NHS
Norfolk and Waveney
Integrated Care Board

Meeting of the Board of NHS Norfolk and Waveney Integrated Care Board (ICB)

Tuesday, 27 September 2022, 1.30pm – 3.30pm

(In Public)

Meeting to be held virtually

Our mission: To help the people of Norfolk and Waveney live longer, healthier and happier lives.

Our goals:

1. **To make sure that people can live as healthy a life as possible.**
2. **To make sure that you only have to tell your story once.**
3. **To make Norfolk and Waveney the best place to work in health and care.**

Chair: Rt Hon. Patricia Hewitt

Item	Time	Agenda Item	Lead
1.	1.30	**Welcome and introductions - Apologies for absence**	Chair
2.		**Minutes from previous meeting and matters arising** To approve the part 1 public minutes of the previous Board meeting.	Chair
3.		**Declarations of interest** To declare any interests that board members may have specific to agenda items that could influence the decisions they make. Declarations made by members of the ICB Board are listed in the ICB's Register of Interests. The Register is available via the ICB's website.	Chair
4.		**Chairs Action Log** To receive an update from the Chair on actions taken since the last meeting.	Chair
5.		**Action log – things we have said we will do** To make sure the ICB completes all the actions it agrees are needed.	Chair
6.		**Chairs and Chief Executives Report** To note an update from the Chair and the Chief Executive of the ICB about the work the ICB has done since the last meeting.	Chair and Tracey Bleakley
7.	1.45	**Nomination and Approval of Integrated Care Board - Vice Chair** To nominate and approve a Vice Chair.	Chair

Item	Time	Agenda Item	Lead
		Learning from people, staff and communities	
8.	1.50	To hear the learning from people, staff and communities in Norfolk and Waveney with lived experience around making decisions about the COVID19 vaccine during pregnancy and to understand what matters to them, and to discuss and learn.	Tricia D'Orsi - Presentation
		Items for Sharing and Board Consideration	
9.	2.15	**Maternity Transformation and Local Maternity and Neonatal (LMNS) Programme report** To provide an update in relation to maternity services in line with the ICB action log.	Tricia D'Orsi
10.	2.25	**Flourish – the ambition for the Children and Young People of Norfolk** To share an overview and update on this ambition.	Rebecca Hulme/Tim Eyres
11.	2.35	**Mental Health Transformation update** To inform members on the current progress in relation to mental health transformation.	Jocelyn Pike Tricia D'Orsi
12.	2.50	**Adult Eating Disorders Procurement** To seek Board approval of the approach detailed.	Steven Course
		Finance and Corporate Affairs	
13.	2.55	**Financial Report for Month 5** To receive a summary of the financial position as at month 5	Steven Course
14.	3.00	**NHS Norfolk and Waveney Clinical Commissioning Group Annual Report** To receive and note the final published version of the annual report for the CCG.	Karen Barker
15.	3.05	**ICB Constitution Amendments** To present the Board with some amendments to the Constitution for approval.	Karen Barker
16.	3.10	**Board Assurance Framework** A review of the risks (things that might go wrong and how we can alleviate them) within the Integrated Care system.	Karen Barker
		Committees Update and Questions from the public	
17.	3.15	**Report from the Audit Committee**	David Holt
18.		**Report from the Quality and Safety Committee**	Cathy Armor
19.		**Report the Finance Committee (verbal due to meeting schedule)**	Hein Van Den Wildenberg
20.		**Report from the Primary Care Commissioning Committee**	James Bullion
21.		**Report from the Performance Committee (verbal due to meeting schedule)**	Dr Hilary Byrne
22.	3.20	**Questions from the Public. Where question in advance relates to items**	Chair

Item	Time	Agenda Item	Lead
23.	3.30	**Any other business**	Chair
Date, time and venue of next meeting: **Tuesday, 22 November 2022, 1.30pm – 3.30pm, Council Chamber , Great Yarmouth Town Hall, Hall Plain, NR30 2QF**			
Any queries or items for the next agenda please contact: **nwccg.corporateaffairs@nhs.net**			

Some explanations of terms used in this Agenda.

Please see further terms defined on our website www.improvinglivesnw.org.uk

Integrated Care System (ICS) - new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups.

Integrated Care Board (ICB) - an organisation with responsibility for NHS functions and budgets. Membership of the board includes 'partner' members drawn from local authorities, NHS trusts/foundation trusts and primary care.

Clinical Commissioning Group (CCG) – NHS bodies that will be replaced by ICBs on 1st July 2022.

Integrated Care Partnership (ICP) - a statutory committee bringing together all system partners to produce a health and care strategy. Representatives include voluntary, community and social enterprise (VCSE) organisations and health and care organisations, and representatives from the ICB board.

Health and Wellbeing Partnerships (HWP) - are local place-based partnerships work on addressing the wider determinants of health, reducing health inequalities and aligning NHS and local government services and commissioning.

Lived experience - knowledge gained by people as they live their lives, through direct involvement with everyday events. It is also the impact that social issues can have on people, such as experiences of being ill, accessing care, living with debt etc.

NHS Norfolk and Waveney Integrated Care Board

DRAFT Minutes of the meeting on Friday, 1 July 2022

PART 1 – Meeting in public

Board members present*:*

- Rt Hon Patricia Hewitt (PH), Chair, NHS Norfolk and Waveney ICB
- Tracey Bleakley (TB), Chief Executive, NHS Norfolk and Waveney ICB
- Steven Course (SC), Chief Finance Officer, NHS Norfolk and Waveney ICB
- Dr Frankie Swords (FS), Interim Medical Director, NHS Norfolk and Waveney ICB
- Patricia D'Orsi (PD'O), Director of Nursing, NHS Norfolk and Waveney ICB
- Hein Van Den Wildenberg (HvdW), Non-Executive Member, NHS Norfolk and Waveney ICB
- Cathy Armor (CA), Non-Executive Member, NHS Norfolk and Waveney ICB
- David Holt (DH), Non-Executive Member, NHS Norfolk and Waveney ICB
- Dr Hilary Byrne (HB), Partner Member – NHS Primary Medical Services
- Stuart Richardson (SR), Partner Member – NHS Trusts (Mental Health and Community Services)
- James Bullion (JB), Local Authority Partner Member
- Emma Ratzer (ER), VCSE Board Member

Participants and observers in attendance:

- Cllr Bill Borett (BB), Chair, Norfolk Health and Wellbeing Board, and Chair-designate, Norfolk and Waveney ICP
- Karen Barker (KB), Director of Corporate Affairs and ICS Development, NHS Norfolk and Waveney ICB
- Andrew Palmer (AP), Director of Performance, Transformation and Strategy, NHS Norfolk and Waveney ICB
- Mark Burgis (MB), Patients and Communities Director, NHS Norfolk and Waveney ICB
- Jocelyn Pike (JP), Director of Place Development and System Support, NHS Norfolk and Waveney ICB
- Louise Smith (LS), Director of Public Health, Norfolk County Council
- Patrick Pearl (PP), Chair, Healthwatch Norfolk

Attending to support the meeting:

- Belle Ward (BW), Executive Assistant, NHS Norfolk and Waveney ICB (Minutes)

1.	**Chair's welcome and introductions**	
	The Chair welcomed all Board members, stakeholders and members of the public to the first meeting of the Board of NHS Norfolk and Waveney ICB. The Chair introduced the meeting by recognising and thanking the many colleagues who undertake vital work looking after the Norfolk and Waveney population. She highlighted that people's physical and mental health depends on much more than the NHS though – work, income, social networks with family and friends, housing, exercise,and many more factors	

	make an enormous difference to our health and wellbeing. As an ICS, we will work with the wider community to help residents of Norfolk and Waveney to lead longer, healthier and happier lives. The Chair explained that the ICB will take on the responsibilities of NHS Norfolk and Waveney Clinical Commissioning Group (CCG). She took the opportunity to pay tribute to all colleagues who served on the CCG's Governing Body.	
2.	**Apologies for absence**	
	Apologies were received from the following Board members: • Jonathan Barber (JB), Partner Member – NHS Trusts (Acutes) • Sue Cook (SC), Local Authority Partner Member	
3.	**Declarations of interest**	
	The Chair noted that all Board members had refreshed their declarations of interest and that these are available on the ICS's website.	
4.	**Action log**	
	It was noted that one action had been transferred from the CCG Governing Body, which was to receive a report on maternity services at the ICB Board's meeting in September.	
5.	**Chair and Chief Executive's Report**	
	TB expressed her thanks to all in attendance, noting it was a day of real change and an opportunity to improve people's health and wellbeing through greater collaboration between health and care services, as well as with the wider public sector, voluntary organisations and communities. TB highlighted work being done around three priority areas: improving mental health services and supporting people's wellbeing, access to general practice and reducing the pressure on health and care services. The report was discussed and noted.	
	Establishment of the Integrated Care Board	
6.	**Establishment of the Board of the ICB – Introduction**	
	KB noted that the Integrated Care Board had been legally established as it was the 1 July 2022 and that the Board had been formally appointed earlier in the morning.	
7.	**NHS Norfolk and Waveney's ICB's Constitution**	
	The ICB Board was asked to note the Constitution of the ICB, which is the 'rule book' for how the organisation operates. KB confirmed the Constitution had been approved by NHS England. The Constitution is in the public domain and available on the ICS's website. The Board **noted** the Constitution of the Integrated Care Board.	

8	**Governance Handbook**	
	The ICB Board was asked to approve The Governance Handbook, which sets out how the organisation ensures good governance through its decision making, through good standards of business conduct and rules relating to conflicts of interest. **Agreed:** The ICB Board approved the Governance Handbook.	
9	**Policy Approval and Transfer**	
	KB explained that the former NHS Norfolk and Waveney Clinical Commissioning Group (CCG) had in place a full suite of policies that covered all aspects of business and how it discharged its responsibilities to patients, staff, partners and stakeholders, whilst meeting its statutory obligations. The Board was asked to approve that all policies be transferred as a 'full suite' to the ICB, apart from the following which in preparation of the ICB's Constitution and accompanying Governance Handbook had been reviewed and prepared in readiness for the 1 July 2022: • Standards of Business Conduct Policy • Conflicts of Interest Policy and Procedures • Policy for Public Involvement and Engagement (named in the Governance Handbook as "An approach to working with people and communities in Norfolk and Waveney") • Complaints Policy **Agreed:** The ICB Board approved: • The transfer of NHS Norfolk and Waveney CCG's policies to the ICB. • That the policies transferred to the ICB will be reviewed in accordance with their individual review dates (subject to any earlier review required, for example by legislation). • The Complaints Policy. The ICB Board noted the policies that had already been reviewed and included in the Governance Handbook and considered under item 8.	
10	**Confirm responsible officer and arrangements for Emergency Planning Resilience and Response (EPRR)**	
	The ICB Board was asked to note the contents of the paper and to approve the appointment of Dr Frankie Swords as the Emergency Planning Resilience and Response (EPRR) Officer / Accountable Officer. **Agreed:** The ICB Board approved the appointment of Dr Frankie Swords as EPRR Officer / Accountable Officer.	

11	**Board Assurance Framework**	
	KB presented the Board Assurance Framework, which summarises the risks for the Integrated Care System. **Agreed:** The ICB Board formally received the Board Assurance Framework, noting the risks and approving the transfer of risks from the CCG.	
12.	**Approval of Board Leads**	
	The ICB Board was asked to approve the alignment of the Mandated and Board Champion roles, as listed below. • Information Asset Owner – Chief Executive Officer, Tracey Bleakley – Mandated • Caldicott Guardian – Director of Nursing, Patricia D'Orsi – Mandated • Senior Information Responsible Officer – Director of Finance, Steven Course – Mandated • EPRR Responsible Officer/Emergency Accountable Officer – Medical Director, Frankie Swords (Interim until 30.09.22) – Mandated • Freedom to Speak Up Non-Executive Champion – Non-Executive Member of the Board, Hein Van Den Wildenburg, Board Champion • Wellbeing Lead – Non-Executive Member, Cathy Armor – Board Champion • Conflicts of Interest Guardian – Audit & Risk Committee Chair, David Holt – In guidance Committee Discharge **Agreed:** The ICB Board approved the alignment of the Mandated and Board Champion roles.	
13.	**Establishment of the Board of the ICB's committees**	
	KB explained that the ICB must ensure that it can effectively discharge its full range of functions and to support the Board to do this it must establish Committees. **Agreed:** The ICB Board: • Approved the establishment of the Committees of the Board of the ICB (as set-out in the paper). • Approved the appointment of the Chairs of the Committees (as set-out in the paper). • Agreed that the ICB forms the Integrated Care Partnership (ICP) along with Norfolk County Council and Suffolk County Council. • Agreed Rt Hon Patricia Hewitt, Chair of the Norfolk and Waveney ICB, would be the ICB founder member of the ICP. The ICB Board noted the Terms of Reference and membership for each Committee, as set out in the Governance Handbook.	

14.	**Agreement of the Board dates from 1 July 2022 to 31 March 2023**	
	The Board agreed the future Board dates set-out in the paper, advising they may be subject to change in future but if they are then it would be confirmed in due course.	
	Learning from people, staff, and communities	
15.	**Learning from people, staff, and communities**	
	PD'O introduced the item as an opportunity to hear the lived experience and voice of patients, carers and communities. A video clip was played to the Board and audience focusing on the experiences of two informal carers. Sharon Brooks (SB), Chief Officer of Carers Voice Norfolk and Waveney, and Belinda Jones (BJ), Awareness and Voice Team Leader from Caring Together, gave a presentation describing feedback from carers and highlighting ongoing work to improve the identification of and support for informal carers. SB requested that the ICB Board consider the following: • Having a designated champion for cares within the ICS/ICB. • Rolling out of a Carers Passport and carers awareness training across the ICS. • Developing the discharge task and finish group. The Chair extended her thanks to both SB and BJ for their presentation, noting that the Shared Care Record, which comes into effect in the next few months, will make a real difference in terms of integrated care. Questions and comments from Board members: • CA asked if there was feedback on the benefits for carers from areas where the carers passport had been rolled out? • SB explained that significant research had been undertaken. Carers in Norfolk and Waveney are very keen to have this rolled out as soon as possible to help support them in their caring roles. • FS commented that the words that struck her were that the carers felt "ignored", "not listened to", "afraid" and "anxious", but then also reflected that they could feel "relief" and "secure" when listened to. • FS referenced her experience as a hospital consultant during the pandemic when visiting was restricted. FS explained that losing the soft intelligence from carers had an impact and that once visiting was reintroduced it made a real difference, making health professionals' jobs easier, as well as being in the best interest of patients. • FS further noted that the experiences of the informal carers in the video had been in an informal caring arrangement for a significant amount of time, yet they were not necessarily next of kin and therefore not recognised as having a formal role in their loved one's care. This makes it very difficult for people trying to do the right thing whilst adhering to information governance legislation. Therefore, the	

	introduction of a carer's passport would revolutionise this and provides a fantastic opportunity. • JB highlighted that if carers didn't exist, the health and social care system wouldn't be able to function and that it relies heavily on informal carers and that this has a financial benefit to the system. • JB asked if there was anything more that could be done to address the health needs of carers themselves, noting they often do not put themselves first. • SB responded that the key thing carers want is to know the person they care for is being looked after. Access to services can be problematic and carers can spend hours a day trying to contact them; a more coordinated approach between services would be a real improvement. SB agreed that often carers do not put themselves first and do not seek help for their own care needs, as their main priority is the person they are caring for. • DH commented that it is important for the ICB Board to continually hear patients' stories. DH noted that both stories shared focused on the acutes and that it would be easy to suggest the problem therefore lies with the acute part of the system. However, many with lived experience, including Board members, have experienced issues across all parts of the health and care system and this needs to be improved for carers for when they encounter any professional within the ICS. • HB commented that from a primary care perspective, that she is often left in awe of what carers manage on a day-to-day basis, including their skill set, which wouldn't necessarily be expected from family carers. • BJ raised the need to be inclusive of young carers. • SR referenced the triangle of care which was in the presentation and asked what the experience was of organisations implementing this and whether this should be mandated training? • BJ responded that the triangle of care is an example of best practice in action and all the references made to carers wanting to be listened to falls under this. Therefore, the triangle of care should be promoted in every situation as the best example of how to listen. • BB questioned why this wasn't happening already and what are the barriers to these behaviours being established in the system? • BJ responded that the key barrier is awareness with some NHS staff not aware of the broad range of definitions of a carer and what this entails. Therefore it is hoped awareness training can form part of mandatory training. • SB added that self-identification is also a barrier and that parent carers need to be more widely recognised. • PD'O reflected that she had been really excited about the presentation and the attention the board members had given regarding the importance of this agenda.	

	• PD'O asked the Chair for their agreement to take forward recommendations for a task and finish group and to meet with SB and BJ to talk further about how to work together across the system in partnership. • The Chair advised the following question had been received online regarding this topic: "Will the carers passport be put as an alert on clinical systems to help with the identification of carers?" The Chair acknowledged that this would be hugely beneficial and asked that it a report is brought back to the September ICB Board meeting regarding the recommendations made by Carers Voice Norfolk and Caring Together, as well as options for digital solutions to including the carers passport as an alert on clinical systems. **Action:** PD'O to provide a briefing paper to the next ICB Board meeting to report on follow-up actions taken in response to the recommendations made by Carers Voice Norfolk and Caring Together. This is to include options for the carers passport to be included as an alert on clinical systems to help with the identification of carers.	**PD'O**
16.	**Question and answer session**	
	A question and answer session was held, with questions submitted in advance, by those watching online and by people at the meeting. Here is a summary of the questions asked and answers given: Q: There is a non-executive member position out to recruitment, where is this advertised as it is not on NHS jobs or your website? A: The Chair confirmed the role had not yet been advertised but would be very soon, adding that anyone interested could pass on their details to a member of staff and they would be kept informed. Q: When are the Norfolk and Norwich University Hospital (NNUH) gynaecology going to follow cancer guideline targets? The two weeks referral, they were late doing, and the 31 days start treatment plan, I'm now 3.5 months and zero treatment and so far, fobbed off with another number and another number for a surgery date. So, my question is when is the NNUH going to stop neglecting patients? A: FS responded, firstly apologising to the individual and others who are waiting too long. She explained there had been a 10% increase in the number of referrals, partly due to people not coming forward during the pandemic. She outlined three things being done to address the situation: 1. Increasing capacity – putting on extra clinics and operating lists wherever possible. 2. Prioritising and reprioritising referrals so that the highest risk patients are seen first.	

3. Understanding and addressing demand. The majority of those referred do not have cancer. Education sessions for GPs are underway to improve the quality of referrals and make it clear which pathway is most appropriate for different patients.

FS explained that the above actions are starting to show an improvement. For gynaecology, in January 2022 only 40% were receiving treatment within 32 days, by March 2022 this had increased to 66% and by May it was 77.8%. However, there is more work to do.

Q: When my family moved to Norfolk almost a decade ago, it was immediately after two members of my family were diagnosed with autism. We found the diagnostic service in Norfolk was significantly underfunded and that has gotten worse. There is no long-term support, and very little short-term support for a diagnosis which is life changing. If in 10 years, none of the health service or council have done anything to improve this, is there any chance that this something that you might prioritise and address now?

A: The Chair responded that herself, CS, and members of the Board had participated in discussions around this really important issue at the Health and Wellbeing Board for some years.

JB responded that the CCG and ICS before this Board was a regular participant in the Norfolk Autism Partnership Board and would expect the ICB to continue to engage with both that Board and more broadly with patients and people about their experience of services.

JB confirmed autism is definitely a priority given the challenge of both diagnostic rates and support post diagnosis. He explained that the ICB and Norfolk County Council are working on a post diagnosis action plan. JB referenced some elements of good delivery, for example NSFT has got a recovery college model which offers support, but acknowledged post diagnosis support does need further consideration. JB noted it was important to state this relates to both children and adult services where waiting times have been increasing.

PD'O added that she is committed to undertaking a review with local authority colleagues to understand what needs to be done differently to ensure we have robust services for people with autism.

Q: In the new partnership, how can I make sure that information that is shared is 100% accurate as information in the past has not been ultimately on the part of adult services and that has led to issues with them in the past as there seems to be no way to delete incorrect information, so I no longer feel that they are trustworthy so reluctant to share information other than the most basic information with anyone. And I am not the only person who is reluctant to share information I know of many others in the Norfolk and North Suffolk area who feel the same.

A: SC answered the question, giving assurance that all organisations in the ICS must adhere to the General Data Protection Regulations (GDPR) and

	Data Protection Act (DPA) 2018. This means they have to have a process for members of the public to inform the organisation when they feel something has been inaccurately recorded in their record, known as the right to rectification. SC noted that there are some exceptions, for example where a request is for deletion of patient information (also known as the right to erasure), there is a statutory need in a health care setting to maintain a full record. Q: Every child, young person and adult in Norfolk and Waveney has a right to live a life free from abuse and harm. This is critical to our health and wellbeing. With the ICBs key role to bring together people, communities and all our partner organisations to consistently work together, what opportunities does the ICB see to ensure that safeguarding is everyday business and that the prevention of harm and abuse to our most vulnerable people is paramount? A: PD'O responded that part of the Director of Nursing's agenda and responsibility to the ICB is to make safeguarding everyone's business. She explained that existing arrangements need to be reviewed and enhanced further to ensure safeguarding flows through everything the ICB does. PD'O noted her commitment to the ICB Board to ensure there is regular safeguarding reporting together with recommendations of how we can work differently and better together. ER noted the positive opportunities the ICB brings, especially regarding safeguarding. From a voluntary, community and social enterprise (VCSE) sector perspective, there is often involvement with the most exploited and vulnerable individuals. ER added that not having VCSE representation at predecessor boards made information sharing with health and social care partners difficult, thus the new way of working will be a great benefit. Q: People with severe mental illness die on average 15 – 20 years earlier than the rest of society. Physical health checks in primary care are one of the ways of ensuring they lead long and fulfilling lives. What more can the ICB do to close that mortality gap? Not enough is done in terms of uptake in communities to offer physical health checks, quite often people don't know these exist or know how to access them; what commitment can you give to raise awareness, including smoking cessation? A: HB commented that during COVID-19 a number of services were paused, including face-to-face physical health checks. However, over the last six months there had been a refocus and much discussion on how to increase uptake, with extra resource to try and get the physical health checks done quicker. She explained that uptake is a challenge and the ICB would welcome any thoughts or ideas on how to increase engagement. Q: Can you tell me whether private companies are going to be excluded from the Board or NHS services? A: The Chair noted that the Health and Care Act was amended to ensure that Board appointments do not compromise the independence of the NHS	

	and provided assurance that the Norfolk and Waveney ICB Board had applied this in all appointments and will continue to do so. Q: The carers passport was intended to have been launched in June, but it did not happen. If you have any influence, please find a simple way to roll out the carer's passport. A: The Chair explained she hopes the interest the Board had shown in the earlier discussion would provide some reassurance that they will do everything they can to get the carers passport launched and that PD'O would lead on this. Q: Provision of local services in rural areas - it can be very challenging for older people particularly when accessing appointments either early or late in the day at the hospital. Is there something that can be done? A: FS responded that there are several things which are being done to help. Firstly, retaining flexible appointments, including virtual appointments if this is an individual's preference. Secondly, the NHS has to agree a mutually convenient appointment with patients, so if a patients misses an appointment because it was imposed on them, they would not be discharged. Thirdly, personalised outpatients and patient-initiated follow-up are being expanded, so that patients are seen when they feel they need it, rather than at automatically set intervals. Q: A Clinical Nurse Specialist at the James Paget University Hospital (JPUH) informed the Board that she has been running the stoma service for several years as well as in partnership with East Coast Community Care. She explained that if patients live outside of the old Great Yarmouth and Waveney CCG boarder, once they leave the JPUH they are no longer looked after by the nurses who cared for them preoperatively and must be discharged. With the new ICS, could patients be able to choose who provides their nursing care postoperatively? A: PD'O responded that she would welcome the opportunity to visit the team at the JPUH and to talk through the issue raised, as well as to discuss what learning and best practice could be shared across the ICS about stoma services. Q: Around one in ten of the UK population has alexithymia, but it is unrecognised and goes undiagnosed. The single centre of excellence for this has been disbanded and there is nowhere for people with the condition to be treated. I'd like to ask you to address this and spread some knowledge. A: SR responded that he would welcome an offline conversation to understand more and how we could work together with the services we currently provide to make sure there is an increased awareness.	

17.	**Any other business**	
	No other business was raised.	
Date, time, and venue of next meeting: **Tuesday, 27 September 2022, 1.30pm – 3.30pm, venue to be confirmed.**		
	Any queries or items for the next agenda please contact: **Amanda Brown at Amanda.brown2@nhs.net.**	

Minutes agreed as accurate record of meeting:

Signed: …… Date: ……...
Chair

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
Patricia Hewitt	Chair, Norfolk and Waveney ICB	Getlink Group	X			Direct	Non-executive director, Getlink Group	2010	April 22	Conflict to be removed October 22 Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Director of Corporate Affairs
		FTI Consulting	X			Direct	Senior advisor, FTI Consulting	2015	Present	Since January 2022 I have not undertaken any work on healthcare or life sciences. Will declare at relevant meetings if a risk arises.
		Newnham College Cambridge			X	Direct	Honorary Associate, Newnham College Cambridge	2018	Present	No conflicts have arisen or foreseen
		Oxford India Centre for Sustainable Development			X	Direct	Chair, Oxford India Centre for Sustainable Development	2018	Present	No conflicts have arisen or foreseen
		ORA Choral Ensemble			X	Direct	Chair, trustees, ORA Choral Ensemble	2020	Present	No conflicts have arisen or foreseen
		Age UK Norfolk			X	Direct	Volunteer, Age UK Norfolk	2020	Present	Declaration of interest made in any relevant conversation
Catherine Armor	Non-Executive Member, Norfolk and Waveney ICB	Brundall Medical Practice			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Norwich University of the Arts			X	Direct	Deputy Chair of Council, Norwich University of the Arts	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
		Evolution Academy Trust			X	Direct	Trustee, Evolution Academy Trust	2022	Present	
		Cambridge University Press		X		Direct	Trustee, Cambridge University Press	Ongoing		
		East of England Ambulance Service NHS Trust		N/A		Indirect	Daughter-in-law is Technician for East of England Ambulance Service NHS Trust	Ongoing		
Jon Barber	Partner Member - Acute, Norfolk and Waveney ICB	James Paget university Hospitals Trust		X		Direct	Director of Strategy & Transformation James Paget university Hospitals Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Broadland St Benedict			X	Direct	Non-executive Director of Broadland St Benedicts – the property development subsidiary of Broadland housing Group	2020	Present	
Tracey Bleakley	Chief Executive Officer, Norfolk and Waveney ICB	Nothing to Declare		N/A			N/A	N/A	N/A	N/A

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

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			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
James Bullion	Partner Member - Local Authority (Norfolk), Norfolk and Waveney ICB	Norfolk County Council		X		Direct	Executive Director Adult Social Services, Norfolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Dr Hilary Byrne	Partner Member - Primary Medical Services	Attleborough Surgeries		X		Direct	GP Partner at Attleborough Surgeries	2001	Present	To be raised at all meetings to discuss prescribing or similar subject. Risk to be discussed on an individual basis. Individual to be prepared to leave the meeting if necessary.
		MPT Healthcare Ltd		X		Direct	Director of MPT Healthcare Ltd	2020	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		Norfolk Community Health and Care Trust (NCH&C)				Indirect	Spouse is employee of NCH&C (Improvement Manager)	2021	Present	
Sue Cook	Partner Member - Local Authority (Suffolk), Norfolk and Waveney ICB	Suffolk County Council		X		Direct	Executive Director Adult Social Services, Suffolk County Council	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
Steven Course	Director of Finance, Norfolk and Waveney ICB	March Physiotherapy Clinic Limited				Indirect	Wife is a Physiotherapist for March Physiotherapy Clinic Limited	2015	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards March Physiotherapy Clinic Limited
Tricia D'Orsi	Director of Nursing, Norfolk and Waveney ICB	Nothing to Declare		N/A			N/A	N/A		N/A
David Holt	Non-Executive Member, Norfolk and Waveney ICB	Solebay Health Centre			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		Tavistock and Portman NHS Foundation Trust		X		Direct	Senior Independent Director, Tavistock and Portman NHS Foundation Trust	2013	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Tavistock and Portman NHSFT

NHS Norfolk and Waveney Integrated Care Board (ICB)
Register of Interests

Declared interests of the Board

Name	Role	Declared Interest- (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial Interests	Non-Financial Professional Interests	Non-Financial Personal Interests			From	To	
		Department of Work and Pensions		X		Direct	Non-Executive Board Member, Department of Work and Pensions. Chair of the Audit Committee and Chair of the Health Transformation Programme Board	2019	Present	Low risk. In the unlikely event that a risk arises I will discuss and agree any appropriate steps which need to be taken with the ICB Chair
Emma Ratzer	Partner Member - VCSE	Access Community Trust	X			Direct	I am the Chief Executive Officer of Access Community Trust, an organisation which holds contracts with NWICB	2009	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Community Access Trust
		VCSE Assembly			X	Direct	I am CEO of a voluntary sector organisation operating in NWCCG and Independent Chair of NWVCSE Assembly	2021	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
Stuart Richardson	Partner Member - Mental Health and Community, Norfolk and Waveney ICB	Norfolk and Suffolk Foundation Trust		X		Direct	Chief Executive Officer, Norfolk and Suffolk Foundation Trust	Ongoing		In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest
Dr Frankie Swords	Interim Medical Director, Norfolk and Waveney ICB	Norfolk and Norwich University Hospitals NHS FT		X		Direct	Honorary Consultant Physician and Endocrinologist at Norfolk and Norwich University Hospitals NHS FT (1 day a week)	2008	Present	In the interests of collaboration and system working, risks will be considered by the ICB Chair, supported by the Conflicts Lead and managed in the public interest.
		N/A			X	Direct	Clinical Advisor of multiple patient charities - Addison Self Help Group - Orchid Testicular Cancer Trust - Pituitary Patient Support Group - Turner syndrome Society	2008	Present	
		Ruby Media		N/A		Indirect	Husband is director of Ruby Media which commissions various professional conferences and other events relating to health and care	2008	Present	Will not have an active role in any decision or discussion relating to activity, delivery of services or future provision of services in regards Ruby Media
Hein van den Wildenberg	Non-Executive Member, Norfolk and Waveney ICB	Lakenham Surgery			X	Direct	Member of a Norfolk and Waveney GP Practice	Ongoing		Withdrawal from any discussions and decision making in which the Practice might have an interest
		College of West Anglia			X	Direct	Governor at College of West Anglia (Note: the College hosts the School of Nursing, in partnership with QEHKL and borough council)	2021	Present	Low risk. If there is an issue it will be raised at the time.

NORFOLK & WAVENEY ICB Chairs Action Log - Tuesday 27 September 2022				
Date	**Matter**	**Details of discussion**	**Decision**	**Date Reported to ICB Board**
27.07.22	Approval of two urgent procurements: due to the ICB Board being established 01.07.22 no further Board meeting was available within month for approval within the timeframe required.	Chair and CEO received full reports on the following two procuremnets: 1. Provision of Mental Health Support Teams in Schools 2. Integrated Front Door, for CYP Mental Health Services in N&W	Both the Chair and CEO confirmed their approval and support to proceed with the procurements. Decision will be shared with the Board at the next scheduled meeting on 27.09.22.Full Copies of the reports are available as required.	27.09.22

NORFOLK & WAVENEY ICB Action Log - Tuesday 27 September 2022							
No:	**Date of Meeting**	**Description**		**RESP**	**Due Date**	**ACTION / UPDATE**	**Status**
1	CCG GB - 26 April 2022	Maternity Report	ICB to receive an update and assurance on the report at a future meeting	Tricia D'Orsi	27-Sep-22	Placed on forward planner.	On agenda 27.09.22
2	01-Jul-22	Carers Passport Update	PD'O to provide a briefing paper to the next ICB Board meeting to report on follow-up actions taken in response to the recommendations made by Carers Voice Norfolk and Caring Together. This is to include options for the carers passport to be included as an alert on clinical systems to help with the identification of carers	Tricia D'Orsi	22/11/2022	Now placed on forward planner for November meeting.	

Norfolk and Waveney
Integrated Care Board

Agenda item: 5

Subject:	**Chair and Chief Executive's report**
Presented by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Prepared by:	**Rt Hon. Patricia Hewitt, Chair, NHS Norfolk and Waveney ICB** **Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**27 September 2022**

Purpose of paper:

To update members of the Board on the work of the ICB.

Executive Summary:

The report covers the following:

A. The first three months of our Integrated Care System
B. System pressures and winter planning
C. Mental health
D. Expansion of Access to Intermittent Scanned Glucose Monitoring and Continuous Glucose Monitoring
E. GP Patient Survey 2022
F. Sustained improvement at two of our acute hospital trusts
G. Caldicott Guardian
H. Women's Health Strategy for England

Report

A. The first three months of our Integrated Care System

NHS Norfolk and Waveney Integrated Care Board (ICB) was established almost three months ago on 1 July when the Health and Care Act came into effect. Since then, our Integrated Care Partnership (ICP) has formally met for the first time, as have most of the ICB's committees. We are out to recruit the fourth non-executive member of the ICB Board and following their appointment our Patients and Communities Committee will meet for the first time.

Overall, the transition to the new arrangements has gone well and we have put in place the foundations for a different way of working that means we are better placed to deal with the challenges we face. However, we have always said we would judge ourselves and ultimately the success of the reforms on whether we are making a difference to people's health, wellbeing and care.

Tackling 104 week waits for treatment has been one of our first achievements. Our approach to tackling the longest waits for NHS services has been another excellent example of what we can achieve through greater collaboration. Reducing waiting times for scans, checks and surgical procedures is a priority for many local people and for us. During the pandemic, the number of patients waiting much longer than we would like for their treatment grew for multiple reasons; there are now no patients waiting two years or more for routine care in our area.

Achieving this target has only been possible thanks to the hard work of our colleagues, close collaboration between our three acute hospital trusts, making effective use of all available capacity, and through strengthening our relationships and mutual aid arrangements across healthcare systems to increase opportunities to move patients around where appropriate and to make the best possible use of our resources – including staff, operating theatres, beds and equipment. The next target in the Elective Recovery Plan is to eliminate 78 week waits by April 2023. There are of course also waits for care in other parts of our system, including primary and community care, as well as mental health services, all of which we are working to reduce.

Over the next three months, we will draft our Integrated Care Strategy, building on previous work, including our Joint Health and Wellbeing Strategies, and in line with the recently published national guidance. This will be an important document that guides all of our work and drafting it is a key function of our Integrated Care Partnership. Work has also started on the ICB's Joint Forward Plan, which will set out how we will deliver the NHS elements of the strategy over the next five years – we expect national guidance on the development of these plans to be published soon.

B. System pressures and winter planning

Our urgent and emergency care services continue to be incredibly busy – as they are across the country – and staff are working around the clock to provide the best possible care to patients. It is a very challenging time for all our teams and

colleagues working hard across health and social care, and we want to thank everyone for their ongoing efforts.

We've been working as a system since before the pandemic to reduce pressure on our hospitals and urgent and emergency care services. It is helpful to look at the journey patients go on to understand what has changed, where we are doing well and where the challenges are.

If we start with what happens to people before they get to hospital, we can see a real change in how we care for people. Data shows that compared to 2019/20 we are dispatching fewer ambulances (there's been a 14% reduction) and fewer people are being taken to hospital by ambulance. Instead, people are being given more help to get care from the most appropriate service. For example, there has been a 37% increase in "hear and treat", which is when 999 call handers give advice to callers about where they can get help if they are not ill enough to require an ambulance. This helps to ensure that the ambulance service can focus on people they are there to help, which is people who have a serious or life-threatening condition, and it prevents people going to our hospitals unnecessarily.

The progress we have made in the pre-hospital care has been the result of a determined and concerted effort before the pandemic by all system partners, including GPs and primary care teams, community services and social care, 111 and the Ambulance Trust, as well as the acute hospitals. It again goes to show the value of system working and how by working together we can and will improve the health, wellbeing and care of people living in Norfolk and Waveney.

The next step in people's journey is what happens when people arrive at our hospitals. People are often having to wait longer to be seen than they should be because our Emergency Departments are very busy and too often it is taking a long time to admit people. But, at the same time, significantly fewer people are going on to be admitted to hospital. Compared with 2019/20 we have seen 9% reduction in emergency admissions and a 2% reduction in the emergency readmission rate.

The final part of people's journey is, for those who needed to be admitted, to then be discharged from hospital. This is where we are seeing significant challenges. People are staying longer in hospital and so our hospitals are fuller. This in turn makes it more difficult to admit the next people who need to stay in hospital and it makes it harder to make space in our Emergency Departments for the next patients who need to be seen.

As a consequence, it is also taking much longer for ambulances to handover patients to our Emergency Departments. When our ambulances are waiting at our hospitals to handover patients they aren't on their way to their next patient, resulting in ambulance response times going up. We know that people who do need an ambulance are too often having to wait too long to be reached, despite the very best efforts of our paramedics and the ambulance trust.

The situation is very challenging and complex. We need to consolidate the improvements we've made and there is more we are doing, but overall demand for these services is not the problem, the challenge for us is how can we improve

discharge and the flow of people through our hospitals and back into the community. It is vital that once patients are well enough, they are discharged quickly, whether that is home, with or without a package of support from social care, or on to intermediate or longer-term care in a residential or nursing home.

To be clear, this is not 'just a social care problem'. Yes, there are real challenges with the capacity of social care and recruitment and retention of staff, particularly in domiciliary care which supports people in their own home. We are working to address this and to support the care market. However, there is also more our acute hospitals can and are doing to improve discharge, including for those patients who don't need a formal package of care, but who can go home, perhaps with some help from their family.

Anyone who has a relative or friend in hospital can also help us to tackle this problem. Every day people do support their loved ones to go home from our hospitals, picking them up, taking them home, doing some shopping for them etc. We heard at our Board meeting in July how we could better support carers and families with this, by involving them earlier when we are planning for a patient's discharge and listening to them about what would work best for the people they know and love. We are committed to doing this.

Since our July meeting, the ICB has identified funding for the production and distribution of the carers ID passports. The passports will help to identify carers early and enable them to be fully involved in conversations about the care and treatment of the person they care for. A design has been agreed for the passports and they will soon be going to print. A programme of communications is being developed to ensure that staff across health and care settings recognise and value the passports. We are working with Carers Voice regarding distribution of the passports, which we expect to launch in the autumn.

Overall, our approach is to treat improving urgent and emergency care as our new covid, applying the same rigour, focus and collective action that worked so well over the past two and half years. We know that improving our discharge arrangements and flow through the system will make a significant difference to the care people receive.

On 12 August NHS England wrote to all systems regarding the next steps for increasing capacity and operational resilience in urgent and emergency care ahead of winter. It outlines the key actions and objectives for systems including performance and accountability. We have been awarded £9.7m of revenue funding and £2m of capital funding to make targeted investments in initiatives to improve discharge and the flow of patients through our hospitals and into the community. We will keep the Board informed of our progress over the coming weeks and months.

C. Mental health

Improving mental health services and supporting people's wellbeing is one of the highest priorities for our system. The ICB has decided to appoint an Acting Director for Mental Health Transformation in recognition of the significant challenges we face and to provide additional senior leadership.

In the months since the Care Quality Commission's (CQC) inspection, Norfolk and Suffolk NHS Foundation Trust (NSFT) has concentrated on the 'must dos' required by the CQC. Together with NHS England and Suffolk and North East Essex Integrated Care Board, we have supported NSFT in this vital work. The next phase will involve the Trust looking at how they address the root cause of issues. System wide groups have been established to move this work forward and support delivery of the organisation's priorities, which are:

- Ensuring our services are safe.
- Improving access to services and reducing waiting times.
- Improving our culture and staff engagement.
- System wide transformation of mental health services across both counties with our partners.

As we've said before, improving people's mental health and wellbeing is about much more than improving NSFT services, vital though that is. We know that the mental health and wellbeing of children and young people has been significantly affected by the pandemic, and we want to draw your attention to two updates:

Firstly, Cambridgeshire Community Services NHS Trust has just been commissioned as the new provider of mental health support in schools across Norfolk and Waveney. Mental Health Support Teams help young people to understand how to tackle some of the challenges they experience. They focus on support for good mental health, helping them to feel more resilient, arming them with techniques to look after themselves and help them cope better with life's ups and downs.

The teams also provide support and guidance to parents and teachers. Providing them with the skills to help young people experiencing difficulties. This includes support through training, workshops, and consultation.

There are currently mental health support teams in King's Lynn, North Norfolk, Lowestoft, South Norfolk, Norwich, and Breckland. Each team supports between 10-12 schools, with a student population of around 7,000. The new provider will now start recruiting staff for two new teams to work with young people in schools in Great Yarmouth and Broadland from January 2023.

CCS have been providing mental health support in schools across Cambridgeshire for a number of years. They also deliver the Healthy Child Programme and Speech and Language Therapy support for children and young people in Norfolk and Waveney. This knowledge of our local communities and experience in delivering mental health support in schools will further benefit young people across Norfolk and Waveney, enabling them to flourish.

Secondly, we were delighted to see that the Mancroft Advice Project (MAP) has been chosen from more than 350 charities across the UK as the overall winner of the 2022 GSK IMPACT Awards. The organisation provides counselling, mental health advice, and support from centres in Norwich and Great Yarmouth, as well as in

schools and community bases around Norfolk. Here is a great video showcasing some of the fantastic work MAP do and the impact their work and that of others across the ICS has for young people.

D. Expansion of Access to Intermittent Scanned Glucose Monitoring and Continuous Glucose Monitoring

We are really pleased to confirm that there will be a significant expansion of access to devices that help people with diabetes to monitor their blood glucose levels. On 31 March 2022, the National Institute for Health and Care Excellence (NICE) issued updated guidance relating to blood glucose monitoring for all people with diabetes. The ICB has approved implementation of the NICE guidance in full, to be rolled out in a staged process that will be overseen by our Diabetes Programme Board.

The decision will increase access to sensors that people wear which measure the glucose levels in the fluid around the tissues just under the skin. The measurements can be stored in a wearable device and transmitted to an app or reader device. The individual can then access that data, without finger pricking, to support self-management of their diabetes. The devices can also be set up to alert the person with diabetes to very high or low glucose levels, allowing them to take action in real time, before an emergency arises.

This transformative technology will mean better care for patients and it will benefit the health and care system. For example, evidence shows that use of these monitors means people make fewer visits to Emergency Departments because their glucose levels are too high or low. The decision is in line with our goal to prevent avoidable illness and it will give people greater control over their own health and wellbeing.

E. GP Patient Survey 2022

In July the results of the 2022 GP Patient Survey were published. The results show that 76% of patients across Norfolk and Waveney had an overall good experience of their GP practice, which is higher than the national average figure of 72%. This is a testament to the dedication of our primary care staff, who are working hard to provide high quality services during what has been a very challenging period responding to the COVID-19 pandemic and supporting the roll out of the biggest vaccination programme in NHS history.

However, we know there is variation in patient experience. When asked about their overall experience of their practice, 87% of respondents at one practice rated their experience as good, while at another this was 60%, with all the other practices falling somewhere in between. We are working closely with GP practices who may need additional help and support to address concerns about access. Also, many of our local practices have asked for guidance from the national Access Improvement Programme to help them identify how they can improve access for their patients.

Over the last couple of years we have invested in digital technology to improve access for patients. We have also expanded GP practice teams to make sure that patients get the right help from the right person first time, which may not always be a

GP. People may now be seen by another member of the team, who may be a physiotherapist, social prescriber or a pharmacist, for example.

Anyone who needs an appointment and has an urgent problem which cannot be managed elsewhere, such as by their pharmacy or NHS 111, should contact their surgery in the usual way. It's really important that people get in touch with their GP practice when they need help, especially where they have signs or symptoms of something which could be more serious.

F. Sustained improvement at two of our acute hospital trusts

NHS England has written to the Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) and the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) to recognise the good progress they have made.

Both trusts were put in System Oversight Framework level four (SOF4, or what used to be called special measures) following inspections by the Care Quality Commission. As a result of a significant amount of work and real improvement, the NNUH exited SOF4 in 2020 and the QEH in 2022. However, as the trusts' regulators, NHS England still had in place a number of legal undertakings.

NHS England's Regional Support Group has now confirmed the removal of all legal undertakings. The Regional Support Group has also agreed that both trusts will remain in System Oversight Framework level three for now, but that mandated support is no longer required and no new undertakings will be put in place. This quite technical language about a change in regulatory approach really is just a recognition of the good progress made in many areas by the trusts and the move to system oversight in others.

We want to thank all the staff at the two trusts for their hard work and to recognise the many colleagues who work in other local health and care organisations for the support they have given to the trusts.

G. Caldicott Guardian

As Board members will know, a Caldicott Guardian is a senior person within a health or social care organisation responsible for protecting the confidentiality of patient information and making sure it is used legally, ethically and appropriately. At our Board meeting in July we received a paper stating that our Nursing Director, Tricia D'Orsi would be our Caldicott Guardian. To update Board members, following further consideration of the portfolios of our Executive Management Team, our Medical Director, Dr Frankie Swords, is now our Caldicott Guardian.

H. Women's Health Strategy for England

Finally, we were pleased to see the recent publication of the Government's ten-year strategy for women's health in England. Although women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. Not enough focus is placed on women-specific issues like miscarriage or menopause, and women are under-

represented when it comes to important clinical trials. This has meant that not enough is known about conditions that only affect women, or about how conditions that affect both men and women impact them in different ways. Our system is looking at how we implement the strategy locally.

Recommendation to the Board:

This agenda item is for information only.

Key Risks	
Clinical and Quality:	N/A
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	N/A
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	N/A

Norfolk and Waveney
Integrated Care Board

Agenda item: 09

Subject:	**Maternity Transformation and Local Maternity and Neonatal (LMNS) Programme report**
Presented by:	**Tricia D'Orsi ICB Director of Nursing** (Senior Responsible Officer for Local Maternity and Neonatal)
Prepared by:	**Toni Jeary – LMNS Programme Manager** **Nicola Lovett – LMNS Lead Midwife**
Submitted to:	**Norfolk and Waveney ICB Board**
Date:	**27 September 2022**

Purpose of paper:

Norfolk and Waveney Integrated Care Board (ICB) are asked to note the statutory responsibility of the LMNS to report to the ICB. As the responsible executive, this report provides the ICB with information to review the progress of the LMNS Programme and the LMNS Capacity & Capability Framework Assessment. It provides detail of the work undertaken on behalf of the ICB to ensure safety and quality oversight of maternity services and details of LMNS Programme risks and mitigating actions.

Executive Summary:

The ICB has responsibility for the Local maternity and Neonatal System (LMNS). The LMNS is a system partnership responsible for supporting the implementation of the Maternity Transformation Programme, formed to co-ordinate and undertake the recommendations from the Better Births (2016) report and National Maternity review. The LMNS supports and facilitates the Better Births ambition of ensuring maternity services in England become safer and more personalised. Surveillance of the delivery of care is outlined in the Perinatal Quality Surveillance Model (Dec 2020) which challenges the ICB to 'take a more formal role in perinatal clinical oversight alongside transformation and improvements activity'. (Implementing a revised perinatal quality surveillance model December 2020, P.7)

The LMNS as an integral part of the ICB is responsible for oversight of the implementation of the recommendations from safety reports such as the Ockenden Review into Maternity Services at the Shrewsbury and Telford Hospital NHS Trust (2021;2022). There is also a pending report by Kirkup, anticipated launch June 2022 (East Kent) and a further pending review by Ockenden in Nottingham.

The recent Capacity and Capability framework (June 2022) highlighted the need for the ICB to have increased responsibility for the LMNS, and the assurance and surveillance responsibilities that sit within this programme.

This report updates on

- Maternity Transformation Priorities
- LMNS Capacity and Capability Framework Assessment
- Equality and Equity Strategy

- Safety and Quality Assurance
- Ockenden
- Serious Incidents
- Training
- Programme Risks
- Good practice

Recommendation to the Board:

For ICB Board to:

- Note the work undertaken by the LMNS to deliver the Maternity Transformation Programme
- Recognise their responsibility under the Capacity and Capability Framework
- Note the LMNS role in Quality and Safety Oversight and response to the Ockenden report
- Note the LMNS Programme risks and mitigating actions being undertaken to address these
- Agree that a LMNS Programme update is presented to the ICB in 6 months' time.

Key Risks	
Clinical and Quality:	Risk of failure to achieve sufficient progress in delivering the quality improvements identified in Better Births, the NHS Long Term Plan and the Ockenden Report population if services not sufficiently accessible or available to meet their needs.
Finance and Performance:	Funding through NHS Long Term Plan and in response to the Ockenden Report Perinatal Quality Surveillance Model and will increase investment in maternity services with a particular focus on workforce and system development. The LMNS will work with all partners to identify areas of challenge and gaps in provision and seek to mitigate these were possible.
Impact Assessment (environmental and equalities):	The guidance supports the rights of families to have access to maternity care, that is responsive and safe, and delivered in settings that meet their health and social needs.
Reputation:	Any risks relating to the rights of families to have access to maternity care that is responsive and safe, and delivered in settings that meet their health and social needs may result in scrutiny.
Legal:	Human rights law gives pregnant women the right to receive maternity care, to make their own choices about their care and to be given standards of care that respect their dignity and autonomy as human beings.
Information Governance:	No impact
Resource Required:	Program to be supported through LMNS Program Team hosted on behalf of the system by Norfolk and Waveney ICB

	Additional sources of funding required
Reference document(s):	Better Birth Maternity Transformation NHS Long Term Plan Ockenden Report Perinatal Quality Surveillance Model,
NHS Constitution:	The guidance and report supports the principles of the NHS Constitution. (values 1-7)
Conflicts of Interest:	No conflicts identified
Reference to relevant risk on the Governing Body Assurance Framework	None

GOVERNANCE

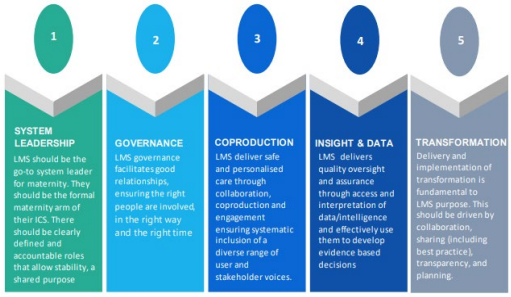
Process/Committee approval with date(s) *(as appropriate)*	

1. LMNS Programme

Maternity Transformation Priorities
LMNS as a System, are asked to take responsibility – with accountability to ICBs – for ensuring universal implementation of initiatives. The work programme is available to Board members on request and is summarised in the Norfolk and Waveney LMNS Programme Blueprint. The LMNS Programme Board receive a monthly highlight report to ensure they are fully sighted on progress against the programme priorities. The Programme is currently on track to achieve the 22/23 deliverables.

LMNS Capacity and Capability Framework Assessment
LMNS Programme deliverables for 22/23 were issued in March 2022. The deliverables include the requirement to complete a Capacity and Capability Framework self -assessment by 15 June 2022 and develop a clear action plan that supports improved function and performance and further embeds and strengthens the governance of LMNS within ICB by October 2022.

There are five standards



The final Capacity & Capability Framework Assurance document was approved by LMNS Board on 15 June 2022 and submitted to NHSE.

In completing the self-assessment LMNS are asked to assess themselves against each characteristic in each domain and assign a level from 0-5:

0. Not Started
1. Significant development required - little evidence of activity or major barriers preventing development in this area
2. Moderate development required – plans are in place and work is progressing on those
3. Functioning well, with minor areas for development – most elements of this domain are met and evidenced
4. Fully functioning – but some areas need further maturation
5. Fully functioning with no identifies development needs – all elements are met and evidenced

The final assessment has the following ratings:

Domain	Title	Overall Assessment
Domain 1	System leadership	**4**
Domain 2	Effective governance	**4**
Domain 3	Coproduction with service users	**3**
Domain 4	Insight and data	**1**
Domain 5	Planning for and delivering quality and transformation	**4**

The resulting action plan identifies ongoing support requirements from the ICB to ensure the LMNS is embedded and resourced effectively.

Maternity Voices Partnership (MVP)

The LMNS supervise and oversee the Norfolk & Waveney Maternity Voices Partnerships (MVP) who are also aligned to the three Acute Trusts. MVPs ensure service user voice is incorporated into in the development, review and updating of maternity guidelines, Standard Operating Procedures (SOPs), surveys and patient information, and the Maternity Transformation Programme.

The significance of co-production and hearing the voices of the services users has been elevated with the publication of the Ockenden Report (2020/2022). Action 2 of the Immediate and Essential actions is *'Maternity services must ensure that women and their families are listened to with their voices heard'*, (p.27), while Principle 3 of the Perinatal Quality Surveillance Model (2021) further supports the involvement and relevance of the MVP when planning services when it states '*There is a formal process for gathering insights from multiple partners including the LMN, neonatal ODNs, maternity clinical networks, Maternity Voices Partnership chairs CQC …..'* (p.10).

The MVP creates and maintains a co-production forum for maternity service users, service user advocates, commissioners, service providers and other strategic partners. Members and the collective forum operate on the following founding five principles:

- Work creatively, respectfully and collaboratively to co-produce solutions together.

Work together as equals, promoting and valuing participation. Listen to, and seek out, the voices of women, families and carers using maternity services, even when that voice is a whisper. Enabling people from diverse communities to have a voice.

- Use experience data and insight as evidence.
- Understand and work with the interdependency that exists between the experience of staff and positive outcomes for women, families and carers.
- Forensic in the pursuit of continuous quality improvement with a particular focus on closing inequality gaps.

The N&W ICB identify funds annually and will cover basic duties of the MVP. This is managed through Community Action Norfolk (CAN) via a Service Level Agreement (SLA). For 2022/23 the finance available is £18 000, which equates to £6K per MVP. The MVP have highlighted that this figure is not sufficient to meet the demands of the role.

Equality and Equity Strategy
MBRRACE-UK reports about maternal and perinatal mortality show worse outcomes for those from Black, Asian and Mixed ethnic groups and those living in the most deprived areas. In September 2021, NHSE responded to those findings by issuing guidance to LMNS for an Equity and Equality Strategy.

The LMNS two aims relating to equity and equality for maternity and neonatal care are to improve:

- equity for mothers and babies from Black, Asian and Mixed ethnic groups and those living in the most deprived areas
- race equality for staff.

All LMN'S are required to publish an action plan on 30 September 2022. The development of the analysis and action plan has involved service users and partners including the ICB and once signed off by LMNS Board on 28 September will be published on the ICB website. Co-production underpins the LMNS Equity & Equality work.

2. Quality and Safety Oversight

The Ockenden Report (2021) requires that '*Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks.'* The LMNS must have greater oversight and has been given '*greater responsibility, accountability and responsibility so that they can ensure the maternity services they represent provide safe services for all who access them'*. Be clear not just N&W

The Clinical Lead Midwife reports monthly to the LMNS Board focusing on issues of safety and quality in line with requirements from Better Birth Maternity Transformation Programme, NHS Long Term Plan, Ockenden Reports and Perinatal Quality Surveillance Model, to ensure there is a system-wide view of quality of maternity services

A refreshed approach to Quality & Safety Surveillance was approved by the LMNS Board on 18 May 2022. This was further amended and approved on 20 July 2022. (Appendix 1 p.12)

Ockenden
The actions required, and monitoring of this, with the Provider Trusts, will be monitored through the Quality and Safety Oversight Group. Key highlights will then be reported to LMNS Board.

Regional Ockenden visits have been completed and final reports submitted to Trusts and LMNS on 01 August 2022. A summary report will be presented to LMNS Board on 28 September 2022.

A summary of the RAG ratings is detailed below:

Trust	Green	Amber	Red
JPUH	39	9	0
QEH	35	11	2
NNUH	26	20	2

Actions have already been undertaken to address all the red areas and good progress is being made against those rated amber. Areas of good practice have been shared between the Trusts and the LMNS will continue to ensure a systemwide approach to learning development and quality improvement.

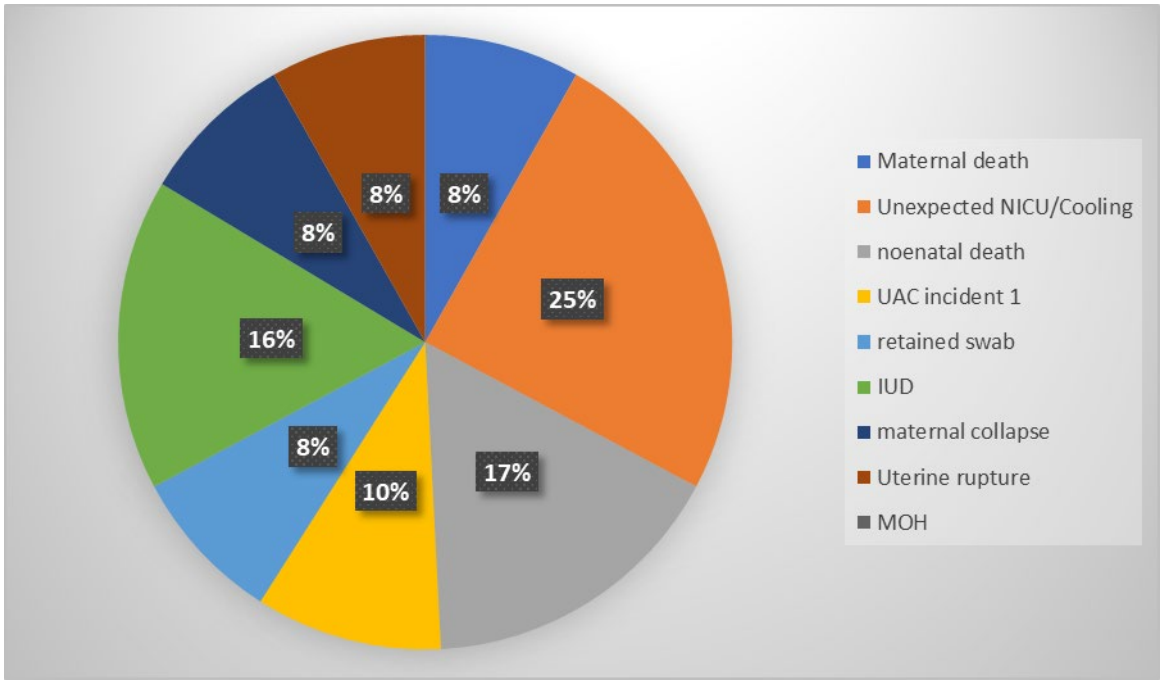
Serious Incidents (SI) Surveillance.
The Ockenden Report (2021) states that '*Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight'*.

The system-wide SI Surveillance meeting for this Quarter was held in June. All incidents from Jan-March 2022 were discussed in depth and themes that emerged were;

- Multi-disciplinary training (MDT) compliance
- Cardiotocography (CTG) interpretation
- Second stage issues leading to Hypoxic Ischaemic Encephalopathy (HIE)
- Communication

These issues are scheduled to be addressed in the planned local learning events (LLE) and will be also taken back to Trusts by their education teams.

Themes for SI reports for April-June 2022 are below.



Ockenden report (2020) states *"All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months."* IEA 1; Enhanced Safety (2020).

Work is underway to ensure that the LMNS and Trusts meet these requirements whilst adhering to the Information Governance requirements of their lead organisations.

Saving Babies Lives Care Bundle 2 (SBLCB2)
The SBLCB2 is a package of maternity care aimed at reducing perinatal mortality across England and brings together five elements of care that are widely recognised as evidenced based/best practice; reducing smoking in pregnancy, risk assessment and surveillance of pregnancies at risk of fetal growth restriction, raising awareness of reduced fetal movements, effective fetal monitoring in labour and reducing pre-term birth.

The Regional Ockenden visits identified that the current training package developed to support Trusts during Covid may not meet all expectations of training for staff under SBLC2 requirements. The LMNS Practice development team are now working with Trusts to revise the current offer and ensure that it meets requirements.

Training
Ockenden (2021) requires that '*Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, three times a year*'. The training report for the previous quarter was discussed at length at LMNS May Board. All three Trusts are addressing training gaps and trajectory plans are in place or being developed to address this. The Quarter April-June was presented to LMNS Board in July, to monitor progress. It was of note that al three Trusts could demonstrate improvements but are still non-compliant.

Quality and safety areas of concern	**LMNS actions**
Non-compliance with mandatory education across the system	Training report to LMNS Board every Quarter and monitor training plans in S&Q oversight group.
SBLCB2-none of the Trusts are compliant, and the current training package no longer meets the demands of Ockenden.	SBLCB2 training package is under review with the LMNS and Trust PDMs and Heads of Service.
Staffing	Staffing issues (QEH) have been raised at ICB Workforce workstream
SI reporting and exception reporting at JPUH	Meeting with DON at JPUH to discuss SI reporting

3. Programme Risks
The LMNS Programme manages risks via each workstream and the LMNS Programme Board. The top three risks that are currently being monitored by the LMNS Board are:

Risk	**Mitigation**
Data & Dashboards Data inconsistencies and reporting	

The LMNS does not have access to accurate data dashboards that provide the intelligence required to inform transformation or understand current performance	Funding approved for Digital Project Manager, post out to advert Dashboard's project commenced August Added to ICB Quality & Performance Committee Risks Data & dashboards workstream has a robust action plan
Staffing to deliver Transformation & Safe Care Reporting is highlighting challenges across the system with recruitment & retention, staff training & digital capacity. This creates a system risk in relation delivering transformation and delivering safe care. This includes Saving Babies Lives compliance	Improved accountability through Quality Surveillance meetings System wide quarterly training report Regional support offered
MVP engagement This will be critical to a number of significant projects to be delivered during 22/23. The LMNS Board 8 May raised this risk to high as clear issues in relation to resourcing and capacity.	Regional and National Review Forward planning meetings in place for September / October SOPs & MoU reviewed for finalising September / October Update to LMNS Board September 2022

4. Good Practice

Maternal Medicines Networks provide pre-pregnancy, antenatal and postnatal care for women who have significant medical problems that pre-date or arise in pregnancy or the first few weeks after delivery. Each area is required to have arrangements in place to ensure effective identification, referral, and management of women with medical conditions. Norfolk and Waveney LMNS has agreed and established appropriate arrangements to meet this requirement with a maternal medicine service hosted by the NNUH launched in March 2022.

Training and Development underpins transformation, N&W LMNS have a team of innovative Practice Development Midwives who we are proud to announce won Team of the Year at the East of England Maternity Awards**.**

Digital and Data is a priority area of focus for the LMNS and to support this work the LMNS Digital Midwife chairs the DMERG (Digital Midwives Eastern Region Group)

The LMNS Prevention work continues to develop system wide support with Maternity Health Advisors (MHAs) in post. A Maternity connect digital gifting project launched and Smoking advisors recruited to and a new Smoking in Pregnancy (SiP) service launched at JPUH 01/08/2022.

Pelvic Health Project – This EI project has now launched taking the innovative approach of leadership via a Pelvic Health physio therapist and the appointment of Therapy Assistant Practitioners. Delivery of successful webinars attracting attention from regional & national colleagues, and the service was fully launched on 01/08/2022.

Covid Vaccination Programme – During Covid 19 to ensure vaccinations were taken up during pregnancy the ICB supported a targeted programme to encourage informed decision making around vaccinations with additional communication about perceived risks and the known benefits, this included a poster campaign, live webinar and production of a multi-language video. The LMNS staff were deployed across Norfolk &

Waveney to support the vaccination campaign. All Trusts ensured a “one stop shop” approach to vaccinations was offered to the whole family whilst attending for ante natal clinic.

5. Conclusion and Next Steps

The LMNS Programme has a clear plan for deliverables and is developing a robust approach to Quality and Safety Surveillance. Risks and challenges within the system are being highlighted and appropriate actions taken.

The LMNS Board will continue to receive detailed reports and take actions as required, with the expectation that it will report to the ICB on delivery of the Transformation Programme, the quality and safety oversight of services and the Capacity and Capability Framework action plan.

6. Recommendations

For the ICB Board to:

- Note the work undertaken by the LMNS to deliver the Maternity Transformation Programme
- Recognise their responsibility under the Capacity and Capability Framework
- Note the LMNS role in Quality and Safety Oversight and response to the Ockenden report
- Note the LMNS Programme risks and mitigating actions begin undertaken to address these
- Agree that a LMNS Programme update is resented to ICB in 6 months’ time

Update to the Integrated Care Board

Tim Eyres, Assistant Director for Commissioning and Partnerships –
Norfolk Children's Services

Rebecca Hulme, Associate Director of Children, Young People and Maternity –
NHS Norfolk and Waveney ICB and Norfolk Children's Services

September 2022

Some context

The Children and Young People Strategic Alliance (CYPSA) has the ambition that Norfolk is a place where all children and young people can Flourish.

The Strategic Alliance brings together representatives from a wide range of partner organisations and sectors to collaborate and respond the needs of children, young people and families through the delivery of '*Flourishing in Norfolk*' as our Children and Young People Partnership Strategy, with senior representatives from:

- Children's Services and Adult Services
- Health – including the ICB, Public Health, key community health providers and acute hospitals
- Education – including schools and post-16 provision
- Criminal Justice – including Norfolk Constabulary, Office of Police & Crime Commissioner, Probation Service and prisons
- Safeguarding partnerships
- Communities – including district councils, housing providers, VCSE sector and DWP
- Service User groups

What FLOURISH means

It is about our ambition as a strategic partnership:

Each letter of FLOURISH reflects an aspect of children and young people's lives that they have told us is important to them

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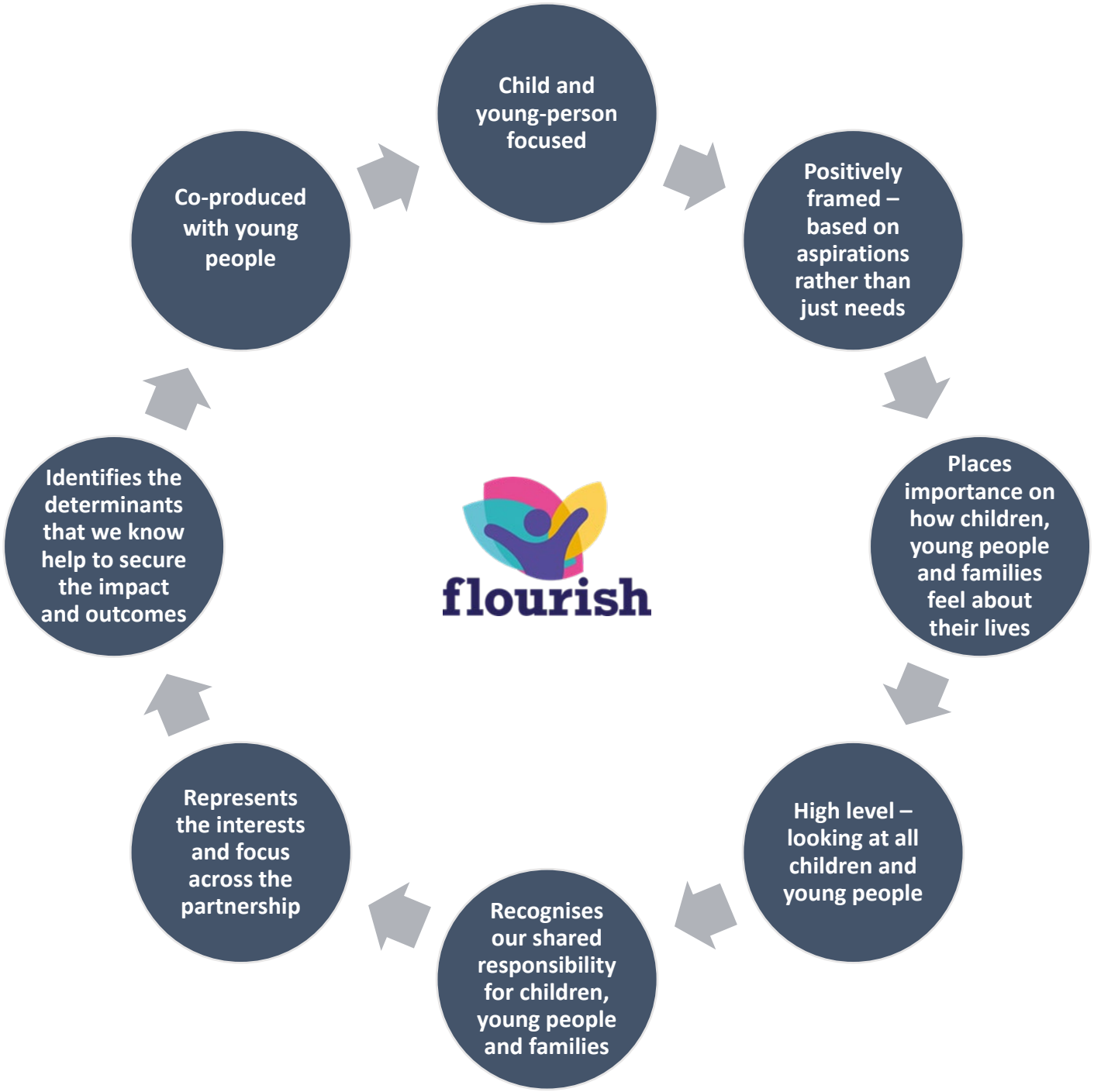
FLOURISH as an Outcomes Framework



FLOURISH includes …

Impact statements

- The long term sustainable change we want to secure for children and young people, through working together as a system

Outcomes

- The differences we want to make for children and young people, which if achieved, will lead to the impacts being secured

Determinants

- The things that we need to focus on and secure if we want to achieve the outcomes (and thereby the impacts), often determined by research, professional knowledge and evidence

Measures

- A set of 'proxy' measures which help evidence whether the outcomes (and thereby the impacts) are being achieved, and enable us to know we are making a positive difference

Family & Friends	Learning	Opportunity	Understood	Resilience	In
Children and young people are safe, connected and supported through positive relationships and networks	**Children and young people are achieving their full potential and developing skills which prepare them for life**	**Children and young people develop as well-rounded individuals through access to a wide range of opportunities which nurture their interests and talents**	**Children and young people feel listened to, understood and part of decision-making processes**	**Children and young people have the confidence and skills to make their own decisions and take on life's challenges**	Chi pec as i con ide app the uni
• As many CYP as possible are able to live safely with family • Where CYP are not able to live with their family, they have the support they need to build a stable foundation of positive relationships • CYP have positive childhood experiences in their homes, schools and communities • CYP have the support they need from their parents and carers • CYP have positive role models and trusted adults in their lives • CYP have the skills and opportunities to develop positive friendships and relationships which support them throughout their lives	• CYP establish a great early years foundation for learning and see the benefit in becoming lifelong learners • CYP enjoy learning and developing skills and feel positive about what they can achieve • CYP have good engagement with learning in and out of school, including attendance and extra-curricular opportunities • CYP make the best possible progress in learning and education • CYP are supported by families, professionals and communities at all stages of their development • YP are equipped with the skills and confidence to live as independently as possible	• CYP have improved equity of opportunity through the removal of barriers including improved economic, geographical and digital inclusion • CYP have a wide range of education, employment, training, social and community activities available to them • All CYP, at every age and regardless of disability or additional needs, have access to opportunities that suit their needs and ambitions • CYP have the emotional, personal and practical support they need to make the most of the opportunities available	• CYP are active, respected and included members of their communities as individuals and collectively • All CYP voices are influential in all decisions made about their lives • CYP feel adults respect their views and opinions and promote CYP influence • CYP know their rights, how to make their views known and are confident to speak up • CYP are confident that all strategies and services for CYP have their needs and ambitions at their heart • CYP are confident that their voice will make a difference and can see the impact they are making	• CYP can understand and make good decisions and are empowered to do so • CYP know what independence entails and are able to transition in the best way for them • CYP are supported to try new things, have a variety of experiences and be curious and aspirational • CYP understand life can be complicated and know asking for help is OK • CYP can recognise when they need help and have choice and control over the support they receive • CYP have a range of options for support and advice	

Family & Friends	Learning	Opportunity	Understood	Resilience	I
• Effective, accessible universal preventative services • Risk and safety mitigation and management • Edge of care support • Safe, stable places to live • Healthy peer relationships • Trusted, safe relationships with adults	• Effective, sufficient, high quality learning provision • Access to life-long learning and skills development • Inclusive and preventative practices • Peer support • Good home learning environments • Engagement with learning	• Understanding of inequalities and barriers • Removal of barriers • Availability of pathways	• System commitment to participation • Embedded co-production • Empowerment of children and young people • Engaging promotion • Children, Young People and Family-led planning • Feedback and encouragement • Advocacy of children and young people's views	• Basic needs are met • Effective transition planning • Risk coaching and mitigation	

How we are using FLOURISH to make a difference for children, young people and families

It enables us to agree and use a common language to define our aims and the outcomes we want to achieve.

It helps everyone think about their contribution, as part of a wider set of services and agencies, to enable children and young people to flourish.

It informs how we best use our collective resources to achieve the impact we need to see for children, young people and families.

It helps us understand the impact of our services and work together – so that we know what difference we are making and what else we need to do.

Making a Flourish Pledge

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- A promise to Norfolk's children and young people that all organisations and sectors can make
- A way to publicise Flourish widely across the county as a truly shared ambition
- A way to turn our shared ambition into reality in what we all do as organisations
- A way to demonstrate and record what different sections of Norfolk's society are doing to help our children and young people to flourish
- A Flourish Pledge 'mark' that can be used by organisations and groups committing to help children and young people to flourish
- There is an offer of support to organisations to help make Flourish a reality in what they do

And for the future: Annual Flourish Awards that recognise and celebrate what is being done, overseen by children, young people and parents/carers, and exploring partnership opportunities to develop a 'Flourish Fund'

Flourishing in Norfolk

Our Children and Young People Partnership Strategy 2021 – 2025

Our *Flourishing in Norfolk* priorities:

1. Strengthening our shared focus and approach on **Prevention and Early Help**

2. Working together to support children and young people's **Mental Health and Emotional Wellbeing**

3. Improving support for children and young people with **Special Educational Needs and Disabilities (SEND)**

4. Addressing gaps in **Learning** following the pandemic

ICB colleagues are actively engaged in the work being undertaken to address these priorities.

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What does FLOURISH already mean for the ICB?

- The ICB is a strong partner in our Children and Young People Strategic Alliance arrangements and has fully endorsed Flourish as our shared ambition and is committed to our Flourishing in Norfolk strategy.
- The Chair of the ICB has already made a Flourish Pledge!
- ICB colleagues and health providers (community, primary care, and acutes) are fully engaged in CYPSA's associated subgroups linked to prevention & early help, mental health, and SEND.
- The ICB is a key partner in Norfolk's Safeguarding Children Partnership and associated activity, which is also aligned to Flourish.
- Our Children's Integrated Commissioning Group (ChICG), alongside joint working within CYPSA priority subgroups, is supporting joint commissioning between Children's Services, other parts of the council, and the ICB.
- There is agreement from ICB colleagues on establishing a joint funding panel for children and young people with complex needs (those that require social care, education and health support)

What is the ‘FLOURISH’ ask from the ICB?

1. To provide leadership within the health system to secure continued commitment to Flourish as our shared ambition for children and young people.
2. To promote and encourage health partners to make and deliver a Flourish Pledge.
3. To work with CYPSA as a strategic partnership mechanism to champion the needs of children and young people within the all-age focus of ICS, to help ensure that they are flourishing.
4. To support the development and operation of a Joint Social Care and Health Assurance Board that enables Children’s and Adult Services to jointly commission and address system issues with the ICB, including in relation to our Flourishing in Norfolk priorities.
5. To help embed effective joint funding arrangements for children and young people with complex needs so that they can Flourish.
6. To continue to support CYPSA’s work in relation to data about how well children and young people are flourishing, sharing stakeholder engagement & insight, and collaborative workforce development.

Waveney

1. Strategic framework for Suffolk Children and Young People, currently under development
2. Norfolk and Waveney ICB partner in this work
3. 5 key priorities
    - Improving health & reducing health inequalities
    - Improving Mental Health & Emotional Wellbeing
    - SEND
    - Providing timely support to Neurodiverse Children and Young People
    - Providing integrated health & care support and services to Children and Young People with complex health needs

This work will continue to develop through the Autumn as an integrated partnership approach.

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Questions and Comments

Tim Eyres – tim.eyres@norfolk.gov.uk
Rebecca Hulme – rebecca.hulme1@nhs.net

Improving lives **together**
Norfolk and Waveney Integrated Care System

NHS
Norfolk and Waveney

Mental health transformation – update September 2022

Jocelyn Pike – Acting director of mental health transformation

Context

- Health and care systems face significant challenges including rising demand, workforce challenges and legacy funding gaps.
- NHS England has stated that the challenges facing providers are too much for any ‘single organisation to tackle’, the answer being a national policy focus on addressing these through system working and exploring the potential of working at scale. (Kings Fund, April 2022)
- The 2022 Health and Care Act establishes the legislative framework that promotes better joined-up services. This includes a duty for all health and care organisations to collaborate to rebalance the system away from competition and towards integration.
- Discussions over collaboration across mental health (MH) in Norfolk and Waveney have been a focus for several years. In 2019 both the adult and children and young people’s (CYP) MH strategies respectively placed integration at the heart of their service models moving forward.
  - Evidence of this in action has been the formation of the Children and Young Peoples Mental Health Alliance and the Flourish model of care; a direct product of the 2019 CYP’s MH strategy.
- Locally the requirement to accelerate MH transformation has been heightened with the challenges faced by the principal MH provider, Norfolk and Suffolk Foundation NHS Trust (NSFT). One of the three objectives of their current CQC Improvement Programme focuses on a need to:

  “Support the rapid recovery of NSFT by harnessing the strength of local system partners” (NSFT Improvement Programme 2022)

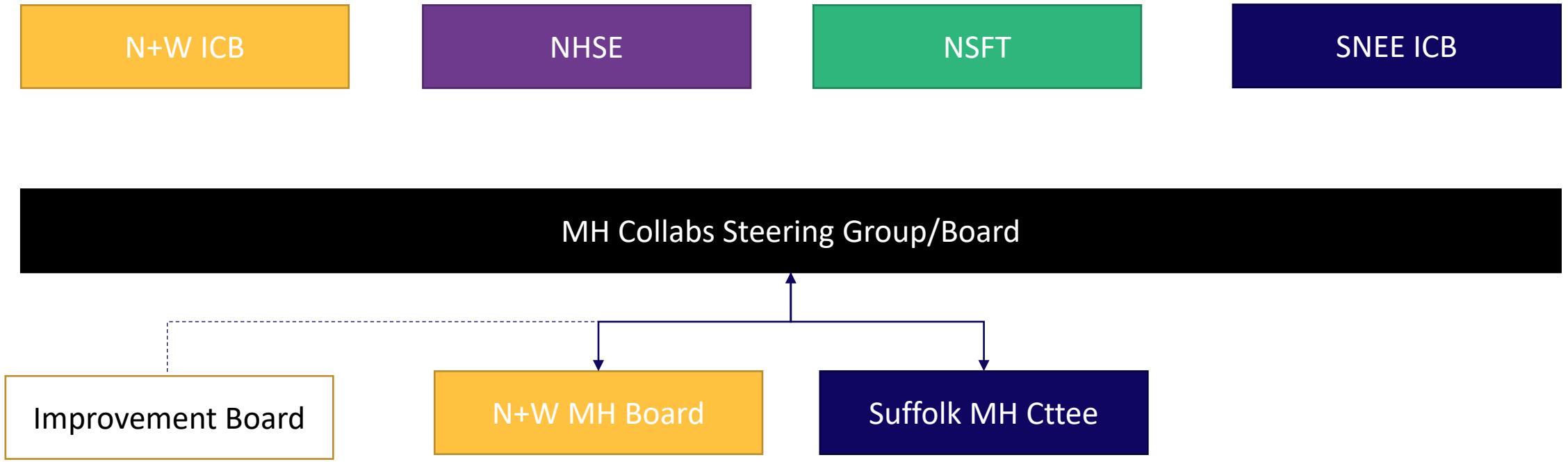
What are we doing? - function

- Engagement task and finish group
  - Service review
    * Engagement
      ……with our patients and our public
      ……with our staff
      ……with key partners – including primary care, VCSE
      ……with elected officials
    * To seek views on what, if any services might be better delivered in a community or non-statutory setting
    * To understand the order of priority for any such re-provision
    * To revisit some of the themes of the 2019 CYP and adult strategies to see if they are still relevant
  - 6 month engagement Oct 22-April 23

What are we doing? - form

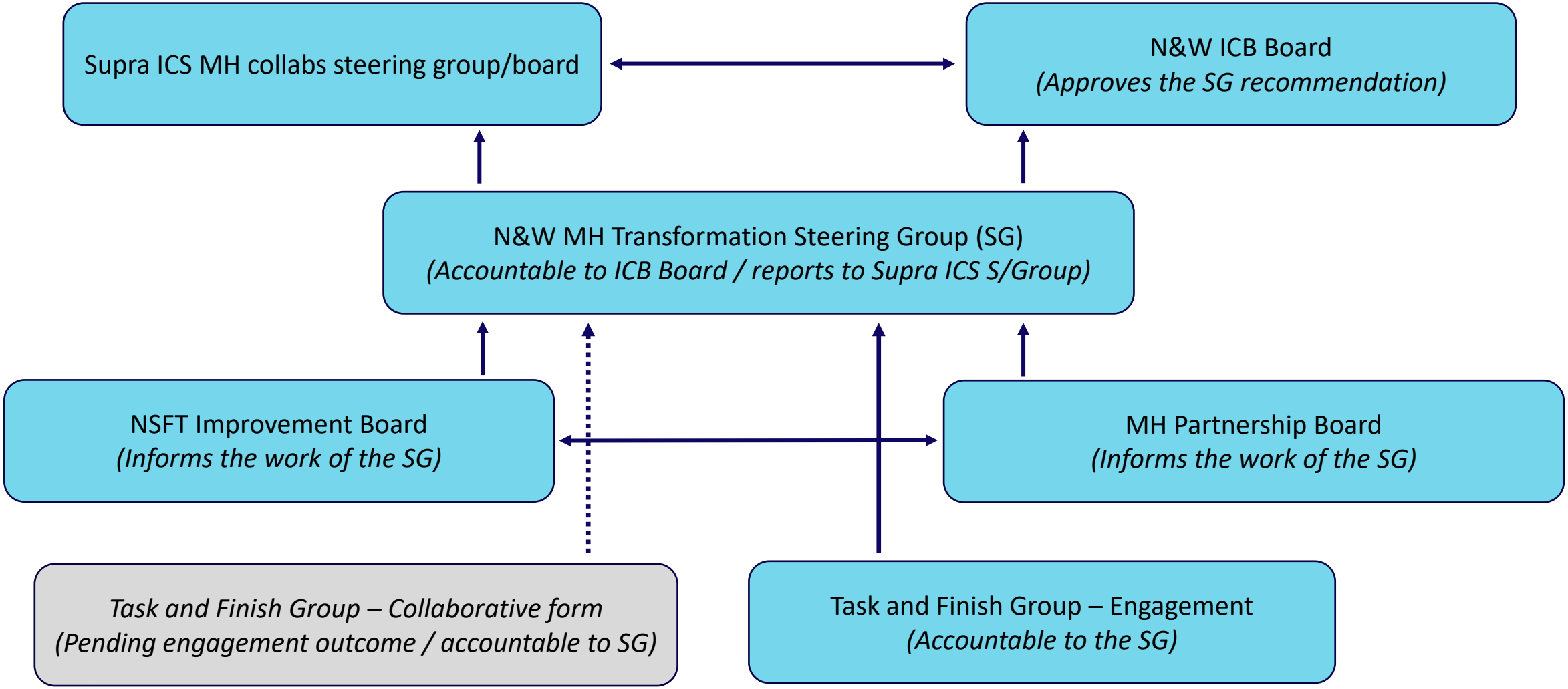
- Collaborative form task and finish group
  - Pending the outcome of the 6 month engagement (Oct 22-April 23)
  - Pending the outcome of the CQC inspections at NSFT
    * To agree on the optimum collaborative form for MH services across N&W
    * To agree the phasing and scale of ambition – for example partnership working – collaboration – provider collaborative/s
    * To identify the level of maturity required to progress through each phase
    * To establish infrastructure to commence phased mobilisation from quarter 3 23
  - 6 month April 23-October 23

Mental health transformation – Supra ICS governance (as at Aug 22)



- Four sponsoring organisations – N+W ICB, NHSE, NSFT and SNEE ICB make up the membership of the MH Collabs Steering Group/Board
- Each organisations has their own Board/Cttee accountable for related programmes of work which are brought together where relevant through the MH Collabs Steering Group/Board
- Identified, interdependent aspects of NSFT Improvement Programme to be incorporated into Collaborative programme oversight and management

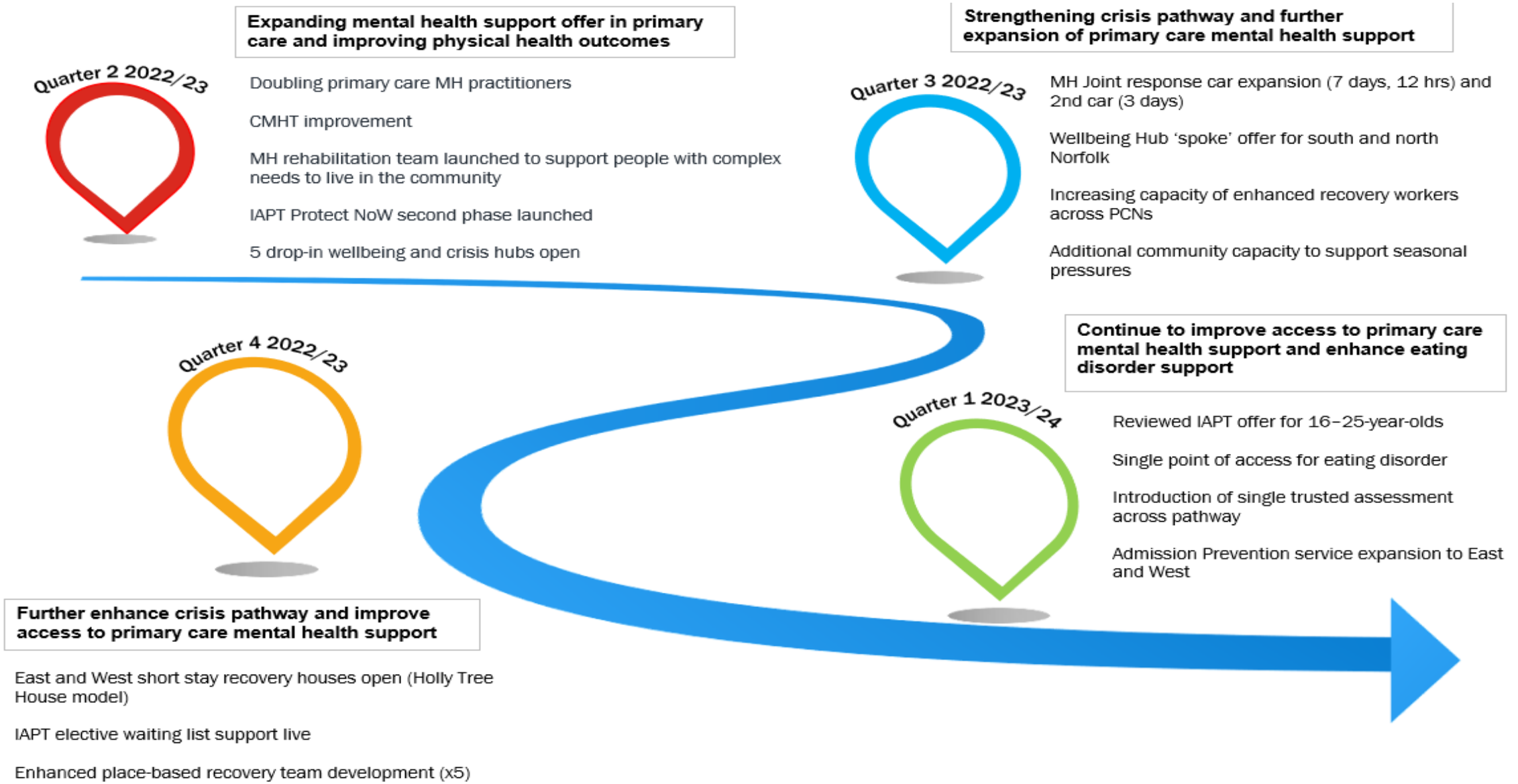
Mental health transformation – N&W governance (proposed)



Key issues for consideration to include…

- Clear communication and an open dialogue with staff to ensure continuity of service is maintained and concern over the ‘future state’ is minimised.
- Communication and dialogue with patients, public and key partners inclusive of the media and elected officials
- Interdependencies and ongoing dialogue with Suffolk to ensure no decisions are taken that arbitrarily affect NSFT’s ability to continue to deliver services.
- Similarly sensitive to/cognisant of service provision in Waveney that cuts across differing local authority boundaries.
- Clinical oversight and leadership as the deciding factor underpinning any decisions taken
- The requirement to continue, today, to deliver, to innovate and to contribute to system working….. see next two slides…

Adult mental health transformation: examples of new initiatives



Children and young people mental health transformation: examples of new initiatives

Initiative	Intended Impact	By When
Mental Health Support Teams	Currently 6 teams offering early intervention MH support across schools in N&W. This winter a 7th and 8th team will be recruited to. The current teams can support 3000 individuals per year (increasing to 4000 in 2023 and 5000 in 2024)	Jan 2023 (two further teams in 24/25)
Community Youth Work Pilot	Piloting a new youth work team in GY and KL to work with primary care and education settings to offer person centred support to prevent the need for a referral to specialist MH services. 200 individuals will be offered extended 1:1 support during the year with more benefitting from lunchtime drop ins and advice sessions	October 2022-October 2023
Integrated Front Door Development	A single point of access for all MH enquiries and referrals - services will be easier to navigate and offers of support will be made at an earlier opportunity (particularly due to enhanced digital offers of support).	Expected Spring/ Summer 2023
Waitlist Initiatives	Waitlist initiatives utilising a combination of agency staff and VCSE provision; projected to directly support 1100 individuals on current waiting lists by April 2023.	Ongoing
The Lighthouse	Day support and respite to family and individuals who have an eating disorder. Exploring expansion of offer (via a hub and spoke type approach) to expand the reach over time.	Open.
Integrated Practice Model	Working with local authority to establish an integrated practice model for where there is complexity and potential safeguarding concerns. Exploring role of psychiatric liaison and dedicated roles within acutes to meet the needs of those in crisis. RUSH (rapid response to self-harm) pathway continues to support individuals presenting across all 3 acutes	Ongoing
Alternatives to Admission/A&E	Exploring opportunities to divert away from A&E in a crisis where there is not a need for an admission. Intensive Day unit and 72 hour respite (Little Acorns) being scoped and business case submitted. Exploring integration with adult 24/7 crisis response e.g. first response cars and wellbeing hubs/crisis cafes.	Pilot Nov 2022-March 2023

Improving lives **together**

Norfolk and Waveney Integrated Care System

NHS

Norfolk and Waveney

Agenda item: 12

Norfolk and Waveney
Integrated Care Board

Subject:	**Adult Eating Disorders Procurement**
Presented by:	**Steven Course, Director of Finance**
Prepared by:	**Roy Weston, Associate Director of Contracting and Procurement**
Submitted to:	**ICB Board**
Date:	**27 September 2022**

Background

The provision of adult eating disorders services is recognised as a key area for development in the NHS Long Term Plan, following significant development and investment in eating disorder services for children and young people. The National Institute for Clinical Excellence (NICE), in collaboration with NHSE/I and the National Collaborating Centre for Mental Health, recommend that the optimal model for delivery of these services is through a 'dedicated, multidisciplinary eating disorder service...delivered in the community'. These services should ideally serve a geographical area with a population of 1 million or greater (all-age), with the skills and competencies to care for a range of people, including first time presentations, long-term and enduring problems and those with comorbid conditions.

This contract will be advertised and procured on the basis of an initial five year contract period, with an option to extend for a further 24 months (seven years in total). The rationale for contract length is that in order to encourage the provider to establish or continue to maintain key relationships in Norfolk and Waveney this needs to be of a substantial length. The length of contract will also enhance the levels of interest from highly specialist providers with suitably qualified workforce.

The existing service value (based on 2022/23 contracts) is £2.6m p.a.. Therefore the award value associated with this procurement is £18m plus annual incremental uplifts during the term of the contract.

The current service is delivered by two organisations in Norfolk and Waveney;

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) operating as Norfolk Community Eating Disorders (NCEDS) - for the areas of North Norfolk, South Norfolk, West Norfolk and Norwich.

Norfolk and Suffolk Foundation Trust (NSFT) - for the area of Great Yarmouth and Waveney.

The intent is to recommission specialist community adult eating disorders services for the whole Norfolk and Waveney ICB footprint under a single service provider.

Procurement Approach

The proposal is to undertake an 'Expression of Interest with evaluation' (EoI) to assess the markets interest in the future delivery of these services. The evaluation process will consist of Pass / Fail criteria to assess the capabilities and capacity of those registering an interest in this service. There are two potential outcomes with this approach;

1. If only one expression of interest is received or only one provider scores Pass for all criteria, we can undertake a "negotiated process without prior publication" (under Regulation 32 of the Public Contracts Regulations 2015). This will mean that we are able to award a contract without further procurement.

2. If more than one expression is received and all Pass criteria is met, a formal competitive process will be undertaken. This would require a procurement under the Light Touch Regime (LTR) and will take six months to complete.

The initial Expression of Interest process will be completed on 26 September. At that date we will know whether there is more than one viable provider available.

Based on the ICB Detailed Delegated Financial Limits, approval to commence a procurement with an award value above £5m requires ICB Board approval. This paper is requesting that the Board approves that;

1. If a single capable provider has been identified through the Expression of Interest process (option 1 above) that the ICB can proceed to make an award under Regulation 32 of the Public Contracts Regulations 2015, or

2. If more than one Expression of Interest has been received that meets the Pass criteria, that a procurement is undertaken under the Light Touch Regime of the Public Contracts Regulations 2015.

Recommendation to ICB Board:

The Board is asked to approve that;

1. If a single capable provider has been identified through the EoI process, that the ICB Makes an award to a single capable provider (as described in option 1), or

2. If there is more than one capable provider identified through the EoI that the ICB commences a Light Touch Regime procurement as defined in the Public Contracts Regulations 2015.

Key Risks	
Clinical and Quality:	If the decision to either award under Regulation 32 or commence a LTR procurement is delayed, then the contract award will not be made before the current contracts expire. This may affect the accessibility of services for patients in Norfolk and Waveney.
Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	If the decision to either award under Regulation 32 or commence a LTR procurement is delayed, then the contract award will not be made before the current contracts expire. This may affect the accessibility of services for patients in Norfolk and Waveney.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

GOVERNANCE

Process/Committee approval with date(s) *(as appropriate)*	N/A

Norfolk and Waveney
Integrated Care Board

Agenda item: 13

Subject:	**Month 5 (August) ICB Finance Report**
Presented by:	**Steven Course, Director of Finance**
Prepared by:	**ICB Finance Team**
Submitted to:	**ICB Board**
Date:	**27th September 2022**

Purpose of paper:

To review the financial performance and financial risk of the Norfolk and Waveney Integrated Care Board, as a statutory organisation.

Executive Summary:

Integrated Care Board (ICB) statutory organization has reported a year-to-date break-even position, which is in line with the plan submission.

The ICB forecast out-turn (FOT) position is also a break-even position, in line with the plan submission on 20th June (as part of the system plan).

The full value of potential risks to the full year position amount to £16.3m – these are items which have not yet crystalised but have been identified as having the possibility of producing a financial issue.

The combined Integrated Care System (ICS) has a year-to-date deficit position of £4.3m, which is adverse to plan by £2.8m.

This is driven by deficits at the JPUH (£3.2m) and QEH (£2.1m), offset by NCH&C surplus (£1.0m), all other organisations are reporting a break-even position.

The ICS FOT position remains at break-even, in line with the plan submission on 20th June.

Report

As attached

Recommendation to the Finance Committee:

This report is presented for information.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	Achievement of Financial plan
Impact Assessment (environmental and equalities):	None
Reputation:	The achievement of the plan impacts the CCGs reputation with NHSE/I.
Legal:	None
Information Governance:	None
Resource Required:	None
Reference document(s):	NHSE/I guidance and communications
NHS Constitution:	None
Conflicts of Interest:	None
Reference to relevant risk on the Board Assurance Framework	None

Governance

Process/Committee approval with date(s) (as appropriate)	N/a

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Norfolk and Waveney Integrated Care System

Integrated Care Board Finance Report

August (month 05)

Board: 27th September 2022

Contents

1. Executive Highlights

Integrated Care Board (ICB) statutory organisation

- This report represents the year-to-date August position of the organisation – this comprises the April to June CCG position (pre-audit), plus the July to August ICB position.
- The consolidated CCG and ICB has reported a **year-to-date break-even position**, which is in line with the plan submission, this is a result of some offsetting variances, the major items being:
  - £(1.7)m increase in acute independent sector activity;
  - £(1.1)m Elective Recovery Fund underachievement;
  - £(1.1)m Continuing Health Care (CHC) excess inflation, above funded levels; offset by
  - £1.8m benefit relating to the movements against year-end accruals in CHC, Primary Care and Prescribing;
  - £0.5m pay vacancies throughout the organisation.
- The **ICB forecast out-turn (FOT)** position is also a **break-even position**, in line with the plan submission on 20th June (as part of the system plan – see below).
- The plan included £5.4m of unmitigated risks in line with NHSEI guidance – relating to excess CHC inflation and Elective Recovery Fund (ERF) income – these risks continue at this level and have not been mitigated at present.
- The full value of potential risks to the full year position amount to £16.3m – these are items which have not yet crystalised but have been identified as having the possibility of producing a financial issue.

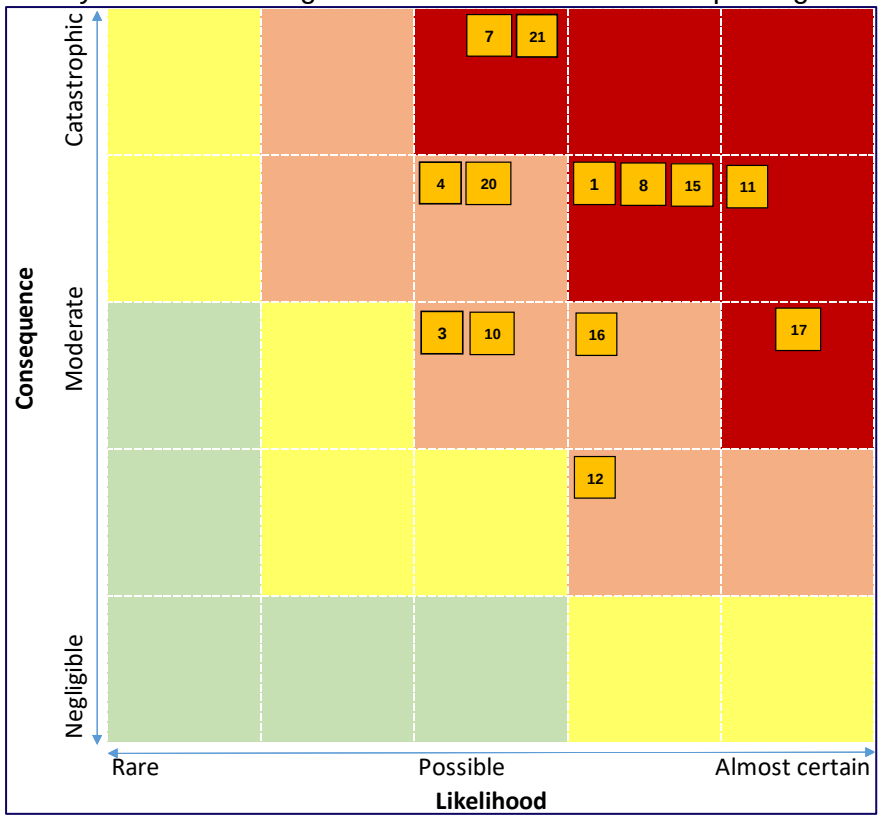
Integrated Care System (ICS)

- The combined ICS has a **year-to-date deficit position of £4.3m**, which is adverse to plan by £2.8m. This is driven by deficits at the JPUH (£3.2m) and QEH (£2.1m), offset by NCH&C surplus (£1.0m), all other organisations are reporting a break-even position.
- The **ICS FOT** position remains at **break-even**, in line with the plan submission on 20th June.

2. ICB Strategic Financial Risks

This risk dashboard categorises the key financial strategic risks by their impact and likelihood to help the strategic focus to be on those that will cause the ICB the greatest issues.

Key: = Worsening Risk = Stable risk = Improving risk



Financial Strategic Risks	Ref.	Details	Risk appetite	Jun-22	Jul-22	Aug-22	Sep-22
Achievement of Financial plan	1	Achieve the 2022/23 financial plan	8	16	16	16	16
	3	Transition following end of HDP top up allocations	6	9	9	9	9
	12	Personal Health Budgets (PHB)	4	15	15	8	8
	15	Underlying deficit position	12	20	20	20	20
	16	Capita - Primary Care payments	9	12	12	12	12
	17	Inflationary pressures	9	15	15	15	15
	19	ISP patient choice	9	9			
	20	Impact of new prescribing guidance	8	12	12	12	12
	21	Impact of Direct Commissioing transfer			15	15	15
Demand and capacity	4	Capacity increases in response to COVID continue	8	12	12	12	12
	5	System approach to service redesign	9	15	15		
	7	Continuing Health Care demand growth	6	15	15	15	15
	9	Acute demand management	8	12	16		
	10	Treatment breaks / cancelled operations	6	9	9	9	9
	11	RTT backlog and Acute demand management	10	20	20	20	20
	18	Care Home capacity	12	12			
Efficiency	8	Efficiency, transformation development/delivery	8	16	16	16	16

There have been no changes to the risks in month.

Of the thirteen open risks seven are rated as extreme (score of between 15 and 25):

- Four relating to the Achievement of the Financial Plan risks;
- Two relating to Demand and Capacity risks; and
- One relating to Efficiency delivery risks.

None of the open risks are currently at their tolerated risk appetite and ongoing management actions are in place to monitor and mitigate the impact of these risks.

3. ICB Statement of Financial Position (SOFP)

The Statement of Financial Position presents the aggregate closing position of the ICB as at 31st August 2022.

Non Current assets:
IFRS16 was implemented in April 2022, this resulted in the inclusion of right of use assets relating to the lease of the premises in King's Lynn. A corresponding entry is also included in Lease Liabilities.

Current assets:
Total current assets have decreased since year end, driven principally by aged debtors and cash. The £3.7m balance is made up of the net aged debtors , prepayments and accrued income of £1.4m. Trade debtors are subject to a quarterly review of bad debt for provision or write off, which are presented to the Audit Committee.

Current liabilities:
Total current liabilities has decreased by £30m since year end driven principally by ICB and system invoice accrual timing. The £163m balance is made up of trade creditors of £2m, Prescription Pricing Authority accruals of £20m, payroll costs including GP pensions of £3m, deferred income of £6m, prior year accruals of £77m and ICB and system invoice accruals of £55m. Provisions have increased since year end and include legal, staffing, estates costs, prescribing and elective recovery claw-back for 2021/22.

Long Term liabilities:
This balance is the deferred income relating to research & development programmes which are funded in advance.

Taxpayers equity:
The ICB is directly funded by NHSE with funding allocated on a monthly basis. Any future commitments to balance the general fund shortfall will be supported by the next months funding request from NHSE. This will however continue to remain negative as the NHSE principle is that funding should only be drawn based upon one months commitment at a time.

NHS NORFOLK & WAVENEY ICB STATEMENT OF FINANCIAL POSITION	Position as at 31/03/22	Position as at 31/07/22	Position as at 31/08/22
ASSETS EMPLOYED			
Non-Current assets			
Right-of-use-Assets	0	66	66
Accumulated Depreciation	0	(18)	(22)
Total non-current assets	0	48	44
Current assets			
Trade and Other Receivables	9,552	2,575	3,693
Cash and Cash Equivalents (less Cash in Hand)	1,481	616	932
Cash in Hand	0	0	0
Total current assets	11,033	3,191	4,625
Current liabilities			
Trade and Other Payables	(195,365)	(164,441)	(163,188)
Lease Liabilities	0	(53)	(53)
Provisions for liabilities and charges (including non-current)	(5,194)	(7,670)	(7,670)
Total current liabilities	(200,559)	(172,164)	(170,911)
Long Term liabilities			
Non-Current Payables	(612)	(612)	(612)
Total non-current liabilities	(612)	(612)	(612)
Net assets employed	(190,138)	(169,537)	(166,854)
FINANCED BY TAXPAYERS EQUITY			
General fund	(190,138)	(169,537)	(166,854)
Total taxpayers equity	(190,138)	(169,537)	(166,854)

4. Operational Risks and Mitigations

The table opposite identifies the significant Financial risks the ICB is experiencing, including the impact that has crystalised in the year to date position, totalling £2.4m ❶; together with the risk that is included within the year end forecast position, of £10.8m (£7.0m M04) ❷.

The Forecast risk includes £4.5m of unmitigated risk identified within the planning submission relating to CHC excess inflation (£1.7m ❸) and ERF income (£2.8m ❹).

In addition, the ICB has identified a net potential uncrystallised unmitigated risk of £16.3m ❺ (M04 = £16.2m), of this, £8.6m ❻ relates to system risk that is being "held" by the ICB.

BAF Reference	Risk Ref.	Risk Details	Risk Score	Prior Month	YTD Crystalised £m	Crystalised in FOT £m	Not in FOT £m
N/a	1	**If** Prescribing for Mental Health continues to reduce **then** further Investment will be needed to ensure delivery of the Mental Health Investment Standard which will exceed the ICBs budget.	3 x 4 = 12	3 x 4 = 12	0.0	0.0	0.8
FINCOM19	2	**If** the Independent Sector Acute activity for Opthalmology increases **then** the ICB will exceed the Acute budgets.	4 x 3 = 12	4 x 3 = 12	0.6	4.5	0.5
N/a	3	**If** the Integrated Community Equipment Store Prices and Volume increase **then** the ICB will exceed the Community budgets.	4 x 3 = 12	4 x 3 = 12	0.2	0.2	0.2
FINCOM08	4	**If** the ICB does not deliver the Efficiency plans embedded in its forecast **then** the ICB will exceed the budgeted spend (Schemes identified as High or Medium Risk)	4 x 4 = 16	4 x 4 = 16	0.0	1.6	4.7
FINCOM20	5	**If** the uptake of the Continued Glucose Monitoring Testing and Drugs is undertaken following NICE guidance **then** the ICB will exceed the GP Prescribing budgets.	3 x 4 = 12	3 x 4 = 12	0.0	0.0	1.7
FINCOM07	6	**If** the Continuing Health Care Non-NHS market Price Rises exceed the forecasted 11% rise overall **then** the ICS will exceed the budget.	3 x 5 = 15	3 x 5 = 15	0.4	1.7 ❸	0.3
FINCOM11	7	If additional ERF actiivty is not achieved then this causes a full year financial adverse variance.	5 x 4 = 20	5 x 4 = 20	1.2	2.8 ❹	0.0
N/a	8	**If** the ICS System partners do not achieve the Efficiency Savings in relation to the Back Office Staff **then** the ICB who hold the gross £(5)m budget will exceed the budget.	5 x 4 = 20	2 x 4 = 8	0.0	0.0	4.5 ❻
N/a	9	**If** the ICS do not defer the System Development Fund projects **then** the slippage assumed in the plan will not be achieved and the ICB will exceed the budget.	3 x 4 = 12	3 x 4 = 12	0.0	0.0	4.1
N/a	10	**A**ggregated other smaller net risks across all portfolios	2 x 3 = 6	2 x 3 = 6	0.0	0.0	5.6
		Total Risks			**❶ 2.4**	**❷ 10.8**	**22.2**
N/a	1	**If** the ICB can secure additional external funding for the NICE approved CGM prescribing costs **then** the ICB will be able to mitigate some presures within the budget.	2 x 3 = 6	2 x 3 = 6	-	-	(1.7)
N/a	2	Aggregated other smaller mitigations across all portfolios	2 x 3 = 6	2 x 3 = 6	(2.4)	(10.8)	(4.3)
		Total Mitigations			**(2.4)**	**(10.8)**	**(6.0)**
FINCOM01		**Total Financial Impact of assessed risk less identified mitigations**	4 x 4 = 16	4 x 4 = 16	**(0.0)**	**(0.0)**	**16.3** ❺

5. ICS Financial summary

Revenue position

The system financial performance is extracted from the M5 working day 9 draft NHSE/I submissions.

The position M5 YTD is a £4.3m deficit, which is £2.8m adverse against plan.

The two most significant variances are at NNUH and JPUH.

- NNUH's overspends predominately relate to the under-delivery of Cost Improvement Plans (CIP) and the additional costs of delivering the significant additional open capacity due to patient volumes with no right to reside.
- JPUH's activity performance achieves the 104%, which achieves baseline ERF but not the additional income over and above this in the plan.

All system organisations are reporting a break even forecast outturn.

Capital position (Capital Delegated Expenditure Limit – CDEL)

Year-to-date the system CDEL expenditure as at August (M5) was £25.9m, £5.1m lower than below plan.

All organisations had an underspend on core projects mainly due to delays in project roll out.

QEH have a year-to-date overspend of £3.8m on RAAC related expenditure.

The full year forecast, remain that outturn capital expenditure will be in line with full year planned levels.

Revenue surplus/(deficit)	M5 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance Fav/ (Adv)	Plan	Actual	Variance Fav/ (Adv)
	£m	£m	£m	£m	£m	£m
JPH	(1.9)	(3.2)	(1.2)	0.0	(0.0)	(0.0)
NNUH	1.8	0.0	(1.8)	0.0	(0.0)	(0.0)
QEH	(2.0)	(2.1)	(0.1)	0.0	0.0	0.0
NSFT	0.0	0.0	0.0	0.0	0.0	0.0
NCH&C	0.7	1.0	0.3	0.0	0.0	0.0
Provider Subtotal	**(1.4)**	**(4.3)**	**(2.8)**	**0.0**	**0.0**	**0.0**
ICB	0.0	0.0	0.0	0.0	0.0	0.0
N&W System Total	**(1.4)**	**(4.3)**	**(2.8)**	**0.0**	**0.0**	**0.0**

System CDEL	M5 YTD			Forecast Outturn		
Organisation	Plan	Actual	Variance (Under)/ Over	Plan	Actual	Variance (Under)/ Over
Excluding RAAC	£m	£m	£m	£m	£m	£m
JPH	3.4	1.2	(2.2)	10.2	10.2	(0.0)
NNUH	10.6	8.8	(1.8)	17.9	17.9	0.0
QEH	4.1	2.8	(1.4)	10.5	10.5	0.0
NSFT	5.4	3.1	(2.4)	9.8	9.8	(0.0)
NCH&C	2.2	1.9	(0.3)	6.0	6.0	0.0
Subtotal excluding RAAC	**25.8**	**17.8**	**(8.0)**	**54.5**	**54.4**	**(0.0)**
RAAC						
JPH	2.0	1.1	(0.9)	14.4	14.4	0.0
QEH	3.2	7.0	3.8	30.0	30.0	0.0
N&W System Total	**31.0**	**25.9**	**(5.1)**	**98.9**	**98.9**	**(0.0)**

Glossary of terms (1)

Term	Description
BCF: Better Care Fund	A programme which supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability and better outcomes for people and carers.
BPPC: Better Payment Practice Code	The NHS national payments code for good practice with associated mandated reporting. Sets a target of 95% compliance of paying suppliers within 30 days.
Cat M: Category M drugs	Part of the Drug Tariff which is used to set the reimbursement prices of over 500 medicines. It is the principal price adjustment mechanism to ensure delivery of the retained margin guaranteed as part of the contractual framework, using information gathered from manufacturers on volumes and prices of products sold plus information from the Pricing Authority on dispensing volumes to set prices each quarter.
CIP: Cost Improvement Programme	A provider measure of Efficiency and Productivity.
CHC: Continuing Health Care	A package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive funding individuals have to be assessed according to a legally prescribed decision making process to determine whether the individual has a ‘primary health need’.
GIRFT: Get It Right First Time	A national programme designed to improve the treatment and care of patients by reviewing health services. The programme undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.
GMS: General Medical Services	Contract which forms the basis of the relationship between the NHS and its GP contractors. The current contract came into force on 1 April 2004 and has been negotiated and updated annually between NHS Employers and the British Medical Association (BMA) since then. It is based upon a multi facetted formula which identifies spend and applies specific ratios resulting in an overall annual percentage pay award for each practice.
GPFV: General Practice Forward View	National development programme of investment in workforce, technology and estates designed to speed up transformation of General Practice services.
HDP: Hospital Discharge Programme	National funding stream to enable earlier discharge increasing flow in the system and release capacity in the acute hospitals.
LCS / LES: Locally Commissioned Services or Locally Enhanced Services	Services provided by GP practices that are either enhanced or additional to the core services offered. These are generally commissioned to meet a local need based on either deprivation or proximity to existing services. Includes services such as phlebotomy, anti-coagulation, atrial fibrillation and care homes. They can reduce onward referrals to Acute settings and funding is separate to practices core contracts.
Model Hospital	An NHS digital information service designed to help the NHS improve productivity, quality and efficiency. Enables health systems and trusts to compare their productivity and quality, and identify opportunities to improve.

Glossary of terms (2)

Term	Description
MHIS: Mental Health Investment Standard	The nationally set requirement for ICBs to increase investment in Mental Health services in line with their overall increase in allocation each year. This is subject to separate external audit on an annual basis to confirm compliance.
NCSO: No Cheaper Stock Obtainable	Items for which in the opinion of the Secretary of State for Health there is no product available to contractors at the price in Part VIII of the Drug Tariff, generally resulting in a higher priced product having to be used.
PHM: Population Health Management	An approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population by focusing on the wider determinants of health by using data to design new models of proactive care and deliver improvements in health and wellbeing which make best use of the collective resources.
PLICS: Patient Level Information and Costing Systems	Costing system which brings together healthcare activity information with financial information in one place. PLICS provides detailed information about how resources are used at patient-level, for example, staff, drugs, and diagnostic tests and combined with other data sources, provides trusts with a rich source of information to help understand their patients and their services.
PMS: Personal Medical Services	Voluntary option for GPs and other NHS staff to enter into locally negotiated contracts. PMS contracts offer local flexibility compared to the nationally negotiated GMS contracts by offering variation in the range of services which may be provided by the practice, the financial arrangements for those services and the provider structure (who can hold a contract).
QIPP: Quality, Innovation, Productivity and Prevention	The collective measure of system transformation efficiencies and productivity.
QOF: Quality and Outcomes Framework payments	This is a voluntary annual reward and incentive programme for all GP practices in England, detailing practice achievement results. It is not about performance management but resourcing and rewarding good practice.
Rightcare	Teams who work locally with systems to present a diagnosis of data and evidence across that population, working collaboratively with systems to look at the evidence to identify opportunities and potential threats. They use nationally collected robust data to complete delivery plans on a continuous basis, to evaluate the system and establish a base plan to maximise opportunities and turnaround issues.
Running costs / Programme costs	Running costs represent the costs of administering the ICB and the work it carries out / Programme costs represent the costs of services commissioned by the ICB.
s.117: Section 117 of Mental Health Act 1983	Entitlement to free after-care if a patient has been in hospital under specific sections of the Mental Health Act 1983. It meets the needs that a patient has because of the mental health condition that caused them to be detained and is designed to reduce the chance of the condition getting worse so avoiding a return to hospital.

Norfolk and Waveney
Integrated Care Board

Agenda item: 14

Subject:	**NHS Norfolk and Waveney CCG Annual Report and Accounts 2021 to 2022**
Presented by:	**Karen Barker, Director of Corporate Affairs and ICS Development**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**ICB Board**
Date:	**27 September 2022**

Purpose of paper:

To present the Annual Report and Accounts of NHS Norfolk and Waveney CCG for the period 1 April 2021 to March 2022.

Executive Summary:

In accordance with the national timetable the penultimate Annual Report and Accounts for the former NHS Norfolk and Waveney CCG was submitted to NHS England to meet its deadline of 22 June 2022.

The Annual Report and Accounts is attached for information and is also published on the ICB Website here. This meets the requirement to publish the report by 30 September 2022.

An Easy Read Annual Report and a Summary Annual Report have also been produced and are also available on the Website.

The final Annual Report and Accounts for the CCG covering the period 1 April 2022 to 30 June 2022 is being prepared with the final submission to NHS England due in June 2023.

Recommendation to the Board:

The Board is asked to note the Annual Report and Accounts for the former NHS Norfolk and Waveney CCG for the period 1 April 2021 to 31 March 2022.

Key Risks	
Clinical and Quality:	N/A

Finance and Performance:	N/A
Impact Assessment (environmental and equalities):	N/A
Reputation:	The Annual Report and Accounts is a key document for the organisation. It sets out the objectives and achievements as well as how the organization has complied with regulatory requirements and guidance. The document also reports on how money has been spent and is audited by external auditors.
Legal:	Production of an Annual Report and Accounts is a statutory requirement. The document is prepared in accordance with the Department of Health and Social Care Group Accounting Manual guidance.
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Board for noting.

Norfolk and Waveney
Clinical Commissioning Group

NHS Norfolk and Waveney CCG Annual Report 2021/22

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.

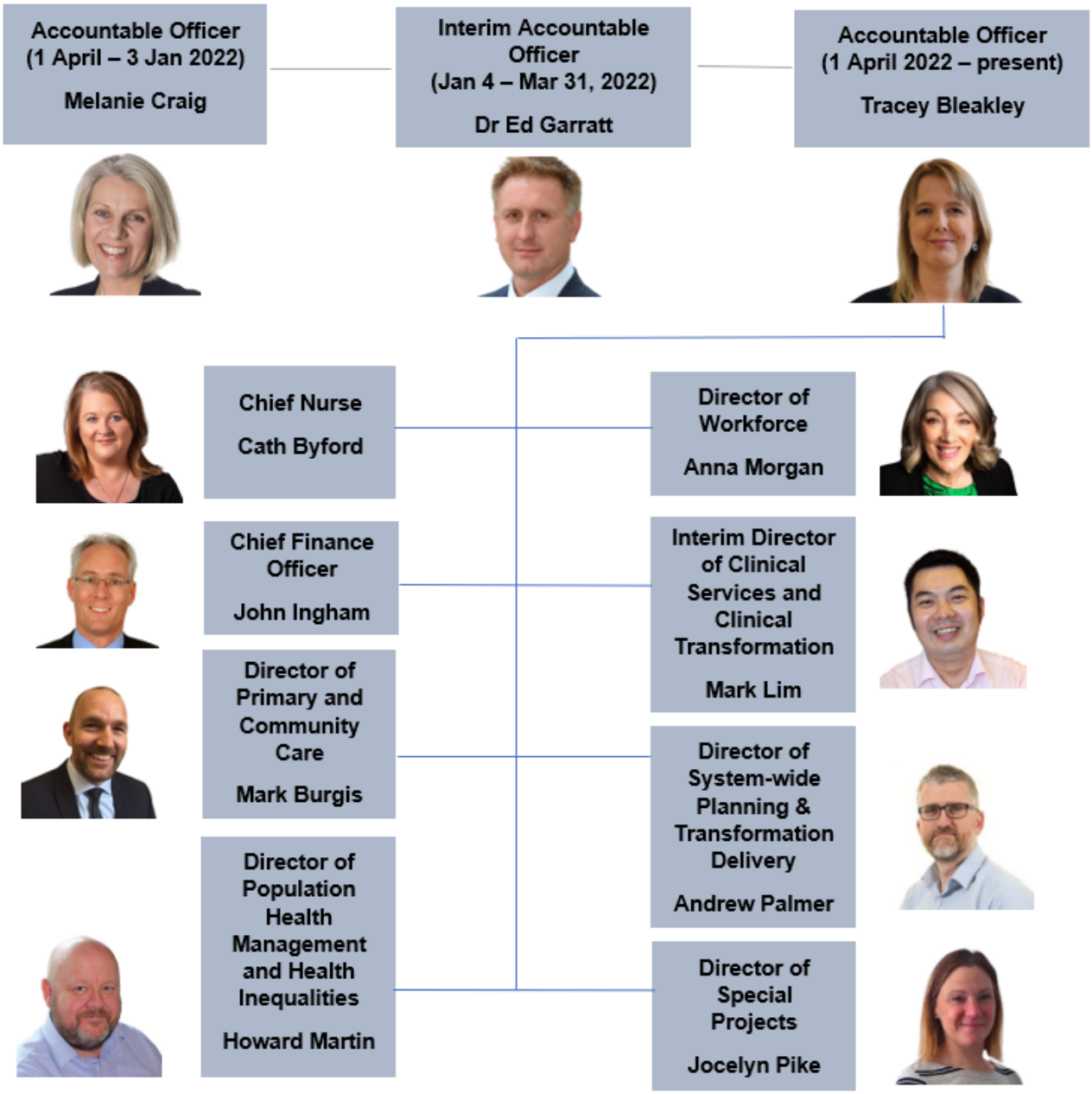
The Council of Members delegates oversight of the CCG to the Governing Body, which is comprised of elected local clinicians from member practices plus lay members and senior CCG management staff.

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.

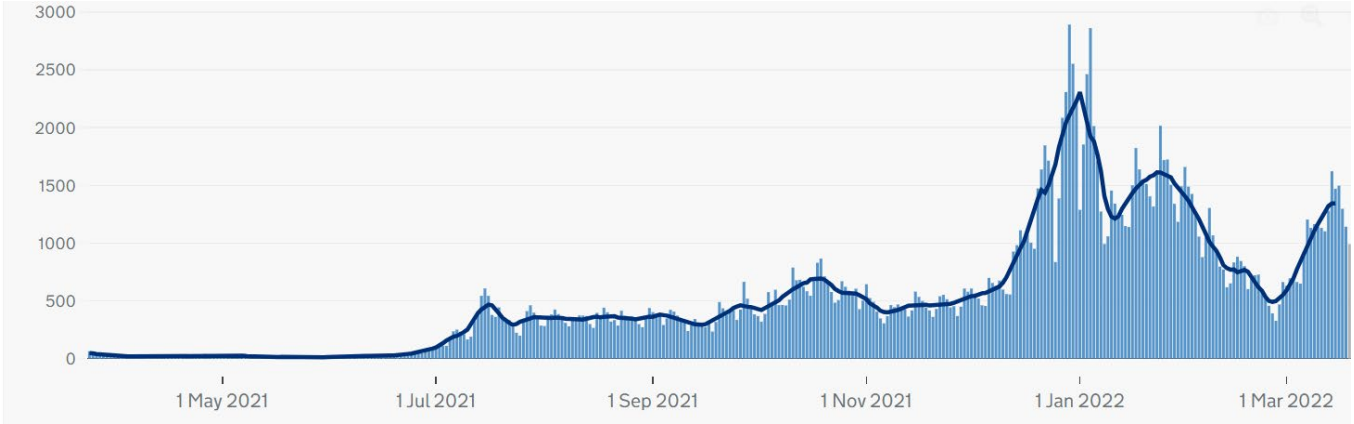
COVID-19

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.

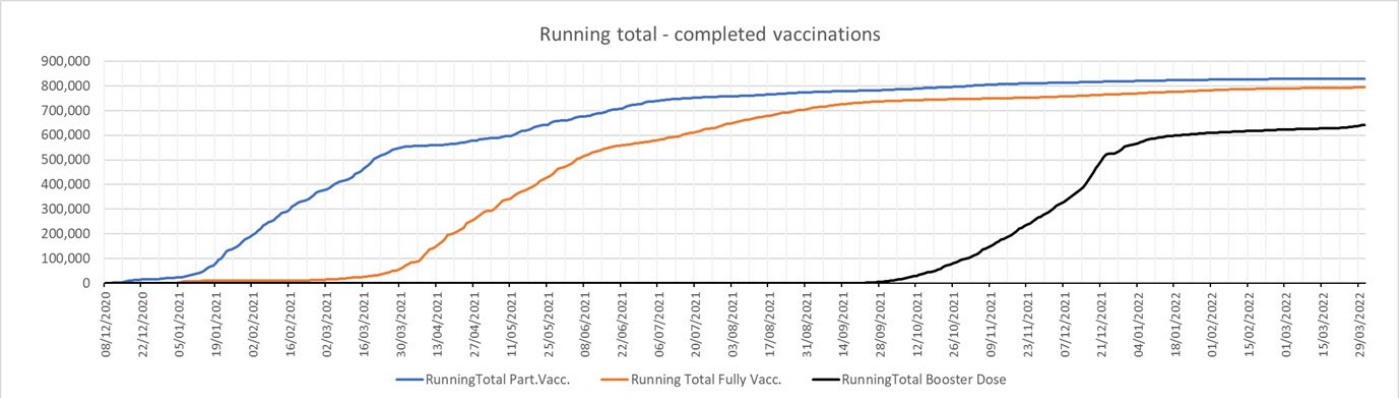
The CCG responded quickly to the government's ambition to provide a booster dose to all adults 18+ by the end of December in response to the threat of the Omicron variant, suspending all routine business that was not focussed on the vaccination programme or supporting Urgent and Emergency Care to redeploy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

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

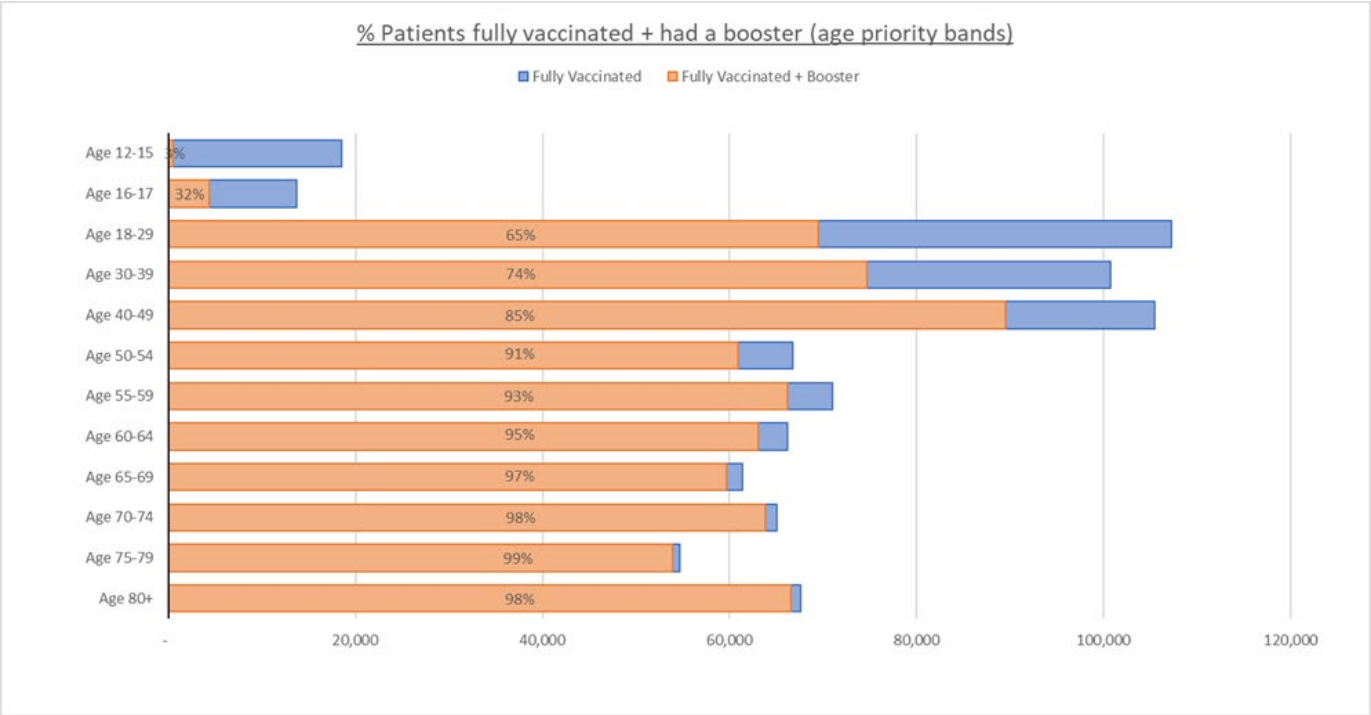
- Three hospital hubs – Queen Elizabeth, Norfolk and Norwich, and James Paget
- 101 GP practices spanning all 17 Norfolk and Waveney PCNs covering our five localities
- Eight large vaccination centres led by Cambridge Community Services NHS Trust
- 22 community pharmacy clinics run by independent pharmacy 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.

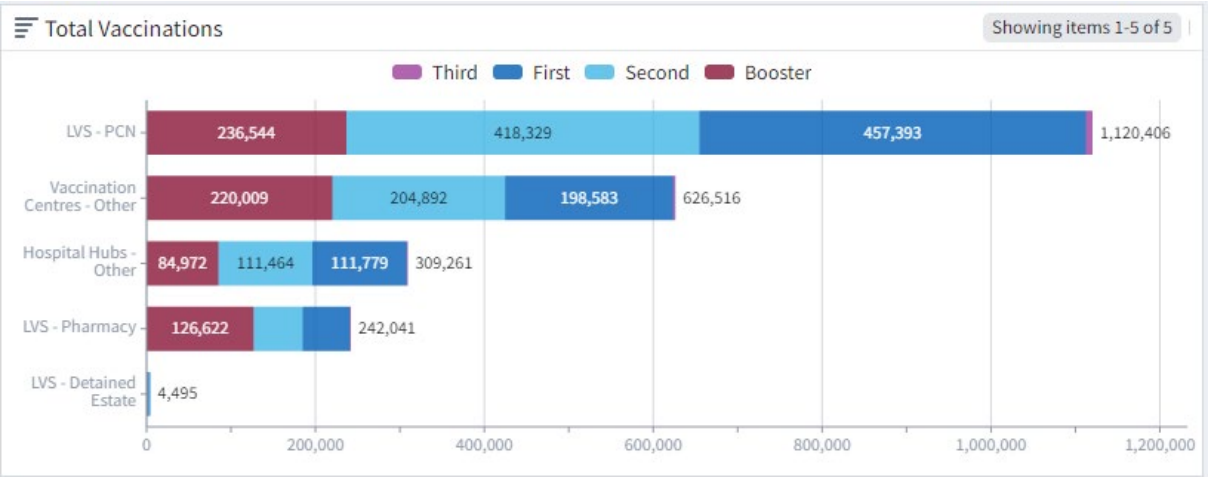
Running Total of first, second and Booster doses



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.

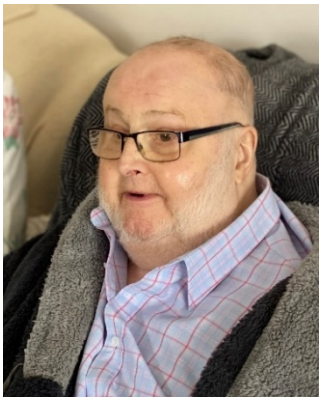
Whilst the number of referrals for cancer services continues to grow it is essential that these referrals continue at pace so that patients can be triaged and entered into the system for treatment and that more cancers can be diagnosed at an earlier stage. While that may mean that performance against 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

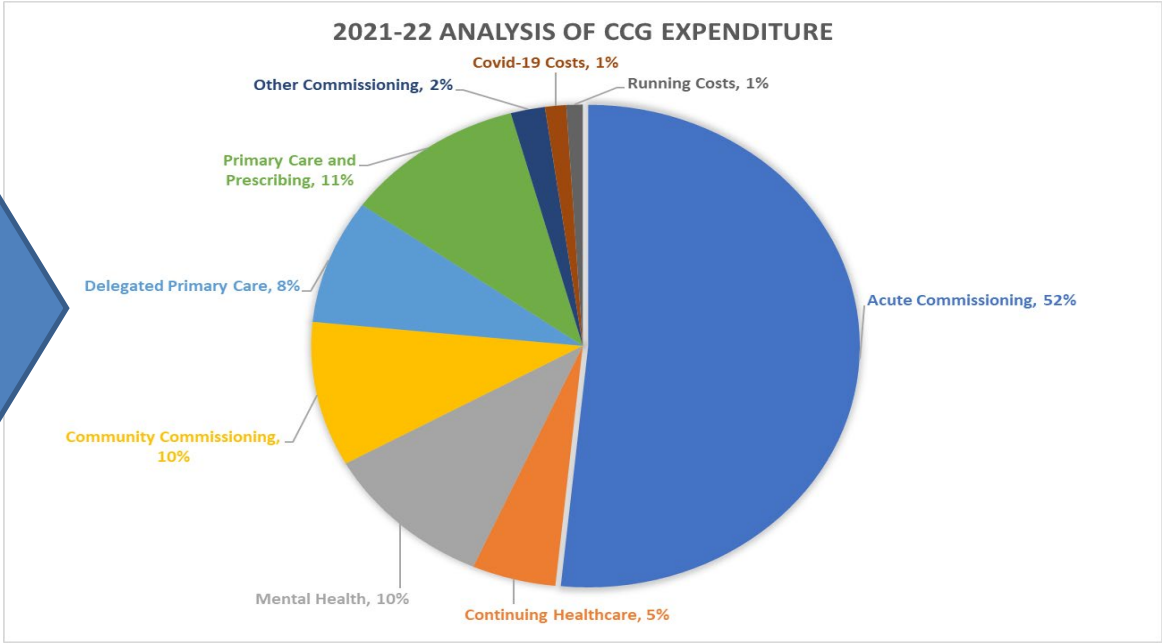
As a result of the NHS response to the COVID-19 pandemic the 2020/21 financial regime changed significantly, in line with the commitment from Government that financial constraints would not get in the way of the pandemic response. This resulted in fixed block contract payments, set by NHSE/I, being made 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

CONTENTS

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.

Building a better working world

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

Norfolk and Waveney
Integrated Care Board

Agenda item:15

Subject:	**Constitution Amendments**
Presented by:	**Tracey Bleakley, Chief Executive, NHS Norfolk and Waveney ICB** **Karen Barker, Director Corporate Affairs and ICS Development NHS Norfolk and Waveney ICB**
Prepared by:	**Karen Barker, Director Corporate Affairs and ICS Development NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**27 September 2022**

Purpose of paper:

To present the Board with some amendments to the Constitution for approval.

Executive Summary:

At its meeting on the 1 July 2022 the Board noted the Constitution of the ICB. This had already been approved by NHS England. Following commencement of the Health and Care Act (2022) NHSE's legal team conducted a review of the model constitution that was published by NHSE in May 2022 which all Constitutions nationally were based on. This review identified several small amendments that need to be made. Accordingly, NHS England requested that the errors are corrected in all ICB Constitutions.

Since the establishment of the ICB the process for approving amendments to the Constitution is set out in section 1.6.2 of the Constitution. In particular that the ICB Board have to approve amendments to the Constitution before being submitted to NHS England for further approval.

To summarise the amendments requested are as follows:

- Section 1.4.7 (f) – Health and Care Act reference 'section 14Z44' corrected to read 'section 14Z45'
- Section 3.2.4 – Reference to the 'sections 56A to 56K of the Scottish Bankruptcy Act 1985' replaced with 'Part 13 of the Bankruptcy (Scotland) Act 2016'.
- Section 3.2.7 – 'A health care professional (within the meaning of section 14N of the 2006 Act)….'. First line updated to remove reference to section 14N of the 2006 Act and capital letters for 'Health Care Professional'. Line to read as follows 'A Health and Care Professional or other professional……..'.
- Section 7.1.1 – Reference to 'paragraph 11(2)' amended to 'paragraph 12(2)'.
- Appendix 1 – Add definition of 'Health Care Professional' to the table. Definition to be added: 'An individual who is a member of a profession regulated by a body

mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002.'

The amendments are also set out in track in the attached version of the Constitution.

The Board will note that the definition of Health Care Professional had already been added to the ICB's Constitution, so this is just an amendment of this definition for the ICB.

Further by virtue of the fact that NHS England have changed the definition of a Health Care Professional, we also need to amend the capitalisations of the words "Healthcare Professional" to "Health Care Professional" at section 3.6.3 so that it is clear it relates to the definition in the Constitution's appendix.

Fortunately, the only difference between the definition the ICB used and that which NHS England are asking us to use is the inclusion of "Social Work England" as one of the bodies covered. Everything else is the same.

Recommendation to Board:

The Board is asked to:

1. Approve the proposed amendments to the Constitution.
2. Agree the submission of the revised Constitution to NHS England .

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	
Legal:	N/A
Information Governance:	N/A
Resource Required:	Corporate Affairs
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	N/A

NHS
Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
V1.0	N/A	July 1 2022
V2.0	27 September 2022	

CONTENTS

1. Introduction

1.1 Foreword

NHS England has set out the following as the four core purposes of ICSs:

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

The ICB will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

Our Integrated Care System

The Norfolk and Waveney Integrated Care System ("the ICS") is made up of a wide range of partner organisations, working together to help people lead longer, healthier and happier lives. The ICS is comprised of an NHS Integrated Care Board working with an Integrated Care Partnership committee formed jointly with local authority partners.

Over and above everything else we want to achieve, we've set ourselves three goals:

1. To make sure that people can live as healthy a life as possible.

This means preventing avoidable illness and tackling the root causes of poor health. We know the health and wellbeing of people living in some parts of Norfolk and Waveney is significantly poorer – how healthy you are should not depend on where you live. This is something we must change.

2. To make sure that you only have to tell your story once.

Too often people have to explain to different health and care professionals what has happened in their lives, why they need help, the health conditions they have and which medication they are on. Services have to work better together.

3. To make Norfolk and Waveney the best place to work in health and care.

Having the best staff, and supporting them to work well together, will improve the working lives of our staff, and mean people get high quality, personalised and compassionate care.

The partners in our ICS work together at 'system' level across Norfolk and Waveney, more locally at 'place' and 'neighbourhood' levels, and through our primary care networks and provider collaboratives.

Our Integrated Care Board

NHS Norfolk and Waveney ICB ("the ICB") was formed on 1 July 2022 and covers the same area as the former Norfolk and Waveney CCG previously did. The ICB brings the local NHS together to improve population health and care. The responsibilities of the ICB include developing a plan to meet the population's health needs and arranging for the provision of health services.

As with all NHS bodies that plan and commission services in England, NHS Norfolk and Waveney ICB and our local NHS trusts and foundation trusts are subject to the triple aim duty, and as such consider the effects of their decisions on:

- the health and wellbeing of the people of England
- the quality of services provided or arranged by both themselves and other relevant bodies
- the sustainable and efficient use of resources by both themselves and other relevant bodies

Our Integrated Care Partnership

Our Integrated Care Partnership ("the ICP") brings together the local NHS, local authorities, the voluntary, community and social enterprise sector and other partners that have an impact on the wider determinants of health. The ICP is responsible for agreeing an integrated care strategy for improving the health care, social care and public health across the whole population. The ICB is required to have regard to the ICP's Integrated Care Strategy when making decisions, commissioning and delivering services. The ICP is a statutory committee of the ICB, Norfolk and Suffolk County Councils.

The membership of the ICP is the same as the Norfolk Health and Wellbeing Board and includes representatives from Suffolk County Council and Waveney. The partners involved are the ICB, providers of health and care services, our county, district, borough and city councils, voluntary, community and social enterprise sector organisations, Healthwatch, the Constabulary and the Office of the Police and Crime Commissioner.

This Constitution for the ICB and the terms of reference for the ICP are aligned to ensure that our governance arrangements are clear, and more importantly, that all partner organisations are working toward the same aim and goals.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Norfolk and Waveney Integrated Care Board ("the ICB").

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is set out in the map below. The ICB covers the whole of the area covered by Norfolk County Council. The ICB also covers part of Suffolk but not all of the area covered by Suffolk County Council. The area covered by the ICB also includes the following local government areas: the District of Breckland, District of Broadland, Borough of Great Yarmouth, Borough of King's Lynn and West Norfolk, District of North Norfolk, City of Norwich, District of South Norfolk and also part of the District of East Suffolk.

1.3.2 All of the Lower Super Output Areas in the District of East Suffolk which are covered by the ICB are set out in Appendix 1.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published at www.improvinglivesnw.org.uk.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the

statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act);
b) Exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act);
c) Duties in relation to children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) Adult safeguarding and carers (the Care Act 2014)
e) Equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35);
f) Information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000); and
g) Provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England, which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under:
a) section 14Z34 (improvement in quality of services),
b) section 14Z35 (reducing inequalities),
c) section 14Z38 (obtaining appropriate advice),
d) section 14Z40 (duty in respect of research)
e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation),
g) sections 223GB to 223N (financial duties), and
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 1 July 2022 by The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 This Constitution must be reviewed and maintained in line with any agreements with, and requirements of, NHS England set out in writing at establishment.

1.5.3 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The Chief Executive of the ICB can propose a change to the Constitution by notifying the board in writing with at least 7 days' notice.
b) The Chair of the ICB will be consulted on any proposed changes.
c) The board of the ICB must approve any changes to the Constitution in accordance with its standing orders.
d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) Standing Orders– which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

a) The Scheme of Reservation and Delegation (SoRD)– sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) Functions and Decision map– a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the

system. The Functions and Decision map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) **Standing Financial Instructions –** which set out the arrangements for managing the ICB's financial affairs.

d) **The ICB Governance Handbook –** This brings together all the ICB's governance documents so it is easy for interested people to navigate. It includes:

- The above documents a) – c)
- Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.
- The up-to-date list of eligible providers of primary medical services under clause 3.6.2

e) **Key policy documents -** which should also be included in the Governance Handbook or linked to it:

- Standards of business conduct policy
- Conflicts of interest policy and procedures
- Policy for public involvement and engagement

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the Integrated Care Board. Further information about the criteria for the roles and how they are appointed is in section 3.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website at www.improvinglivesnw.org.uk.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the board" and members of the ICB are referred to as "board members") consists of:

a) a Chair
b) a Chief Executive
c) at least three Ordinary Members.

The membership of the ICB (the board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.4 NHS England Policy, requires the ICB to appoint the following additional Ordinary Members:

a) three Executive Members, namely:
   - Director of Finance
   - Medical Director
   - Director of Nursing
b) At least two non-executive members.

2.1.5 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following and appointed in accordance with the procedures set out in Section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description
- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing social care and whose area coincides with or includes the whole or any part of the ICB's area.

While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has 5 Partner Members:

a) 2 Partner members: NHS trusts and foundation trusts
b) 1 Partner Member: primary medical services
c) 2 Partner Members: local authorities

2.2.2 The ICB has also appointed the following further Ordinary Members to the board:

a) 2 Non-executive Members
b) Member from the VCSE Assembly Board
c) Member from the Integrated Care Partnership

2.2.3 The board is therefore composed of the following members:

a) Chair
b) Chief Executive
c) 2 Partner members NHS trusts and foundation trusts
d) 1 Partner member primary medical services
e) 2 Partner members local authorities
f) 4 Non-executive Members
g) Director of Finance
h) Medical Director
i) Director of Nursing
j) Member from the VCSE Assembly Board
k) Member from the Integrated Care Partnership.

2.2.4 The Chair will exercise their function to approve the appointment of the Ordinary Members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The board will keep under review the skills, knowledge, and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at board meetings

2.3.1 The board may invite specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

a) Director of Performance, Transformation and Strategy
b) Director of People
c) Patients and Communities Director
d) Director of Corporate Affairs and ICS Development
e) Director of Population Health Management
f) Director of Place Development and System Support
g) Director of Digital and Data
h) Director of Public Health for Norfolk County Council (unless they are one of the local authority Partner Members)
i) Director of Public Health for Suffolk County Council (unless they are of the local authority Partner Members)

Further system Directors may be invited to participate as relevant by the Chair.

2.3.3 Observers will receive advanced copies of the notice, agenda and papers for board meetings. They may be invited to attend any or all of the board meetings, or part(s) of a meeting by the Chair. Any such person may not address the meeting and may not vote.

a) Healthwatch Norfolk
b) Healthwatch Suffolk
c) Norfolk and Waveney Local Medical Committee

2.3.4 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the board passes a resolution to exclude the public as per the Standing Orders

3 Appointments process for the board

3.1 Eligibility Criteria for Board Membership:

3.1.1 Each member of the ICB must:

a) Comply with the criteria of the "fit and proper person test"
b) Be willing to uphold the Seven Principles of Public Life (known as the Nolan Principles)
c) Fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification criteria for board membership

3.2.1 A Member of Parliament.

3.2.2 A person whose appointment as a board member ("the candidate") is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

3.2.3 A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

a) in the United Kingdom of any offence, or
b) outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

3.2.4 A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

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3.2.5 A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

3.2.6 A person whose term of appointment as the chair, a member, a director or a governor of a health service body, has been terminated on the grounds:

a) that it was not in the interests of, or conducive to the good management of, the health service body or of the health service that the person should continue to hold that office
b) that the person failed, without reasonable cause, to attend any meeting of that health service body for three successive meetings,
c) that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
d) of misbehaviour, misconduct or failure to carry out the person's duties;

3.2.7 A Health Care Professional or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

a) the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
b) the person's erasure from such a register, where the person has not been restored to the register
c) a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
d) a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

3.2.8 A person who is subject to:

a) a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
b) an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

3.2.9 A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

3.2.10 A person who has at any time been removed, or is suspended, from the management or control of any body under:

a) section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or

b) section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State.

3.3.2 In addition to criteria specified at 3.1, this member must fulfil the following additional eligibility criteria
a) The Chair will be independent.

3.3.3 Individuals will not be eligible if:
a) They hold a role in another health and care organisation within the ICB area.
b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 The term of office for the Chair will be 3 years and the total number of terms a Chair may serve is 3 terms.

3.4 Chief Executive

3.4.1 The Chief Executive will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.4.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England

3.4.3 The Chief Executive must fulfil the following additional eligibility criteria
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act

3.4.4 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.4.3(a), they hold any other employment or executive role

3.5 Partner Member(s) - NHS trusts and foundation trusts

3.5.1 These Partner Members are jointly nominated by the NHS trusts and/or FTs which provide services for the purposes of the health service within the ICB's area and meet the forward plan condition or (if the forward plan condition is not met) the level of services provided condition.

- James Paget University Hospitals NHS Foundation Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust

3.5.2 These members must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an Executive Director of one of the NHS Trusts or FTs; or
b) Be an Executive Director of East Coast Community Healthcare CIC within the ICB's area; and
c) Any criteria set out in NHS England's guidance from time to time; and
d) One member to have particular knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness, and of community services
e) One member bringing particular knowledge and experience in acute hospital services; and
f) Senior level operational expertise.

3.5.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any exclusion criteria as set out in NHS England guidance applies

3.5.4 These members will be appointed by a panel subject to the approval of the Chair.

3.5.5 The appointment process will be as follows:

a) Joint Nomination:
    - When a vacancy arises, each eligible organisation listed at 3.5.1.a will be invited to make nominations.
    - The nomination of an individual must be seconded by one other eligible organisation.
    - Eligible organisations may nominate individuals from their own organisation or another organisation
    - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.
b) Assessment, selection, and appointment subject to approval of the Chair under c)
    - The full list of nominees will be considered by a panel convened by the Chief Executive.
    - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.5.2 and 3.5.3
    - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
    - A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval

- The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.5.6 The term of office for these Partner Member will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms, in the case of a 3 year term, and 1 term in the case of a 4 year term.

3.6 Partner Member - providers of primary medical services

3.6.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.6.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook. The list will be kept up to date but does not form part of this Constitution.

3.6.3 This member must fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Any criteria set out in NHS England's guidance from time to time;
b) This member must be a Health Care Professional, either a partner or employee, actively working within a practice in the Norfolk and Waveney ICB area; or
c) A locum that is active for the majority of their time within a practice in Norfolk and Waveney ICB area.
d) Fulfil the requirements relating to the relevant experience, knowledge, skills and attributes set out in a role and person specification.

3.6.4 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) Any criteria as set out in NHS England guidance applies.

3.6.5 This member will be appointed by a panel subject to the approval of the Chair.

3.6.6 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation described at 3.6.1 and listed in the Governance Handbook will be invited to make nominations.
   - The nomination of an individual must be seconded by three other eligible organisations.
   - Eligible organisations may nominate individuals from their own organisation or another organisation.
   - All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 10 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour

with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.6.3 and 3.6.4
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment

c) Chair's approval
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.7 The term of office for this Partner Member will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms in the case of a 3 year term, and 1 term in the case of a 4 year term.

3.7 Partner Member(s) - local authorities

3.7.1 These Partner Members are jointly nominated by the local authorities responsible for the provision of social care whose areas coincide with, or include the whole or any part of, the ICB's area. Those local authorities are:

a) Norfolk County Council
b) Suffolk County Council

3.7.2 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria

a) Be the Chief Executive or hold a relevant Executive level role of one of the bodies listed at 3.7.1; and
b) Any criteria set out in NHS England's guidance from time to time.

3.7.3 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS E guidance applies.

3.7.4 This member will be appointed by the panel subject to the approval of the Chair.

3.7.5 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each eligible organisation listed at 3.7.1.a will be invited to make nominations.
   - Eligible organisations may nominate individuals from their own organisation or another organisation

- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until a consensus is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.7.2 and 3.7.3
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval
   The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.6 The term of office for these Partner Members will be 3 or 4 years as agreed with the Chair at the start of the term, and the total number of terms they may serve is 2 terms, in the case of a 3 year term, and 1 term in the case of a 4 year term.

3.8 Medical Director

3.8.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner;
c) Any further criteria as set by NHS England from time to time; and
d) Meet the criteria as set out in the person specification for the role.

3.8.2 Individuals will not be eligible if:

a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria set out in NHS England guidance applies.

3.8.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

3.9 Director of Nursing

3.9.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse
c) Any further criteria as set by NHS England from time to time; and
d) Meet the criteria as set out in the person specification for the role.

3.9.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.9.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

3.10 Director of Finance

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Any further criteria as set by NHS England from time to time; and
c) Meet the criteria as set out in the person specification for the role.

3.10.2 Individuals will not be eligible if:
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.10.3 This member will be appointed by the Chief Executive subject to the approval of the Chair. This will be after a recruitment process is undertaken which includes the Chief Executive and Chair on the selection panel.

3.11 Four Non-executive Members

3.11.1 The ICB will appoint four Non-executive Members.

3.11.2 These members will be appointed by a panel subject to the approval of the Chair.

3.11.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Not be an employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation in the ICS area
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit Committee
d) Another shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration, People and Culture Committee
e) Another shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Finance Committee.

f) Another shall have specific knowledge, skills and experience with regard to the people and the community of Norfolk and Waveney.
g) Any other criteria as set out by NHS England's guidance.

3.11.4 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the ICB area; and
c) any criteria as set out in NHS England's guidance applies.

3.11.5 The term of office for a Non-executive Member will be 3 years and the total number of terms an individual may serve is 3 terms, after which they will no longer be eligible for re-appointment.

3.11.6 Initial appointments may be for a shorter period in order to avoid all Non-executive Members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity.

3.11.7 Subject to satisfactory appraisal the Chair may approve the re-appointment of a Non-executive Member up to the maximum number of terms permitted for their role.

3.12 Other Board Members

VCSE Assembly Board member

3.12.1 This member is nominated by the Norfolk and Waveney VCSE Assembly Board.

3.12.2 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:
a) Be the Chief Executive or hold a relevant Executive level role in one of the VCSE sector legal entities in Norfolk and Waveney; and
b) Any criteria set out in NHS England's guidance from time to time

3.12.3 Individuals will not be eligible if
a) Any of the disqualification criteria set out in 3.2 apply; and
b) any criteria as set out in NHS England guidance applies.

3.12.4 This member will be appointed by a panel subject to the approval of the Chair.

3.12.5 The appointment process will be as follows:
a) Joint Nomination:
- When a vacancy arises, each member of the Norfolk and Waveney VCSE Assembly Board will be invited to make nominations.
- The nomination of an individual must be seconded by one other eligible member of the Norfolk and Waveney VCSE Assembly Board.
- Eligible members may nominate individuals from their own organisation or another organisation
- All eligible members of the Norfolk and Waveney Assembly Board will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days

being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.12.2 and 3.12.3
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment

c) Chair's approval
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

Integrated Care Partnership Board Member

3.12.6 This member is nominated by the Norfolk and Waveney Integrated Care Partnership.

3.12.7 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria
   a) Be a member of the Integrated Care Partnership Committee; and
   b) Any criteria set out in NHS England's guidance from time to time

3.12.8 Individuals will not be eligible if
   a) Any of the disqualification criteria set out in 3.2 apply; and
   b) any criteria as set out in NHS England guidance applies.

3.12.9 This member will be appointed by a panel subject to the approval of the Chair.

3.12.10 The appointment process will be as follows:

a) Joint Nomination:
   - When a vacancy arises, each individual member of the Integrated Care Partnership Committee will be invited to make nominations.
   - The nomination of an individual must be seconded by one other member of the Integrated Care Partnership Committee.
   - Eligible members may nominate individuals from their own organisation or another organisation
   - All members will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement. This will be determined by a simple majority being in favour with nil responses taken as assent. If they do agree, the list will be put forward to step b) below. If

they don't, the nomination process will be re-run until majority acceptance is reached on the nominations put forward.

b) Assessment, selection, and appointment subject to approval of the Chair under c)
   - The full list of nominees will be considered by a panel convened by the Chief Executive.
   - The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.12.7 and 3.12.8
   - In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.
   - A fit and proper person test will also be undertaken on the preferred candidate before appointment.

c) Chair's approval
   - The Chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.13 Board Members: Removal from Office

3.13.1 Arrangements for the removal from office of board members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.13.2 With the exception of the Chair, board members shall be removed from office if any of the following occurs:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance.
b) If they fail to attend a minimum of 90% of the meetings to which they are invited including ICB Board and Committee meetings unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance at their annual appraisal
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the honour and interest of the ICB and is likely to bring the ICB into disrepute. This includes but it is not limited to dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) Are deemed to have failed to uphold the Nolan Principles of Public Life
f) Are subject to disciplinary proceedings by a regulator or professional body

3.13.3 Members may be suspended pending the outcome of an investigation into whether any of the matters in 3.13.2 apply.

3.13.4 Executive Directors (including the Chief Executive) will cease to be Board members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.13.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State.

3.13.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) terminate the appointment of the ICB's Chief Executive; and
b) direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.14 Terms of appointment of Board Members

3.14.1 With the exception of the Chair and Non-executive members, arrangements for remuneration and any allowances will be agreed by the Remuneration, People and Culture Committee in line with the ICB remuneration policy and any other relevant policies published at www.improvinglivesnw.org.uk.and any guidance issued by NHS England or other relevant body. Remuneration for Chairs will be set by NHS England. Remuneration for Non-executive Members will be set by the Board. Any discussions about remuneration for the Non-executive Members will be held without the Non-executive Members present.

3.14.2 Other terms of appointment will be determined by the Remuneration, People and Culture Committee.

3.14.3 Terms of appointment of the Chair will be determined by NHS England.

3.15 Specific arrangements for appointment of Ordinary Members made at establishment

3.15.1 Individuals may be identified as "designate Ordinary Members" prior to the ICB being established.

3.15.2 Relevant nomination procedures for Partner Members in advance of establishment are deemed to be valid so long as they are undertaken in full and in accordance with the provisions of 3.5 to 3.7.

3.15.3 Any appointment and assessment processes undertaken in advance of establishment to identify designate ordinary members should follow, as far as possible, the processes set out in section 3.5-3.12 of this Constitution. However, a modified process, agreed by the Chair, will be considered valid.

3.15.4 On the day of establishment, a committee consisting of the Chair, Chief Executive and one other will appoint the ordinary members who are expected to be all individuals who have been identified as designate appointees pre ICB establishment and the Chair will approve those appointments.

3.15.5 For the avoidance of doubt, this clause is valid only in relation to the appointments of the initial ordinary members and all appointments post establishment will be made in accordance with clauses 3.5 to 3.12.

4 Arrangements for the exercise of our functions

4.1 Good governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England.

4.1.2 The ICB has agreed a standards of business conduct policy which sets out the expected behaviours that members of the board and its committees will uphold whilst undertaking ICB business. It also includes a set of principles that will guide decision making in the ICB. The ICB standards of business conduct policy can be found on our website at www.improvinglivesnw.org.uk.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England;
d) have regard to statutory guidance including that issued by NHS England; and
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England.
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a) any of its members or employees
b) a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation

4.4.1 The ICB has agreed a scheme of reservation and delegation (SoRD) which is published in full at www.improvinglivesnw.org.uk

4.4.2 Only the board may agree the SoRD and amendments to the SoRD may only be approved by the board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the board;
b) those functions that have been delegated to an individual or to committees and sub committees;
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published at www.improvinglivesnw.org.uk.

4.5.3 The map includes:

a) Key functions reserved to the board of the ICB
b) Commissioning functions delegated to committees and individuals.
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body;
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and sub-committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the board. All terms of reference are published in the Governance Handbook.

4.6.4 The board remains accountable for all functions, including those that it has delegated to committees and subcommittees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub committees that fulfil delegated functions of the ICB, will be required to:

a) Submit regular decision or assurance reports to the board
b) Comply with any internal audit findings of the ICB
c) Conduct annual committee effectiveness reviews
d) Submit their term of reference for board approval.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the standing orders as well as the Standing Financial Instructions and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit and Risk Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit Committee will be chaired by a non-executive member (other than the Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration, People and Culture Committee:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration, People and Culture Committee will be chaired by a non-executive member other than the Chair or the Chair of Audit Committee.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB Scheme of Reservation and Delegation and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the board.

4.7.4 The board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these are detailed in the delegation arrangements, summaries of which will be published in the ICB's Governance Handbook.

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings; and
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook.

6 Arrangements for conflict of interest management and standards of business conduct

6.1 Conflicts of Interest

6.1.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.1.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website at www.improvinglivesnw.org.uk

6.1.3 All board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.1.4 All delegation arrangements made by the ICB under section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.1.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of interest Policy and the Standards of Business Conduct Policy.

6.1.6 The ICB has appointed the Audit and Risk Committee Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest;
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest;
c) Support the rigorous application of conflict of interest principles and policies;
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation;
e) Provide advice on minimising the risks of conflicts of interest.

6.2 Principles

6.2.1 In discharging its functions the ICB will abide by the following principles:

a) The ICB acts in the public interest at all times
b) Avoiding undue influence
c) Transparency and Accountability.

6.3 Declaring and registering interests

6.3.1 The ICB maintains registers of the interests of:
a) Members of the ICB
b) Members of the board's committees and sub-committees
c) Its employees.

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website at www.improvinglivesnw.org.uk.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.3.7 Interests (including gifts and hospitality) of decision-making staff will remain on the public register for a minimum of six months. In addition, the ICB will retain a record of historic interests and offers/receipt of gifts and hospitality for a minimum of six years after the date on which it expired. The ICB's published register of interests states that historic interests are retained by the ICB for the specified timeframe and details of whom to contact to submit a request for this information.

6.3.8 Activities funded in whole or in part by third parties who may have an interest in ICB business such as sponsored events, posts and research will be managed in accordance with the ICB policy to ensure transparency and that any potential for conflicts of interest are well-managed.

6.4 Standards of business conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:
a) act in good faith and in the interests of the ICB;
b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles);
c) comply with the ICB's Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct policy.

7 Arrangements for ensuring accountability and transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12(2) of Schedule 1B to the 2006 Act.

7.2 Meetings and publications

7.2.1 Board meetings, and committees composed entirely of board members or which include all board members, will be held in public except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.2.2 Papers and minutes of all meetings held in public will be published.

7.2.3 Annual accounts will be externally audited and published.

7.2.4 A clear complaints process will be published.

7.2.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner Office requirements regarding the publication of information relating to the ICB.

7.2.6 Information will be provided to NHS England as required.

7.2.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

- Conflicts of interest policy and procedures
- Registers of interests
- Key policies

7.2.8 The ICB will publish, with our partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next five years. The plan will explain how the ICB proposes to discharge its duties under:

- sections 14Z34 to 14Z45 (general duties of integrated care boards), and
- sections 223GB and 223N (financial duties)

and

a) proposed steps to implement the Norfolk and Waveney joint local health and wellbeing strategies

7.3 Scrutiny and decision making

7.3.1 At least three Non-executive members will be appointed to the board including the Chair; and all of the board and committee members will comply with the Seven Principles of Public Life(the Nolan Principles) and meet the criteria described in the fit and proper person test.

7.3.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime.

7.3.3 The ICB will comply with the requirements of the NHS Provider Selection Regime including:

a) Complying with existing procurement rules until the provider selection regime comes into effect.
b) evidencing that it has properly exercised the responsibilities conferred on it by the regime, once this is published, by:
   - publishing the intended selection approach in advance.
   - publishing the outcome of decisions made and the details of contracts awarded.
   - keeping a record of decisions made under the regime, including evidence that all relevant issues and criteria have been considered and that the reasons for any decision are clearly justified.
   - recording how conflicts of interest were managed.
c) monitoring compliance with this regime via an annual internal audit process, the results of which will be published.
d) including in the annual report a summary of contracting activity as specified by the regime.
e) ensuring that appropriate internal governance mechanisms are in place to deal with representations made against provider selection decisions and that any such representations are considered fairly and impartially within the timescales prescribed.

7.3.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.4 Annual Report

7.4.1 The ICB will publish an Annual Report in accordance with any guidance published by NHS England and which sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised), and
d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The board has established a Remuneration, People and Culture Committee which is chaired by a Non-executive Member other than the Chair or Audit Chair.

8.1.3 The membership of the Remuneration, People and Culture Committee is determined by the board. No employees may be a member of the Remuneration People and Culture Committee, but the board ensures that the Remuneration People and Culture Committee has access to appropriate advice by:

a) The Chair may invite relevant staff to the meeting as necessary in accordance with the business of the committee
b) Meetings may also be attended by the following individuals, who are not members of the committee, for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote:
   - The ICB's most senior HR Advisor or their nominated deputy
   - The Director of Finance or their nominated deputy
   - The Chief Executive or their nominated deputy, and
   - Director of Corporate Affairs and ICS Development or their nominated deputy

8.1.4 The board may appoint independent members or advisers to the Remuneration People and Culture Committee who are not members of the board.

8.1.5 The main purpose of the Remuneration People and Culture Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the ICB's Governance Handbook.

8.1.6 The duties of the Remuneration People and Culture Committee include for the Chief Executive, Members of the Board and other Very Senior Managers:

a) Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, pensions and cars;
b) Determine arrangements for termination of employment and other contractual terms and non-contractual terms.

For all staff:

a) Determine the ICB pay policy, including the adoption of pay frameworks such as Agenda for Change;
b) Oversee contractual arrangements;
c) Determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

For Clinical Advisors:

a) Determine ICB pay policy
b) Oversee contractual arrangements

8.1.7 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the ICB
b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them, and
c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act the ICB has made the following arrangements to consult its population on its system plan:

a) All consultation proposals will be formally agreed by the ICB and will be shared with a range of key stakeholder prior to the start of any consultation process to ensure that the proposals are robust and representative.
b) Work with Healthwatch Norfolk and Healthwatch Suffolk to ensure patient and public voice is embedded into the work of the Norfolk and Waveney Integrated Care Board, embracing co-production and co-design wherever possible.

9.1.3 The ICB has adopted the ten principles set out by NHS England for working with people and communities:

a) Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.
b) Start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions.
c) Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.
d) Build relationships with excluded groups – especially those affected by inequalities.
e) Work with Healthwatch and the voluntary, community and social enterprise sector as key partners.
f) Provide clear and accessible public information about vision, plans and progress to build understanding and trust.
g) Use community development approaches that empower people and communities, making connections to social action.
h) Use co-production, insight and engagement to achieve accountable health and care services.
i) Co-produce and redesign services and tackle system priorities in partnership with people and communities.

j) Learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 These arrangements, include:

a) Working with patients and members of the public across the ICS to ensure patients and members of the public are involved in helping to shape services at a local level.
b) Strengthening Patient Participation Groups, supporting them to embrace new ways of reaching out to local communities and feeding these views into local alliances.
c) Working with the Norfolk and Waveney Communications and Engagement Group (including NHS, local authorities, both Norfolk and Suffolk Heathwatch, and VCSE) to consider as part of Norfolk and Waveney wide campaigns, communication and engagement activities.
d) Working with the Integrated Care Board to include patient stories at their meetings, linked to and focussed on highlighting the importance of patient and public views and voices to help inform decision making.

Appendix 1: Definitions of Terms Used in This Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
ICB board	Members of the ICB
Area	The geographical area that the ICB has responsibility for, as defined in part 2 of this Constitution
Committee	A committee created and appointed by the ICB board.
Sub-committee	A committee created and appointed by and reporting to a committee.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's area.
Health Ccare Professional	~~A member of a profession that is regulated by one of the following bodies:~~ ~~the General Medical Council (GMC)~~ ~~the General Dental Council (GDC)~~ ~~the General Optical Council~~ ~~the General Osteopathic Council~~ ~~the General Chiropractic Council~~ ~~the General Pharmaceutical Council~~ ~~the Pharmaceutical Society of Northern Ireland~~ ~~the Nursing and Midwifery Council~~ ~~the Health and Care Professions Council~~ ~~any other regulatory body established by an Order in Council under Section 60 of the Health Act 1999~~An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
Place-based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the Integrated Care Board, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.

Ordinary Member	The board of the ICB will have a Chair and a Chief Executive plus other members. All other members of the board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following**:** • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Health Service Body	Health Service Body as defined by section 9(4) of the NHS Act 2006 or (b) NHS Foundation Trusts.

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of the Norfolk and Waveney Integrated Care Board so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 1 July 2022

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per clause 1.6.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These Standing Orders apply to all meetings of the board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the Director Corporate Affairs and ICS Development, will provide a settled view which shall be final.

3.5. All members of the board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the board for action or ratification and the Audit Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

4.1.1. Meetings of the board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2. In normal circumstances, each member of the board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.

b) One third of the members of the board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.

4.1.3. A public notice of the time and place of meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4. The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2. Chair of a meeting

4.2.1. The Chair of the ICB shall preside over meetings of the board.

4.2.2. If the Chair is absent, or is disqualified from participating by a conflict of interest, then the Deputy Chair of the ICB shall preside over the meeting of the board. The Deputy Chair shall be appointed by the board. If both the Chair and the Deputy Chair are absent, or are disqualified from participating by a conflict of interest, then the board may appoint a temporary deputy to preside over meetings of the board.

4.2.3. The board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3. Agenda, supporting papers and business to be transacted

4.3.1. The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2. Except where the emergency provisions apply, supporting papers for all items must be submitted at least seven calendar days before the meeting takes place. The

agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3. Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website at www.improvinglivesnw.org.uk.

4.4. Petitions

4.4.1. Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with the ICB policy as published in the Governance Handbook.

4.5. Nominated Deputies

4.5.1. With the permission of the person presiding over the meeting, the Executive Directors of the board may nominate a deputy to attend a meeting of the Board that they are unable to attend. For the avoidance of doubt, the deputy may speak but may not vote on their behalf.

4.5.2. Partner Members will not be permitted to send deputies.

4.5.3. The decision of person presiding over the meeting regarding authorisation of nominated deputies is final.

4.6. Virtual attendance at meetings

4.6.1. The board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means when necessary, unless the terms of reference prohibit this.

4.7. Quorum

4.7.1. The quorum for meetings of the board will be 10 members, including:

a) Either the Chief Executive or the Director of Finance
b) Either the Medical Director or the Director of Nursing
c) At least one Independent member (which can include the Chair)
d) At least one Partner Member.

4.7.2. For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.

4.7.3. For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8. Vacancies and defects in appointments

4.8.1. The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2. In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

- For a limited period the quorum will be reduced by one per vacancy.

4.9. Decision making

4.9.1. The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2. Generally it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers(as detailed within paragraph 5.6. of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

<u>Disputes</u>

4.9.3. Where necessary or helpful, the board may draw on third party support such as peer review or support from NHS England.

<u>Urgent decisions</u>

4.9.4. In the case urgent decisions and extraordinary circumstances, every attempt will be made for the board to meet virtually. Where this is not possible the following will apply.

4.9.5. The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees) subject to every effort having made to consult with as many members as possible in the given circumstances.

4.9.6. The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit and Risk Committee for oversight.

4.10. Minutes

4.10.1. The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2. The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3. No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4. Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11. Admission of public and the press

4.11.1. In accordance with Public Bodies (Admission to Meetings) Act 1960 All meetings of the board and all meetings of committees which are comprised of entirely board members or all board members at which public functions are exercised will be open to the public.

4.11.2. The board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3. The person presiding over the meeting shall give such directions as he/she thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the board's business shall be conducted without interruption and disruption.

4.11.4. As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5. Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the board.

5. Suspension of Standing Orders

5.1. In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least two other members,

5.2. A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

5.3. A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit Committee for review of the reasonableness of the decision to suspend Standing Orders.

Appendix 3: Lower Super Output Areas covered by Norfolk and Waveney ICB

District of East Suffolk

Lower Super Output Areas covered by Norfolk and Waveney ICB in the District of East Suffolk
East Suffolk (PARTIAL) including LSOAs: E01030240, E01030241, E01030242, E01030259, E01030260, E01030261, E01030262, E01030277, E01030279, E01030281, E01030266, E01030267, E01030271, E01030278, E01030280, E01030246, E01030248, E01030249, E01030250, E01030264, E01030265, E01030255, E01030263, E01030270, E01030289, E01030290, E01030233, E01030235, E01030268, E01030269, E01030288, E01030247, E01030254, E01030256, E01030258, E01030276, E01030257, E01030274, E01030275, E01030287, E01030291, E01030234, E01030236, E01030237, E01030238, E01030223, E01030224, E01030225, E01030227, E01030228, E01030226, E01030286, E01030292, E01030293, E01030294, E01030239, E01030251, E01030252, E01030253, E01030272, E01030273, E01030230, E01030231, E01030232, E01030285, E01030282, E01030283, E01030284, E01030295, E01030229, E01030243, E01030244, E01030245

Norfolk and Waveney
Integrated Care Board

Agenda item: 16

Subject:	**Board Assurance Framework (BAF)**
Presented by:	**Karen Barker, Director Corporate Affairs and ICS Development NHS Norfolk and Waveney ICB**
Prepared by:	**Martyn Fitt, Corporate Affairs Manager NHS Norfolk and Waveney ICB**
Submitted to:	**ICB Board**
Date:	**27 September 2022**

Purpose of paper:

To present the Board with a copy of the ICB's Board Assurance Framework (BAF) and the ICB's Risk Management Framework.

Executive Summary:

The Board is presented with a copy of the ICB's Board Assurance Framework (BAF) (item 16.1) and associated risk visual (below.)

The Board is also presented with the Risk Management Framework (item 16.2)

Effective risk management is an essential part of the ICB's system of internal control and supports the provision of a fair and well-illustrated Annual Governance Statement

Since the ICB's first Board meeting on 1 July 2022 the BAF has been review in full by the Executive Directors. The Board is asked to note the following notable updates:

- **Resilience of general practice**. This risk has been updated by the primary care commissioning committee to combine two principal risks and has resulted in an increased mitigated risk rating to 4x4=16. Full updates have been provided to support the increase in risk.

- **Health Inequalities**. This risk has increased to a mitigated risk rating of 4x4=16. Full updates have been provided to support the increase in risk.

- **EEAST Response Times and Patient Harms**. This risk has increased to a mitigated risk rating of 5x4=20. Full updates have been provided to support the increase in risk.

- **Financial Wellbeing**. This is a new risk which has been added to the BAF and is in respect of risks associated with the cost of living and impact on staff wellbeing.

The BAF has also been reorganised to categorise risks around our three goals:

1. To make sure that people can live as healthy a life as possible.

2. To make sure that you only have to tell your story once.

3. To make Norfolk and Waveney the best place to work in health and care.

This is to enable the Board to identify clearly where achievement of the goals maybe at risk.

This Board Assurance Framework now includes more detail on the controls for each risk as well as current actions.

Risk Management Framework

The risk management framework sets out the ICB's arrangements for managing risk as an ICB. It includes information on the process that will be used to review and rate risks as well as where this information will be presented. The draft risk management framework is attached for review and approval. In accordance with the ICB's Governance Handbook the Board is to approve the arrangements for managing risk.

The Executive Management Team are continuing to work to update the risks and ensure that they are as clear as they can be. They are also looking at where risks go across more than one Directorate and how they can best be articulated. The Board will see further information on this work as it develops at coming meetings.

Recommendation to Board:

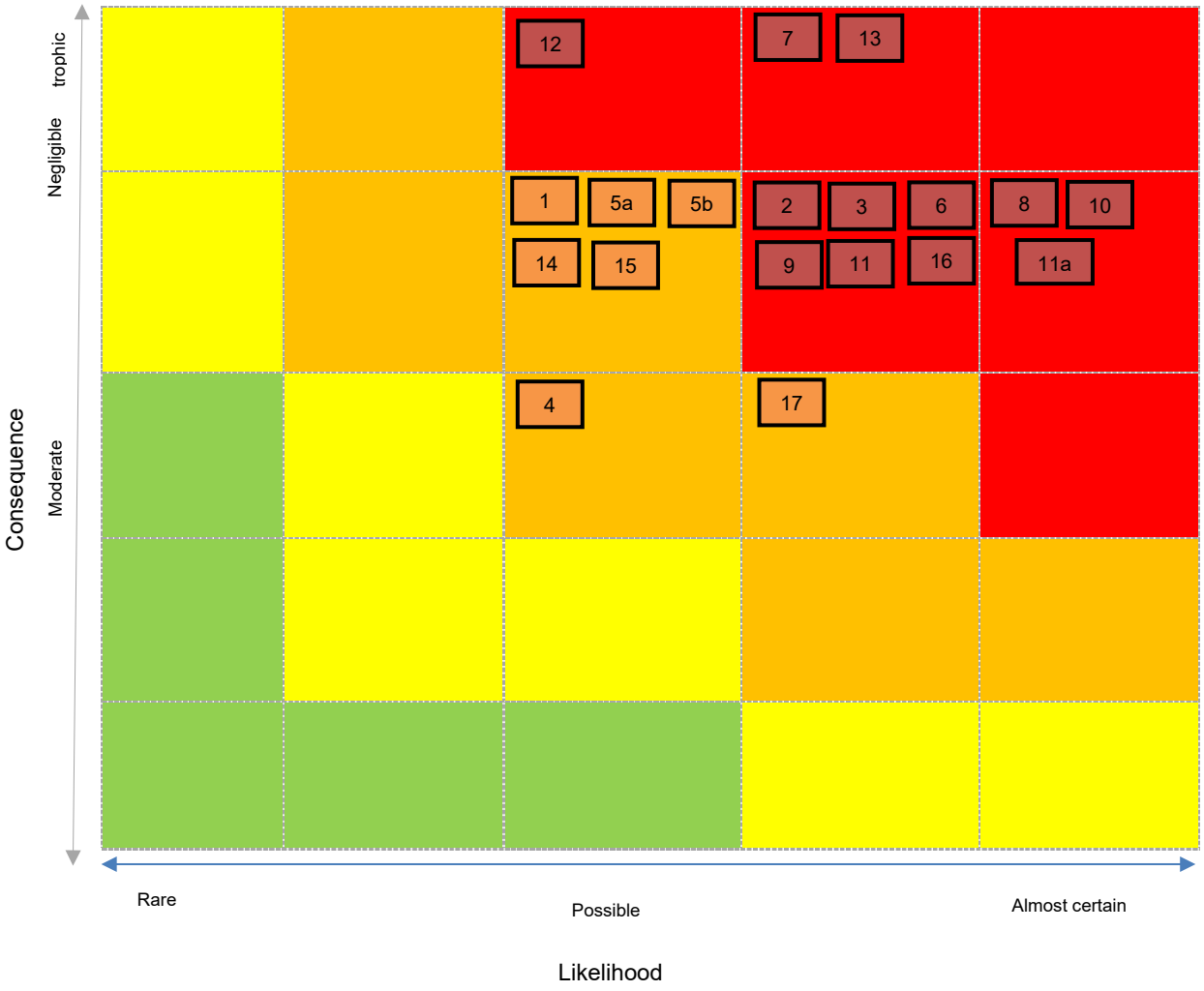
The Board is asked to:

1. Approve the Risk Management Framework;

2. To receive and review the risks presented on the Board Assurance Framework.

Key Risks	
Clinical and Quality:	None
Finance and Performance:	None
Impact Assessment (environmental and equalities):	None
Reputation:	It is important the Board is apprised of the key risks in the organisation currently.
Legal:	N/A
Information Governance:	N/A
Resource Required:	Corporate Affairs risk management resource
Reference document(s):	None
NHS Constitution:	N/A
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework	See table.

Risk visual


trophic
Negligible
Moderate
Consequence
12
7
13
1
5a
5b
2
3
6
8
10
14
15
9
11
16
11a
4
17
Rare
Possible
Almost certain
Likelihood

NHS Norfolk and Waveney ICB – Board Assurance Framework (BAF)

Norfolk and Waveney ICB aim: To make sure that people can live as healthy a life as possible

Principal risk: That people in Norfolk will experience poor health outcomes due to suboptimal care.

Summary of risks

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
BAF01	Living with COVID-19				12	12	12						
BAF02	System Urgent & Emergency Care				16	16	16						
BAF03	Providers in CQC 'Inadequate' Special Measures (NSFT)				16	16	16						
BAF04	Cancer diagnosis and treatment				9	9	9						
BAF05A	Barriers to full delivery of the Mental health transformation programme - A				12	12	12						
BAF05B	Barriers to full delivery of the Mental health transformation programme - C				12	12	12						
BAF06	Health Inequalities				12	12	16						
BAF07	RAAC Planks				20	20	20						
BAF08	Elective Recovery				20	20	20						
BAF09	NHS Continuing Healthcare				16	16	16						
BAF10	EEAST Response Time and Patient Harms				16	20	20						
BAF11	Achieve the 2022/23 financial plan				16	16	16						
BAF11A	Underlying deficit position				20	20	20						

BAF01	
Risk Title	Living with COVID-19
Risk Description	There is continued risk that new variants may contribute to increase in transmission and alter severity of illness. The local healthcare system is currently going through a period of high system pressure set against restoration and recovery, and compliance with robust Infection Prevention and Control Measures.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Karen Watts	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	3	4	12	1	5	5

Controls	Assurances on controls
• Testing options reflect national guidance. • A Norfolk and Waveney system approach to managing positive and asymptomatic patients has been agreed reflecting national guidance with local risk assessment as required. • The vaccination programme has been accelerated and is delivering against national plan. September booster programme for COVID-19 and Flu is due to start imminently. • Vaccination sites are managing their capacity against need. There is a mixed model of vaccination delivery that is inclusive of harder to reach groups. Wherever possible, Flu vaccinations have been co-administered. • Protect NoW is focusing on health inequalities and outreaching to vulnerable groups. • System has collaborated on the approach to planned visiting to inpatient areas and local risk assessments regarding national guidance around testing and use of face coverings.	**Internal:** Vaccination Programme Board, Daily Operational Touchpoint, Clinical Directors Meeting, ICB Executive Management Team (EMT), System EMT, Quality & Safety Committee, ICB Board. **External**: Regional Vaccination Operational Cell, Regional COVID-19 and Flu Operational Group, NHSE national oversight

Gaps in controls or assurances

- Numbers of COVID-19 positive patients circulating in the community are not fully understood due to changes in testing.
- Retention of workforce continues to be the key risk to delivery. Staff wellbeing and resilience continues to be impacted. Pension abatement guidance is awaited pending 'end date' of national extension. This will impact on the availability of experienced reservists.
- Prevalence of COVID-19 inpatient admissions has decreased, however, planning must take place to be prepared by further waves and seasonal pressures.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
17/06/22	Continue to utilise local and regional outbreak surveillance to enable risk assessment and response.		30/09/22
25/08/22	Delivery of the COVID-19 September booster programme is on target to begin, in conjunction with Flu		01/12/22

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12						
change				New	→	→						

BAF02	
Risk Title	System/Urgent & Emergency Care (UEC) pressures
Risk Description	There continues to be a risk that the Norfolk and Waveney health and social care system does not have sufficient resilience or capacity to meet the urgent and emergency care needs of the population whenever a need arises. This can result in longer than acceptable response times to receive treatment and as a result potentially poorer outcomes for our patients. The above risk manifests itself as an increasing number of patients remaining in hospital, when they no longer meet the nationally prescribed "criteria to reside", with the associated increase in longer lengths of stay and higher occupancy levels in all three of our acute hospitals. The higher occupancy levels result in delays in admitting patients from our emergency departments (EDs) into a bed this in turn congests the EDs slowing down ambulance handover leading to more crews outside hospital who are unable to respond to 999 calls.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Patients and Communities	Ross Collett	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	4	16	3	4	12

Controls	Assurances on controls
• UEC System Transformation Steering Group is overseeing a system wide transformation programme to improve Urgent and Emergency care pathways • A seven-day System Resilience Team and East of England Ambulance Service (EEAST) System Oversight Cell (SOC) are in place, working together to coordinate and smooth operational flow across sites • All Trusts, including community, 111 and primary care have business continuity plans in place to manage peaks in demand Specific controls to reduce emergency care demand • IC24 Clinical Advice Service (CAS) reduce ambulance demand by validating ambulance dispositions and utilising a range of urgent care pathways as an alternative to conveyance • Low acuity 999 calls are transferred to IC24 or other urgent community services to reduce delays for low acuity patients • GP Streaming is in place at all acutes to manage lower acuity pts and reduce footfall through EDs • EEAST enact Intelligent Conveyancing to manage and even out the ambulance demand profile across acute sites Specific controls to create surge capacity • A range of cohorting measures are available at all acutes to provide ED surge capacity and reduce ambulance crews waiting to handover at hospital	**Internal:** ICB Executive Management Team; Norfolk and Waveney UEC System Transformation Steering Group (STSG); 3 x Acute led Locality Boards SORTs (System, Operations, Resilience and Transformation) **External**: Trust Boards; System Executive Management Group; UEC System Serious Incident Tactical Group System Gold Command Group, set up as required using Operational Pressure and Escalation Levels (OPEL). NHSE UEC Board Assurance Framework being implemented from September 2022.

• Hospital Ambulance Liaison Officers (HALOs) manage effective offload plans for all vehicles on site and support patient and staff welfare • Arrangements in each ED enable a limited number of additional rapid ambulance handovers to release waiting ambulance crews to attend very urgent community calls where there is an extreme risk of adverse clinical outcome from delay • Use of surge beds across acute and community inpatient units provides limited additional capacity to support flow and alleviate pressure on EDs • A System Discharge Dashboard is in place to track discharge delays across organisations • All acute hospitals have ambulance handover plans to improve handover performance and accommodate surges in demand Specific controls to improve discharge • Discharge Director is ensuring best practice is in place via a 30,60,90-day plan and 100 day discharge challenge. • Capacity and Demand modelling work has taken place and funding made available to support an increase in capacity equivalent to 250 acute inpatient beds.	

Gaps in controls or assurances

- Measures to reduce demand arriving at ED have been effective but progress in improving flow through reducing the volume of patients that are awaiting discharge from hospital (i.e.no longer meet the Criteria to Reside) has not been sustained.
- Lack of available care market workforce may compromise additional capacity and delay improvements in discharge flow.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
20/06/22	A Director of Discharge has been appointed from April 2022 to lead a programme of work to review and plan a robust strategy for long term health and care provision that supports discharge demand. Funding has been made available to support an uplift in capacity across a range of care settings, equivalent to an increase of 250 acute hospital beds. Ambulance handover plans are in place at each acute hospital site with a range of actions to reduce handover times to below 60 minutes by October 2022.		31/10/22

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	16	16						
change				New	→	→						

BAF03	
Risk Title	Providers in CQC 'Inadequate' Special Measures (NSFT)
Risk Description	There is a risk that services provided by Norfolk & Suffolk Foundation Trust (NSFT) do not meet the required standards in a timely and responsive way. If this happens, people who use our services will not receive access to services and care that meets the required quality standard. This may lead to clinical harm, poor patient experience and delays in treatment or services.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Karen Watts	01/07/2022	31/12/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	2	4	8

Controls	Assurances on controls
• The report published on 28/04/22 gave an overall reduced rating of inadequate. The Trust was able to provide adequate assurance to mitigate the need for a Section 31 enforcement notice during the inspection. • The Trust's Improvement Plan is over seen by an Improvement Board with a focus on the areas set out in the section 29a letter and Must Do's issued in April 2022. Stakeholder engagement has been strengthened. Evidence Assurance Panel established with attendance by ICB MD and DoN. • Regular NHSE/I Oversight, and Assurance Group in place. Dedicated senior NHSE/I and ICB support has been taken up. • Staff engagement events have taken place across Trust sites and staff groups, with support from the Norfolk & Waveney and Suffolk ICBs. • Weekly internal Performance Board is driving progress. NHSE and ICB are working collaboratively to support the Trust. • Transformation plans continue to progress alongside Quality Improvement. • Strengthened leadership to support key clinical areas. • The ICB MH Strategic Commissioning Team are attending 'pillar' meetings around Culture, Leadership & Governance, Safety, Demand & Capacity and Service Offer. Each pillar is led by an NSFT Executive SRO, supported by an external consultant supporting delivery of the overarching improvement plan. ICB staff are participating in working groups. • ICB supporting Trust with data validation, completion of dashboard and South Norfolk community capacity pilot. • ICB attending Trust Quality and Safety Reviews (QSR) with frontline teams and working closely with NHSE on a governance review.	**Internal:** Clinical Governance Meetings, Quality and Performance Committee, ICB Executive Management Team (EMT), System EMT, SIAG and ICB Board. **External**: ICB attendance at Key Trust Meetings, Care Quality Commission, System Quality Group, Norfolk and Suffolk Healthwatch organisations, NHSE/I Oversight and Assurance Group.

Gaps in controls or assurances

- There is an increase in people presenting with Mental Health problems without previous history, as well as those already engaged with services, as a result of the pandemic. High levels of patient acuity are being reported. Capacity is not currently able to meet demand.
- There is variation in clinical governance processes across the Trust, which means that some service areas are less sighted on their levels of risk to care quality than others.
- Workforce pressures. Staff sickness and absence combined with unfilled vacancies and difficulties recruiting to key posts. Impact of 'inadequate' rating on staff wellbeing and morale.
- 12hr 'decision to admit' breaches reported for patients presenting to hospital Emergency Departments, who require a Mental Health bed, which requires a systemwide health and social care solution.
- There is a risk that progress may be delayed or diluted if Norfolk and Suffolk commissioners are not aligned in their transformation programme, where relevant.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
03/11/21	Progress on the Trust's Integrated Quality Improvement Plan is reported into the weekly internal Improvement Board and to the external Overview and Assurance Group. Ongoing transformation of current pathways for both adults and children to improve access to services.		31/03/23
17/12/21	Additional programme governance has been put in place around 12Hr ED breaches in order to meet the requirement for SOF 4 recovery. This brings together commissioners, service providers and other key stakeholders to implement a system recovery plan looking at early intervention and crisis support, front and back door hospital processes and the 'flow' between these areas.		31/03/23
03/11/22	The ICB supports multidisciplinary meetings for complex patients, where there are difficulties accessing ongoing care for example patients with eating or disorder eating		31/03/23
13/05/22	Since February 2022 the Trust has undertaken Quality Service Improvement Review visits to all of their inpatient areas, revisiting where support is required. Some areas will be ready to be reinspected by CQC. Reviews have now been extended to include community teams and are supported by members of the Norfolk and Waveney ICB Quality Team.		31/03/23
13/05/22	Staff engagement visits have been undertaken across sites, supported by the Norfolk and Waveney and Suffolk ICBs.		31/03/23
13/05/22	Large scale recruitment events have continued with successful recruitment of support workers.		31/03/23
17/06/22	Trust in dialogue with NHSE regarding SOF 4 exit criteria.		31/03/23
17/06/22	Staff engagement with CFYP Teams to support quality initiatives.		31/03/23
25/08/22	Trust reports 80% completion of Must Do's as of end of July 2022. Evidence Panel to meet and provide assurance.		30/09/22
25/08/22	CQC re-inspection due imminently.		30/09/22

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	16	16						
change				New	→	→						

BAF04	
Risk Title	Cancer diagnosis and treatment
Risk Description	There is a risk that patients with cancer will not be diagnosed and treated as early as possible due to the multiple impacts of the pandemic. Delayed diagnosis and treatment can lead to poorer long term outcomes for cancer patients as well as significant psychological distress to those waiting for treatment.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality & Safety	Dr Mark Lim	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	3	9	2	3	6

Controls	Assurances on controls
• Prioritisation of planned care recovery alongside system response to COVID-19 and urgent and emergency care pressures. • The elective recovery board is overseeing significant work to expand the capacity of out patient clinics and elective surgery across the system to address the backlog as quickly and as fairly as possible. • The diagnostics board is overseeing work to transform how diagnostics are performed and organised to increase access to diagnostics for people with confirmed or suspected cancer to accelerate their diagnosis and treatment. • The Cancer Programme Board continues to work in close partnership with regional cancer screening and North EOE Cancer Alliance, supporting work to expand capacity and to transform how care is delivered to increase speed and efficiency of care and elective recovery. Transformation projects are focused on streamlining the 2ww pathways to improve effectiveness and efficiency. • Unified prioritisation and harm review process of reviewing patients on waiting lists for possible harm, to ensure that elective capacity is used to deliver care to patients in order of clinical priority in place at all acute trusts. • There is an ongoing review of 2ww documentation to support more appropriate and complete referrals into the 2ww pathways. • Dedicated capacity for care co-ordination in Primary Care is also being piloted. • Norfolk & Waveney Cancer Programme working with Public Health England to support improved local screening uptake in partnership with local Primary Care Networks. • A new breast screening network has also been set up to specifically address delays in the recovery of that pathway. • Additional educational webinars to Primary Care provided, to support the early recognition of possible cancers, and to reinforce NICE criteria for suspected cancer referrals.	**Internal:** • Monthly reports on elective capacity, waiting times, waiting list size, and recovery against pre COVID care delivery to Elective Recovery Board, reporting to Transformation Board. • Monthly reports on diagnostics capacity, waiting times and backlog to Diagnostics board, reporting to Transformation Board. • Quarterly reports to Cancer Programme Board on screening backlogs. • Oversight of all performance metrics to come to ICB Performance Committee and individual trust data also overseen by NHSEI performance oversight meetings. • All trusts using rolling programme of clinical prioritisation using national definitions to ensure that patients at highest risk of harm are prioritised. • All harms identified subject to duty of candour and incident investigation process and overseen through ICB quality and safety committee. **External**: PHE, NHSE/I, Regional Cancer Network

• A local communication plan is in place to educate patients on worrying symptoms and encourage presentation to Primary Care. • Cancer rapid diagnostic service now operational across the system to support review of patients with nonspecific symptoms which may be suggestive of cancer • Multiple pilots in place to target early diagnosis of specific cancers eg targeted lung health checks from August 22, for people in GY identified to be at high risk of lung cancer before they develop any symptoms. • National Grail trial has included Norfolk and Waveney targeting deprived populations to recruit local residents to access a new biomarker for cancers. Any residents with a positive result are directed onto a 2ww pathway.	

Gaps in controls or assurances

- COVID-19 has had a significant impact on public behaviour in attending screening / seeking support & advice for worrying symptoms. This led to a fall in people coming forward during the pandemic and has in turn led to an increase in people with delayed presentations post the initial peaks.
- It is not possible to define the possible harm on these patients due to delays in their diagnosis until they have been detected and treated but this may be contributing to excess deaths both nationally and within our system.
- The EOE Cancer Alliances are quantifying this risk, with the current estimate of approx 600 missed cancer diagnoses in Norfolk and Waveney over the COVID period.
- Environmental challenge of providing services during continued COVID surges continue in particular re the safe delivery of diagnostic tests and treatments to comply with infection control guidance.
- Staffing resilience due to challenge of operational pressures, self-isolation and sickness
- Availability of capacity and human resources to meet the demand of the backlog, new and follow-up patients and 52 week wait recovery in a timely way whilst managing COVID-19 response
- Significant pressure on breast, colorectal and prostate cancer diagnostic pathways and treatment capacity at the local cancer centre.
- Additional requirement to safely manage backlog and waiting lists across cancer, elective care and diagnostics is leading to increased pressure on administrative personnel and processes which could impact upon appropriate progression of patient pathways, and ability to progress transformative list management
- There remain significant pressures on Cancer Services across the system due to surges in two week wait (2ww) demand with variable performance across providers and pathways. This is putting pressure on Breast, Colorectal and prostate diagnostic pathways and exacerbating long term issues with system cancer waiting time performance. Screening, diagnostic and treatment backlogs continue to be monitored via the system Cancer Programme Board
- A formal plan for the recovery of the NNUH breast cancer pathway is being reviewed internally at present. Operational delivery of the system mutual aid policy/SOP is challenging for the cancer pathways across the trusts as there is little spare capacity and the complex surgery is provided by the NNUH as cancer centre.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
08/04/22	Operational and staffing pressures beginning to ease but still significant. Continued focus on recovering 2ww pathways. Screening, diagnostic and treatment backlogs continue to be monitored via the system cancer programme board.		Ongoing

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				9	9	9						
change				New	→	→						

BAF05A - Adults	
Risk Title	Barriers to full delivery of the Mental health transformation programme
Risk Description	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet the need If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Jo Yellon	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8

Controls	Assurances on controls
• Effective system wide governance framework. • 22/23 Planning submission agreed by NHS England & Improvement Finance working group meets monthly to drive robust financial arrangements Working group and process in place to manage financial slippage and deliver planned MHIS investment. • System commitment to increase knowledge skills and expertise and develop additional capacity through use of digital. • New MH Workforce Lead in post to work with system partners and implement the N&W MH workforce strategy • Ongoing work with Population health management team to proactively contact and offer support/ physical health assessment and vaccination. • Co-developed eating disorder strategy to direct implementation of national ambitions. • Plan agreed to secure services where the contract is due to expire in 22/23 and where quality improvement underway, providing stability and delivery of planned improvement	**Internal:** SMT, EMT, Viard **External**: CYPMH Executive Management Group, CYP Strategic Alliance Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Forum, NHSE/I

Gaps in controls or assurances

- Capacity and commitment within providers to support transformation and collaboration impacted by increased demand and historical backlog
- Impact of continued CQC rating of inadequate for NSFT following CQC visit in November, and publication of report with associated negative publicity end April 2022
- Cultural shift required system-wide to enable successful transformation and ensure mental health is better understood and regarded as 'everyone's business'
- Cultural, digital and operational collaboration to enable access and easily navigable mental health services, is at an early stage of development
- Conflicting priorities across complex system transformation agenda
- Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address.
- Ability to recruit, retain and train a viable number of staff to enable service expansion and meet the MH and well-being needs of the N&W population
- Limited influence on alternative provision within a tightly prescribed IAPT model – National NHSEI and HEE guidance is restrictive and does not allow local flexibility.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
29/04/22	ICB and providers recognise the need for increased programme management support, to support operational and clinical leads to plan and deliver transformation		31/03/23
29/04/22	Joint approach between ICB and NSFT to support response to CQC concerns and joining up the transformation programme plan to deliver sustainable change. Continued commitment to partnership working and enabling system partner response.		31/03/23
29/04/22	Continued development of the N&W MH Partnership Board to effectively lead and model change, and transition to a fully functioning Provider Collaborative in due course (Timeline TBC). Upskilling workstream (one of 4 MH workforce groups) to influence positive change, and co-locating services where beneficial to support joint working.		31/03/24
29/04/22	Continuing to develop effective partnerships and ownership of the N&W MH Transformation Programme Plan. Utilising leadership expertise and frequently reviewing the whole programme, as well as individual projects to ensure effectively joined up. Co-production with Experts by Experience and Reference Group is central to initiating and sustaining positive change.		31/03/23
29/04/22	Collaborative annual planning process supported by regular (e.g., monthly) reviews of priority areas and ensure governance structure and oversight effectively managing inter-dependencies and risk. Shared understanding of conflicting priorities and phased approach to management.		31/03/23
24/08/21	MH Digital Working Group established, co-led by ICB and Provider Leads, involving partners to scope and identify solutions which align to MH Digital priorities.		31/03/23
29/04/22	MH Workforce lead driving development of workforce dashboard, and transformation programme. Working with system partners, to set up 4 focused work groups that will implement the N&W MH workforce strategy.		31/03/24
29/04/22	IAPT N&W System leads working with Regional NHSEI and HEE leads, in conjunction with EofE system leads to work up a proposal to influence a revised approach to IAPT training provision at national level.		31/10/22
29/04/22	Developed Recovery Improvement Plans with support from NHSEI to work towards recovery of trajectories for the following areas: increasing Physical Health Checks for people with Severe Mental Illness, improving Dementia Diagnosis, all negatively impacted by the pandemic which has increased demand, limited opportunity for early intervention and reduced access to services. This will enhance support for areas where N&W do not yet meet the national standard.		31/03/23

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12						
change				New	→	→						

BAF05B - CYP	
Risk Title	Barriers to full delivery of the Mental health transformation programme
Risk Description	There is a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care are not sufficient to meet demand. If this happens individual need will not be met at the earliest opportunity, by the right service or by the most appropriate person and need will escalate. This may lead to worsening inequality and health outcomes, increased demand on other services and reputational risk

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Rebecca Hulme	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	2	4	8

Controls	Assurances on controls
• Dedicated CYP strategic commissioning team now in place • Effective System wide governance framework • Collaboration with system partners to understand demand and capacity has begun and the shared resource is better understood. • Development of robust understanding of the financial envelope available to drive the transformation, and investment necessary, including appropriate measures to reconcile these is still in process. • System approach to increasing knowledge skills and expertise across agencies and developing additional capacity through use of digital. Greatly assisted by digital appointing a digital lead. Digital workstream initiated • Financial slippage is being mitigated against protecting our ability to maintain MHIS investment • Implementation of system wide transformation programme	**Internal:** SMT, EMT, Integrated Care Board, Finance Committee, Quality Committee, **External**: CYPMH Executive Management Group, CYP Strategic Alliance Board, HWBs Norfolk and Suffolk, NW Health and Care partnership MH Board, NHSE/I Regional MH Board and subgroups, HOSC Norfolk and Suffolk, System Improvement and Assurance Group

Gaps in controls or assurances

- Capacity and commitment within providers to support transformation and collaboration impacted by increased demand and historical backlog
- Capacity within the substantive CYP integrated commissioning team to deliver on the scale of transformation required.
- Conflicting priorities across complex system transformation agenda
- Intra-system Electronic Patient Record connectivity, especially at the interface of primary/secondary/social care and third sector provision, remains a challenge and priority to address.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
23/12/21	Schemes for £800K Winter funding to support Urgent and Emergency Care and discharge put forward. Region keen for schemes to continue next year if successful using SDF and MHIS		31/12/22
23/12/21	CYP Senior Programme Manager now in post to lead on the development and mobilisation of the CYP Integrated Front Door which will improve efficiencies and flow through the system		30/06/22

23/12/21	Continued work to address significant historical CYP waits across providers Current system waits for treatment circa 2500 reduced from 3500 March 2021		31/03/22
02/05/22	Six out of ten CYP Integrated Commissioning Team posts are now substantive. Remaining four are fixed term and will be reviewed once Community transformation work is completed		31/03/23
02/05/22	Intensive Day Support for CYP with eating disorders is due to open this month for 5 CYP and their families on a six month test & learn basis before expanding support offer to 12 CYP.		30/11/23
02/05/22	CYP team secured £800K in slippage to support system wide waiting list initiatives, enhanced support for 18-25 and trauma informed training		31/03/22
02/05/22	£180K of winter funding secured to support CYP on acute paediatric wards, development of an integrated practice model and respite for CYP with NDD and their families		31/06/22
02/05/22	Development of Integrated Front Door progressing well, dedicated team in place to develop model, ensure pathways and capacity sitting behind front door will meet the need, procurement process has begun with an expected go live date early 2023. Talking Therapies collaborative being developed as part of model to increase capacity		31/03/23
02/05/22	Mobilisation of three focussed waiting list initiatives to support circa 1000 CYP on waiting lists.		31/12/22
02/05/22	Working alongside adult commissioning team to enhance support offer for 18-25 year olds in wellbeing hubs. Task and finish group set up to improve IAPT offer for 16-25 to improve access, engagement and outcomes.		31/03/23
02/05/22	Increased funding to CYP Crisis team to increase capacity, expand skill mix and increase level of seniority. Scoping out options to meet 24/7 crisis assessment and support offer, in line with NHS Long Term Plan ambition		31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12						
change				New	→	→						

GBAF06	
Risk Title	Health inequalities
Risk Description	The combined long-term impact of the COVID pandemic and recent rapid increases in economic pressures that are impacting on the cost of living and the number of Norfolk & Waveney residents living in absolute poverty further exacerbate health inequalities whilst placing increasing pressure on our health system.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Howard Martin	Patients and Communities	Howard Martin	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	4	16	1	4	4

Controls	Assurances on controls

• NHSE/I 5 Action areas to address inequalities, are embedded into all N&W system recovery plans, 5 year strategy development & operational plans. Progress against key national delivery timelines are regularly reported on via appropriate governance structures.
• Whole system approach to reducing inequalities in development through emerging governance structures.
• Monthly ICS Health Inequalities Oversight Group established and taking place monthly with clear objectives identified to be presented to Exec. Cross-system representation, key workstreams identified, including:
  ○ Data and insight – alignment of system resources to provide clear data picture of need & issues at System & Place level
  ○ Vaccine Inequalities – oversight of approaches to reduce vaccination inequalities & implementation of Wellbeing on Wheels approach.
  ○ Core20+5 – scoping and development of system approach.
  ○ Community engagement – development of Norfolk & Waveney Community Voices programme to respond to People & Communities guidance and provide insights to inform strategy and planning.
  ○ Inclusion health – supporting access to healthcare for underserved communities, including development of roving model.
  ○ NHS Anchors – development of strategic framework to support NHS anchors approaches to tackle wider determinants of health.
  ○ Population health management – alignment of HIOG with new PHM Board in Sept 22 & development of
	Internal: Health Inequalities Oversight Group (HIOG), Health Improvement Transformation Group (HITG), Inclusion Health Group, Integration & Partnership team, Protect NoW/PHM team
	
	External: Integrated Care Board, Health & Wellbeing Partnerships, Place Boards, Clinical and Operational steering groups

PHM roadmap in conjunction with developing digital strategy. ○ Mental health inequalities – supporting mental health transformation agenda and the alignment of resources to reduce MH inequalities. • System Health Improvement Transformation Group (HITG) established with developing work programmes in response to key priorities: ○ Development of system strategy for health improvement & prevention ○ Reduction in smoking ○ Reduction in physical inactivity rates • Development of VCSE Assembly to support integration of VCSE into ICS governance arrangements, which will support a reduction in inequalities and enable preventative approaches. • Elective care recovery – draft EQIA in development • Place Health & Wellbeing Partnerships, along with the Integrated Care Partnership, have recognised the reduction of health inequalities as one of their key priorities, and will be developing localised plans in response.	

Gaps in controls or assurances

- Further development, coordination and oversight of actionable projects to mitigate against risk, respond to gaps and maximise resources, now that governance structures are clearly defined
- Alignment of governance and approaches into overarching ICS HI strategy, informed by foundations developed through HIOG. The aggregation of Place-based projects to ensure we avoid duplication of effort and the maximisation of system resources.
- Development of ICS 5 year strategy – disconnect between strategy development and existing programmes of work/teams.
- System-wide strategy for inequalities and impending cost of living crisis, that will likely affect system pressures – acknowledge this will form part of Place-led strategy through HWB Partnerships.
- Development of BAF/risk log and corresponding work programme & reporting.
- Connectivity between Place Boards/Health & Wellbeing Partnerships and system governance structures, such as HIOG & HITG – opportunity for these structures to 'own' system priorities.
- Duplication of effort, energy and resources at Place level – lack of coordination/sharing of learning between Partnerships.
- Duplication of effort – alignment between ICS governance structures such as HITG/HIOG/ECRB
- Capacity – lack of programme oversight of health inequalities across the system, particularly with reference to Core20+5 & VCSE integration agenda, resources in wider system (i.e. local government) to support agenda, and lack of integration with Public Health
- Resources – ring-fenced resources to support emerging work programmes and respond to system priorities, non-recurrent funding arrangements for existing workstreams, prioritisation of prevention in resourcing strategies
- Evaluation methodology for key work programmes – support required to ensure impact measurement

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
23/12/21	N&W VCSE Assembly is supporting the development of VCSE place-level networks/forums to ensure effective VCSE participation in the place-led discussions, where tackling health inequalities will be a significant priority.		30/08/22
23/12/21	Core20Plus5, health inequalities initiative has been produced by NHSE which will help to galvanise ICS action to tackling health inequalities		31/03/23
31/08/22	Development of ICS 5 year strategy – embedding of HI priorities		31/03/23

31/08/22	Development of clear actionable plans linked to each of the HIOG/HITG workstreams		31/03/23
31/08/22	Development of system & place HI data packs to inform prioritisation & strategy development through HIOG and HWP Partnerships		31/03/23
31/08/22	Development of insights reporting process aligned to Norfolk & Waveney Community Voices programme		31/03/23
31/08/22	Development of PHM strategy, building on learning identified through Protect NoW, Optum & PDP programmes		31/03/23
31/08/22	Inclusion health, population health LCS		31/03/23
31/08/22	Working group to develop and manage system HI risk log, NHSE reporting and update GBAF		31/03/23
31/08/22	Opportunities for further resourcing of Core 20 approach, including EAHSN funding, Core20 Connectors, Core20 Ambassadors & GP fellows programmes and the development of a Core20 Strategy		31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	16						
change				New	→	↑						

BAF07	
Risk Title	RAAC Planks
Risk Description	There is a risk of failure of the current roofing structures at two Norfolk and Waveney Acute Trusts due to their composition with RAAC Planks which are now significantly beyond their initial intended lifespan. This could affect the safety of patients, visitors and staff. The rolling programme of inspections and remedial work to detect and mitigate this also presents a risk to the system through the requirement to close areas for remedial work, further impacting patient and staff experience as well as the ability to deliver timely urgent, emergency and elective care to our patients.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Board	Dr Frankie Swords	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	5	25	4	5	20	3	5	15

Controls	Assurances on controls
• Trusts have robust plans in place to manage a possible incident; however these only cover immediate evacuation and not reprovision • Regular surveys and assessments are being carried out to determine the severity of the issue and to identify and address signs of deterioration. • Region-wide scoping piece commissioned to look at ongoing service transition and recovery expected to report by the end October 2022 • Current work ongoing to address issues found on inspection as issues identified. Each issue is separately risk assessed using NHSE led guidelines for 'Best Buy' hospitals and a RAACter Scale used to assess level of issue. • ICB seeking legal position on their responsibilities should there be a catastrophic failure at either acute. • Exercise Walker Spring 2022 – Region-wide desk top exercise to test current business continuity plans with ongoing rolling programme	**Internal:** SMT, EMT, ICB Board **External**: ICS Boards, Estates, NHSE/I, Individual trust boards

Gaps in controls or assurances
• QEH not currently in line for HIP2 support

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
16/02/22	Scoping piece to assess service transition and recovery post RAAC failure to conclude in July 2022, now expected the end of October 2022		ongoing

Visual Risk Score Tracker												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20						
change				New	→	→						

BAF08	
Risk Title	Elective recovery
Risk Description	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, failure to meet Constitutional requirements and may lead to an increased risk of clinical harm for individual patients resulting from prolonged waits for treatment.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Dr Frankie Swords	Quality & Safety	Dr Mark Lim	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	3	4	12

Controls	Assurances on controls
• he Elective Recovery Cell was upgraded to an Elective Recovery Board meeting bi-weekly. • Each Provider has undertaken a waiting list clinical validation process. • Workstreams are in place to expand capacity where possible, maximise efficiency of current services, to reduce variation in waiting times between different providers and to transform care pathways to accelerate elective recovery, each led by a chief operating officer or medical director. • A unified process of clinical harm review and prioritisation in line with national guidance is now in place across all providers to ensure that patients' care is undertaken in order ot clinical priority and to prevent harm where this is identified as a risk. • Local data have ben uploaded onto the new national patient resource to allow patients to identify average waiting times and to provide additional information to support people to improve their health and wellbeing whle awaiting care https://www.myplannedcare.nhs.uk/ • A more detailed local patient information site has also been established: https://norfolkandwaveneyICB.nhs.uk/while-you-wait	**The initial focus to clear all patients waiting 104 weeks or more across our system by 1 July 2022 was met with data confirmed by NHSEI.** **Internal:** Weekly and monthly performance metrics for each workstream scrutinised at biweekly elective recovery board. **External**: Trust Board Governance processes and returns to NHSEI, National contract monitoring by NHSEI and Elective Recovery Board.

Gaps in controls or assurances
• The situation around patients waiting over 78 weeks remains challenging and is the specific focus of a summit meeting. • Ongoing staffing challenges, as well as the operational impact of RAAC plank issues has led to a fall in performance against trajectory since July 2022. • The digital infrastructure remains a concern. Although a system for managing patients on a single waiting list has been developed, due to competing priorities relatively little support has been available for outpatient transformation.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**

16/05/22	The situation around patients waiting over 78 or 104 weeks remains challenging and is the specific focus of a summit meeting.		31/03/23

Visual Risk Score Tracker – 2022/23												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20						
change				New	➔	➔						

BAF09				
Risk Title	NHS Continuing Healthcare			
Risk Description	There is a risk that NHS Continuing Healthcare (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 and effective care packages will be compromised. This may lead to increased financial cost to secure a care package, could impact on hospital discharges and admissions and poor outcomes for people requiring NHS funded care in the community.			
Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Tricia D'Orsi	Quality & Safety	Sarah Jane Ward	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	3	9

Controls	Assurances on controls
• Recruiting to vacant posts within the CHC team to support assessments and care sourcing. • Commence work with finance team and contract team in NWICB and Local Authorities (LAs) to work to stabilise the market. • Link with Local Authority (LA) workforce teams to support care providers in additional training and support required. • Regular financial updates to Finance Committee and Executive Management Team (EMT) to monitor impact of cost of care packages. • Monthly operational finance meetings for Quality in Care (QiC) team. • Monitoring of time taken to secure complex care packages and escalation process for CHC team if unable to source. • Attendance at regional meetings to support feedback and sharing of good practice and innovation. • CHC Business Intelligence (BI) has developed relevant pictorial data sets for analysis which are included in the monthly QiC Quality report for the Quality & Safety Committee. • Weekly meetings held with Norfolk and Suffolk NHS Foundation Trust (NSFT) and NCC to improve communication and partnership working around discharge planning. Complex discharges from acute mental health hospital beds are progressively delayed by lack of suitable complex care in the local provider market. • Contracting, Finance and CHC teams collaborating to share relevant information regarding uplifts.	**Internal:** Senior Management Team (SMT); EMT; Quality & Safety Committee; Finance Committee; Board **External**: NHS England/Improvement; Regional CHC Team, Joint Collaborative Forum (Norfolk County Council (NCC)), Care Market Cell (Suffolk County Council), System partners

Gaps in controls or assurances
• Ability to source and retain suitable workforce for either the NWICB CHC team or care provider market

- Lack of a whole system Care Workforce Strategy
- Ability to stabilise the care market post Covid-19 and EU Exit
- Capacity of CHC team to source or revise care packages
- From 30/06/22, funded Discharge to Assess pathway 3 ceases. CHC team does not have staff resources to manage the extent of workload that will require progressing.
- Following the CHC contract procurement in October 2022, as at 02/09/22, there are 125 CHC eligible individuals with ICB commissioned care who do not have a provider with a current NHS contract. We currently continue to commission new packages of care with some of these providers. Full details are within Quality and Safety risk QiC-CHC-027 'Care providers without contracts'.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
11/02/22	Active recruitment into newly established roles to enhance the team's capacity and maximise clinical functionality of the team. Eight new commissioning support officers and two nurses.		30/09/22
14/04/22	NSFT Discharge to Assess model to continue. £100K available to continue this scheme.		30/09/22

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	16	16						
change				New	➔	➔						

BAF10	
Risk Title	EEAST Response Time and Patient Harms
Risk Description	Ongoing systemwide pressures continue to result in conveyancing delay, in the community and transferring between care providers, as well as longer handover time of patients at Emergency Departments and ambulances waiting to clear for redeployment into the system. This is impacting on Ambulance Service ability to assess, treat and convey patients according to emergency needs, incurring significant patient harms and impacting on the wellbeing of frontline staff. There is a risk that service delivery will continue to be impacted across the Norfolk & Waveney footprint.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Tricia D'Orsi	Quality & Safety	Karen Watts	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	5	25	5	4	20	3	3	9

Controls	Assurances on controls
• Daily sit-rep ensures ICB is sighted on real-time demand and resource. • HALO role and cohorting in place across all Acute sites to support ED. Pre-alert and 'drop and go' processes in place with safety netting for patients waiting to be seen. Ambulance revalidations embedded. • Proactive public comms to promote appropriate use of NHS service options. This is reinforced across seasonal campaigns. • Internal ICB meeting held with UEC and Primary Care colleagues regarding emerging Primary Care harms. • ICB has confirmed that funding of JPUH and QEHKL HALO resource will continue. • Tactical Group set up to implement new SI 'System' Learning approach in Norfolk & Waveney. • Pilot of 'drop and go' for high-risk C2 calls in place across the three Acute Hospitals. • Pilot of a multi-disciplinary review of some 999 calls, integrating through CAS at IC24, in place.	**Internal:** EMT, N&Q Senior Team, ICB Clinical Lead for UEC and UEC Commissioning Team, ICB Quality and Safety Committee, ICB Board, Provider Governance Forum. **External**: Regional Commissioning Consortium, NHSE Regional Team, OAG and CQC.

Gaps in controls or assurances

- The Trust has seen prolonged periods of high activity which continues to fluctuate from REAP level 4 and surge levels 2 to 4. Systemwide pressures impact on the ability of Ambulances to handover patients at the Emergency Departments (ED) and release to respond to new calls in a timely way. Incidents have been reported by Primary Care, where Health Care Professionals have assessed the need for an Ambulance and experienced a significant delay in response. Incidents have also occurred where transfers from local Acute Hospitals out to tertiary centres for specialist care have also been delayed.
- Patient harms have increased in July 2022, which has triggered an increase in risk rating.
- Discharge pressures, effecting patient flow through Acute Trusts. Significant challenge in social care re. capacity and workforce required to support packages of care in the community.
- Variation in use of alternative pathways. Scope for more work to be done around signposting into alternative pre-hospital provision.
- The Trust continues to experience workforce challenges in relation to recruitment, retention and wellbeing and morale. System pressures are compounding this, leading to a significant risk to the resilience of teams

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
21/09/21	Close monitoring of serious incidents and associated harms, ensuring sharing of information with the lead commissioner. System-wide operational meetings in place daily with on-call arrangements to manage system pressures. System-wide focus on handover delays due to risk of harm to patients. Tactical Group in place to enable systemwide learning and solutions.		31/03/23
17/11/21	Commissioners are sighted on the change to paediatric conveyance threshold and are working with the Trust and system partners to review the potential impact of this change on clinical quality and patient safety.		31/07/22
17/06/22	'Perfect Week' planned for July 2022. This will include Ambulance Handover Delays. The premise of the week is to adjust daily working practices to ensure that the right number of staff are able to do the right thing at the right time to support the safe, effective and timely care of patients and explore alternative pathways.		31/08/22

Visual Risk Score Tracker – 2022/23												
Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	20	20						
change				New	↑	→						

BAF11	
Risk Title	Achieve the 2022/23 financial plan
Risk Description	If the ICB does not deliver the 2022/23 Financial Plan of a break-even position, then the ICB may not be able to maintain spending on current levels of service, or to continue with plans for further investment. This may lead to a reduction in the levels of services available to patients

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steve Course	Finance	Jason Hollidge	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	2	4	8

Controls	Assurances on controls
• Monthly monitoring of risks and mitigations, reported to NHSE/I. • Detailed plan for 2022/23 approved by Board and submitted to NHSE/I as part of the break-even system plan. • Monthly Finance Report presented to Finance Committee and Board.	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports, Budget manager review. **External**: ICB assurance process, early flagging of risk with NHSE/I.

Gaps in controls or assurances

- Identification of risks and associated mitigations reviewed on a monthly basis;
- Escalation to EMT, Finance Committee and Board if appropriate, should total unmitigated risks crytalise;
- No contingency reserve in plan;
- £5.4m of unmitigated risk in the plan.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
14/07/22	Review of M5 year to date performance and assess forecast out-turn evaluated risks and mitigations.		Ongoing

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				16	16	16						
change				New	→	→						

BAF11A	
Risk Title	Underlying deficit position
Risk Description	If the ICB underpins its financial position via non-recurrent funding, then, this provides a risk to future years financial sustainability due to lower allocations based on historic expenditure.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Steve Course	Finance	Jason Hollidge	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	5	4	20	3	4	12

Controls	Assurances on controls
• Analysis and understanding of underlying recurrent position, including drivers of the deficit. • ICS Medium Term Financial Model has been developed that suggests an improving position over future years	**Internal:** Board Reports and Minutes, Audit Committee reports and Internal Audit work plan, Finance Committee reports. **External:** ICB assurance process, early flagging of risk with NHSEI.

Gaps in controls or assurances

- ICB has an underlying deficit position of c£38m with no plan at present to bring to a break even position.
- Development and approval of Medium Term Financial Plan is not yet complete.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
06/09/22	Develop ICS (and ICB) medium term financial strategy to assess achievability of a break-even position. This requires significant levels of efficiencies to be delivered over a continuous time frame.		30/09/22
08/09/22	Understanding of the key drivers of the underlying deficit identified and work continues to attempt to reduce this position.		31/03/23

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20						
change				New	→	→						

Norfolk and Waveney ICB aim: To make sure that you only have to tell your story once

Principal risk: That people in Norfolk will have their time wasted due to lack of integration and poor data sharing between different providers of health and care. This could lead to frustration for patients and staff, and introduce errors due to multiple handovers of information

Summary of risks

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
BAF12	Cyber Security				15	15	15						
BAF13	Personal data				20	20	20						

BAF12	
Risk Title	Impact on Business Continuity in the event of a Successful Ransomware Cyber Attack
Risk Description	Current heightened risk of hostile cyber attack affecting the UK may, via a ransomware attack, impact on the ICB's ability to maintain business continuity, if access to data stored within Office 365 on the national NHS tenant, is compromised or prohibited (by data getting onto and corrupting the local network via Ransomware)
ICB priority	To make sure that people can live as healthy a life as possible

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Andrew Palmer	Board	Anne Heath	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	3	5	15	2	3	6

Controls	Assurances on controls
• ICB and CSU are already signed up to receive CareCERT alerts. Remedial action is implemented where necessary • Windows 10, Threat Protection and MDE are in place for ICB and Primary Care devices • Secure boundary protection is in place • Ivanti patching process to prevent Ransomware getting on the network • The process for accessing the out of hours support provided by NHS Digital to resolve major incidents will be established	**Internal:** Cyber Security Assurance Manager, Head of Digital, IG Working Group, NWICB N365 Technical Workstream Delivery Group **External**: National Cyber Security Operations Centre, NHS Digital, AGEM CSU, MTI Technology Limited (technical partner to NHS Digital)

Gaps in controls or assurances

- An organisation's staff are the first line of defence in preventing a ransomware attack so can be a control and a risk. The threat posed by Ransom Cyber Attacks is greatly driven by user's behaviour. Greater Cyber Security awareness provides better prevention. A lack of awareness in users to recognize Phishing emails increases the risk of a successful Ransomware Attack happening. Good awareness can help prevent them. A new campaign will be launched for winter.
- Staff passwords may not follow best practice as the most recent advice has not been communicated – an awareness campaign has been run and will be part of a new campaign for winter.
- Staff may not be aware that their online presence on social media, whether work or personal, may reveal details that can be used to access their account – a digital footprint awareness campaign will be run in the autumn.
- A protocol informing staff of how to act in the event that they do become the victim of a phishing attack needs to be put together and made available to all staff in a prominent location, this should include details of "first aid" actions a user can take as well as how to notify the service desk and how to escalate the issue if they feel the response is not adequate.
- A source of resources and information for staff on how to prevent and report a phishing or ransomware attack has been put in place and is available on the intranet.
- Advice and guidance for staff on how to activate MFA is currently being developed. NHS Digital have provided specific advice that this is rolled out first to finance teams.
- Starter and leaver processes for NHS mail accounts are not standardized either within the ICB or Primary Care – users need to be made aware how important it is that all leavers have their NHS Mail accounts disabled – this guidance is currently being developed.
- The ICB is asked to provide NHS Mail accounts for non ICB or Primary Care staff – current cyber awareness training does not include these groups and they therefore pose a greater threat. NHS Digital advice is that organisations must meet DSPT standards.
- There is no out of hours cyber process for on-call managers to follow
- Out of hours cyber support from the commissioned IT provider is on a goodwill basis only
- There is no out of hours cyber support for Primary Care staff
- Microsoft 365 works on a system of retention rather than traditional backup. DSPT requires evidence of backup.

- Currently unable to test how support from the national Office 365 team will support the ICB to recover data in the event of a cyber attack .
- There is no regional Cyber Security Operations Centre (CSOC) available to provide expert technical resource to support business continuity, data recovery and cyber breach remediation – although there is evidence of NHS Digital providing this function to other organisations.

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
16/05/22	Cyber security behaviour change support and awareness package with clear guidance being developed to include: • how to spot and report a phishing email • how to get help if you have fallen for a phishing email • campaign to improve password security • campaign to raise awareness of giving your data away on social media • campaign to encourage self-enrolment for MFA • provision of a channel dedicated to cyber awareness and information making MFA mandatory for non ICB or Primary Care staff provided with an NHS Mail address		Complete – further campaign for autumn planned
16/05/22	Guidance has now been provided which includes a central Data Security helpline where all incidents can be reported and the nhs.net helpdesk should be contacted for the recovery of data.		Unknown
16/05/22	Details of CSU point of contact for cyber security issues will be made available to silver and gold on-call directors via EPRR lead		31/07/22
16/05/22	Assurance has now been provided by NHS Digital both nationally and regionally to a level that meets DSPT requirements.		Complete
16/05/22	Digital Team currently testing implementation of InTune with mobile device management. Before scoping and agreeing rollout to staff using ICB issued and personal devices to access NHS Mail and MS Teams to be implemented as part of transfer to new IT provider		31/10/2022
16/05/22	A feasibility including costed plan for the implementation of MFA for all staff across both the ICB and Primary Care is being developed and will be presented to the ICB's September IG Working Group.		30/09/2022

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				15	15	15						
change				New	➔	➔						

BAF013	
Risk Title	Personal data
Risk Description	There is a risk that the ICB's constitution and statutory / delegated functions will not permit it to process personal data without consent, once the protection of the current COPI Notice ceases on 30 June 2022; particularly functions that have been stood up during the pandemic. This also includes the risk to the CEfF (the access to controlled financial data pertaining Patient Identifiable Data). The ICB has not as yet been given legal right to access personal confidential data
ICB priority	To make sure that people can live as healthy a life as possible

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Andrew Palmer	Audit and Risk	Anne Heath	01/07/2022	31/03/2023

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	5	20	4	5	20	3	3	9

Controls	Assurances on controls
• Guidance from the ICS Establishment CoP suggests that all functions currently conducted by a CCG can transition to an ICB Constitution for NHS Norfolk and Waveney ICB allows for the transition of all functions delivered by the CCG	**External:** ICS Establishment COP and EOE IG ICB Transition Group **External**: IG Working Group and Population Health and Care Operational Delivery Group

Gaps in controls or assurances

- Functions established under the COPI Notice, which the ICB wishes to continue will need to move to BAU with supporting Data Sharing or Data Processing Agreements
- Buy in from GP Practices to enable the ICB to continue to use primary care data for functions such as the Virtual Support Team, after the COPI Notice has expired

Updates on actions and progress

Date	Action	RAG	Target completion
10/06/22	A review of services has been conducted using COPI registers and the outcome has identified the areas that require to continue to process data.		complete
10/06/22	A data processing contract was agreed with Kafico and has been disseminated to General Practice to support areas which have been identified as BAU for the ICB and would need to continue. PHM team collating update of signed agreement.		complete
10/06/22	Letter from director of Data and Information Management systems of NHSE provided on 28th June 2022 detailing the CAG approval of the amendment from CCG to ICB for the existing section 251 agreements in place for invoice validation and risk stratification.		complete
23/08/22	PHM team are engaged with practices for signatures of agreements. IG team are seeking regular updates for assurance that agreements are being signed.		

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				20	20	20						
change				New	→	→						

Norfolk and Waveney ICB aim: To make Norfolk and Waveney the best place to work in health and care

Principal risk: That people will not want to work in health and care in Norfolk and Waveney leading to difficulties recruiting and retaining staff. This could lead to difficulties in providing our services

Summary of risks

Ref	Risk description	Month risk rating											
		1	2	3	4	5	6	7	8	9	10	11	12
BAF14	#WeCareTogether People Plan				12	12	12						
BAF15	Staff Burnout				12	12	12						
BAF16	Primary Care resilience				12	12	16						
BAF17	Financial Wellbeing						12						

BAF14	
Risk Title	#WeCareTogether People Plan
Risk Description	There is a risk that there is failure in the implementation of our *#WeCareTogether* People Plan in respect to improving health and wellbeing, creating new opportunities, maximising skills of our staff and creating a positive and inclusive culture at work. If this happens then we will not achieve our goal to be the 'best place to work'. This may lead to increased sickness and turnover, high vacancies and poor patient care, and our people may experience bullying and discrimination.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Emma Wakelin	People and Culture	Emma Wakelin	01/07/2022	01/04/24

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	3	3

Controls	Assurances on controls
ICB controls • Staff Involvement group in place provides forum for reps from the ICB to discuss internal topics relating to our people • SMT – review of ToR for this group to ensure the role and remit aligins to requirements of ICB, this will include oversight and management of some people functions • OD plan implementation – Plan has been running for 24 months but would benefit from enhanced resource to address all elements of people within an effective organisation • Associate Director of Workforce Transformation working closely with ICB DoN and MD to collaborate on workforce transformation • AD Workforce Transformation meets on a monthly basis with Chair of Remuneration, people & Culture Committee System Alignment • Monthly Health and Wellbeing Board Systems Leads meeting to respond to the emerging needs and issues in place. • Bi weekly Workforce Workshops commenced which showcase workforce transformation activity and allow our staff across ICB and ICS to attend to hear more, ask questions, and collaborate on the #WCT programme • Monthly Workforce Governance meetings in place to steer discussions on: growing our own; up skilling staff. *#WeCareTogether* People Plan has over40 key projects to help us achieve our goal. • Inclusive Culture: Monthly EDI Systems Inclusions meeting to; develop a system plan to shape and support an inclusive and just culture; respond to any emerging needs and issues; support focus groups to enable staff to have a voice in shaping this work. • *#WeCareTogether* system wide People Plan in place since August 2020.	**Internal:** EMT, SMT, SIG

Gaps in controls or assurances
• Lack of clarity for People Function within ICB – People Director or Director of Governance portfolios to be agreed. Insufficient internal people resource to deliver requirements of people function to ensure the ICB is a healthy and effective organisation. Review of statutory people functions and those required to transform the ICB is underway which will include key risks and mitigations for EMT to review. • Greater focus on internal staff communication and engagement is required • Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements • Lack of dedicated resource to effectively analyse our 'people data'; a 'people dashboard; that is reviewed and considered with the same scrutiny as operational and financial performance • Lack of significant and consistent progress/focus on WRES standards. • Lack of sight on impact of retention, wellbeing as a result of Covid retirement flight risk, burnout, might undermine our grow, attract and retain strategy. Increasing sickness levels against historic picture. • High vacancies and sickness levels.

Updates on actions and progress			
Date opened	**Action / update**	**BRAG**	**Target completion**
26/12/21	We now have 4 workstreams (system recruitment, reducing sickness, bank & agency, e-rostering) mapped to our SOF 4 plan for workforce. These workstreams will be monitored at the monthly system finance meetings and the WDG. These themes will reduce workforce risks on implementation.		31/3/23
30/03/22	Workforce Dashboard to monitor high level milestones and assess progress in place.		31/03/23
01/04/22	EDI lead commenced in role to support focus on WRES and Inclusion across the system.		31/03/23
19/08/22	ICS people plan #WeCareTogether will be refreshed (national mandate) – resource secured to lead this work which will ensure ICB staff are included		Ongoing

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12						
change				New	→	→						

BAF15	
Risk Title	Staff burnout
Risk Description	Burnout is measured by three elements. • Exhaustion - an imbalance between work demands and individual resources. • Individual strain - an emotional response of exhaustion and anxiety, which is heightened by not feeling effective • Defensive coping - changes in attitudes and behaviour, such as greater cynicism System pressures (increasing activity, workforce vacancies, sickness, and resilience) have increased the risk of fatigue and exhaustion. We are seeing increases in poor physical and mental wellbeing, low morale and motivation. The transition from CCG to ICB also presents a risk of staff feeling unsettling and anxious in line with a change process which will require focussed support to lead people. The narrative that we are failing to meet targets (clinical and financial) is constant. Individuals need to feel they are making a difference. This could lead to an increase in staff absence rates (short and longer term), retention and most worryingly significant mental and physical issues. If this happens this could have a significant impact on the services that they deliver.
ICB priority	To make Norfolk and Waveney the best place to work in health and care

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Emma Wakelin	People and Culture	Emma Wakelin	01/07/2022	31/03/23

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	3	4	12	1	4	4

Controls	Assurances on controls
• We are seeing an increase in ICB staff requesting support from System Workforce Team – in particular line management culture change, new ways of working, developing teams. • The Staff Involvement Group and Senior Management Team continue to flag issues regarding economic and cost of living rises – agreement to add as a new risk to ICB corporate risk register as the impact of lifestyle pressures will impact on peoples resilience and increase likelihood of burnout • Discussion at future EMT regarding the Internal People function is tabled, the incoming People Director is a HR professional and we will seek their guidance on future form and function • Despite the 2022 pay increase, with the pension contribution changes some of our staff will be worse off. Add this to the cost-of-living pressures (see BAF17) this could further demotivate	**Internal:** SMT, EMT, ICB Board, Staff Involvement Group, Wellbeing Guardian **External**: ICS Boards, NHSE/I

Gaps in controls or assurances
• Changes in NHS legislation, increased/additional workload and pressures post pandemic • Issues are not new, they have been enhanced by the pandemic – longer term culture change required to support staff (especially in our appoach to Flexible Working to support our people to obtain a better work/life balance) • Currently no dedicated budget or resource to support health and wellbeing initiatives

- Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
October 2021	Established H&WB Champions and Steering Group, utilising NHS H&WB Diagnostic and resources to shape actions and approach		31/01/23
May 2022	In response to NSS results, pilot new approach to wellbeing conversations, incorporating available resources and support. Fully implement in July 2022		30/07/22
May 2022	Communications and engagement review has now completed with findings to be presented to EMT in August/September		September 2022
May 2022	Refocussed Extended Senior Leadership agenda to focus on the People Promise values and to include regular updates and opportunities to receive updates, share information, and collaborate on the change process for the ICB. Meetings now held face to face to encourage collaboration and enhance relationships		September 2022

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	12						
change				New	→	→						

BAF16	
Risk Title	The resilience of general practice
Risk Description	There is a risk to the resilience of general practice due to several factors including the ongoing Covid-19 pandemic, workforce pressures and increasing workload. There is also some evidence of increasing poor behaviour from patients towards practice staff. Individual practices could see their ability to deliver care to patients impacted through lack of capacity and the infrastructure to provide safe and responsive services will be compromised. This will have a wider impact as neighbouring practices and other health services take on additional workload which in turn affects their resilience. This may lead to delays in accessing care, increased clinical harm because of delays in accessing services, failure to deliver the recovery of services adversely affected, and poor outcomes for patients due to pressured general practice services.

Risk Owner	Responsible Committee	Operational Lead	Date Risk Identified	Target Delivery Date
Mark Burgis	Primary Care	Sadie Parker	01/07/2022	31/03/2023

Risk Scores

Unmitigated			Mitigated			Tolerated		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
5	4	20	4	4	16	3	4	12

Controls	Assurances on controls
• Locality teams and strategic primary care teams prioritised around supporting the resilience of general practice, dedicated resource to support the Covid vaccination programme. All practices have been supported to review business continuity plans • PCN ARRS (additional roles reimbursement scheme) funding has increased again in 2022/23 • Primary care workforce and training team working closely with locality teams to identify clinical and volunteer workforce and to ensure training available to support practices and PCNs in setting up and maintaining services • Resilience funding process has been completed earlier this year (Q2) to provide practices with more opportunity to bid and respond	**Internal:** EMT, Strategic Command, SMT, workforce steering group, primary care cell **External**: Primary Care Commissioning Committee, NHS England via delegation agreement, Health Education England, Norfolk and Waveney Local Medical Committee

Gaps in controls or assurances

- Practice visit programme, CQC inspections focused on where there is a significant risk or concern
- Unplanned risk associated with outbreaks or positive cases
- Impact of ambulance delays diverting practice teams from routine and urgent care to respond to emergencies
- Continued reports of poor patient behaviour across practices, decrease in patient satisfaction with general practice through GP patient survey, consistent with national position

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion
01/09/22	This risk (resilience impact due to Covid-19 pandemic) has been combined with an additional primary care risk (general practice resilience) following agreement at the primary care commissioning committee in July.		30/11/22

	Resilience funding process has been completed with practices invoicing where funding has been awarded. It is expected there will be national funding for general practice for winter – discussions are taking place to determine how to invest this funding for best impact. There has been an unplanned influx of asylum seekers into our system in August and September, with several local hotels being procured as contingency accommodation. This is having an impact on practices local to the hotels, as well as on wider health and care partners. Work is underway to support both an immediate response and a longer-term system approach to the needs of asylum seekers. There are currently four practices rated as inadequate by the CQC, requiring increased support and development from multiple teams in the ICB, as well as the increased work and focus for the teams in the practices to respond. Training and learning are being shared with all practices on an ongoing basis.		

Visual Risk Score Tracker

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score				12	12	16						
change				New	→	↑						

BAF17	
Risk Title	Financial wellbeing
Risk Description	There is a risk that in the current climate staff will become increasingly under pressure to maintain cost of living. As well as financial wellbeing, this will also impact on peoples physical, mental and social wellbeing – which is likely to impact on resilience and productivity at work. People may also consider alternative employment which offers more flexibility or increased income, take on secondary jobs, or access other avenues outside of workspace to increase financial wellbeing. We also anticipate this will affect working arrangements – for example, reluctance to attend f2f meetings because of fuel or parking costs, or an increase in requests for office working in the winter to reduce personal heating bills which will affect the space available at our sites (eg NCC).
ICB priority	To make Norfolk and Waveney the best place to work in health and care

Risk Owner	**Responsible Committee**	**Operational Lead**	**Date Risk Identified**	**Target Delivery Date**
Emma Wakelin	People and Culture	Emma Wakelin	01/08/2022	ongoing

Risk Scores								
Unmitigated			**Mitigated**			**Tolerated**		
Likelihood	Consequence	Total	Likelihood	Consequence	Total	Likelihood	Consequence	Total
4	4	16	4	3	12	4	4	12

Controls	**Assurances on controls**
• Monthly Staff Involvement Group Meetings in place with representation from all Directorates provides a safe space to highlight risks and issues for staff wellbeing that can be responded to • Weekly staff briefings will have regular inputs from SIG members with information and guidance for support and to demonstrate that we hear and are doing what we can to support staff needs • Recognition that financial wellbeing can affect any member of staff regardless of salary – SMT and EMT to recognise this to ensure compassionate and mindfulness to all staff • Identification of an Employee Reward and Benefit Programme. Many other organisations in our system offer this but the ICB does not have anything in place. They also offer an integrated Employee Assistance Programme (EAP) to support wellbeing and advice on financial management. We do have an EAP which we currently pay for, but sits in isolation under HR. Perhaps not utilised as much as it could be. Plans will include potential alignment to ICS Partner organisations to maximise offer for our system workforce. • Close working with ICS partner organisations coordinated through the ICB System Associate Director of Workforce Transformation and HRD network. This includes a T&F group for financial wellbeing with reps from NHS Providers, LA, and ICB.	**Internal:** SMT, EMT, ICB Board, Staff Involvement Group, Remuneration People & Culture Chair **External**: HRDs, N&W People Board

• EoE Regional Teams (HEE/NHSEI) also provide support, resources and regular updates on national responses.	

Gaps in controls or assurances

- This is a macro issue, relatively outside of our control. The country's economic climate shows no sign of easing
- Currently no dedicated budget or resource to support health and wellbeing initiatives nor a dedicated Health and Wellbeing Co-ordinator with expertise in all elements of wellbeing. This would be beneficial as we currently rely on volunteer HWB champion roles.
- Change in roles for Health and Wellbeing, EDI, and Freedom to Speak up Guardians represents a risk until we identify replacements

Updates on actions and progress

Date opened	Action / update	BRAG	Target completion

Visual Risk Score Tracker – 2022/23

Month	1	2	3	4	5	6	7	8	9	10	11	12
Score					12	12						
change					New	➔						

Norfolk and Waveney
Integrated Care Board

Norfolk and Waveney Integrated Care Board (ICB)

Risk Management Framework

Document Control Sheet

This document can only be considered valid when viewed via the ICB's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one online.

Approved documents are valid for use after their approval date and remain in force beyond any expiry of their review date until a new version is available.

Name of document	Risk Management Framework
Version	0.1
Date of this version	TBC
Produced by	Martyn Fitt, Corporate Affairs Manager
What is it for?	To ensure the ICB complies with its statutory duty to effectively manage risk
Evidence base	HM Government Orange Book
Who is it aimed at and which settings?	All Norfolk and Waveney system partners, the public and patients
Consultation	N/A
Impact Assessment:	EQIA
Other relevant approved documents	
References:	
Monitoring and Evaluation	
Training and competences	
Reviewed by:	ICB Board
Approved by:	ICB Board
Date approved:	27 September 2022
Signed:	
Dissemination:	
Date disseminated:	
Review Date:	1 October 2023
Contact for Review:	Corporate Affairs Manager

Version Control

Revision History	Summary of changes	Author(s)	Version Number
1	Approval for the Norfolk and Waveney ICB	Corporate Affairs Manager	1

Contents

1 Introduction

1.1 This policy applies to NHS Norfolk and Waveney Integrated Care Board, hereafter referred to as "the ICB".

1.2 The ICB recognises risk management as an essential business activity which underpins the delivery of its objectives. A proactive and robust approach to risk management can:

- Reduce risk exposure through the development of a 'lessons leant' culture and environment and more effective targeting of resources.
- Support better informed decision making to enable innovation and opportunity.
- Enhance compliance with applicable laws, regulations, and national guidance.
- Increase stakeholder confidence in corporate governance and the organisation's ability to deliver.

1.3 This framework incorporates the key principles described in *"The Orange Book – Management of Risk – Principles and Concepts" (HM Government)*:

- Risk management is an essential part of governance and leadership and is fundamental to how the organisation is directed, managed and controlled at all levels.
- Risk management is integral to all organisational activities, supporting decision making and the achievement of objectives, incorporated within strategic and operational planning processes at all levels across the ICB.
- Risk management is collaborative and informed by the best available information and expertise.
- Risk management processes include: risk identification and assessment, risk treatment, risk reporting and continual improvement.

Building on this, the ICB will:

- Ensure all staff are provided with appropriate guidance and training on the principles of risk management and their responsibilities to implement risk management effectively.
- Foster a culture of openness that encourages organisation wide learning.
- Develop an appropriate risk management culture and will regularly review and monitor the implementation and effectiveness of the risk management process.

1.4 The ICB recongises it is impossible to eliminate all risk from its activities and that systems of control should not stifle innovation and the imaginative use of limited resources to achieve health benefits for the population of Norfolk and Waveney.

1.5 The ICB acknowledges the need for all its commissioned services to have in

place rigorous risk management systems and processes as described in the Francis Report (May 2013).

1.6 The values of the organisation (Inclusive, Respectful, Innovative) support our risk culture and our risk management framework supports our values through an open, fair and positive learning culture.

2 Purpose

2.1 The purpose of this policy is to provide a framework which enables staff to understand the need to undertake effective identification, assessment, control and action to mitigate or manage the risks affecting the ICB. It is supported by a Risk Handbook which guides staff internally through this process in more detail.

2.2 This policy sets out an organisation wide approach to managing risk, in a proportionate, straightforward and clear manner for timely, efficient and cost-effective management of risk at all levels within the organisation.

This policy aims to:

- ensure that risks to the achievement of the ICB's objectives are understood and effectively managed;
- ensure that the risks to the quality of services that the organisation commissions from healthcare providers are understood and effectively managed;
- assure the public, patients, staff and partner organisations that the ICB is committed to managing risk appropriately; and,
- protect the services, staff, reputation and finances of the ICB through the process of early identification of risk, risk assessment, risk control and, if possible, elimination.

3 Definition

3.1 ISO 31000:2018 defines risk as the "effect of uncertainty on objectives" and states that:

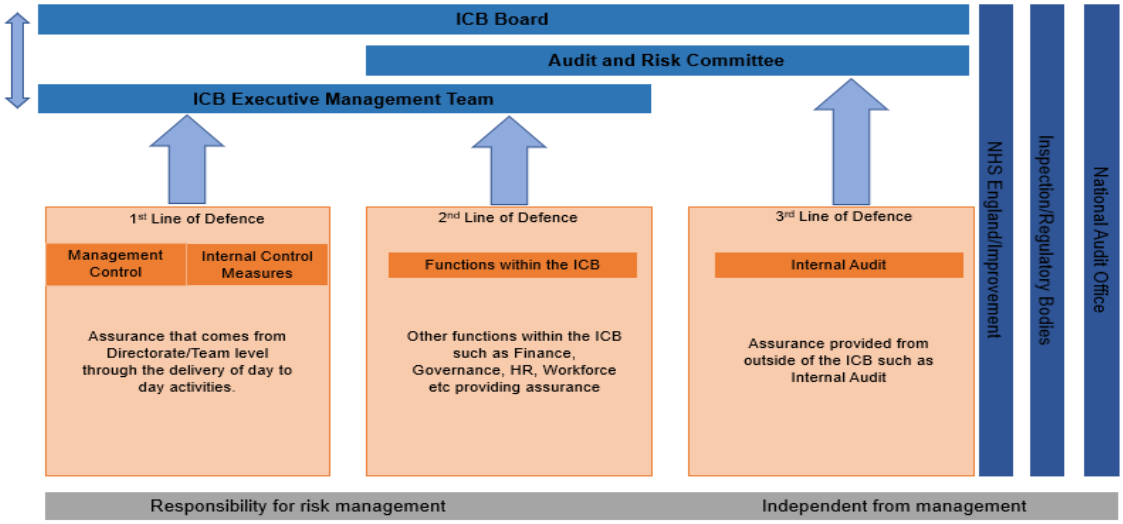
> ***"Risk is often expressed in terms of a combination of the consequences of an event and the associated likelihood of occurrence"***

3.2 Risk management is further defined in ISO 31000:2018 as "coordinated activities to direct and control an organisation with regard to risk." This risk management framework sets out the activities and coordination mechanisms specific to the ICB.

3.3 A full list of ICB - specific definitions are available at Appendix A.

4 Risk Management Framework

4.1 The ICB has based its Framework on the "three lines of defence" model described within *The Orange Book – Management of Risk – Principles and Concepts" (HM Government).* The model sets out a simple and effective way to coordinate risk management functions. The model is not intended to be a blueprint and therefore organisations have the freedom to adapt the model to meet its needs. Ours is below:



4.2 The ICB has adopted a proactive (Operational Risk Management) and reactive (Strategic Risk Management) approach to risk. The population of risk registers with the further development of appropriate action plans will provide the ICB with greater knowledge of where risks lie. As systems and processes become further defined, the ICB will become more sophisticated in its approach to essential risk prevention.

4.3 Strategic Risk Management

Strategic risks are high-level risks that are proactively identified that threaten the achievement of the ICB's strategic objectives and key statutory duties. Strategic risks are owned by members of the Executive Management Team and are outlined within the ICB's **Board Assurance Framework (BAF).**

The Strategic Risks will be categorised under each of our three Goals. These are:

1. To make sure that people can live as healthy a life as possible.
2. To make sure that you only have to tell your story once.
3. To make Norfolk and Waveney the best place to work in health and care.

Each goal has its own principle risk and the strategic risks sit categorised within these

on the Board Assurance Framework.

The Assurance Framework provides the ICB Board with confidence that it has identified its strategic risks and has robust systems, policies and processes in place (*controls*) that are effective and driving the delivery of their objectives (*assurances*). It provides confidence and evidence to the ICB's leadership that '*what needs to be happening is actually happening in practice'*.

The Assurance Framework plays an important role in informing the production of the ICB's Annual Governance Statement. It is the main tool that the ICB Board should use in discharging overall responsibility for ensuring that an effective system of internal control is in place.

The ICB Board approves the strategic risks during the first quarter of the financial year, following agreement of the strategic objectives. The Board reviews the Assurance Framework at each of its public meetings to ensure controls and assurances are in place in relation to the organisation's strategic risks.

The Assurance Framework is reviewed and updated by Executive Leads monthly. This involves a review of the effectiveness of controls and what evidence (internal or external) is available to demonstrate that they are working as they should (assurances). Any gaps in controls or assurances will be highlighted at this point and actions identified.

The Audit and Risk Committee receives a rolling programme of targeted assurance reports which, over a 12-month period, covers all of the ICB's strategic objectives (the full Assurance Framework). This enables a focussed review on specific sections of the Assurance Framework and allows for robust discussions on the actions in place to remedy any identified gaps in controls and assurances

More information on the characteristics of strategic risks is available at Appendix B

4.4 Operational Risk Management

Operational risks are 'live' risks the organisation is currently facing which are by-products of day-to-day business delivery. They arise from definite events or circumstances and have the potential to impact negatively on the organisation and its objectives.

Operational risk management relies upon reactive identification of risks, which are 'dynamic' in nature. Operational risks are managed via additional mitigations and are captured via ICB's **Committee Risk Registers.**

The Committee Risk Registers are where the ICB records its operational risks. Whilst risks will feature across a number of the ICB's processes, it is important that these are captured centrally to provide a comprehensive log of prioritised risks that accurately reflects the ICB's risk profile.

The Committee Risk Registers contains details of the risk, the current controls in place and an overview of the actions required to mitigate the risks to the desired level. A named individual (risk owner) is given responsibility for ensuring the action is carried out by the chosen due date. Members of the Senior Management Team are assigned 'risk owners' for operational risks within the Committee Risk Registers.

Most operational risks should have the ability to reduce in impact and/or likelihood and the relevant risk treatment must be performed to mitigate risks to an acceptable level.

More information on the characteristics of operational risks is available at Appendix B.

5 Risk Appetite

5.1 Good risk management is not about being risk averse, it is about recognising the potential for events and outcomes that may result in opportunities for improvement, as well as threats to success.

5.2 A 'risk aware' organisation encourages innovation in order to achieve its objectives and exploits opportunities and can do so in confidence that risks are being identified and controlled by senior managers.

5.3 With this in mind, the Board has agreed to the following risk appetite statement:

"The ICB must recognise that its long-term sustainability and ability to improve quality and health outcomes for the people of Norfolk and Waveney depend on the achievement of our strategic and local objectives. This will involve a willingness to accept that risks are part of the journey. This may also include working collaboratively with our partner organisations on system-wide risks as we strive for more joined up care and as an integrated care system.

The ICB will endeavour to adopt a 'mature' approach to risk where the long-term benefits are outweighed by any short-term losses, in particular when working with system partners across the Norfolk and Waveney health and care system. However, such risks will be considered in the context of the current economic and political environment and in accordance the ICB's risk framework.

We will seek take all reasonable steps to minimise risks that could impact negatively on the health outcomes of our patients or in meeting the legal requirements and statutory duties of the ICB. We will also seek to minimise any undue risk of adverse publicity, risk of damage to the ICB's reputation and any risks that may impact on our ability to demonstrate high standards of probity and accountability.

The ICB recognises that its risk appetite will not necessarily remain static due to the changing landscape of the NHS. The ICB's Board has overall freedom to vary the amount

of risk we are prepared to tolerate depending on the circumstances at the time. It is expected that the levels of risk the ICB is willing to accept are subject to regular review. The Board also recognises that risk appetite may vary between risks too. For example, we may a very low appetite (4) for risks aligned to quality and safety and with regulatory issues but decide to have a higher appetite on other matters." This will be agreed by the Board as further work on risk progresses.

6 Risk tolerance

6.1 Whilst risk appetite is about the pursuit of risk, risk tolerance is concerned with the level of risk that can be accepted (e.g. it is the minimum and maximum level of risk the ICB is willing to accept reflective of the risk appetite statement above).

6.2 In respect of operational risks the ICB's leadership teams (either Executive Management Team or Senior Management Team) will take a measured approach on what risks will be tolerated. However, this is subject to these groups being satisfied that no other actions can be undertaken, and that robust management and monitoring controls are in place.

6.3 Some risks are unavoidable and will be out of the ICB's ability to mitigate to a tolerable level. Where this is the case, the focus will move to the controls in place to manage the risks and the contingencies planned should the risks materialise.

7 Risk Registers

7.1 The risk register is a management tool that enables the organisation to understand its comprehensive risk profile. Its purpose is to record risk information.

7.2 The risk register is a log of all kinds of risks that threaten the ICB's ability to deliver its objectives or discharge its functions. It is a dynamic and living document, which is populated through the organisation's risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how they should be treated.

7.3 Registers are monitored and reviewed by the ICB Committees, Senior Management Team and Executive Management Team for completeness, accuracy and consistency. It is administered by the Corporate Affairs team who is responsible for reporting to the Audit and Risk Committee and ICB Board.

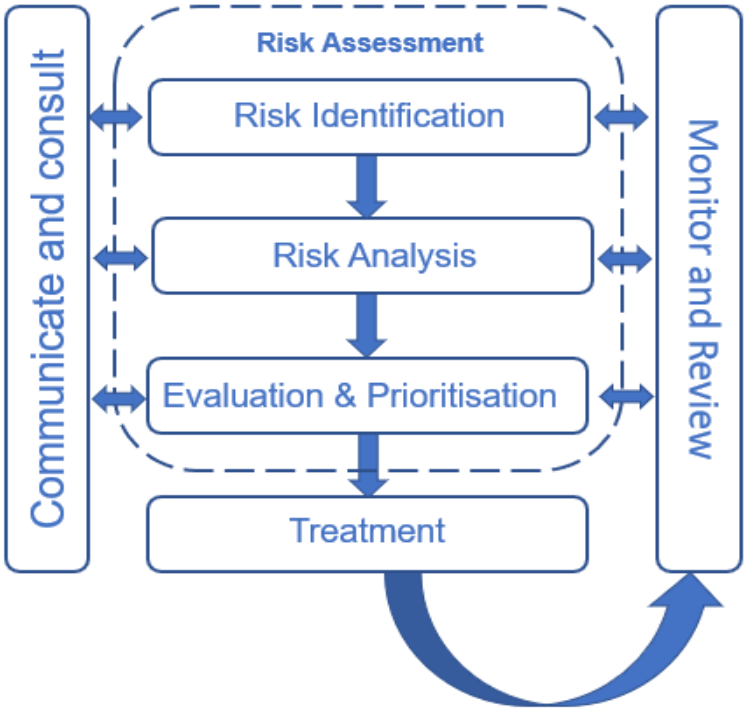
8 Risk process

8.1 Risk management processes will be conducted systematically, iteratively and collaboratively. They will draw on the knowledge and views of experts and stakeholders. To support risk management there will be appropriate communication and consultation with internal and external stakeholders. Communication will support sharing of

information and promoting awareness and understanding of risks. Communication and consultation with appropriate stakeholders will assist the understanding of the risks faced, the basis for decision-making and the reasons why particular actions are required. Communication and consultation will:

- Bring together different functions and areas of professional expertise in the management of risk
- Ensure that different views are appropriately considered
- Provide sufficient information and evidence to support oversight and decision making
- Build a sense of ownership and inclusion among those affected by risk

8.2 The Risk Management process structure - (HM Government 'The Orange Book')



8.3 Risk identification

The following factors and the relationships between them should be considered when identifying risks:

- Tangible and intangible sources of risk
- Changes in the internal and external context
- Uncertainties and assumptions within options, strategies and plans
- Indicators of emerging risks
- Limitations of knowledge and reliability of information

Each Committee will ensure that risks are identified within their area of business and escalated where appropriate. The description of risks will follow best practice:

'**There is a risk that'** (risk event), '**Due to/As a result of**' XXX (Cause).

Risks will be proactively identified through (but not limited to):

- Top-down assessment of strategic risks involving the ICB Board, it's Committees, Executive Management Team and wider management
- Bottom up reporting and risk discussions
- Project risks identified by the Programme Management approach
- Assessment of emerging risks and horizon scanning
- Risk identification to support business planning and determining strategic Priorities

When a risk has been identified and described, risk ownership needs to be agreed and assigned. A member of the Executive Team will own the risk and identify an appropriate lead.

For more information on describing a risk, please see Appendix E

8.4 Risk Analysis

In order to anticipate, rather than react to risks identified, a formal mechanism for risk assessment will be adopted.

The aim of a risk assessment is to determine how to manage or control the risk and translate these findings into a safe system of work that is then communicated to the appropriate level of management.

A risk assessment is a careful examination of what could go wrong. Those assessing need to weigh up whether there are sufficient controls in place, and if not, they must establish the extent of control and ensure that action is proportionate to the level of risk.

Risk assessments are subjective; therefore, it is good practice to approach assessing and scoring risks as a team including clinical input where it is reasonable and necessary to do so.

All risks are graded using the risk grading matrix. A copy of the Risk Grading Matrix can be found in Appendix F.

8.5 Risk evaluation

It is accepted that it is neither realistic nor possible to totally eliminate all risk. It is however, feasible to develop a systematic approach to the management of risk so that adverse consequences are minimised, or in some cases, eliminated.

The ICB utilises an accepted system for grading risk (see Appendix F), which takes into account parameters that include probability of occurrence and impact on the organisation. A grading system enables a method of quantification which can be used to prioritise risk treatment at all levels. Incidents and risks are graded according to the ICB's risk grading matrix which considers the actual consequence of the incident or

potential consequence of the risk and the likelihood of occurrence or recurrence. The grading results in a level of risk to the organisation.

8.6 Risk Treatment

During the process of risk assessment, analysis and evaluation it is possible to identify controls in place or required to reduce or eliminate risk. These control strategies cover a number of possible solutions, as described below:

- risk avoidance – discontinuing a hazardous operation/activity.
- risk retention – retaining/accepting risks within financial operations.
- risk transfer – the conventional use of insurance premiums.
- risk reduction – prevention/control of any remaining residual risk.

Once controls (either in place or required) have been identified the risk must be re-graded in order to establish whether the action proposed is adequate and will reduce the risk to an acceptable level. These controls and further treatments may be cost neutral or require action that requires investment. At this point it is imperative that action plans are submitted as part of the ICB's usual process for service planning.

Risks should continue to be monitored by the relevant area to ensure that the controls remain effective, once the actions have been implemented and the risk has been eliminated the risk may be closed on the risk register. The reasons for the closure must be recorded in the narrative of the risk register to provide an auditable trail. The ICB recognises that in some cases high risks may be long standing which cannot be reduced to an acceptable level for a number of reasons, and even having been reviewed and accepted by the Board, these risks shall remain on their respective register and exception reported to Board to serve as a reminder that the risks are still significant.

8.7 Risk Management and Review

Through a process of audit and monitoring the ICB will undertake a review of the risk control measures regularly. It is anticipated that risk control and monitoring measures will include some or all of the following:

- aggregated statistical and trend reporting of incidents, complaints and claims to the ICB Board and relevant committees
- audit of implementation of the range of risk management policies, procedures and guidelines throughout the organisation
- ongoing review of Committee risk registers
- annual review of the risk management strategy
- monitoring of the Audit and Risk Committee
- audits undertaken by internal and external auditors.

9 A listening and learning organisation

9.1 The ICB has a lead role in improving the health and wellbeing of its local community and the effective identification and management of risk is integral to this role.

9.2 The ICB cannot do this in isolation. All partners need to be aware of the ICB's approach to risk management, if a common and mutual approach to shared risks and agendas is to be supported.

9.3 Developing such a culture is a prerequisite of successful risk management. Accordingly the ICB will:

- be open, fair and transparent
- approach all incidents, complaints and issues fairly and equally
- ensure transparency in the review of incidents, complaints and other issues and transfer the learning both internally and externally
- ensure all staff are aware of this framework and processes and all other associated policies that complement delivery of robust internal control
- support and advise staff
- provide relevant training, information and resources
- acknowledge reports received and provide feedback on actions and decisions taken to demonstrate it has listened
- ensure there is a framework through which staff can raise concerns of malpractice and impropriety in a supportive manner
- respond to gaps in policy and process to improve outcomes, experience and the overall management of risk.

10 Management across organisational boundaries & system risk

10.1 The management of risk across organisational boundaries is complex and, even more so, during any period of transition. Governance models should allow sovereign organisations to manage their own risks independently, whilst enabling a strong and holistic partnership approach to risk management to support the delivery of system objectives. The ICB's risk management framework will develop and evolve during any period of transition

10.2 Risk continues to be an important feature within the different parts of the system architecture e.g. Integrated Care Boards (ICBs), Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs). Partnership working can often lead to risks regarding risk ownership and accountability. As such, it is important that there are clear inter-relationships regarding the management and ownership of risks between these different elements

10.3 Risks identified in meetings with system partners will be fed back to the ICB's EMT via relevant leads. Any such risks will be considered through the lens of a strategic commissioner and included, if appropriate, within the ICB's Board Assurance Framework.

11 Implementation and training

11.1 This policy will be published and maintained in line with the ICB's Policy Management Framework.

11.2 This policy will be highlighted to new staff as part of the local induction process and made available to all staff through the ICB's internal communication procedures and Internet/Intranet sites.

11.3 The ICB's Audit and Risk Committee will review the effectiveness of this policy, and its implementation, via quarterly risk management update reports.

11.4 The ICB Board will review the risk appetite on an annual basis.

11.5 Internal Audit will report on the implementation of this policy as part of the annual Head of Internal Audit Opinion work programme

11.6 The Corporate Affairs team will proactively raise awareness of the policy across the ICB and provide ongoing support to committees and individuals to enable them to discharge their responsibilities. Members of the Corporate Affairs team can be contacted for formal training at team meetings (or other forums) by email: nwicb.corporateaffairs@nhs.net

11.7 Any individual who has a query regarding the content of the policy, or has difficulty understanding how it relates to their role, should contact the ICB's Corporate Affairs team by email: nwicb.corporateaffairs@nhs.net

12 Equality

12.1 The ICB pays due regard to the requirements of the Public Sector Equality Duty (PSED) of the Equality Act 2010 in policy development and implementation, both as a commissioner and as an employer

12.2 As a commissioning organisation, we are committed to ensuring our activities do not unlawfully discriminate on the grounds of any of the protected characteristics defined by the Equality Act, which are age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation

12.3 We are committed to ensuring that our commissioning activities also consider the disadvantages that some people in our diverse population experience when accessing health services.

12.4 To help ensure that these commitments are embedded in our day-to-day working practices, an Equality Impact Assessment has been completed for, and is attached to, this policy

13 References

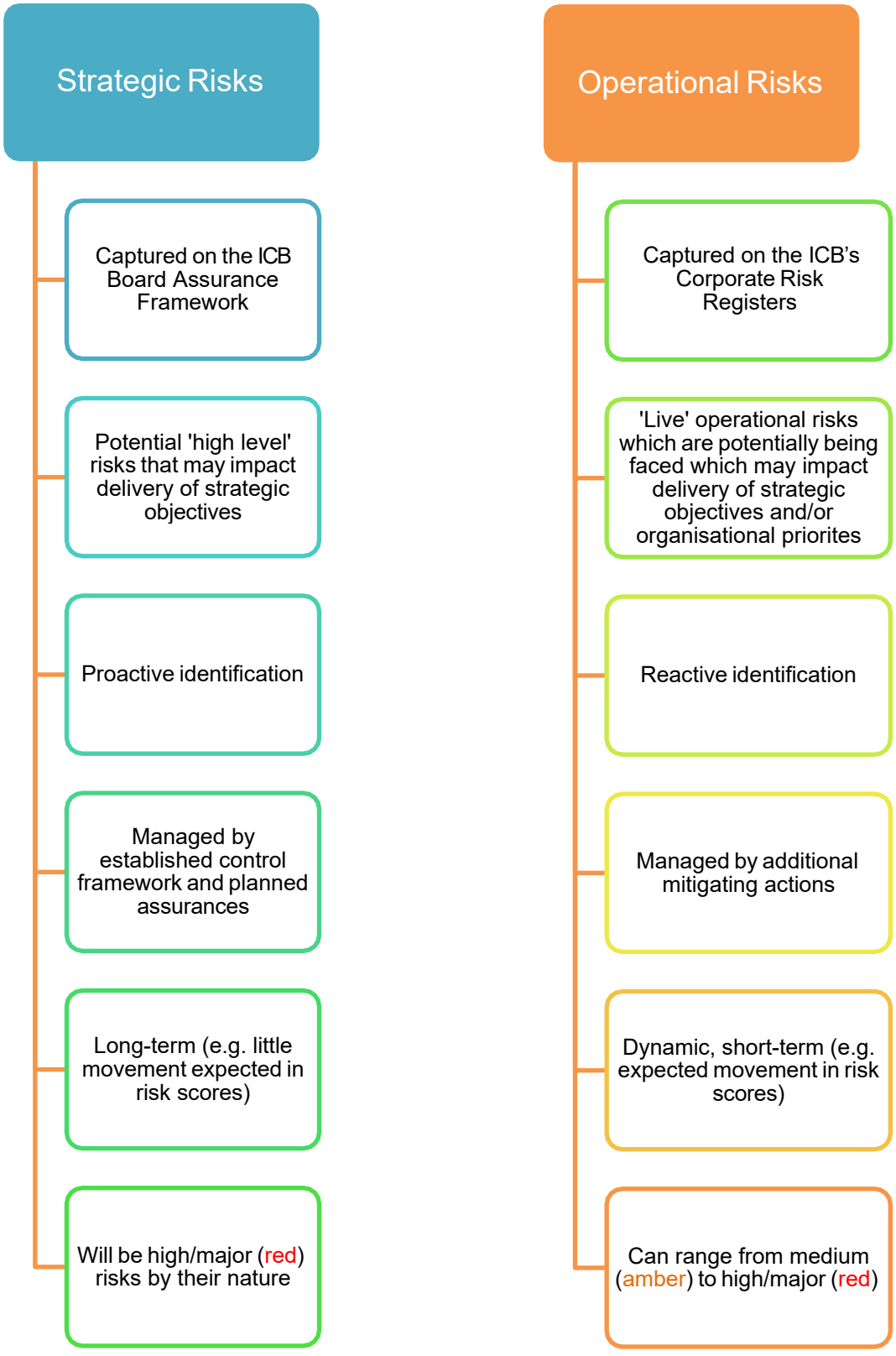
- Assurance Frameworks, (2012). HM Treasury.
- A Risk Practitioners Guide to ISO 31000:2018, (2018). The Institute of Risk Management.
- Board Assurance: A toolkit for health sector organisations, (2015). NHS Providers.
- The Orange Book: Management of Risk – Principles and Concepts, (2020).
- Risk Appetite & Tolerance, (2011). The Institute of Risk Management.
- NHS Audit Committee Handbook, (2018). Healthcare Financial Management Association
- NHS Governance Handbook, (2017). Healthcare Financial Management Association
- Risk Appetite for NHS Organisations: A matrix to support better risk sensitivity in decision taking. (2012). The Good Governance Institute.

Appendix A: Glossary and definitions

Term	Definition
Action	A specific process once completed that will bring the risk to a desired measured state in terms of likelihood and impact, to within the risk tolerance of the ICB.
Assessment	The process by which risk is analysed through identification, description, estimation and evaluation.
Assurance Framework	An Assurance Framework is an integral part of the system of internal control. It defines the significant potential risks which may impact on delivery of the organisation's priorities. It also summarises the controls and assurances that are in place, or are planned, to mitigate against them. Gaps are identified where key controls and assurances are insufficient to reduce the risk of non-delivery of objectives. This enables the governing body to develop and subsequently monitor assurance.
Cause	The reason for the risk to potentially occur
Consequence	The results should the risk materialise
Control	A measure which put in place to mitigate a risk from occurring. Different types of control can be preventative, detective, directive and corrective.
Impact	A measure of the impact that the predicted harm, loss or damage would have on the people, property or objectives affected.
Issue	An issue is a problem which has actually occurred that may have a negative effect on a project's chances of achieving its objectives
Gaps in controls or assurances	Where an additional system or process is needed, or evidence of effective management of the risk is lacking.
Likelihood	A measurement of the chance that a risk will materialise

Mitigation	An action that will control a risk. Different types include tolerate, transfer, terminate and treat.
Risk	Uncertainty of outcome, whether positive opportunity or negative threat, of actions and events. It is the combination of likelihood and impact, including perceived importance
Risk appetite	The organisation's unique attitude towards risk taking that, in turn, dictates the amount of risk that it considers is acceptable.
Risk management	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying and analysing, evaluating, treating, monitoring and communicating risk.

Appendix B: Characteristics of strategic and operational risks


Strategic Risks
Captured on the ICB Board Assurance Framework
Potential 'high level' risks that may impact delivery of strategic objectives
Proactive identification
Managed by established control framework and planned assurances
Long-term (e.g. little movement expected in risk scores)
Will be high/major (red) risks by their nature
Operational Risks
Captured on the ICB's Corporate Risk Registers
'Live' operational risks which are potentially being faced which may impact delivery of strategic objectives and/or organisational priorites
Reactive identification
Managed by additional mitigating actions
Dynamic, short-term (e.g. expected movement in risk scores)
Can range from medium (amber) to high/major (red)

Appendix C: Schedule of roles and responsibilities

Role	Responsibilities
Board	The ICB Board has overall accountability for risk management and, as such, needs to be satisfied that appropriate arrangements are in place and that internal control systems are functioning effectively. The Board determines the ICB's risk appetite and risk tolerance levels and is also responsible for establishing the risk culture.
Audit and Risk Committee	The Audit and Risk Committee provides the Board with assurance on the effectiveness of the Board Assurance Framework and the robustness of the ICB's operational risk management processes. The Committee's role is not to 'manage risks' but to ensure that the approach to risks is effective and meaningful. In particular, the Committee supports the Board by obtaining assurances that controls are working as they should, seeking assurance about the underlying data upon which assurances are based and challenging relevant managers when controls are not working, or data is unreliable
All Committees	All committees are responsible for monitoring operational risks related to their delegated duties. This will include monitoring the progress of actions, robustness of controls and timeliness of mitigations. They are also responsible for identifying risks that arise during meeting discussions and ensuring that these are captured on the Risk Register
Chief Executive	The Chief Executive has a responsibility for having an effective risk management system in place within the ICB for meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of governance. The Chief Executive must sign, on behalf of the ICB, an *Annual Governance Statement* which is required to provide assurance about the stewardship of the organisation to the Chief Executive and the governance statement should be included in the annual report and accounts
Director of Corporate Affairs and ICS Development	The Director of Corporate Affairs and ICS Development is the executive lead for corporate governance and risk and assurance systems across the ICB. This includes promoting the ICB's risk culture within the Executive Management Team and wider directorates.

Non-Executive Members	As members of the Board and committees, NEMs will ensure an impartial approach to the ICB's risk management activities and should satisfy themselves that systems of risk management are robust and defensible.
Director of Corporate Affairs and ICS Development	The Director of Corporate Affairs and ICS Development leads on the implementation of corporate governance and risk and assurance systems across the ICB. This includes the development, implementation and co-ordination of the ICB's risk management activities and provision of training and advice in relation to all aspects of this policy.
Senior Information Risk Owner (SIRO)	The SIRO takes ownership of the ICB's information risks and acts as advocate for information risk on the Board.
Risk Owners	Risk owners are responsible for ensuring robust mitigating actions are identified and implemented for their assigned risks.
Individuals	All individuals are responsible for complying with the arrangements set out within this policy and are expected to: • Routinely consider risks when developing business cases, commencing procurements or any other activity which could be impacted by unexpected events (undertaking specific risk assessments as necessary). • Ensure that any operational risks they are aware of are captured on the Corporate Risk Register or Directorate/Team Risk Logs as appropriate.

Appendix D: Categories of risk

ICB function	Description	Responsible Committee
Finance	Risks to all areas pertaining to finance and financial control. This also includes risks related to contractual enforcement issues.	Finance Committee
Quality	Risks in maintaining and improving quality; including the safety and effectiveness of treatment and care and patient experience (not including safeguarding or primary care services).	Quality and Safety Committee
Health outcomes and health inequalities	Risk of failure to ensure better outcomes for patients as a result of ICB commissioned services.	Quality and Safety Committee, Patients and Communities
Safeguarding	Risks relating the ICB's statutory duties for safeguarding children and vulnerable adults.	Quality and Safety Committee
Primary Care	Risks relating to delegated commissioning responsibilities for primary care services, including quality of primary care services.	Primary Care Commissioning Committee
Compliance	Risk of failure to comply with statutory duties and other regulatory and legal requirements; for example the Public Sector Equality Duty, information governance requirements, procurement regulations and employment law.	Audit and Risk Committee
Information Governance	Risk of failure to comply with information governance regulatory and legal requirements.	Audit and Risk Committee
Governance / Probity	Risk of failure to comply or to demonstrate compliance with standards of business conduct. This includes transparency in decision-making, the robust management of conflicts of interest and adherence with the ICB's policy on gifts, hospitality and sponsorship.	Audit and Risk Committee
Workforce	Risk of failure to ensure a skilled and effective workforce, incorporating issues related to staff recruitment and retention, training and development (including succession planning) and organisational morale and culture.	People, Culture and Remuneration Committee
Engagement and Partnership collaboration	Risk of failure to engage effectively with patients, carers, the public, clinicians and all other stakeholders.	Patients and Communities Committee

Appendix E: Describing a risk

Describing the risk is providing a concise description of the risk which may occur, and how it could prevent the delivery or achievement of a particular objective.

The HM Treasury recommends the following format known as the: *cause event and effect methodology* when articulating risks.

> "Risk is often expressed in terms of a combination of the consequences of an event and the associated likelihood of the occurrence"

By identifying the risk(s) it then helps to:

- Separate it from the outcome that the risk might have, such as the non-achievement of that objective; and

- Risks can be articulated far more clearly when the tangible success measures of an objective have been identified, which have been clearly recorded and are commonly understood.

For example:

There is a possible concern about the ICB's lack of consultation with the public and stakeholders about a changes to a service:

Risk Event:

- There is a risk that the ICB breaches its statutory duty to consult

Causes:

- Lack of an understanding about when to consult
- External factors, system pressures, financial pressures

Effect(s):

- Risk of a judicial review
- Delay in implementation of the service change
- Financial implications
- Loss of public confidence and reputational damage
- Claims of litigation and complaints received may increase

The "Risk, Cause, Effect" method helps the person to clearly describe the risk. This method is used to outline 'There is a risk that' (risk event), 'Due to/As a result of' XXX (Cause), 'This could lead to' XXX (effect).

By applying this method to the same example above it would read as:

"There is a risk that the ICB breaches it statutory duty to consult. This is due to system financial pressures forcing a timelier response to business need. This could lead to judicial review and legal claims

Appendix F: Risk Scoring Matrix

The information in the Appendix is based on guidance issued by the National Patient Safety Agency (www.npsa.nhs.uk)

Table 1: Likelihood score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	1	2	3	4	5
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	May happen in exceptions circumstances (I.e less than once per year.)	The event could occur (once per year.)	The event could occur at some time. (once per month)	The event will occur in most circumstances (more than once per month/weekly)	The event is expected to occur in all circumstances (more than weekly/or daily.)

Table 2: Consequence score (C)

Choose the most appropriate 'domain' for the identified risk from the left-hand side of the table, then work along the columns in the same row to assess the severity of the risk on the scale of 1 to 5. This helps to determine the consequence score, which is the number at the top of the column.

Impact score	1	2	3	4	5
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**

Impact on the safety of patients, staff or public (physical or psychological harm)	Minimal inquiry requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major inquiry leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Service/business interruption, environmental impact	Loss/interruption of >1 hour Minimal or no impact on business or environment	Loss/interruption of >8 hours Minor impact on business or environment	Loss/interruption of >1 day Moderate impact on business or environment	Loss/interruption of >1 week Major impact on business or environment	Permanent loss of service or facility Catastrophic impact of business on environment
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution. Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of service treatment/service Gross failure of patient safety if findings not acted on Inquest/Ombudsman inquiry Gross failure to meet national standards
Impact score	**1**	**2**	**3**	**4**	**5**
Domain	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**

Human resources/organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low morale No staff attending mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory/key training on an ongoing basis
Statutory duty/inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/improvement notice	Enforcement action Multiple breaches in statutory duty/ies Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty/ies Prosecution Complete system change required Zero performance rating Severely critical report
Adverse publicity/reputational damage	Rumours Potential for public concern	Local media coverage Short-term reduction in public confidence Elements of public expectation not being met	Local media coverage Long-term reduction in public confidence	National media coverage with >3 days well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation MP concerned (questions in the House) Total loss of public confidence
Business objectives/projects	Insignificant cost increase Schedule slippage	<5 percent over project budget Schedule slippage	5-10 percent over project budget Schedule slippage	Non-compliance with national 10-25 percent over project budget Schedule slippage Key objectives not met	Incident leading to >25 percent over project budget Schedule slippage Key objectives not met

Financial, including claims	Small loss Risk of claim remote	Loss of 0.1 - 0.25 percent of budget Claim < than £10,000	Loss of 0.25 - 0.5 percent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective Loss of 0.5 - 1 percent of budget Claim(s) between £100,000 and £1m Purchasers failing to pay on time	Non-delivery of key objective Loss of >1 percent of budget Failure to meet specification/slippage Loss of contract/payment by results Claim(s) >£1m

Table 3 Risk Scoring: Likelihood x Consequence

Consequence		Likelihood				
		1	2	3	4	5
		Rare	Unlikely	Possible	Likely	Almost certain
5	Catastrophic	5	10	15	20	25
4	Major	4	8	12	16	20
3	Moderate	3	6	9	12	15
2	Minor	2	4	6	8	10
1	Negligible	1	2	3	4	5

	1-3	Low risk
	4-6	Moderate risk
	8-12	High risk
	15-25	Very high risk

Norfolk and Waveney
Integrated Care Board

Agenda item: 17

Subject:	**Audit and Risk Committee Report**
Presented by:	**David Holt, Non-executive Member, Audit and Risk Committee Chair**
Prepared by:	**Amanda Brown, Head of Corporate Governance**
Submitted to:	**Board**
Date:	**27 September 2022**

Purpose of paper:

To advise the Board on the Audit and Risk Committee meeting 27 July 2022.

Executive Summary:

The purpose of this paper is to provide a report on the first meeting of the NHS Norfolk and Waveney Integrated Care Board (ICB) Audit and Risk Committee which was held on 27 July 2022.

1. **Terms of Reference and Action Log**
   The meeting noted its Terms of Reference and discussed actions carried over from the former NHS Norfolk and Waveney Clinical Commissioning Group (CCG) Audit Committee. The meeting identified those actions that could be closed and those that would be monitored by the Committee.

2. **Draft Internal Audit Plan**
   The Committee discussed the draft Internal Audit Plan. The Committee asked Internal Audit to consider further changes to reflect the new ways of working following the transition from CCG to ICB. It was agreed that an additional audit of financial sustainability was needed in line with NHS England requirements.

3. **Internal Audit Summary Controls Assurance Report**
   The report detailed progress against the former CCG plan and audits planned for 2022/23. There were two priority 2 audit recommendations that were overdue and five recommendations not yet due.

4. **ICB Governance Assurance**
   A paper providing assurance on the transition from the former CCG to the ICB was received. The paper confirmed that the transition was completed in line with the requirements in the Health and Care Act (2022) and related guidance.

5. **CCG Annual Report April to June 2022**
   A remaining action from the transition is the completion of the April to June 2022 Annual Report and Accounts. A draft report is due to be submitted on 5 October 2022 with the final version submitted in June 2023 together with the first ICB Annual Report and Accounts

6. **Board Assurance Framework**
   A paper was presented to the Committee detailing the work programme for Board Assurance Framework. This included a quality assessment to determine what risks are of material interest and those that have materialised and are issues not risks, aligning risks to vision and aims of the system and working with system partners to identify their risks. The Committee discussed the importance of this work and the need for progress.

7. **Counter Fraud, Bribery and Corruption Policy**
   The meeting reviewed the Counter Fraud, Bribery and Corruption Policy. It was noted at the meeting that statutory guidance had been published for ICBs that described the division of responsibilities between the counter fraud functions of ICBs and NHS England. The ICB policy was compliant with the statutory guidance and approved by the Committee.

Recommendation to the Board:

The Board is asked to note the contents of this report and raise any questions on its contents.

Key Risks	
Clinical and Quality:	Not applicable
Finance and Performance:	It is important that there is scrutiny of financial management of the ICB and this function is performed by the Audit and Risk Committee.
Impact Assessment (environmental and equalities):	Not applicable
Reputation:	Ensuring effective committees and order of business essential for maintaining the reputation of the ICB
Legal:	Audit and Risk Committee is a statutory committee of the ICB.
Information Governance:	Not applicable.
Resource Required:	None.
Reference document(s):	Not applicable.
NHS Constitution:	Not applicable.

Conflicts of Interest:	Not applicable.
Reference to relevant risk on the Board Assurance Framework	Not applicable

Governance

Process/Committee approval with date(s) (as appropriate)	Audit and Risk Committee meeting 27 July 2022, Board meeting 27 September 2022.

Agenda item: 18

Norfolk and Waveney
Integrated Care Board

Subject:	Quality and Safety Committee Report to Board
Presented by:	Cathy Armor
Prepared by:	Evelyn Kelly, Quality Governance & Delivery Manager
Submitted to:	Integrated Care Board Meeting in Public
Date:	27 September 2022

Purpose of Paper:

This report summarises the monthly meeting of the ICB Quality and Safety Committee, over the period of June 2022 to August 2022.

Executive Summary:

Report sub-headings comprise of the following items:

1. Committee Development Session, 08 August 2022 *(see also Appendix 1)*
2. Committee Risk Overview *(see also Appendix 2)*
3. Nursing and Quality
4. Quality in Care
5. Children, Young People & Maternity
6. Mental Health
7. Clinical Transformation and Performance
8. Committee Approvals

Recommendation to Quality and Safety Committee:

The Board is asked to note and respond to the content of this report.

Key Risks	
Clinical and Quality:	This report highlights clinical quality and patient safety risks and mitigating actions.
Finance and Performance:	Finance and performance are intrinsically linked to the clinical quality, effectiveness, and safety of commissioned services.
Impact Assessment (environmental and equalities):	N/A
Reputation:	See above.
Legal:	N/A
Information Governance:	N/A
Resource Required:	N/A
Reference document(s):	N/A
NHS Constitution:	The report supports the clinical quality and patient safety elements of the NHS Constitution.
Conflicts of Interest:	N/A
Reference to relevant risk on the Board Assurance Framework:	BAF01, BAF04, BAF05, BAF07a, BAF07b, BAF12, BAF13 and BAF14.

GOVERNANCE:

Process/Committee approval with date(s) *(as appropriate)*	Report approved by P D'Orsi 16.09.2022 and Cathy Armor 20.09.2022

PAPER:

1. Committee Development Session, 08 August 2022

Committee members met in August 2022 to agree a collective aspiration for the development of the existing Committee into its new format as an ICB forum for accountability and decision making; and the infrastructure and governance required to enable its effective function. The output of the session discussion has informed the development of six pillars of development which will support the establishment of a shared system approach to quality management, which can be found at **Appendix 1** of this report. The ICB Director of Nursing provided a challenge to the Committee to consider how we ensure that the lived experience of service users is driving our transformation plans across Norfolk and Waveney and the role of Quality and Safety Committee to ensure that we harness the insight of our communities, to make a real, tangible, and sustainable difference for patients, carers, and staff delivering care.

2. Committee Risk Overview

An overview of this quarter's Committee risk activity can be found at **Appendix 2** of this report. A summary of risks opened and closed across this reporting period is as follows:

- 'Compliance with new Deprivation of Liberty Safeguard Standards' and 'CHC Fast Track Reviews' transferred from the Quality in Care Team onto the Committee risk register in June 2022 in readiness for ICB transition.

- 'Ockendon Maternity Data Requirements' and 'Digital Maternity Shared Care Records' were escalated from the Local Maternity and Neonatal System onto the Committee risk register in June 2022 in readiness for ICB transition.

- 'COVID-19 Phase 3 Vaccination' was de-escalated and closed in June 2022, as this work is now BAU with a robust programme and governance framework which will escalate any emerging risks to delivery.

- 'Care Providers Without Contracts' was opened as a new risk in August 2022, reflecting a cohort of care providers within the system who do not have a contract based on the national NHS Care Framework. This is a risk to our ability to commission adequate Continuing Healthcare for our population.

- 'Paediatric Continence Provision (East Locality)' was de-escalated and closed in August 2022, as the risk has reduced, with a plan to monitor the service locally.

An outcome of the Committee Development Session on 08 August 2022 was to take a forward a review of quality and patient safety risks across the whole system, to develop a shared understanding of risk across the commissioning and provider landscape. This approach is supported by provider representation within the proposed new membership of the Committee.

3. Nursing and Quality

3.1. System Infection Prevention and Control (IP&C) Update

Committee received the ICB IP&C Team report on healthcare related infections across Norfolk and Waveney and the mitigating actions in place to reduce incidences of harm, based on end

of year data for 2021-2022. Headlines included good local performance in relation to MRSA Bacteraemia, with Norfolk & Waveney sitting second lowest for cases in the East of England per 100,000 population. A regional increase in Clostridium Difficile infections has been identified, which is mirrored locally. The Norfolk and Waveney system is sitting fourth and fifth highest for cases of Klebsiella and Pseudomonas in the East of England per 100,000 population and is an outlier in Gram Negative Blood Stream Infections (GNBSIs) which are mainly attributed to E. coli, associated with Urinary Tract Infections. The ICB is currently setting up a Strategic Infection Prevention & Control and Antimicrobial Stewardship Network with an operational workstream to deliver collective objectives. Our GNBSI surveillance has informed a programme of work around Urinary Tract prevention and treatment, including a successful bid for dedicated funding to pilot a hydration project to improve practice around encouraging and enabling adequate hydration among people who are at risk of infections. This is supported by the re-launch of staff resources including the local UTI treatment bundle and guidance on urine sampling. The ICB's Primary Care IP&C Champion Network continues to share learning and best practice and a coordinated campaign is being planned to take forward national learning around overuse of gloves in healthcare settings, to raise awareness across local health and social care settings.

Norfolk and Norwich University Hospital Trust (NNUH) COVID-19 Outbreak
Committee were briefed around a COVID-19 outbreak which was declared at NNUH in May 2022, effecting an Older People's Medicine Ward on the site. A 'supportive measures' response was implemented by the Trust's Infection Prevention and Control Team which enabled the Ward to reopen safely following their Outbreak Policy step-down criteria. Learning from this outbreak will be shared with other providers across the system.

Monkeypox Virus Infection Response
Committee members heard that community providers have mobilised swiftly to provide a clear pathway for diagnostic swabbing for monkeypox, with Public Health and iCASH services leading on planning for vaccination roll-out to targeted communities, following UK Health Security Agency guidance.

3.2. Urgent & Emergency Care (UEC), Ambulance Response Times and Patient Harms
Committee has continued to receive oversight of long waits to handover patients into Acute Hospital Emergency Departments and the subsequent impact on ambulance response times to attend new calls in the community. Key risks for the Norfolk & Waveney system include social care pressures, discharge and system flow, workforce and the ongoing impact of COVID-19 and an increase in serious incidents related to Ambulance Response Times. The East of England Ambulance Service Trust is continuing to prioritise actions to maximise their availability of Double Staffed Ambulances and enable the continuation of the invaluable Hospital Ambulance Liaison Officer (HALO) role. Cohorting of patients outside ED is initiated where appropriate to release crews quickly. The Trust is delivering a range of interventions to support staff wellbeing and resilience. Elsewhere in the UEC system, IC24 continue to re-validate calls, to ensure that emergency resources are prioritised on clinical need.

The ICB continues to host a system Tactical Group which brings together providers to develop learning from the serious incidents reported, into system-level actions to improve quality and safety. This approach acknowledges that the surge pressures resulting in patient harm are the shared responsibility of all system partners and as such, the solutions must be collective, within our system and across the East of England footprint. The Tactical Group has set up defined workstreams around Ambulance and Emergency Department interface, pre-hospital Stroke Pathways and staff wellbeing, linking in with the larger programme of work around addressing system resilience and responding to the sustained surge pressures that we continue to focus as a system priority. An example of this work is the ICB System Resilience Team's multidisciplinary 'virtual room' hosted by NHS 111, which enables community services

to review lower acuity calls on the Ambulance call stacks in real time and identify patients who can be seen more appropriately by their teams, to improve patient experience and support urgent and emergency care colleagues focussing on resource allocation to higher risk calls. Committee have requested to be briefed as this work continues to be embedded and evaluated.

Committee also discussed the critical work taking place with the Norfolk and Suffolk local authorities to support the Social Care market to ensure that patients are discharged from hospital more swiftly and effectively, releasing much needed space for emergency admissions. This includes potential to scope the development of a High Intensity Team to support providers who are most impacted by staffing shortages and other operational challenges.

4. Quality in Care

4.1. Care Home Quality Improvement

Committee receives a regular report from the Associate Director of Quality in Care, providing an overview of residential, nursing, and domiciliary care provision, in relation to quality of care as rated by the CQC and the surveillance and support activities that are jointly provided by both the ICB and local authorities. It was noted that a shared quality strategy is currently in development. Committee members reflected on the importance of support to the care market and the impact of social care workforce pressures, and the capacity and resilience of social care is a key factor in understanding wider pressures for the system such as delayed emergency admissions at the hospital front doors and discharge delay and patient deconditioning.

4.2. Monitoring of Learning Disability and Autism Inpatient Cohort

Since the previous report to Board, this item has been developed to cover all ages groups. The ICB Associate Director of Quality in Care presented an overview, which covered the oversight of care for service users that the ICB are responsible for placing and funding and those that are placed in specialist commissioned forensic and secure accommodation. Since the two service user deaths at Cawston Park Hospital, which has now closed, the national Learning Disability and Autism Inpatient Self and Wellbeing Review Programme has been developed with NHS England and the level of oversight and engagement with patients and their families has been strengthened considerably. The ICB Associate Director of Children, Young People and Maternity spoke to the need to identify the needs of young people transitioning into Adult Services as early as possible. Joint work is taking place with Norfolk County Council around the future planning for transition support, including complex care packages and enhanced staffing levels. Committee noted the programme of work to support families experiencing periods of escalating need, to empower families and help them to avoid crisis and emergency admission. A cohesive multiagency response across services and specialties is central to effective support and the ICB Care Navigator roles are key to facilitating this, working alongside these young people, their parents and carers and professionals.

NHSE Transforming Care Commitment

Committee received a paper highlighting the NHS England transforming care regional commitment to enable systems to support people cared for on these inpatient pathways and work towards safe, effective, and meaningful discharges into the community. At a system level, local authorities are investing funding into their specialist housing programme, building bespoke properties, and working with social landlords and care providers.

Specialist dental care access for the transforming care cohort of service users in Norfolk and Waveney continues to be a challenge and was part of the discussion with the NHS England Dentistry Transformation Team at a previous Committee meeting.

5. Children, Young People & Maternity

5.1. Local Maternity and Neonatal System (LMNS)

Committee received a report on progress against the Local Maternity and Neonatal System (LMNS) commitment to maintaining safe and personalised maternity care, and to support the service transformation required by NHS England as detailed in Better Births, the Ockenden Report, and the NHS Long Term Plan. Committee noted that they approved submission of the system Capacity and Capability Framework supporting these priorities. Committee discussed the current inequity in access to community Maternity Hubs in Central Norfolk, specifically in the Norwich area. Since the pandemic, pre-birth checks have stopped taking place on General Practice sites and this presents a significant risk in relation to service users who must be seen and supported face to face. Committee reflected that this should be captured within the system's risk profile, while additional capacity across community services is being scoped. Recruitment has been a challenge across Trusts and vacancies in maternity teams, particularly in the West of the county, has impacted on the delivery of continuity of care. Committee noted that work has been funded to collaborate with local communities at a grassroots level to develop the support offer to our most socially deprived areas.

5.2. Neurodevelopmental Disorder Transformation Programme

The ICB Associate Director for Children, Young People and Maternity provided an update to the August 2022 meeting following the recent Norfolk Health Overview Scrutiny Committee (HOSC) Meeting. Significant progress has been made over the last 12 months and remains a key shared priority for the ICB and local authorities. While the pandemic may have delayed the full impact for children and their families, Committee were given assurance that the overall risk has reduced and collaborative working as a system around children and young people with Special Needs and Disabilities has improved.

6. Mental Health

6.1. 12hr Mental Health Decision to Admit Breaches

The Mental Health Transformation Team briefed Committee on the impact of admission avoidance work, as evidenced by the drop in ED referrals for inpatient mental health beds since March 2022, following a steady climb from December 2021. Forward plans include a review of the Crisis Pathway in Central Norfolk and evaluation of the impact of the Mental Health Joint Response Car pilot; a formal update was scheduled for the September 2022 Committee Meeting. Committee reflected on the importance of care for people close to their families and communities, to aid their recovery and were briefed on the system priorities to enable this for service users in Norfolk and Waveney. This includes embedding Mental Health Practitioners, Recovery Workers, and Link Psychiatrists within GP Practices to streamline care and the establishment of five new Wellbeing Hubs and three Crisis Hubs to deliver early support and intervention in community settings, to be fully mobilised across Norfolk and Waveney by April 2023. A whole system health, social care and VCSE 'neighbourhood' approach to improving the physical and mental health services for people living with Serious Mental Illness, aligned to Community Mental Health and Primary Care Teams, continues into its second phase in 2022/23.

6.2. Eating Disorder Service Demand and Community Provision

Committee were briefed on positive progress made in respect of the community Medical Monitoring pathway and the launch of the Norfolk Community Eating Disorder Service (NCEDS) Intensive Community Support Service which launched at the end of 2021-22 to

support people in the community to avoid admission and step down in a more supported way from periods of inpatient care. This was followed in June 2022 with a children's day support service. In May 2022, the system's All-Age Eating Disorder Strategy was ratified, with the following key strategic aims for 2022-23:

- Launch of an Avoidant Restrictive Food Intolerance Disorder (ARFID) Pathway
- Establishment of a Single Access Route for all Eating Disorder Referrals
- Upskilling and Training, for non-specialist Clinicians

ARFID was noted as an area of need that is rising, particularly among neurodiverse children, young people, and adults with complex sensory needs.

6.3. Increasing Access to Psychological Therapies (IAPT)

Committee has been briefed on the progress of joint working between the ICB and Norfolk and Suffolk Foundation Trust, supported by the implementation of an integrated system IAPT Steering Group. Protect NoW has been engaged to develop a more targeted approach to service user groups with lower access rates; initially people aged 65+. A digital approach to first contact has been embedded to support signposting of patients to the IAPT service that can best meet their needs. Baseline data and monitoring is being established to evidence impact and improve experience. Workforce development and training underpins this work and services are looking at opportunities to broaden patient choice with the re-establishment of face-to-face access options.

7. Clinical Transformation and Performance

7.1. Insulin Pump Provision

Committee hear that the Norfolk and Norwich University Hospital Trust Diabetes Service currently provides specialist care for around 2,200 people in Norfolk and Waveney living with Type 1 Diabetes and has one of the largest adolescent and young adult diabetic populations in the UK, as well as one of the largest rates of Gestational Diabetes. Continuous subcutaneous insulin infusion therapy, delivered by insulin pump, is a standard treatment option for people with Type 1 Diabetes, with evidence that it can improve glycaemic control, reduce risk of hypoglycaemia, and improve quality of life. The National Insulin Pump Audit Report (2017/2018) has indicated that the Norfolk and Waveney has the lowest rate of new patients starting this treatment option, in the country. This has prompted a recommendation by the Trust and the ICB to expand provision. Committee agreed for this item to be added to the Committee Risk Register in September 2022 to increase oversight, while the case is being reviewed by the system Clinical Care and Transformation Group.

7.2. Two Week Wait Cancer Pathway

Committee discussed resilience and performance of this pathway, with an emphasis on improving access, patient experience, and subsequently, outcomes for patients with 'two week wait' symptoms. The main risk around this area of service provision is currently the increase in referral activity and reduced incidence of overall confirmed diagnoses, which appears to reflect the ongoing impact of the 2020 campaign encouraging the public to stay at home and protect the NHS during the pandemic peak. The paper presented, highlighted specific concerns in relation to the long-term sustainability of Breast pathways in their current form, and reduced incidences of confirmed Prostate Cancers. The East of England Cancer Alliance data has also indicated an increase in later presentations, reflecting delayed attendance to health services, which has also been reported by local Palliative Care Teams. Committee were briefed on a range of interventions aimed at increasing early diagnosis of Cancer, including Lung Health Checks, Cytosponge, and Rapid Diagnostic Services. The three Acute Hospitals within the system have responded to the referral activity with an increased two week wait outpatient capacity to mirror increases in demand. Work is taking

place with NHS England to ensure that the three Breast are able to work closer together to increase resilience. ICB colleagues noted positive engagement from Primary Care Networks around the screening and early diagnosis challenges and supported Public Health guidance to ensure there is a focus on communities and cohorts that are known to be most impacted by health inequalities.

7.3. Elective Care Backlog

Workforce shortages and operational pressures continue to impact on all three of the Acute hospitals in Norfolk and Waveney and additional outpatient and treatment clinics have been put in place over weekends to reduce the backlog and provide more choice to patients waiting to be seen. The increase in Cancer referrals, as described above, has had an impact on the delivery of elective appointments and the system's 52 week wait backlog continues to be a significant risk. Mutual aid is being used proactively to enable the Acute hospitals to offer more choice to patients waiting and to utilise resources and capacity collectively. Validation programmes have been put in place for Gynaecology and Dermatology specialities, to identify patients who no longer require a review appointment. This is being extended to Ear Nose and Throat; ensuring that lists are prioritised by patient needs. ICB funding is in place for community clinics to review our longest wait Gynaecology patients. A specialist nurse role has also been identified to review Ophthalmology lists, building on the work of the recent dep dive into waiting times.

NNUH Trauma and Orthopaedics Personalisation Project

The ICB is currently delivering a joint pilot project with NNUH to embed a personalisation approach to support waiting list management. This will upskill staff and provide targeted social prescribing support to enable patients to access community resources that can help keep them as active and well as possible while waiting and to optimise patients prior to their surgery, with the aim to improve patient experience, prepare patients for their awaited procedure and improve their recovery and rehabilitation potential.

8. Committee Approvals

The following policies and reports were ratified by the ICB Quality and Safety Committee over this reporting period:

June 2022

- Guidance for Managing CYP with Complex Medical Needs in Education Settings
- Mental Capacity Act Policy

July 2022

- Policy for Children's Continuing Care
- Guidance for CHC Staff Working Overnight in the Homes of Children and Families
- Child Death Overview Panel Annual Report

August 2022

- *No approvals tabled on Agenda*

Appendix 1: Norfolk & Waveney ICB Quality Development Pillars (September 2022)

Appendix 2: Committee Risk Overview (June, July, and August 2022) Table 1 of 3

August 2022: Quality & Performance Risk Dashboard
Table 1 of 3

This Risk Dashboard categorises the key quality and safety risks by their Likelihood and Consequence (Impact) to enable focus on the risks that will cause the ICB the greatest concern. Key: High Risk = Red / Significant Risk = Amber / Moderate Risk = Yellow.

Risk Ref.	Risk Details	Risk Tolerance/ Month	Mitigated Risk Rating / Committee Month and Year		
	1-4: Nursing & Quality (KW)	**M05: Aug-22**	**M03: June-22**	**M04: July-22**	**M05: Aug-22**
NQ26	EEAST Workforce Resilience and Special Measures (previously EEAST Paramedic Workforce)	**6**	12	12	**12**
NQ35	Surge Capacity to Support Local Acute Trusts	**4**	16↑*	16	**20↑**
NQ04	Norfolk Community Health & Care Trust Wheelchair Service (All Ages)	**4**	12	12	**12**
NQ16	Variation in Gram-Negative Bloodstream Infection Rates	**4**	12	12	**12**
	5-10: Performance (ML)				
PF1	52 Week Waits	**6**	16	16	**16**
PF2	Independent Service Providers	**9**	16	16	**16**
PF3	Clinical Pathway Changes	**6**	16	16	**16**
PF4	Community Dermatology Pilot	**4**	12	9↓	**4↓**
PF7	104 Week Waits	**6**	16	16	**16**
PF8	Eye Care (Ophthalmology) Waiting List	**6**	16	16	**16**

TABLE 2 SUMMARY
Risk score increases in month: NQ35 'Surge Capacity to Support Local Acute Trusts' (likelihood increased to 5)
Risk score decreases in month: PF4 'Community Dermatology Pilot' (likelihood reduced to 2, consequence reduced to 2)
New Risks in month: N/A
Risks with closure requested in month: N/A

Appendix 2: Committee Risk Overview (June, July, and August 2022) Table 2 of 3

August 2022: Quality & Performance Risk Dashboard

Table 2 of 3

This Risk Dashboard categorises the key quality and safety risks by their Likelihood and Consequence (Impact) to enable focus on the risks that will cause the ICB the greatest concern. Key: High Risk = Red / Significant Risk = Amber / Moderate Risk = Yellow.

Risk Ref.	Risk Details	Risk Tolerance/ Month	Mitigated Risk Rating / Committee Month and Year		
	11-16: Quality in Care (SJW)	**M05: Aug-22**	**M03: June-22**	**M04: July-22**	**M05: Aug-22**
QiC-LD-007	Discharge from LD-MH Hospitals	**8**	15	15	**15**
QiC-All-025	Care Provider Capacity System-Wide Impact	**6**	20	20	**20**
QiC-All-026	Legal Right to s117 Personal Health Budget (PHB)	**6**	12	12	**12**
QiC-SGA-009	Compliance with Deprivation of Liberty Safeguard (DoLS) Standards	**6**	16	16	**16**
QiC-CHC-024	CHC Fast Track Reviews	**9**	16	16	**16**
QiC-All-027	**NEW RISK:** Care Providers Without Contracts	**8**	-	-	**16**
	17-19: Mental Health (JY)				
MH1	IAPT Mental Health	**4**	12	12	**12**
MH2	Adult - ED Disorder Provision	**8**	12	12	**12**
MH3	12 Hour Admission Physical and Mental Health Breaches	**8**	16	16	**16**

TABLE 3 SUMMARY
Risk score increases in month: N/A
Risk score decreases in month: N/A
New Risks in month: QiC-All-027: 'Care Providers Without Contracts'
Risks with closure requested in month: N/A

Appendix 2: Committee Risk Overview (June, July, and August 2022) Table 3 of 3

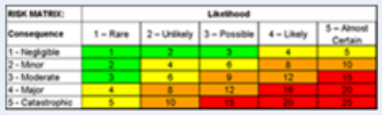
August 2022: Quality & Performance Risk Dashboard

Table 3 of 3

This Risk Dashboard categorises the key quality and safety risks by their Likelihood and Consequence (Impact) to enable focus on the risks that will cause the ICB the greatest concern. Key: High Risk = Red / Significant Risk = Amber / Moderate Risk = Yellow.

Risk Ref.	Risk Details	Risk Tolerance/ Month	Mitigated Risk Rating / Committee Month and Year		
	20-30: Children, Young People & Maternity (RH)	**M05: Aug-22**	**M03: June-22**	**M04: July-22**	**M05: Aug-22**
CYPM 120	NDS Community Paediatrics	**12**	20	20	**20**
CYPM 137a	CYP Mental Health: Allocation of Case Managers	**9**	20	20	**20**
CYPM 137b	CYP Mental Health: Crisis Assessment & Intensive Support Team (CAIST)	**8**	20	20	**20**
CYPM 137c	CYP Mental Health: Waiting Lists	**9**	12	12	**12**
CYPM 137d	CYP Mental Health: Mental Health Support Teams	**6**	12	12	**12**
CYPM 138	CYP Eating Disorder Provision	**8**	12↓	12	**12**
CYPM 142	LD CAMHS (Central and West)	**9**	20	20	**20**
CYPM 143	Paediatric Podiatry Services (Central) – ***Potential to Close***	**12**	16	16	**16**
CYPM 144	Lack of Community Epilepsy Provision for Children and Young People in Lincolnshire and Cambridgeshire	**9**	16	16	**16**
CYPM-LMNS-002	Ockendon: Data Requirements	**12**	20	20	**20**
CYPM-LMNS-003	Digital: EPR / Shared Care Record	**12**	16	16	**20**

TABLE 4 SUMMARY
Risk score increases in month: **N/A**
Risk score decreases in month: **N/A**
New risks in month: **N/A**
Risks with closure requested in month: **N/A ('CYPM141 Paediatric Continence East' closed during Meeting on 04/08/22)**



Norfolk and Waveney
Integrated Care Board

Agenda item: 20

Subject:	**Primary Care Commissioning Committee**
Presented by:	**James Bullion, PCCC chair**
Prepared by:	**Sadie Parker, associate director of primary care**
Submitted to:	**ICB Board**
Date:	

Purpose of paper:

To provide an update to members on decisions made at Primary Care Commissioning Committee meetings in July and August 2022.

Executive Summary:

The Primary Care Commissioning Committee meets monthly, it has four voting members (ICB Local Authority Board member, Non-executive ICB Board member, Director of Finance and Director of Nursing) and includes other non-voting attendees, such as Practice Manager members, ICB GP Partner member, Local Medical Committee, Healthwatch and Health and Wellbeing Board members.

The committee makes decisions in relation to the GP contract and other areas of funding affecting general practice, such as transformation funding, medicines and primary care estates.

Report

Committee meeting held on 12 July 2022

- This was the first meeting of the new ICB PCCC, therefore the **Terms of Reference** were noted and new members to the committee welcomed
- The **risk register** was noted. It was agreed to combine two risks, one relating to general practice resilience and the other (which also appears on the Board Assurance Framework) relating to the Covid pandemic affecting resilience
- Members noted a report on the progress in improving the uptake of **severe mental illness health checks**. Discussion included the critical link between this programme and the challenges faced by the mental health provider trust, the links to the locally commissioned service with GP practices and the link to the mental health programme board, which was also monitoring this programme of work

- Members noted a report on the progress in improving the uptake of **learning disability health checks**. The risk had been reduced this month, reflecting the programme framework in place and progressing being made, including a priority focus on those that hadn't had a health check in the last 12 months. It was noted that, while there had been a significant improvement overall, there remained variation between practice populations and between the five Places
- A report was noted on the **interface** work which was ongoing and also formed part of the risk register. The group had established task and finish groups to work on the priority areas of non-contracted activity, private referrals and ICE user registrations. Progress on implementation would continue to be monitored by the monthly interface meetings
- Members noted an update and the conclusion of the **locally commissioned services project**. The committee reflected on some of the learning and successes from the project, including streamlining commissioning and common pricing, equitable services for our population, patient engagement and strong working relationships with the Local Medical Committee. Work on implementing warfarin monitoring continued in Great Yarmouth and Waveney. There was opportunity to review the LCS in Q3 to determine if any changes could be made to improve them for 2023/24
- The committee approved the **wave 4b primary care hubs programme business case**
- Members noted a 'good' rating had been received by the **Cromer Medical Practice** following their Care Quality Commission inspection
- Members noted the **prescribing** and **finance** reports

Committee meeting held on 9 August 2022

- Members noted the **Director of Patients and Communities report**, which focused on the work being done to support the urgent and emergency care system (recognising that 80% of urgent care is carried out in general practice), the new Place-based Boards which were now meeting, and the new clinical engagement approach being taken by the Medical Director
- A report on **learning disability health checks** was noted, along with the system's improving achievement when compared regionally. Members asked for a cumulative report of uptake to be reported, rather than just from April to provide a more accurate reflection of uptake
- Members noted a report on the uptake of **severe mental illness health checks**, reflecting on the role of the voluntary sector in supporting uptake
- Members noted the **primary care estates update**, including an offer from NHS England to fund a piece of work to develop service and estates strategies for each of the primary care networks. Work was beginning on launching this to clinical directors and their teams
- Members noted a **primary care digital update**, including receiving further information on the national cyber incident and its minimal impact in Norfolk and Waveney. Members asked for more information on the roll out of the shared care record in a future report
- Members noted the inadequate ratings for **Heacham, Orchard and Manor Farm practices** following their recent **Care Quality Commission inspections**, including the action plans which had been developed to address concerns. All three practices were being supported by ICB primary care, quality and medicines management teams as well as having procured their own external support, and work was progressing well
- Members noted both the **prescribing** and **finance** reports

Recommendation to the Board:

Board members are invited to note the report.

Key Risks	
Clinical and Quality:	Care Quality Commission inspection reports are brought to committee meetings
Finance and Performance:	Finance reports are noted monthly
Impact Assessment (environmental and equalities):	N/A
Reputation:	The committee meeting is held monthly in public and includes membership from the Local Medical Committee, Healthwatch Norfolk and Suffolk and the Health and Wellbeing Boards in Norfolk and Suffolk
Legal:	Terms of reference, primary medical services contracts, premises directions and policy guidance manual
Information Governance:	Any confidential or sensitive information is heard in private
Resource Required:	Primary care commissioning team
Reference document(s):	Primary medical services regulations, statement of financial entitlements, premises directions and policy guidance manual
NHS Constitution:	N/A
Conflicts of Interest:	Arrangements are in place to manage conflicts of interest
Reference to relevant risk on the Board Assurance Framework	N/A

Governance

Process/Committee approval with date(s) (as appropriate)	Regular report to ICB Board.