Norfolk and Waveney
Clinical Commissioning Group

NHS Norfolk and Waveney CCG Annual Report 2021/22

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PERFORMANCE REPORT

Performance Overview

The purpose of this overview is to provide sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives, and how it has performed during the year. There is further detail in the Performance Analysis, Accountability Report, and Accounts sections.

Accountable Officer and Chair's Statement

This has been another historic year for the NHS as we continue to address the impacts of the COVID-19 pandemic. A programme like no other, the Norfolk and Waveney COVID-19 vaccination programme has significantly reduced the impact of the virus on the people of Norfolk and Waveney, as more than 94% of people over the age of 18 have had at least one dose of the vaccine.

Throughout this year of recovery, COVID-19 has continued to influence how we manage and deliver our services. It has fostered continuing co-operation and support amongst our partners in the Norfolk and Waveney Health and Care Partnership and challenged us to be more innovative in our approach to how we deliver our services.

We are incredibly proud of the way our local system has come together to deliver the vaccination programme at such speed given the complexities involved and the significant pressures facing services. The people of Norfolk and Waveney have been vaccinated at one of the fastest rates of any health system, with our system consistently in the top five performing systems for vaccinations in England.

In writing this report, we are both proud and humbled by the extraordinary amounts of effort, determination, and sacrifice that have been made to deliver the vaccination programme whilst continuing to deliver essential health and care services to the people of Norfolk and Waveney. We would like to take this opportunity to say a profound thank you to all CCG staff and others working for the NHS in Norfolk and Waveney, as well as our colleagues in local authorities, the care sector, and the thousands of volunteers for your hard work and commitment over this last year.

The last two years have seen us face extraordinary challenges, and we know many of our staff and local NHS colleagues are feeling the effects of the pace and pressure of the last two years. Our people are our greatest asset, and as we look forward to the coming year, we will be ramping up our efforts in helping to make Norfolk and Waveney the best place to work in health and social care.

The impact of COVID-19 will be felt for a long time to come and will continue to present challenges. Like most other health and care systems across the country, we're now working at pace to address the backlog of routine elective and diagnostic procedures that were cancelled or delayed due to the pandemic. We know that many people are having to wait for planned and elective procedures, and we will continue to do all we can, working with colleagues in the local NHS to reduce waiting times and support people to stay well.

We continue to see the impact of the pandemic on people's mental health and wellbeing with increases in the number of people presenting with mental health conditions. To help address this, Norfolk and Waveney has invested heavily into our mental health transformation programme which is yielding improvements and innovation in our local mental services. There is a lot of work to be done, but we are committed to ensuring those who need help receive the support they need.

While we reflect on the successes and challenges of the previous year, we also must acknowledge where performance fell short, and seek to learn and improve on the quality of service when we do not get things right. This year the publication of the Norfolk Safeguarding Adult Review into the deaths of three patients at Jeesal Cawston Park highlighted serious failings in patient care. We are committed to learning from the mistakes that were made to prevent other individuals or families from experiencing harm because of ineffective services in future. We also recognise we need to improve our efforts in supporting our mental health provider, Norfolk and Suffolk Foundation Trust (NSFT) following its 'inadequate' rating by the Care Quality Commission (CQC). While we work with them to make the necessary quality improvements to improve safety and quality of care for those accessing mental services, we also would like to acknowledge our thanks and appreciation to NSFT staff, who were rated as 'good' within the CQC's report.

This year, we will formally transition to an Integrated Care Board, which you will read more about in this report. This is an important step for us as an Integrated Care System and will strengthen our approach to working more collaboratively with partners in the voluntary and community sector to deliver more joined-up care, and foster greater engagement with residents in how services are commissioned and delivered across Norfolk and Waveney.

COVID-19 has not left us and we now need to learn to live with the virus. As we move forward, we will adapt and rise to the challenge of living with COVID-19, as well as continuing our efforts to deliver quality, safe and effective health and care services to the people of Norfolk and Waveney.

Tracey Bleakley
Interim Accountable Officer

Dr Anoop Dhesi
Chair

Reflections from the Chair of the CCG

This annual report is the last full report of NHS Norfolk and Waveney CCG before we transition to an Integrated Care Board (ICB) later this year.

This year we have made great progress towards that transition, building on our strong local network of partnerships to develop the systems and infrastructure that will enable us as an ICS to improve on existing inequalities in outcomes, experience and access to health and care services.

Over the course of the last year we have seen some important changes internally, too. Melanie Craig, our Chief Executive and Accountable Officer of the CCG, left in December 2021. I would like to thank Melanie again for the tremendous contributions she made to our local health and care partnership. She led the highly successful creation of the single CCG that came into existence just as the Covid-19 pandemic struck in early 2020, and her contribution to the vaccination programme, one of the most successful in the country, is a further tribute to her achievements.

Recruitment to the leadership post of the ICS this last winter resulted in the successful appointment of Tracey Bleakley as Chief Executive designate to lead the Integrated Care Board (ICB) of the ICS.

Dr Ed Garratt, Chief Officer of Suffolk and North East Essex ICS, stepped in as Interim Accountable Officer for three months from January until Tracey took up her post as Accountable Officer from 1 April 2022. I would like to thank Ed for taking on this additional responsibility and supporting the CCG to continue to deliver services during an extremely challenging winter, and to welcome Tracey into her new role.

As a single CCG, Norfolk and Waveney has seen some significant developments in health and care services for local residents.

Some of these will strengthen our system as an ICS, for example the development of a VCSE Assembly which will build stronger and more equitable partnerships between our large, diverse and vibrant voluntary sector and NHS and social care organisations, and the appointment of its first chair, Emma Ratzer.

Developments in primary care will improve outcomes for patients. Primary Care is now organised into Primary Care Networks which are groups of GP practices that work closely with community, mental health, and social care staff to improve services for local people. A digital transformation is also underway within primary care, creating new opportunities to improve how practices are run and how services are offered, which will further improve patient experience.

Collaborative working is at the heart of what we have done as a CCG and will do as an ICS, and during the last two years there have already been excellent instances of this. For example, the investment in our mental health transformation, which has enabled a programme of work to join up organisations that provide mental health services in the community so that people have more access to support services closer to where they live and work. And our vaccination programme, which sees system partners come together to share data, insight and resources to be able to deliver one of the most successful vaccination programmes in the country.

We have a strong foundation to build upon as the CCG transitions into an ICB, and I am extremely grateful to all my colleagues who have worked tirelessly over the last two years to deliver health services in the most challenging of conditions. And also to our partners across the ICS who have come together to provide collaborative solutions to help us recover from the unprecedented challenges wrought by the COVID-19 pandemic.

Dr Anoop Dhesi
Chair

Purpose and Activities of the Organisation

NHS Norfolk and Waveney Clinical Commissioning Group (CCG) is responsible for planning and buying safe, high quality health services. The CCG agrees and administers contracts with hospitals, community services, the mental health trust, GP practices, the ambulance trust, and other organisations who provide care and treatment services, and monitors the performance of the delivery of these services.

The CCG at a glance:

The services the CCG commissions are for people living (or registered with a GP) in the Norfolk and Waveney area. Primary Care is now organised into Primary Care Networks (PCNs) which are groups of GP practices that work closely with community, mental health, and social care staff to improve services for local people. The map below shows the PCNs operating within the CCG geographical boundary.

NHS England and NHS Improvement (NHSE/I) revised the CCG assessment method in 2020/21 due to the continued impact of COVID-19 and the change in CCG priorities. This approach means that CCGs are no longer being given an overall rating and will instead receive a narrative assessment of performance. More information is provided in the Performance Summary section.

Structure of the CCG

The CCG is made up of 105 Member Practices grouped into 17 PCNs (see map above), and more information on PCNs is available at Primary Care Networks - Norfolk and Waveney CCG. Each Member Practice is entitled to be represented at the Council of Members, which holds the CCG to account for its business, strategy, and policies.

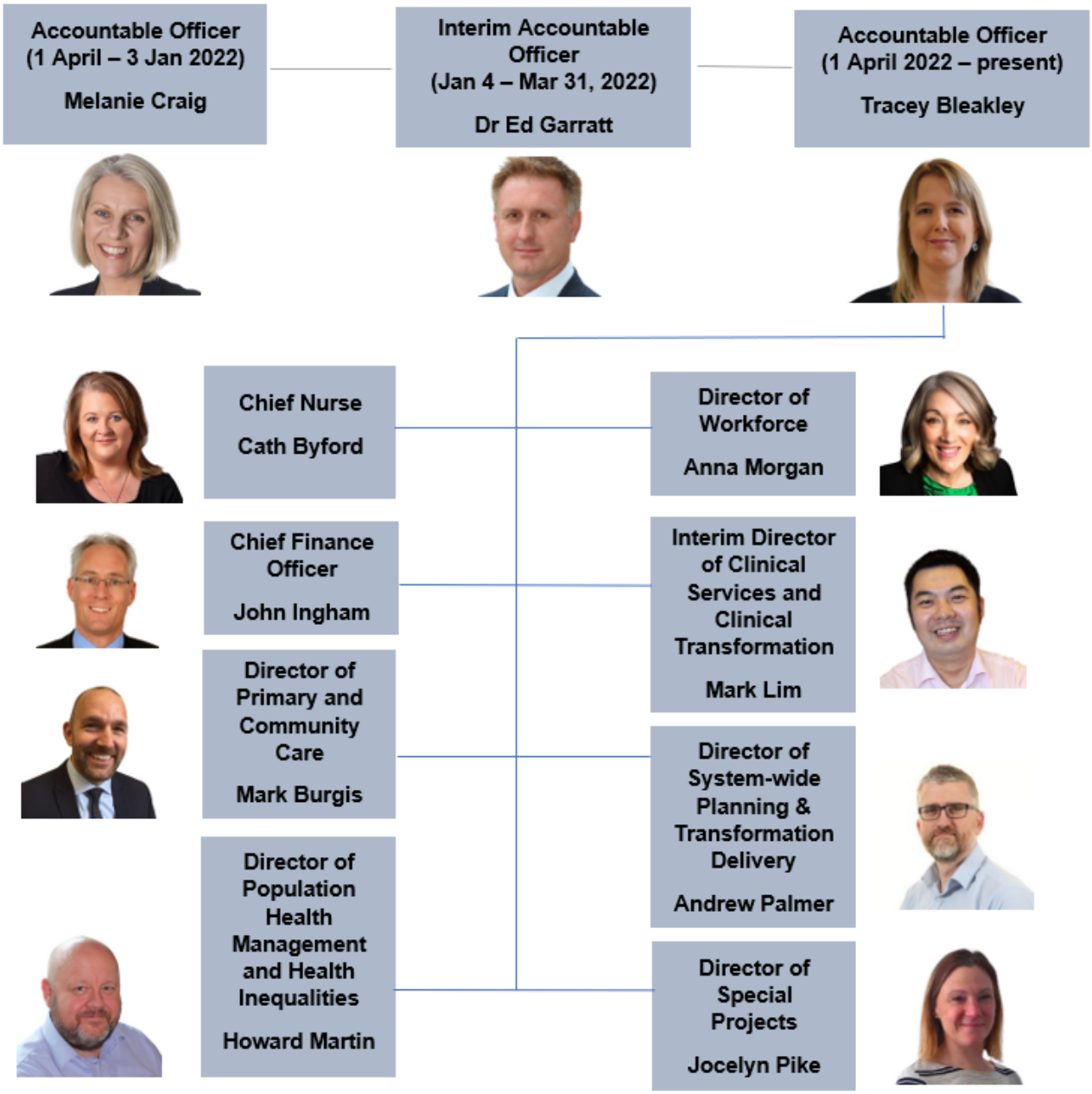
The Council of Members delegates oversight of the CCG to the Governing Body, which is comprised of elected local clinicians from member practices plus lay members and senior CCG management staff.

Due to COVID-19 and the pressures on primary care, the CCG paused the roll out of the Council of Members so that member practices could focus on addressing the pandemic. The CCG has not held a formal Council of Members meeting from 1 April 2021 up to the date of submission of the annual report on 22 June 2022. More information on the Council of Members actions and responsibilities is contained with the Accountability report.

The CCG will formally transition to an Integrated Care System on 1 July 2022. Recruitment for a Chief Executive Officer was conducted in winter 2021 which resulted in the appointment of Tracey Bleakley as Chief Executive Officer-designate of the Integrated Care Board of the Norfolk and Waveney Integrated Care System. Dr Ed Garratt was appointed as the CCG's Interim Accountable Officer from 4 January – 31 March 2022.

Operationally, the CCG is led by the Accountable Officer and a team of directors who, along with other senior colleagues, meet regularly as an Executive Management Team.

A diagram of the Executive Management Team is below.



The Norfolk and Waveney Health and Care Partnership

The CCG is an active member of the Norfolk and Waveney Health and Care Partnership which was confirmed as an Integrated Care System (ICS) by NHSE/I in December 2020.

This confirmation recognised that over the past few years the CCG, with system partners in the NHS, local authorities, voluntary and charity sectors, has worked with increasing collaboration to tackle the issues and challenges that no partner can solve on their own. Equally, it has also given way to working together on transformation programmes and projects, realising that working together has enormous benefits for the people of Norfolk and Waveney. This was accelerated during the COVID-19 pandemic, and cross-system relationships have strengthened at every level through the pandemic recovery.

From 1 July 2022, ICSs will be made up of two core elements: Integrated Care Boards and Integrated Care Partnerships. Locally these two elements will perform the following core functions:

- The **Integrated Care Board** (ICB) will be responsible for the strategic development, funding, and health commissioning activities for the partnership.
- The **Integrated Care Partnership** (ICP) will be responsible for integrating the care system with the wider public and charitable sector and will have statutory responsibility for developing the strategy to address health inequalities.

The Health and Care Bill 2021 contains a series of measures to formally establish ICBs. Having received Royal Assent, ICBs will become statutory bodies on 1 July 2022 and replace CCGs. Therefore, the formal transition of the Norfolk and Waveney CCG to become NHS Norfolk and Waveney Integrated Care Board has a confirmed date of 1 July 2022.

A number of key appointments have already been made to the Norfolk and Waveney ICB:

- Rt Hon Patricia Hewitt has been appointed as Chair-designate of the ICB
- Tracey Bleakley has been appointed as Chief Executive designate of the ICB
- Councillor Bill Borrett has been appointed as Chair-designate of the ICP
- Cathy Armor has been appointed as Non-Executive Member-designate of the ICB
- Hein van den Wildenberg has been appointed as Non-Executive Member-designate of the ICB
- David Holt has been appointed as Non-Executive Member-designate of the ICB

The CCG and its system partners have a clear vision and set of common goals for improving the health, wellbeing and care of people living locally, and have developed the right relationships between the different parts of the health and care system to enable the ambitions of the ICS to be realised. More information can be found at www.norfolkandwaveneypartnership.org.uk

The goals of the ICS

The partnership has identified three overarching goals it would like to achieve as an ICS:

1. To make sure that people can live as healthy a life as possible - Preventing avoidable illness and tackling the root causes of poor health to reduce health inequalities across our area.

2. To make sure that you only have to tell your story once - Services must work better together so that key information doesn't have to be repeated to every health and care professional.

3. To make Norfolk and Waveney the best place to work in health and care – Supporting staff development and wellbeing will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

Key Risks and Issues

The CCG is proactive in identifying and managing risks and issues that might adversely affect its plans or business.

Key risks to performance are formally logged on the Governing Body Assurance Framework (GBAF) document, which is reviewed by the CCG's committees and reported to Governing Body at each meeting. For each risk identified there are mitigating actions identified and provided to the Governing Body with assurance that they are being managed.

This year the key risks recorded on the GBAF included:

- System Urgent and Emergency Care pressures risk impacting on patient assessment and care, and timely discharge from hospital
- The risk that the number of patients waiting for elective treatment may fail to meet Constitutional requirements
- Cancer diagnosis and treatment delays, and elective backlogs
- The risk that East of England Ambulance Trust (EEAST) response times could potentially lead to significant risk of patient harm
- Potential structural (RAAC roof and wall plank) failure at Queen Elizabeth Hospital (King's Lynn) and James Paget Hospital (Great Yarmouth)
- COVID-19 resurgence during winter 2021 risks overwhelming existing system pressures
- Financial pressures risk impacting on ability to deliver current levels of service in 2022/23
- Capability and capacity of providers to deliver Continuing Health Care packages

Further information can be found in the Governance Statement.

This year the continued demands placed on the health and care system from the coronavirus pandemic, and the demands on the Urgent and Emergency Care system, have been exceptional. These demands presented key challenges and risks to the CCG, which are highlighted below.

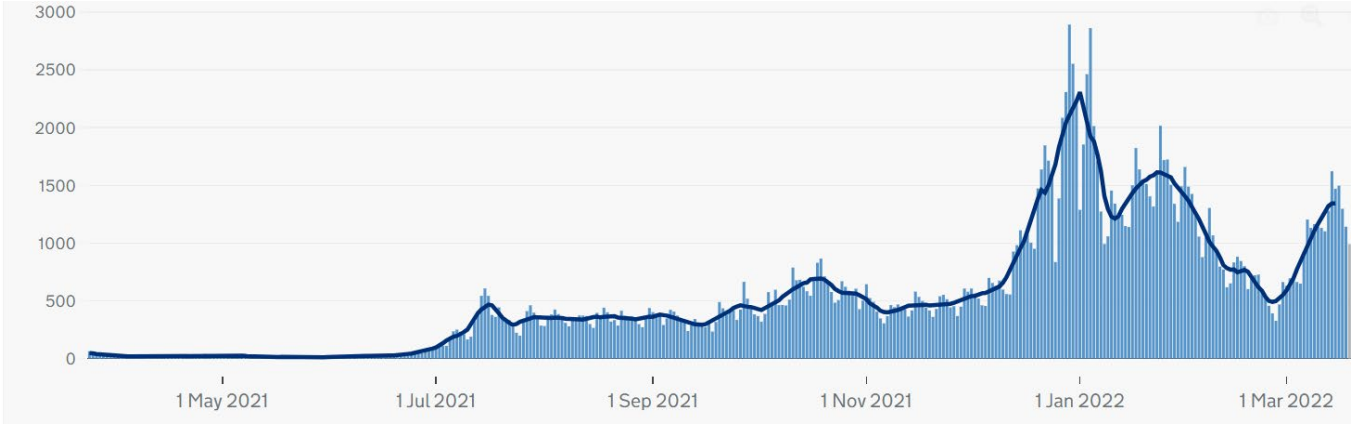
COVID-19

COVID-19 continued to present significant risks to CCG operations and health and care services throughout the year as new variants spread through communities. The first new variant in July (Delta variant) and another in January (Omicron variant).

The table below highlights the range of infection rates not just between the different variants but between different districts as well. East Suffolk District Council covers the Waveney area.

Area	Date of July Peak	7-day incidence rate per 100,000	Date of January Peak	7-day incidence rate per 100,000
Breckland	04/08/2021	258.4	04/01/2022	1,482.4
Broadland	18/07/2021	359.3	02/01/2022	1,952.5
Great Yarmouth	19/07/2021	809.5	04/01/2022	2,232.9
King's Lynn and West Norfolk	19/07/2021	335.2	04/01/2022	1,652.3
North Norfolk	19/07/2021	257.7	04/01/2022	1,507.1
Norwich	02/08/2021	468.4	04/01/2022	1,941.9
South Norfolk	20/07/2021	318.7	04/01/2022	1,739.8
East Suffolk	20/07/2021	270.4	04/01/2022	1,883.2
Norfolk	19/07/2021	357.8	04/01/2022	1,766.8
East of England	19/07/2021	469.1	04/01/2022	1,970.8
England	19/07/2021	555.4	04/01/2022	2,201.7

The steep rise in infection rates of the Omicron variant saw an increase in patients with COVID-19. While the vaccines have been effective in reducing hospitalisations and serious illness, there has been an increase in patients needing care as coronavirus restrictions have eased



Norfolk COVID-19 infection rates, sourced from https://coronavirus.data.gov.uk/

COVID-19 continued to impact on staffing levels both in terms of infection rates and staff needing to isolate. This put additional pressure on all health services and impeded progress of the return to business-as-usual services such as elective and non-elective patient services.

Rigorous infection prevention and control practices and patient zoning were required in acute settings to separate positive, negative, and symptomatic patients which impacted on patient flows and ambulance handover times.

Pressure on Urgent and Emergency Care services

Following sustained and unprecedented pressure on health and care services, the system was in “Critical Incident” status from 30 December 2021 until end of January 2022. The system remains at OPEL 4 (Operations Pressure Escalation Level 4), the highest operational pressure escalation level, due to continued high demand for health and care services.

All parts of the system were affected, from general practice and community health services, through to the acute hospitals, the mental health trust, social care services and voluntary sector organisations. The pressure stemmed from a combination of the backlog of patients who could not be discharged to suitable care in the community or at home, and the impact of the Omicron variant on the workforce. This resulted in fewer staff able to care for the patients that need care, and blockages in flow through hospitals as people that were well enough to leave were not able to be discharged.

Additional funding and capacity were allocated to help address these challenges, see more in the Urgent and Emergency Care and Mental Health sections below.

Risks to staff wellbeing and burnout

The increased and sustained pressure on staff across the CCG and the wider ICS has not abated since the start of the pandemic in winter 2020. This presents an ongoing risk to staff health and wellbeing and has resulted in increased staff sickness absences and staff turnover, which risks impacting on patient care. See more information in the Workforce section below.

Performance Summary

This is a summary of the Performance Analysis. Further details about performance and a more detailed look at the work of the CCG can be found from page 13.

The NHS Norfolk and Waveney CCG launched in April 2020 amidst a backdrop of the demands and challenges of the COVID-19 pandemic. But despite these challenges, COVID-19 has been an accelerator of transformation in many areas, including remote consultation, digital and IT transformation, PCN development, and provider collaboration.

As the nation emerged from the pandemic, Norfolk and Waveney saw an increased demand for health services that affected all parts of the health and care system. This has presented key system risks including enormous elective backlogs, delayed ambulance response times, poor hospital flow with high bed occupancy, challenges in discharging people from hospitals due to lack of bed space in care homes and the community, and high workforce absence rates due to redeployment priorities, isolation and sickness.

Funding allocations, service innovations, and collaborative approaches across ICS partners have been strategically deployed to address demands on the health system, support recovery plans, and help patients to access health services equitably and safely.

However, despite all that has been done to keep services running, primary and secondary care still face unprecedented levels of unmet patient need due to the pandemic. COVID-19 has directly led to significant increases in the number of patients waiting for operations and other procedures beyond the 18-week target. More information is contained in the Performance Analysis section.

Norfolk and Waveney's COVID-19 vaccination programme is one of the top performing in the country, thanks to its collaborative and data-led approach. Teams from the CCG have been working with system partners to remove barriers that prevent harder to reach groups from accessing the vaccine, helping to mitigate the impact of health inequalities on vaccine uptake. More information on the approach and highlights of the programme are in the COVID-19 Vaccination section.

In August 2021, all Integrated Care Systems in England were placed in one of four segments of NHS England and Improvement's (NHSE/I) System Oversight Framework Ratings (SOF). The Norfolk and Waveney ICS was placed in segment 4 (SOF4) and in so doing joined the Recovery Support Programme (RSP). The RSP provides national mandated intensive and integrated improvement support to help strengthen the system to address complex, deep-seated problems and embed lasting quality and financial solutions.

For Norfolk and Waveney, this support focuses on improving the system's underlying financial position, improving urgent care performance including long waits for Mental Health patients, and supporting two of the provider trusts (Queen Elizabeth Hospital in King's Lynn (QEH) and Norfolk and Suffolk Foundation Trust (NSFT)) to make necessary quality improvements. Significant amounts of work have been undertaken from all system partners to work towards the required improvements, and the CCG was delighted when the QEH came out of special measures in February 2022. The CCG recognises that significant work remains in supporting NSFT to make quality improvements following its 'inadequate' rating by the Care Quality Commission (CQC) in April 2022, and is working alongside other system partners to support the Trust to make the improvements outlined in the CQC's report.

Health Services

Demand for all NHS services rose this year. As it is across the country, recruitment and retention of clinicians remains a significant issue which was compounded by the announcement of Vaccination as Condition of Deployment (VCOD) and the impact on staff health and wellbeing of two years of delivering services against the backdrop of COVID-19. Introducing new clinical skill mixes and mixed appointment models within GP surgeries has been positive, and the CCG recognises the dedication of our clinical colleagues who have worked incredibly hard throughout the year to look after patients in their care.

Key highlights and achievements of the CCG and its partners include:

- **Primary Care** – PCNs and GP practices played a crucial role in delivering the COVID-19 vaccination programme, with over 50% of doses administered in a primary medical care setting. General practice continued to adapt to deliver a mixed model of care (face-to-face, telephone, and online consultations) to offer more patient choice and reduce waiting times for appointments.

- **Community Care** – Norfolk Community Health & Care NHS Trust (NCH&C) coordinated delivery of the COVID-19 vaccination programme's roving model which formed part of the CCG's strategy to improve vaccine access and reduce health inequalities. This model included a vaccination bus, pop-up clinics, and Worry Clinics to reach areas of low uptake and high levels of vaccine hesitancy. NCH&C provided specialist teams who could offer the time, space and extra support needed for anyone who was anxious about having a vaccine, and address concerns around fertility, pregnancy, vaccine safety and needle phobia.

  Acute Care – New hubs and service innovations were unveiled this year to improve access to services outside of hospital settings. These include a new maternity hub operated by the Queen Elizabeth Hospital (QEH) in Downham Market that provides antenatal and postnatal care to reduce the need to attend routine appointments in an acute hospital setting, and the new North Norfolk Macmillan Centre at Cromer and District Hospital, operated by the Norfolk and Norwich University Hospital Foundation Trust (NNUH), which has brought cancer treatment and support services closer to thousands of people in North Norfolk. Virtual Wards were launched out of the NNUH as well, providing remote monitoring and follow-up service for patients that can be safely discharged to continue their recovery in the comfort of their home. Patients receive daily phone or video calls as part of "virtual ward rounds," where they receive advice and support including remote checking of temperature, pulse, blood pressure and oxygen saturation levels.

  The three acute hospitals also introduced a shared consent policy, the first joint policy which will set the foundation for improved care and more efficient hospital services across Norfolk and Waveney. It is the first of many policies being developed across the three hospitals which will ensure consistency in patient care and improve efficiencies for clinical staff who move between sites.

  A Care Hotel in Norwich was piloted in February 2022 to support patients to leave hospital safely and to relieve pressure on hospitals, and a Multi Agency Discharge Event (MADE) was coordinated amongst health and care colleagues to improve discharge and flow across the three hospitals over the busy winter months. Additionally, partners across the ICS have worked collectively to support flow through the whole acute and community pathway, supporting discharge and the urgent care response. Additional capacity has been commissioned in several

care homes where available, along with therapy and medical support from local providers and practices to ensure that patients receive the full reablement offer with the aim to return home.

- **Mental Health** – The CCG has continued to work with Norfolk and Suffolk NHS Foundation Trust (NSFT) and system partners to deliver the All-age Mental Health Transformation programme. Whilst the pandemic has driven increased demand for services and led to later and more complex presentations of mental health issues, this year system partners have committed to a strategic and collaborative working approach to deliver the aims of the programme and improve outcomes for patients. Significant funding has been invested to improve access to services, including Wellbeing Hubs, Community Teams, and funding new roles to support mental health within Primary Care. Additional targeted digital services for young people (through Kooth), and adults (through Qwell), have been commissioned to provide free and confidential access to professional help for any mental health concern, as and when needed.

  To support achievement of the Mental Health Transformation programme, partners have prioritised promotion of mental wellbeing to support early prevention and reduce escalation, and delivered innovative programmes to enhance mental health provision in the community such as the Joint Response Ambulance Car and increasing capacity within the community via Primary Care Network Mental Health Practitioners who provide safe, effective and responsive mental health services closer to where people live and work. These, combined with the collaboratively developed Mental Health workforce and digital strategies, have resulted in the Norfolk and Waveney system being on track to achieve 10 of the 15 national key performance indicators for 2022/23.

Performance of local health services continue to be significantly impacted by the effects of the coronavirus pandemic and should be expected to do so for a long time to come. Performance data on services is contained in a table in the Performance Analysis section of this report.

PERFORMANCE ANALYSIS

Risks and uncertainties around achievement of the CCG's performance are managed by the CCG. There are numerous factors which create risk and uncertainty, in particular demands on the workforce and demand on health services.

Risks and uncertainties to the delivery of the CCG's performance are reported in the Governing Body Assurance Framework. The GBAF is a live document and can be found on the CCG's website among the bi-monthly published Governing Body papers at https://www.norfolkandwaveneyccg.nhs.uk/publications/governing-body-agendas-and-minutes

Further information about the CCG's risks can be found in the Governance Statement.

CCG Performance

The narrative assessment for 2020/21 by NHSE/I was received by the CCG in August 2021 and was the last received by the CCG prior to completion of this Annual Report.

NHSE/I recognised Norfolk and Waveney CCG's efforts and commitments over the previous year to the COVID-19 response, vaccination programme, and steps towards restoration for partners, staff, and patients in extremely challenging circumstances.

The summary headline points from the 2020/21 assessment (the last received by NHSE/I) include:

- Delivery of an in-year surplus of £0.6m for the year ended 31 March 2021
- Successful merger of the five CCGs from 1 April 2020
- Delivery of COVID-19 and flu vaccination programme
- Supported the system to develop and deliver reset and recovery plans
- Nationally recognised COVID Protect scheme reaching out to over 40,000 of Norfolk and Waveney's most vulnerable people

Alongside these successes, NHSE/I also recognised the CCG needed to continue in its leadership role to advance the transformation of community mental health services to improve patient outcomes. Addressing elective, planned care and cancer waiting lists; developing an Urgent and Emergency Care blueprint to help the system cope better with the sustained growth in demand; and developing robust Discharge to Assess pathways to reduce the use of acute beds by medically fit patients so they can be used to meet the significant elective demands currently on the system were also highlighted as key priorities for the CCG looking forward to 2021/22.

Performance of NHS services

Information about the overall performance of services is contained in the table and narratives below.

The table below shows an overall RAG (Red / Amber / Green) performance against constitutional targets based on an average summary of monthly performance over the year. Green indicates that all targets were achieved, Amber that some targets were achieved, and Red that no targets were achieved.

Constitutional Area	2021/22 Performance RAG
Cancer Waiting Times	2 / 8
Diagnostics Waiting Times	0 / 1
Referral to Treatment Waiting Times	0 / 2
A&E Waits	0 / 2
Ambulance Response Times	0 / 6
Ambulance Handovers	0 / 4
Infection Control	0 / 3
Mental Health - IAPT	3 / 4
Mental Health - Other	2 / 4
Community (RTT, 111 & OOH)	2 / 12

The impact of COVID-19 continued to be felt across NHS services over the year as unmet patient demand fed back into the health system. This, along with workforce pressures and COVID-19 infection prevention and control guidance constraining how quickly patients can move through the health and care system, has created enormous pressure which is reflected in the performance against targets outlined above.

Performance against targets for cancer waiting times in Norfolk and Waveney were not all met, with only 31 days subsequent anti-cancer drugs and 31 days subsequent radiotherapy achieving targets (averaged 98% and 95.8% over the year, respectively). Whilst the remaining six cancer waiting time targets weren't met, the latest performance data from February/March 2022 shows improved performance compared to the annual average indicating a positive trend towards recovery of cancer

targets. This improving trend reflects the collaborative work that colleagues across the ICS have undertaken to balance demand for cancer services with the available capacity across the system to help address the backlog and to accelerate diagnostic pathways. More detailed information on activities to support recovery of cancer performance can be found in the Cancer section.

Diagnostic waiting times and Referral to Treatment waiting times failed to meet all targets over the year, due to the unprecedented demand for services and backlog from the pandemic impacting on available diagnostic and treatment capacity. Whilst the performance against target of 99% of diagnostic tests to be completed within 6 weeks wasn't met this year, the latest performance data shows improved performance (67.8%) compared to the annual average (65.2%) indicating a positive trend towards recovery to target. Referral to treatment targets also underperformed, and recovery has been hampered by the growing number of patients that are waiting for elective treatments. More information on the performance and priority actions to improve diagnostic and referral to treatment waiting times can be found in the Cancer and Planned and Elective Care sections.

The local performance of emergency services reflects the regional and national picture, with increased demand for health services, staff shortages, COVID-19 infection prevention and control guidance, and constraints in the social care market all compounding pressures on A&E departments and ambulance services to unprecedented levels. The performance target of 95% of A&E attendances to be seen in under four hours was not met, averaging 68.4% of patients over the year, and a reduction from the 81.1% target achieved at March 2021. Ambulance response times for all categories of calls, as well as handover times, were all significantly below target owing to the demands on available capacity. More information and performance data are provided within the Urgent and Emergency Care and Discharge to Assess sections.

There has been renewed and strengthened system partnership and working to collaboratively develop strategies to support early intervention of mental health issues. This has seen performance for areas of the Improving Access to Psychological Therapies (IAPT) service improve on performance in 2021/22. The numbers of people accessing support for anxiety disorders and depression through the IAPT service had an improving trend through 2021/22: March 2022 saw a 41.8% increase in patients entering treatment compared with March 2021 (2,260 compared with 1,594) however this was below the national aspiration of 2,477. While we did not achieve the nationally set access numbers in 2021/22, we did achieve the highest ever access rate for Norfolk and Waveney and continue to build on the positive work to develop wider system reach through 2022/23. This was also achieved while maintaining other crucial performance indicators. The other national IAPT targets were exceeded including 96.6% of patients completing their wait for treatment within 6 weeks (target 75%), 99.4% of patients completing their wait for treatment within 18 weeks (target 95%) and 52.8% of patients moved to recovery following treatment (target 50%). Key to continuing to improve access is increasing the workforce within the service, in order to ensure people can start treatment as soon as possible.

Treatment fell below performance for Children and Young People (CYP) targets for eating disorders due to the total number of eating disorder referrals doubling and a significant increase in acuity, with urgent "high risk" cases more than five times higher than prior to the pandemic. Just under 42% of routine referrals for CYP with eating disorders were in treatment within 4 weeks against a 95% target and just under 57% for urgent cases. An all-age eating disorder strategy has been co-developed with system partners and service users with lived experience to redesign eating disorder services across Norfolk and Waveney and transform support options and improve patient access to quality and timely care. More information on these can be found in the Adult Mental Health, Children's and Young People's Mental Health, and the Engaging People and Communities sections of this report.

Performance against targets for 111 services fell below target this year, with an average of 16.5% of 111 calls abandoned over the year (against a target of 5%) and just under 42% of calls answered in under

one minute against a target of 95%. Out of hours health services had similar performance, failing to meet all targets apart from the number of Primary Care Centre less urgent patients seen in under 6 hours, with 97.8% of patients seen within that timeframe against a target of 95%. The out of hours and 111 performance, both provided by IC24, have been impacted by staffing levels and high call volumes, which is discussed more comprehensively in the Urgent and Emergency Care section.

Community referral to treatment measures also had mixed performance, with referrals to paediatric consultants exceeding target (97.8% against a target of 95%), however wheelchair waiting time performance has dropped below target owing to a range of factors including increased demand and complexity of referrals; availability of equipment; staff re-deployment during COVID-19; and a change in delivery model to ensure the safety of staff and patients, with a greater amount of domiciliary visits reducing clinic capacity.

COVID-19 Vaccination Programme

Launched in December 2020, the NHS COVID-19 Vaccination Programme has been the single most important mechanism in halting the widespread impacts of the pandemic and allowing recovery of elective and non-elective patient services and the ability to delivery effective health and care provision in the community.

The CCG has continued to lead the roll out of the vaccination programme across the health and care system during 2021/22, employing a highly resilient model across multiple partner organisations to ensure choice, agility, and geographic coverage.

Despite the challenges of rurality, an older population age profile (less able to travel), and the constraints of transporting the vaccine safely between widespread sites, Norfolk and Waveney has some of the highest vaccine uptake figures in the country. Our success is thanks to a robust delivery model – spanning multiple provider partners - and significant support from GP practice sites in providing local clinics within the communities they serve.

Norfolk and Waveney has received regional and national recognition for the performance of the vaccination programme. Over the last year, the system has regularly featured in the top five performing health and care systems in England (out of 42).

By 1 April 2021, vaccinations had been offered to all those aged 50. COVID-19 vaccinations were gradually opened up to all adults aged 18+ (including those within three months of their 18th birthday), moving down the age cohorts on a phased basis between mid-April and mid-June 2021.

In the week to 6 June 2021, Norfolk and Waveney was ranked first in the country for the highest number of vaccinations given in England and had achieved the national ambition to achieve 85% vaccination uptake within the eligible population by the end of July 2021.

16- and 17-year-olds became eligible for vaccination on 19 August 2021 and the schools' immunisation service started delivering COVID-19 vaccines for young people aged 12-15 in September 2021. During February and March 2022, children aged 5-11 who were clinically at risk or lived with someone who is immunosuppressed were invited for vaccination, and all children aged 5+ will be offered a vaccine from April 2022.

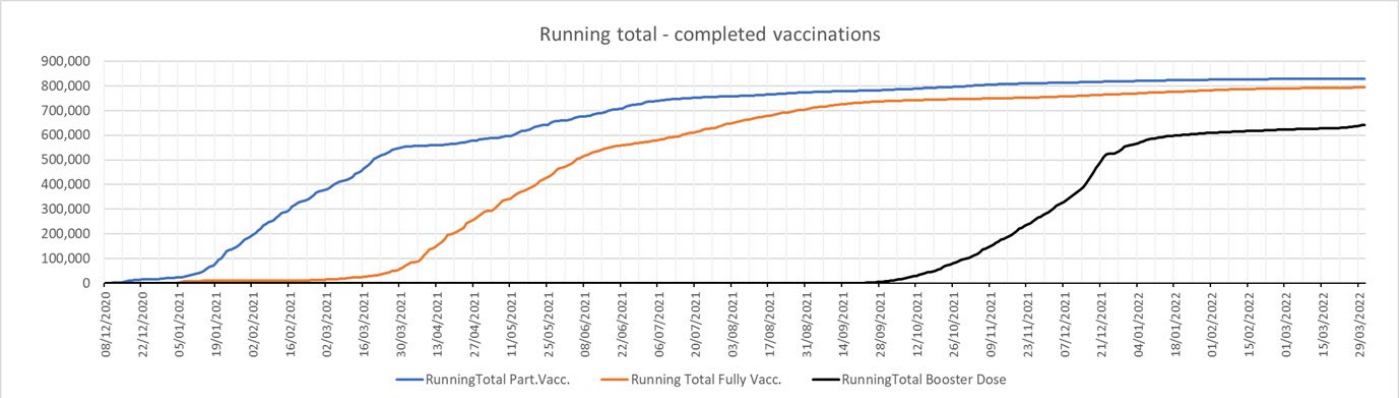
The CCG responded quickly to the government's ambition to provide a booster dose to all adults 18+ by the end of December in response to the threat of the Omicron variant, suspending all routine business that was not focussed on the vaccination programme or supporting Urgent and Emergency Care to redeploy staff to support delivery of the booster programme.

During 2021/22, vaccinations have been delivered from the following locations:

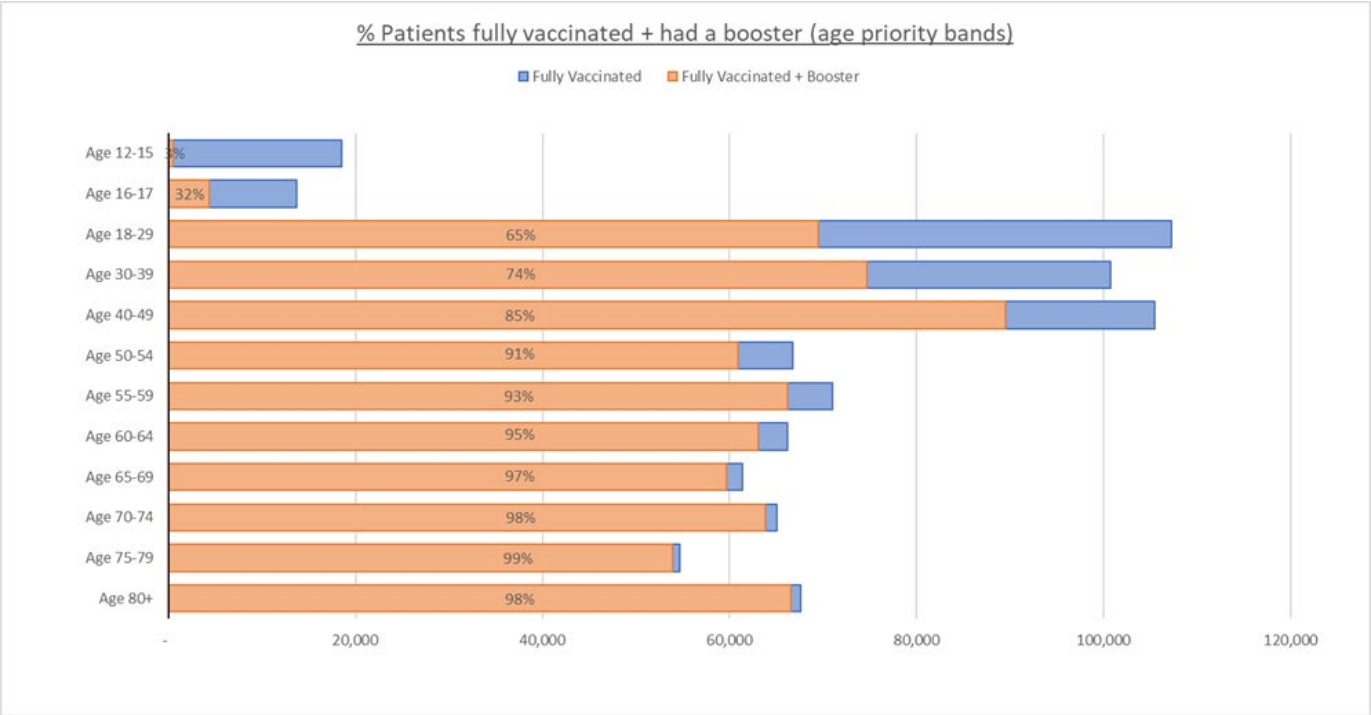
- Three hospital hubs – Queen Elizabeth, Norfolk and Norwich, and James Paget
- 101 GP practices spanning all 17 Norfolk and Waveney PCNs covering our five localities
- Eight large vaccination centres led by Cambridge Community Services NHS Trust
- 22 community pharmacy clinics run by independent pharmacy providers
- Care homes, supported living accommodation and patient homes (housebound home visits) through GP practice and community health teams
- Community venues, places of worship, large-scale public events, workplaces, further and higher education settings, homeless and asylum seeker hostels through a targeted roving model, using the vaccination bus or providing pop up clinics within community estates
- All senior schools (years 7-11, 12+13) via the schools' immunisation service

As of 31 March 2022, more than 2.3m vaccinations have been given across Norfolk and Waveney and 806,000 (94%) of people over the age of 16, have received at least one vaccination (compared to an England average of 92%). The following graphs capture key aspects of our performance over the last year.

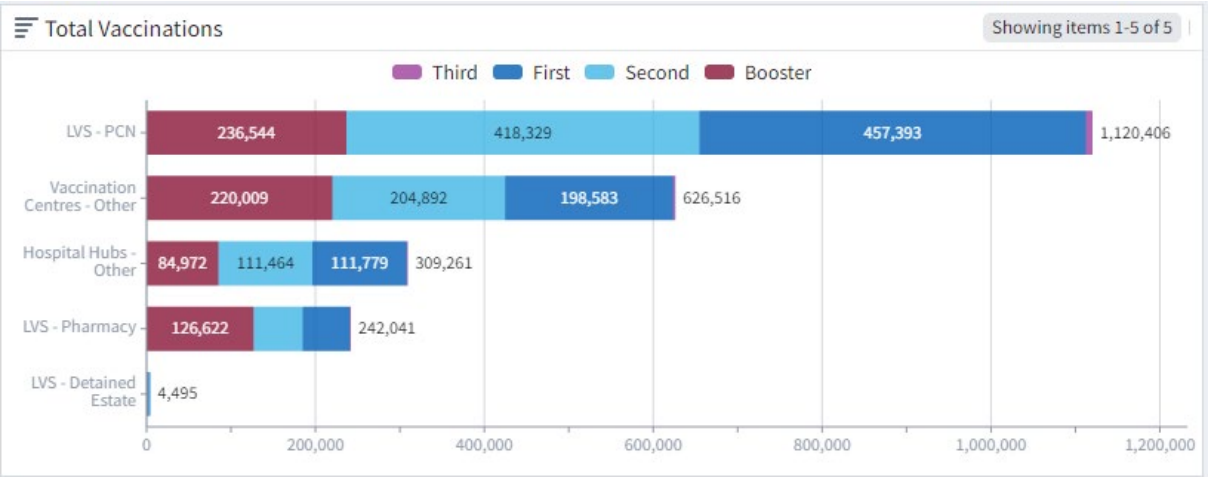
Running Total of first, second and Booster doses



Percentage of patients who have received first and second doses (fully vaccinated) plus booster doses (fully vaccinated + booster)



Total number of first, second, third (primary) and booster doses by delivery model



LVS - Local Vaccination Services

The success of the vaccination programme is underpinned by continued support from colleagues in general practice, district and borough council neighbourhood teams, Norfolk Constabulary (site security) and Norfolk County Council (Public Health, social care, commissioner of care providers and highway authority) and our NHS provider partners.

Partnership working through fortnightly meetings of our Vaccination Inequalities Operational Group (VIOG) meant that all the agencies involved had clear oversight of the latest uptake data related to age, ethnicity and geographical location. This Public Health data provided crucial insight for planning site locations, pop up clinics and roving models. Identifying gaps in provision early meant the delivery model could be adapted and tailored to address demand, improve access, and address inequalities.

Key successes in supporting inclusive vaccination uptake and reducing barriers to access included:

- Rebecca Crossley, a Learning Disability (LD) nurse, won a national award for Learning Disability Nurse of the Year for pioneering an accessible vaccination clinic at the James Paget University Hospital (JPUH) to encourage and support young patients with LD or Autism to be vaccinated.

- A vaccination bus was deployed to reach areas where travel time and transport links prevented easy access to larger/static vaccination sites. The vaccination bus also reached migrant workers and staff at large food production facilities where pockets of high infection were common.
- Launch of a CCG-funded 'Jab Cab' which provides free return taxi journeys to vaccination sites to encourage uptake and remove barriers to access.
- In response to direct contacts from patients via our social media channels, a "Worry Bus" was deployed with specialist teams providing the time, space and extra support needed for anyone who was anxious about having a vaccine and addressing concerns around fertility, pregnancy, vaccine safety and needle phobia.
- A targeted COVID-19 clinic for pregnant people at the JPUH helped to increase vaccination uptake in this group by 20%. Two thirds of participants said they would not have had the vaccine without this service and 50% were from our most deprived communities. An article in The British Journal of Midwifery was co-written by colleagues from JPUH and the CCG.

Cancer

The CCG aims to prevent as many people as possible from developing cancer, and the CCG's priorities for cancer care in Norfolk and Waveney are in line with national NHS cancer objectives. For those that do develop cancer, the CCG aims to deliver the improvements outlined in the NHS Long Term Plan around increasing cancer survival rates and the number of cancers diagnosed at an earlier stage.

The CCG acknowledges there is a significant backlog of people waiting for cancer treatments. This backlog has been caused by an unprecedented surge in demand for cancer services, driven by the number of urgent cancer referrals returning into the system after the pandemic, which is impacting on available diagnostic and treatment capacity. In particular, increased demand for breast, colorectal and urology pathway services is creating significant pressure on available capacity.

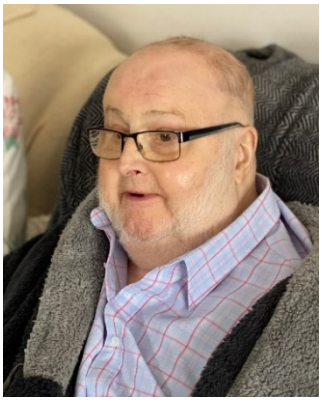
Whilst the number of referrals for cancer services continues to grow it is essential that these referrals continue at pace so that patients can be triaged and entered into the system for treatment and that more cancers can be diagnosed at an earlier stage. While that may mean that performance against targets for waiting times falls below where we would like them to be, the CCG and partners across the programme board are working collaboratively to manage the demand and waiting times.

To address the backlog and help to mitigate the impact on health outcomes for patients associated with diagnostic and treatment delays, close partnership working with partners from the Cancer Transformation team has helped to identify capacity constraints. System partners have developed a mutual aid approach to help balance demand for diagnostic and treatment capacity across the three local acute Trusts, alongside other measures to streamline and accelerate diagnostic pathways (see below).

The pandemic has had a continuing influence on patient behaviours, including reluctance to seek help for worrying symptoms and attend for diagnostic and treatment appointments. Communications campaigns, shared learning opportunities with Primary Care to identify “vague symptoms,” and telephone and virtual support to encourage patients to attend appointments have been undertaken to encourage people to seek help for their symptoms.

Some aspects of the work undertaken to improve cancer services over the last year includes:

- The Protect NoW Cervical Cancer Screening programme has helped to identify reasons for screening hesitancy and learning has been shared with system partners and Public Health England. More information on the Cervical Cancer Screening programme can be found in the Protect NoW programme section of this report.
- Continued development of a shared cancer patient tracking list (PTL) which will help address system capacity pressure, support patient flow through referral and treatment pathways, and reduce pressure on administrative personnel to accelerate progress against the backlog associated with the pandemic.
- Development of the Rapid Diagnostic Service (RDS) for patients with non-specific symptoms of cancer. This service helps to reduce the number of GP visits that patients would have to make before referral and will increase the number of cancers diagnosed in the early stages. This service includes patients who do not meet the cancer 2 week wait pathway criteria, and approximately 8% of these patients will be diagnosed with cancer.
- Pilot of the Macmillan Telephone Buddy Service, which provides a weekly call from one of the charity’s trained telephone buddies to offer personalised support to those living with cancer. Trevor Greenacre, 78, from Burgh Castle (pictured), was buddied following his incurable prostate cancer diagnosis. “He got me through the very, very low stage of my life and how to talk to my wife and my children… I felt much better in myself each time he called, and it made it easier that he called me because it can be hard to pick up the phone to ask for help.”



- Pilot of the Cancer Connect Project, which gifted a digital device to cancer patients who are digitally excluded. Access to this device has provided cancer patients with a tool to communicate with their healthcare providers and to access online support services.
- Several awareness campaigns have been delivered in response to local data and health inequalities data, such as the “Point it Out” prostate cancer campaign that was developed

because data showed that prostate cancer accounts for one-third of cancers that have gone untreated since the pandemic compared to pre-pandemic.

Planned and Elective Care

As the performance table on page 14 demonstrates, hospital services remained under pressure over the year and performance targets around diagnostic and referral to treatment times were not met. The loss of capacity due to COVID-19 has continued throughout the year alongside high levels of demand for services, resulting in a growing backlog of patients waiting for treatment.

As elective demand continues to grow across all three acute hospitals there are ongoing challenges in finding capacity to treat patients experiencing long waits for routine appointments. This, along with the rising demand for urgent and emergency care and cancer care, is hampering progress in reducing the number of patients waiting for care and the duration of their wait.

The table below shows the change in the number of patients waiting for procedures in Norfolk and Waveney over the last 24 months from February 2020 to February 22 and illustrates the overall growth in patient numbers since February 2020. The increase in figures this year compared to 2020/21 reflects the return to business-as-usual services whilst attempting to manage the backlog of cases caused by the pandemic. Clearly COVID-19 has left a legacy that will require significant extra resources and quite probably many years to recover.

	February 2020	**February 2021**	**February 2022**
Total number patient waiting list	79,370	88,822	111,077
Total waiting up to 18 weeks	18,172	40,431	61,582
Total waiting over 52 weeks	40	11,976	11,314
Total waiting over 78 weeks	4*	1,470*	3,532
Total waiting over 104 weeks			1170

*Not included within validated submissions
Source NHS England: Statistics » Consultant-led Referral to Treatment Waiting Times Data 2021-22

As of February 2022, the Norfolk and Waveney system is the 3rd highest nationally for the number of people waiting for treatment beyond 78 weeks, representing 5% of the national total.

The elective recovery programme is working to build relations between the three hospitals in the system and to maximise the capacity available to address the key priorities for elective care, which are: urgent (P2, or those patients needing treatment within a month), cancer (31 day and 62 day), as well as meeting and reducing the number of longest waiting patients.

At present, the system is focusing on treating all patients who have been waiting over 104 weeks with the aim of providing the necessary care to these patients and closing this cohort by the end of June 2022. Following that, the system is looking at mechanisms to reduce and remove the number of patients waiting 78 weeks+. This includes maximising the current theatre capacity through national measures such as Getting It Right First Time (GIRFT) and High Volume Low Complexity (HVLC) which will focus on ensuring that the theatres are working effectively. During 2021/22 the NNUH were able to protect their elective beds to maintain surgery during the busy winter period when COVID-19 infections were high, and both the JPUH and QEH are continuing to work to ensure their elective activity is maintained during busy periods.

System partners are also looking at options to move patients to where there is capacity between hospitals in a model called Mutual Aid. This allows patients to have their main care at their local hospital but to have the surgical component at another hospital within Norfolk and Waveney. Additionally, system partners are investigating what additional options are available in the independent sector and further afield with neighbouring systems to ensure we can address this challenge.

Within the 2022/23 elective plan, system partners are also looking to further reduce the long waits for non-surgical specialties and to reduce the total waiting list size.

Funding from NHSE/I has been utilised to support improvements in the elective recovery programme including:

- Development of a single waiting list for Norfolk and Waveney acute providers to address the significant variation in waiting times for appointments and treatments. This creates more equitable access to timely care for all patients using the Mutual Aid process to share patients across providers, thereby reducing overall waiting times and reducing health inequalities. The system has developed shared policies for access and reviewing clinical harm to support this process and ensure all patients have equal access to treatment.
- The review of long wait patients to identify if patients are at risk of physical or mental deterioration, and to provide access to a wide range of support from social services, wellbeing services and other tools to improve the patient's health while waiting. These reviews ensure the more vulnerable patients can be supported effectively.
- "Pre-habilitation" measures ensuring that patients remain fit and healthy while waiting for surgery and reducing the risk of cancellation on day of surgery due to being unfit. Great care is taken to ensure that patients are not excluded from the reviews due to digital exclusion by using trained call handlers, interpretating services as well as online questionnaires.
- Supporting outpatient transformation schemes such as virtual outpatients and patient initiated-follow ups (see more under Sustainable Development), and innovations such as an Outpatient Waiting List Review and a community teledermatology service.

The elective recovery programme is working to a five-year plan to achieve resilience and recovery across the whole system. The elective care transformation and improvement initiatives discussed above have been undertaken in the first year, providing a solid foundation to support the elective recovery with a focus on ensuring patients are prioritised by clinical need and seen at the right time, by the right service.

Primary Care

Like other health and care providers, general practice has faced significant challenges in the past two years due to the response required to the pandemic. Whilst safeguarding their staff and other patients from COVID-19, general practice has continued to ensure that patients have access to primary medical care and clinical advice when needed. In fact, more appointments were available over the last year than before the pandemic.

Primary care played a crucial role in the successful roll out of the vaccination programme, with more than 50% of Norfolk and Waveney's 2.3 million vaccination doses being delivered in a primary medical care setting, either at a PCN designated site, GP practice, or as part of a general practice roving model into Care Home settings.

Within Norfolk and Waveney, primary medical care is made up of 105 GP practices operating across 150 sites and 17 PCNs delivering 81.9% of the system's same day, urgent care appointments. The table below shows general practice appointment activity over the last three years, demonstrating the enormous efforts undertaken within primary care over the last year to provide care for patients whilst supporting the vaccination programme:

Activity	Total appointments 2019/20	Total appointments 2020/21	Total appointments 2021/22	Comments
Appointments (face to face, telephone, online, and home visits)	6,310,466	5,831,548	6,545,600	This is 3.7% higher than 2019/20 (excluding COVID-19 vaccination activity)
COVID-19 vaccinations			717,832	1,118,339 COVID-19 vaccination appointments were provided in general practice since the programme launched in December 2020

In Norfolk and Waveney, a higher proportion of appointments are face to face, 70.3% versus 62% nationally. In March 2022, Norfolk and Waveney offered 8.3% more face to face appointments than national. In fact, overall appointment activity over the last year exceeded that of pre-pandemic levels, 2.6% higher in 2021/22 overall than in 2019/20 (152,000 more appointments provided).

Throughout the year, all practices have remained open and accessible to patients through a clinical triage model of care and a mixed appointment model of face-to-face when clinically necessary, telephone and online consultations. A digital transformation is taking place to give improved access to digital services for patients to offer more choice and reduce waiting times for appointments. Whilst general practice is open and accessible to patients, the CCG recognises that there are areas for improvement with some patient groups and to reduce health inequalities, and this will continue to be a priority for the CCG together with general practice and PCNs.

The CCG recognises that some patients may not use or cannot use digital technology and therefore ensuring that practices are open and accessible to all patients is critical in reducing health inequalities. A mixed model of care helps to reduce waiting times for appointments by allowing patients who are willing and able to use digital technologies to communicate with practices, which frees up time and resources to see patients in general practice who are unable to use digital technology or who wish or need to see a clinician face to face.

Waiting times overall for all appointments have significantly reduced. During March 2022, 243,813 (40.9%) appointments were for the same day, an increase of 14% on the same month in 2019. 45,066 appointments were for next day appointments, an increase of 30% on March 2020.

The latest appointment data from NHS Digital shows how hard practices have worked over the last year to balance patient care needs and increase face-to-face appointments, alongside keeping staff and patients safe whilst supporting the vaccination roll-out.

Appointment Type	Apr-21	March-22	Variance	Variance %
Face to Face	322,993	419,706	96,713	29.94%
Home Visit	2,029	3,706	1,677	82.65%
Telephone	149,392	144,960	-4,432	-2.97%
Video/online	3,079	2,375	-704	-22.86%
Unknown	22,940	26,261	3,321	14.48%
COVID-19 vaccination	180,896	3,632	-177,264	-97.99%
Total Appointments	681,329	600,640	-80,689	-11.84%
Total Appointments excluding COVID-19 vaccinations	**500,433**	**597,008**	**96,575**	**19.30%**

Source: Appointments in General Practice - NHS Digital

The CCG successfully bid for £4.8 million from the national Winter Access Fund to increase the numbers of appointments and services available to support patients within primary care over the busy winter period. This has provided funding for a range of schemes including additional clinical and administrative roles to enhance access and patient choice; funded clinical workforce specialists in Learning Disabilities and Severe Mental Illness; and Primary Care Hubs offering freely accessible mental health support within communities.

Ensuring that the local population are informed of the services provided within general practice is a priority for the CCG. A new primary care campaign was released in November 2021 to raise awareness of the many ways in which patients can access local primary care services (GP practices, pharmacy, optometry, and dental services), as well as urging people to be kind to staff who continue to work tirelessly to care for patients. Key themes of the campaign include “Choosing the right service,” “The importance of self-care,” “Using digital tools in primary care,” “Supporting a zero tolerance of abuse to staff,” and “Introducing the vast range of health and care professionals.”

The CCG undertook a Locally Commissioned Services review on four commissioned services in early 2022 to ensure that services offered to patients via practices are consistent, equitable, sustainable and, most importantly, help achieve good health outcomes for the people of Norfolk and Waveney and avoid unwarranted clinical variations. More information on the review can be found within the Engaging People and Communities section.

To further improve access to primary care, work progressed this year on the development of the Wave 4b Primary Care Hubs, which has seen £25.2m capital investment awarded to the system to develop five new primary care hubs. Development was delayed due to the pandemic, but this year the CCG secured an additional £0.7m from the Estates Technology Transformation Fund to progress with project management, architectural services, and business support to develop business cases so work can proceed toward the target operational date of June 2024.

Workforce

There has been an increase in staff sickness absences and staff turnover in the CCG this year which mirrors the trends seen across the ICS provider organisations.

CCG staff have continued to work in challenging conditions to deliver core business activities as well as provide additional support to contribute to system pressures brought on by the pandemic and COVID-19

response. This additional support included Primary Care and Locality teams working as part of PCN vaccination teams; clinical staff vaccinating across the system; and redeployment of CCG admin and clerical staff to both UEC and Vaccination teams. Fifty-three clinical and non-clinical CCG staff trained to become vaccinators in December/January 22 in response to the Government's winter booster target. The commitment of CCG staff to the COVID-19 response has been phenomenal. The additional ask of our workforce presents an ongoing risk to staff health and wellbeing however, and the CCG continues to work in partnership with our ICS Partners to collaborate and develop interventions to reduce risk and improve wellbeing for our people.

Across the system, the number of staff leaving has increased from April 2018 at 11.9%, which decreased in 2020 to 11.4%, and has now increased to 13.2%. The turnover rate for Support to Clinical staff is now approximately 30-40% higher than it was before the pandemic, which is a concern. Sickness and absence rates peaked at 7.2% in Dec-Jan 22 (3.0% COVID-19 related), and as of 31 March is now reducing back to pre-pandemic levels. However, services are still feeling the pressure of increased demand, rising waiting lists and staff shortages due to vacancies and the lack of continuity of support staff. This is likely to result in sickness remaining above average for some time.

One of the four aims of the ICS's #WeCareTogether People Plan for 2021-25 is promoting good health and wellbeing for our people. The CCG has worked with system partners since the start of the pandemic to ensure we collectively meet this priority for staff.

A focus on staff belonging and empowerment for change continues across the ICS and is localised within the CCG through staff networks including the Equality Diversity and Inclusion group and Health and Wellbeing Group. Leadership is in place with Health and Wellbeing Guardians appointed to NHS Providers, the CCG and ECCH. In addition, four Primary Care Health and Wellbeing professional leads have been appointed for General Practice, Optometry, Dentistry, and Pharmacy, who are championing a "Who cares about you?" programme for primary care workforce.

The Norfolk and Waveney Workforce Transformation team and partner organisations are doing more to address the CCG and wider system challenges around sickness and turnover and have launched several projects this year focussing on people retention. These align to the ambitions of people set out in national policy documents such as the NHS People Plan and People Promise, The Future of HR and OD framework, and ICS Workforce 10-point plan. Some examples include:

- Norfolk and Waveney's large-scale support worker programme is a project that will recruit, train and support up to 800 Support Workers across health and social care providers. This is a core project supporting SOF4 and system recovery plans.
- The Reservist workforce (around 200 staff) are a mix of returners to the NHS and current students. They have been the backbone of the vaccination programme and are expanding their scope to support other areas of health and social care.
- A Collaborative Bank launched in autumn, offering staff flexible opportunities to grow in skills, experience, and confidence as they opt to work across the three acute trusts in the first phase, and will extend to all providers, primary and social care in the future.
- The Legacy Health & Care Professionals have been in post for 12 months to work with clinical staff who need support considering their role, next steps, and retention. Feedback shows:
    - Three-quarters of staff have greater confidence in their role
    - More than two-thirds of staff reported increased job satisfaction

    - Critically, over half "**strongly agreed**" they were more likely to continue working in the NHS

- The Primary Care workforce team/Training Hub are working in partnership with the ICS Workforce team to develop a more integrated approach to workforce recruitment and retention planning. A range of initiatives are in place or being developed to support increased recruitment and retention of both clinical and non-clinical workforce, including a new Flexible Pooling Scheme which has been expanded to include any clinician and administrative staff.
- Supporting PCN development and maturity, the Additional Roles Reimbursement Scheme (ARRS) enables GP practices to develop a clinical skill mix to increase the clinical workforce and improve access to general practice to suit local needs and patient demographic. This includes roles such as clinical pharmacists, social prescribers, mental health practitioners, physiotherapists, care coordinators, Physician Associates, trainee nurse associates, podiatrists, paramedics, health and wellbeing coaches and dieticians. In 2021/22 the CCG invested £9.6m in ARRS recruitment and the number of individuals in these roles has increased this year from 150 Whole Time Equivalent staff (WTE) in April 2021 to 325 WTE at the end of March 2022.

Prescribing and medicines optimisation

The CCG delivers medicines optimisation through the Medicines Optimisation (MO) Team, which manages the entry of new drugs into the health economy, ensuring formularies and local guidance are aligned to national guidance; and engages with both clinicians and patients, producing supporting materials to enable practices to implement the NHS England recommendations on conditions that patients should be encouraged to self-manage.

There has been a continuing focus on 'de-prescribing' in frail patients, and drug holidays are being encouraged in patients receiving a class of drugs that are associated with cognitive impairment and falls. Alongside this, the team continues work to reduce the number of prescriptions of high dose opiates and other harmful dependence forming medicines.

The Prescription Ordering Direct (POD) is a repeat prescription management service which aims to reduce costly medicines waste and improve medicines safety. The service processes patients' repeat prescription requests, highlights quality issues to prescribers such as medication reviews, and ordering and medication compliance issues. POD supports 17 GP practices, 15 in the Great Yarmouth and Waveney area and 2 in West Norfolk, and over the last year POD answered an average of 13,000 calls and processed 5,400 online requests per month.

The service has made several improvements to help address health inequalities, including introducing online ordering which enables those with telephone communication difficulties to send a digital order for medicines, using the InTran service to support orders for those who don't speak English, as well as implementing a text back service to avoid waiting in phone queues that patients may be paying for.

Learning Disabilities and Autism

Learning disability and autism (LD&A) services are provided by Norfolk County Council and the CCG across Norfolk and Waveney, focussed on the assurance that Adult's specialist needs have been supported during the pandemic and as we move into the recovery period.

Weekly COVID-19 meetings were established within Adult Social Care, which CCG officers attended, to ensure that all vulnerable groups were reviewed for efficacy of service delivery and to address areas

which may have resulted in health inequalities. The Community Learning Disabilities Intensive Support Team (IST) also extended availability to support people with LD&A over a 7-day period.

A major event that took place this year was the publication about the tragic deaths of three patients at Jeesal Cawston Park, an independent mental health hospital for people with LD&A, between 2018 and 2020. A Norfolk Safeguarding Adult Review (SAR) was published in September 2021 which highlighted that the human rights of the three individuals, Jon, Joanna, and Ben, had not been met while they were in care at Jeesal Cawston Park.

The CCG fully accepts the findings of the SAR and is committed to preventing another person or family experiencing physical or emotional harm as a result of services that are ineffective or inadequate in their delivery of health and care.

The CCG is committed to using the findings and recommendations of the SAR as a platform for change in Norfolk and Waveney. Following the publication of the SAR, the CCG has worked to improve services, including:

- A review of how LD&A services are commissioned
- A review of how the CCG maintains oversight and provides services for people with LD&A
- The implementation of increased surveillance and quality monitoring tools
- A review of and improvements made to the escalation process
- A commitment to a minimal reliance on independent hospital provision
- Introducing a programme of engagement, listening and hearing with patients, families and carers and a focus on the lived experience of the individuals and their families

The SAR highlighted significant learning locally and nationally. One of the key NHS England actions were that every inpatient would have a robust review of their care before the end of February 2022 known as a Safe and Wellbeing Review (SAWR). The SAWR's have been completed and signed off by the specially convened ICS panel for scrutiny, system learning, and addressing any key barriers to discharge.

The CCG continually aims to reduce the number of patients that are admitted to institutions, however this year the CCG met NHS England's maximum number of 14 people placed in LD&A mental health hospitals. The CCG recognises that more people need to be discharged appropriately and safely back to their home or to a new home within the community and has worked with NHS England and the local authorities to develop a new programme of housing and accommodation development to support people to leave hospital and prevent admissions.

The learning from deaths of people with a learning disability (LeDeR) programme was set up as a service improvement programme to look at why people are dying and what the NHS can do to change services to improve the health of people with a learning disability and reduce health inequalities. This year the CCG recruited a team of 5 LeDeR reviewers to complete reviews on behalf of the ICS. Due to the backlog, not all reviews have been completed but are on track to be completed in the 6-month timeframe set by NHS England.

There has been a continued focus on health inequalities within the CCG with the commencement of a 12-month Annual Health Check Pilot in March 2021 which has improved uptake of health checks and

the quality of service for people with LD&A during their visits. More information on the Annual Health Checks can be found in the section on Health Inequalities.

Safeguarding

The CCG provides strategic leadership in line with current requirements of the Care Act 2014, Health and Social Care Act 2015 and 2020, and other relevant documents about the roles and responsibilities of NHS bodies as partners of the Safeguarding Adults Boards in Norfolk and Suffolk.

Safeguarding is a key part of the CCG's work, and in the interest of patient and public protection has worked in partnership with local authorities and other organisations over the last year to support people who may be subject to abuse and are not able to seek help due to continuing social isolation.

Continuing Health Care (CHC)

The CHC team is clinically led, with registered practitioners undertaking the assessment process to determine whether individuals have a 'primary health need' to qualify for a fully funded package of continuing healthcare. Over the year providing assessments has been challenging against the backdrop of recruiting to vacant posts, supporting early discharge or admission avoidance, and workforce challenges within the care sector.

The CHC team have continued with recruitment over the last year, however it has not been possible to recruit to all vacant clinical posts. Staff sickness has presented challenges, alongside staff retention as a number of skilled and experienced staff have been attracted to other agencies and sectors. However, despite these challenges and the backlog of cases from the COVID-19 pandemic, steady improvements were made over the year towards meeting NHS England targets for assessment as shown below.

The table below illustrates CCG performance up to 31 March 2022.

Table illustrating CCG performance in relation to

Quality Premium standard of CHC completion ≥ 80% within 28 days of referral

June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
68.4%	62.1%	70.07%	77.27%	80.36%	77.5%	82.14%	89.29%	89.36%	77.05%

The CHC team are also involved in supporting care providers who may be experiencing difficulties in maintaining the quality and safety of their service, including Jeesal Residential Care Services. The team have worked with both Norfolk and Suffolk County Councils to provide a collaborative approach to support.

In the last quarter of 2021/22, the CCG commissioned Liaison Care to complete reviews of individuals in receipt of Fast Track NHS Continuing Healthcare. With comprehensive oversight form the CHC senior leadership team of the quality of this work, a successful partnership has been developed to deliver reviews of a high quality that the team had been unable to complete. This has resulted in some efficiencies by removing NHS funding from individuals who do not meet the criteria to receive either Fast Track or standard NHS Continuing Healthcare.

Adult Mental Health

Norfolk and Waveney CCG has achieved the Mental Health Investment Standard (MHIS) in 2021/22 by spending £171.4m against a target of £171.1m. The allocation of this has been to deliver the NHS Long Term Plan ambitions and to support continued service developments to meet the needs of residents in Norfolk and Waveney.

The pandemic has driven increased demand for mental health services due to the psychological impact of COVID-19 and lack of access to preventative services. This has led to people presenting for support later and with more complex presentations, adding to existing system pathway pressures and increasing the need for out of area placements. Referrals from all system partners increased over the year, with increased presentations around anxiety, depression, self-harm, and eating disorders.

After an initial drop in demand for mental health services during 2020/21 due in part to the usual referral sources such as GPs and schools not being accessed during the initial lockdown, there has been an 11% increase in external referrals to NSFT Secondary Care Mental Health Services during 2021/22 compared to pre-pandemic levels in 2019/20.

	External referrals to NSFT
2019/20	32,301
2020/21	30,639
2021/22	35,853

Treatment and support for individuals with eating disorder has been an area of significant investment and focus of improvement work. Over the last year this has seen increased workforce in specialist community teams, new roles of Clinical Associate Psychologist and additional medical roles into teams, introduction of the FREED provision of early intervention (First episode and Rapid Early intervention for Eating Disorders), increased delivery of medical monitoring, and introduction of new alternative to admission options which are supporting people to stay well in the community.

The CCG recognises that our work must be influenced and informed by national recommendations and learning. This includes the learning from tragic events which led to the Prevention of Future Deaths report in March 2021 which identified key improvements required to reduce the risk of future avoidable deaths.

The CCG has built strong foundations across the system, working with stakeholders to address the findings of the Prevention of Future Deaths report and develop services which will focus on prevention and early intervention and strive to be innovative and collaborative, with an all-age quality improvement driven approach. These initiatives are being mapped into a co-produced all-age eating disorder strategy, and the CCG continues to work at pace to deliver best practice services and to meet the increasing incidence and acuity of eating disorders.

The mental health system transformation aims to bring safe, effective, and responsive mental health services closer to where people live and work. In 2021/22 funding was allocated to improve access to services for adults with moderate to severe mental health conditions including eating disorders, those in need of mental health rehabilitation, and those with a personality disorder.

Additional Service Development Funding supported the Community Transformation leading to development of community focussed services closer to home and aligned to GP practices. The CCG

was also awarded additional Spending Review money to support Mental Health Discharges and funding for new Crisis Alternatives services following successful bids. These have been used to support achievement of Mental Health Transformation priorities including:

- New roles to support mental health within Primary Care, including dedicated Primary Care Network Mental Health Practitioners (MHPs) which are 50% funded as part of the additional roles reimbursement scheme (ARRS) and the remaining 50% funded by the system, and recovery support workers that are based in PCNs and GP practices to offer specialist support closer to where people live. Over the year 23 MHPs have been recruited across all PCNs.
- Developing community wellbeing hubs in Norwich, Gorleston, and King's Lynn, with two more due to open in South Norfolk and North Norfolk later in 2022. These hubs enable earlier and easier access to mental health support, providing direct support, supported referral, signposting and access to services in the community.
- Developing crisis alternatives such as the mental health response car, which is crewed by a paramedic and a specialist mental health practitioner to respond quickly to 999 calls where there is a mental health concern; and expanding the service of the Julian Support acute mental health admission prevention service in North and South Norfolk.
- Transforming community service by strengthening access to psychological therapies (IAPT), delivering a new partnership with Voluntary, Community, and Social Enterprise (VCSE) to improve Dementia support and diagnosis across the system; and delivering enhanced Perinatal Mental Health services.
- Mental health funding to support winter pressures was made available for the mental health trust to block book an additional 22 beds at a local Norfolk provider to help with system pressures.
- Launching the online Qwell platform to support adults aged 26+ to access professional mental health support, which works alongside other NHS commissioned services within the established mental health pathways.

Other key areas of work this year included improvements in perinatal support as access targets for perinatal were achieved and face to face appointments increased over the year, and plans are in place for the service to be expanded. The Lotus Maternal Therapeutic Outreach Team also launched in June 2021, which works closely with other services to offer support to women and birthing people who have experienced trauma in pregnancy, birth and immediately afterwards. Additional support pathways have been developed within this team for birth trauma, Tokophobia, and child loss.

Following an extensive whole system workforce engagement, the Norfolk and Waveney Mental Health Workforce Strategy has been developed which will steer growth and improvement of the mental health workforce across the system to better support delivery of services that improve the health and lives of mental health service users, their carers, and families. Additional capacity has already been added with the creation of 24 new mental health roles. Clinical Associate Psychologists (CAPs) are trained in partnership with UEA and have already been deployed across secondary mental health care teams at NSFT.

In April 2022, the Care Quality Commission (CQC) rated the mental health provider, NSFT, as 'inadequate' following their inspection in November and December 2021. The report outlined several key improvements the Trust must make, including maintaining safe staffing levels, ensuring training is completed, supervising and appraising staff to support safe and effective patient care, and embed good governance to oversee performance and communicate priorities. Whilst the overall rating was inadequate, CQC inspectors also recognised the Trust as a caring organisation, rating the quality of

care provided by staff as ‘good’ and that care on wards for people with learning disability or autism, and community-based mental health services for older people, were also ‘good’.

The CCG, along with Suffolk and North East Essex CCG, are increasing levels of support to the Trust so the necessary improvements can be achieved, including:

- CCG representation at a number of the Trust’s internal boards and committees, such as the Quality and Patient Safety Committee, Evidence Boards, and a weekly System Improvement meeting;
- Focused support from senior nurses from the CCG Nursing and Quality team to work in partnership on patient safety and quality improvement plans; and
- Attendance by the Associate Director for Nursing and Quality at a series of staff engagement events to support the Trust.

Children’s and Young People’s Mental Health

The mental health and wellbeing of Norfolk and Waveney’s children and young people (CYP) is of central importance to the CCG and is in line with the NHS Long Term Plan and local priorities. Significant funding of £3.1 million was invested into the CYP mental health transformation programme of work to improve emotional wellbeing and mental health services for CYP up to their 25th birthday, of which £558,000 was specifically spent on enhancing the 18-25 offer.

The pandemic and lockdown restrictions had a significant impact on the emotional wellbeing and mental health of CYP, and that has continued throughout the last year during the pandemic recovery. The pandemic has increased presentations of under 18s needing mental health support from 1 in 9 to 1 in 6. Norfolk and Waveney had the highest referral rates in the country for CYP mental health services pre- and post-pandemic, and the number and acuity of referrals has risen dramatically in the last 12 months.

A return to face-to-face as well as virtual provision began to be offered during the last year, depending on clinical need and choice. The detrimental impact of the pandemic continued to be evident, with the number of referrals and acuity rising significantly, in particular around eating disorders and children and young people presenting to services in crisis.

In 2021, 830 children and young people presented in crisis, compared to 254 in 2018. The number of total eating disorder referrals doubled, with urgent “high risk” cases more than five times higher than prior to the pandemic. This increase in referrals and acuity has been compounded further with the closure of nearly a third of specialist bed provision.

Referral rates and acuity into core community mental health services have continued to rise over the year, impacting on waiting lists and resulting in long waits for care. The ability to address these issues has been hampered by staff sickness and several local providers going into business continuity.

Despite these challenges, access to CYP mental health services has continued to surpass national standards over the last year, with 43% of CYP who have a mental health need accessing support against the national standard of 35%, which is a notable increase from 28% in 2020/21. This is a direct result of financial investment to increase capacity, new roles, and focused waiting list initiatives.

Together with system partners the CCG has worked hard to address the ongoing challenges. Examples of work over the last year include:

- Waiting list initiatives, supported by £700,000 of funding, to target core community teams
- Development of an information leaflet for CYP and their families providing information on services that are able to provide immediate support whilst they wait for treatment
- Expansion of the crisis team and additional funding and mental health input to acute hospitals to support CYP admitted onto paediatric wards with mental health needs
- Development of an all age eating disorder strategy to transform delivery of services to meet the increase in demand
- Increased funding to both statutory and VCSE providers to increase community mental health provision

Children and Young People and Maternity

Children and Young People (CYP) and maternity services teams delivered several key service improvements over the last year, despite the challenges of a reduced workforce as many staff were redeployed to support the vaccination programme as well as maternity units.

The Local Maternity Neonatal System (LMNS) team continued to introduce the Continuity of Carer (CoC) model in line with the target of cutting perinatal mortality by 50% by 2025, by increasing their surveillance role and having greater responsibility to ensure maternity services provide safe care.

The release of both the Ockenden Report and Perinatal Quality Surveillance Model in January 2021 has increased the surveillance role of the LMNS. The Ockenden Report requires the function of the LMNS to 'be given greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them.' In response to the Ockenden Report, the LMNS has co-developed a blended learning education programme with the University of East Anglia (UEA) on Saving Babies Lives to support the increased education requirements outlined, as well as increased its surveillance role which now includes monthly Quality and Surveillance meetings with the Heads/ Director of Midwifery, and quarterly Serious Incident Surveillance meetings.

The release of the final Ockenden Report in March 2022 acknowledges that in 2022 there remain concerns that NHS maternity services and trust boards are still 'failing to adequately address and learn lessons from serious maternity events occurring now' (Ockenden 2022, P. 4). This report further identifies the CCG role in governance and scrutiny. The report identifies that there were many missed opportunities and that the Trust Board and the CCG were 'reassured' rather than 'assured' with regards to governance and safety within the maternity service. There are now a further 15 Immediate and Essentialisation's that Trusts and the LNMS need to be addressing and a combined gap analysis is currently underway.

Following several successful funding bids, the Pelvic Floor project was launched which engages women around pelvic health in pregnancy and into the postnatal period, as well as development and delivery of several training webinars including COVID-19 in pregnancy; Infant Feeding; and Pelvic Health.

The Continuing and Complex Care Team provides support to CYP and their families who meet the criteria for continuing care as outlined by NICE. Despite the ramifications of COVID-19 and the impact on staff availability, the team has safely managed to actively support 70 CYP in their homes over the last year.

Norfolk & Waveney were successful in securing £345,000 of funding to become an early adopter of the pilot Care Navigators programme in September 2021. This programme trials a new way of working to

support CYP with a learning disability / autism who have complex care and support needs to prevent escalation of need, inpatient admissions and ultimately improve outcomes for CYP up to the age of 18. The Care Navigators provide highly personalised and flexible face-to-face support to children, young people and their families to help them to navigate the education, social care and health systems. The team has supported 27 CYP since launch and the Navigators have collectively had over 3,000 contacts with young people, families and professionals. Following the success of the pilot the service plans to expand in 2022/23 to provide support to CYP up to the age of 25.

Significant improvements in paediatric services have been achieved to address service gaps and deliver service improvements during the last year including:

- A new provider for Speech and Language Therapy which has managed to see over 50% of children who have been waiting over two years for therapy.
- Mobilisation of the Norfolk Maternal Medicine Network, which provides regional clinical leadership on the identification and management of women with rare/complex medical conditions during pregnancy
- New support available for children with bereavement and sleep issues
- Launch of the Transition Network and a provider toolkit to enable clinical colleagues to begin implementing transition protocols within their trusts

Urgent and Emergency Care

The Norfolk and Waveney system entered “Critical Incident” on 30 December 2021 due to sustained and ongoing pressures on the health system arising from a backlog of patients who could not be safely discharged into appropriate care in the community or at home, and the devastating impact of the Omicron variant on the workforce.

Considerable work was undertaken at pace and scale across Norfolk and Waveney to improve discharge and flow across the three hospitals to be able to exit Critical Incident and improve patient journeys. The system exited Critical Incident on 26 January 2022, following intense system collaboration including the Multi Agency Discharge Event and pilot of a Care Hotel. More information on these can be found below in the Discharge to Assess section.

The pandemic has had a lasting impact on the urgent and emergency care system (UEC), both in terms of managing the increase in COVID-19 positive patients alongside existing demand, and the complexity of the infection control measures needed to protect non-COVID-19 patients, or those recovering from it, from coming into contact. These factors, alongside challenges in patient flow and discharge from hospital, have compounded pressures on UEC over the last year.

Following a period of reduced attendances at Emergency Departments (ED, also referred to as A&E) during the first lockdown in 2020, attendances at ED rose dramatically as the lockdown restrictions were gradually eased throughout 2021. In the first quarter (Q1) of 2021/22, ED attendances were up 9.3% on pre-pandemic levels in Q1 of 2019/20. Meanwhile over the same period 999 calls were also increased, with 2,906 more calls in Q1 2021/22 compared to Q1 2019/20.

The summer was also particularly busy, likely due to ‘staycations’ and increases in the temporary population size linked to short-term tourism. May 2021 saw 14.5% more ED attendances than in May

2019 at NNUH, and in June 2021, JPUH and QEH experienced increases of 10% and 18% respectively when compared to 2019/20 activity.

Increases in attendances have had a knock-on effect on UEC performance against national access standards over the year. Nationally, performance in UEC has been impacted by the pandemic and local performance also reflects this, as set out below:

	JPUH	NNUH	QEH	ICS	Target
Emergency Departments					
ED 4-hour performance 95% of people admitted, transferred of discharged in 4 hours	69.3%	69.2%	68.8%	68.1%	95%
12-hour decision to admit 100% of patients should be admitted to a ward within 12 hours of decision to admit	98.1%	99.5%	99.5%	98.7%	100%
Ambulance Response Times					
C1 Mean				12:03	7 min
C1 90th centile				20:09	15 mins
C2 Mean				50:16	18 mins
C2 90th centile				106:44	40 mins
C3 90th centile				372:09	120 mins
C4 90th centile				485	180 mins
NHS 111					
NHS 111 calls answered in 60 seconds				41.9%	95%
NHS 111 calls abandoned				16.5%	5%

Ambulance response times categories are explained below:

Category	Meaning
C1	An immediate response to a life-threatening condition, such as cardiac or respiratory arrest. Response time to 90% of all C1 incidents should be 15 minutes
C2	A serious condition, such as stroke or chest pain, which may require rapid assessment and/or urgent transport. Response time to 90% of all C2 incidents should be 40 minutes
C3	An urgent problem, such as an uncomplicated diabetic issue, which requires treatment and transport to an acute setting. Response time to 90% of all C3 incidents should be 2 hours
C4	A non-urgent problem, such as stable clinical cases, which requires transportation to a hospital ward or clinic. Response time to 90% of all C4 incidents should be 3 hours

The ED 4-hour waiting time target has been negatively impacted by a number of factors listed below. The 4-hour waiting time target performance has steadily decreased and Norfolk and Waveney remains in the lowest national quartile.

Date	ICS ED Attends	CCG 4-hour target performance
Apr-21	23,187	71%
May-21	25,459	67%
Jun-21	25,967	65%
Jul-21	26,614	62%
Aug-21	25,342	58%

Sep-21	24,719	57%
Oct-21	24,751	54.4%
Nov-21	22,788	54%
Dec-21	21,367	51%
Jan-22	20,896	55.3%
Feb-22	20,296	51.0%
Mar-22	23,573	48.8%

In April to July 2021, the system saw the impact of restricted international travel and an increase in staycations, which in part drove higher ED attendances in our hospitals, particularly the QEH and JPUH.

In addition to a pattern of rising ED attendances as outlined above, in the first two quarters of the year additional pressures impacting the UEC system have been:

- The continued use of COVID-19 infection prevention and control (IPAC) guidance, which requires separate physical space to treat and accommodate positive, negative and symptomatic patients which results in less physical space, impacting flow in hospitals.
- Routine COVID-19 testing for staff within health and social care, which results in staff isolation and absence, and impacting sickness levels.
- The continued high numbers of non-Criteria to Reside (non-CTR) patients in hospitals. These are patients who are medically fit to leave hospital but who still require assessments for their onward care arrangements. Requiring these assessments to be done in hospital (rather than at home or in the community) is adding to flow pressures as pace of discharge cannot keep up with admissions. More information on this is in the Discharge to Assess section below.
- Ambulance handover delays remain while patient flow through hospital remains blocked, despite several measures that have been implemented this year to help to reduce the risk of long ambulance offload delays. These include the EEAST System Operations Cell (SOC), dedicated cohorting space and resources, and Hospital Ambulance Liaison Officers (HALOs).

NHS111 services saw a rapid increase in call volumes during the pandemic, and staff at 111 call centres were affected by COVID-19 absences which had significant impact on call answering performance. Pre-pandemic call volumes and peaks in activity were far easier to predict than they are now, and colleagues are continuing to work to establish new benchmarks for call volumes and spikes in call demand to ensure more calls are answered swiftly and abandonment rates are reduced.

There has been attrition of 111 call handler staff to other recovering sectors, which has affected call abandonment rate and call answering targets. IC24 is the local provider for 111 services and has consistently placed in the higher end of performance across the country. As part of the response to the pandemic and to futureproof the service, call handling service providers have increased pay and improved rota patterns, as well as offering the home working option to improve staff retention and attract more staff to the sector.

Despite the challenges outlined above, there have been some positive achievements through the Clinical Assessment Service (CAS) programme which focusses on reducing ED recommendations and ambulance dispatches from 111 calls:

- The number of recommendations to attend ED dropped from 10% of all 111 calls in 2019 down to 6%. This translates to just over 8,230 that have been diverted from attending ED following a 111 call that directed them to GP led assessment and triage through CAS.
- The number of ambulance dispatches from 111 to 999 dropped from 17% in 2019 down to 14%. This translates to 6,394 fewer ambulances that had to be dispatched from 111 following GP led assessment and triage through CAS.

Discharge to Assess

The Discharge to Assess (D2A) programme aims to provide a personalised model of care for patients and their families, ensuring that people are able to leave hospital on the day they have a right to be discharged, and that they have a personalised recovery plan in place.

Information about the Discharge pathways from each of the acute hospitals is provided below. The Pathways are defined as:

Pathway	Description
Pathway 0	Simple discharge home; no new or additional support is required to get the person home, or such support constitutes only informal input from support agencies; a continuation of an existing health or social care support package that remained active while the person was in hospital.
Pathway 1	Able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home. Every effort should be made to follow Home First principles, allowing people to recover, re-able, rehabilitate or die in their own home.
Pathway 2	Recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home.
Pathway 3	For people who require bed-based 24-hour care. This includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting. Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

The table below shows the total number and percentage of all people discharged from each of the three acute hospitals during 2021/22:

	JPUH totals	JPUH %	NNUH totals	NNUH %	QEH totals	QEH %
Pathway 0	10,940	83.2	46,709	84.8	10,860*	81.7*
Pathway 1	1,346	10.2	5,661	10.2	1,546*	11.6*
Pathway 2	799	6	2480	4.5	824*	6.2*
Pathway 3	59	0.45	340	0.6	64*	0.49*
Total	13,144		55,067		13,294*	

*Not included within validated submissions

National expectations are that 50% of people aged 65+ will be discharged on Pathway 0, 45% on Pathway 1, 4% on Pathway 2 and 1% on Pathway 3 (note the figures in the table above are for all people, not just those 65+). Acute hospitals in Norfolk and Waveney are discharging a higher proportion of people on Pathway 0, which is positive performance as there is strong clinical evidence demonstrating better outcomes for those able to go home first. All acutes are reporting little discharge

activity via Pathway 1 but both JPUH and NNUH are reporting higher than expected discharges via Pathway 2. The CCG will continually review the discharge pathway performance and investigate how performance may be related to the sociodemographic make-up of the area.

The D2A programme works on a Home First ethos and has started using “Criteria to Reside” to assess when people should be discharged from hospital and carry on their recovery in their own home or a place of care in the community. For those patients requiring ongoing health or social care support this process of assessment takes place once rehabilitation, reablement and recovery has started, with such assessments taking place outside of hospital in a more natural environment.

The D2A team have established Home First Hubs in all three hospitals with a single point of access, and community teams are in place at the neighbourhood and PCN level. These pathways are essential to reduce the use of acute beds by medically fit patients so they can be used to meet the significant elective demands currently on the system. Links with the voluntary and community sector are also being established to help facilitate the process.

Despite these measures, pressures in the domiciliary home care markets have reduced both residential and home care availability, linked to local care provider workforce shortages and COVID-19 IPAC requirements. This, combined with staff sickness and shielding, has meant access to care and residential placements has been reduced with the knock-on effect of delays in patients leaving hospital.

A significant amount of investment for winter funding was allocated to put additional capacity in place to support flow across the system. Additionally, in January staff across the Norfolk and Waveney health and care system worked together on a Multi- Agency Discharge Event (MADE) which was key in helping the system to de-escalate from Critical Incident status. It brought together the local health and care system to support improved patient flow across the system; recognise and unblock delays; and provide opportunities to challenge, improve and simplify complex discharge processes – all of which help to free-up beds and reduce length of stay.

Innovative measures such as Live-in Carers and the Care Hotel were set up as temporary, short-term measures to support patients ready to leave hospital who need additional support arranged in the community before they can go home. All such innovations are critically assessed and evaluated to identify if they deliver the outcomes anticipated. The Live-in Carer model will continue to be developed as this has worked well, however the Care Hotel will not as it did not deliver the outcomes anticipated. The CCG is currently looking at the system and processes that underpinned this initiative to see what lessons can be learnt to inform future initiatives.

Palliative and End of Life Care

The Norfolk and Waveney Palliative and End of Life Care programme board has facilitated weekly operational working groups with local health providers to further develop and embed a systems working approach. This has helped all providers to work collectively to react to the challenges of the pandemic and winter pressures. The operational group has also strengthened relationships between providers which has enabled cross boundary support when capacity has varied.

Although most activities were stepped down to support the pandemic response, some key programmes of work included:

- The creation of a new system wide syringe driver policy to bring consistent clinical practice.
- Commencement of a pilot for carer/family administration of subcutaneous anticipatory medicines. This pilot has been rolled out by ECCH CIC and will run throughout 2022/23.

- Continued progression of our Compassionate Communities model at The Pear Tree Centre, Halesworth, a collaborative piece of work with The Pear Tree Fund, St Elizabeth's Hospice, and the University of East Anglia.

Protect Norfolk and Waveney (Protect NoW)

Protect NoW is the Norfolk and Waveney Integrated Care Partnership's proactive response to reducing health inequality and improving the healthy life expectancy of its population. This data-led, innovative programme of work is founded on Population Health Management (PHM) methodology and comprises a growing number of distinct projects, each focused on a common cause of mental and/or physical ill health.

The Protect NoW programme of work was developed from learning following the successful COVID-19 Protect project which ran during 2020. This innovative response to the pandemic engaged and supported 40,000 shielding and vulnerable patients during the initial lockdowns when access routes to traditional health and care services were impacted.

COVID-19 Protect was the first large-scale PHM initiative undertaken across Norfolk and Waveney. It was nominated for six national awards in 2021 and won the Health Service Journal's Connecting Services and Information Award, and GP Team of the Year at the General Practice Awards.

Its legacy is Protect NoW, a dynamic collaboration between NHS organisations, Local Authorities, the voluntary sector, and independent partners working across Norfolk and Waveney to address health inequality and reduce clinical variation.

Primary Care Networks and their member GP practices are key partners in the Protect NoW programme. Alongside clinical leadership, our partners Prescribing Services Ltd provide the bespoke data analysis, technical solutions and digital platforms that underpin the Protect NoW projects.

Each project is chosen based on its potential to reduce reversible risk and improve health outcomes in the populations least likely to access or engage with health and care services. Protect NoW projects during 2021/22 have included:

Increasing uptake of Flu Vaccination - targeted Virtual Support Team (VST) support to patients that had not been vaccinated against flu in the preceding 12 months.
Before COVID-19 vaccination was available, this project focused on the extremely vulnerable cohort and doing all we could to reduce their risk of hospitalisation and catching COVID-19. The VST directly contacted more than 3,000 patients to book them in for a flu vaccination.
Diabetes Prevention - reducing inequalities and unwarranted clinical variation and increasing referrals to lifestyle change support.
15,000 pre-diabetic patients have been identified through their recent GP blood glucose results. Protect NoW contacted patients most at risk of developing diabetes on behalf of primary care to encourage them to join the National Diabetes Prevention Programme (NDPP) to prevent / reverse their diabetes risk. More than 7,000 patients responded (48.6% engagement rate) with more than 3,000 referred to NDPP.

Increasing uptake of Cervical Cancer Screening - reducing inequalities and unwarranted clinical variation.
Protect NoW worked with practices to locate patients with no recorded cervical screening, or none in last 3-5 years. More than 2,500 patients most at risk through smoking and lifestyle were identified and contacted directly with and offer of support to access screening. More than 1,400 patient questionnaires were completed offering valuable insight into reasons for screening hesitancy.
Increasing referrals to IAPT Wellbeing Services - reducing inequalities and unwarranted clinical variation.
Protect NoW identified and contacted patients who had been prescribed anti-depressants or anxiety medication by their GP, but had not accessed the NSFT Wellbeing Service, which offers talking therapies. The project focused on the practice areas that referred least and concentrated on older patients and those living in areas of most deprivation. More than 2,000 patients were contacted to encourage participation and promote self-referral. 58.% of patients engaged following contact, with more than 1,000 completed patient questionnaires and 300 patients starting treatment.
Increasing uptake of COVID-19 vaccination – reducing health inequalities and reaching underserved communities.
Protect NoW used vaccination data to make text message contact with 103,543 individuals (500,000+ SMSs) encouraging uptake / signposting to vaccination bookings and walk-in opportunities. Cohorts in scope included the Clinically Extremely Vulnerable, potentially housebound (to encourage alternatives to home visits), health and social care staff, unpaid carers, and areas of greatest deprivation / least uptake. The project saw a significant spike in traffic to Norfolk County Council's walk-in clinic finder webpage following each text burst – 1 in 4 (23,000) came forward for vaccination within seven days of receiving a localised text.
Development of Priority Patient Review - reducing avoidable admissions and improving quality of life.
The latest Protect NoW project sees the use of the Eclipse system in GP practices to auto-generate primary care risk alerts related to six biomedical markers. The markers are amongst the most common indicators of potential hospital admission due to stroke, cardiovascular disease, frailty, and falls. Where data reveals tested levels are outside the normal range, patients are proactively contacted for clinical review and action planning.

The positive impact made by Protect NoW projects - and the significant potential that implementing wider PHM approaches has – is being recognised across the system. This has led to a recent expansion of the Virtual Support Team (VST) and additional resource and infrastructure being agreed to support the development and delivery of future projects.

Research

This year the CCG Research Office had its most successful year to date, securing seven research grants over the financial year worth more than £7.5 million, with a further 12 National Institute for Health Research grants totalling £10.3 million either in set-up, progress, or approaching completion. The CCG is one of only nine CCGs awarded research grant-related Research Capability Funding (RCF), which is a measure of an organisation's success in winning research funds and is currently 4th in that table having increased our RCF allocation by 84% over last year to £346,775, with between £550,000 and £600,000 expected for 2023/24.

In 2021/22, over 8,000 patients and staff across 65 general practices teams in Norfolk and Waveney took part in over 30 nationally important research studies. These studies include:

- The world-leading PANORAMIC trial, the world's largest trial of new antiviral treatments for COVID-19 in the community, with over 400 participants to date recruited through our OneNorwich practices.

- The Psychological Impacts of COVID-19 study, whose results have just been published, saw over 7,000 people in Norfolk and Waveney taking part over the last 2 years, the highest number of any CCG in the country.

- The University of Cambridge SAFER - Screening for Atrial Fibrillation Study (cam.ac.uk) is exploring if an Atrial Fibrillation screening programme can help prevent strokes. Over 1,400 patients in Norfolk and Waveney enrolled in the study.

Over 60% of the CCG's general practices are regularly engaged in research, well above both the national average of 42% and target of 45%.

Digital

The CCG's digital strategy aims to improve care through innovation and new technology, ensuring that digital technologies are a core part of commissioning and delivery strategies and that residents are enabled to access health services through accessible technology.

The use of digital technology is a major element within the NHS Service Model and is an organisation driver for the CCG during 2021/22. Throughout the year the CCG has continued to increase and improve the digital capability of our workforce, which has transformed our way of working and reduced our carbon footprint. The CCG has adopted cloud technologies such as N365 and MS Teams and remote working, and further investment in cloud technology, including telephony, will see staff in the CCG joined up to wider ICS partners and able to work in a wider range of locations.

Digital access and triage enable patients to be directed to the right person the first time and to access care and services when they need to and reduce waiting times for appointments. The coming year will also see projects across the ICS that explore the use of remote monitoring and remote observation technologies, building on the success of the Virtual Wards project at NNUH.

All GP practices in Norfolk & Waveney have had their data migrated to the Cloud and have adopted N365, enabling them to collaborate and access shared resources and use Teams for meetings and calls. This will enable practices to be an active part of the ICS, working flexibly from any internet connected location.

Support is also available to Care Homes to ensure that they and their residents are enabled to make better use of technology. The SystmOne Care Home Module allows for easy communication with health service providers as well as enabling Care Homes to effectively manage residents, their information, care planning and connect patient records with other care providers in the area.

Working in partnership with Digital, Clinical and Care colleagues and partners across the ICS, the CCG has successfully procured a Shared Care Record, supplied by InterSystems Corporation. This positive collaboration will provide our system with a combined health and care record from across Primary Care, Community, Mental Health, Acute and Social Care. The single holistic record will support frontline services with access to key information at the point of care. This will lead to smoother patient flow and better decisions, helping to improve a person's care experience and outcomes. This project also aligns with the ICS goals to make Norfolk and Waveney the best place to work, giving more information so

frontline teams can have more confidence when making difficult decisions, whilst also improving system efficiency. The project is currently in mobilisation with plans to go-live by October 2022.

Across the ICS, a Health and Care Data Architecture model is being developed which will enable data from multiple sources to be joined together to design and develop proactive models of health and care and inform the future design of health and care services.

Sustainable Development

As an NHS organisation, and as a spender of public funds, the CCG has an obligation to work in a way that has a positive effect on the communities we serve and the environment we live in. Sustainability means spending public money well, using natural resources efficiently, and helping to build healthy, resilient communities. By making the most of social, environmental, and economic assets we can improve health both in the immediate and long term, even in the context of rising cost of natural resources. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012).

The health and care system in England is responsible for an estimated 4-5% of the country's carbon footprint. In October 2020 the NHS set an ambition to be the first "net zero" health service in the world, in recognition of the global "climate emergency which is also a health emergency". It committed to two challenging targets:

- to reach net-zero by 2040, for the carbon emissions we control directly (the NHS Carbon Footprint), and
- to reach net-zero by 2045 for the broader emissions we can influence.

The CCG acknowledges this responsibility to our patients, local communities, and the environment by working hard to minimise our carbon footprint. During the last year some of the work that has been undertaken to improve sustainability includes:

- The development of an ICS Green Plan Delivery Group which operates within the Norfolk and Waveney Health and Care Partnership in line with the requirements from the NHSE/I Public Board. Its role is to develop and deliver an ICS Green Plan for the strategy period 2022-2025, through collaborative working with partner organisations, ensuring we meet Government, NHS and local Net Zero ambitions.

- The CCG is working on several schemes with local providers to reduce the carbon footprint by reducing the overall number of patient journeys required. These include extending the use of virtual outpatient appointments; using Advice and Guidance and pre-referral triage schemes (e.g., dermatology) to reduce number of hospital appointments; assisting with the drive towards patient-initiated follow-up schemes to reduce hospital visits for follow-up appointments; and developing a range of ambulatory monitoring at home schemes so patients don't need to attend hospital for monitoring appointments.

- The number of emails the CCG produces and sends, particularly with large attachments, leaves a carbon footprint. The Digital Team's "Think Green. Go Digital" initiative is building awareness of the environmental impact of work processes whilst encouraging and enabling staff to rethink how they use digital technologies to benefit the environment. Alongside a CCG-wide commitment to reduce emails by 50% by August 2022, webinars providing guidance and training

in the effective use of MS Teams are supporting staff to work collaboratively whilst reducing the need for travel.

- This year the CCG supported the change to subscribe environmentally friendly “greener” inhalers which could reduce user’s carbon footprint by the equivalent of driving around 1,740 miles a year. These dry powder inhalers are more environmentally friendly than the traditional metered dose inhalers as they do not use powerful greenhouse gases to propel the medication into the patient’s lungs. As a result, greener inhalers have an estimated carbon footprint equivalent of just 20g per dose compared with 500g in metered dose inhalers.

- The POD service drives a reduction in wastage of medicines in the community, by preventing over-ordering of medicines and thereby preventing both wastage of medicines that cannot be reused, but also the additional environmental impact of waste incineration.

Improve Quality

During 2021/22 the CCG has worked in collaboration with provider organisations to support and deliver quality improvement and patient safety initiatives across the local health and social care system, both in terms of the system response to the COVID-19 pandemic and recovery of service delivery and access to care for our local population.

The CCG Nursing & Quality Team has worked flexibly in order to enable deployment of senior clinical staff to support provider organisations to deliver on system priorities such as COVID-19 vaccination, hospital discharge and the development of new community capacity, as well as maintaining oversight of clinical quality and patient safety across the healthcare economy. This has enabled us to work even more closely with our commissioned service providers to enable continuous improvement through service redesign, integrated care pathways and collective leadership.

Examples of shared system objectives include:

- Work with healthcare partners, local authorities, and social care colleagues to focus around supporting safe discharge from hospitals and creating additional capacity in the community during the pandemic, with an emphasis on ‘home first’ wherever safe and appropriate.

- Continued development of the Norfolk & Waveney Quality Surveillance Group (QSG), which provides a platform for quality surveillance, governance and improvement with a reach right across the system, sharing skills, expertise and experiences to enable a shared view of risks to quality and patient safety and identifying opportunities for collaborative improvement.

- Establishment of a Norfolk and Waveney Patient Safety Specialists Network, with representation from system partners from across the local healthcare system. The purpose of the group is share best practice and progress with the implementation of the Patient Safety Incident Response Framework, along with potential challenges and barriers that can be worked through with a collective system approach.

- Establishment of a Norfolk and Waveney Medical Examiner Implementation Group. This group was established to support the local implementation of Medical Examiners service which is due to become statutory later in 2022/23. The initial focus of this forum has been to increase communication with all system partners, including general practice to raise awareness of the

medical examiner process, while providing an opportunity for concerns and queries to be explored at a local level.

- Launch of a Personalised Care Acute Service Project, piloting enhanced personalised care within the Central Norfolk Trauma & Orthopaedic pathway, with the aim of improving patient experience, health, wellbeing and outcomes for patients on treatment waiting lists.

- Design and implementation of the Norfolk Care Hotel Project (see the Discharge to Assess section for more information).

Engaging People and Communities

The CCG has a duty to ensure it works closely with others to help plan and influence local NHS services. A key value that sits at the very core of the CCG's work is working together for and with patients.

Through the past year the CCG's engagement team has worked with: people with mental health conditions, representatives from migrant and minority ethnic communities, non-English speakers, unpaid and family carers, people with learning disabilities and/or autism, older people's forums, maternity voice partnerships, patient participation groups (PPGs), and children, young people and families.

During the roll out of the vaccination programme the CCG offered support across the system to ensure the associated messages were suitable for the local population.

The CCG worked with local VCSE organisations and patient stakeholders, to listen to the concerns of local people and encourage increased vaccine uptake, especially among underserved populations and those with poorer health outcomes. This was done by engaging with representatives of local communities to make sure the messages were targeted and relevant.

Despite the challenges of the pandemic the CCG maintained its formal statutory functions of engagement with stakeholders. Some highlights of the engagement activities and projects from the last year include:

ICS Communications and Engagement Development

A wide range of resources and materials are currently being developed to support conversations, communications and engagement with people and communities and to promote awareness around these changes to the health and care landscape. Assets and materials being developed include a social media campaign, a communications toolkit which includes FAQs, website copy, videos, images, banners and infographics, a jargon buster and resources in other formats including easy read.

A new Norfolk and Waveney ICS website is being developed to help us effectively communicate and engage with people and communities, keeping them up to date on the latest information needed to live longer, healthier, and happier lives. A public survey has been developed and shared to gather views about what this should look like and the kind of content it should include. This will close late April 2022 and will feed into the new ICS website design and function.

Commitment to making all public meetings accessible in British Sign Language

The COVID-19 pandemic introduced us to a world of working virtually and remotely, which has proven successful across the public sector and healthcare system. However, we know that virtual meetings are not always accessible by everyone, particularly those who are deaf or hard of hearing.

The CCG is now able offer British Sign Language (BSL) interpretation for virtual public meetings, such as Governing Body, Primary Care Commissioning Committee and ICS Partnership Board meetings, in order to comply with our statutory and mandated duties to provide inclusive communication, to all members of our communities.

Once a virtual meeting has finished, the recording is interpreted in BSL by local supplier Deaf Connexions and added on to the recording, which is then shared on our Youtube channel, website and social media channels.

Vaccine hesitancy campaigns

To support the COVID-19 vaccination and booster programme, the communications and engagement team developed targeted vaccine hesitancy campaigns. These campaigns were aimed at promoting the COVID-19 vaccination and booster, encouraging those eligible to have their vaccination and if they were not coming forward, seeking to understand why not and the reasons behind vaccine hesitancy.

Every Vaccine Counts:

- A campaign aimed at under 30s, as data indicated the 18-30 year old age group had the lowest vaccination uptake.
- Developed in partnership with Norfolk County Council using behavioural science and insight from VCSE partners and local people using online surveys and focus groups.
- Strong imagery of young people attending local vaccination centres was promoted through high visibility media, such as Chapelfield Shopping Centre digital screens, bus stops; social media; and asking community champions to share materials to reach hard to engage audiences.

Every Vaccine Counts 2:

- Every Vaccine Counts 2 was launched to support the COVID-19 booster rollout, again targeting the under 30s age group who were not having their booster vaccine.
- Insight from local 18-30 year olds was used to develop the key messages for the campaign. These messages focussed on COVID-19 fatigue, the misconception of Omicron being mild and being fully protected without a booster.
- In the first week of the campaign, over 1,000 18-30 year old first dose vaccinations were given.

Vaccination in pregnancy

Significant work took place to involve pregnant women in the COVID-19 vaccine programme, from myth-busting to understanding concerns and addressing misinformation, which resulted in significant improvements in vaccination rates. The CCG hosted a virtual question and answer session with the Public Health team to answer questions and reassure pregnant women. The session was translated into

several different languages and shared online. The work was based on local data and intelligence and had direct engagement with women from Polish, Lithuanian and Portuguese ethnicities.

In addition, a vaccination experience survey was distributed that sought feedback from people who have had their COVID-19 and flu vaccinations in order to improve the vaccination service and experience for patients.

Winter Well campaign

A system-wide winter prevention campaign was co-developed with partners including Public health, Local and district councils and health colleagues to support winter well-being and reduce pressure on NHS services over the winter. Key campaign themes included a mental health strand highlighting the impact of winter on mental and physical health and signposting to a range of support services, advice on local health services, and handy winter health and wellbeing tips to prevent unnecessary hospital visits.

The intended outcomes of the campaign were:

- Better health results for people across Norfolk and Waveney during the winter period
- Reducing avoidable attendances at ED so that capacity was reserved for those who need it

Key outputs included:

- £50,000 multimedia campaign across Norfolk and Waveney from November – March
- A dedicated campaign landing page with key winter messages.
- A5 booklet with health and wellbeing information delivered to 476,000 households in Norfolk and Waveney in mid-December.
- A4 poster and social media assets translated into 17 different languages, shared with VCSE partners and Community Outreach groups
- Posters designed for vulnerable groups including homeless and sex workers
- A range of videos: pharmacist interviews about Self Care topics and pharmacy services, 111 call handlers, running alongside system pressures videos

The CCG and system partners are reviewing the effectiveness of the campaign and using public surveys to engage with people and communities gauge effectiveness of the campaign in helping people to look after their health. Feedback from public and partners will be used to inform the messages and campaign plan for next winter.

Digital Engagement and Social Media

The CCG social media channels saw an increase in reach, engagement, and new followers every month from October 2021. Most months the CCG gained more than 100 followers on all our accounts combined.

The CCG launched a TikTok channel in January of 2022, and videos have engaged nearly 3,000 people since then with six videos produced to date.

The most engaging social media posts have contained content relating to COVID-19 vaccination information, walk-in availability, and the importance of wearing a face covering. By using organic and paid promotions, the CCG's channels have seen a significant increase in reach, impressions, engagement such as link clicks, and inbound messages from followers and members of local communities.

By working with local organisations on the COVID-19 vaccine campaign, such as Norwich City Football Club, CCG messages and information have been able to reach a wider audience and target people who were part of low vaccination uptake groups.

Chair appointed for Norfolk and Waveney VCSE Assembly

In May 2021, Emma Ratzer was appointed as the first Chair of the Norfolk and Waveney VCSE Health and Social Care Assembly. This is an important appointment as the local Integrated Care System moves towards its launch on 1 July 2022, bringing health and social care services, together with the voluntary sector, to join up and improve the delivery of services to the people of Norfolk and Waveney.

Learning Disabilities event

A Facebook Live event hosted and led by About with Friends, a learning disability support organisation based in North Norfolk, attended by representatives from Norfolk and Waveney CCG, Norfolk Community Health and Care (NCH&C) and Norfolk County Council in May 2021. Adults with learning disabilities and their carers were asked about getting their COVID-19 vaccination.

Adults with learning disabilities were involved in running the event and reading the questions. Feedback from adults with learning disabilities who got their vaccine was:

- They didn't wait long.
- They thought that vaccine staff were great and supported them well.
- They liked having it at their day centre and getting the jab locally.
- They were mostly happy about it, but a few were a bit anxious.

New pregnancy resource coproduced with service users

In June 2021, the Local Maternity & Neonatal System (LMNS) developed a comprehensive digital resource to help prospective parents, pregnant women, and birthing people to achieve the birth they plan, in the place they would like and feel safe, wherever possible.

The resource was developed in co-production with maternity teams and service users and provides women and families with a concise and comprehensive guide to maternity services in their area. The LMNS has worked closely with Trusts, clinical staff, specialist midwives, and local Maternity Voices Partnerships (MVP) from across Norfolk and Waveney to develop this resource.

Eating Disorder Service Redesign

The CCG has worked with NHS partners, the voluntary sector, and local councils to improve Eating Disorder Services.

A survey was co-produced with service users and published in February 2022 with Rethink Mental Illness, who ensure Experts by Experience and the wider community can help inform mental health transformation. The survey captured feedback and views from people of any who have experienced an eating disorder and also the views of people who have supported friends, family and peers with an eating disorder.

The CCG has already received some valuable feedback about NHS services and services offered by voluntary and charitable organisations across the region. Comments about age-based transitions,

thresholds for accessing services and about how the system works together will be used to inform the all-age strategy for eating disorders, which will guide development of next steps in the transformation of provision of eating disorder support options in Norfolk and Waveney.

Cancer Services Feedback

A survey seeking feedback from people who have received a cancer diagnosis and cancer care during the COVID-19 pandemic has been ongoing since January 2022 and a report will be published shortly with the results of this engagement. The survey was shared with stakeholders across the health system as well as cancer service user groups.

Locally Commissioned Service (LCS) Review

An LCS review has been undertaken, with focused engagement taking place during March 2022. The review has been delayed due to the pandemic and the CCG has worked closely with the Local Medical Committee (LMC) to ensure it could have the new arrangements in place for 1 April 2022.

This review, which has been clinically led, has changed the pathway of a small number of services across Norfolk and Waveney: Earwax removal, Deep Vein Thrombosis D-Dimers, Hospital Provision, and 24-hour ECG services.

This review was delivered at pace however the CCG was still able to engage with patients to understand any impact where pathways have changed. The communications were reviewed by the LMC and Healthwatch Norfolk. The CCG shared a patient survey via the website and worked with GP practices for further distribution. This both informed patients and provided a platform for patients to have their say.

Planning what future engagement will look like through the 'Working with People and Communities' strategy

ICBs are expected to develop a system-wide strategy for engaging with people and communities by 27 May 2022, using the 10 principles in the guidance as a starting point. This will form the 'Working with People and Communities' strategy.'

The CCG has already been working closely with partners across the ICS to develop arrangements for ensuring that integrated care partnerships (ICPs) and place-based partnerships have representation from local people and communities in priority-setting and decision-making forums.

Work is taking place to ensure that the CCG builds on the great work achieved so far and strengthen our partnership approach to working with people and communities across Norfolk and Waveney.

Reducing Health Inequality

The CCG is committed to equality and inclusion. It recognises and implements all legislation relevant to its role and functions including the Equality Act 2010, meeting statutory Human Rights legislation; the Equality Delivery System EDS); the Workplace Race Equality Standard (WRES); the Modern Day Slavery Act; and the Equality Impact Assessments (EIAs) and Equality Analysis. More information can be found at: Equality and Inclusion - Norfolk and Waveney CCG

The CCG has worked to reduce health inequalities across all services, and this is described throughout this annual report.

COVID-19 amplified existing health inequalities, disproportionally affecting people and communities who already have some of the greatest levels of need and health inequality. This includes older age people and those from Black and Minority Ethnic communities; people with underlying health conditions and

those with more common conditions like obesity; as well as individuals experiencing specific socioeconomic factors, socially excluded groups such as homeless and sex workers, and those living in deprivation.

The pandemic has highlighted the significant importance of collaboration and partnership to reduce inequalities in our communities, and over the last year the CCG has accelerated and enhanced its plans to tackle inequality to both mitigate the impact of COVID-19 on the most vulnerable and improve take-up of the vaccination programme.

A Norfolk and Waveney Vaccine Inequalities Oversight Group (VIOG) was formed in January 2021. With wide-ranging system partner representation, one of the main functions of the VIOG was to use data-led insight provided by the Insight & Analytics team at Norfolk County Council to inform the design and delivery of local vaccine provision. Working in partnership, stakeholders were able to use the data, combined with local intelligence about possible reasons for vaccine hesitancy and lower uptake, to collaboratively design services and local engagement responses, including roving models, communications campaigns, community engagement and community champion initiatives. The planned responses by VIOG partners supported the outcome of Norfolk and Waveney having the highest rates of dose 1 and 2 uptake across the Eastern Region.

An Inclusion Health workstream was developed as part of the VIOG. Inclusion health groups describe people who are socially excluded. The groups typically experience multiple overlapping risk factors for poor health, experience stigma and discrimination, and are not consistently accounted for in electronic records. These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes. Through the VIOG, bespoke vaccination offers for our homeless populations and sex workers with outreach hostel pop ups and community venues were offered. Pop-up vaccination clinics to mosques and Asylum seeker and refugee communities, and targeted engagement with our Gypsy Roma Traveller community through trusted communicators were also offered.

Building on the learning from VIOG, the CCG has co-developed its future system approach to inequalities with local government, providers, and voluntary and community sector colleagues. The Norfolk & Waveney Health Inequalities Oversight Group (HIOG) is the ICS's strategic approach to inequalities which will see system partners collaboratively deliver the commitments in national policy and guidance and key local strategic plans such as the NHS Long Term Plan, 5 urgent actions for addressing inequalities in ICS guidance, and Core20PLUS5. The key workstreams within HIOG have been agreed, including programmes that address Core20plus5, Community Engagement through the Community Voices programme, NHS Anchors, as well as VIOG and an inclusion health programme.

Below are some additional examples of the work initiated by the CCG to address wider health inequalities:

- The Protect NoW programme aims to reduce health inequality and improve the healthy life expectancy of the population. More information can be found in the Protect NoW section.

- To improve access to primary care appointments by the Deaf community, the CCG's Training Hub rolled out training to GP practices on the Accessible Information Standard and is working with local organisations and the voluntary sector to expand the training to cover specific subjects such as supporting patients who are hard of hearing and those with Learning Disabilities, as well as how to access BSL interpreters through the new Language Empire contract.

- The 12-month Annual Health Pilot launched in March 2021 which saw a team from the CCG work with primary care to increase the uptake and quality of annual health checks, including working with hard to engage audiences such as Black, Asian and Minority Ethnic groups. The pilot has improved uptake of annual health checks and the quality of service for people with Learning Disability and Autism during their visits as well. The pilot identified 199 people who had not had a health check until the team contacted them, and over a third have already had their health check appointment. As a result of the pilot's success the CCG has committed to funding this for a further 12 months.

- The cancer programme board has developed an inclusive recovery plan for the system which undertakes specific actions to help identify and reduce health inequalities. This includes using data to identify unwarranted variations in cancer rates and developing strategies to minimise digital exclusion for people with cancer from particular patient groups and demographics.

- High levels of physical inactivity were identified as a key contributing factor to health inequalities in West Norfolk. The CCG along with other local partners successfully secured a place on the 'Ideas to Action' Sport England/Lottery-funded development programme for tackling inequalities though physical activity. A shared programme of engagement activity and projects in deprived areas has been developed, including new neighbourhood activity trails for young families, the launch of a new 'All to Play For' mental health football support programme, and a pilot programme for funded sports centre memberships for people in hardship.

Health and Wellbeing Strategy

Joint Health and Wellbeing Strategies

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

Norfolk priority: A single sustainable system **Suffolk theme: Health and care integration**
Over the last year the COVID-19 pandemic has continued to accelerate our system working and to deepen cross-system relationships at every level. The CCG has played an active role in supporting and enabling system working throughout the pandemic, including by discharging its role to provide tactical coordination during incidents and by working with partners through the local resilience fora. Our preparations for the transition from CCG to statutory ICS have also progressed our work towards creating a single sustainable system. We have made appointments to key system roles, including the chair designate and chief executive designate of our Integrated Care Board, and made significant progress with determining how our Integrated Care System will operate from 1 July 2022, pending the successful passage of the Health and Care Bill through Parliament. Importantly, we have taken the decision as a system that the Norfolk and Waveney Integrated Care Partnership should be established with the same membership as the Norfolk Health and Wellbeing Board (including Waveney/Suffolk members) and that they should hold streamlined meeting arrangements.
Norfolk priority: Prioritising prevention **Suffolk theme: Embedding prevention**
The CCG, working with partners from across the health and care system, has made good progress over the last year with using population health management techniques to offer early help and to prevent or reduce demand for specialist services. Following the success of the award winning Covid Protect early in the pandemic, Protect Norfolk and Waveney (Protect NoW) has made strong progress and delivered a range of population health

management projects over the past year. This is helping our system to provide more anticipatory and preventative care.
Our approach has evolved to include the establishment of a permanent, in-house Virtual Support Team, comprising clinical leads, a supervisor and call handlers who have been trained in motivational interviewing / health coaching techniques. We have a forward programme of work, including projects to support people in accessing cervical screening, flu vaccination, covid vaccination, talking therapies and the diabetes prevention programme, as well as risk stratification and care management to reduce urgent care contacts and hospital admissions.
In addition to our population health management work, the CCG continues to commission preventative services and work with partners on the prevention agenda.

Norfolk priority: Tackling inequalities in communities
Suffolk theme: Addressing inequalities

The COVID-19 pandemic has highlighted some of the health and wider inequalities that persist in our society. As a system we are committed to working together to address these inequalities, with the CCG's Director of Population Health Management and Health Inequalities, leading work on equalities and diversity for the system.
The COVID-19 and flu vaccination programme has been a priority over the past year. The Norfolk and Waveney Vaccine Inequalities Oversight Group has used data-led insight to inform the design and delivery of local vaccine provision. Our approach has included targeted interventions for our most vulnerable and underserved populations who experience multiple overlapping risk factors and poor health. The roving model has reached and engaged with many of our underserved communities and in future will deliver a wider range of health and wellbeing interventions, in line with our 'Making Every Contact Count' approach.
The CCG's Integration and Partnerships teams have continued work to embed a shared understanding of the challenges facing our most vulnerable communities, in collaboration with their local partners, and to highlight local intervention opportunities. This collaborative approach is underpinned by data and local intelligence, and is supported by Public Health teams in both Norfolk and Suffolk.
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. Going forward, this work will be led by the new Norfolk and Waveney Health Inequalities Oversight Group, which importantly will include work around mental health, as well as physical health.

For more information, please refer to the 'Reducing Health Inequality' section of this report.

Norfolk priority: Integrating ways of working
Suffolk theme: Stronger and resilient communities

The CCG has continued to work hard with partners to develop integrated ways of working at neighbourhood, place and system levels, supporting both vertical and horizontal integration of services, as well as to create stronger and more resilient communities. For example:

- At neighbourhood level, the CCG has continued to support the development of our 17 Primary Care Networks (PCNs) and integrating our workforce. The PCNs have come into their own during the pandemic, improving people's care and helping general practice, as well as other health and care services, to remain resilient.
- At place level, the CCG has worked with partners to agree our system's approach to place-based working and working with communities at a more local level, including around addressing the wider determinants of health.
- At system level, the CCG has been supportive of our three acute hospital trusts and the arrangements they are putting in place to work together as a group of hospitals to enable transformation and collaboration.
- Throughout the pandemic we have strengthened partnership working with district councils and the voluntary, community and social enterprise sector, with numerous examples of how we've collaborated to support local people.

The Norfolk Health and Wellbeing Board has been consulted over the contents of this section of the report. It was sent to the April 2022 meeting of the Board for information and comment.

It was also sent to the Suffolk Health and Wellbeing Board via email for information and comment.

Financial Review

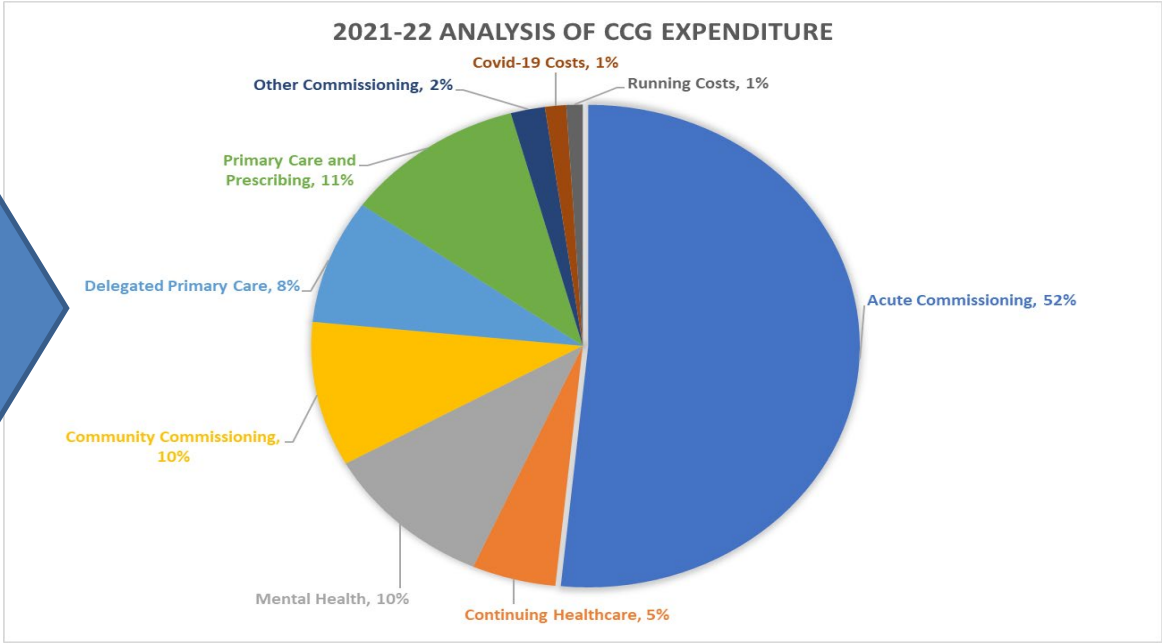
As a result of the NHS response to the COVID-19 pandemic the 2020/21 financial regime changed significantly, in line with the commitment from Government that financial constraints would not get in the way of the pandemic response. This resulted in fixed block contract payments, set by NHSE/I, being made to NHS providers, together with significant amounts of non-recurrent funding to cover the costs of the NHS in providing a fast and effective response.

This is also the second year of operation for the single Norfolk and Waveney CCG, an organisation representing the amalgamation of five legacy CCGs (Norwich CCG, North Norfolk CCG, Great Yarmouth and Waveney CCG, West Norfolk CCG and South Norfolk CCG).

The total amount of money allocated to the CCG was £2,110.1m (2020/21: £1,904.9m). Of this £397.8m was allocated non-recurrently.

This total allocation was split, £2,089.5m (2020/21: £1,865.1m) for commissioning of health care services, and £20.6m (2020/21: £20.3m) for the CCG running costs.

This is how the CCG spent its total budget during 2021/22. 99% related to 'Programme' costs – the proportion of its budget devoted to commissioning healthcare for the patients of Norfolk and Waveney. Only 1% related to the costs of running the organisation.



Spend area	2021/2022	2020/2021
Acute Commissioning	£1,088.8m	£907.4m
Primary Care & Prescribing	£227.9m	£236.9m
Mental Health	£216.8m	£192.5m
Community Commissioning	£204.7m	£136.9m
Delegated Primary Care	£175.8m	£166.3m
Continuing Healthcare	£105.4m	£87.8m
Other Commissioning	£43.1m	£68.7m
COVID-19 Costs	£26.6m	£68.6m
Programme Costs	£2,089.0m	£1,865.1m
Running Costs	£20.5m	£20.3m
TOTAL COSTS	**£2,109.6m**	**£1,885.4m**

As noted in the table above the CCG has seen a significant increase in the Acute, Community and Mental Health areas of expenditure compared to the previous year, resulting from nationally set block contracts with NHS providers which were designed to bring the Provider organisations to a break-even position together with additional expenditure in Continuing Healthcare, Primary Care, Prescribing and separately specific COVID-19 expenditure resulting from the ongoing response to the COVID-19 pandemic.

Running costs have increased by £0.2m principally as a result of the unfunded pay awards in line with National directions. Ongoing benefits since the merger of five legacy CCGs in April 2020 continue to save costs from the single organisation structure together with the reduction in costs following remote working because of the pandemic.

As a result of the maintained changes to financial regime from 2020/21, the ability for the CCG to make efficiency savings which reduce the cost base have remained restricted. The CCG has focused on non-block discretionary spend and achieved total efficiency savings of £4.23m (2020/21 £1m). These savings arise from Programme expenditure costs for Prescribing and Continuing Healthcare, and from Running Costs.

At the end of the year, the CCG delivered an in-year surplus of £0.56m, against a planned breakeven position. This movement from plan results from net underspends in the Programme portfolio of £0.45m and Running costs of £0.11m.

SIGNED

Tracey Bleakley
Interim Accountable Officer
17 June 2022

ACCOUNTABILITY REPORT

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

The **Corporate Governance Report** sets out how we have governed the organisation during 2021/22, including membership and organisation of our governance structures and how they supported the achievement of our objectives.

The **Remuneration and Staff Report** describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

This is the second Accountability Report for NHS Norfolk and Waveney Clinical Commissioning Group (the CCG) as the CCG was established with effect from 1 April 2020. Prior to this date there were five CCGs in Norfolk and Waveney and these all ceased to exist on 31 March 2020.
The CCG is due to be abolished on 30 June 2022 with functions transferring to an Integrated Care Board with effect from 1 July 2022. This means that this Annual Report and Accounts is the penultimate report for the CCG. The final report will cover the period for April, May and June 2022 and is due to be reported in 2023.

Members' report

The CCG's Constitution came into effect on 1 April 2020 and provides for the establishment of a Council of Members to ensure that membership is involved, engaged and that communication is effective and appropriately maintained. The Constitution also provides that each member practice has a Member Practice Representative who represents their practice in its dealings with the CCG. Member Practice Representative responsibilities include selecting four Nominated Practice Representatives to represent them on the Council of Members on behalf of their locality. The CCG has five localities made up of West Norfolk, Norwich, South Norfolk, North Norfolk and Great Yarmouth and Waveney.

Due to COVID-19 the CCG paused the roll out of the Council of Members so that member practices' focus is on addressing the pandemic. During 2021/22 the CCG has not received any requests from member practices to hold a Council of Members meeting and no meeting has taken place. It has therefore not been possible to confirm the Nominated Practice Representatives.

Member profiles and practices

The CCG has 105 member GP practices in Norfolk and Waveney. For an interactive map showing the name and location of the member GP practices please see *https://www.norfolkandwaveneyccg.nhs.uk/about-us/our-members*.

Composition of Governing Body - The members of the Governing Body are as follows:

Dr Anoop Dhesi
Chair

Tracey Bleakley
Interim Accountable Officer
From 1 April 2022

Ed Garratt
Accountable Officer
4 January 2022 to 31 March 2022

Melanie Craig
Accountable Officer
1 April 2020 to 3 January 2022

Rob Bennett
Lay Member for Audit and Financial Management

Hein van den Wildenberg
Lay Member Financial Performance

Doris Jamieson
Lay Member Primary Care

John Ingham
Chief Finance Officer

Dr Clare Hambling
Healthcare Professional

Mark Jeffries
Lay Member Patient and Public Involvement

Dr Ardyn Ross
Healthcare Professional

Tracy Williams
Healthcare Professional

Dr Peter Harrison
Secondary Care Specialist

Kathy Branson
Registered Nurse

Dr Hilary Byrne
Healthcare Professional

Committees of the Governing Body

Please see the Annual Governance Statement page 59 for details of the Audit Committee and all other Governing Body Committees.

Register of Interests

The Register of Governing Body Interests can be found here: https://www.norfolkandwaveneyccg.nhs.uk/publications/declarations-of-interest**.** More information on how the CCG manages interests can be found in the 'Annual audit of conflicts of interest management' section on page 76.

Personal data related incidents

During the year 2021 to 2022 and up to the submission of the Annual Report and Accounts there were three data security breaches reported to the Information Commissioner's Office (ICO). The ICO investigated these matters and identified that the breaches were not reportable to the ICO and no enforceable action was required. In one instance the CCG was advised to continue to ensure that the data we hold is accurate and, where possible, kept up to date and the root cause of all incidents should continue to be reviewed to identify whether actions can be taken to prevent a recurrence.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report

- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

The CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking but does not meet the requirements for producing an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015.

SIGNED

Tracey Bleakley
Interim Accountable Officer
17 June 2022

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Executive to be the Accountable Officer of NHS Norfolk and Waveney CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities).
- The relevant responsibilities of accounting officers under Managing Public Money,
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended)),
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that Norfolk and Waveney CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

SIGNED

Tracey Bleakley
Interim Accountable Officer
17 June 2022

Governance Statement

Introduction and context

NHS Norfolk and Waveney Clinical Commissioning Group (the CCG) is a body corporate established by NHS England on 1 April 2020 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2021, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

From 1 April 2021, Norfolk and Waveney as a system was formally recognised as an Integrated Care System (ICS). Accordingly, Norfolk and Waveney has established an interim ICS Partnership Board. More details can be found on page 70.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

COVID-19 and Reducing the Burden Guidance

The impact of COVID-19 during 2021/22 has continued to be significant and has affected all aspects of the NHS where the focus has been on delivering care for patients and reducing infection rates. At the start of the pandemic the CCG redeployed many staff from across departments into new roles to focus on support for primary and secondary care and delivery of vaccinations. To support NHS organisations to refocus work on key areas, NHS England and Improvement (NHSE&I) wrote to system leaders in March 2020 setting out NHSE&I's support for providers and commissioners to reduce the burden on maintaining some aspects of business as

usual and freeing up as much capacity as possible to prioritise the workload so that it was focused on doing what is necessary to manage the response to COVID-19.

This included standing down some meetings such as Council of Members meetings so that primary care could focus on addressing the pandemic, streamlining other meetings including those of the Governing Body, reducing the requirement for corporate reporting to NHSE&I, as well as pausing some internal processes and digital submissions.

In January 2021 NHSE&I wrote to NHS organisations again confirming the unprecedented level of pressure from COVID-19. The letter supported the continuation of freeing up of management capacity and resources to focus on the priorities of delivering the complexity of the national COVID-19 vaccination programme and continuing to provide non-COVID care.

In December 2021 NHSE&I wrote to NHS organisations declaring a level 4 national incident. The letter emphasised the need to ramp-up the COVID-19 vaccination programme, maximise availability of COVID-19 treatments for those at highest risk, maximise capacity across acute and community settings and support patient safety in urgent care pathways across all services.

A further letter was issued on 24 December 2021 highlighting the significant challenge from COVID-19 and highlighting key priorities.

The CCG responded to these system pressures by redeploying many staff from across directorates to support the national vaccination programme. The CCG ensured that there was sufficient staff to support the strategic direction and delivery of the vaccination programme. As the vaccination programme rolled out there has been a shift towards normal working practices but acknowledging the significant pressures that continue to be placed on all services and a continued focus on managing the pandemic.

NHS Arden & Greater East Midlands Commissioning Support Unit (AGEM CSU)

The CCG is supported in its work by a range of outsourced support services to AGEM CSU. this includes the provision of HR services, Business Intelligence, GPIT and Medicines Management.

The CCG Governance Framework

The CCG's Constitution and Governance Handbook

The CCG's Constitution is based on the model Constitution Framework produced by the NHS Commissioning Board (known as NHS England and NHS Improvement) in 2018 and agreed by member practices.

The Constitution sets out the way in which the CCG observes the principles of good governance in the way it conducts its business including the highest standards of propriety, good governance standards for public services, the Nolan Principles, the principles set out in the NHS Constitution, the Equality Act and the standards for Members of NHS Governing Bodies in England.

The CCG's standing orders, together with the CCG's overarching scheme of reservation and delegation are contained within the Constitution. The CCG's Governance Handbook contains the detailed scheme of reservation and delegation and the prime financial policies. Together they provide a procedural framework within which the CCG discharges its business. The CCG's Constitution also sets out how the CCG discharges its statutory functions via its governing structure. Terms of reference for statutory committees are contained in the Constitution, whilst those for non-statutory committees are set out in the Governance Handbook. Together with the CCG's Standards of Business Conduct and Conflicts of Interest Policy contained in the

Governance Handbook, the Constitution sets out how the CCG manages conflicts of interest. It puts in place processes to follow if a conflict of interest means that a meeting is not quorate to make a decision and ensures that key principles of selflessness, honesty and integrity are upheld.

Council of Members

The Constitution makes clear that the CCG is a Clinical Membership organisation. It clearly sets out the composition and function of the Council of Members which was agreed with the Membership. Each Member Practice has a nominated lead Healthcare Professional who is known as the Member Practice Representative and who represents the practice in its dealings with the CCG. One of the roles of a Member Practice Representative is to select Nominated Practice Representatives for their locality. The CCG has five localities, North Norfolk, South Norfolk, West Norfolk, Great Yarmouth and Waveney, and Norwich. Each locality has four Nominated Practice Representatives.

This means that there are 20 Nominated Practice Representatives that represent their localities on the unified Council of Members. Governing Body members are not eligible to be Nominated Practice Representatives.

Due to the COVID pandemic and the pressures on primary care the CCG has not held a formal Council of Members meeting from 1 April 2021 up to the date of submission of the annual report on 22 June 2022. The powers listed below were reserved to the Council of Members:

1. Calling a Council of Members meeting
2. Attending and contributing to the Council of Members meetings
3. A Healthcare Professional of any Member Practice to put themselves forward for election to the Governing Body
4. A Healthcare Professional of any Member Practice to put themselves forward to be a Member Practice Representative or a Nominated Practice Representative
5. In accordance with the requirements of the Constitution, approval of changes to it
6. Support the CCG in taking forward plans to develop and improve primary care services within the geographical area covered by the CCG
7. Hold the Governing Body to account for delivery of its functions, duties duty and roles
8. Receive the CCG's Annual Report and Accounts.
9. Subject to regulatory requirements, approval of arrangements for:
   i. Appointment and removal of Healthcare Professionals from Member Practices to represent the CCG's membership on the Governing Body

During the year there were no issues requiring a decision or action by the Council of Members.

Governing Body

The Governing Body comprises of 13 members, including five positions elected by the Membership one of whom is the Chair, four Lay Members, a Secondary Care Specialist doctor, a Registered Nurse, the Accountable Officer and the Chief Finance Officer.

The CCG is a clinically led organisation with the Constitution providing that to be quorate a minimum of seven members must be present. This must include either the Accountable Officer or the Chief Finance Officer, four clinicians and two lay members. There is provision for emergency decision making in the Constitution.

There have been changes to the membership of the Governing Body from 1 April 2021 up to the date of submission of this Annual Report on 22 June 2022. Melanie Craig left the CCG on

secondment to another NHS organisation on 3 January 2022 and Ed Garratt was appointed interim Accountable Officer on 4 January 2022. Ed Garratt's term as interim Accountable Officer ended on 31 March 2022 and Tracey Bleakley was appointed Accountable Officer from 1 April 2022.

Subject to the passing of legislation the CCG is expected to cease to be a legal entity on 30 June 2022. This will mean that all Governing Body members will finish in their roles on this date.

Meetings

The CCG held six Governing Body meetings in public between 1 April 2021 and 31 March 2022.

Due to the COVID-19 pandemic meetings have been held in public virtually via Microsoft Teams to ensure that good governance principles of openness are adhered to. Details on how to access public meetings is available on the CCG website with a recording available after each meeting on the CCG's YouTube channel. Each meeting has been well attended and quorate. Members of the Executive Management Team also routinely attended meetings.

Membership and 'voting' attendance is recorded in the table below:

Member	Name	Attendance
GP Member (Chair)	Dr Anoop Dhesi	5 out of 6 meetings (83%)
Accountable Officer	*Ed Garratt	2 out of 2 meetings (100%)
Accountable Officer	*Melanie Craig	4 out of 4 meetings (100%)
Chief Finance Officer	John Ingham	6 out of 6 meetings (100%)
Healthcare Professional	Dr Ardyn Ross	4 out of 6 meetings (67%)
Healthcare Professional	Dr Hilary Byrne	5 out of 6 meetings (83%)
Healthcare Professional	Tracy Williams	6 out of 6 meetings (100%)
Healthcare Professional	Dr Clare Hambling	5 out of 6 meetings 83(%)
Secondary Care Specialist	Dr Peter Harrison	6 out of 6 meetings (100%)
Registered Nurse	Kathy Branson	6 out of 6 meetings (100%)
Lay Member	Rob Bennett	6 out of 6 meetings (100%)
Lay Member	Hein van den Wildenberg	6 out of 6 meetings (100%)
Lay Member	Doris Jamieson	6 out of 6 meetings (100%)
Lay Member	Mark Jeffries	6 out of 6 meetings (100%)

**Melanie Craig left the organisation on 3 January 2022 and Ed Garratt joined the organisation on 4 January 2022*

The minutes of Governing Body meetings are available at:
https://www.norfolkandwaveneyccg.nhs.uk/about-us/our-governing-body/governing-body-meetings

Additional private meetings were held throughout the year to discuss matters where the wider public interest or commercial confidentiality clearly required it.

The Governing Body approved the Constitution and Governance Handbook in April 2020. The Governance Handbook was further updated in April 2021. These documents contain the overarching scheme of reservation and delegation and the detailed scheme of reservation and delegation respectively.

The Governing Body has a number of functions conferred on it by the Health and Social Care Act 2012 (the "Act"). The main function is to ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with good governance. The Governing Body also leads on setting the vision and strategy of the organisation. The Act also requires the Governing Body to determine the remuneration, fees and

other allowances including any pension scheme payable to employees or other persons providing services to the CCG. The Governing Body has established a Remuneration Committee to review these matters and make recommendations to the Governing Body.

The CCG's Constitution sets out the responsibilities delegated to the Governing Body. These include providing assurance of strategic risks, ensuring registers of interest are reviewed regularly, and that financial reports including details about allocation and financial variances against plan are reviewed. These matters are standing agenda items at each Governing Body meeting.

The Governing Body frequently discusses the following topics at its meetings:

- System pressures
- Covid-19 vaccination programme
- Elective recovery
- Clinical threshold policy recommendations
- Drug & therapeutic recommendations
- Financial reporting
- Risk reporting
- Reports from Committees

The Governing Body completed a self-assessment of its own performance and effectiveness during April 2022. This was discussed at a Governing Body meeting in April 2022. The findings from the self-assessment were that the Governing Body was effective during 2021/22 and no significant issues were raised.

Governing Body Committees

The Governing Body has appointed six committees and these are detailed below.

Primary Care Commissioning Committee

The role of this Committee is to carry out the functions relating to the commissioning of primary medical services except those that relate to individual GP performance management which have been reserved to NHS England.

Since 1 April 2021 and up to 31 March 2022 the Committee met 11 times.

The Constitution provides that membership of this Committee is as follows:

- Lay Member who leads on primary care who is the Chair
- Lay Member who leads on financial performance
- Chief Finance Officer or the Director of Commissioning Finance
- Registered Nurse

Membership of the Primary Care Commissioning Committee together with the attendance record is provided in the table below

Member	Name	Attendance
Lay Member (Chair)	Doris Jamieson	10 out of 11 meetings (91%)
Lay Member	Hein van den Wildenberg	10 out of 11 meetings (91%)
Registered nurse	Kathy Branson	9 out of 11 meetings (82%)
Chief Finance Officer/ Director of	John Ingham Jason Hollidge	11 out of 11 meetings (100%)

Commissioning Finance		

Some of the highlights of the work of the committee in 2021/22 include:

- Review of NHS England primary care budgets
- Review and monitoring of the Primary Care Risk Register
- Provide input to and approves the Primary Care Committee Future Plan
- Review of the response to Covid-19 and the roll-out of the vaccination programme
- Review of practice issues
- Approval of support programmes, e.g. GP Resilience funding and support for practices
- Monitoring CQC outcomes
- Receiving regular reports on GP practice prescribing especially in relation to opiates and dependence forming drugs
- Review and approve procurement and commissioning decisions e.g. translation services, incentive schemes for GP practices.
- Offer of support to practices, if required

Audit Committee

The Audit Committee provides the Governing Body with an independent and objective view of the CCG's assurance processes. This is achieved by reviewing financial systems, the risk management structure and ensuring compliance with the laws, regulations and directions that govern the CCG.

The Audit Committee is comprised of:

- The Lay Member with a lead role in overseeing financial management and audit, who is also the Chair;
- The Lay Member with a lead role in championing Patient and Public Involvement;
- The Lay Member who leads on financial performance
- A Healthcare Professional Governing Body member drawn from Member Practices

The Chair of the Audit Committee is Rob Bennett who is the Lay Member with a lead role in overseeing financial management and audit and also the CCG's Conflicts of Interest Guardian.

Since 1 April 2021 the Audit Committee met seven times up to the 31 March 2022. Each meeting was well attended and quorate.

Membership of the Audit Committee together with the attendance record is provided in the table below:

Member	Name	Attendance
Lay (Chair)	Rob Bennett	7 out of 7 meetings (100%)
Lay Member	Mark Jeffries	6 out of 7 meetings (86%)
Lay Member	Hein van den Wildenberg	6 out of 7 meetings (86%)
Healthcare Professional	Dr Clare Hambling	7 out of 7 meetings (100%)

The Committee is supported by regular attendance of the CCG's Chief Finance Officer, Associate Director of Corporate Affairs and ICS Development, Associate Director of Financial Management and Director of Commissioning Finance. In addition, the Accountable Officer also attended a meeting in line with the Committee's terms of reference.

The primary role of the Audit Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the CCG's activities supporting the achievement of the CCG's objectives.

The Audit Committee reviewed the adequacy and effectiveness of:

- Internal control systems;
- Risk and control related disclosure statements prior to endorsement by the CCG;
- Principal risks and policies for ensuring compliance with regard to regulatory, legal, code of conduct requirements and self-certification;
- Policies and procedures for work related to fraud and corruption and information governance.

The Committee primarily utilises the work of Internal Audit and External Audit but is not limited to these sources. It also seeks reports and assurances from directors and managers as appropriate. The Committee concentrates on the overarching systems of integrated governance, risk management and internal control.

The Audit Committee is also responsible for ensuring that arrangements are in place for countering fraud and reviews the work of the counter-fraud specialist.

Key areas of work of the Audit Committee in 2021/22 included:

- Monitoring the work of Internal Audit, External Audit and Anti-Crime
- Reviewing the Risk Management Framework and Governing Body Assurance Framework providing assurance to the Governing Body
- Reviewing financial and contractual management processes
- Reviewing transition arrangements for MyCareBanking moving personal health care budgets from a cash basis to a digital solution reducing the risk of misspent funds
- Reviewing Information Governance work to provide assurance to the Governing Body
- Reviewing the Annual Report and Accounts

Remuneration Committee

The Remuneration Committee is accountable to the Governing Body. The Committee makes recommendations to the Governing Body about the pay and remuneration for employees of the CCG and others who provide services to it.

The Governing Body has delegated the function of reviewing and determining the remuneration for elected Governing Body members excluding pension arrangements which are for the determination of the Governing Body. The CCG is mindful of conflicts of interest requirements. As such conflicted members do not form part of the decision making.

The Remuneration Committee is comprised of:

- Lay Member with a lead role in championing patient and public involvement who is the Chair
- Lay Member with a lead role in overseeing financial performance
- The Secondary Care Specialist
- The Registered Nurse
- A Healthcare Professional Governing Body member drawn from Member Practices

Since 1 April 2021 the Remuneration Committee has met seven times up to 31 March 2022. Each meeting was well attended and quorate. Meetings were supported by the Associate Director of Corporate Affairs and ICS Development and the Head of Human Resources Business Partners for Arden & Greater East Midlands, Commissioning Support Unit. The Committee

reviewed and amended its terms of reference in April 2021. These amendments were confirmed by the Governing Body at its meeting in April 2021.

Membership of the Remuneration Committee together with the attendance record is provided in the table below

Member	Name	Attendance
Lay Member	Mark Jeffries	7 out of 7 meetings (100%)
Lay Member	Hein van den Wildenberg	7 out of 7 meetings (100%)
Registered Nurse	Kathy Branson	5 out of 7 meetings (71%)
Secondary Care Doctor	Dr Peter Harrison	7 out of 7 meetings (100%)
Healthcare Professional	Dr Ardyn Ross	3 out of 7 meetings (43%)

Highlights of the Remuneration Committee's work in 2021/22 included:

- Reviewing the agreements for Healthcare Professional members of the Governing Body
- Reviewing and agreeing recommendations to the Governing Body on executive level pay
- Reviewing and approving a range of HR policies

Quality and Performance Committee

The Quality and Performance Committee is accountable to the Governing Body. The Committee provides the Governing Body with assurance in relation to the quality and safety of its commissioned services and the internal process to support safe, effective, and continuous improvement in services.

The membership of the Committee is as follows:

- The Registered Nurse, who is the Chair of the Committee
- Accountable Officer
- Two Healthcare Professional Members of the Governing Body
- Lay Member with a lead role in patient and public involvement
- Secondary Care Specialist, who is the Deputy Chair of the Committee
- Chief Nurse
- Interim Director of Clinical Services and Clinical Transformation

Since 1 April 2021 the Quality and Performance Committee met ten times up to 31 March 2022. The membership of the Quality and Performance Committee together with the attendance record is provided in the table below:

Member	Name	Attendance
Registered Nurse	Kathy Branson	10 out of 10 meetings (100%)
Accountable Officer*	Melanie Craig	7 out of 8 meetings (88%)
Interim Accountable Officer*	Ed Garratt	2 out of 2 meetings (100%)
Healthcare Professional	Dr Ardyn Ross	8 out of 10 meetings (80%)
Healthcare Professional	Tracy Williams	9 out of 10 meetings (90%)
Lay Member	Mark Jeffries	10 out of 10 meetings (100%)
Secondary Care Specialist	Dr Peter Harrison	8 out of 10 meetings (80%)
Chief Nurse	Cath Byford	7 out of 10 meetings (70%)
Interim Director of Clinical Services and Transformation	Mark Lim	9 out of 10 meetings (90%)

** Melanie Craig left the organisation on secondment on 3 January 2022 and Ed Garratt joined as Interim Accountable Officer on 4 January 2022.*

A key role of the committee is to monitor the quality and safety of providers through soft intelligence and patient feedback. The Committee uses this information to identify themes and provides assurance to the CCG Governing Body. The Committee also receives and reviews quality and performance reports and agrees any recommended actions for potential and known clinical and performance risks. It will ensure all such risks are documented within the directorate or operational risk register for the Committee and where relevant escalated to the Governing Body Assurance Framework. The Committee identifies learning and improvement opportunities and communicates them appropriately. Where appropriate it provides reports to external bodies.

The Quality and Performance Committee discusses regular reports on Nursing and Quality, Patient and Public Involvement, Quality in Care and System Performance. This provides a consistent overview of clinical quality and effectiveness across services, with escalation of exceptional issues requiring additional oversight and mitigation. Issues emerging over 2021/2 have included:

- Adult safeguarding and discharge from LD/MH hospitals
- Ambulance response times
- Children and Young People's Mental Health
- 'All Age' Neurodevelopmental Disorder Pathway
- System Pandemic Impact and Elective Care Recovery
- Eating Disorder Service Provision
- IC24 Local Assurance Review
- National 'Ockenden Report' Maternity Review

The Quality and Performance Committee continues to provide constructive feedback on CCG policies and reports that impact on clinical quality and patient safety. Documents reviewed and ratified by the Committee during 2021/2 include:

- CCG Complaints Policy
- CCG Safeguarding Children Policy
- CCG LeDer Review Annual Report and Governance Framework
- Local Maternity and Neonatal System Governance Framework
- CCG Adult Safeguarding Policy
- Guidance for managing Children and Young People with complex medical care needs in Education settings v12 November 2020
- Policy for Children's Continuing Care v1
- Guidance for Staff working nights in the Homes of Children and Families v1 (Sleeping on Duty Guidance)

Finance Committee

The Finance Committee supports the Governing Body in scrutinising and tracking delivery of key financial and service priorities, plans and targets as specified in the CCG's Strategic and Operational Plans. The Committee also submits information as appropriate to the Audit Committee and provides advice to the Governing Body on strategic financial matters.

From 1 April 2021 the Finance Committee membership comprised of:

- Lay Member with a lead role in Financial Performance (Chair)

- Lay Member with a lead role in Primary Care (vice-Chair)
- Accountable Officer
- Chief Finance Officer
- Interim Director of Clinical Services and Clinical Transformation
- Chief Nurse (or deputy), or Head of Continuing Healthcare
- Secondary Care Specialist
- Two Healthcare Professional Members of the Governing Body

The Finance Committee met 11 times from April 2021 up to 31 March 2022. Each meeting was well attended and quorate. Membership of the Finance Committee together with the attendance record is provided in the table below

Member	Name	Attendance
Lay Member (Chair)	Hein van den Wildenberg	11 out of 11 meetings (100%)
Lay Member	Doris Jamieson	10 out of 11 meetings (91%)
Accountable Officer*	Melanie Craig	5 out of 8 meetings (63%)
Interim Accountable Officer*	Ed Garratt	0 out of 3 meetings (0%)
Chief Finance Officer	John Ingham	11 out of 11 meetings (100%)
Interim Director of Clinical Services and Clinical Transformation	Dr Mark Lim	10 out of 11 meetings (91%)
Chief Nurse	Cath Byford	7 out of 11 meetings (64%)
Secondary Care Specialist	Dr Peter Harrison	7 out of 11 meetings (64%)
Healthcare Professional	Dr Clare Hambling	10 out of 11 meetings (91%)
Healthcare Professional	Dr Hilary Byrne	9 out of 11 meetings (82%)

** Melanie Craig left the organisation on secondment on 3 January 2022 and Ed Garratt joined as Interim Accountable Officer on 4 January 2022.*

Key pieces of work undertaken to secure assurance include:
- Review of the membership, terms of reference, and remit of the Committee;
- Review annual budgets and detailed plans for approval by the Governing Body;
- Monitor the CCG's financial standing in-year and recommend corrective action to the Governing Body should year-end forecasts suggest that the financial plan will not be achieved;
- Receive detailed reports at each meeting concerning the CCG's financial performance, to incorporate narrative relating to key variances from plan;
- Receive in-depth insights into area requiring specific attention of the committee.
- Scrutinise the Finance Directorate's Risk Register;
- Monitor implementation of any recommendations arising from the internal audit of finance functions;
- Receive briefings on the financial position of the wider Norfolk & Waveney Health & Care Partnership to understand the context within which the CCG is operating;
- Review impact of Covid-19 on the CCG financial performance.

The committee's work dovetails with that of the Audit Committee in order to provide assurance to the Governing Body that the robust management of finance is in place.

Conflicts of Interest Committee

The committee is established to make decisions on issues where there is a conflict of interest for example, but not limited to, where a decision is required that affects Healthcare Professional members of the Governing Body in their capacity as providers of services to the CCG.

- Membership of this committee consists of the following:
- Lay member with a lead role in overseeing financial management and audit who is the Chair and also the Conflicts of Interest Guardian
- Lay member with a lead role in primary care
- Registered Nurse
- Chief Finance Officer or nominated deputy

The Committee has met four times up to 31 March 2022. The membership of the Conflicts of Interest Committee together with the attendance record is provided in the table below

Member	Name	Attendance
Lay Member (Chair)	Rob Bennett	4 out of 4 meetings (100%)
Lay Member	Doris Jamieson	4 out of 4 meetings (100%)
Chief Finance Officer	John Ingham	4 out of 4 meetings (100%)
Registered Nurse	Kathy Branson	4 out of 4 meetings (100%)

The Committee is authorised to make decisions on behalf of the Governing Body with regard to issues which could not be decided by the Governing Body due to conflicts of interest.

Some of the highlights of the Committee during 2021/22 are:

- Considering approach to addressing a conflict of interest when declared in a meeting
- Review of Conflicts of Interest Audit Report and recommendations
- Considering approach to conflicts of interest when not in a meeting setting
- Review of conflicts of interest action plan and training compliance

Freedom to Speak Up (Whistleblowing)

The CCG's Freedom to Speak Up (FTSU) Guardian is Doris Jamieson, who is a Lay Member on the Governing Body. During 2021/22 the FTSU Guardian received seven contacts leading to three cases being opened, one case that was carried over from 2020/21 was closed in the year. Three cases remain open as at 31 March 2022. The process has been shown to be effective with several cases raising concerns relating to more than one issue including patient safety, attitudes and behaviours, and competencies. In November 2021, to support the work of the FTSU Guardian, the CCG appointed FTSU Champions to raise awareness and promote the work of the Guardian. (Freedom to) Speak Up training is a mandatory requirement for all staff. Further training has also been released by the National Guardian's Office, entitled Listen Up, for staff to complete. A third module, Follow Up, was launched in April 2022. The three modules are cumulative and managers and senior staff will need to complete the requisite number of modules.

Executive Management Team Meeting

The Executive Management Team (EMT) is a CCG meeting comprising the Accountable Officer, Chief Finance Officer and the Executive Directors of the CCG (as set out in the Remuneration report) as well as other senior representation. It is the operational forum for exercising the Accountable Officer and Chief Finance Officer's authority under the CCG's Scheme of Reservation and Delegation. It is not, however, a formal committee of the Governing Body.

The EMT meets weekly and monitors the operational discharge of statutory duties, approved corporate contracts and oversees HR and organisational development and establishment control and monitors budgets. The EMT reports relevant items to the Governing Body via the Accountable Officer's report.

During the early part of the year the EMT met as Strategic Command to address Covid-19 matters at least weekly, and during the height of pandemic it was meeting on a daily basis. Strategic Command directs and commands the response of NHS resources during an incident by ensuring NHS service delivery for both the incident and normal services.

Since January 2022 the EMT has introduced an additional ICS EMT weekly meeting. This meeting is attended by all the system Chief Executives and CCG Directors. The aim of the meeting is to provide a forum to discuss system issues including system pressures, financial matters and the progress of the vaccination programme.

The Senior Managers Team (SMT) meeting addresses a range of corporate issues that supports the EMT to focus on strategic matters. The SMT reviews internal operational matters and work includes policy review, estate matters, overseeing the discharge of the CCG's duties with regard to equality and diversity. The SMT also reviews the Governing Body Assurance Framework and updates the document for oversight by the EMT.

The SMT meets weekly and comprises of a core team of senior managers. It has no formal decision-making authority and reports on its work to the EMT. SMT is chaired by the Director of Commissioning Finance.

ICS Partnership Board

Health and care systems nationally are moving from working in a Sustainable Transformation Partnership to Integrated Care Systems (ICS). A white paper has been produced which proposes to put ICSs on to a formal legal basis from July 2022. The Norfolk and Waveney interim ICS Partnership Board is Chaired by the Right Honourable Patricia Hewitt and was established in April 2021. Subject to the passing of legislation, on 1 July 2022 the Right honourable Patricia Hewitt will become Chair of the Integrated Care Board and Councillor Bill Borrett will become Chair of the Integrated Care Partnership. Whilst the Partnership Board has no direct authority it will achieve its remit through forging strong partnership working based on mutual trust and respect and use its collective influence to bring about transformation and improvement. Meeting details can be found here: https://www.norfolkandwaveneypartnership.org.uk/about-us/interim-partnership-board/interim-partnership-board-meetings.html

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Risk management arrangements and effectiveness

The CCG Risk Management Framework

The CCG's integrated risk management strategy and framework set out the CCG's approach to risk management.

In accordance with the framework, risks are evaluated in terms of the likelihood and consequence using an organisational risk matrix. Scores for likelihood and consequence are given out of 5 and multiplied together. The results give one of four categories of risk grading as follows:

Serious risk - immediate action required by a director

High risk – urgent senior management attention needed with action plan

Moderate risk - responsibility for assessment and action planning allocated to a named individual

Low risk – normal risks which can be managed by routine procedures

The CCG developed a Risk Management process to ensure that risks were identified throughout the organisation. This is supported by a staff handbook to ensure that the process is clearly understood.

The Audit Committee reviews the risk management framework. Risk is reviewed regularly by the Senior Management Team and also the Executive Management Team with risks assessed, rated and agreed for either escalation or removal from the GBAF (Governing Body Assurance Framework). The Audit Committee reviews the risk register to ensure that matters are appropriately reported and that action plans are robust and progress is being made. Through these mechanisms the CCG's risk appetite is assessed and regulated.

The Governing Body meets in public every other month. Members of the public are able to see Governing Body papers including the GBAF ahead of the meetings and they are able to ask questions at the meeting or raise queries via the website in advance.

An exercise was undertaken to update the format of the GBAF during the year to make it easier to review. The new format was reviewed by the Audit Committee and the EMT before being presented to the Governing Body in September 2022. The new format brings risks into a single word document which makes it easier to focus on key information. The process for managing the GBAF is being reviewed and updated in readiness for the transition to the Integrated Care Board on 1 July 2022.

The CCG has various controls to address its risks. These are set out clearly for each risk in the assurance framework and include internal as well as external controls.

The CCG's control mechanisms are used to protect financial assets, operational systems and ensure that important laws and regulations are complied with. The table below sets out some of the internal controls used and the benefits they provide:

Management of current risks	CCG Governing Body Assurance Framework; Regular assurance and finance reports to the Governing Body. This year a key aspect of assurance reporting focussed on the vaccination programme. Identification of risks associated with the provision of services to patients. These are mitigated though the work of the quality team and contract management of provider contracts via the contract with the CSU and in house commissioning staff; A robust programme of counter fraud and anti-bribery activity supported by

	the Anti-Crime Specialist whose annual plan is scrutinised by the Audit Committee.
Prevention of Risk	Through the processes mentioned above the CCG regularly horizon scans to identify potential areas of risk. In addition, the CCG uses its experience of and learning from adverse events to ensure that lessons are learnt. Preventative measures include: Policy development; Identifying and ensuring that staff comply with mandatory training requirements; Establishing risk-sharing agreements; Root cause analysis of incidents; Mandating limits to decision making authority; and Ensuring secure access to IT systems.
Deterrent to risks arising	Developing risks are managed through a number of systems and include: Risk review by Committee and Governing Body meetings as well as senior management team meetings; Finance reports to the Governing Body; In this year reports on the Covid-19 pandemic and vaccination programme status; Robust programme of counter fraud and anti-bribery supported by the Anti-Crime Specialist.

Capacity to Handle Risk

The CCG's Integrated Risk Management Strategy and Framework supports a positive staff attitude to risk management, encouraging staff to identify, assess, manage and report risks. Staff are clear about their personal accountability and responsibilities through the Risk Management Staff Handbook, appraisal, induction and on-going training. Support is given to risk owners by the Corporate Affairs Team.

As set out above Governing Body Assurance Framework risks were reviewed monthly by the senior management including SMT and EMT. At these meetings risks are further discussed and escalated as appropriate on to the Governing Body Assurance Framework. This ensures that changes to risk registers are debated and agreed at the SMT and EMT before being put on to the GBAF.

To provide further assurance the Audit Committee reviews the overarching Risk Management Framework which incorporates the Integrated Risk Management Strategy and Framework and the Staff Handbook, this having been approved by the Governing Body.

The CCG continued to develop its approach to risk management, drawing on best practice and recommendations from the internal auditors. The internal audit assurance rating for the GBAF in March 2022 was substantial assurance.

Risk Assessment

Risk is assessed using a standardised organisational risk matrix, looking at risk based on likelihood and consequence. Guidance in the form of a staff handbook has been produced setting out a formal process for risk identification and evaluation.

The key risks identified as part of this process include:

Covid-19 Resurgence

There is a risk that the system may experience an increase in COVID-19 cases as national restrictions are lifted and increased freedom of movement. There is a risk that new variants may contribute to increase in transmission. The local healthcare system is currently going through a

period of high system pressure set against restoration and recover, and compliance with robust Infection, Prevention and Control Measures.

A system approach has been taken to manage positive and asymptomatic patients with the key priorities on COVID-19 vaccination and urgent and emergency care. Planned care is prioritised based on clinical need. In addition, multiple testing options are available locally for symptomatic and asymptomatic cases reflecting national guidance with an accelerated vaccination programme delivering against national plan for spring boosters. The retention of workforce continues to be the key risk to delivery of controls against this risk.

System/Urgent & Emergency Care pressures
There is a risk that any increase in COVID-19 variants coupled with 'normal' increases in demand will place severe pressure on the Norfolk and Waveney urgent and emergency care services. The infection prevention and control measures needed to manage Covid patients and the normal increase in demand from winter will likely cause congestion at Emergency Departments resulting in delays to ambulance offload and reduce East of England Ambulance Trust (EEAST) resources which in turn impacts on community response times. The higher acuity of patients entering urgent and emergency care services adds further pressure on access to beds and increases in hospital occupancy unless discharge services capacity can keep pace with demand. All services that provide urgent and emergency care across health and social care could be severely impacted by increased sickness as staff need to isolate because of COVID-19.

The controls in place to reduce this risk include seven-day system level working coordinated via EEAST and CCG resilience teams smoothing demand across sites, ambulance crews available 12-24.00 at all acutes to provide emergency department surge capacity and a system discharge dashboard in place to track discharge delays across organisations.

Elective recovery
There is a risk that the number of patients waiting for elective treatment in Norfolk and Waveney, which has grown significantly during the pandemic, cannot be reduced quickly enough to a level that meets NHS Constitutional commitments and which protects patients from the risk of clinical harm. If this happens, it will contribute to a poor patient experience, fail to meet Constitutional requirements and may lead to an increased risk of clinical harm resulting from prolonged waits for treatment.

To reduce the likelihood of this risk the system has established a multi-disciplinary Elective Recovery Cell to track and seek to reduce the backlog in elective treatments within the scope of what is possible during the pandemic response. The Cell is developing plans to increase activity to seek to reduce the backlog of treatments as quickly as possible. Each provider has also enacted a waiting list clinical validation process and surge status has been invoked for the Independent Sector, allowing an increased number of patients to be treated each week.

Financial pressures
During the 2021/22 financial year there was a risk that the CCG would not deliver breakeven. This would have meant that the CCG would not have been able to maintain spending on current levels of service, or to continue with plans for further investment. It could have led to a reduction in the levels of services available to patients.

Work undertaken to reduce this risk included monthly monitoring of risks and mitigations report to NHSEI and a balanced plan for April – Sept approved by the Governing Body and submitted to NHSEI as part of a balanced system plan.

Quality – Providers in CQC Special Measures
There is a risk that services provided by the system's providers in special measures do not meet the required standards. If this happens, some patients will not receive access to services and care that meet the required quality standard.

This may lead to clinical harm, poor patient experience and delays in treatment or services. A re-inspection of the QEH has brought this provider out of special measures. NSFT remains in special measures, however. This was confirmed in a recent CQC report. Work continues to assist the Trust and a weekly internal Performance Board meets that works collaboratively to support the Trust to make the improvements necessary.

Cancer diagnosis and treatment
There is a risk that there is a failure to improve early diagnosis and treatment. If this happens there may be poorer health outcomes for cancer patients and a failure to rapidly reduce elective backlogs. This may lead to increased waiting times and potential harm to patients.

To mitigate this risk prioritisation of planned care recovery is in place alongside system response to COVID-19 and urgent and emergency care pressures. The Norfolk and Waveney Cancer Programme is also working with Public Health England to support improved local screening uptake in partnership with local Primary Care Networks. In addition, a local communication plan is in place to educate patients on worrying symptoms and encourage presentation to primary care. Local screening uptake is reviewed by our business intelligence team and patient presentations to primary care and '2 week wait' GP cancer referrals data is used to target interventions to improve early diagnosis.

Continuing Health Care
There is a risk that NHS Continuing Health Care (CHC) funded packages will not be filled by the provider either due to the complexity of the care required and/or their capacity or the proposed cost of care. If this happens significant pressures will be placed on the CHC nurses to source a package of care. Staff vacancies and absences may increase and the infrastructure to support provision of safe effective care packages will be compromised. This may lead to increased financial cost to secure a care package and it could impact on hospital discharges and admissions and poor outcomes for people requiring NHS Funded care in the community.

A range of measures are being taken to support the management of this risk including vacant posts being recruited to within the CHC team to support assessments and care sourcing. In addition, there is cross organisational working with the local authority to support care providers and additional support and training is provided as required. There are weekly meetings with NSFT and Norfolk County Council to improve communication and partnership working around discharge planning. This helps support complex discharges from acute mental health hospital beds which would otherwise be progressively delayed by a lack of suitable complex care in the local provider market.

Impact on general practice from the COVID-19 pandemic
There is a risk services provided by general practice across Norfolk and Waveney system may be impacted by COVID-19 due to the impact of staff testing positive, staff isolating, increased demand from patients that have put off accessing services during the pandemic, and the delivery of the PCN Covid vaccination campaign. If this happens, significant pressures will be placed on practices and other primary care services, as well as urgent and emergency care and community services. Staff absences will increase and the infrastructure to provide safe and responsive

services will be compromised. This may lead to delays in accessing care, increased clinical harm as a result of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured Primary Care services.

To support general practice and reduce the likelihood of this risk work has included locality teams and strategic primary care teams prioritising support for the resilience of general practice and the Covid vaccination programme. All practices have been supported to review business continuity plans and the primary care workforce and training team are working closely with locality teams to identify clinical and volunteer workforce and to ensure training available to support practices and Primary Care Networks in setting up and maintaining services.

Mental health transformation programme
There is a risk that there is a failure to implement mental health transformation, collaboration, improved capacity and outcomes. If this happens there will be insufficient capacity and quality of care to meet needs and to meet the ambitions of the NHS Long Term Plan. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk.

There are a number of actions being taken to support this area and mitigate against this risk. This includes investment in strategic commissioning with new staff starting in posts. There is a system approach to increasing knowledge skills and expertise across agencies and developing additional capacity through the use of digital methods. In addition, the use of an effective system wide governance framework including Experts by Experience Reference Group and development of enabling workstreams to focus on unifying programme goals and priorities for example tackling health inequalities, Mental Health workforce development, developing a digital approach and Mental Health pathway development.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The Governing Body assures itself that the organisation has effective control via regular reporting of the highest red rated risks to the Governing Body and delegating to its Audit Committee the review of the assurance framework. In addition, the Audit Committee has the role of reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the CCG's activities.

The CCG established the Quality and Performance Committee to seek assurance that robust clinical quality is in place. This Committee regularly reports to the Governing Body.

Internal Audit provides regular reports to the Audit Committee on key areas as set out in its audit plan. This plan was agreed by the Audit Committee in March 2021 recognising that it would need to be kept under review and approved by the ICB Audit Committee.

The CCG's External Auditor is Ernst and Young who were appointed in January 2021.

Other control mechanisms included:

- Financial Plan and Reporting;
- The Serious Incident (SI) process for reporting and investigating serious incidents
- Adoption and review of various policies
- The Quality and Performance Committee monitors provider serious incidents and risks
- The Finance Committee reviews finance performance and risk
- The Information Governance team including the Senior Information Risk Owner, Data Protection Officer and Caldicott Guardian, review data protection and confidentiality compliance, implementation of privacy by design and default, information and cyber security, management of information risk, which is evidenced by the CCG's annual Data Security Protection Toolkit submission.
- The work of the Anti-Crime Specialist

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG's Internal Auditors completed the conflicts of interest audit in October 2021. The finding from this audit was that reasonable assurance could be provided on the CCG's management of Conflicts of Interest.

As part of conflicts of interest management, the CCG maintains Registers of Interests for Governing Body and Committee members, all staff and member practice GP partners. Due to the impact of Covid-19, however, and with the re-deployment of staff into key roles to support the pandemic it was not possible to fully maintain the Registers this year. This means that whilst the Registers for Governing Body and Committee members was maintained, the Registers for GP partners was not up to date. However, there were no decisions taken in year by the Council of Members so no such conflicts arose. Staff registers were paused at the start of the year and have since been fully updated.

The audit also highlighted that the CCG does not receive regular assurance from the CSU. Good practice was also identified with respect to Governing Body and Committee meetings as there is an opportunity to declare interests at all meetings. The review of Primary Care Co-Commissioning Meetings also confirmed that there was a good balance in place for those in attendance as directed by the Constitution.

Declarations of interest are a standing item on all CCG Committee agendas. A Declaration of Interest form is also completed by all candidates as part of the recruitment process, and by all parties involved in any procurement evaluation process. Parties involved in procurement evaluation processes are those people (typically only CCG employees) that are part of the evaluation team. Evaluation team members will typically be requested to contribute to evaluating specific aspects of a proposal or tender based on their area of expertise such as finance, quality etc.

The CCG also ensured that staff and Governing Body members complete conflicts of interest training. The CCG's Conflicts of Interest Guardian is Rob Bennett, the Lay Member for governance and audit and who is also the Audit Committee Chair and the Conflicts of Interest Committee Chair.

Data Quality

The CCG recognises the need to provide accurate, timely and clear information. Papers for the Governing Body are provided one week in advance of the meeting. This gives members time to read and adequately prepare in advance of the meeting so that they can fully contribute to it. Papers are also reviewed by senior management prior to distribution to ensure that they are clear and complete. Papers for the Council of Members would normally be circulated 20 days in advance of the meeting, however, due to the impact of Covid-19 no Council of Members meeting has taken place during the year.

The Governing Body members also considered the following statements in relation to the quality of data as part of their annual self-assessment in April 2022 as follows:

- Are Agendas and reports circulated in good time for Governing Body Members to give them due consideration?
- Are the minutes and actions circulated in good time for Governing Body Members to give them due consideration?

Members responded positively to the above questions.

Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing / have developed information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. The CCG is pleased to report that there were no Serious Untoward Incidents in relation to data security breaches during 2021-22. To demonstrate best practice and ensure that staff learn from the management of incidents, the CCG continues to record low level or near miss breaches within an IG Incident Log, which is subsequently reported to the IG Working Group. The mitigation of incidents is used to inform staff awareness bulletins, policy revisions and training. To demonstrate the CCG's commitment to transparency in respect of its management of potential IG incidents, it has self-reported two incidents in relation to data quality and cyber security, which were both identified as unreportable by the Information Commissioner's Office.

The IG Team continue to embed a culture of "privacy by design and default" across the organisation which helps the organisation to identify and document its information risk profile and manage its risk appetite. In addition, the CCG continues to adopt an Information Risk Management Policy to ensure that its processing activities are closely monitored and any information risks arising out of a change in process are captured within an Information Risk Register. The Register is reviewed by the IG Working Group on a monthly basis, which is

chaired by the CCG's Senior Information Risk Owner. The Information Risk Register and associated policy mirrors the CCG's Risk Management Assurance Framework, which facilitates a process for escalation and de-escalation of risks where necessary.

In 2021-22 the following key risks were identified and managed:

- Management of our IT Estate through consistent patching, installation of anti-virus and encryption of all endpoint devices, servers and removable media
- Exit arrangements from the Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002 (COPI Notice) to support the CCG to return to business as usual

The Data Security and Protection Toolkit (DSPT) is an online self-assessment tool that enables organisations to measure their performance against the National Data Guardian's 10 data security standards. The national submission deadline for the DSPT is now the 30 June 2022. The CCG is currently working towards achieving a "Standards Met" submission. The requirement for CCGs to have an internal audit of their DSPT submission has been removed for 2021/22, and therefore this submission will not be audited.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG continues to implement its information governance management framework and processes and procedures in line with the DSPT. The CCG ensures all staff undertake annual information governance training, which is enhanced by a programme of monthly in-house IG awareness sessions and bespoke training for teams to process patient identifiable data.

A key focus for the CCG in 2021-22 is the management of its information assets and the use of digital solutions to support remote working, to ensure that assets are managed in accordance with the latest information security standards, best practice and the Records Management Code of Practice for Health and Social Care 2021.

Business critical models

The CCG reviewed the Macpherson report and concluded that it did not operate business critical models. The CCG's approach to quality assurance is to ensure there is transparency, periodic review and staff competency to ensure processes and information that feed into decision-making are of suitable quality. Processes and systems to ensure good version control, testing and scrutiny of systems, as well as internal and external audits, as appropriate, are in place. Where possible, the CCG uses standard NHS approaches to ensure that every process can be audited.

Third party assurances

The CCG relies on third party providers for a number of services. Assurances are provided in the form of Service Auditor Reports (SARs). The following SARs have been provided to the CCG:

Provider and Services Delivered	Comment
NHS Shared Business Services: Finance and Accounting SAR	*Qualified Opinion* In PWC's opinion, in all material respects, except for the matter described in the 'Basis for qualified opinion' paragraph above, based on the criteria described in the Service Organisation's management statement in section I: • the description in sections III and IV fairly presents the Service Organisation's Finance and Accounting services as designed and implemented throughout the period 1 April 2021 to 31 March 2022; • the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period 1 April 2021 to 31 March 2022 and the customers applied the complementary controls referred to in the scope paragraph of this assurance report; and • the controls tested, which, together with the complementary user entity controls referred to in the scope paragraph of this assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period 1 April 2021 to 31 March 2022.
NHS Shared Business Services: Prescription Payments SAR for the period 1 April 2020 to 31 March 2021	*Qualified Opinion* In PWC's opinion, in all material respects, except for the matter described in the 'Basis for qualified opinion' paragraph above, based on the criteria described in the Service Organisation's management statement in section I: • the description in section III and IV fairly presents the Service Organisation's Prescriptions Payments process as designed and implemented throughout the period 1 April 2021 to 31 March 2022; • the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period 1 April 2021 to 31 March 2022 and the customers applied the complementary controls referred to in the scope paragraph of this assurance report; and • the controls tested, which, together with the complementary user entity controls referred to in the scope paragraph of this assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period 1 April 2021 to 31 March 2022.
NHS Digital: GP Payments to providers of General Practice services in England	*Qualified Opinion* In PWC's opinion, in all material respects, except for the matter described in the 'Basis for qualified opinion' paragraph above, based on the criteria described in the Service Organisation's management statement in Section I: • the description in Section IV and V fairly presents the Service Organisation's Extraction and Processing of General Practitioner Data services as designed and implemented throughout the period 1 April 2021 to 31 March 2022; • the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period 1 April 2021 to 31 March 2022 and the user entity applied the complementary controls referred to in the scope paragraph of this assurance report; and • the controls tested, which, together with the complementary user entity controls referred to in the scope paragraph of this assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period 1 April 2021 to 31 March 2022
Capita PCSE	Qualified opinion

Primary care support services to NHS England and delegated CCGs.	In Mazar's opinion, in all material respects, except for the matters discussed above: 1. The description fairly presents the controls systems as designed and implemented throughout the period from 1 April 2021 to 31 March 2022; 2. The controls related to the control objectives stated in the description were suitably designed throughout the period from 1 April 2021 to 31 March 2022; and 3. The controls tested, which were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2021 to 31 March 2022.
AGEM CSU Financial Ledger Accounts Payable Accounts Receivable Financial Reporting Treasury & Cash Management Payroll	In Deloitte's opinion which has been formed on the basis of matters outlined in their report. In our opinion, in all material respects, based on the criteria including specified control objectives described in the Senior Management's statement on pages 7 and 8: (i) the description in Sections 3 and 4 fairly presents the service organisation activities that were designed and implemented throughout the period from 1 April 2021 to 31 March 2022; (ii) the controls related to the control objectives stated in the description on pages 13 to 24 and pages 30 to 75 were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2021 to 31 March 2022 and customers applied the complementary user entity controls referred to within section 4.7 of this report; and (iii) the controls that we tested were operating with sufficient effectiveness to provide reasonable assurance that the related control objectives stated in the description were achieved throughout the period from 1 April 2021 to 31 March 2022.
Whittington Hospital NHS Trust Payroll and pension services to the CCG.	From an internal audit report dated 29 April 2019 the findings were that overall, the Trust's controls are appropriately designed and are operating effectively for the period under review, however, one or more areas have been identified where control design and operating effectiveness could be improved. There were 2 Low priority weakness in the design and operating effectiveness of controls in place to ensure business objectives are achieved. Based on the work performed, the Trust's system of internal control for Payroll Processing achieved significant assurance with improvement required.
NHS Electronic Staff Record Programme Provides NHS organisations with integrated payroll and HR service system	Qualified opinion In PWC's opinion opinion, in all material respects, except for the matter described in the 'Basis for qualified opinion' paragraph above, based on the criteria described in the Service Organisation's and the included Subservice Organisation's management statement in Section 2: • the description in Sections 5 and 6 fairly presents the Service Organisation's provision of the ESR system, and the IT and payslip printing services to the Service Organisation provided by the included Subservice Organisation to the Service Organisation, as designed and implemented throughout the period 1 April 2021 to 31 March 2022; • the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period 1 April 2021 to 31 March 2022 and the user entities applied the complementary controls referred to in the scope paragraph of this assurance report; and • the controls tested, which, together with the complementary user entity controls referred to in the scope paragraph of this assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period 1 April 2021 to 31 March 2022.
National Calculating Quality Reporting Service is an	*Qualified Opinion* In Deloitte's opinion except for the matter referred to in the Basis for Qualified Opinion paragraphs and described in the Senior Management's statement on pages 6 to 8, in our opinion, in all material respects, based on the criteria including specified control objectives described in the

approvals, reporting and payment calculation system for GP practices and supports the CCG's delegated functions	Senior Management's statement on pages 6 and 8: (i) the description in Sections 3 and 4 fairly presents the service organisation's CQRS National activities that were designed and implemented throughout the period 1 October 2021 to 31 March 2022; (ii) the controls related to the control objectives stated in the description on pages 11 to 16 and pages 22 to 35 were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 October 2021 to 31 March 2022 and service users applied the complementary commissioning user entity controls referred to within section 4.7 of this report; and (iii) the controls that we tested were operating with sufficient effectiveness to provide reasonable assurance that the related control objectives stated in the description were achieved throughout the period from 1 October 2021 to 31 March 2022.

The qualification findings do not impact the CCG's control environment, annual report or statement of accounts.

Control issues

The control issues identified by the CCG and the mitigating actions are:

Quality and Performance – Access to Services and Capacity

There has been a substantial impact on performance of most commissioned services due to the Covid 19 Pandemic. This has led to non-delivery of constitutional standards in a range of areas including Referral to Treatment, Emergency Department, Cancer, Operations, A&E and Children and Adolescent Mental Health Services waiting times. As a CCG in line with guidance we have paused elements of governance in year. For example we have taken a light-touch approach to risk management, so that we could focus on the immediate operational priorities.

The system agreed to declare a critical incident on 30 December 2021. This was because of heightened clinical risk to patients due to delayed ambulance response times, poor hospital flow resulting in restricted bed availability and high occupancy, lost capacity due to infection, prevention and control in hospitals and care homes, high workforce absence rates linked to covid. A gold level incident control was established, meeting daily to identify actions and provide additional support to high-risk areas.

The Norfolk and Waveney system de-escalated from a critical incident declaring an Operations Pressure Escalation Levels (OPEL) 4 on 26 January 2022. OPEL is a method used to measure the stress, demand and pressure being experienced by hospital, community and emergency health services. Business continuity actions continued in place in response to operational pressures and COVID-19 surge activity. This meant that the gold level incident control continued to meet twice a week to maintain strategic oversight and direction. In April 2022 an improving picture emerged, and a review of system OPEL thresholds led to a de-escalation to system OPEL 3.

Quality and Performance – Referral to Treatment / 52 week waits

There has been a significant impact on RTT/52 week waits. To mitigate this Elective Recovery is overseen by the ICS's Elective Recovery Board which is chaired by Caroline Shaw, Chief Executive of the Queen Elizabeth, and meets fortnightly with an update to date performance pack. Reporting into this are Workstreams on clinical harm review and prioritisation, diagnostics and models of care (each led by a Medical Director) performance, theatres and unified waiting list management (each led by Chief Operating Officer) workforce, inequalities and outpatient transformation (each led by a CCG director).

The CCG received a 'limited assurance' opinion for the Continuing Health Care internal audit. The areas of weakness are listed below:

- CHC cases have not been reviewed at the designated time intervals. Reviews were paused during Covid-19 pandemic, and whilst these have commenced there is significant backlog that needs to be addressed.
- CHC cases are not being assessed timely in accordance with the 28 days target.
- A process needs to be developed to ensure that retrospective claim documentation is being chased promptly.

The CCG received a limited assurance opinion for the Personal Health Budgets internal audit. The areas of weakness are listed below:

- The CCG does not have a current Personal Health Budget (PHB) policy which covers all localities
- There are a number of barriers which are preventing full transition of cases on to my care banking (MCB). The barriers need to be addressed as the risk of fraudulent and inappropriate use of PHBs is higher when cases are not on MCB.
- An updated plan and trajectory is needed to support transition of cases on to MCB.
- More frequent financial reviews need to be undertaken of PHBs whilst they are awaiting transition on to the MCB.

The CCG has since made significant progress in addressing these recommendations.

As part of the internal audit process the CCG responds to audit recommendations and findings and agrees the actions it will take to secure improvement in its processes. The Audit Committee recognises that it is appropriate at times to receive reports with limited assurance as the internal audit plan is focused on areas of risk or concern and is an important management tool to identify the improvements required.

Review of economy, efficiency & effectiveness of the use of resources

The continuation of the Covid-19 pandemic has resulted in a very different approach to the financial regime within the NHS for 2021/22, this included two half year planning periods as opposed to a full year planning cycle, fixed block contracts for NHS providers and allocations to the System based upon organisational cost bases, due to the continuously changing nature of the pandemic.

This has not prevented a planned and controlled use of its financial allocation in line with guidance from NHS England and Improvement and aligned to its strategy and intentions to the operational plans wherever possible. Services have been procured through robust processes in line with Covid-19 guidance and contract management has taken place in-year where appropriate. The Governing Body received reports of the work of the CCG as to the pandemic and regular reports on progress with the vaccination programme as well as the CCG's, financial position and forecasts each month. The Chief Finance Officer was responsible for ensuring that proper procedures were in place to enable regular checking of the adequacy and effectiveness of the control environment in line with the response to the pandemic. The Finance Committee scrutinised the financial reports and held the Chief Finance Officer to account for financial performance on a monthly basis. This committee reported to the Governing Body it's assuredness on the accuracy and transparency of the reported financial position.

For 2021/22 the national Improvement and Assessment Framework which assessed CCGs was replaced by the NHS System Oversight Framework (SOF). This new framework assigns a system to one of four segmentations. The segmentation decision indicates the scale and general nature of support needs for the system as a whole. The Norfolk and Waveney ICS has been assessed as SOF 4, which indicates a requirement for mandated intensive support. Further details and the segmentation assessment can be found here: https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

External Audit provides an independent opinion on the Annual Accounts, which incorporates the Value for Money opinion; Internal Audit conducts audits into and gives its opinion on various aspects of business as directed by the work plan set by the Audit Committee as part of its delegated functions.

In 2021/22, the CCG has achieved an in-year surplus of £0.56m.

Despite the pandemic the CCG continues to use the system wide transformation and efficiency processes to identify opportunities to achieve economy, efficiency and effectiveness via the CCG project management office which is embedded within the system Planning and Transformation team. This will also be a key aspect of successful delivery of the system's activity restoration to ensure timely delivery of projects together with the increased capacity within this team to ensure ongoing achievement of system targets on a planned basis.

The central management costs for the CCG were £20.5m representing 0.97% of the total CCG expenditure; this represents an increase of £0.3m against last year's costs of £20.3m, but a reduction in the proportion of central management costs in relation to total costs against last year where 1.07% was reported. Drivers of cost increases were principally unfunded nationally adopted pay rises of 3% mitigated by high vacancies and associated efficiency savings.

The impact from the Covid-19 pandemic has had a profound effect on the 2022/23 planning with the CCG's plan containing inherent risks such as not fully delivering the savings plan, unforeseen overspends and further, as yet unknown, cost pressures - all of which have the potential for leading the organisation into an in-year deficit and therefore breaching the statutory break-even duty and Value for Money duty in 2022/23. This emphasises the need for the continuation of effective reporting and scrutiny processes via the CCG Finance Team and Finance Committee respectively.

Budgets are set and approved by the Finance Committee and Governing Body with day-to-day management delegated to senior levels in the organisation in addition to monthly senior finance reviews of variances to maintain a firm grip on the CCG's financial management, risks and mitigations.

Delegation of functions

The CCG delegates functions internally. In particular:

The **Council of Members** delegates to the Governing Body decisions and activity such as approval of the arrangements to minimise clinical risk, maximise patient safety and secure continuous improvement in quality and patient outcomes;

The **Governing Body** delegates to committees of the Governing Body responsibility for ensuring the CCG exercises its functions effectively, efficiently and economically and adheres to generally accepted principles of good governance:

- the **Audit Committee** assures the Governing Body that effective systems of integrated governance, risk management and internal control are in place across the whole of the CCG's activities; both internal and external auditors attend these meetings;
- the **Finance Committee** monitors delivery of the Financial Plan and provides assurance to the Governing Body on the CCG's financial performance;
- the **Quality and Performance Committee** assures the Governing Body concerning the safety and quality of the CCG's commissioned services;
- the **Remuneration Committee** scrutinises proposals for the remuneration of employees and other people who provide services to the CCG and makes recommendations to the Governing Body taking into account national and local guidance;

- the **Conflicts of Interest Committee** is established to determine matters where the Governing Body is conflicted in commissioning decisions and to ensure the issue would be dealt with in a consistent and transparent way, avoiding conflicts of interest; and
- the **Primary Care Commissioning Committee** is established to carry out the functions relating to the commissioning of primary medical services which includes review of the response to Covid-19 and the roll-out of the vaccination programme and receiving regular reports on GP practice prescribing especially in relation to opiates and dependence forming drugs.

The Chair of each Committee reports to the Governing Body on the work of their respective Committees, both generally as part of the meeting and as necessary to provide further detail on Committee work.

The CCG contracts with Arden and Greater East Midlands Commissioning Support Unit (CSU) for the delivery of certain functions. These functions are subject to both service auditor reporting and internal audit review. These reports are received by the Audit Committee. The CCG's internal owners of functions are held to account by the Audit Committee for the resolution of adverse findings.

The Chief Finance Officer is responsible for the overall contract and associated performance discussions with the CSU, including scrutiny of budgetary performance.

Counter fraud arrangements

The CCG is required under the terms of the Standard NHS Contract and in accordance with the new Government Functional Standard GovS 013: Counter fraud - Counter fraud, bribery and corruption, to ensure that appropriate counter fraud measures are in place.

There is a robust programme of counter fraud and anti-bribery activity, supported by the accredited Anti-Crime Specialist (ACS) whose annual proportionate proactive work plan to address identified risks, was monitored by the Chief Finance Officer and the Audit Committee. The Chief Finance Officer is the first point of contact for any issues to be raised by the Anti-Crime Specialist. Online Fraud, Corruption and Bribery Act awareness training has been made mandatory for all CCG staff.

Counter fraud material is disseminated to staff regularly through the intranet and email. The ACS inputs to the review of various policies, including the Counter Fraud, Bribery and Corruption Policy and the Secondary Employment Policy during 2021/22 to ensure that they are up-to-date and accurate. Policies are reviewed in line with current legislation, from a best practice and counter fraud perspective. Details of all policies, procedures and key documents reviewed are reported to the Audit Committee.

The ACS attends CCG Audit Committee meetings regularly to provide progress reports and updates, as well as providing an Annual Report of the Counter Fraud Work undertaken. The Government Functional Standard GovS 013 Counter fraud - Counter fraud, bribery and corruption Return was completed by the ACS and was submitted with an overall score of Green (TBC). Appropriate action would be taken regarding any NHS Counter Fraud Authority (NHSCFA) quality assurance recommendations.

The ACS issued NHSCFA Intelligence Bulletins and various TIAA Fraud Alerts during 2021/22 relating to subjects such as various COVID related scams, fake invoices, fake emails sent to NHS staff, remote employees working two jobs, mandate frauds continuing to target the NHS and the heightened threat of cyber-attacks, which are ongoing fraud issues nationally within the NHS and the wider public sector.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and

effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

Reasonable assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

The basis for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and

2. An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

Additional areas of work that may support the opinion will be determined locally but are not required for Department of Health purposes e.g. any reliance that is being placed upon Third Party Assurances.

3. There are no matters to bring to your attention which have had an impact on the Head of Internal Audit Opinion.

During the year, Internal Audit issued the following audit reports:

Area of Audit	**Level of Assurance Given**
Financial Management	Substantial
GBAF and Risk Management	Substantial
Key Financial Systems	Substantial
Management of Complaints	Reasonable
HR Workforce Controls	Reasonable
Managing Conflicts of Interests	Reasonable
Protect Norfolk and Waveney - Governance	Reasonable
Primary Care Delegated Commissioning	Reasonable
Medicines Management/Prescribing	Reasonable
Continuing Health Care	Limited Assurance
Personal Health Budgets	Limited Assurance

In addition, operational reviews were carried out on the ICT Project Management, Review of decision making, HR due diligence and HR advisory matters.

There were no audits with no assurance. There were two audits with limited assurance, Continuing Health Care and Personal Health Budgets. Further information on these is given above in the Control Issues section on page 81:

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Governing Body who review the GBAF regularly at meetings in public and seek assurances on the effectiveness of controls from senior managers. This is supplemented by regular review at the Senior Management Team meeting;
- The Audit Committee who scrutinises the underpinning processes behind the GBAF and seek assurances on the effectiveness of controls from senior managers;
- Internal Audit as it provides an independent, objective opinion on systems of internal control as described above;
- The Finance Committee that scrutinises annual budgets and medium-term financial plans prior to agreement by the Governing Body and monitors delivery of financial standing in-year, including delivery of the productivity plan, to ensure that the CCG meets its financial statutory duties;
- The Quality and Performance Committee that scrutinises processes for holding providers to account for the quality and safety of their contracted services and utilises reports from regulatory bodies as appropriate;
- Reliance where possible is placed on third party assurance (Service Auditor Reports) as described above;
- The work of the Health Overview & Scrutiny Committee that provides an independent view of CCG performance; and
- Patient and public engagement events and feedback through a variety of mechanisms including complaints, compliments, Friends and Family Test and Quality Issue Reporting, which provides insight into provider services.

Conclusion
With the exception of the internal control issues that I have outlined in the Annual Governance Statement, to which appropriate actions have been or are being taken, my review confirms that a sound system of internal control was in place in NHS Norfolk and Waveney CCG for the year ended 31 March 2022 and up to the date of approval of the Annual Report and Accounts.

SIGNED

Tracey Bleakley
Interim Accountable Officer
17 June 2022

Remuneration and Staff Report

Remuneration report

Introduction

This report gives details of NHS Norfolk and Waveney CCG's (the CCG) Remuneration Committee and its policies in relation to the remuneration of its senior managers which the Governing Body defined as Executive Directors and members of the Governing Body.

Details of remuneration payable to the senior managers of the CCG in respect of their services during the year ended 31 March 2022 are given in the tables within this report.

This Remuneration and Staff Report is not subject to audit with the exception of those sections specifically marked as such.

This will be the final full year Remuneration and Staff Report of the CCG, with a final report issued for the period 1 April 2022 to 30 June 2022. This is because under proposed new legislation Clinical Commissioning Groups will be abolished on the 30 June 2022, and their functions will be transferred to the new Integrated Care Board (ICB) from 1 July 2022. The CCG Governing Body will cease to exist on the abolition of CCGs. An employment commitment is in place for staff below board level. This means that staff will transfer to the ICB on the same terms and conditions of employment.

Remuneration Committee

The Remuneration Committee is a committee of the Governing Body and has responsibility, under its Terms of Reference for making recommendations to the Governing Body for the remuneration, terms of service and benefit arrangements for all staff (including the Accountable Officer and Executive Directors). The Committee also has responsibility for agreeing remuneration payable to clinical advisors that support the work of the CCG.
The Remuneration Committee is chaired by the Governing Body Lay Member for Patient and Public Involvement, Mark Jeffries. The Committee's other members are Hein van den Wildenberg (Lay Member for Financial Performance), Dr Peter Harrison (Secondary Care Specialist), Dr Ardyn Ross and Kathy Branson (Registered Nurse).

Policy on the remuneration of Executive Directors

The salaries for the Chief Officer (CO) and the Chief Finance Officer (CFO) of the CCG are determined by the Governing Body following recommendations from the Remuneration Committee and covered by the guidance issued by the NHS Commissioning Board which are informed by and consistent with the principles set out in the Hutton Fair Pay Review. Further, additional consideration of the pay and employment conditions of other employees is taken into account when determining senior managers' remuneration. No bonus payments were made to any Director during 2021-22.
Direction for determining notice periods for the Accountable Officer and the Directors were laid out in the NHS Bodies Employment Contracts (Notice Periods) Directions 2008. The contractual notice period for the termination of the Chief Officer and all other directors of the CCG is six months on either side.

Executive Directors and GP members of the Governing Body are, subject to eligibility, able to participate in the NHS Pension Scheme which provides salary-related pension benefits on a defined benefit basis.

The CCG did not apply any performance conditions or assessment methods associated with senior staff/Governing Body member reward.

An interim arrangement was in place for Ed Garratt. All other Executive Directors have rolling service contracts; the table below discloses contract start and end dates for the CCG:

Executive Directors in post 2021-22	Role	Position start date	Position end date
Melanie Craig *	Chief Officer	01/04/2020	03/01/2022
Ed Garratt **	Chief Officer Interim	04/01/2022	31/03/2022
John Ingham	Chief Financial Officer	01/04/2020	n/a
Jocelyn Pike	Director of Special Projects	01/04/2020	n/a
Catherine Byford	Chief Nurse	01/04/2020	n/a
Mark Lim	Interim Director of Clinical Services & Clinical Transformation	20/04/2021	n/a
Mark Burgis	Locality Director Norwich, South Norfolk & North Norfolk	01/04/2020	14/06/2021
Mark Burgis	Director of Primary & Community Care	15/06/2021	n/a
Kathryn Ellis ***	Locality Director - Great Yarmouth & Waveney	01/04/2020	25/04/2021
Howard Martin	Locality Director - West Norfolk	01/04/2020	14/06/2021
Howard Martin	Director for Population Health Management & Health Inequalities	15/06/2021	n/a

** Melanie Craig commenced a secondment to NHS England and was replaced by Ed Garratt on an interim basis.*
*** Ed Garratt is a shared post with NHS West Suffolk CCG.*
******Kathryn Ellis commenced a secondment to Norfolk & Suffolk FT and was not replaced in the role of Locality Director - Great Yarmouth & Waveney. Kathryn left N&W and secondment ended 31/01/2022***

The roles of the executive directors were reviewed as a result of the Covid pandemic during the year and the updated changes are reflected in the table above.

Governing Body Remuneration Policy (excluding executive members)

Remuneration for the Lay Members, the Registered Nurse and Secondary Care Specialist consists of a fee that reflects the commitment and time required to fulfil their obligations effectively. They are also eligible to be reimbursed for out-of-pocket expenses incurred on CCG business. Lay Members, the Registered Nurse and Secondary Care Specialist are not eligible to participate in the NHS Pension Scheme.

All Healthcare Professional members of the Governing Body are paid at the same sessional rate however the contracted number of sessions varies according to the portfolio of responsibilities allocated to them. Healthcare Professional members of the Governing Body that are GPs are eligible to participate in the GP Solo pension scheme.

Governing Body members (excluding executive members) during 2021-22 were as follows

Governing Body members	Role	Start date	End date
Dr Anoop Dhesi	Chair	01/04/2020	n/a
Dr Ardyn Ross	Healthcare Professional	01/04/2020	n/a
Dr Clare Hambling	Healthcare Professional	01/04/2020	n/a
Tracy Williams	Healthcare Professional	01/04/2020	n/a
Dr Hilary Byrne	Healthcare Professional	01/04/2020	n/a
Dr Peter Harrison	Secondary Care Specialist	01/04/2020	n/a
Kathy Branson	Registered Nurse	01/04/2020	n/a
Rob Bennett	Lay Member	01/04/2020	n/a
Hein van den Wildenberg	Lay Member	01/04/2020	n/a
Doris Jamieson	Lay Member	01/04/2020	n/a
Mark Jeffries	Lay Member	01/04/2020	n/a

All of these Governing Body roles will finish on the 30 June 2022 when the CCG ceases to exist. This is subject to the passing of The Health & Social Care Bill.

Remuneration of Very Senior Managers

Details of remuneration payable to the senior managers of NHS Norfolk and Waveney CCG in respect of their services during the year ended 31 March 2022 are given in the table below. Three senior managers were paid more than £150,000 per annum. Two of these posts relate to a single role for the CCG and the other post relates an ICB designate role.

One CCG position received a 1.03% consolidated increase in accordance with NHSEI recommendations in 2020 which resulted in the annual salary exceeding £150,000 per annum. This pay increase took effect in April 2021.

One CCG Director was on an interim arrangement into NHS Norfolk & Waveney CCG between 4 January to 31 March 2022.

One position relates to an Integrated Care Board (ICB) designate role which whilst employed by the CCG during 2021-22 did not undertake CCG decision making duties. The salaries for these posts are in accordance with NHS guidance issued in March 2022 and developed and agreed with the Department of Health and Social Care for ICBs with a population size of 1 – 1.5 million. The salaries for these posts have also been approved by NHS England and NHS Improvement (NHSEI).

All very senior manager salaries for CCG roles have been agreed by the CCG's remuneration committee and Governing Body having been considered appropriate in line with NHSEI guidance.

Senior manager remuneration (including salary and pension entitlements) (subject to audit) –

Name & title	1 April 2021 – 31 March 2022					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses	(e) ** All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Melanie Craig - Accountable Officer *	115-120	0	0	0	40-42.5	155-160
Ed Garratt - Interim Accountable Officer *[1]	20-25	0	0	0	122.5-125	140-145
John Ingham - Chief Finance Officer	135-140	0	0	0	35-37.5	170-175
Cath Byford - Chief Nurse	115-120	0	0	0	35-37.5	150-155
Jocelyn Pike - Director of Special Projects	110-115	0	0	0	27.5-30	135-140
Mark Burgis - Locality Director Norwich, South Norfolk & North Norfolk to 14/06/2021 then Director of Primary & Community Care	110-115	0	0	0	27.5-30	140-145
Kathryn Ellis - Locality Director - Great Yarmouth & Waveney *[2]	5-10	0	0	0	65-67.5	70-75
Howard Martin - Locality Director - West Norfolk to 14/06/2021 then Director for Population Health Management & Health Inequalities	105-110	0	0	0	27.5-30	135-140
Dr Anoop Dhesi - Chair	100-105	0	0	0	0	100-105
Dr Ardyn Ross - Governing Body Member	60-65	0	0	0	0	60-65
Dr Clare Hambling - Governing Body Member	60-65	0	0	0	0	60-65
Tracy Williams - Governing Body Member *3	70-75	0	0	0	22.5-30	90-95
Dr Hilary Byrne - Governing Body Member	60-65	0	0	0	0	60-65
Dr Peter Harrison - Secondary Care Doctor	15-20	0	0	0	0	15-20
Kathy Branson - Registered Nurse - Governing Body	10-15	0	0	0	0	10-15
Rob Bennett - Lay Member	10-15	0	0	0	0	10-15
Hein van den Wildenberg - Lay Member	10-15	0	0	0	0	10-15
Doris Jamieson - Lay Member	10-15	0	0	0	0	10-15
Mark Jeffries - Lay Member	10-15	0	0	0	0	10-15
Mark Lim - Interim Director of Clinical Services & Clinical Transformation *[4]	100-105	0	0	0	65-70	165.170

*Melanie Craig left the organisation on secondment to another NHS organisation on 03/01/2022 and continues to accrue pension benefits.

*[1] Ed Garratt is a shared post with NHS West Suffolk CCG starting 04/01/2022. Ed's total salary across both organisations is 175-180 (bands of £000). Note that the full amount of pension benefits is disclosed not the pro rata portion.

*2 Kathryn Ellis's post ended 25/04/2021. Kathryn moved to another NHS organisation and will continue to accrue pension benefits. Note that the full amount of pension benefits is disclosed not the pro rata portion.
*3 Tracy Williams figures includes remuneration of 5-10 (banded salary £000) for a second role within the CCG
*4 Mark Lim's post commenced 20/04/2021.
** Total in column (e) is detailed in the Pension benefits as at 31 March 2022 table below.

The figures in the table above represent the actual payments made in year rather than full year salaries. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

Salaries and Allowances 1 April 2020 to 31 March 2021 (for comparison)

Name & title	1 April 2020 – 31 March 2021					
	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Melanie Craig - Accountable Officer	150-155	0	0	0	25-27.5	175-180
John Ingham - Chief Finance Officer	130-135	0	0	0	137.5-140	270-275
Cath Byford - Chief Nurse	110-115	0	0	0	55-57.5	170-175
Jocelyn Pike - Director of Special Projects	110-115	0	0	0	32.5-35	140-145
John Webster - Director of Strategic Commissioning	115-120	0	0	0	15-17.5	130-135
Mark Burgis - Locality Director Norwich, South Norfolk & North Norfolk	110-115	0	0	0	30-32.5	140-145
Kathryn Ellis - Locality Director - Great Yarmouth & Waveney	105-110	0	0	0	45-47.5	150-155
Howard Martin - Locality Director - West Norfolk	105-110	0	0	0	25-27.5	130-135
Dr Anoop Dhesi - Chair	105-110	0	0	0	0	100-105
Dr Ardyn Ross - Governing Body Member	60-65	0	0	0	0	60-65
Dr Clare Hambling - Governing Body Member	60-65	0	0	0	0	60-65
Tracy Williams - Governing Body Member	60-65	0	0	0	127.5-130	190-195
Dr Hilary Byrne - Governing Body Member	60-65	0	0	0	0	60-65
Dr Peter Harrison - Secondary Care Doctor	15.20	0	0	0	0	15-20
Kathy Branson - Registered Nurse - Governing Body	10-15	0	0	0	0	10-15
Rob Bennett - Lay Member	10-15	0	0	0	0	10-15
Hein van den Wildenberg - Lay Member	10-15	0	0	0	0	10-15
Doris Jamieson - Lay Member	10-15	0	0	0	0	10-15
Mark Jeffries - Lay Member	10-15	0	0	0	0	10-15

Pension benefits as at 31 March 2022 (subject to audit)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2022 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2022 (bands of £5,000)	(e) Cash Equiv-alent Transfer Value at 1 April 2021	(f) Real Increase in Cash Equivalent Transfer Value	(g) Cash Equiv-alent Transfer Value at 31 March 2022	(h) Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Melanie Craig - Chief Officer *	0-2.5	0-2.5	40-45	75-80	729	27	791	0
John Ingham - Chief Finance Officer	2.5-5	0-2.5	55-60	135-140	1027	41	1093	0
Cath Byford - Chief Nurse	2.5-5	0-2.5	30-35	55-60	516	30	565	0
Jocelyn Pike - Directors Of Special Projects	0-2.5	0	25-30	45-50	422	18	458	0
Mark Burgis - Locality Director Norwich, South Norfolk & North Norfolk to 14/06/2021 then Director of Primary & Community Care	0-2.5	0	20-25	0	255	16	287	0
Kathryn Ellis - Locality Director - Great Yarmouth & Waveney	0-2.5	0-2.5	25-30	50-55	311	3	366	0
Howard Martin - Locality Director - West Norfolk to 14/06/2021 then Director for Population Health Management & Health Inequalities	0-2.5	0-2.5	15-20	15-20	228	19	263	0
Tracy Williams - Governing Body Member	0-2.5	0	25-30	45-50	481	20	512	0
Ed Garratt - Interim Accountable Officer *	0-2.5	0-2.5	40-45	65-70	483	21	598	0
Mark Lim - Interim Director of Clinical Services & Clinical Transformation *	0-2.5	0-2.5	25-30	40-45	302	40	360	0

* Total in (f) and (h) for Kathryn Ellis, Melanie Craig, Ed Garratt and Mark Lim are for part year as per dates in Executive Directors in post 2021-22 table. Kathryn Ellis and Melanie Craig have continued to accrue pensionable membership since their role end dates.

The above tables reflect the total benefits for each individual to include benefits accrued through prior employment with other NHS organisations.

In accordance with the Disclosure of Senior Managers' Remuneration (Greenbury) 2020 guidance, no CETV will be shown for pensioners and senior managers over normal pension age (NPA).

The declaration of pension contributions in this report is made in accordance with the guidelines issued under the Greenbury Report.

The details contained in the above tables relate to those members of the Governing Body and Senior Management Team for whom pension details were available. Those not included were:

- Lay members whose remuneration is not pensionable
- GPs on the Governing Body who were not members of the normal NHS Pension Scheme but did contribute to the NHS GP Solo Pension Scheme. The GP Solo Pension Scheme benefits are not included in the above table as we are unable to identify which part of that scheme relates to their work as Governing Body Members.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in the NHS 2015 Scheme. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement.

There was a consultation outcome 3rd March 2022 which makes proposed changes to the NHS Pension Scheme. More information on the McCloud remedy is available on the below Government Website:

https://www.gov.uk/government/consultations/nhs-pension-scheme-mccloud-remedy-part-1-proposed-changes-to-scheme-regulations-2022/mccloud-remedy-part-1-proposed-changes-to-nhs-pension-schemes-regulations-2022.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office (subject to audit)

No compensation was paid on early retirement or for loss of office.

Payments to past members (subject to audit)

There were no payments made by the CCG to past senior managers for services rendered or compensation due either in this or the previous financial year.

Pay multiples (Subject to audit)

The increase in the highest paid director's salary as compared to 2020-21 is 9.8%. The increase in pay multiples from 2020-21 is a result of implementing the ICB pay ranges for those executives undertaking ICB designate positions.

The average increase in respect of employees' salaries of the entity as compared to 2020-21 is 3.2%. Following National directions pay increases for 2021-22 were awarded at 3%.

No performance pay or bonuses were paid in 2021/22, (None paid in 2020/21)

As at the reporting date based on annualised full time equivalent salary cost the below pay relationships existed:

(1) The banded remuneration of the highest paid director/Member in Norfolk and Waveney CCG in the financial year 2021/22 was 4.2 times the median remuneration of the workforce. (In 2020/21 this was 3.9 times).
(2) The banded remuneration of the highest paid director/Member in Norfolk and Waveney CCG in the financial year 2021/22 was 6.0 times the 25th Percentile (lowest quarter) remuneration of the workforce. (In 2020/21 this was 6.1 times).
(3) The banded remuneration of the highest paid director/Member in Norfolk and Waveney CCG in the financial year 2021/22 was 3.1 times the 75th Percentile (highest quarter) remuneration of the workforce. (In 2020/21 this was 2.9 times).

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose a salary component.

The banded remuneration of the highest paid director/Member in Norfolk and Waveney CCG in the financial year 2021/22 was £190,000-195,000 (2020/21: £150,000-155,000).

The relationship to the remuneration of the organisation's workforce is disclosed in the tables below:

2021-22	25th percentile	Median	75th Percentile
Total remuneration (£)	16,014	29,885	45,901
Salary component of total remuneration (£)	15,770	29,885	45,841
Pay ratio information	6.0:1	4.2:1	3.1:1

2020-21	25th percentile	Median	75th Percentile
Total remuneration (£)	15,790	28,061	44,829

Salary component of total remuneration (£)	15,790	27,179	44,504
Pay ratio information	6.1:1	3.9:1	2.9:1

In 2021/22, no employees (2020/21 also no employees) received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £20,330 to £190,000 (2020/21: £18,005 to £150,000). The change from 2020/21 to 2021/22 is the result of implementing the ICB pay ranges for those executives undertaking ICB designate positions. ICB pay ranges have been developed and agreed with the Department of Health and Social care and consistent with the expected overall approach to very senior manager pay.

* Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not include severance payments paid to an employee. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

** Salary is the basic pay element paid to an employee.

Staff report

The CCG has a highly skilled, motivated and experienced workforce of commissioning managers and support staff. During the year the average workforce was 503.7 WTE (whole time equivalent), (406.7 WTE in 2020-21). In addition to employed staff, the CCG engaged with general practitioners and nurses from across the Norfolk and Waveney area to provide clinical expertise and input into its decision making and actively supporting the organisation in aspiring for better health, better care and better value for the population.

The CCG is also supported by NHS Arden & GEM CSU in a range of outsourced support services to include the provision of GPIT, Financial Accounting, BI, HR & Medicines Management.

Staff numbers and composition (subject to audit)

As an employer we adopt the National Agenda for Change (AfC) pay framework and the following tables show the breakdown of functional categories and gender as at year end:

The staff headcount is of all staff employed by the CCG as at 31 March 2022.

Staff Composition by Occupational Code (headcount)	Female	Male	Total
Chair, Lay, Non-Exec & Governing Body Members	3	4	7
Clinical Member	18	15	33
Senior Managers	13	10	23
Managers	85	41	126
Nursing Professionals	97	10	107
Clerical and Administrative	243	48	291
Scientific, Therapeutic & Technical Professionals	11	2	13
Other - Seconded in staff	11	12	23
Other - Non AfC non CCG shared posts	10	4	14
Total	**491**	**146**	**637**

NHS Occupational codes presented above reflect the nature of the role undertaken, this may show a difference to the roles in the table below. For example, Governing Body Members where occupational codes consider these as Nursing or Clinical.

Staff Composition by band (headcount)	Female	Male	Total
Band 3	59	3	62
Band 4	47	5	52
Band 5	44	10	54
Band 6	79	14	94
Band 7	83	22	104
Band 8a	48	19	67
Band 8b	44	16	60
Band 8c	26	11	37
Band 8d	15	14	29
Band 9	8	2	10
VSM	5	7	12
Non Executives & Governing Boby Members (Including Clinical Members)	7	5	12
Other - Non AfC CCG members	16	14	30
Other - Non AfC non CCG shared posts	10	4	14
Total	**491**	**146**	**637**

Whilst these tables detail the breakdown of staffing by banding from a gender perspective, other metrics are monitored including the Workforce Race Equality Standard (WRES) which reflects career progression and personal perceptions of black and minority ethnic staff treatment by colleagues. The progress against workplans are reviewed by both the workforce team and the staff Equality, Diversity and Inclusion Group.

The CCG also recognises that individuals may identify themselves outside of female or male categories however these tables capture the CCG's workforce.

Employee benefits

	2021-22 Total	2020-21 Total
Employee benefits	**£'000**	**£'000**
Salaries and wages	24,507	19,056
Social security costs	2,545	2,039
Employer Contributions to NHS Pension scheme	4,042	3,214
Other pension costs	13	13
Apprenticeship Levy	104	28
Termination benefits	19	15
Gross employee benefits expenditure	31,230	24,364

2021-22 employee benefits expenditure has increased mainly due to additional staff as a result of in housing contracting services previously provided by the CSU and hosting the System Support Functions previously provided by Norfolk & Waveney system partners.

Apprentice Levy was paid on legacy 2 CCG's in 2020-21 whereas in 2021-22 the legacy payrolls merged resulting on The Levy due for the whole CCG (5 legacy SSG's)

Sickness absence data

Department of Health & Social Care (DHSC) has taken the decision to not commission the data production exercise for NHS bodies for 2021-22. The link to the NHS Digital publication series is as follows:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff turnover

As at 31 March 2022 the staff turnover for NWCCG stood at 2.84% (This is based on figures for a rolling 12-months). As at 31 March 2021 the CCG reported 0.67% staff turnover.

Staff engagement percentages

The CCG participated in the 2021 National Staff Survey (NSS) as we are committed to improving staff experiences across the NHS. The survey's strength is in providing a national picture alongside local detail. It captures how people experience their working lives and for the first time in 2021 the NSS is aligned to the NHS People Promise. The NSS is a snapshot in time with the information gathered at the same time each year. It helps us to understand how staff are feeling and to help us to learn from their experience. The results are used to improve local working conditions and ultimately to improve patient care.

75% of our eligible staff completed the NSS which was slightly lower than our comparator average of 78%.

Staff policies

The CCG contracts with NHS Arden and Greater East Midlands Commissioning Support Unit to provide Human Resources support including the development of HR policies. All CCG HR policies are based on NHS Business Services Authority policies and as such have been agreed by Trade Unions. HR policies are also reviewed by a Staff Involvement Group (SIG) which has been established to ensure that the CCG has the opportunity to engage with and listen to the views of staff to help inform organisational decision making and planning. The CCG has a member of staff who is also a trade union representative who sits on the SIG and reviews and comments on policies to support their development and review. Where relevant HR personnel engage with trade unions to support good working relationships.

The CCG follows an Equality, Diversity and Inclusion Policy and is committed to equality of opportunity for all employees. This is about giving fair consideration to applications for employment from groups of people with particular characteristics who may otherwise face discrimination. The nine protected characteristics are age, disability, ethnic origin and race, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The CCG gives full and fair consideration to applications for employment made by disabled persons and promotes the provision of training and guidance and the impartial application of all employment policies and procedures. Occupational health advice and support is available to all staff and specialist advice sought for disabled employees. More information on the CCG's approach to equality and inclusion can be found under 'Other employee matters' below.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) regulations 2017, requires relevant public sector organisations to report on trade union facility time in their organisations. Facility time is paid time off for union representatives to carry out trade union activities.

Relevant union officials

Total number of employees who were relevant union officials during 2021/22:

Number of employees who were relevant union officials during 2021/22	Full-time equivalent employee number
1	0.6

Percentage of time spent on facility time

Percentage of working time spent on facility time by employees who were relevant union officials employed during 2021/22:

Percentage of time	Number of employees
0%	0
1-50%	1
51-99%	0
100%	0

Percentage of pay bill spent on facility time

Percentage of total pay bill spent on paying employees who were relevant union officials for facility time during 2021/22:

Total cost of facility time	£
Total pay bill	£30,785,607
Percentage of the total pay bill spent on facility time	0%

Paid trade union activities

Percentage of total paid facility time hours spent by employees who were relevant union officials during 2021/22 on paid trade union activities:

Time spent on paid trade union activities as a percentage of total paid facility time hours	0%

Other employee matters

Staff Consultation

As mentioned at the start of the Remuneration Report, it is expected that this is the final full Remuneration and Staff Report as CCGs will be abolished on 30 June 2022. Staff will transfer to the NHS Norfolk and Waveney Integrated Care Board (ICB). The statutory mechanism for the transfer of staff from the CCG to the new ICB will be a transfer scheme. The process that the CCG will follow is the Transfer of Undertakings (Protection of Employment) Regulations 2006 as amended by the Collective Redundancies and Transfer of Undertakings (Protection of Employment) (Amendment)

Regulations 2014 (TUPE) and the Cabinet Office Statement of Practice 'Staff Transfers in the Public Sector' (COSOP) guidance. The transfer will not result in any changes to individuals' current employment terms and conditions

Equality, Diversity and Inclusion

The CCG has due regard to the three aims of the public sector equality duty under the Equality Act 2010 to:

- Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act
- Advance the equality of opportunity between people who share a protected characteristic and people who do not share it, and
- Foster good relations between people who share a protected characteristic and people who do not share it.

To support this work the CCG has established an Equality, Inclusion and Diversity Group to ensure that the CCG continues to develop opportunities for all employees. A key aim of the CCG is to ensure that diversity is viewed positively with each individual's unique experience, knowledge and skills recognised and valued equally. To support this work an Equality, Inclusion and Diversity Lead has been appointed by the CCG.

Underpining this work is the Equality, Inclusion and Diversity Policy and Strategy. More information on equality and inclusion can be found on the CCG website: https://www.norfolkandwaveneyccg.nhs.uk/get-involved/equality-and-diversity?highlight=WyJlcXVhbGl0eSIsImVxdWFsIiwiZXF1YWxseSIsImVxdWFsaXRpZXMiXQ

Health and Safety

The CCG is committed to ensuring the health, safety and welfare of its employees and of course others who may be affected by CCG activities. The CCG takes all reasonably practicable steps to achieve this commitment and to comply with statutory obligations and to promote a positive health and safety culture throughout the organisation. Health and safety training is provided via e-learning for all staff. This mandatory training covers the core requirements for a low risk office environment and each module contains an assessment that must be passed by staff.

Pension

Employees of the CCG are covered by the provisions of the NHS Pension Scheme.

For information as to how pension liabilities were treated, please refer to accounting policy 3.4. In respect of senior managers in the CCG, pension entitlements are disclosed within this Remuneration Report.

Expenditure on consultancy

Where the CCG does not have the requisite skills or capacity within the organisation to deliver specific aspects of its obligations or to develop further the services that it would wish to provide it relies on external organisations and individuals to provide those skills or capacity.

During 2021/22 the CCG spent a total of £647,414 on consultancy services as outlined below (2020/21 £54,810).

Consultancy service	Cost

Marketing & Communications Consultancy	£6,048
Strategy Consultancy	£20,300
Technical Consultancy	£21,300
Programme Project Management Consultancy	£599,766
Total	**£647,414**

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2022 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2022	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0

Table 2: New off-payroll engagements

Where the reformed public sector rules apply, entities must complete Table 2 for all new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than £245 per day and that last for longer than 6 months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0

Table 3: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2021 and 31 March 2022

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	3

Exit packages, including special (non-contractual) payments (subject to audit)

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
£10,000-£25,000	1	18,945	0	0	1	18,945	0	0
TOTALS	1	18,945	0	0	1	18,945	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS Pension Scheme. Exit costs in this note are the full costs of departures agreed in year. This disclosure reports the number and value of exit packages agreed in year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period. Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table (£Nil).

SIGNED

Tracey Bleakley
Interim Accountable Officer
17 June 2022

Parliamentary accountability and audit report

NHS Norfolk and Waveney CCG is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report where relevant. An audit certificate and report is also included in this Annual Report at page 139.

ANNUAL ACCOUNTS

Financial Statement and Notes

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Statement of Comprehensive Net Expenditure for the year ended
31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Income from sale of goods and services	2	(16,719)	(12,866)
Other operating income	2	(34)	-
Total operating income		**(16,754)**	**(12,866)**
Staff costs	3	31,230	24,364
Purchase of goods and services	4	2,088,991	1,871,414
Depreciation and impairment charges	4	21	21
Provision expense	4	4,139	1,055
Other operating expenditure	4	1,922	1,416
Total operating expenditure		**2,126,303**	**1,898,270**
Net operating expenditure		**2,109,549**	**1,885,404**
Finance expense	6	10	-
Net expenditure for the year		**2,109,560**	**1,885,404**
Net (gain)/loss on transfer by absorption	7	-	107,172
Total net expenditure for the financial year		**2,109,560**	**1,992,576**
Comprehensive expenditure for the year		**2,109,560**	**1,992,576**

Notes on pages 109 to 138 form part of this statement

Statement of Financial Position as at
31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Non-current assets:			
Property, plant and equipment		-	31
Total non-current assets		-	**31**
Current assets:			
Trade and other receivables	9	9,552	27,691
Cash and cash equivalents	10	1,481	1,444
Total current assets		**11,033**	**29,135**
Total assets		**11,033**	**29,166**
Current liabilities:			
Trade and other payables	11	(195,365)	(165,959)
Provisions	12	(4,977)	-
Total current liabilities		**(200,342)**	**(165,959)**
Total assets less current liabilities		**(189,310)**	**(136,793)**
Non-current liabilities:			
Trade and other payables	11	(612)	(435)
Provisions	12	(217)	(1,055)
Total non-current liabilities		**(828)**	**(1,490)**
Assets less Liabilities		**(190,138)**	**(138,283)**
Financed by taxpayers' equity:			
General fund		(190,138)	(138,283)
Total taxpayers' equity:		**(190,138)**	**(138,283)**

The notes on pages 109 to 138 form part of this statement

The financial statements on pages 105 to 108 were approved by the Governing Body on 17 June 2022 and signed on its behalf by:

SIGNED

Tracey Bleakley
Chief Executive Officer
17 June 2022

Statement of Changes In Taxpayers Equity for the year ended 31 March 2022

	Note	2021/22 General fund £'000	2020/21 General fund £'000
Changes in taxpayers' equity for 2021-22			
Balance at 01 April		(138,283)	-
Changes in NHS CCG taxpayers' equity for 2021-22			
Net operating expenditure for the financial year	SoCNE	(2,109,560)	(1,885,404)
Transfers by absorption to (from) other bodies	7	-	(107,172)
Net recognised NHS CCG expenditure for the financial year		**(2,109,560)**	**(1,992,576)**
Net funding	SoCF	2,057,705	1,854,293
Balance at 31 March		**(190,138)**	**(138,283)**

The notes on pages 109 to 138 form part of this statement

Statement of Cash Flows for the year ended 31 March 2022

	Note	2021-22 £'000	2020-21 £'000
Cash flows from operating activities			
Net operating expenditure for the financial year		(2,109,560)	(1,885,404)
Depreciation and amortisation	4	21	21
Other gains & losses	6	10	-
(Increase)/decrease in inventories		-	81
(Increase)/decrease in trade & other receivables	9	18,139	(13,259)
Increase/(decrease) in trade & other payables	11	29,583	43,699
Increase/(decrease) in provisions	12	4,139	1,055
Net cash inflow (outflow) from operating activities		**(2,057,668)**	**(1,853,806)**
Cash flows from financing activities			
Net funding received		2,057,705	1,854,293
Net cash inflow (outflow) from financing activities		**2,057,705**	**1,854,293**
Net increase (decrease) in cash & cash equivalents	10	**37**	**487**
Cash & cash equivalents at the beginning of the financial year	10	**1,444**	**957**
Cash & cash equivalents at the end of the financial year	10	**1,481**	**1,444**

The notes on pages 109 to 138 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups (CCGs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2021-22 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

As set out in Note 18 – Events after the end of the reporting period, on 28 April 2022 the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of NHS Norfolk & Waveney CCG will transfer to NHS Norfolk & Waveney Integrated Care Board from the 1 July 2022.

Where a CCG ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis. It remains the case that the Government has issued a mandate to NHS England and NHS Improvement for the continued provision of services in England in 2022/23 and CCG published allocations can be found on the NHS England website for 2022/23 and 2023/24. The commissioning of health services (continuation of service) will continue after 1 July 2022 but will be through the NHS Norfolk & Waveney Integrated Care Board, rather than NHS Norfolk & Waveney CCG.

Mergers or a change to the NHS Structure, such as the transfer of CCG functions to the ICB, is not considered to impact on going concern. Our considerations cover the period through to 30 June 2023, being 12 months beyond the date of authorisation of these financial statements. Taking into account the information summarised above, the Governing Body have a reasonable expectation that the CCG (and the successor commissioning organisation) will have adequate resources to continue in operational existence for the foreseeable future.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention

1.3 **Pooled Budgets**

The CCG has entered into a pooled budget arrangement with both Norfolk County Council and Suffolk County Council in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled to jointly commission or deliver health and social care, known as the Better Care Fund.

The pool is hosted by Norfolk County Council and Suffolk County Council. The CCG accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

The CCG has exercised judgement on the accounting for pooled budgets, further details included in note 1.10.1.

1.4 **Revenue**

The main source of funding for the CCG is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation.

Payment terms are standard reflecting cross government principles.

1.5 **Employee Benefits**

1.5.1 **Short-Term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the CCG commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.6 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.7 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the CCG's cash management.

1.8 **Financial Assets**

Financial assets are recognised when the CCG becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

All financial assets are recorded at amortised cost.

1.8.1 **Financial Assets at Amortised Cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.9 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the CCG becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.10 **Critical Accounting Judgements and Key Sources of Estimation Uncertainty**

In the application of the CCG’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.10.1 **Critical Accounting Judgements in Applying Accounting Policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the CCG's accounting policies and that

have the most significant effect on the amounts recognised in the financial statements.

Better Care Fund
The CCG has entered into a partnership agreement and a pooled budget with both Norfolk County Council and Suffolk County Council in respect of the Better Care Fund (BCF). This is a national policy initiative and the funds involved are material in the CCG accounts. Having reviewed the terms of the partnership agreement, the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the appropriate financial reporting standards, the CCG has determined that there are three elements to the BCF and they are accounted for as follows:

(1) The major part is controlled by both Norfolk County Council and Suffolk County Council which commissions services from various non-NHS providers. Whilst the services are determined in partnership, the risks and rewards of the contracts remain wholly with the council. The CCG accounts for this on a lead commissioner basis as healthcare expenditure with the local authority.

(2) The second part is controlled by the CCG which commissions various services from NHS and non-NHS providers. The risks and rewards of these contracts are the responsibility of the CCG, which considers itself to be acting as a lead commissioner for those services on behalf of the partnership. The CCG accounts for these costs as healthcare purchased from NHS and non-NHS providers

(3) The final part of the BCF is an integrated community equipment store. Norfolk County Council acts as the host body for this service which is provided by a third party. Each partner is however wholly responsible for their own share of the expenditure and this is accounted for as a joint operation.

Otherwise there were no critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements.

1.10.2 **Sources of Estimation Uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Prescribing Liabilities:
NHS England actions monthly cash charges to the CCG for prescribing contracts. These are issued approximately 6 weeks in arrears. The CCG uses information provided by the NHS Business Authority as part of the estimate for full year expenditure. For 2021-22 an accrual of £33,724,026 (2020-21: £31,609,129) was included for February and March anticipated expenditure, this figure is not believed to represent a significant level of uncertainty.

1.11 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2021-22. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 planned for implementation in 2022-23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

The application of IFRS 16 and IFRS 17 is not anticipated to have a material impact on the accounts.

1.12 **Provisions**

Provisions are recognised when the CCG has a present legal or constructive obligation as a result of a past event, it is probable that the CCG will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties.

1.13 **Contingent Liabilities**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the CCG, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

1.14 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.14.1 **The Clinical Commissioning Group as Lessee**

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.15 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

For 2021-22 a value of £13,861 (2020-21: £Nil) has been incurred relating to the writing off of old legacy CCG Non-NHS Trade Debtors. This write off follows the CCG Financial governance process and requires review and recommendation through the CCGs Audit Committee. Losses of these nature do not require prior approval from HM Treasury.

2. Other Operating Revenue

	2021-22 Total £'000	2020-21 Total £'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	4,237	1,933
Other contract income	12,483	10,933
Total Income from sale of goods and services	**16,719**	**12,866**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	34	-
Total Other operating income	**34**	**-**
Total operating Income	**16,754**	**12,866**

3. Employee benefits and staff numbers

3.1 Employee benefits	Total 2021-22			Total 2020-21		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee benefits						
Salaries and wages	23,488	1,019	24,507	18,596	460	19,056
Social security costs	2,539	6	2,545	2,039	-	2,039
Employer contributions to NHS Pension scheme	4,036	7	4,042	3,214	-	3,214
Other pension costs	13	-	13	13	-	13
Apprenticeship Levy	104	-	104	28	-	28
Termination benefits	19	-	19	15	-	15
Total employee benefits excluding capitalised costs *	**30,199**	**1,032**	**31,230**	**23,903**	**460**	**24,364**

* Employee benefit cost increases include application of the 3% National pay award, and the inhouse of services previously undertaken by other system providers and NHS Arden & Gem Clinical Support Unit.

Further analysis of employee benefits is shown in the remuneration and staff report on pages 87 to 102.

3.2 Average number of people employed

	2021-22			2020-21		
	Permanently employed	Other	Total	Permanently employed	Other	Total
	Number	Number	Number	Number	Number	Number
Total *	**474**	**29**	**503**	**385**	**21**	**407**

* Employee number increases include the inhouse of services previously undertaken by other system providers and NHS Arden & Gem Clinical Support Unit.
Further information in respect of staff numbers is included from page 96 of the annual report

3.3 Exit packages agreed in the financial year

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
£10,001 to £25,000	1	18,945	-	-	1	18,945
Total	**1**	**18,945**	**-**	**-**	**1**	**18,945**

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	£	Number	£	Number	£
£10,001 to £25,000	-	-	1	14,596	1	14,596
Total	**-**	**-**	**1**	**14,596**	**1**	**14,596**

Analysis of Other Agreed Departures

	2021-22 Other agreed departures		2020-21 Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	-	-	1	14,596
Total	**-**	**-**	**1**	**14,596**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or In full in a previous period. Redundancy and other departure costs have been paid in accordance with the provisions and conditions of Agenda for Change. Exit costs are Accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

3.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

The employer contribution rate remained at 20.6% in line with 2020-21. The rate increase in April 2019 from 14.3%, with the additional costs being paid being paid by NHS England on the CCGs behalf. The full cost and related funding has been recognised in these accounts.

3.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

3.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.
The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

For 2021-22, employers’ contributions of £4,042,000 (2020-21: £3,214,000) were payable to the NHS Pensions Scheme at the rate of 20.6% of pensionable pay.

4. Operating expenses

	2021-22 Total £'000	2020-21 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	10,495	12,969
Services from foundation trusts *	1,165,945	992,032
Services from other NHS trusts **	161,994	147,514
Services from Other WGA bodies	82	89
Purchase of healthcare from non-NHS bodies	295,130	298,044
Purchase of social care	11,283	11,645
Prescribing costs	189,583	186,347
GPMS/APMS and PCTMS ***	196,465	177,955
Supplies and services – clinical	91	992
Supplies and services – general	34,021	17,898
Consultancy services	642	84
Establishment	6,732	8,893
Transport	10,069	9,646
Premises	2,905	3,231
Audit fees	209	215
Other professional fees	2,200	2,852
Legal fees	419	362
Education, training and conferences	726	649
Total purchase of goods and services	**2,088,991**	**1,871,414**
Depreciation and impairment charges		
Depreciation	21	21
Total depreciation and impairment charges	**21**	**21**
Provision expense		
Provisions	4,139	1,055
Total provision expense	**4,139**	**1,055**
Other operating expenditure		
Chair and Non Executive Members	551	343
Grants to other bodies	-	346
Research and development (excluding staff costs)	1,337	609
Expected credit loss on receivables	14	-
Inventories consumed	-	81
Other expenditure	21	37
Total other operating expenditure	**1,922**	**1,416**
Total operating expenditure	**2,095,073**	**1,873,907**

* £174m increase in Foundation Trust expenditure includes payments to three acute providers of £163m and the mental health trust of £10m. Payment rises reflect increases to block values, price and growth inflation and full year impact of Covid and Top-up costs reflecting the National interim finance regime during the covid pandemic.

** £14m increase in Other NHS Trust expenditure includes payments to the community health trust of £12m. Payment rises reflect increases to block values, price and growth inflation and full year impact of Covid and Top-up costs reflecting the National interim finance regime during the covid pandemic.

*** £18m increase in GPMS/APMS expenditure includes rises of £6m in relation to the Additional Role Reimbursement Scheme, £4m for Winter Access Fund and £4m for GMS contract baseline value increases.

4.1 - Limitation on Auditor's liability

The limitation on auditors' liability for external audit work is £2m (2021-22: £2m).

5. Better Payment Practice Code

Measure of compliance	2021-22 Number	2021-22 £'000	2020-21 Number	2020-21 £'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	59,351	564,174	46,594	515,097
Total Non-NHS trade invoices paid within target	58,153	549,664	43,260	461,217
Percentage of Non-NHS trade invoices paid within target	**97.98%**	**97.43%**	**92.84%**	**89.54%**
NHS Payables				
Total NHS trade invoices paid in the year	1,419	1,333,192	4,695	1,172,523
Total NHS trade invoices paid within target	1,372	1,328,558	3,969	1,145,003
Percentage of NHS trade invoices paid within target	**96.69%**	**99.65%**	**84.54%**	**97.65%**
Total Payables				
Total trade invoices paid in the year	60,770	1,897,366	51,289	1,687,620
Total trade invoices paid within target	59,525	1,878,222	47,229	1,606,220
Percentage of all trade invoices paid within target	**97.95%**	**98.99%**	**92.08%**	**95.18%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice. Target performance against these categories is at 95%.

In 2021-22 this target delivery was achieved in all categories.

6. Other gains and losses

	2021-22 £'000	2020-21 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	(10)	-
Total	**(10)**	**-**

7. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
The CCG received balances on 1 April 2020, from the five predecessor CCG's: Great Yarmouth & Waveney CCG; North Norfolk CCG; Norwich CCG; South Norfolk CCG; and West Norfolk CCG

	2021-22 £'000	2020-21 £'000
Transfer of property plant and equipment	-	52
Transfer of inventories	-	81
Transfer of cash and cash equivalents	-	957
Transfer of receivables	-	14,432
Transfer of payables	-	(122,695)
Net loss on transfers by absorption	**-**	**(107,172)**

8. Operating Leases

8.1 As lessee

8.1.1 Payments recognised as an expense

	2021-22			2020-21		
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	1,038	33	1,071	1,312	22	1,334
Total	**1,038**	**33**	**1,071**	**1,312**	**22**	**1,334**

8.1.2 Future minimum lease payments

	2021-22			2020-21		
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	847	-	847	985	-	985
Between one and five years	1,283	-	1,283	297	-	297
After five years	52	-	52	-	-	-
Total	**2,181**	**-**	**2,181**	**1,282**	**-**	**1,282**

9.1 Trade and other receivables	Current 2021-22 £'000	Current 2020-21 £'000
NHS receivables: Revenue	7,261	21,768
NHS prepayments	654	187
NHS accrued income	394	400
Non-NHS and Other WGA receivables: Revenue	2,823	4,618
Non-NHS and Other WGA prepayments	292	432
Non-NHS and Other WGA accrued income	140	161
VAT	752	124
Expected credit loss allowance-receivables	(2,765)	
Other receivables and accruals	-	1
Total Trade & other receivables	**9,552**	**27,691**

9.2 Receivables past their due date but not impaired

	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000
By up to three months	484	31	1,625	114
By three to six months	172	32	114	92
By more than six months	-	2,190	261	2,265
Total	**656**	**2,253**	**2,000**	**2,471**

9.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000
Balance at 01 April 2021	-
Lifetime expected credit losses on trade and other receivables-Stage 2	(2,765)
Lifetime expected credit losses on trade and other receivables-Stage 3	(14)
Amounts written off	14
Total	**(2,765)**

10. Cash and cash equivalents

	2021-22 £'000	2020-21 £'000
Balance at 01 April 2021	1,444	957
Net change in year	37	487
Balance at 31 March 2022	**1,481**	**1,444**
Made up of:		
Cash with the Government Banking Service	1,481	1,442
Cash in hand	-	2
Balance at 31 March 2022	**1,481**	**1,444**

11. Trade and other payables	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
NHS payables: Revenue	13,872	-	3,606	-
NHS accruals	1,327	-	3,240	-
NHS deferred income	191	-	-	-
Non-NHS and Other WGA payables: Revenue	29,860	-	27,284	-
Non-NHS and Other WGA accruals	133,850	-	114,440	-
Non-NHS and Other WGA deferred income	10,764	612	7,572	435
Social security costs	377	-	305	-
Tax	330	-	267	-
Other payables and accruals *	4,794	-	9,245	-
Total trade & other payables	**195,365**	**612**	**165,959**	**435**
Total current and non-current		**195,977**		**166,394**

* Other payables include £1,730,000 outstanding pension contributions at 31 March 2022 (31 March 2021: £1,493,000).

12. Provisions

	Current 2021-22 £'000	Non-current 2021-22 £'000	Current 2020-21 £'000	Non-current 2020-21 £'000
Redundancy	399	-	-	-
Legal claims	453	-	-	219
Other	4,125	217	-	836
Total	**4,977**	**217**	**-**	**1,055**
Total current and non-current	**5,194**		**1,055**	

	Redundancy £'000	Legal Claims £'000	Other * £'000	Total £'000
Balance at 01 April 2021	**-**	**219**	**836**	**1,055**
Arising during the year	399	453	4,341	**5,194**
Reversed unused	-	(219)	(836)	**(1,055)**
Balance at 31 March 2022	**399**	**453**	**4,341**	**5,194**
Expected timing of cash flows:				
Within one year	399	453	4,125	**4,977**
Between one and five years	-	-	217	**217**
Balance at 31 March 2022	**399**	**453**	**4,341**	**5,194**

* Other Provisions include Estates and Staffing costs, and Recovery of funding in relation to the Elective Recovery Fund.

All provisions made satisfy the CCGs Accounting Policy in recognition of a Present obligation from a Past event with a reliable estimate for a probable outflow.

13. Contingencies

	2021-22 £'000	2020-21 £'000
Contingent liabilities		
Legal Claim	200	114
Net value of contingent liabilities	**200**	**114**

The Contingent Liability relates to ongoing employment and other legal cases, where some risks remain but is not considered either probable and/or the reliability of estimate value is poor.

14. Financial instruments

14.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the CCG is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. This includes additional funding received throughout the Covid pandemic consistent to the nationally adopted finance direction. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The CCG has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the CCG and internal auditors.

14.1.3 Credit risk

Because the majority of the CCG revenue comes parliamentary funding, the CCG has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.4 Liquidity risk

The CCG is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

14.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

14. Financial instruments cont'd

14.2 Financial assets

	Financial Assets measured at amortised cost	Financial Assets measured at amortised cost
	2021-22	**2020-21**
	£'000	**£'000**
Trade and other receivables with NHSE bodies	4,464	4,214
Trade and other receivables with other DHSC group bodies	3,802	19,711
Trade and other receivables with external bodies	2,351	3,024
Cash and cash equivalents	1,481	1,444
Total	**12,099**	**28,392**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost	Financial Liabilities measured at amortised cost
	2021-22	**2020-21**
	£'000	**£'000**
Trade and other payables with NHSE bodies	4,601	2,207
Trade and other payables with other DHSC group bodies	14,674	36,505
Trade and other payables with external bodies	164,428	119,102
Total	**183,703**	**157,814**

15. Operating segments

The CCG consider they have only one segment: Commissioning of Healthcare Services.

16. Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arrangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

16.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2021-22				Amounts recognised in Entities books ONLY 2020-21			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Norfolk County Council Better Care Fund	NHS Norfolk and Waveney CCG and Norfolk County Council	Joint Commissioning of Care services, hosted by Norfolk County Council, net accounting adopted	-	-	-	69,120	-	-	-	65,469
Norfolk County Council Children and Adolescent Mental Health Services*	NHS Norfolk and Waveney CCG and Norfolk County Council	Joint provision of children and adolescent mental health services	-	-	-	-	-	-	-	1,768

Name of arrangement	Parties to the arrangement	Description of principal activities	Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
Suffolk County Council Better Care Fund	NHS Norfolk and Waveney CCG and Suffolk County Council	Joint Commissioning of Care services, hosted by Suffolk County Council, net accounting adopted	-	815	-	9,927	-	-	-	9,413
Suffolk County Council Mental Health Services	NHS Norfolk and Waveney CCG and Suffolk County Council	Joint provision of mental health services	-	-	-	199	-	-	-	198

Name of arrangement	Parties to the arrangement	Description of principal activities	Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
Children and Young People's Alliance Agreement*	NHS Norfolk and Waveney CCG, Norfolk County Council, Suffolk County Council, Norfolk and Suffolk NHS Foundation Trust, Ormiston Families, Mancroft Advice Project, Cambridgeshire Community Services NHS Trust, James Paget University Hospitals NHS Foundation Trust, East Coast Community Healthcare CIC and Norfolk Community Health and Care NHS Trust	Alliance agreement for Children and Young People.	-	-	1,011	2,555	-	-	-	-

* During 2021-22 an Alliance for Children and Young People was established replacing the legacy Children and Adolescent Mental Health Services Group.

17. Related party transactions

Details of related party transactions with individuals are as follows:

	2021-22				2020-21			
Governing Body Members (including General Practitioner Practice Payments)	**Payments to Related Party**	**Receipts from Related Party**	**Amounts owed to Related Party**	**Amounts due from Related Party**	**Payments to Related Party**	**Receipts from Related Party**	**Amounts owed to Related Party**	**Amounts due from Related Party**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Dr Anoop Dhesi, The Staithe Surgery	1,470	-	-	-	1,566	-	-	-
Dr Hilary Byrne, Attleborough Surgery	2,931	-	-	-	2,725	-	22	-
Dr Clare Hambling, Bridge Street Surgery	1,414	-	-	-	1,371	-	12	-
Dr Ardyn Ross, Millwood and Falkland Surgery	3,099	-	-	-	2,781	-	19	-
Tracy Williams, Bacon Road Partnership	652	-	-	-	567	-	4	-
Tracy Williams, Castle Partnership	2,410	-	-	1	2,368	-	15	-

Dr Ed Garratt joined the CCG as Interim Chief Officer between January and March 2022. During this time no new transactions were undertaken with his employing or associated related parties other than his salary recharge.

The Department of Health and Social Care is regarded as a related party. During the year the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent. The entities with whom the value of transactions exceed £500k are listed below:

- Bedfordshire Hospital NHS Foundation Trust

- Cambridge University Hospital NHS Foundation Trust

- Cambridge and Peterborough NHS Foundation Trust

- Community Health Partnerships
- East of England Ambulance Service NHS Trust
- East Suffolk and North East Essex NHS Foundation Trust
- Guy's and St Thomas' NHS Foundation Trust
- Hertfordshire Partnership University NHS Foundation Trust
- James Paget University Hospital NHS Foundation Trust
- NHS Arden & Greater East Midlands CSU
- NHS Property Services
- Norfolk Community Health and Care NHS Trust
- Norfolk & Norwich University Hospital NHS Foundation Trust
- Norfolk & Suffolk NHS Foundation Trust
- North West Anglia NHS Foundation Trust
- Royal National Orthopaedic Hospital NHS Foundation Trust
- Royal Papworth Hospital NHS Foundation Trust
- The Queen Elizabeth Hospital NHS Foundation Trust
- University College London Hospital NHS Foundation Trust
- West Suffolk NHS Foundation Trust

In addition, there have been further material transactions in the ordinary course of the clinical commissioning group's business with a number of other government departments, central and local government bodies as follows:

- Norfolk County Council

- Suffolk County Council

18. Events after the end of the reporting period

On 28 April 2022, the Health and Care Act 2022 received Royal Assent. As a result, Clinical Commissioning Groups will be abolished and the functions, assets and liabilities of NHS Norfolk & Waveney CCG will transfer to NHS Norfolk & Waveney Integrated Care Board from the 1 July 2022. This constitutes a non-adjusting event after the reporting period. This does not impact the basis of preparation of these financial statements.

19. Financial performance targets

NHS Norfolk & Waveney Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). Performance against those duties was as follows:

	NHS Act Section	Duty Achieved?	2021-22 Target £'000	2021-22 Performance £'000	2020-21 Target £'000	2020-21 Performance £'000
Expenditure not to exceed income	223H(1)	Yes	2,126,873	2,126,314	1,898,915	1,898,270
Revenue resource use does not exceed the amount specified in Directions	223I(3)	Yes	2,110,119	2,109,560	1,886,049	1,885,404
Revenue administration resource use does not exceed the amount specified in Directions	223J(3)	Yes	20,621	20,510	20,296	20,157

20. Losses and special payments

Losses

The total number of CCG losses and their total value, was as follows:

	Total Number of Cases 2021-22 Number	**Total Value of Cases 2021-22 £'000**	Total Number of Cases 2020-21 Number	Total Value of Cases 2020-21 £'000
Administrative write-offs in relation to Bad Debts	21	14	-	-
Total	**21**	**14**	**-**	**-**

There were no individual cases over £300,000.
These amounts are reported on an accruals basis but exclude provisions for future losses.

Special payments

There were no Special payments made during 2021-22, or 2020-21.

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS NORFOLK & WAVENEY CLINICAL COMMISSIONING GROUP

Opinion

We have audited the financial statements of NHS Norfolk & Waveney Clinical Commission Group ("the CCG") for the year ended 31 March 2022 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes 1 to 20, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and UK adopted international accounting standards as interpreted and adapted by the 2021/22 HM Treasury's Financial Reporting Manual (the 2021/22 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2021/22 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England).

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Norfolk & Waveney Clinical Commissioning Group as at 31 March 2022 and of its net expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021 to 2022; and
- have been properly prepared in accordance with the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Emphasis of Matter – Transition to an Integrated Care Board

We draw attention to Note 18 - Events After the end of the Reporting Period, which describes the Clinical Commissioning Group's transition into the NHS Norfolk & Waveney Integrated Care Board from the 1 July 2022. Our opinion is not modified in respect of this matter.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the CCGs, or the successor body's, ability to continue as a going concern for a period of 12 months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accountable Officer with respect to going concern are described in the relevant sections of this report. However, because not all future events or conditions can be predicted, this statement is not a guarantee as to the CCG's ability to continue as a going concern.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The Accountable Officer is responsible for the other information contained within the annual report.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on the Remuneration and Staff Report

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2021/22.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued in the Department of Health and Social Care Group Accounting Manual 2021/22; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 (as amended) because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we make a written recommendation to the CCG under section 24 and schedule 7 of the Local Audit and Accountability Act 2014 (as amended); or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We have nothing to report in these respects.

Responsibilities of the Accountable Officer

As explained more fully in the Statement of Accountable Officer's Responsibilities in respect of the Accounts, set out on pages 57 to 58, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is also responsible for ensuring the regularity of expenditure and income.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or has no realistic alternative but to do so.

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect irregularities, including fraud. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery or intentional misrepresentations, or through collusion. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below. However, the primary responsibility for the prevention and detection of fraud rests with both those charged with governance of the entity and management.

We obtained an understanding of the legal and regulatory frameworks that are applicable to the CCG and determined that the most significant are the Health and Social Care Act 2012 and other legislation governing NHS Clinical Commissioning Groups, as well as relevant employment laws of the United Kingdom. In addition, the CCG has to comply with laws and regulations in the areas of anti-bribery and corruption and data protection.

We understood how the CCG is complying with those frameworks by understanding the incentive, opportunities and motives for non-compliance, including inquiring of management, the Head of Internal Audit, the Local Counter Fraud Specialist and those charged with governance and obtaining and reviewing documentation relating to the procedures in place to identify, evaluate and comply with laws and regulations, and whether they are aware of instances of non-compliance.

We assessed the susceptibility of the CCG's financial statements to material misstatement, including how fraud might occur by planning and executing a journal testing strategy and testing the appropriateness of relevant entries and adjustments. We have considered whether judgements made are indicative of potential bias and considered whether the CCG is engaging in any transactions outside the usual course of business. We identified two specific fraud risks, relating to the risk of fraud in expenditure recognition through key estimates/judgements and misstatements due to fraud or error in relation to the classification of Admin and Programme costs.

Based on this understanding we designed our audit procedures to identify noncompliance with such laws and regulations. Our procedures involved enquiry of management, the Head of Internal Audit, the Local Counter Fraud Specialist and those charged with governance, reading and reviewing relevant meeting minutes of those charged with governance and the Governing Body and understanding the internal controls in place to mitigate risks related to fraud and non-compliance with laws and regulations.

To address our fraud risk of management override of controls, we tested specific journal entries identified by applying risk criteria to the entire population of journals. For each journal selected, we tested the appropriateness of the journal and that it was accounted for appropriately. We assessed accounting estimates for evidence of management bias and evaluated the business rationale for significant unusual transactions.

To address our fraud risk of fraud in expenditure recognition, we tested the appropriateness of expenditure recognition accounting policies and tested that they had been applied correctly during our detailed testing, tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements, reviewed accounting for evidence of management bias, tested a sample of accruals based on our established testing threshold for reasonableness, performed cut-off testing of transactions both before and after year-end to ensure that they were accounted for in the correct year, reviewed the Department of Health (DoH) agreement of balances data and investigated significant differences (outside of DoH tolerances), considered the completeness of liabilities included in the financial statements by performing unrecorded liability testing.

To address our fraud risk in relation to the classification of Admin and Programme costs we reviewed accounting estimates for evidence of management bias, evaluated the business rationale for significant unusual transactions, considered the results of our work on revenue and expenditure recognition as set out above, specifically considering any instances of management bias and tested judgements made by management on the classification of programme and admin expenditure, ensuing the classification is compliant with relevant guidance.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice 2020, having regard to the guidance on the specified reporting criteria issued by the Comptroller and Auditor General in December 2021 as to whether the CCG had proper arrangements for financial sustainability, governance and improving economy, efficiency and effectiveness. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 (as amended) to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 (as amended) requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Report on Other Legal and Regulatory Requirements

Regularity opinion

We are responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Local Audit and Accountability Act 2014 (as amended) (the "Code of Audit Practice").

We are required to obtain evidence sufficient to give an opinion on whether in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

In our opinion, in all material respects the expenditure and income reflected in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Certificate

We certify that we have completed the audit of the accounts of NHS Norfolk & Waveney Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 (as amended) and the Code of Audit Practice.

Use of our report

This report is made solely to the members of the Governing Body of NHS Norfolk & Waveney Clinical Commissioning Group in accordance with Part 5 of the Local Audit and Accountability Act 2014 (as amended) and for no other purpose. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.

Mark Hodgson
Ernst & Young LLP

…….. **Date:** 20 June 2022

Mark Hodgson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Cambridge