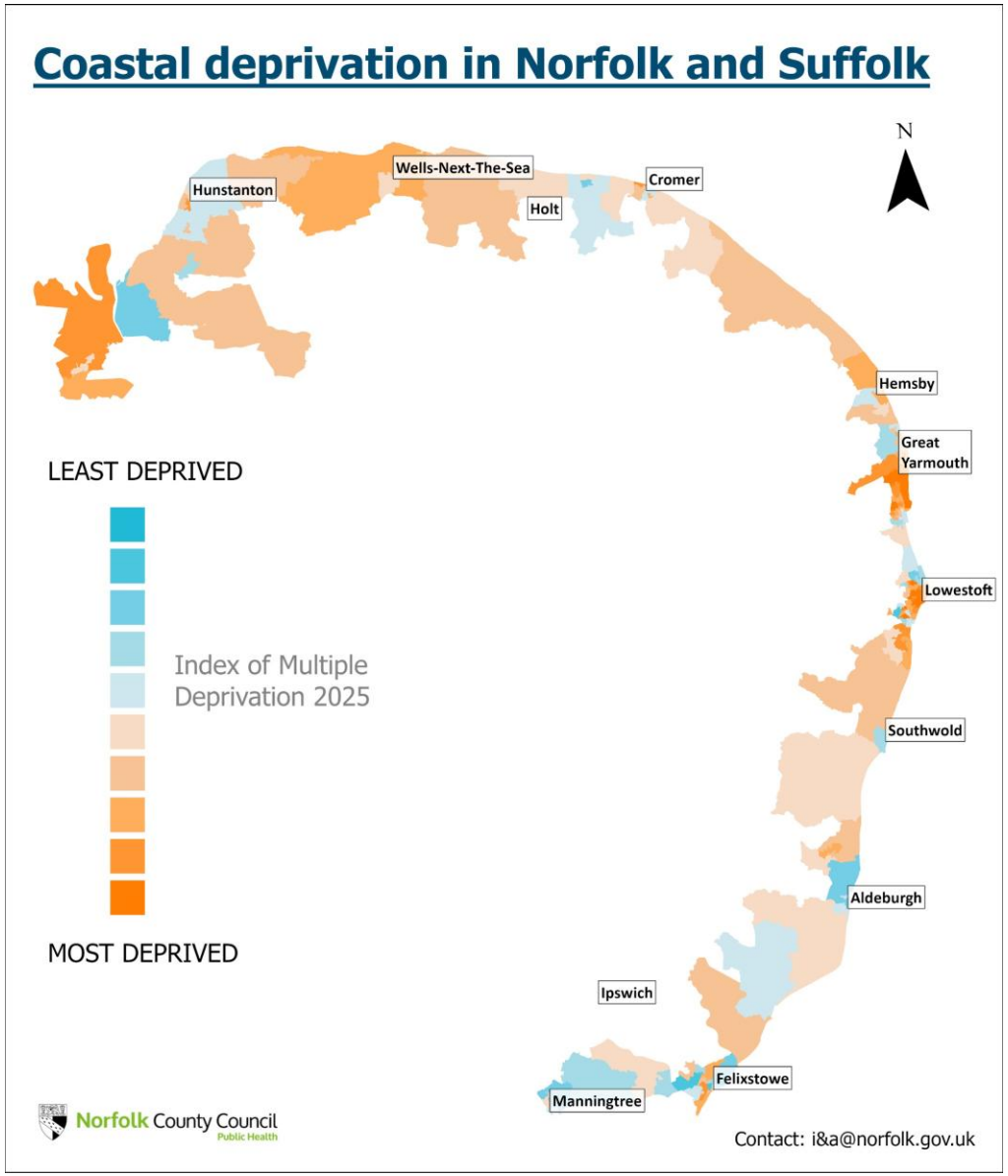
Inequalities exist across the deprivation deciles where outcomes for people that live in the most deprived 20% of communities are worse than for people elsewhere.



most deprived

least deprived

The 2025 Index of Multiple Deprivation highlights persistent and concentrated areas of deprivation in our coastal areas, reinforcing the need for long-term place-based intervention and strategies to reduce inequalities and improve outcomes…



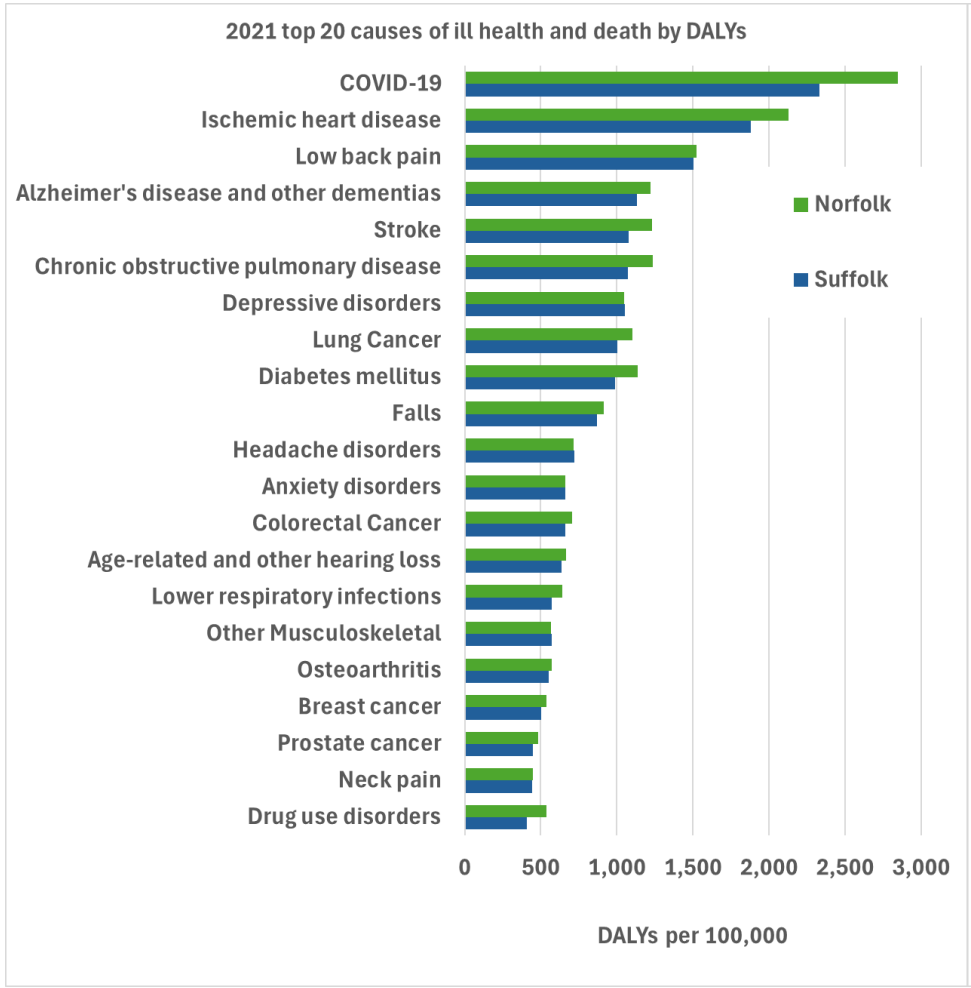
Echoing the Chief Medical Officers report- it is recognised that coastal communities are not homogenous, and each is shaped by its own unique history and culture. However, there are characteristics that are similar and can help us target actions…

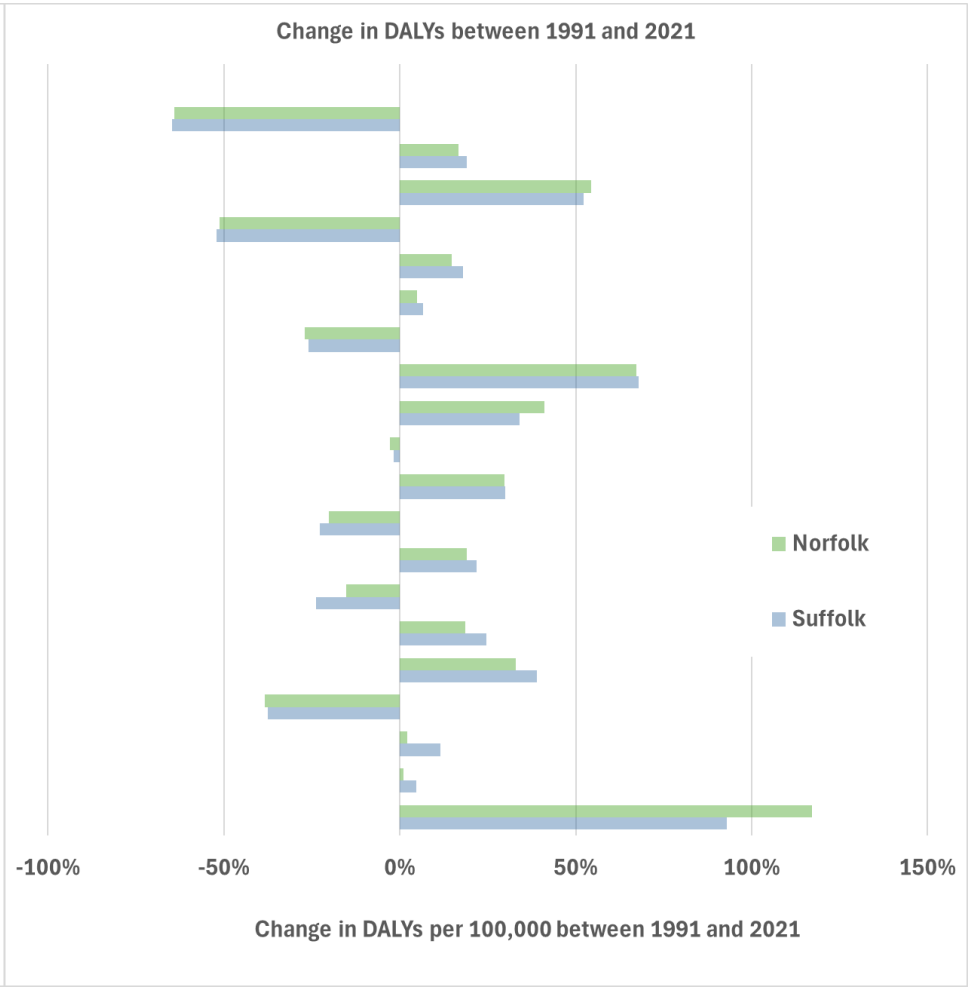
Our most deprived coastal areas have:

- **Persistent and concentrated deprivation:** Many of England's most deprived neighbourhoods are coastal, with places like Lowestoft and Great Yarmouth consistently ranking among the most deprived nationally.
- **Multiple, overlapping challenges:** The most deprived coastal areas typically face high deprivation across several domains—income, employment, health, education, crime, barriers to housing/services, and living environment.
- **Health inequalities:** Coastal communities experience poorer health outcomes, including higher rates of premature mortality and long-term conditions. These are driven by a mix of elements including: socioeconomic disadvantage, limited access to healthcare, and workforce shortages.
- **Older and less diverse populations:** Coastal settlements have a higher median age and a greater proportion of residents aged 65+ compared to inland areas. This demographic profile increases demand for health and social care and can exacerbate isolation and digital exclusion.
- **Young people that face disadvantage:** Research has also found that young people living in deprived coastal areas are likely to become unhealthier young adults than those living in deprived inland communities.
- **Barriers to opportunity:** Physical isolation, poor transport links, and limited access to services (including digital) are more acute in coastal areas, compounding disadvantage and making it harder for residents to access jobs, education, and healthcare.
- **Housing pressures:** Coastal areas often face unique housing challenges, such as high concentrations of second homes, holiday lets, and houses in multiple occupation (HMOs), which can drive up prices and reduce availability for local people.
- **Policy implications:** The data highlights the need for long-term, place-based strategies and investment, rather than piecemeal or short-term funding. It also calls for improved data, cross-departmental coordination, and a focus on the specific needs of coastal communities.

More information: English Indices of Deprivation 2025

The Global Burden of Disease (GBD) study and Disability Adjusted Life Years or DALYs measure helps understand what is driving poor health outcomes and leading to early death. This includes time lived in poor health and years of life lost from early deaths.





This data shows a shift over the last 30 years from mortality to morbidity.

Compare **reductions** in relative contribution of CVD related conditions and some cancers...

to **increases** in relative contributions from Back pain, Dementia, Diabetes, Falls, Anxiety Musculoskeletal, Osteoarthritis, hearing loss and Drug use Disorders

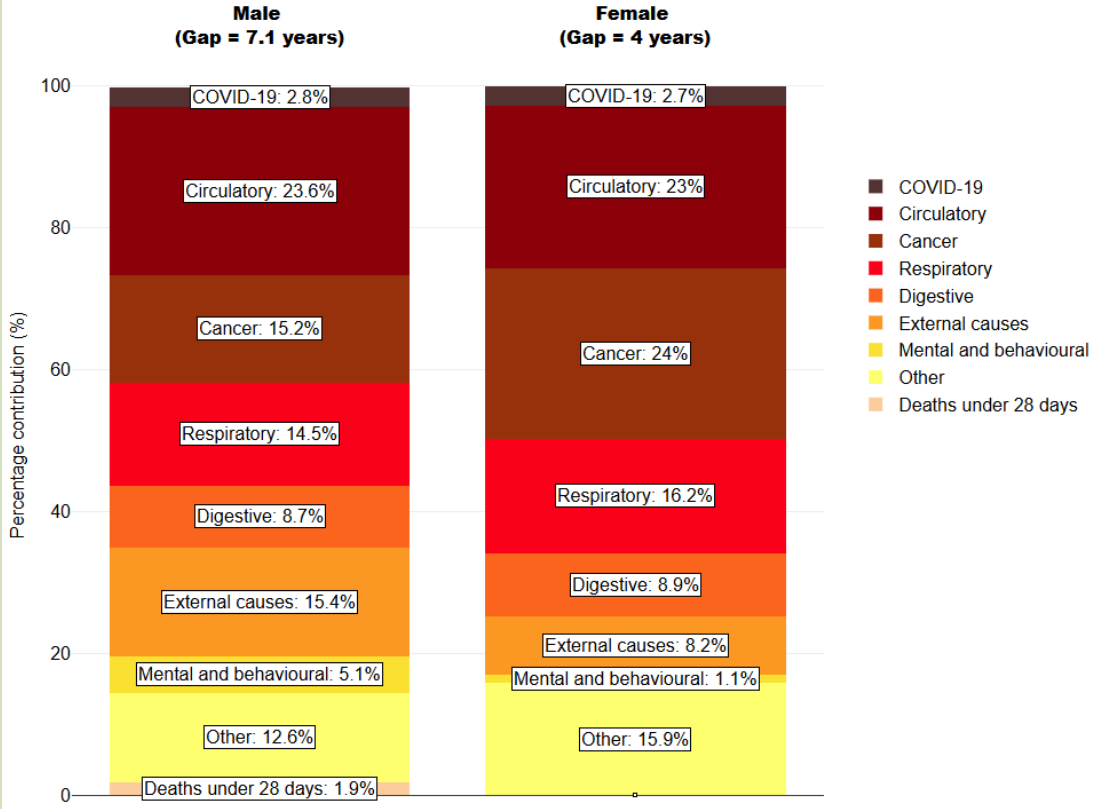
This shift aligns with drivers of low healthy life expectancy.

What's a DALY? Disability-Adjusted Life Years (DALYs): A measure of overall disease burden. One DALY equals one lost year of "healthy" life, combining: **Years of life lost (YLL):** due to premature death. **Years lived with disability (YLD):** time lived in less than full health. 👉 DALYs allow comparison across conditions by showing both the **impact of early death** and the **impact of living with illness or disability** in a single metric.

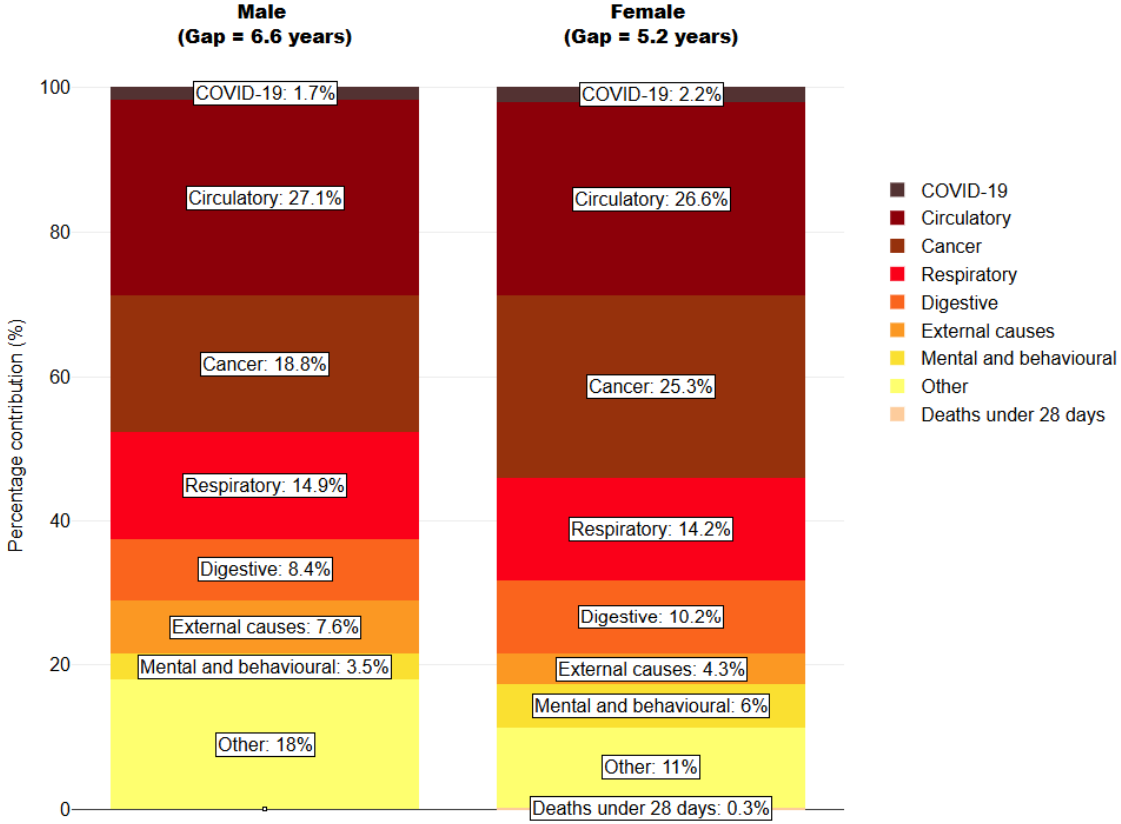
Source: GBD Compare
*No C-19 trend data available as new condition.

Despite reductions in the number of DALYs in CVD and Cancer, these conditions are still the largest contributors to the gap in early deaths between the most deprived and least deprived. The drivers are similar but there are some localised differences between Norfolk (left) and Suffolk (right)...

Breakdown of the life expectancy gap between the most and least deprived quintiles of Norfolk by cause of death, 2022-2023



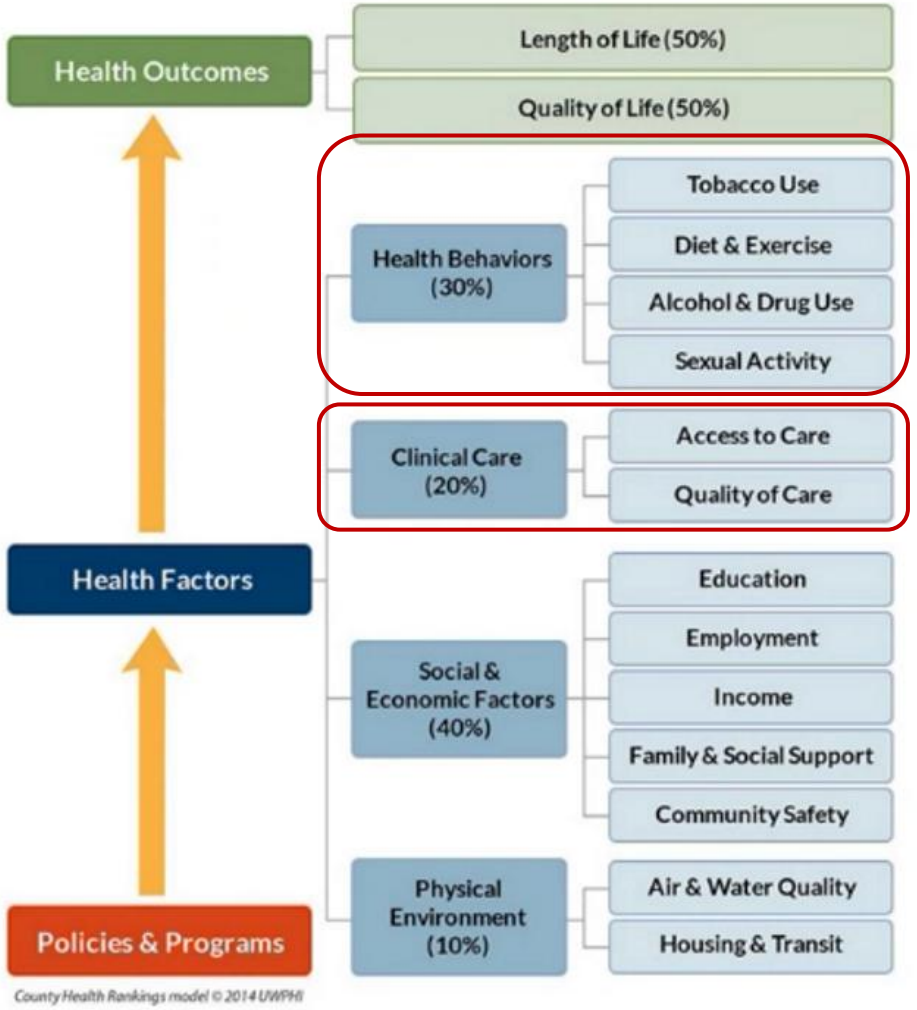
Breakdown of the life expectancy gap between the most and least deprived quintiles of Suffolk by cause of death, 2022-2023



Source: Office for Health Improvement and Disparities based on ONS death registration data and provisional mid year population estimates for the relevant years, and Ministry of Housing, Communities and Local Government Index of Multiple Deprivation, 2019.

Footnote: Data are calculated using 2021 Census based mid-year population estimates. Circulatory includes heart disease and stroke. Respiratory includes flu, pneumonia, and chronic lower respiratory disease. Digestive includes alcohol-related conditions such as chronic liver disease and cirrhosis. External includes deaths from injury, poisoning and suicide. Mental and behavioural includes dementia and Alzheimer's disease. Percentages may not sum to 100 due to rounding. Chart labels can be removed from the chart by clicking once on them.

And we can do something about these gaps and poor outcomes: Looking at what influences quality and length of life there are several parts of the jigsaw of total health where we can make a difference to a person's health outcome and address inequalities.



From a health perspective we can make a difference and help reduce the gap in outcomes between the most deprived populations and others by:

- Working with people to change **health behaviours** (smoking, diet, exercise, alcohol, screening)

- Ensuring better **access to care**
  - Accessible financially and physically in the most deprived areas
  - Poverty proof services by considering transport costs and timing of appointments to negate the need for time off work etc.
  - Access for rural and coastal populations

- Focusing on even better **quality of care** (and improving patient engagement)

https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods/the-evolution-of-the-model

Taking the reasons for ill health, reasons for inequality gaps and areas where we can have an impact leads to some shared public health focus areas for Suffolk and Norfolk that can improve population health, reduce inequalities and support sustainable delivery.

Focus area	Description	Impact on Services	Recommended Focus for Commissioning
Ageing Population & Long-Term Conditions (LTCs)	Rapidly growing over-65 population with rising multimorbidity	Increased demand for chronic disease management, social care, and geriatric services	Integrated care for multimorbidity, frailty prevention, dementia support, proactive mid-life interventions such as promoting good health at work
Health Inequalities & Deprivation areas	Significant disparities in health outcomes between most and least deprived areas	Higher preventable mortality and service pressure in deprived urban/coastal areas	Targeted services in deprived areas, Core20PLUS5 continuation (also noting new Marmot place in East Suffolk), housing and employment-linked health support
Health Behaviours (Obesity and Overweight, Smoking)	High rates of overweight/obesity and persistent smoking, especially in deprived communities	Drives cardiovascular disease, diabetes, cancer; strains primary and secondary care	Smoking cessation, weight management, physical activity promotion, alcohol harm reduction programmes
Health improvement and protection (Screening & Immunisation)	Opportunities to improve newborn hearing screening coverage, some routine childhood immunisations and maintain and improve cancer screening	Missed opportunities for prevention and early diagnosis; higher burden of preventable illness in under-vaccinated and under-screened groups	Initiatives to improve screening uptake in disadvantaged groups; targeted campaigns and outreach for routine immunisations; increased flu and PPV coverage in at-risk populations; strengthen partnerships with primary care and community providers
Mental Health & Social Wellbeing	Rising mental health needs across age groups; loneliness and isolation in rural/coastal areas	Increased referrals to mental health services, social prescribing, and crisis support	Suicide prevention, early intervention, integrated mental-physical care, youth mental health support
Access to Services Specifically: Rural/Coastal Areas and in relation to digital exclusion	Geographic barriers to care due to rurality and coastal nature of communities; limited connectivity; lower digital access and literacy in some groups	Challenges in reaching remote populations; pressure on emergency and outreach services; risk of exclusion from digital-first service models; reduced awareness of available services among digitally excluded groups	Improve reach in rural/coastal areas; strengthen dental access and screening uptake; enhance community navigation and outreach; expand digital inclusion initiatives; ensure alternative (non-digital) access routes; invest in broadband and mobile coverage

We also have a segmentation model of the population where each person is allocated to one of six segments to help us understand the potential size and costs associated with cohorts related to the areas of focus:

Area of focus	Segmentation model	Commissioning options
Health Behaviours (Obesity and Overweight, Smoking)	**Be well** *Unhealthy behaviours*	Smoking cessation, weight management, physical activity promotion, alcohol harm reduction programmes
Mental Health & Social Wellbeing	**Feel well** *Mental Health Conditions*	Suicide prevention, early intervention, integrated mental-physical care, youth mental health support
Ageing Population & Long-Term Conditions (LTCs)	**Stay well** *Long Term Conditions and Cancer*	Integrated care for multimorbidity, frailty prevention, dementia support, proactive mid-life interventions such as promoting good health at work
	Age well *Multimorbidity, dementia, frailty*	

This is in the process of being updated to be more granular and include a specific CYP domain.

Poorer Health Outcomes

	Live well *Not in any other segments*	Be well *Unhealthy behaviours*	Feel well *Mental Health Conditions*	Stay well *Long Term Conditions and Cancer*	Age well *Multimorbidity, dementia, frailty*	Die well *Palliative care, end-stage*
Population	320.8K	21.4K	7.6K	245.4K	42.1K	7.6K
Total Spend per year	£164M	£18M	£27M	£484M	£471M	£117M
Spend per person, per year	£511	£841	£3,587	£1,970	£11,195	£15,437
Long Term Conditions % Prevelance						
Hypertension	-	-	-	34.7%	67.5%	66.1%
Asthma	-	-	-	22.9%	25.4%	19.7%
Chronic Pain	3.7%	8.6%	4.4%	14.4%	27.3%	26.9%
Cardiovascular Diseases	0.4%	2.0%	0.7%	10.3%	45.6%	53.1%
Diabetes	-	-	-	11.2%	32.9%	27.3%
Chronic Kidney Disease	-	-	-	6.5%	32.0%	41.0%
Cancer	-	-	-	9.7%	15.0%	35.7%
Atrial Fibrillation	-	-	-	3.8%	23.5%	27.0%
COPD	-	-	-	2.9%	16.2%	28.1%
Osteoporosis	-	-	-	2.9%	13.7%	15.2%
Heart Failure	-	-	-	1.3%	15.9%	31.1%
Stroke	-	-	-	1.2%	11.1%	9.4%
Epilepsy	-	-	-	1.8%	5.4%	4.2%
Rheumatoid Arthritis	0.3%	0.8%	0.5%	1.6%	4.5%	5.0%
Inflammatory Bowel Disease	0.5%	0.9%	0.8%	1.3%	1.9%	2.2%
Transient Ischaemic Attack	-	-	-	0.9%	7.2%	5.4%
Peripheral Artery Disease	-	-	-	0.7%	4.9%	5.8%
Chronic Liver Disease	0.1%	0.3%	0.4%	0.5%	1.5%	5.4%
Parkinson's Disease	0.1%	0.1%	0.0%	0.3%	2.0%	2.3%
Multiple Sclerosis	0.1%	0.2%	0.1%	0.3%	0.8%	1.0%
Cerebral Palsy	0.0%	0.0%	0.1%	0.1%	0.5%	0.4%
Anxiety	-	-	-	35.4%	38.3%	27.1%
Dementia	-	-	-	-	12.8%	14.6%
Depression	-	-	-	27.4%	32.9%	22.2%
Learning Disability	-	-	-	0.6%	5.4%	1.2%
Serious Mental Illness	-	-	9.7%	1.3%	4.9%	2.8%
Other Factors						
Alcohol Abuse	1.5%	4.5%	3.9%	7.0%	10.0%	11.1%
BMI Obese	2.3%	66.6%	8.6%	23.4%	32.6%	24.8%
Current Smoker	7.6%	36.1%	21.1%	14.7%	12.7%	12.9%

We have a list of suggested outcome statements for each segment (domain) that will help us understand if we are making progress ...

Cross Cutting Theme: To **reduce unwarranted variation** across all domains by monitoring gaps between places and groups, acting on outliers, and tracking progress

Domain	Outcome Statement	Indicator(s)	Detailed Description	Rationale
Start Well	**All babies in Norfolk and Suffolk are born healthy and given the best start and thrive in life.**	Low birthweight prevalence / Infant mortality / SATOD	Proportion of all births under 2,500g (2023). Suffolk: 7.0% (430 infants/year). Norfolk: 6.9% (473 infants/year) Infant mortality rate (2022-24) Suffolk: 3.8 and Norfolk 4.6 per 1,000	Low birthweight is linked to increased risk of infant mortality, developmental delays, and chronic disease later in life. It reflects maternal health, deprivation, and access to antenatal care.
	All children in Norfolk and Suffolk grow up healthy, active, and at a healthy weight.	Childhood obesity rates	Percentage of children overweight or obese at Reception (age 4–5) and Year 6 (age 10–11). Suffolk and Norfolk: Nearly 1 in 4 at Reception, 1 in 3 by Year 6.	Childhood obesity is a strong predictor of future health risks (diabetes, heart disease, mental health). The trend is worsening locally, making it a system-wide challenge for prevention and early intervention.
Be Well	**Everyone in Norfolk and Suffolk has the knowledge, opportunities, and environments that support healthy eating and active living.**	Excess weight (including obesity)	Percentage of adults with BMI ≥25 (overweight/obese). Suffolk: 67.2% and Norfolk: 66.5% (both statistically higher than England).	Excess weight drives diabetes, cardiovascular disease, cancer, and musculoskeletal problems. High prevalence makes this a priority for prevention and system-wide action.
	Fewer people smoke in Norfolk and Suffolk , and everyone can live in smoke-free homes, workplaces, and communities.	Smoking prevalence / Smoking at time of delivery	Percentage of adults who smoke, with breakdowns by occupation and mental health status. Suffolk: 11.0% overall (3 yr range), 17.9% in routine/manual jobs, 20.8% with long-term mental health conditions . Norfolk: 10.7% overall (3 yr range), 18.4% in routine/manual jobs, 20.2% with long-term mental health conditions.	Smoking is the leading modifiable risk factor for morbidity and mortality. Disproportionately affects deprived groups, driving health inequalities.
Feel Well	**Young people in Norfolk and Suffolk feel emotionally well, supported, and able to thrive.**	Hospital admissions for self-harm (10–24 years)	Number and rate of emergency hospital admissions for self-harm among young people. Suffolk and Norfolk rates for 10-24 year olds are statistically higher than England; 440 Suffolk admissions and 455 Norfolk admissions in 2023/24.	Acute indicator of mental health crisis and unmet need. High rates signal pressure on services and the need for targeted prevention and crisis support.
	Adults in Norfolk and Suffolk experience good mental health and wellbeing and feel satisfaction with their lives.	Self-reported wellbeing (adults) / suicide rate	Proportion of adults reporting low life satisfaction, high anxiety, or low happiness (ONS wellbeing survey). Suffolk: 20.8% high anxiety, 4.4% low satisfaction. Norfolk: 22.3% high anxiety, 3.9% low satisfaction.	Captures population mental health and resilience. Sensitive to social, economic, and environmental stressors; guides community and system-level interventions.
Stay Well	**People in Norfolk and Suffolk live longer in good health, with fewer long-term conditions and better management of them when they occur.**	Prevalence and management of long-term conditions (LTCs)	Number and rate of adults diagnosed with hypertension, diabetes, CKD, asthma, CVD prevention and management. Suffolk: 149,712 with hypertension, 57,383 with diabetes. Norfolk: 173,057 with hypertension, 71,706 with diabetes	LTC prevalence reflects the burden of disease, service demand, and need for integrated care. High rates in deprived areas highlight inequalities and system pressure.
	Everyone with diabetes in Norfolk and Suffolk has access to high-quality education and support to manage their condition.	Diabetes education offer	Percentage of diagnosed diabetes patients (type 2) offered structured education within 12 months of diagnosis. SNEE: 66.4% NW: 72.4% (below England average) (2022).	Early education improves self-management, reduces complications, and supports prevention. Low offer rates indicate missed opportunities for better outcomes.
Age Well	**People living with dementia and their carers in Norfolk and Suffolk are supported through regular, personalised care planning.**	Dementia care plan reviews	Percentage of people with dementia who had a care plan review in the last 12 months. SNEE: 77.2% (above England average). NW: 75.1% (similar to the England average) (2024/25).	Regular reviews support independence, quality of life, and carer support. High rates reflect good practice; gaps indicate risk of unmet need.
	Older people in Norfolk and Suffolk stay active and independent for longer, with fewer falls and fractures.	Hip fracture rate (65+)	Number and rate of hip fractures among adults aged 65+. Suffolk rate is lower than England, but >850 fractures 2023/24. Norfolk rate similar to England but 1,215 fractures in 2023/24	Hip fractures are a proxy for frailty, falls risk, and system effectiveness in prevention. They drive hospital admissions, loss of independence, and care costs.
Die Well	**Fewer people in Norfolk and Suffolk die early from preventable causes, and everyone has the chance to live a long, healthy life.**	Premature (under 75) preventable mortality	Number and rate of deaths under age 75 from causes considered preventable (e.g. CVD, cancer, suicide). Suffolk: around 2,766 deaths (2022-24), lower than England average. Norfolk around 3,685 deaths for same period (also lower than England average)	Measures avoidable deaths and system effectiveness in prevention. High numbers indicate where earlier intervention could save lives.
	People in Norfolk and Suffolk are supported to die with dignity in the place of their choosing.	Place of death in line with patient preference	Proportion of deaths occurring in the patient's preferred place (home, hospice, care home). Supported by advance care planning and compassionate companion services.	Quality marker for end-of-life care. Reflects dignity, choice, and system responsiveness; improves experience for patients and families.

… to improve outcomes along the life course for people in Suffolk (Updated Dec 2025)

Knowledge Intelligence and Evidence Team at Suffolk County Council

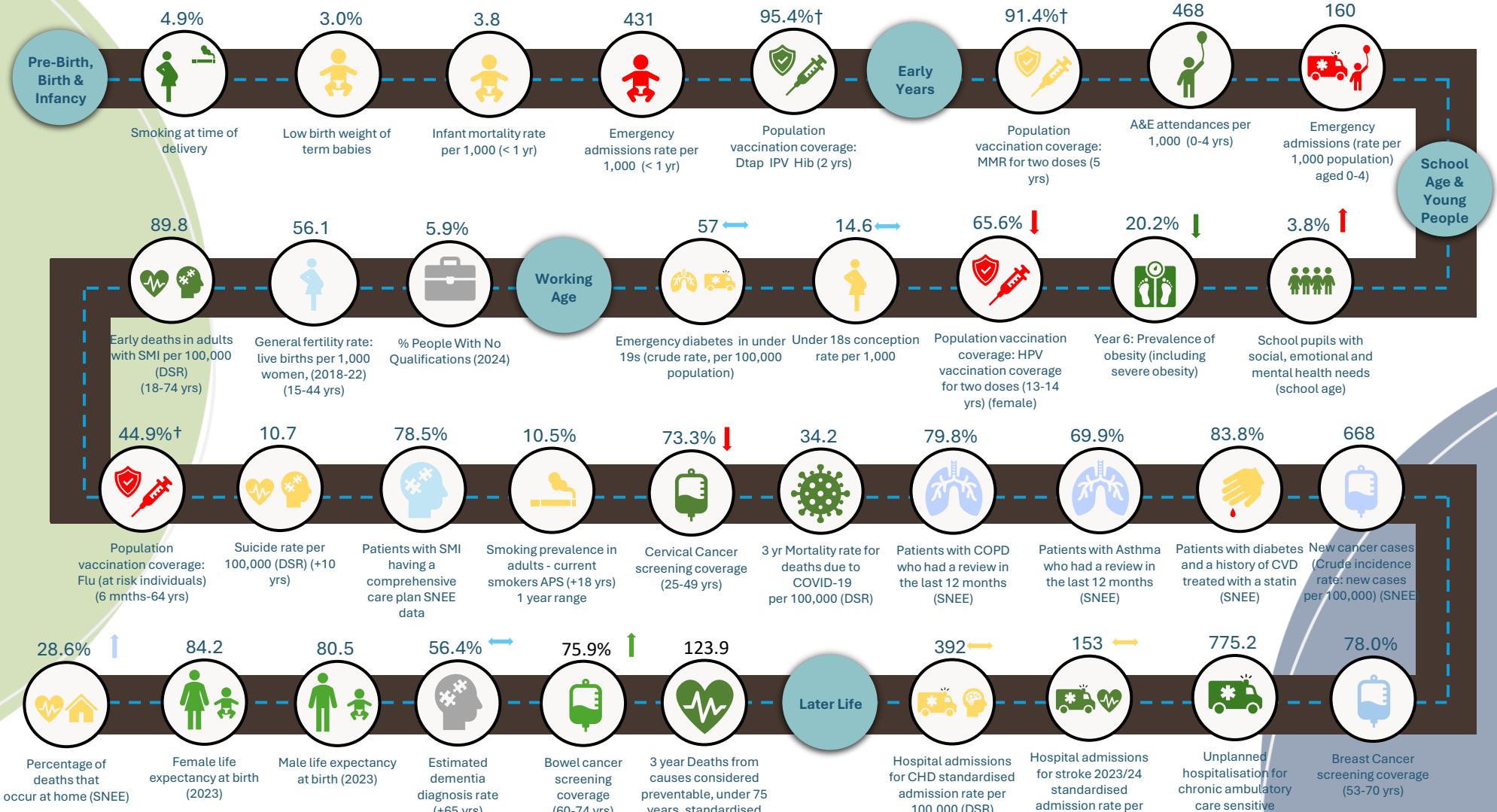
Arrows represent the trend (if available):

Getting better ↓↑ Staying the same ↔ Getting worse ↓↑

Icon colours show the indicator compared to the national average (if available):

Worse Similar Better

Lower Higher



Sources: NHS Digital, NOMIS, OHID, ONS

[a] NHS OF measures are indirectly standardised to the 2012 England population structure: the ratio of actual local counts to expected (the 2012 England age rates applied to local age populations) is multiplied to the original 2012 England rate.

†Compared to goal

Outcomes along the life course for peopl in Norfolk (December 2025)

Insight and Analytics at Norfolk County Council

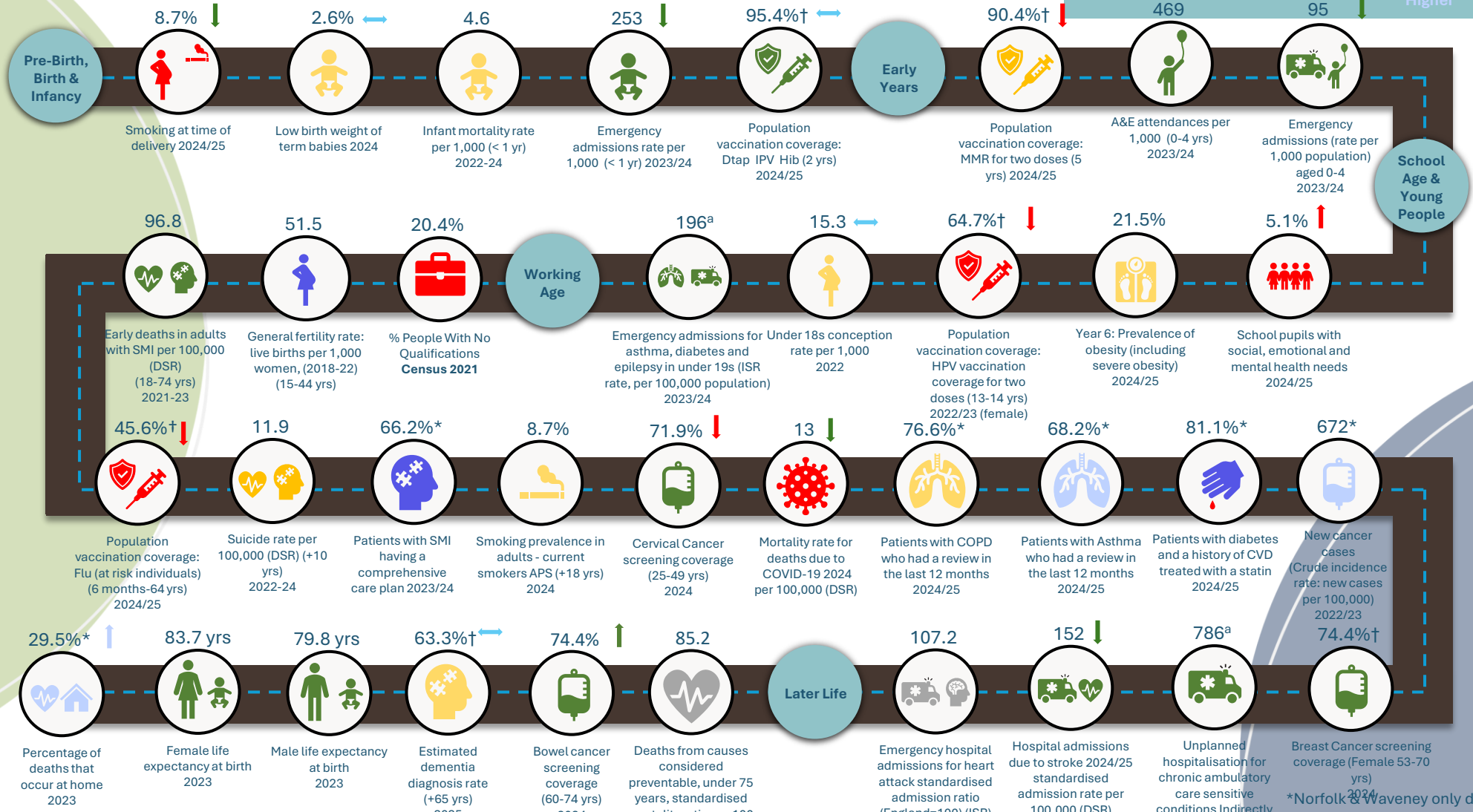
Arrows represent the trend (if available):

Getting better ↓↑ Staying the same ↔ Getting worse ↓↑

Icon colours show the indicator compared to the national average (if available):

Worse Similar Better

Lower Higher



Sources: NHS Digital, NOMIS, OHID, ONS

*Norfolk & Waveney only due to data availability

†Compared to goal

[a] NHS OF measures are indirectly standardised to the 2012 England population structure: the ratio of actual local counts to expected (the 2012 England age rates applied to local age populations) is applied to the original 2012