NHS
Norfolk and Waveney
Clinical Commissioning Group

NHS Norfolk and Waveney CCG Annual Report

April 1st – June 30th (Q1) 2022

Contents

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

We started the 2022/23 financial year (1 April – 30 June, Q1) as the final chapter of the Norfolk and Waveney Clinical Commissioning Group (CCG). From 1 July, the CCG formally transitioned to become Norfolk and Waveney Integrated Care Board (ICB) following the passage and Royal Assent of the Health and Care Bill. This was an important step for us as the Norfolk and Waveney Integrated Care System (ICS), strengthening our approach to working more collaboratively with partners in the voluntary and community sector to deliver more joined-up care, and fostering greater engagement with residents in how services are commissioned and delivered across Norfolk and Waveney.

Incredible amounts of planning and preparation were undertaken internally across the CCG to prepare for this transition, whilst we continued to work alongside our network of local partners to develop the systems and infrastructure that would enable us as an ICS to improve on existing inequalities in outcomes, experience and access to health and care services. We would like to thank all the teams across the ICS who worked so diligently to ensure a smooth transition.

Alongside this important work, our vaccination programme continued to make great strides in protecting all Norfolk and Waveney residents against COVID-19. Children and young people aged 5-11 became eligible to receive their vaccination, and the rollout of the Spring Booster campaign saw vaccination teams going out to care homes to administer the life-saving vaccine to our most vulnerable residents and the staff who care for them, as well as to thousands more residents who were at-risk.

Our vaccination teams led the way in vaccinating residents, with more of our population (78.9%) receiving three doses than any other health and care system in the country during Q1. This was down to the unwavering determination, co-operation and hard work our system colleagues demonstrated in order to protect Norfolk and Waveney residents. We extend our profound thanks and appreciation to all colleagues and partners for their efforts in helping to keep people safe.

GPs across the county played a central role in the successful delivery of the vaccination programme, all whilst continuing to ensure that patients had access to primary care services. In fact, more appointments are available now than before the pandemic, which has been achieved by adopting mixed models of care to expand provision of appointment services. The last two years have presented incredible challenges in primary care, and we would like to acknowledge our thanks to all clinical and non-clinical colleagues working in primary care for their ongoing efforts to deliver care for residents.

Our urgent and emergency care system continued to experience unprecedented levels of demand for services during Q1. Ongoing challenges in discharge and flow of patients through hospitals and into ongoing care either in the community or at home created pressure both at the front door of our Emergency Departments and out in wider community health and ambulance services. Colleagues across the system have been working together, alongside national Discharge teams, to identify best

practice and innovative approaches that can be learned from other systems to help improve discharge and flow through our hospitals and improve outcomes for patients and their families.

The impact of COVID-19 continued to be felt and presented on-going challenges to the return to business-as-usual services. Like most other health and care systems across the country, we have continued to see an increase in waiting lists during Q1 and have been working at pace to address the backlog of routine elective and diagnostic procedures that were cancelled or delayed due to the pandemic. We would like to acknowledge the hard work of all acute trust colleagues working across the Elective Recovery programme for their efforts towards elective recovery, but we know there are many people are still having to wait for appointments and procedures. As our elective recovery proceeds, we will continue to do all we can to reduce waiting times and support people to stay well.

At the start of this new financial year, our system continued to face underlying financial challenges and a key focus of the ICB management team from 1 July will be to look ways to reduce the system's underlying deficit financial position.

As a system, we continued to support our mental health provider, Norfolk and Suffolk NHS Foundation Trust (NSFT) to make the necessary quality improvements to improve safety and quality of care for those accessing mental services following its 'inadequate' rating by the Care Quality Commission (CQC). There is a lot of work still to be done, but we are committed to ensuring those who need help receive the support they need, and that our provider has the support of system colleagues in making the required improvements.

Finally, we would like to express our gratitude to all the ICS partners working across health and social care in Norfolk and Waveney. From our vibrant and thriving voluntary sector, district and local authorities and community teams, through to ambulance teams, pharmacy colleagues, carers, and all colleagues working across social care – we know how diligently everyone has been working to deliver their important services and we thank you all for your ongoing efforts to support the health and wellbeing of our residents.

This report is the last annual report of Norfolk and Waveney CCG, as future reports will report on the operations of the ICB, or NHS Norfolk and Waveney.

We are grateful to our colleagues in the CCG for all the achievements, hard work, and challenges faced and overcome over the last two years. It's been a long road, with many twists and turns, but as we close this chapter on the CCG and prepare for a new era as NHS Norfolk and Waveney, we are confident in the skills and determination of our staff and partners to deliver safe and quality care for the people of Norfolk and Waveney.

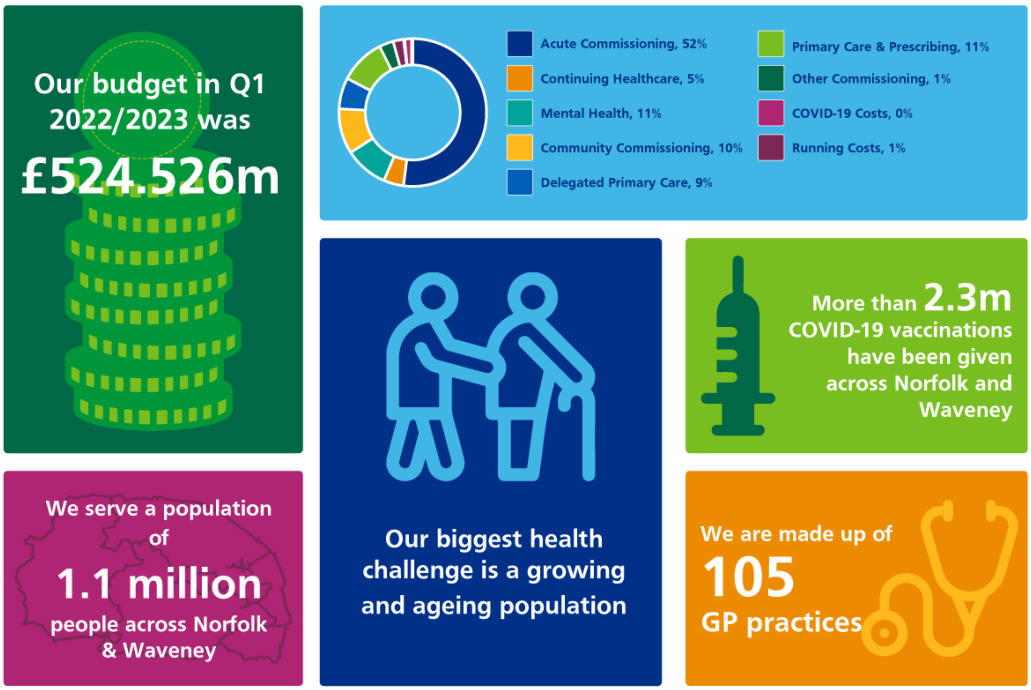
Tracey Bleakley
Accountable Officer

Anoop Dhesi
Chair

Purpose and Activities of the Organisation

NHS Norfolk and Waveney CCG was responsible for planning and buying safe, high quality health services. The CCG agreed and administered contracts with hospitals, community services, the mental health trust, GP practices, the ambulance trust, and other organisations who provide care and treatment services, and monitored the performance of the delivery of these services.

The CCG at a glance:



The services the CCG commissioned were for people living (or registered with a GP) in the Norfolk and Waveney area. Primary Care is 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.

Structure of the CCG

The CCG was 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. Each Member Practice was entitled to be represented at the Council of Members, which held the CCG to account for its business, strategy, and policies.

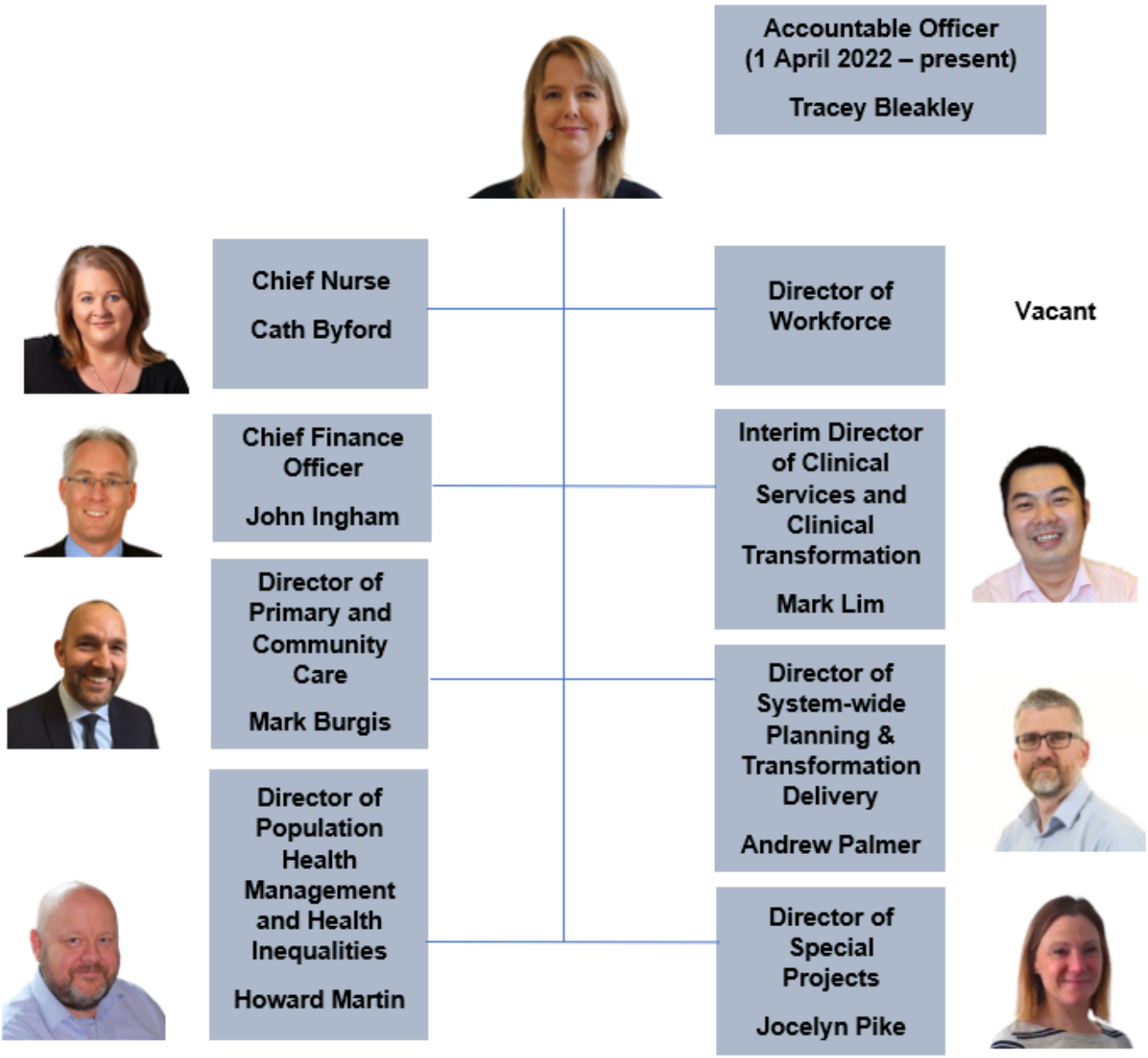
The Council of Members delegated oversight of the CCG to the Governing Body, which was comprised of elected local clinicians from member practices plus lay members and senior CCG management staff.

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 did not hold a formal Council of Members meeting during the period 1 April 2022 to 30 June 2022. More information on the Council of Members actions and responsibilities is contained with the Accountability report.

The Health and Care Bill 2021 contained a series of measures to formally establish Integrated Care Boards (ICBs) as part of Integrated Care Systems. Having received Royal Assent, ICBs became statutory bodies on 1 July 2022 and replaced CCGs. Recruitment for a Chief Executive Officer for the future Norfolk and Waveney ICB was conducted in winter 2021 which resulted in the appointment of Tracey Bleakley as Chief Executive Officer-designate of the ICB. From 1 April 2022, Tracey became Accountable Officer of the CCG. As of 1 July 2022, Tracey Bleakley became Chief Executive Officer of the ICB.

Operationally, the CCG was 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 during Q1 2022/23 is below.



The Norfolk and Waveney Health and Care Partnership

The CCG was an active member of the Norfolk and Waveney Health and Care Partnership which was confirmed as an Integrated Care System (ICS) by NHS England and NHS Improvement (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, had worked with increasing collaboration to tackle the issues and challenges that no partner could solve on their own. Equally, it also gave way to working together on transformation programmes and projects, with partners working together in a way that had enormous benefits for the people of Norfolk and Waveney. This was accelerated during the COVID-19 pandemic, and cross-system relationships strengthened at every level through the pandemic recovery.

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

- The **Integrated Care Board** (ICB) is responsible for the strategic development, funding, and health commissioning activities for the partnership.

- The **Integrated Care Partnership** (ICP) is responsible for integrating the care system with the wider public and charitable sector and has statutory responsibility for developing the strategy to address health inequalities.

By Q1 2022/23, a number of key appointments had already been made to the Norfolk and Waveney ICB and the ICP elements of the Norfolk and Waveney ICS:

- Rt Hon Patricia Hewitt was appointed as Chair-designate of the ICB
- Tracey Bleakley was appointed as Chief Executive designate of the ICB
- Councillor Bill Borrett was appointed as Chair-designate of the ICP
- Cathy Armor was appointed as Non-Executive Member of the ICB
- Hein van den Wildenberg was appointed as Non-Executive Member of the ICB
- David Holt was appointed as Non-Executive Member 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 Norfolk and Waveney Integrated Care System (ICS) (improvinglivesnw.org.uk)

The goals of the ICS

The ICS has three overarching goals:

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

Key risks to performance were formally logged on the Governing Body Assurance Framework (GBAF) document, which was reviewed by the CCG's management teams and committees, and was 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.

During Q1 the key issues and 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
- 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)
- The risk that hostile cyber-attacks affecting the UK may impact on CCG business continuity
- 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
- The risk that mental health services provided by NSFT do not meet the required standards, leading to risk of poor patient experience, delays in treatment or services, and clinical harm

A new risk was presented to the Board in Q1 in relation to the enhanced cyber risk coming out of the conflict in the Ukraine, particularly around ransomware. Ransomware is a type of malware attack in which the attacker locks and encrypts the victim's data and important files, and then demands a payment to unlock and decrypt the data. If the CCG's data stored within N365 were to be encrypted by such an attack, there would be a significant impact on the CCG's ability to function until access to the data was restored.

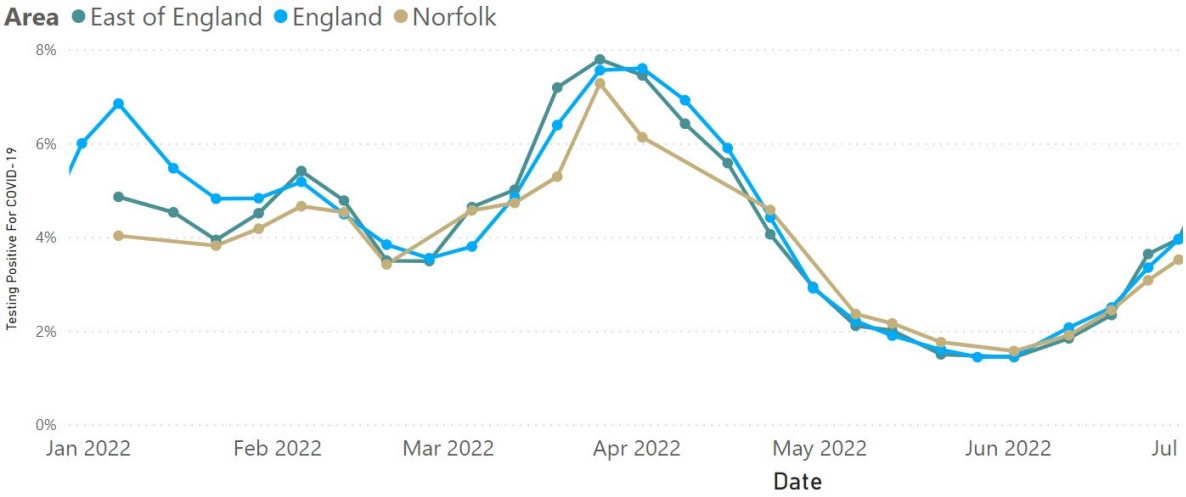
To mitigate this the CCG had multi-layered controls in place to reduce the risk of such malware being introduced. The CCG also had detailed information from NHS Digital on the data security and recover controls that were in place on the N365 national tenant, which provided assurance that the files stored within N365 were protected from malicious encryption. This would reduce the likelihood of the CCG suffering such an attack and also provided assurance that if it did there were processes in place to recover.

In Q1, the demands placed on the health and care system from ongoing COVID-19 infection prevention and control practices, and the demands on the Urgent and Emergency Care system, were exceptional. These demands presented key challenges and risks to the CCG, which are highlighted below.

<u>COVID-19</u>

COVID-19 continued to present significant risks to CCG operations and health and care services during Q1 of 2022/23.

The graph below presents the percentage of the population testing positive for COVID-19 each month.



Following the largest wave of infections in January 2022, Norfolk and Waveney experienced a number of “mini-waves,” with a peak at the start of Q1 2022/23 in April which flattened down and then started to rise again at the end of Q1, as illustrated by the graph below. This indicates that pressures on the health and care system arising from COVID-19 infections during the winter didn’t really start to abate till mid-May, and then started to rise again towards end of June.

The incidence rates in the community resulted in more patients in hospital with COVID-19, as well as staff being ill or 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 continued to be 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

The health and care system continued to experience sustained and intensive demand for services in Q1. The high levels of demand, alongside challenges moving patients through and out of hospital, meant the system remained at OPEL 3 and OPEL 4 throughout Q1. OPEL is Operational Pressure Escalation Levels, which is used to describe how well NHS systems are operating, with OPEL 1 meaning normal operations and OPEL 4 meaning the system is unable to offer comprehensive care to patients.

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 unrelenting demand for emergency care services. More information about urgent and emergency care, and discharge through hospitals is included later in this report.

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 presented an ongoing risk to staff health and wellbeing, resulting in increased staff sickness absences and staff turnover, which risked impacting on patient care. See more information in the Workforce section below.

Further information on risks can be found in the Governance Statement.

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.

As we emerged from the pandemic in 2021/22 and into the period of recovery that continued during Q1 2022/23, the CCG continued to work at great pace to support the return to business-as-usual services whilst tackling the backlog of patients waiting for treatment and supporting system partners to continue to deliver quality, safe, and efficient care for residents.

Alongside this critical work, the CCG was preparing for the upcoming transition to an ICB and working more closely than ever with colleagues across the health and care system to ensure that the infrastructure and services were in place to ensure a smooth transition from 1 July 2022.

Like other systems across the country, Norfolk and Waveney was managing exceptionally high levels of demand for health and care services which put pressure on effective delivery of services as well as impacting efforts to improve our elective recovery position. This presented key system risks including 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, ongoing elective backlogs, and high workforce sickness and absence rates.

Whilst collaborative work towards system improvement was taking place, overall the health and care system remained in a challenged position. Funding allocations, service innovations, and collaborative approaches across ICS partners were employed to address demands on the health system, support our elective recovery plans, and help patients to access health services equitably and safely.

However, despite all that was being done to keep services running, primary and secondary care continued to face unprecedented levels of demand during Q1 2022/23. The impact of the COVID-19 pandemic continued to be felt in terms of the high number of patients waiting for operations and other procedures which impacted the CCG's ability to meet constitutional targets around patient waiting times. More information is contained in the Performance Analysis section.

Norfolk and Waveney's COVID-19 vaccination programme was one of the top performing in the country, thanks to its collaborative and data-led approach. Teams from the CCG worked 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 the most recent Spring Booster 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 NHSE/I's 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 has focussed 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. The CCG recognised that significant work remained in supporting NSFT to make quality improvements following its 'inadequate' rating by the Care Quality Commission (CQC) in April 2022 and was working alongside other system partners to support the Trust to make the improvements outlined in the CQC's report.

During this time, the underlying financial challenges to the system also remained, and the successful achievement of the in-period plan was only possible as a result of non-recurrent measures. Following the CCG transition to the ICB, a key focus of the ICB management team will be the reduction of the system's underlying deficit financial position.

Health Services

Demand for all NHS services remained at an exceptionally high level during Q1 2022/23.
As it was across the country, recruitment and retention of clinical and non-clinical staff remained a significant issue. Introducing new clinical skill mixes in healthcare settings and provision of mixed appointment models within GP surgeries was positive, and the CCG would like to take this opportunity to acknowledge the dedication of all our colleagues who were and are working incredibly hard to look after patients in their care.

During Q1 key highlights and achievements of the CCG and its partners included:

- **Primary Care** – GP practices continued to work incredibly hard to meet the ongoing demands for patient services, and more appointments were available for residents during Q1 than in the comparable period prior to the pandemic. General practice continued 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. More face-to-face appointments were available than the national average, whilst practices continued to support the efforts of the vaccination programme.

- **Community Care** – To support the vaccination programme's Spring Booster campaign, Norfolk Community Health & Care NHS Trust (NCH&C) coordinated delivery of the 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 offered 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 unveiled in 2021/22 continued to provide improved access to services outside of hospital settings. These included the 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 North Norfolk Macmillan Centre at Cromer and District Hospital, operated by the Norfolk and Norwich University Hospital Foundation Trust (NNUH), which brought cancer treatment and support services closer to thousands of people in North Norfolk. Virtual Wards launched out of the NNUH during 2021/22 continued to provide 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.

ICS partners, including colleagues from acute hospitals, community hospitals, social care and primary care, continued to work collectively to support flow through the whole acute and community pathway, supporting the discharge and the urgent care response. A system-wide transformation team was established that funded and delivered a range of innovative measures to support safe and timely discharges, and review and improve processes to help patient flow through hospital.

- **Mental Health** – The CCG continued to work with Norfolk and Suffolk NHS Foundation Trust (NSFT) and system partners to deliver the All-age Mental Health Transformation programme. The impact of the pandemic continued to be felt in ongoing demand for services, and later and more complex presentations of mental health issues. During Q1, system partners were continuing to work collaboratively to deliver the aims of the programme and improve outcomes for patients. Over the last year significant funding was invested to improve access to services which continued to provide support in Q1 2022/23, 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), were providing 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 were prioritising promotion of mental wellbeing to support early prevention and reduce escalation and enhance mental health provision in the community. Examples include the Joint Response Ambulance Car and the Primary Care Network Mental Health Practitioners who provide safe, effective and responsive mental health services closer to where people live and work.

Performance of local health services continued 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 were managed by the CCG. There were numerous factors which created 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 were reported in the Governing Body Assurance Framework. Further information about the CCG's risks can be found in the Governance Statement.

CCG Performance

The annual narrative assessment from NHSE/I for 2021/22 was received in June 2022 and was the last received by the CCG prior to completion of this report.

NHSE/I recognised Norfolk and Waveney CCG's efforts and commitments over the previous year in improving healthcare for the local population and system.

Summary headline points include:

- The CCG has worked exceptionally hard during 2021/22 to ensure that patient safety and the quality of care, access to services and outcomes underpin all its work
- The CCG has supported the whole system to collaborate in an effective manner to both respond to COVID-19 and also to help meet the needs of the population
- Both elective recovery and urgent and emergency care continue to be a priority, and the CCG's role in supporting this agenda has been key
- The CCG is recognised for having introduced numerous schemes to help understand and reduce inequalities and prevent ill health
- The CCG has supported their staff through both the pressure of the COVID-19 pandemic and also through the change to operational structure and the introduction of ICBs
- The CCG has demonstrated how it has successfully continued to involve and consult with the public

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 months in Q1. Green indicates that all targets were achieved, Amber that some targets were achieved, and Red that no targets were achieved.

Constitutional Area	22/23 Q1 Performance RAG
A&E Waits	0 / 2
Ambulance Handovers	0 / 4
Ambulance Response Times	0 / 6
Cancer Waiting Times	2 / 8
Diagnostics Waiting Times	0 / 1
Referral to Treatment Waiting Times	0 / 2
Infection Control	3 / 3
Community (RTT, 111 & OOH)	2 / 12
Mental Health - IAPT	3 / 4
Mental Health - Other	1 / 4

The impact of COVID-19 continued to be felt across NHS services during Q1 as unmet patient demand returned to the health system. This, along with ongoing workforce pressures and COVID-19 infection prevention and control guidance constraining how quickly patients could move through the health and care system, created enormous pressure which is reflected in the performance against targets outlined above.

Norfolk and Waveney cancer waiting times performance across 2022/23 Q1 remained similar to 2021/22, with only '31 days subsequent anti-cancer drugs' achieving target. Cancer 2 Week Wait Breast showed achievement of target however this was down to a data recording error at one of the acute hospitals; the other acute providers had achieved target. High level of demand continued for the Cancer services, with 2 Week Wait pathways having 14% more treatments compared to the same period in 2019/20. Whilst the remaining cancer waiting time targets were not met, collaborative work continued across the ICS 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.

All acute trusts continued to work towards improving their elective performance and recovery towards the Diagnostic and Referral to Treatment (RTT) targets. During Q1 2022/23 the combination of COVID-19 and Urgent Emergency Care (UEC) pressures had significant impact on the acute hospital trusts' ability to provide elective patient services. Diagnostic target performance was maintained at around 66% despite the challenges mentioned above, which were compounded by machine issues within the MRI service. The targets for RTT waiting times and numbers of patients waiting over 52 weeks were not met due to a combination of factors including an increase in post-pandemic referrals to the services, reduced elective activity due to COVID-19 and UEC pressures, and a focussed effort to support the longest waiting patients with the aim to stop waits over 2 years by the end of July 2022. 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 reflected 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, totalling 67.4% of patients during Q1, a 1% reduction from the percentage achieved during the same period the previous year. 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 was renewed and strengthened system partnership and working to collaboratively develop strategies to support early intervention of mental health issues. This saw 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 that continued into 2022/23: April to June 2022 saw a 44.8% increase in patients entering treatment compared with the same 3 months in 2021 (6,889 compared with 4,759) however this was below the national aspiration of 7,561 in this period. 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, including recovery rates and waiting times to accessing treatment: 92.4% of people completed their wait for treatment within 6 weeks (target 75%); 99.9% of patients completed their wait for treatment within 18 weeks (target 95%); and 52.6% of patients moved to recovery following treatment (target 50%). Key to continuing to improve access is ensuring people of Norfolk and Waveney seek out support while we increase 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 ongoing volume of referrals and a significant increase in acuity, with urgent "high risk" cases

remaining significantly higher than prior to the pandemic. Just over 46% of routine referrals for CYP with eating disorders were in treatment within 4 weeks against a 95% target, and 80% of urgent cases received treatment against the 95% target. Work continued to improve performance against targets as implementation of the all-age eating disorder strategy was rolled out in Q1 2022/23. The strategy was co-developed with system partners and service users with lived experience to redesign eating disorder services across Norfolk and Waveney. Implementation will transform support options and improve patient access to quality and timely care.

Performance against targets for 111 services also fell below target during Q1, with 14% of 111 calls abandoned over the three months (against a target of 5%), although an improving trend on the 16.5% of abandoned calls reported for 2021/22. 47.8% of calls were answered in under one minute against a target of 95%, again an improvement on the 42% previously reported. Out of hours health services failed to meet all targets except for the number of Primary Care Centre less urgent patients seen in under 6 hours, with 97.1% 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 in the Urgent and Emergency Care section.

Community referral to treatment measures had mixed performance, with referrals to paediatric consultants exceeding target, however, wheelchair waiting time performance was below target owing to a range of factors including increased demand and complexity of referrals; availability of equipment; and staff absence reducing clinic capacity. The majority of patients waiting (87% as at June 2022) had an assessment and were waiting for equipment.

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 continued to lead the roll out of the vaccination programme across the health and care system during Q1 2022/23, 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 was 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. During 2021/22 the system regularly featured in the top five performing health and care systems in England (out of 42) and consistently appeared in the top ten, and in June 2022 the system was top of the leader board for administration of the first three doses, having given 43,378 (78.9%) doses to the population.

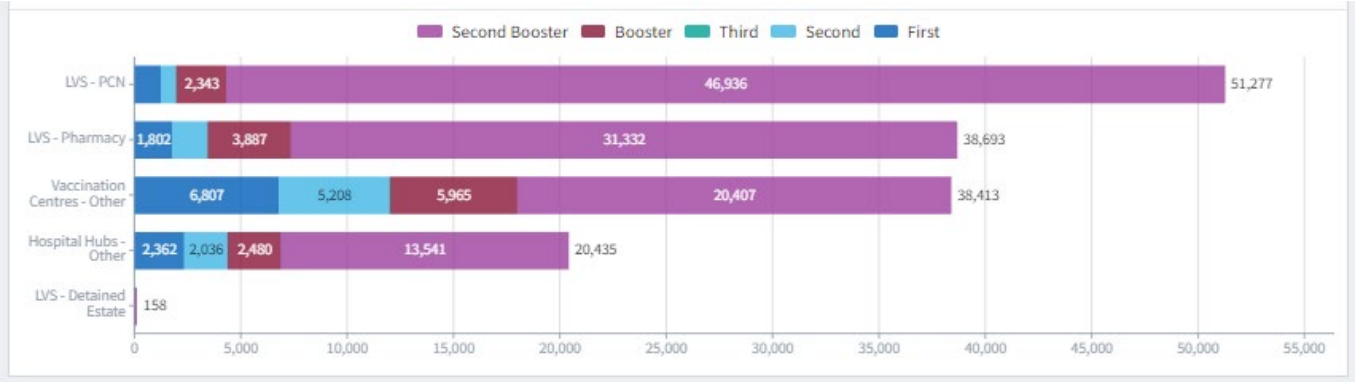
As of April 2022, vaccinations had been offered to all age group from age 5+. Following the success of the initial rollout of the COVID-19 vaccination programme, a Spring Booster dose was issued to people aged 75 years and older starting in Spring 2022.

COVID-19 is more serious in older people and those with a weakened immune system, and protection from the vaccine may be lower and may decline more quickly in these residents. For this reason, people

aged 75 years and over, those in care homes, and those aged 12 years and over with a weakened immune system were offered the Spring Booster as a precaution as these residents were the first to receive the first (winter) booster and their protection from that vaccine may have been reduced.

The Spring Boosters (or Second Booster as displayed in the graph below), were administered in care homes by Vaccination teams deployed by PCNs. Other sites such as pharmacies, hospital hubs, and the vaccination centres also administered doses to our most vulnerable residents.

Delivery methods for the Spring Booster vaccinations



During 2021/22 and into Q1 2022/23, vaccinations were 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 Q1 2022/23 more than 2.3m vaccinations had been given across Norfolk and Waveney and 94% of people over the age of 16 had received at least one vaccination (compared to an England average of 92%).

The success of the vaccination programme was 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 the 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.

During Q1 additional work to support the vaccination programme included:

- Working with Norfolk Community Health & Care NHS Trust (NCH&C) to coordinate delivery of the roving model which included a vaccination bus, pop-up clinics, and Worry Clinics to reach areas of low uptake and high levels of vaccine hesitancy and help to address health inequalities.

- We continued to take the SOS bus out into the community and into areas where it could be used not only to vaccinate people but also carry out Hepatitis C testing. The SOS bus evolved from the original 'Worry Bus' and was deployed with specialist teams who could provide 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 communications campaign that encouraged those who were eligible to come forward and get their vaccinations. The campaign reached residents through social media, as well as advertisements in high footfall areas (such as shopping malls) to promote messages and reach those who may not have been engaged to come forward.

- The children's 5-11 vaccination programme was implemented, initially to the Clinically Extremely Vulnerable children who were at risk. Two vaccinations were offered 12 weeks apart. A dedicated campaign to target this group was developed alongside partners across the health and care system. Children were encouraged and celebrated when they received their vaccine, with bright certificates and stickers that were specially designed for our system. These have been well received by both vaccinators and children.

Cancer

Preventing as many people as possible from developing cancer is a key aim, 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 acknowledged the significant backlog of people waiting for cancer treatments. This backlog has been caused by unprecedented surges in demand for cancer services, driven by the number of urgent cancer referrals returning into the system after the pandemic, which impacted on available diagnostic and treatment capacity.

Whilst the number of referrals for cancer services continued to grow, it was essential that these referrals continued at pace so that patients could be triaged and entered into the system for treatment and that more cancers were diagnosed at an earlier stage. While that meant that performance against targets for waiting times fell below where we would like them to be, the CCG and partners across the Cancer Programme Board were 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 helped to identify capacity constraints. System partners 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. Cancer themed "Help Us to Help You" communications campaigns continued

during Q1, and the Cancer Programme Board ensured that learning was shared with Primary Care colleagues to help them to identify those patients who presented with “vague symptoms” that were suspicious of cancer and to continue to offer them support to attend appointments and seek help for their worrying symptoms.

Some aspects of the work undertaken to improve cancer services during Q1 included:

- Continued development of a shared cancer patient tracking list (PTL) which helps 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.
- Continued development of the Rapid Diagnostic Service (RDS) for patients with non-specific symptoms suspicious of cancer. This service helps to reduce the number of GP visits those 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.
- Colon Capsule Endoscopies (CCE) re-commenced in JPUH and NNUH to alleviate pressure on endoscopy waiting lists and ensure patients were on the correct pathway. JPUH completed CCEs for 66% of patients offered the service to date with NNUH at 71%; the national rate sits at 75%. The QEH was in the process of recommencing their CCE service and were training readers and sourcing the correct IT equipment to read the CCE data.
- Cancer Care Navigators were introduced at JPUH, working alongside Clinical Nurse Specialists and existing supporting teams to help and support people affected by cancer with their non-clinical needs and to ensure people receive practical and emotional support throughout their cancer diagnosis.
- Pilot of the Cancer Connect Project continued with Norfolk Libraries, which gifts a digital device to cancer patients who are digitally excluded. Access to this device provided cancer patients with a tool to communicate with their healthcare providers and to access online support services.
- Evaluation of the Population Health Management Cervical Screening was completed and shared. A toolkit was being developed to support PCNs to increase coverage of cervical screening, and the CCG was supporting a review of health inequalities impact assessments of local cancer pathways.
- The team continued to support the delivery of the Earlier Diagnosis Direct Enhanced Service/Quality Improvement work in partnership with Macmillan. We have refreshed our support offer to Primary Care, which includes:
    - Pilot of x 5 primary care, care co-ordinator roles
    - Pilot of training programme for care navigators
    - Pilot of cancer admin support forum
    - Programme of GP webinars, PCN and practice visits

The CCG continued to promote the national “Help Us, Help You” campaigns to raise awareness of symptoms that might be suggestive of a cancer, as well as developing local resources to support local residents and had encouraged our colleagues to engage with underserved patient groups.

The CCG also supported Public Health England and NHS England in raising awareness of screening and awareness and worked in partnership with voluntary sector organisations to extend reach.

Planned and Elective Care

As the performance table on page 14 demonstrates, hospital services remained under pressure during Q1 2022/23 and performance targets around diagnostic and referral to treatment times were not met. The loss of capacity due to COVID-19 continued during this time, especially during April and May. This occurred alongside continuously high levels of demand for non-elective services since winter 2021/22.

Elective referrals continued to grow across all three acute hospitals. This, along with the rising demand for urgent and emergency care and cancer care, hampered 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 15 months from February 2021 to June 22. The table illustrates the overall growth in patient numbers since February 2021, but also shows the focused work undertaken to reduce the number of patients waiting the longest time for treatment. The continued increase in number of patients waiting during Q1 reflects the return to business-as-usual services whilst attempting to manage the backlog of cases caused by the pandemic.

	February 2021	**February 2022**	**June 2022**
Total number patient waiting list	88,822	111,077	122,806
Total waiting up to 18 weeks	40,431	61,582	68,370
Total waiting over 52 weeks	11,976	11,314	12,747
Total waiting over 78 weeks	1,470*	3,532	2,679
Total waiting over 104 weeks		1170	72

Source NHS England: Statistics » Consultant-led Referral to Treatment Waiting Times Data 2021-22

In February 2022, the Norfolk and Waveney system had the 3rd highest number of people waiting for treatment beyond 78 weeks nationally, representing 5% of the national total. However, due to the hard work of staff across the system it was possible to reduce the number of longest waiting patients to 72 by the end of June 2022.

The Elective Recovery Programme works by building relations between the three hospitals in the system and maximising 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.

Work continued to eliminate waiting lists of over 78 weeks, which included maximising the current theatre capacity through national measures such as Getting It Right First Time (GIRFT) and High Volume Low Complexity (HVLC) which focus on ensuring that the theatres are working effectively. System partners also looked at options to move patients between hospitals to where there is capacity in a model called Mutual Aid. This allowed 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 were investigating what additional options were available in the independent sector and further afield with neighbouring systems to help reduce waiting times for patients.

Funding from NHSE/I continued to be 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 reduce overall waiting times and help reduce 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 front-end module for this was in development and expected to be ready for pilot in autumn 2022.
- The review of long-wait patients on both the admitted and non-admitted waiting lists was to identify if patients were 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 ensured the more vulnerable patients could be supported effectively.
- "Prehabilitation" 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. The system introduced a new electronic system called My PreOp that enabled the pre-assessment teams to assess each patient at the point at which they were listed for surgery and maximise their fitness during the waiting period. This aimed to reduce the number of on the day cancellations and improve patient recovery post-surgery.
- 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. Also, sharing good practice within the system was rolled out to other trusts.

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 were undertaken with the first year and a half, providing a solid foundation to support continued elective recovery with a focus on ensuring patients were prioritised by clinical need and seen at the right time, by the right service.

Primary Care

Like other health and care providers, general practice 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 continued to ensure that patients had access to primary medical care and clinical advice when needed. In fact, more appointments were available during Q1 than in the comparable period 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 comparative general practice appointment activity over the last three Q1s, demonstrating the enormous efforts undertaken within primary care over the last year to provide care for patients whilst supporting the vaccination programme:

	Total appointments			Comments
	Apr - Jun 20/21	**Apr - Jun 21/22**	**Apr - Jun 22/23**	
Appointments (face to face, telephone, online, and home visits)	1,114,264	1,533,534	1,586,814	Excluding COVID 19 Vaccinations activity
Total GP referrals to acute care	28,061	56,844	59,377	
COVID-19 vaccinations	N/A	406,451	50,961	1,167,613 COVID-19 vaccination appointments were provided in general practice since the programme launched in December 2020

During the Q1 2020/21, general practices were adapting their service provision in light of COVID-19. Practices 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. This may have resulted in a reduced level of referrals as fewer patients were seen in general practice.

Throughout 2021/22 and into Q1 2022/23, practices continued to increase overall appointment availability. In Norfolk and Waveney, a higher proportion of appointments are face to face than the national average. Over Q1 2022/23, face-to-face appointments accounted for 71.6% of all appointment types, an average of 7.6% more compared to national face-to-face appointment totals during that period.

During Q1 2022/23, GP practices 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 was taking place to give improved access to digital services for patients to offer more choice and reduce waiting times for appointments. Whilst general practice was open and accessible to patients, the CCG recognised 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 recognised that some patients may not use or cannot use digital technology and therefore ensuring that practices were open and accessible to all patients was critical in reducing health inequalities. A mixed model of care helped to reduce waiting times for appointments by allowing patients who were willing and able to use digital technologies to communicate with practices, which freed up time and resources to see patients in general practice who were unable to use digital technology or who wished or needed to see a clinician face to face.

The latest appointment data from NHS Digital shows that compared to Q1 of 2021/22, in Q1 2022/23 GP practices had been increasing face-to-face and home visit appointments whilst reducing the number of telephone and video conference appointments. Overall appointment activity increased 3.47%

compared to the previous year, as the reduction in vaccination appointments has been balanced by increases in face-to-face and home visit appointments.

Appointment Type	Apr - Jun 2021	Apr - Jun 2022	Variance	Variance %
Face to Face	1,003,508	1,135,737	132,229	13.18%
Home Visit	6,921	10,083	3,162	45.69%
Telephone	445,631	368,434	-77,197	-17.32%
Video/online	8,012	5,297	-2,715	-33.89%
Unknown	69,462	67,263	-2,199	-3.17%
COVID-19 vaccination	406,451	50,961	-355,490	-87.46%
Total Appointments	**1,939,985**	**1,637,775**	**-302,210**	-15.58%
Total Appointments excluding COVID-19 vaccinations	**1,533,534**	**1,586,814**	**53,280**	**3.47%**

Source: Appointments in General Practice - NHS Digital

Ensuring that the local population are informed of the services provided within general practice was a priority for the CCG. A primary care campaign released in November 2021 continued during Q1 of 2022/23, raising 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 included “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.”

To further improve access to primary care, work progressed on the development of the Wave 4b Primary Care Hubs, which saw £25.2m capital investment allocated to the system to develop four new primary care hubs. Development was delayed due to the pandemic, but 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 could proceed toward the target operational date of Spring 2024. The Programme was revised following initial NHS England feedback on the Programme Business Case. Department of Health and Social Care approval was anticipated September 2022 and the development of the individual “Full Business Cases” for each scheme was already underway.

Workforce

CCG staff 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. The commitment of CCG staff in supporting a return to services alongside the demands of COVID-19 was phenomenal. The continued demands on the workforce presented an ongoing risk to staff health and wellbeing however, and the CCG continued to work in partnership with ICS partners to collaborate and develop interventions to reduce risk and improve wellbeing for our people.

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

A focus on staff belonging and empowerment for change continued across the ICS and was localised within the CCG through staff networks including the Equality Diversity and Inclusion group and Health and Wellbeing Group. Leadership was 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 had been appointed for General Practice, Optometry, Dentistry, and Pharmacy, who were championing a “Who cares about you?” programme for primary care workforce.

The Norfolk and Waveney Workforce Transformation team and partner organisations were doing more to address the CCG and wider system challenges around sickness and turnover and launched several projects over the previous year focussing on people retention that were continuing into Q1. These aligned 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 were the backbone of the vaccination programme and were expanding their scope to support other areas of health and social care.
- A Collaborative Bank offers 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 over a year, working 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 were working in partnership with the ICS Workforce team to develop a more integrated approach to workforce recruitment and retention planning. A range of initiatives were 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 was 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 increased from 150 Whole Time Equivalent staff (WTE) in April 2021 to 356 WTE at the end of June 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 engaging 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 continued focus on ‘de-prescribing’ in frail patients, and drug holidays encouraged in patients receiving a class of drugs that were associated with cognitive impairment and falls. Alongside this, the team continued 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, answering an average of 13,000 calls and processing 5,400 online requests per month.

Several improvements had been made in the service 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 setting up 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 Adults’ specialist needs have been supported during the pandemic and beyond.

Weekly COVID-19 meetings were established within Adult Social Care, which CCG officers continued to attend 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) had extended availability to support people with LD&A over a 7-day period.

A major event that took place in 2021/2 which continued to impact on LD&A work was the publication of the Norfolk Safeguarding Adult Review (SAR) 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. The SAR 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 accepted the findings of the SAR and remained committed to preventing another person or family experiencing physical or emotional harm as a result of services that were ineffective or inadequate in their delivery of health and care.

The CCG was 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 continued its work 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 SAWRs had 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 aimed to reduce the number of patients that were admitted to institutions. In 2021/22 the CCG met NHS England's maximum number of 14 people placed in LD&A mental health hospitals. Importantly, no one with a learning disability was detained under the mental health act in a hospital-based unit during Q1 2022/23. The CCG recognised that more people need to be discharged appropriately and safely back to their home or to a new home within the community and 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.

In April 2022 the Learning Disability Community Forensic Services was established, with a formal launch in May 2022 involving system partners, specialist provider collaborative and the provider of the Learning Disability Community Forensic Service Hertfordshire Partnership Foundation Trust. This team was fully recruited to and was specialising in ensuring people with a learning disability were prevented and diverted away from activities that may put them in contact with the criminal Justice System.

In May 2022 the Norfolk and Waveney system exposed itself to a Peer Review to judge how well we had implemented the 'Building the Right Support' programme. The SAR recommended that a Peer Review should be undertaken to act as a 'critical friend' to the Norfolk and Waveney system. This included the CCG and Norfolk and Suffolk County Councils. The aim of the Peer Review was to ensure all partners were working to prevent people with a learning disability and/or Autism from being admitted to mental health hospitals, to ensure that those who did enter hospital had a timely discharge, and to form a judgement on the sufficiency of our statutory services and community assets. Recommendations for improvement that could be made have been heard and an implementation plan was being developed.

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. In 2021/22 the CCG recruited a team of 5 LeDeR reviewers to complete reviews on behalf of the ICS, however due to the backlog not all reviews had been completed but remained on track to be completed in the 6-month timeframe set by NHS England.

The focussed work to address health inequalities within the CCG continued as the Annual Health Check Pilot recommenced in Q1 following its launch in March 2021. The first year's pilot 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 improved uptake of annual health checks and the quality of service for people with Learning Disability and Autism during their visits as well. 199 people had a health check after they were contacted by the

team, and over a third attended their health check appointment. As a result of the pilot's success the CCG has committed to funding the programme for 2022/23.

Safeguarding

The CCG provided 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 was a key part of the CCG's work, and in the interest of patient and public protection has continued to work in partnership with local authorities and other organisations during Q1 to support people who may be subject to abuse and were unable to seek help due to continuing social isolation.

Continuing Health Care (CHC)

The CHC team was 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.

During Q1, providing a comprehensive CHC service to meet the requirements of the National Framework for CHC had 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 continued with recruitment, however it was not possible to recruit to all vacant clinical posts. Staff sickness presented challenges, alongside staff retention. This impacted the CHC team's performance over the three months.

The table below illustrates CCG performance during Q1 2022/23 against the Quality Premium standard of CHC completion ≥ 80% within 28 days of referral:

April 2022	May 2022	June 2022
81.58%	47.50%	52.18%

The CHC team aimed to support care providers who were experiencing difficulties in maintaining the quality and safety of their service. The team continued to work with both Norfolk and Suffolk County Councils to provide a collaborative approach to support. This included urgent reviews of individuals in receipt of CHC to establish if care needs were being met.

The CCG continued to commission Liaison Care to complete reviews of individuals in receipt of Fast Track NHS Continuing Healthcare. Outstanding Fast Track reviews continued to be a legacy from the COVID-19 pandemic when CHC was stood down. With comprehensive oversight from the CHC senior leadership team of the quality of this work, a successful partnership continued to deliver reviews of a high quality. This resulted in some efficiencies by removing NHS funding from individuals who did not meet the criteria to receive either Fast Track or standard NHS Continuing Healthcare.

Adult Mental Health

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

In Q1 2022/23 the CCG completed the annual planning process and committed a total of £22.2m in mental health investment, achieving NHSE's MHIS and Long-Term Plan (LTP) investment requirements.

The pandemic had driven increased demand for mental health services in part due to the psychological impact of COVID-19 and difficulties accessing services. This led to people presenting for support later and with more complex presentations, increasing pressures on system pathway and increasing the need for out of area placements. Referrals from all system partners increased during 2021/22, and that trend was continuing into Q1, with increased need for support to help people manage 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 was an 11% increase in external referrals to NSFT Secondary Care Mental Health Services during 2021/22 compared to pre-pandemic levels in 2019/20. This trend was continuing in Q1, as although the figure was reduced from the elevated referrals last year, there was still a 7.64% increase on pre-pandemic levels.

	External referrals to NSFT
Q1 2019/20	8,033
Q1 2020/21	5,960
Q1 2021/22	9,045
Q1 2022/23	8,647

Treatment and support for individuals with eating disorder continued to be an area of significant investment and focus of improvement work, building on the foundational work developed during 2021/22. The workforce was increased, with new roles 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 were supporting people to stay well in the community.

The CCG recognised that our work must be influenced and informed by national recommendations and learning. This included 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 built strong foundations across the system, working with stakeholders to address the findings of the Prevention of Future Deaths report and develop services which would focus on prevention and early intervention and strive to be innovative and collaborative, with an all-age quality improvement driven approach. These initiatives were mapped into a co-produced all-age eating disorder strategy, and

the CCG continued 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 aimed to modernise care pathways and bring safe, effective, and responsive mental health services closer to where people live and work. Funding allocated in 2021/22 continued to be delivered in Q1 2022/23: improving 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 to support Community Transformation had been used to improve care pathways and develop community focussed services, aligned to GP practices to support people closer to home. The CCG was also awarded additional Spending Review money to support Mental Health Discharges and funding for new Crisis Alternatives services following successful bids. This funding was being used to support achievement of Mental Health Transformation priorities in Q1 including:

- Continuing to fund new roles to support mental health within Primary Care. These included dedicated Primary Care Network Mental Health Practitioners (MHPs) which were 50% funded as part of the additional roles reimbursement scheme (ARRS) and the remaining 50% funded by the system, and Enhanced Recovery Workers (ERWs) that were based in PCNs and GP practices to offer specialist support closer to where people live. During 2021/22 there were 23 MHPs and 23 ERWs recruited across all PCNs; the ambition was to double numbers in 2022/23.
- Undertaking work to develop a multi-disciplinary multi-agency rehabilitation and reablement team to provide person-centred support to those with complex psychosis at risk of relapse and readmission. This was a pilot service that planned to commence in July 22 covering Norwich, North Norfolk, and South Norfolk, with a view to expand across the patch after evaluation.
- Developing and implementing a Complex Emotional Needs Pathway. Led by NSFT, a structure of new roles and training opportunities was being embedded into current mental health services and primary care to provide support to patients where it was most needed.
- Continuing recruitment to the Clinical Associate in Psychology (CAP) roles. CAPs provide psychological assessment, treatment, and intervention to support people with longstanding and complex difficulties supervised by a clinical psychologist. These roles fill the skills gap between the Assistant Psychologists and Clinical Psychologists and increase diversity and inclusion in the clinical psychological workforce. The first cohort of CAP trainees (23) commenced their apprenticeship in Dec 2021. Three CAPs were recruited for cohort 2, ready to commence in September 2022 with plans to increase these numbers for cohort 3 in April 2023.
- Developing community wellbeing hubs in Norwich, Gorleston, and King's Lynn, Thetford and Alysham. These hubs enable earlier and easier access to mental health support, providing direct support, (including an evening crisis service), supported referral, signposting and access to wider services in the community.
- Supporting crisis alternatives such as the mental health joint 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. 111 Mental Health Option 2 went live in April 2022, providing advice to people in need of urgent mental health support similar to the 111 model. There has also been an expansion of the service of the Julian Support mental health admission prevention service in

North and South Norfolk.

- Continuing work to transform community services by strengthening access to psychological therapies (IAPT), delivering a partnership with Voluntary, Community, and Social Enterprise (VCSE) to improve Dementia support and diagnosis across the system; and delivering enhanced Perinatal Mental Health services.

During Q1 22/23, a series of clinically led huddles took place to focus on access points for people with mental health concerns to establish current pathways, issues, and opportunities. Information from the huddles was evaluated along with clinically led workforce and Activity Redesign (CLEAR) findings to produce a draft patient pathway model that incorporates elements of community transformation, wellbeing hubs, and showing entry/exit points to prevention, wellbeing, and the Urgent Emergency Care pathway.

Following the extensive whole system workforce engagement that took place last year, the Norfolk and Waveney Mental Health Workforce Strategy 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. Creating and embedding new roles to provide additional capacity to meet demand was a priority.

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 embedding 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, increased levels of support to the Trust so the necessary improvements could 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;
- CCG Mental Health leads were members of the five CQC Pillar improvement groups set up by NSFT to respond to the CQC’s actions and manage the organisation-wide improvement plan;
- Focused support from senior nurses from the CCG Nursing and Quality team were working in partnership on patient safety and quality improvement plans; and
- The Associate Director for Nursing and Quality attended a series of staff engagement events to support the Trust.

<u>Mental Health Workforce Transformation</u>

We were continuing to deliver on our Mental Health Workforce Plan as part of the Norfolk & Waveney #wecaretogether people strategy across our mental health system. As part of this, we were implementing five workstreams to drive aspirations: New Opportunities, Upskilling, Culture and Leadership, Health and Wellbeing, and Retention. These workstreams were monitored by the Mental Health Workforce Project Board to support partners to work together to address key Mental Health workforce challenges within our ICS. As an example of innovative work, the workforce project board had supported a new ways of working approach which included peer support worker (PSW) expansion, recruiting social workers and occupational therapists to fill nurse vacancies, and overseas nursing

recruitment.

Children's and Young People's Mental Health

The mental health and wellbeing of Norfolk and Waveney's children and young people (CYP) was of central importance to the CCG and was 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. This funding was continuing to support activity into Q1 2022.

The pandemic and lockdown restrictions had a significant impact on the emotional wellbeing and mental health of CYP, which continued into Q1. The pandemic 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 continued to remain high.

Face-to-face as well as virtual provision was offered, depending on clinical need and choice. The detrimental impact of the pandemic continued to be felt, with the number of referrals and acuity still higher than pre-pandemic, in particular around eating disorders and children and young people presenting to services in crisis.

For example, 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 was compounded further with the closure of nearly a third of specialist bed provision.

Referral rates and acuity into core community mental health services continued to remain high, impacting on waiting lists and resulting in long waits for care. The ability to address these issues was hampered by staff sickness and several local providers going into business continuity.

Despite these challenges, access to CYP mental health services surpassed national standards during 2021/22, with 43% of CYP with a mental health need accessing support against the national standard of 35%. This progress continued into Q1 of 2022/23 as a direct result of financial investment to increase capacity, new roles, and focused waiting list initiatives.

Together with system partners the CCG worked hard to address the ongoing challenges. Examples of work that have continued to progress during Q1 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 were delivering several key service improvements during Q1, despite the ongoing challenges of a reduced workforce.

The Local Maternity Neonatal System (LMNS) team continued the rollout of 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 JPUH will be launching their final CoC team in November 2022, while NNUH and QEH have plans to launch once staffing and Hubs are in place.

The release of both the Ockenden Report and Perinatal Quality Surveillance Model in January 2021 increased the surveillance role of the LMNS. The release of the final Ockenden Report in March 2022 acknowledged 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 identified the CCG role in governance and scrutiny. The report identified 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 we were taking a systemwide approach to address the gaps.

Ockenden Assurance visits were undertaken by Region to Norfolk and Waveney's Trusts, and the reports generated provided positive overall feedback. As a system, ICS partners met to share experiences and plan to close gaps. Many of the identified issues had already been addressed, with clear action plans in place for the remaining. This was monitored by the LMNS Safety and Quality Oversight Group and concerns will be raised to LMNS Board.

Increased reporting and oversight of Trust Serious Incidents (SI) had been established, with quarterly SI oversight meetings and scrutiny at Safety and Quality Oversight Group, which feed SI themes and trends to LMNS Board and system-wide learning in local learning events (LLE).

As part of the NLS Long Term Plan, the smoking in pregnancy pilot commenced at JPUH during Q1. JPUH has the highest Smoking at Time of Delivery rates (SATOD) in the region. New staff are appointed and currently in indication and planning phase with roll out of the bespoke provision scheduled for October 2022.

The Equality and Equity Action plan had been co-produced by the LMNS, Public Health, CCG, VCSE, and the Maternity Voices Partnership. During Q1 the action plan was in final draft, ready for sign off at the LMNS Board in September and publication.

The Neonatal Critical Care review had been produced and submitted to Region within the required timescales. This work formed the action plans for the Neonatal workstream.

Following the £345,000 of funding secured in September 2021 to become an early adopter of the pilot Care Navigators programme in September 2021, in April 2022 NHS E/I awarded the ICS a further £508,000 in response to a bid to expand the Navigator service to support more families across Norfolk & Waveney. On 1st April 2022, the Navigator Team extended their referral criteria to offer support to not

only those children and young people in inpatient settings and those RAG rated Red, Amber or Green on the Dynamic Support Register (DSR), but to:

- Young people living in a community residential placement/educational placement, and the provider has raised concerns that they feel unable to meet the young person's needs and the placement is considered unstable.
- Young people at risk of being removed from the family home and placed in institutional care due to the family/carer struggling to manage the situation and carer strain/fatigue is becoming a concern.
- Young people regularly (50% or more) refusing to attend their educational placement.
- Young people regularly presenting to A&E due to a mental health difficulty.

Furthermore, on 1st June 2022, the Navigator Team expanded their service further to support young people up to the age of 25, who meet one of the referral criteria listed above. To support the expansion of the service, five additional Transforming Care Navigators were recruited and commenced their roles in June 2022.

SEND Update

The Designated Clinical Officer (DCO) Team for Special Educational Needs and Disabilities (SEND) continued to work with colleagues at Norfolk County Council (NCC) to undertake seven quality assurance visits within schools during Q1 to review and support their health/ medical needs processes and the provision available for children and young people. Feedback from schools was positive and further visits throughout the next academic year were planned.

Re-establishment of the SEND clinical network commenced, with regular meetings in place to bring together SEND leads across the providers as well as key colleagues from Norfolk County Council (NCC). The network helped to support multi agency relationships and acted to communicate SEND updates out to health colleagues.

The DCO team had also been developing and delivering 'Writing good health advice for Education, Health, and Care Plan (EHCP) needs assessment' training; undertaking quality assurance work to look at the quality of health advice being submitted for education; as well as continuing to review an average of 30-40 EHCP that are submitted by NCC each month.

Urgent and Emergency Care

The urgent and emergency care system (UEC) faced sustained pressures through Q1 of 2022/23 due to the continuing backlog of patients who could not be safely discharged into appropriate care in the community or at home.

During this time the system deescalated from a Level 2 Critical Incident / OPEL 4 to OPEL 3 (Operational Pressure Escalation Levels, which is used to describe how well NHS systems are operating. OPEL level 1 means services are working normally, up to OPEL level 4 which means the hospital is unable to offer comprehensive care.) Towards the end of Q1 operational pressures escalated and the system returned to OPEL 4.

The UEC system continued to feel the impact of the pandemic. Ongoing waves of COVID-19 required infection prevention and control measures to protect patients, and levels of staff sickness and isolation compounded the impact on hospital flow and discharge.

Following a period of reduced attendances at Emergency Departments (ED, also referred to as A&E) during the COVID-19 pandemic, total attendances at ED rose dramatically as the lockdown restrictions were gradually eased throughout 2021 and had surpassed pre-pandemic levels. In Q1 of 2022/23, total ED attendances were up 12.5% on levels in Q1 of 2019/20.

Meanwhile over the same period, 999 callouts reduced, with 5,066 fewer callouts in Q1 2021/22 compared to Q1 2019/20. This could be attributed in part to significant investment in IC24 Clinical Assessment Service (CAS) resulting in clinical validation of ambulance dispositions by 111 and support to East of England Ambulance Service (EEAST) to access community pathways as an alternative to ambulance dispatch.

Disruption to patient flow through the hospital discharge pathways resulted in congestion in ED departments and this, along with increases in attendances, had a knock-on effect on UEC performance against national access standards. Nationally, performance in UEC was impacted by the pandemic and local performance also reflected this, as set out below:

Emergency Departments (Apr 22 – Jun 22)					
	JPUH	**NNUH**	**QEH**	**ICS**	**Target**
ED 4-hour performance 95% of people admitted, transferred of discharged in 4 hours	64.4%	44.5%	60.8%	54.5%	95%
12-hour decision to admit 100% of patients should be admitted to a ward within 12 hours of decision to admit	96.4%	98.1%	95.9%	97.3%	100%
Ambulance Response Times (Apr-22 to Jun-22)					
C1 Mean				11:18	7 min
C1 90th centile				20:54	15 mins
C2 Mean				61:28	18 mins
C2 90th centile				133:49	40 mins
C3 90th centile				403:35	120 mins
C4 90th centile				605:22	180 mins
NHS 111 (Apr-22 to Jun-22)					
NHS 111 calls answered in 60 seconds				47.7%	95%
NHS 111 calls abandoned				22.3%	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 was negatively impacted by a number of factors listed below.

Date	ICS ED Attends	CCG 4-hour target performance
Apr-22	22,879	55.5%
May-22	25,830	54.7%
Jun-22	25,092	53.6%

In addition to a pattern of rising ED attendances as outlined above, in Q1 additional pressures impacting the UEC system were:

- The continued use of COVID-19 infection prevention and control (IPAC) guidance, which required separate physical space to treat and accommodate positive, negative and symptomatic patients which resulted in less physical space, impacting flow in hospitals.
- 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.
- Issues with workforce availability were having a negative impact on the UEC pathway resulting in high vacancy rates and reduced resilience during times of sickness, e.g., during waves of COVID-19 infection. Key staff groups such as therapists were difficult to recruit, and limited workforce availability restricted ability to transform services in key areas.

Ambulance handover delays continued to be experienced while patient flow through hospitals remained congested. Several measures had been implemented to help to reduce the risks associated with long ambulance offload delays. These included patient and staff welfare checks; early medical reviews in ambulances where necessary; dedicated cohorting space and resources; local coordination via the EEAST System Operations Cell (SOC) and Hospital Ambulance Liaison Officers (HALOs); use of Intelligent Conveyancing to smooth demand across acute hospital sites; and rapid release arrangements to release queuing ambulances to attend high acuity community patients.

Where ambulances were delayed at hospital this also had an impact on community response times. This increased clinical risk as a result of attendance delays to patients out in the community. Measures were implemented to support EEAST to pass lower acuity calls to IC24 CAS at a rate of up to 3 calls per hour (72 per day). Call Stack multidisciplinary meetings were piloted in April 2022 to support EEAST to pass calls to IC24 CAS GPs, community nursing teams, mental health crisis support and urgent social

care provision where alternative care could be provided. This enabled EEAST to focus available resources on higher acuity C1 and C2 patients.

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. Changes to pre-pandemic call volumes and peaks in activity required colleagues to establish new activity benchmarks for spikes in call demand to ensure calls continue to be answered swiftly and abandonment rates were reduced.

There was continuing attrition of 111 call handler staff to other recovering sectors, which affected call abandonment rate and call answering targets. IC24 was the local provider for 111 services and had consistently placed in the higher end of performance across the country. As part of ongoing efforts to futureproof the service, call handling service providers 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.

Discharge to Assess

The Discharge to Assess (D2A) programme aimed to provide a personalised model of care for patients and their families, ensuring that people were able to leave hospital on the day they have a right to be discharged, and that they had 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.

On 1st April the nationally funded Hospital Discharge Programme came to an end, as well as the funding of 4 weeks of free care. In light of these changes, the CCG agreed with ICS CEOs to implement a transition and transformation plan. A transformation team was established with support from the Programme Management Office which funded and delivered projects to the value of £5m during Q1 to support hospital discharges. These projects include:

- Enhanced home support
- Enhanced reablement support
- Additional reablement workers
- Provision of 91 short term beds
- Provision of 10 reablement beds
- Provision of 15 additional pathway 2 beds and 6 pathway 3 beds
- Provision of 20 live in carers
- A health economist review of demand across Pathways 0 – 3.

In addition, the Hubs providing a single point of access for discharge for all three localities within Norfolk and Waveney were established and strengthened. A single “Transfer of Care” form was developed and used by all system partners, alongside a digital version of this form to support more timely discharges from hospital.

The Norfolk and Waveney Discharge to Assess Blueprint was updated and implemented via a new 30-60-90-day programme approach. Each quarter of the financial year has a separate 90-day plan to achieve exemplar practice by the end of the financial year. This approach was underpinned by the 8 High Impact changes for managing transfers of care and learning from best practice elsewhere in England which had also been developed during this period, and was incorporated into the plan and approved by the system UEC System Transformation Steering Group (STSG).

A health economist was commissioned to support the health and care system to understand its historical data concerning demand, capacity, activity, bottlenecks, and to better understand the “As Is” pathways so the data could be used to create a new “To Be” set of pathways during the first 90-day cycle. Work was underway on developing a five-year strategy for discharge in Norfolk and Waveney to be published later in 2022/23, alongside a funded business case and implementation plan. A focus on high quality data will be undertaken to validate the current perception of higher-than-normal Pathway 0 patients and lower than normal Pathway 1 patients.

ICS partner organisations were actively involved in the National Discharge Taskforce Workstreams: the JPUH participated in Workstream 1, the NNUH and NCH&C participated in Workstreams 2 and 3, while Norfolk County Council’s Director of Social Care was leading nationally Workstream 4. Lessons learned and best practice will be shared across the Norfolk and Waveney system.

Community Providers such as East Coast Community Healthcare (ECCH) and NCHC supported the development of Discharge to Assess (D2A) to date and in Q1 were continuing to provide:

- Community Clinicians supporting flow out of ED and Acute Wards
- Community Clinicians working in integrated teams to facilitate and coordinate post discharge care
- Acute therapists working in the community to ensure capacity moves with activity as per D2A Guidance
- Maximum flow through community beds to support D2A 2 Flow by implementing initiatives such as “Red to Green”
- Nursing and therapy support to NHS and County Council procured beds in Nursing/Residential homes to support D2A 2 flow
- A Health and Social Care integrated operational management team which supports improved D2A 1 flow
- Close working with reablement services to provide coordinated post discharge reablement and rehabilitation
- Accelerated use of technology to facilitate multi-organisational and multidisciplinary team working to facilitate discharges e.g., use of virtual rooms in MS Teams.

Towards the close of Q1, NHSE announced the Acute Hospital Discharge "100-Day Challenge." This was based on the outcomes of the initial work that the ICS had participated in with the National Discharge Taskforce described above. Ten best practice initiatives were identified that demonstrably improve flow and should be implemented in every trust and system to improve discharge. These very closely aligned to the work our system had commenced with the 30-60-90 plans, and adjustments will be made to our programme to fully align with the new challenge on discharge.

These best practice initiatives include:

100 Day Challenge	**N&W 30-60-90 Plan**
Identify patients needing complex discharge support early	High Impact Change 1
Ensure MDT engagement in early discharge plan	High Impact Change 1 & 3
Set EDD and discharge within 48 hours of admission	High Impact Change 1
Ensuring consistency of process, personnel, and documentation in ward rounds	High Impact Change 3
Apply 7-day working to enable discharge of patients during weekends	High Impact Change 5
Treat delayed discharge as a potential harm event	D2A Quality Group
Streamline operations of transfer of care hubs	High Impact Change 4
Develop demand / capacity modelling for local and community systems	High Impact Change 2
Manage workforce capacity in community and social care setting to better match predicted patterns in demand for care and any surges	Workforce Task and Finish group High Impact Change 8
Revise intermediate care strategies to optimise recovery and rehabilitation	NCC 11 Workstreams Beds Task and Finish Group Pathway 1 Task and Finish Group Home Solutions Task and Finish Group

Palliative and End of Life Care

The pandemic had a significant impact on progress on the Palliative and End of Life Care Programme with a majority of workstreams stood down to focus on the pandemic response, but by Q1 we were beginning to recover from the pandemic pressures.

The programme welcomed the amendment to The Health and Care Act 2022 receiving Royal Assent on 28th April 2022 which placed a legal responsibility on ICBs to commission palliative care services, providing a further foundation for the programme to build upon.

Norfolk and Waveney's annual Dying Matters event in support of Hospice UK's Dying Matters Campaign 2022 took place on May 5th. The event was organised by Jane Shuttler, a 'lived experience' representative, and was well attended with a diverse collection of speakers and knowledge shared, including the launch of The Pear Tree Fund's 'You'll Be Fine.'

A new system wide Syringe Pump Policy was launched in June. This was an excellent example of collaborative work with multi-provider input and commitment, an exemplar for future system-wide polices.

Locally, community providers were piloting a new approach to delivering urgent, emergency care through lay carer administration of subcutaneous anticipatory medicines by family and carers. With support from Primary Care and joined up working, tremendous progress continued to be made.

With the reforms to the Health and Care Act 2022, the launch of the Integrated Care Board and publication of the NHS England Palliative Care Statutory Guidance for ICBs all in progress at the end of Q1, the Palliative Care programme will reflect on these additions and explore new opportunities as we move forwards as an ICS.

Protect Norfolk and Waveney (Protect NoW)

Protect NoW is the ICS's proactive response to reducing health inequality and improving the healthy life expectancy of local residents. 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. Projects which were continuing during Q1 2022 include:

Diabetes Prevention - reducing inequalities and unwarranted clinical variation and increasing referrals to lifestyle change support.

Pre-diabetic patients are identified through their recent GP blood glucose results. Protect NoW contacts 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.
Increasing uptake of Cervical Cancer Screening - reducing inequalities and unwarranted clinical variation.
Protect NoW works with practices to locate patients with no recorded cervical screening, or none in last 3-5 years. Patients most at risk through smoking and lifestyle are identified and contacted directly with and offer of support to access screening.
Increasing referrals to IAPT Wellbeing Services - reducing inequalities and unwarranted clinical variation.
Protect NoW identifies and contacts patients who were prescribed anti-depressants or anxiety medication by their GP, but had not accessed the NSFT Wellbeing Service, which offers talking therapies. The project focuses on the practice areas that referred least and concentrated on older patients and those living in areas of most deprivation.
Increasing uptake of COVID-19 vaccination – reducing health inequalities and reaching underserved communities.
Protect NoW uses vaccination data to make text message contact with individuals to encourage 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.
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 – was recognised across the system. This 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

The CCG Research Office had its most successful year in 2021/22, 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 was 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.

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%.

The Evidence and Evaluation Hub

The Evidence and Evaluation Hub (EE Hub) was established in March 2022 as a two-year pilot, addressing the increasing demand for evaluations and evidence to support commissioning decisions. The Hub is a quasi-independent, data-led service and is dedicated to identifying the best outcomes for the population of Norfolk and Waveney. It is part-funded through the Digital Aspirant Programme and NHS Norfolk and Waveney ICB.

At the end of June 2022, the team were working with colleagues from across Norfolk and Waveney on 11 requests for evaluation support. The electronic patient record and virtual ward were prioritised for support over the coming year.

Digital

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

The use of digital technology was a major element within the NHS Service Model and was an organisation driver for the CCG . In Q1, the CCG was continuing to increase and improve the digital capability of our workforce, which had transformed our way of working and reduced our carbon footprint. The CCG 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 enabled 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. Plans for projects were in place 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 had their data migrated to the Cloud and adopted N365, enabling them to collaborate and access shared resources and use Teams for meetings and calls. This enabled practices to be an active part of the ICS, working flexibly from any internet connected location.

Support was also available to Care Homes to ensure that they and their residents were enabled to make better use of technology. The SystmOne Care Home Module allowed 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 had 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 was in mobilisation with plans to go-live by October 2022.

Across the ICS, a Health and Care Data Architecture model was being developed which would 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 had an obligation to work in a way that had 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 acknowledged this responsibility to our patients, local communities, and the environment by working hard to minimise our carbon footprint. During Q1 much of the work undertaken to improve sustainability continued, including:

- The ICS Green Plan Delivery Group was developing the 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. It will be ready to publish in September 2022.

- The CCG continued to work 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 built 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 were supporting staff to work collaboratively whilst reducing the need for travel.

- The CCG supported the change to subscribe environmentally friendly "greener" inhalers which can 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.

Improve Quality

Since the pandemic, the CCG 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 worked flexibly to enable deployment of senior clinical staff to support provider organisations to deliver our 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 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 during Q1 included:

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

- Norfolk & Waveney System Quality Group (SQG) expanded to provide a strategic forum at which partners from across health and social care, Public Health, and the wider ICS could come together. The SQG brings together different parts of the system to share information and learning. It provided a proactive forum to have a shared view of identifying risks to quality through sharing intelligence, maximising opportunities for quality improvements and sharing of best practice. The forum was well established created through a culture of support and collective leadership with mutual holding to account and challenge to provide assurance of the services our local population are receiving and patient experience.

- We were delighted to report the Queen Elizabeth Hospital Kings Lynn Norfolk hospital was given formal confirmation that it left special measures in April 2022, after being rated ‘inadequate’ by the Care Quality Commission (CQC) in 2019 when inspectors raised concerns over staffing levels, patient safety and leadership. The CQC rated the hospital ‘caring, effective and well-led’ after follow-up inspections with the regulator and NHS England confirming they no longer needed ‘mandated intensive support’ and noted significant improvements from the previous inspection.

- Norfolk and Suffolk NHS Foundation Trust were reinspected by the CQC in April 2022 and rated overall as inadequate, with five section 29a warning notices issued, placing the Trust in special measures. NSFT has worked collaboratively with the CCG and NHS E/I intensive support team to address immediate quality and safety concerns and complete several essential recommendations.

- Norfolk and Waveney Patient Safety Specialists Network was established with representation from system partners across the local health and social care system. Key areas of focus were

the recruitment to Patient Safety Partners, across the ICS and continued preparation for the role out of the Patient Safety Incident Response Framework.

- Norfolk and Waveney Medical Examiner Implementation Group continued to focus on the local implementation of the Medical Examiner service which will become statutory from April 2023. Good progress had been made in communicating with colleagues in General Practice, raising awareness of the process, along with sharing supportive tools to make this as simple and efficient as possible. We are working collaboratively at place level with several practices from Norfolk and Waveney.

- The ICS had established a quality faculty which was responsible for the delivery of a consistent quality management approach across constituent partner organisations. The aim of the faculty was to drive innovation, quality improvement, and transformation across the local health and social care system. A programme of quality improvement had been developed for local staff to access, with a suite of quality improvement tools available to support implementation of future initiatives.

- The NNUH was undertaking a personalisation pilot in collaboration with the CCG to support patients on the orthopaedic hip and knee surgical pathway to wait well to optimise their physical and psychological wellbeing whilst waiting for their procedure. The pilot included education and training opportunities for clinical and non-clinical staff, patient panel representatives, and a suite of patient information and signposting, including social prescribing where appropriate.

- The CCG worked with care providers within social care such as care homes and domiciliary care, and facilitated Champion networks in key areas of care such as nutrition and hydration, medication and safeguarding. Alongside those we also facilitated education in specific illness and evidence-based practice to care for the individual. This work was vital to support the care market but also ensured the CCG was supporting evidence-based practice and supporting the wellbeing of Norfolk and Waveney residents.

- The CCG worked collaboratively with partners in general practice to offer multidisciplinary in-reach support to practices both pre- and post-CQC inspection. The support is bespoke to the needs of the individual practice, with support being offered both remotely and on site. A monthly, co-produced programme of bite size learning recently commenced, focusing on the most common areas requiring improvement from CQC reports. Aligned to this was a regular Clinical Learning and Sharing Seminar (CLASS) that provide practices with updates on clinical pathways and national guidance.

- The health and care workforce across Norfolk and Waveney ICS had been under extreme pressure over the last several months, with the impact of the COVID-19 pandemic and vacancies in several areas putting frontline staff under increased pressure. The Urgent and Emergency Care system remained exceptionally challenged due to lack of bed capacity and flow throughout the system. Despite this, there continued to be positive examples of staff going the extra mile for their patients to ensure they received the best possible care and treatment. Norfolk and Waveney ICS would like to formally acknowledge and thank all of our workforce for their continued hard work and tenacity, to ensure our local population receive the care they need.

Engaging People and Communities

Prior to the transition to an ICB on 1 July, the CCG had been engaging with residents and wider stakeholders on the approach the ICB will take to working with People & Communities in Norfolk & Waveney.

Integrated Care Boards (ICBs) were 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 would form our 'Working with People and Communities' strategy'.

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

A draft ICS People and Communities approach was shared with NHS E/I, and also shared widely with our people and communities, with help from our partners. The aim was to seek their views on our system-wide approach to engagement in the new world of ICB and ICS.

We produced an easy read summary version, a communication toolkit, and a short animation explaining the approach, which we published on our website and shared widely with partners and stakeholders across our networks.

From June 6 to July 18 2022, people and communities were able to comment on the draft approach via an online survey and paper copies were sent out as requested. Feedback was generally positive and supported the approach we had set out. There were also some of areas of feedback, such as the complexity of language in the document and more information around the delivery and evaluation of the approach, that we have taken on board and will address in the next revision of the Working with People and Communities approach.

We continued to promote and update our partners and people and communities by regularly updating our website and partners on this ICS wide piece of work.

<u>Carers Co-production</u>

The CCG, Caring Together, Carers Voice Norfolk and Waveney and Family Voice Norfolk had been working together to capture feedback from carers across the county as to their recent experience with health settings.

Carers told us that they wish to be identified as a Carer at as early a stage as possible so that they are valued, respected, listened to and involved in the health and care pathway of the person they are caring for. Carers of all ages have called for better awareness, identification and recognition of the role and expertise of carers by all health and social care professionals.

These two projects have developed from the numerous workshops and co-production sessions, which have taken place over the past six months between carers, health organisations and voluntary sector organisations:

1. Carers' Passport

A Carers' Passport is seen as key to ensuring carers receive early identification prior to hospital admission – so that they can be recognised and valued as experts by experience before crisis hits and can be involved in discharge plans at an early stage (in line with their new legal rights).

2. Carer awareness and support

There was a real desire amongst carers for carer awareness to form part of mandatory training for relevant staff and for where it is not mandatory training, that there is work to ensure those staff have an awareness of carers.

We continued to work closely with carers and carer organisations to implement these projects.

Back to Basics – COVID-19 prevention video

To mark the two-year anniversary of the initial COVID-19 lockdown, we created a short video with local primary school children to reinforce the COVID-19 safety measures, such as washing hands, wearing a face covering, using sanitiser stations and avoiding crowded spaces.

The video was well received on social media and helped promote good basic hygiene tips and COVID-19 prevention tips.

Give Your NHS a Hand campaign feedback

A survey was created and shared with partners and the public, to get feedback on our winter campaign and the services provided, which was used to help inform future health campaigns.

Vaccination experience survey

We promoted a vaccination survey, seeking feedback from people who have had their COVID-19 and flu vaccinations. It was promoted further following the Spring Booster and will share the feedback gathered with vaccination leads, to improve the vaccination service and experience for patients.

Reducing Health Inequality

The CCG was committed to equality and inclusion. It recognised and implemented 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. The CCG worked to reduce health inequalities across all services as is described throughout this report.

The pandemic highlighted the significant importance of collaboration and partnership to reduce inequalities in our communities, and during Q1 2022/23 the CCG continued to progress and enhance its plans to tackle inequality to both mitigate the impact of COVID-19 on the most vulnerable and improve take-up of the COVID-19 vaccine.

Norfolk and Waveney's Vaccine Inequalities Oversight Group (VIOG) had wide-ranging system partner representation, and 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. During Q1, VIOG continued to have system-wide oversight utilising data and learning to achieve a good COVID-19 vaccination up-take and maintain engagement with communities in areas of higher deprivation during the Spring Booster campaign.

The VIOG included an Inclusion Health workstream. Inclusion health groups describe people who are socially excluded. These 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. The system wide inclusion health group continued to develop the health inequalities roving model offer, making every contact count, and offering additional health interventions and social prescribing to support health improvement to these groups.

Building on the learning from VIOG, the Norfolk & Waveney Health Inequalities Oversight Group (HIOG) was the ICS's strategic approach to inequalities which saw 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 were agreed, including programmes that address Core20plus5, Community Engagement through the Community Voices programme, NHS Anchors, as well as VIOG and an inclusion health programme. HIOG continued to meet monthly, bringing together Health Inequality leads from all Norfolk and Waveney's ICS partner organisations to progress these priority workstreams.

Below are some additional examples of work to address wider health inequalities that were underway during Q1:

- The Active NoW programme is a whole system approach to physical activity. It included a single point of coordination for the system, a strategic work programme to drive referrals and embed the model into pathways, and the development of local programmes connected to the Health & Wellbeing Partnerships. Bringing together partners across local government, Voluntary Community and Social Enterprise (VCSE) organisations and the health system, Active NoW aims to drive down rates of inactivity and improve a range of health, wellbeing and social outcomes. The 'service' element was due to launch across the system in October 2022, with a Protect NoW pilot planned to support targeted recruitment, and a robust evaluation mechanism to track and report progress.

- The Norfolk & Waveney Community Voices pilot launched in April 2022. This project sought to build capacity across the system within those organisations that can act as 'trusted communicators' in our communities, especially those that experience the greatest inequalities. Working with system partners, the CCG initiated the development of a network of 'Champions' that built on existing infrastructure, supporting them with training and the resources they need to have conversations with communities about their health. The project developed an 'insight bank' approach where summaries of these conversations were fed back to the system to support decision-making based on the barriers and enablers that communities face. This approach was being embedded into the ICS's People and Communities plan as a key tool to engage our residents, and the CCG was developing scale-up plans and business cases to support further expansion, strategic alignment, and continuation of the model.

- The ICS's approach to Population Health Management (PHM) was encompassed within the ProtectNoW programme (find out more in the ProtectNoW section). The PHM approach seeks to identify those patients, often non-engaged people, with the greatest reversible health risk and engage them in targeted services through a variety of targeted channels, including the Virtual Support Team (VST). Through the ProtectNow projects, the VST had demonstrated the capability to support patients with relatively complex needs. Their focus was to deliver a high-quality service for patients in the most deprived areas who have disproportionately high healthcare requirements. The team also focused on improving accessibility of communications as a tool in reducing health inequalities, ensuring that Protect NoW communications were tailored for specific population groups, for example using 'easy read' letters and language translation services when speaking to patients whose first language is not English.

- The Inclusion Health Locally Commissioned Service (LCS) went live on 1 April 2022. It was made up of three elements that aimed to ensure equity of access to primary care to the Inclusion Health groups. The first element was Inclusion Friendly which provides training to all Primary Care staff and encourages practices to become a Safe Surgery. The second element included

the first element plus provision of initial health assessments as well as flexible appointments. The third element was for practices to provide outreach clinics to their local patient cohort, to enable those patients who would not otherwise access general practice to be able to receive primary medical services. Since the launch of the LCS, across Norfolk and Waveney 102 practices had signed to the Inclusion Friendly element, 17 practices had signed up to provide the Health Assessment and 3 practices had signed up to provide outreach support.

- In response to the Ukraine war, a multi-agency strategic meeting was set up by the CCG to address the health needs and identify the appropriate routes for those fleeing Ukraine to engage with Primary Care. This fed into the county-wide working group chaired by Norfolk County Council tasked with supporting the welfare and safeguarding of those fleeing Ukraine. Working with acute, community, pharmacy, and mental health colleagues across the ICS, a coordinated approach to clarify and agree local arrangements was agreed to maximise efforts and reduce duplication. From identifying the Ukrainian's health needs, a health assessment LCS was developed along with a latent TB pathway which was written in collaboration with the Ukrainian Health Lead, Inequalities Clinical Lead, TB health leads, and the CCG's Infection, Prevention and Control Team. The LCS and latent TB pathway were planned to go live in September to support Ukrainians registered at practices across Norfolk and Waveney.

Health and Wellbeing Strategy

Joint Health and Wellbeing Strategies

NHS Norfolk and Waveney CCG had been an active member of both the Norfolk and Suffolk Health and Wellbeing Boards. The CCG 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**
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 progressed our work towards creating a single sustainable system. We made appointments to key system roles, including the chair designate and chief executive designate of our Integrated Care Board, and determined how our Integrated Care System will operate from 1 July 2022, following the successful passage of the Health and Care Bill through Parliament. Importantly, we had already 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. We built on this during the first quarter of this year, drafting terms of reference for the ICP and agreeing how the partnership will operate from 1 July 2022.
Norfolk priority: Prioritising prevention **Suffolk theme: Embedding prevention**

The CCG, working with partners from across the health and care system, has made good progress 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 continued to make strong progress and delivered a range of population health management projects. 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 continued to be a priority. 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 and Suffolk Health and Wellbeing Boards have been consulted by email over the contents of this section of the report.

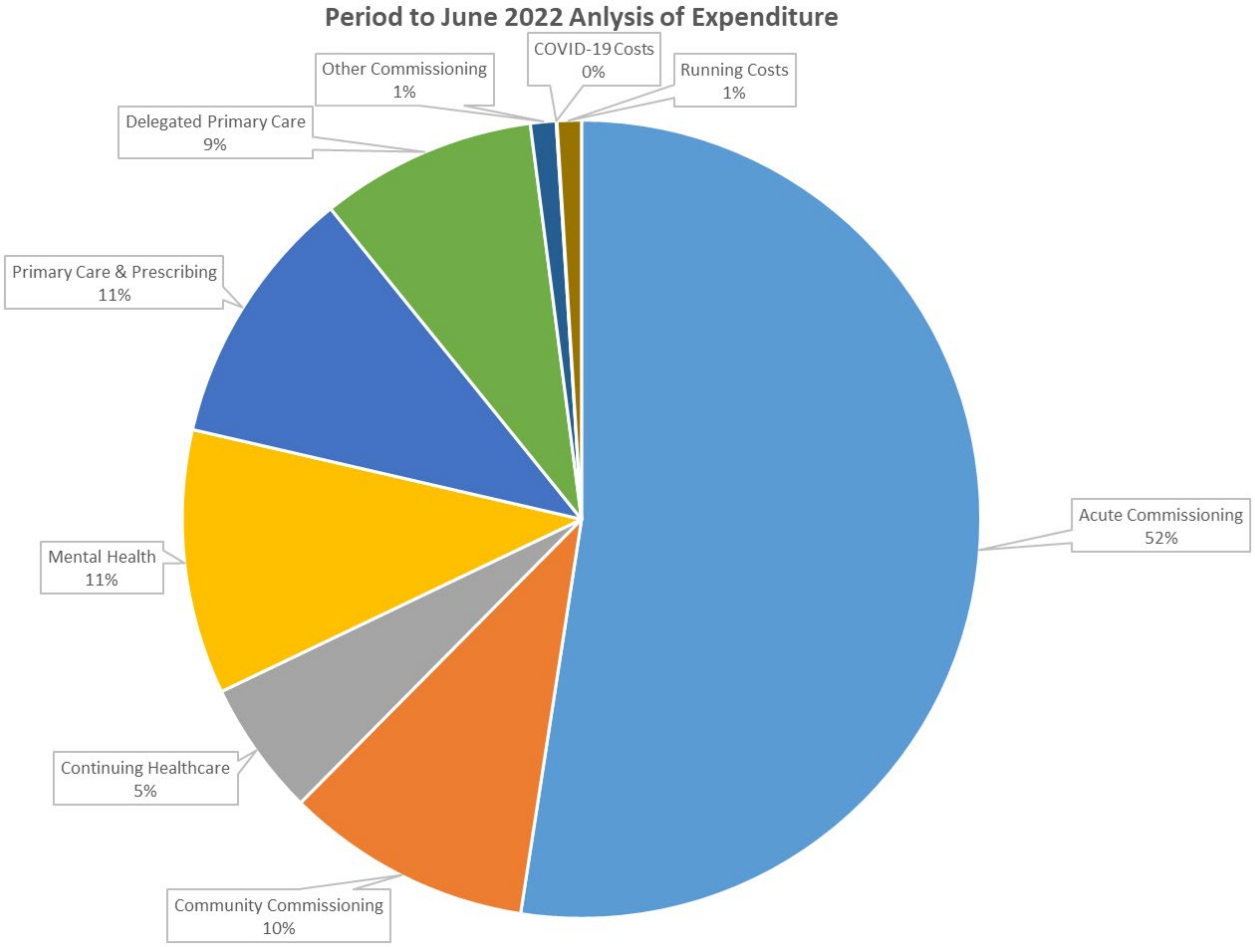
Financial Review

As a result of the NHS response to the COVID-19 pandemic the 2020/21 financial regime changed significantly whereby fixed block contract payments set by NHS England and Improvement were established for NHS providers; in addition to significant amounts of non-recurrent funding to cover the costs of the NHS in providing a fast and effective response to the pandemic incurred.

Whilst these block NHS provider payment arrangements remained in place for the final accounts of the CCG to 30 June 2022 (2022-23), the non-recurrent funding awarded was now targeted at Elective backlog recovery of waiting lists rather than the cost of managing the pandemic incurred by the CCG.

The total amount of money allocated to the CCG for the period to June 2022 was £524.5m (2021/22: £2,110.1m). Of this £1.5m (2021/22 £397.8m) was allocated non-recurrently.

This total allocation was split, £519.4m (2021/22: £2,089.5m) for commissioning of health care services, and £5.2m (2021/22: £20.6m) for the CCG running costs.



Expenditure Categories	Period to June 2022		2021/2022	
Acute Commissioning	£275.1 m	52%	£1,088.8 m	52%
Community Commissioning	£52.4 m	10%	£204.7 m	10%
Continuing Healthcare	£28.7 m	5%	£105.4 m	5%
Mental Health	£56.2 m	11%	£216.8 m	10%
Primary Care & Prescribing	£55.5 m	11%	£227.9 m	11%
Delegated Primary Care	£46.0 m	9%	£175.8 m	8%
Other Commissioning	£5.4 m	1%	£43.1 m	2%
COVID-19 Costs	£0.2 m	0%	£26.6 m	1%
Total Programme Costs	£519.5 m	99%	£2,089.1 m	99%
Running Costs	£5.2 m	1%	£20.5 m	1%
Total Costs	**£524.7 m**	100%	**£2,109.6 m**	100%

As noted in the table above the CCG spend on a £m basis is very different due to the current period containing only three months, whereas the prior year is for a full year (12 months).

On a proportionate basis (shown in %'s), Expenditure Categories remained consistent to those of the prior year.

Increases in the Acute, Community and Mental Health areas of expenditure resulted from nationally set block contracts with NHS providers uplifted from 2021-22 for inflation over both price and demand growth. Cost in relation to targeting the Elective Recovery backlog were incurred by the providers within the wider Integrated Care System and shown within the relevant expenditure category.

Significant increases in Continuing Healthcare were being seen due to a higher demand on these Non-NHS beds supporting patient flow through our acute services, these demands were against a backdrop of higher costs of delivery by the care home providers (on pay and non-pay related aspects).

Running costs remained at 1% of the total CCG's Expenditure but had increased for price inflation in relation to outsourced services. Financial pressures remained for the CCG similar to those reported in 2021-22 as a result of unfunded pay awards in line with National directions which have been provided for on a Provisions basis as they were unpaid at the end of the CCGs form.

As a result of the maintained changes to financial regime from 2021-22, the ability for the CCG to make efficiency savings in the current year which reduce the cost base remained restricted. The CCG focused on non-block Influenceable spend and had a full 2022-23-year plan of £19.7m far in excess of those achieved for 2021-22 (£4.23m). These savings arose from Programme expenditure costs for Prescribing and Continuing Healthcare, Vacancies, and In-housing efficiencies, and from Running Costs.

At the end of the period to June 2022, the CCG delivered a break-even position which was in-line with the national directions. This was achieved by way of being awarded allocations to equate to our expenditure. The allocations awarded for this period did not impact on the full year allocations for 2022-23 but were only a timing difference.

SIGNED

Tracey Bleakley
Interim Accountable Officer
29 June 2023

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 the period 1 April to 30 June 2022, 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 third 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 was dissolved on 30 June 2022 with functions transferring to NHS Norfolk and Waveney Integrated Care Board with effect from 1 July 2022. This means that this Annual Report and Accounts is the final report for the CCG covering the period April, May and June 2022 (the reporting period).

Members' report

The CCG's Constitution came into effect on 1 April 2020 and provided for the establishment of a Council of Members to ensure that membership was involved, engaged and that communication was effective and appropriately maintained. The Constitution also provided for each member practice to have a Member Practice Representative to represent their practice in its dealings with the CCG. Member Practice Representative responsibilities included selecting four Nominated Practice Representatives to represent them on the Council of Members on behalf of their locality. The CCG had 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 was on addressing the pandemic. During the reporting period the CCG did not receive any requests from member practices to hold a Council of Members meeting and no meeting took place. It was therefore not possible to confirm the Nominated Practice Representatives.

Member profiles and practices

The CCG had 105 member GP practices in Norfolk and Waveney.

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

Dr Anoop Dhesi
Chair

Tracey Bleakley
Interim Accountable Officer

John Ingham
Chief Finance Officer

Rob Bennett
Lay Member for Audit and Financial Management

Hein van den Wildenberg
Lay Member Financial Performance

Doris Jamieson
Lay Member Primary Care

Dr Hilary Byrne
Healthcare Professional

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

Committees of the Governing Body

Please see the Annual Governance Statement page 57 for details of the Audit Committee and all other Governing Body Committees.

Register of Interests

The Register of Governing Body Interests has been archived and can be found here: https://webarchive.nationalarchives.gov.uk/ukgwa/20220707111948/https://www.norfolkandwaveneyccg.nhs.uk/publications/declarations-of-interest?sort=touched_on. More information on how the CCG managed interests can be found in the 'Annual Audit of Conflicts of Interest Management' section on page 74.

Personal data related incidents

During the reporting period there were no data security breaches reported to the Information Commissioner's Office (ICO).

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 29 June 2023

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.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National health Service Act 2006 (as amended) Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

SIGNED

Tracey Bleakley
Interim Accountable Officer

29 June 2023

Governance Statement

Introduction and context

NHS Norfolk and Waveney Clinical Commissioning Group 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.

Between 1 April 2022 and 30 June 2022, the clinical commissioning group was 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 established an interim ICS Partnership Board. More details can be found on page 67.

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.

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 were contained within the Constitution. The CCG's Governance Handbook contained the detailed scheme of reservation and delegation and the prime financial policies. Together they provided a procedural framework within which the CCG discharged its business. The CCG's Constitution also set out how the CCG discharged its statutory functions via its governing structure. Terms of reference for statutory committees were contained in the Constitution, whilst those for non-statutory committees were 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 set out how the CCG managed conflicts of interest. It put in place processes to follow if a conflict of interest meant that a meeting was not quorate to make a decision and ensured that key principles of selflessness, honesty and integrity were upheld.

Council of Members

The Constitution made clear that the CCG was a Clinical Membership organisation. It clearly set 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 was known as the Member Practice Representative and who represented the practice in its dealings with the CCG. One of the roles of a Member Practice Representative was to select Nominated Practice Representatives for their locality. The CCG had five localities, North Norfolk, South Norfolk, West Norfolk, Great Yarmouth and Waveney, and Norwich. Each locality has four Nominated Practice Representatives.

This meant that there were 20 Nominated Practice Representatives that represented their localities on the unified Council of Members. Governing Body members were not eligible to be Nominated Practice Representatives.

Due to the COVID pandemic and the pressures on primary care the CCG did not hold a formal Council of Members meeting during the reporting period. 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 comprised 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 was a clinically led organisation with the Constitution providing that to be quorate a minimum of seven members must be present. This needed to include either the Accountable Officer or the Chief Finance Officer, four clinicians and two lay members. There was provision for emergency decision making in the Constitution.

There were no changes to the membership of the Governing Body during the reporting period.

Following the passing of legislation the CCG ceased to be a legal entity on 30 June 2022 and all Governing Body members finished their roles on this date.

Meetings

The CCG held one Governing Body meeting in public between 1 April 2022 and 30 June 2022.

Due to the COVID-19 pandemic meetings had 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 was available on the CCG website with a recording available after each meeting on the CCG's YouTube channel. Each meeting had 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	1 out of 1 meeting (100%)
Accountable Officer	Tracey Bleakley	1 out of 1 meeting (100%)
Chief Finance Officer	John Ingham	1 out of 1 meeting (100%)
Healthcare Professional	Dr Ardyn Ross	1 out of 1 meeting (100%)
Healthcare Professional	Dr Hilary Byrne	1 out of 1 meeting (100%)
Healthcare Professional	Tracy Williams	1 out of 1 meeting (100%)
Healthcare Professional	Dr Clare Hambling	0 out of 1 meeting (0%)
Secondary Care Specialist	Dr Peter Harrison	1 out of 1 meeting (100%)
Registered Nurse	Kathy Branson	0 out of 1 meeting (0%)
Lay Member	Rob Bennett	1 out of 1 meeting (100%)
Lay Member	Hein van den Wildenberg	1 out of 1 meeting (100%)
Lay Member	Doris Jamieson	1 out of 1 meeting (100%)
Lay Member	Mark Jeffries	1 out of 1 meeting (100%)

The minutes of Governing Body meetings have been archived and are available at: https://webarchive.nationalarchives.gov.uk/ukgwa/20220707112224/https:/www.norfolkandwaveneyccg.nhs.uk/publications/governing-body-agendas-and-minutes?sort=touched_on.

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 contained the overarching scheme of reservation and delegation and the detailed scheme of reservation and delegation respectively.

The Governing Body had a number of functions conferred on it by the Health and Social Care Act 2012 (the "Act"). The main function was to ensure that the CCG had appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with good governance. The Governing Body also led on setting the vision and strategy of the organisation. The Act also required 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 had established a Remuneration Committee to review these matters and make recommendations to the Governing Body.

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

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

Primary Care Commissioning Committee

The role of this Committee was 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 2022 and up to 30 June 2022 the Committee met 3 times.

The Constitution provided that membership of this Committee was 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	3 out of 3 meetings (100%)
Lay Member	Hein Van Wildenberg	3 out of 3 meetings (100%)
Chief Finance Officer / Director Commissioning Finance	John Ingham Jason Hollidge	3 out of 3 meetings (100%)
Registered Nurse	Kathy Branson	2 out of 3 meetings (67%)

Some of the highlights of the work of the committee during April to June 2022 include:

- Review of NHS England delegated primary care budgets for general practice, as well as transformation, digital and estates budgets
- Review and monitoring of the Primary Care Risk Register, including overseeing progress against actions plans to increase the uptake of learning disability health checks and severe mental illness health checks and work to improve the interface between primary and secondary care
- Provide input to and approves the Primary Care Committee Future Plan
- Review of the ongoing 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, workforce development and support for practices
- Monitoring CQC inspection reports and the actions being taken by practices
- Receiving regular reports on GP practice prescribing especially in relation to opiates and dependence forming drugs

Audit Committee

The Audit Committee provided the Governing Body with an independent and objective view of the CCG's assurance processes. This was 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 was 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 led on financial performance
- A Healthcare Professional Governing Body member drawn from Member Practices

The Chair of the Audit Committee was Rob Bennett who was 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 2022 the Audit Committee met three times up to the 30 June 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 Member, Financial Management and Audit (Chair)	Rob Bennett	3 out of 3 meetings (100%)
Lay Member, Patient and Public Involvement	Mark Jeffries	3 out of 3 meetings (100%)
Lay Member, Financial Performance	Hein van den Wildenberg	3 out of 3 meetings (67%)
Elected Healthcare Professional	Dr Clare Hambling	2 out of 3 meetings (100%)

The Committee was supported by regular attendance of the CCG's Chief Finance Officer, Director of Corporate Affairs and ICS Development, Associate Director of Financial Management and Director of Commissioning Finance.

The primary role of the Audit Committee was 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 utilised the work of Internal Audit and External Audit but is not limited to these sources. It also sought reports and assurances from directors and managers as appropriate. The Committee concentrated on the overarching systems of integrated governance, risk management and internal control.

The Audit Committee was also responsible for ensuring that arrangements were in place for countering fraud and reviewed the work of the counter-fraud specialist.

Key areas of work of the Audit Committee during the reporting period included:

- 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 the Annual Report and Accounts

Remuneration Committee

The Remuneration Committee was accountable to the Governing Body. The Committee made recommendations to the Governing Body about the pay and remuneration for employees of the CCG and others who provided services to it.

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

The Remuneration Committee was 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 2022 the Remuneration Committee met twice up to 30 June 2022. Each meeting was well attended and quorate. Meetings were supported by the Director of Corporate Affairs and ICS Development and the Head of Human Resources Business Partners for Arden & Greater East Midlands, Commissioning Support Unit. Membership of the Remuneration Committee together with the attendance record is provided in the table below

Member	Name	Attendance
Lay Member	Mark Jeffries	2 out of 2 meetings (100%)
Lay Member	Hein van den Wildenberg	1 out of 2 meetings (50%)
Registered Nurse	Kathy Branson	2 out of 2 meetings (100%)
Secondary Care Doctor	Dr Peter Harrison	2 out of 2 meetings (100%)
Healthcare Professional	Dr Ardyn Ross	2 out of 2 meetings (100%)

The Remuneration Committee's work during April to June 22 included:

- Reviewing and agreeing recommendations to the Governing Body on executive level pay
- Reviewing the guidance note on oversight of exit and severance payments and business cases for redundancy.

Quality and Performance Committee

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

The membership of the Committee was 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 2022 the Quality and Performance Committee met three times up to 30 June 2022. The membership of the Quality and Performance Committee together with the attendance record is provided in the table below:

Member	Name	Attendance
Governing Body Registered Nurse (Chair)	Kathy Branson	2 out of 3 meetings (67%)
Accountable Officer	Tracy Bleakley	2 out of 3 meetings (67%)
Associate Director Planned Care & Cancer/deputy	Mark Lim /Janice Shirley	2 out of 3 meetings (67%)
Chief Nurse	Cath Byford (left May)/Lynne Wigens	3 out of 3 meetings (100%)
Governing Body Lay Member and Public Involvement	Mark Jefferies	3 out of 3 meetings (100%)
Governing Body Secondary Care Specialist	Dr Peter Harrison	1 out of 3 meetings (33%)
Healthcare Professional	Dr Ardyn Ross	2 out of 3 meetings (67%)
Healthcare Professional	Tracy Williams	2 out of 3 meetings (67%)

A key role of the committee was to monitor the quality and safety of providers through soft intelligence and patient feedback. The Committee used this information to identify themes and provide assurance to the CCG Governing Body. The Committee also received and reviewed quality and performance reports and agreed any recommended actions for potential and known clinical and performance risks. It ensured all such risks were documented within the directorate or operational risk register for the Committee and where relevant escalated to the Governing Body Assurance Framework. The Committee identified learning and improvement opportunities and communicated them appropriately. Where appropriate it provided reports to external bodies.

The Quality and Performance Committee provided constructive feedback on CCG policies and reports that impacted on clinical quality and patient safety. Documents reviewed and ratified by the Committee during the period of the report include:

- Learning Disabilities Mortality Review (LeDeR) Annual Report
- Guidance for Managing Children and Young People with Complex Medical Care Needs in Education Settings
- Mental Capacity Act Policy

Finance Committee

The Finance Committee supported 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 would submit information as appropriate to the Audit Committee and provided advice to the Governing Body on strategic financial matters.

The membership of the Finance Committee 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 3 times from April 2022 up to 30 June 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 for Financial Performance (Chair)	Hein Van Den Wildenberg	3 out of 3 meetings (100%)
Lay Member for Primary Care Commissioning (Vice Chair)	Doris Jamieson	3 out of 3 meetings (100%)
Health Care Professional	Dr Hilary Byrne	3 out of 3 meetings (100%)
Elected Healthcare Professional	Clare Hambling	2 out of 3 meetings (67%)
Secondary Care Doctor	Peter Harrison	2 out of 3 meetings (67%)
Chief Officer	Tracey Bleakley	0 out of 3 meetings (0%)
Chief Finance Office	John Ingham	3 out of 3 meetings (100%)
Chief Nurse (or deputy)	Cath Byford (left May)/Dawn Newman	3 out of 3 meetings (100%)

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 CCG's Strategic Financial 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 dovetailed with that of the Audit Committee in order to provide assurance to the Governing Body that robust management of finance was in place.

Conflicts of Interest Committee

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

Membership of the committee consisted 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 met once from 1 April to 30 June 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 Financial Management and Audit (Chair)	Rob Bennett	1 out of 1 meeting (100%)
Lay Member for Primary Care	Doris Jamieson	1 out of 1 meeting (100%)
Registered Nurse	Kathy Branson	1 out of 1 meeting (100%)
Chief Finance Officer	John Ingham	0 out of 1 meeting (0%)

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

At the final meeting of the Committee, it reviewed the conflicts of interest action plan and training compliance

Freedom to Speak Up (Whistleblowing)

The CCG's Freedom to Speak Up (FTSU) Guardian was Doris Jamieson, who was a Lay Member on the Governing Body. During the period of this report the FTSU Guardian did not receive any new contacts and closed the three cases that had been open. The CCG process had been shown to be effective with several cases raising concerns relating to more than one issue including patient safety, attitudes and behaviours, and competencies. The work of the FTSU Guardian was supported by the appointment of FTSU Champions to raise awareness and promote the work of the Guardian. (Freedom to) Speak Up training was a mandatory requirement for all staff. Further training was 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 were required to complete the requisite number of modules.

Executive Management Team Meeting

The Executive Management Team (EMT) was 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 was the operational forum for exercising the Accountable Officer and Chief Finance Officer's authority under the CCG's Scheme of Reservation and Delegation. It was not, however, a formal committee of the Governing Body.

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

There was also an ICS EMT weekly meeting. This meeting was attended by all the system Chief Executives and CCG Directors. The aim of the meeting was 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 addressed a range of corporate issues that supported the EMT to focus on strategic matters. The SMT reviewed internal operational matters and work included policy review, estate matters, overseeing the discharge of the CCG's duties with regard to equality and diversity. The SMT also reviewed the Governing Body Assurance Framework and updated the document for oversight by the EMT.

The SMT met weekly and comprised of a core team of senior managers. It had no formal decision-making authority and reported on its work to the EMT. SMT was 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). From July 2022 ICS was on a formal legal basis. The Norfolk and Waveney interim ICS Partnership Board was Chaired by the Right Honourable Patricia Hewitt and established in April 2021. With the passing of legislation, on 1 July 2022 the Right honourable Patricia Hewitt became Chair of the

Integrated Care Board and Councillor Bill Borrett became Chair of the Integrated Care Partnership. Whilst the Partnership Board had no direct authority it achieves its remit through forging strong partnership working based on mutual trust and respect and uses its collective influence to bring about transformation and improvement. There were no public meetings during the period April to June 2022, but details of earlier meetings can be found here: https://www.norfolkandwaveneypartnership.org.uk/about-us/interim-partnership-board/interim-partnership-board-meetings.html.

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

The CCG was supported in its work by a range of outsourced support services by AGEM CSU. This included the provision of HR services, Business Intelligence, GPIT and Medicines Management.

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, I can confirm that 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 were evaluated in terms of likelihood and consequence using an organisational risk matrix. Scores for likelihood and consequence were given out of 5 and multiplied together. The results gave 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 was supported by a staff handbook to ensure that the process was clearly understood.

The Audit Committee reviewed the risk management framework. Risk was 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 reviewed the risk register to ensure that matters were appropriately reported and that action plans were robust with progress being made. Through these mechanisms the CCG's risk appetite was assessed and regulated.

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

The process for managing the GBAF was reviewed and updated in readiness for the transition to the Integrated Care Board on 1 July 2022.

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

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

Management of current risks	CCG Governing Body Assurance Framework; Assurance and finance reports to the Governing Body. Identification of risks associated with the provision of services to patients. These were 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 was scrutinised by the Audit Committee.
Prevention of Risk	Through the processes mentioned above the CCG regularly horizon scanned to identify potential areas of risk. In addition, the CCG used its experience of and learning from adverse events to ensure that lessons were learnt. Preventative measures included: • 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 were managed through a number of systems and included: • Risk review by Committee and Governing Body meetings as well as senior management team meetings; • Finance reports to the Governing Body; • 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 supported a positive staff attitude to risk management, encouraging staff to identify, assess, manage and report risks. Staff were clear about their personal accountability and responsibilities through the Risk Management Staff Handbook, appraisal, induction and on-going training. Support was 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 were further discussed and escalated as appropriate on to the Governing Body Assurance Framework. This ensured that changes to risk registers were debated and agreed at the SMT and EMT before being put on to the GBAF.

To provide further assurance the Audit Committee reviewed the overarching Risk Management Framework which incorporated 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 was produced setting out a formal process for risk identification and evaluation.

The key risks identified as part of this process included:

Covid-19 Resurgence
There continued to be a risk that new variants may contribute to increase in transmission and alter severity of illness. The local healthcare system was going through a period of high system pressure set against restoration and recovery, and compliance with robust Infection Prevention and Control Measures.

A system approach was taken to manage positive and asymptomatic patients with the key priorities on COVID-19 vaccination and urgent and emergency care. Planned care was prioritised based on clinical need. In addition, multiple testing options were 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 continued to be the key risk to delivery of controls against this risk.

System/Urgent & Emergency Care pressures
The risk that any increase in Covid 19 variants coupled with increases in demand placed severe pressure on the Norfolk and Waveney urgent and emergency care services. The infection prevention and control measures (IPaCs) 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 EEAST resources impacting community response times. Higher acuity of patients entering urgent and emergency care services will add further pressure on access to beds and increase hospital occupancy unless discharge services capacity can keep pace with demand.

The controls in place to reduce this risk included 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
The risk that the number of patients waiting for elective treatment in Norfolk and Waveney, which grew significantly during the pandemic, cannot be reduced quickly enough to a level that meets NHS Constitutional commitments and protects patients from the risk of clinical harm. If this was to happen it will contribute to a poor patient experience, failure 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 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 enacted a waiting list clinical validation process and surge status was invoked for the Independent Sector, which allowed an increased number of patients to be treated each week.

Financial pressures
During the 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 was a risk that services provided by the system's providers in special measures do not meet the required standards. If this was to happen some patients would 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 which was confirmed in a recent CQC report. Work continued to assist QEH and a weekly internal Performance Board meets that works collaboratively to support the Trust to make the improvements necessary.

Cancer diagnosis and treatment
There was a risk of a failure to improve early diagnosis and treatment. If this was to happen 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 was in place alongside system response to COVID-19 and urgent and emergency care pressures. The Norfolk and Waveney Cancer Programme also worked with Public Health England to support improved local screening uptake in partnership with local Primary Care Networks. In addition, a local communication plan was 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 was 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 happened significant pressures would have been 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 in turn could 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 were 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 was cross organisational working with the local authority to support care providers and additional support and training provided as required. There were weekly meetings with NSFT and Norfolk County Council to improve communication and partnership working around discharge planning. This helped 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 was a risk services provided by general practice across Norfolk and Waveney system would 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 happened significant pressures would be placed on practices and other primary care services, as well as urgent and emergency care and community services. Staff absences increase and the infrastructure to provide safe and responsive services would be compromised. This in turn could 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 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 was available to support practices and Primary Care Networks in setting up and maintaining services.

Mental health transformation programme
There was a risk that during a period of unprecedented mental health demand and acuity of need current system capacity and models of care were not sufficient to meet the need If this happened individual need would not be met at the earliest opportunity, by the right service or by the most appropriate person and need would have escalated. This could have lead to worsening inequality and health outcomes, increased demand on other services and reputational risk.

There were a number of actions taken to support this area and mitigate against this risk. This included investment in strategic commissioning with new staff starting in posts. There was 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 reviewed by the Audit Committee in February 2022 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.

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

A Declaration of Interest form was 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 were those people (typically only CCG employees) that were part of the evaluation team. Evaluation team members would have typically been 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 completed conflicts of interest training. The CCG's Conflicts of Interest Guardian was Rob Bennett, the Lay Member for governance and audit and who was also the Audit Committee Chair and the Conflicts of Interest Committee Chair.

Data Quality

The CCG recognised the need to provide accurate, timely and clear information. Papers for the Governing Body were provided one week in advance of the meeting. This gave members time to read and adequately prepare in advance of the meeting so that they could fully contribute to it. Papers were also reviewed by senior management prior to distribution to ensure that they were 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 took place during the reporting period.

The Governing Body members 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 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 1 April to 30 June 2022.

To demonstrate best practice and ensure that staff learn from the management of incidents, the CCG continued 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 was used to inform staff awareness bulletins, policy revisions and training.

The IG Team continued to embed a culture of “privacy by design and default” across the organisation which helped 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 were closely monitored and any information risks arising out of a change in process were captured within an Information Risk Register. The Register is reviewed by the IG Working Group on a monthly basis, which was chaired by the CCG’s Senior Information Risk Owner. The Information Risk Register and associated policy mirrored the CCG’s Risk Management Assurance Framework, which facilitates a process for escalation and de-escalation of risks where necessary.

The key risks identified and managed were:

- 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 was 30 June 2022. The CCG achieved a "Standards Met" submission. The requirement for CCGs to have an internal audit of their DSPT submission was removed for 2021/22, and therefore this submission was not audited.

The CCG placed high importance on ensuring there were robust information governance systems and processes in place to help protect patient and corporate information. The CCG continued to implement its information governance management framework and processes and procedures in line with the DSPT. The CCG ensured staff undertook annual information governance training, which was 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 was the management of its information assets and the use of digital solutions to support remote working, to ensure that assets were 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 was 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, were in place. Where possible, the CCG used standard NHS approaches to ensure that every process can be audited.

Third party assurances

The CCG relied on third party providers for a number of services. Assurances are usually provided in the form of Service Auditor Reports (SARs). As this is a part year report SARs are not available to cover the period 1 April 2022 to 30 June 2022, but the following bridging letters have been provided:

Provider and Services Delivered	**Comment**
NHS Business Services Authority • Dental Payments • Prescription Payments • Electronic Staff Record • Human Resources Shared Services	Bridging letter dated 24 August 2022 confirmed that there had been no changes to the control environments of the stated services. Information was provided on the actions taken to address findings of the Prescription Payments, Dental Payments and the ESR audit findings.
NHS Business Services Authority: Finance and Accounting	Bridging letter dated 31 August 2022 confirms review of the internal controls described in the NHS SBS ISAE3402 2021/22 Finance & Accounting and Procurement signed Reports ("ISAE3402 21/22") issued by Pricewaterhouse Coopers LLP ("PWC") for the period 1 April 2021 to 31 March 2022.

	That for the period of 1st April 2022 through to 30th June 2022, to their knowledge, there have been no changes to the internal controls for Finance and Accounting or Procurement (NHS SBS), which were described in the ISAE3402 21/22 Reports, that could materially or adversely affect such internal controls subsequent to the date of the ISAE3402 2021/22. That with regards to ISAE3402 21/22 all exceptions have been addressed. The letter was requested and delivered in connection with the service agreement between NHS Shared Business Services and NHS England including the limitation of liability provisions included therein.
Capita – Primary Care Support England Services to NHS England and delegated CCGs	Letter of comfort dated 26 August 2022 relating to Primary Care Support England (PCSE) services, which were operated by Capita for the period 1 April 2022 to 30 June 2022. This period included the Transformation of some areas of the PCSE services, which required updates to a number of the standard operating procedures and controls tested in the 2021/22 service auditor report provided by Mazars. For 2021/22, the auditors noted exceptions on 8 out of 17 control objectives. The report provided a Qualified Opinion that the exceptions were minor. NHS England continue to work with Capita to assure the control measures in place are applied consistently by the operational teams and to address the improvement actions identified. The key actions that have been introduced to address the 21/22 exceptions are: • Increased validation checks on the monthly payment files; • Improved quality assurance process for performer list changes; • Review of the pensions validations process; • Improved validation process for corrections to the upload file for payments service; • Timely removal of access rights for leavers.
Whittington Hospital NHS Trust Payroll and pension services to the CCG.	From an internal audit report on payroll processing 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.
AGEM CSU Financial Ledger Accounts Payable, Accounts Receivable, Financial Ledger, Financial Reporting Treasury & Cash Management, Payroll	Bridging letter dated 17 August 2022 confirms that for the control period 1 April 2022 to 30 June 2022 and for the control environment relevant to the Service Auditor Report: • there have been no significant changes to the description within the latest report • there have been no changes to the risks within the In-scope control environment that would give rise to changes to any of the control objectives listed in the last report • There has been no reduction in the coverage of risk provided by the control objectives for the services covered per the last report

	• There have been no changes to the control activities within our control environment, significant enough to cause one or more of the existing control objectives not to be met • Control activities listed within the report have been operationally effective

Control issues

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

Quality and Performance – Accident and Emergency

- Pressures across the Norfolk and Waveney Urgent and Emergency care pathways continued during April to June 2022. OPEL is a method used to measure the stress, demand and pressure being experienced by hospital, community and emergency health services. All acute hospitals oscillated between OPEL 3 and 4, regularly utilising Full Capacity Protocols and declaring Level 1 Critical Incident status on a frequent basis with senior decision makers and processes for rapid assessment and treatment planning. The Mitigations and actions in place included:
- Development of Same Day Emergency Care units as an alternative to the Emergency Department
- Primary Care Streaming services 12hrs per day at all acutes
- On site Mental Health Liaison Teams at all acutes

Quality and Performance – Ambulance Services

Throughout the period all 3 acute Norfolk and Waveney hospitals experienced pressures caused by compromised discharge pathways which led to longer lengths of stay, higher occupancy levels and loss of resilience to respond to day-to-day fluctuations in demand through emergency assessment areas. Congested Emergency Departments resulted in frequent inability of ambulances to handover patients and resulted in high numbers of long delays at hospital. This delayed ambulance resources leaving hospital and created upstream delays for East of England Ambulance Trust (EEAST) in meeting the required community ambulance response time standards. Mitigations and actions in place include:

- Bank holiday weekends during May and June created additional issues with disruption to discharge flow. IC24 validate low acuity ambulance dispositions to reduce referrals to EEAST
- Improved access to alternative community pathways to decrease need for conveyance to hospital
- Local EEAST N&W System Oversight Cell to support localised decision making on conveyances
- Hospital Ambulance Liaison Officers at all acutes
- Ambulance cohorting areas to provide surge capacity

Quality and Performance – Mental Health

The Norfolk and Suffolk Mental Health Trust (NSFT) is our main mental health provider and is in special measures. There is a risk that services 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. The main gaps in controls are listed below: • 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 and capacity is not currently able to meet demand. Mitigation: Development of transformational plan for the N&W system.

- 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.

Mitigation: Attendance at Quality meetings, check and challenge meetings within the trust, members of the ICB Quality team supporting the NSFT Governance team. Chief Nurse regular attendee of the Improvement Board, MD chairs the Evidence Assurance Group.

- 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.

Mitigation: Workforce plan being developed to address staffing vacancies. Trust recently appointed Director of People to work on organisational development plan for the trust.

- 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. Mitigation: Plans in development for MH suite.

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 an acute hospital Chief Executive and meets fortnightly with an update to the 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). Additionally, the CCG commissioned a number of community-based schemes aimed at providing appropriate alternative pathways to hospital care keeping patients safe while waiting for outpatient appointments.

As part of the internal audit process the CCG responded to audit recommendations and findings and agreed the actions it will take to secure improvement in its processes.

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 the CCGs final three months ending June 2022, the CCG delivered a break-even financial position.

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 £5.15m representing 1.0% of the total CCG expenditure consistent to the share reported in last year's position.

The impact from the Covid-19 pandemic continued to have a profound effect on the full year 2022/23 planning with the CCG's plan containing inherent risks. These included significant risks in the financial plan such as not fully delivering the savings plan, our reliance on non-recurrent measures, the costs of backlog activity recovery and the significant underlying deficit. All add to the significant risk of 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 were 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 delegated functions internally. In particular:

The **Council of Members** delegated 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** delegated to committees of the Governing Body responsibility for ensuring the CCG exercised its functions effectively, efficiently and economically and adhered to generally accepted principles of good governance:

- the **Audit Committee** assured the Governing Body that effective systems of integrated governance, risk management and internal control were in place across the whole of the CCG's activities; both internal and external auditors attended these meetings;
- the **Finance Committee** monitored delivery of the Financial Plan and provided assurance to the Governing Body on the CCG's financial performance;
- the **Quality and Performance Committee** assured the Governing Body concerning the safety and quality of the CCG's commissioned services;
- the **Remuneration Committee** scrutinised proposals for the remuneration of employees and other people who provided services to the CCG and made recommendations to the Governing Body taking into account national and local guidance;
- the **Conflicts of Interest Committee** was established to determine matters where the Governing Body was 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** was established to carry out the functions relating to the commissioning of primary medical services which included review of the response to Covid-19 and the roll-out of the vaccination programme and received regular reports on GP practice prescribing especially in relation to opiates and dependence forming drugs.

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

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

Counter fraud arrangements

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

There was 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 was the first point of contact for any issues to be raised by the Anti-Crime Specialist. Online Fraud, Corruption and Bribery Act awareness training was mandatory for all CCG staff.

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

The ACS attended 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 Counter Fraud Functional Standard Return (CFFSR) was completed by the ACS and was submitted with an overall score of Green (June 2023). 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 the period of this report relating to subjects such as council tax and suspicious bank account related scams.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2022 to 30 June 2022 for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG'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.

The basis for forming my opinion is as follows and is a result of completed internal audit work.

1. An assessment of the transition and governance arrangements for the move to an ICB with effect from 1 July 2022, which provided a 'substantial assurance' report;
2. An assessment of the management of the internal audit recommendations follow-up process and progress with implementation of agreed actions, which found overall

good progress and a regular review and update process in place, supported by the Governance Team; and

3. An assessment of the governance and risk management processes as reported to the Audit Committee in May 2022, which found key governance and assurance processes to have been operating effectively during the period.

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

During the period 1 April to 30 June 2022 Internal Audit issued the following audit reports:

Area of Audit	Level of Assurance Given
Transitional Governance	Substantial

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 reviewed the GBAF regularly at meetings in public and sought assurances on the effectiveness of controls from senior managers. This was supplemented by regular review at the Senior Management Team meeting;
- The Audit Committee who scrutinised the underpinning processes behind the GBAF and sought assurances on the effectiveness of controls from senior managers;
- Internal Audit as it provided an independent, objective opinion on systems of internal control as described above;
- The Finance Committee that scrutinised annual budgets and medium-term financial plans prior to agreement by the Governing Body and monitored delivery of financial standing in-year, including delivery of the productivity plan, to ensure that the CCG met its financial statutory duties;
- The Quality and Performance Committee that scrutinised processes for holding providers to account for the quality and safety of their contracted services and utilised reports from regulatory bodies as appropriate;
- Reliance where possible was placed on third party assurance (Service Auditor Reports) as described above;
- The work of the Health Overview & Scrutiny Committee that provided 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 provided 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 taken, my review confirms that a sound system of internal control was in place in NHS Norfolk and Waveney CCG for the period 1 April 2022 to 30 June 2022

SIGNED

Tracey Bleakley
Interim Accountable
Officer 29 June 2023

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 period 1 April 2022 to 30 June 2022 (the reporting period) 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 is the final Remuneration and Staff Report of the CCG as under new legislation Clinical Commissioning Groups will be abolished on the 30 June 2022 and their functions 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 was a committee of the Governing Body and had 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 had responsibility for agreeing remuneration payable to clinical advisors that supported the work of the CCG.

The Remuneration Committee was chaired by the Governing Body Lay Member for Patient and Public Involvement, Mark Jeffries. The Committee's other members were Hein van den Wildenberg (Lay Member for Financial Performance), Dr Peter Harrison (Secondary Care Specialist), Dr Ardyn Ross (Elected Healthcare Representative) 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 were determined by the Governing Body following recommendations from the Remuneration Committee and covered by the guidance issued by the NHS Commissioning Board which were 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 was taken into account when determining senior managers' remuneration. No bonus payments were made to any Director during the reporting period.

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 was six months on either side.

Executive Directors and GP members of the Governing Body were, subject to eligibility, able to participate in the NHS Pension Scheme which provided 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.

All Executive Directors had rolling service contracts; the table below discloses contract start and end dates for the CCG:

Executive Directors in post 1 April 2022 to 30 June 2022	**Role**	**Position start date**	**Position end date**
Tracy Bleakley	Chief Executive Officer	01/04/2022	30/06/2022
John Ingham	Chief Finance Officer	01/04/2020	30/06/2022
Cath Byford	Chief Nurse	01/04/2020	08/05/2022
Dr Lynne Wigens	Interim Director of Nursing	03/05/2022	30/06/2022
Howard Martin	Director for Population Health Management & Health Inequalities	01/04/2020	30/06/2022
Mark Lim	Interim Director of Clinical Services & Clinical Transformation	20/04/2021	30/06/2022
Mark Burgis	Director of Primary & Community Care	01/04/2020	30/06/2022
Jocelyn Pike	Director of Place Development & System Support	01/04/2022	30/06/2022
Karen Barker	Director of Corporate Affairs & ICS Development	01/04/2022	30/06/2022
Andrew Palmer	Director of System-Wide Planning & Transformation Delivery	01/04/2022	30/06/2022

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

All Healthcare Professional members of the Governing Body were paid at the same sessional rate however the contracted number of sessions varied according to the portfolio of

responsibilities allocated to them. Healthcare Professional members of the Governing Body that were GPs were eligible to participate in the GP Solo pension scheme.

Governing Body members (excluding executive members) during the reporting period were as follows

Governing Body members	Role	Start date	End date
Dr Anoop Dhesi	Chair	01/04/2020	30/06/2022
Dr Ardyn Ross	Healthcare Professional	01/04/2020	30/06/2022
Dr Clare Hambling	Healthcare Professional	01/04/2020	30/06/2022
Tracy Williams	Healthcare Professional	01/04/2020	30/06/2022
Dr Hilary Byrne	Healthcare Professional	01/04/2020	30/06/2022
Dr Peter Harrison	Secondary Care Specialist	01/04/2020	30/06/2022
Kathy Branson	Registered Nurse	01/04/2020	30/06/2022
Rob Bennett	Lay Member	01/04/2020	30/06/2022
Hein van den Wildenberg	Lay Member	01/04/2020	30/06/2022
Doris Jamieson	Lay Member	01/04/2020	30/06/2022
Mark Jeffries	Lay Member	01/04/2020	30/06/2022

All of these Governing Body roles finished on the 30 June 2022 when the CCG ceased to exist.

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 reporting period are given in the table below. Two senior managers were paid more than £150,000 per annum.

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 in April 2021. This senior manager was on a secondment to NHS England throughout the reporting period 1st April to 30th June 2022.

The salaries for these posts were 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 were 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 and Title	1 April to 30 June 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 (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Tracey Bleakley - Chief Executive Officer *3	45-50	0	0	0	65-67.5	110-115
Cath Byford - Chief Nurse *1	10-15	0	0	0	5-7.5	20-25
Dr Lynne Wigens - Interim ICB Director of Nursing *3	5-10	0	0	0	0	5-10
Howard Martin - Director for Population Health Management & Health Inequalities *3	25-30	0	0	0	22.5-25	50-55
Mark Lim - Interim Director of Clinical Services & Clinical Transformation *3	25-30	0	0	0	2.5-5	30-35
Mark Burgis - Patient and Communities Director *3	25-30	0	0	0	60-62.5	85-90
John Ingham - Chief Finance Officer *3	30-35	0	0	0	7.5-10	40-45
Jocelyn Pike - Director of Place Development & System Support *3	25-30	0	0	0	62.5-65	90-95
Karen Barker - Director of Corporate Affairs & ICS Development *3	25-30	0	0	0	40-42.5	65-70
Andrew Palmer - Director of System-Wide Planning & Transformation Delivery *3	25-30	0	0	0	57.5-60	85-90
Dr Peter Harrison - Secondary Care Doctor	0-5	0	0	0	0	0-5
Kathy Branson - Registered Nurse - Governing Body	0-5	0	0	0	0	0-5
Dr Clare Hambling - Governing Body Member	15-20	0	0	0	0	15-20
Mark Jeffries - Lay Member	0-5	0	0	0	0	0-5
Dr Ardyn Ross - Governing Body Member	15-20	0	0	0	0	15-20
Hein van den Wildenberg - Lay Member	0-5	0	0	0	0	0-5
Rob Bennett - Lay Member	0-5	0	0	0	0	0-5
Dr Hilary Byrne - Governing Body Member	15-20	0	0	0	0	15-20
Dr Anoop Dhesi - Chair	25-30	0	0	0	0	25-30
Doris Jamieson - Lay Member	0-5	0	0	0	0	0-5

Name and Title	1 April to 30 June 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 (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
	£000	£	£000	£000	£000	£000
Tracy Williams - Governing Body Member *2 *3	15-20	0	0	0	45-47.5	65-70

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

*1 Cath Byford's post ended 08/05/2022. Cath 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.

*2 Tracy Williams figures includes remuneration of 0-5 (banded salary £000) for a second role within the CCG. Tracy also has another NHS pensionable role outside of CCG employment that reflected in the figure for 'All pension related benefits' (Greenbury figures provided include NHS pension benefits across all employments).

* 3 Senior managers transferring employment to the ICB 1st July 2022 will continue to accrue pension benefits. Note that the full amount of pension benefits is disclosed for the year 1 April 2022 – 31 March 2023 not the pro rata portion.

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

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
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

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.

Pension benefits as at 31 March 2023 (subject to audit)

Due to the CCG transitioning to ICB the Greenbury data available and provided is for the full year 1st April 2022 to 31st March 2023.

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 2023 (bands of £5,000)	(d) ** Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	(e) Cash Equiv-alent Transfer Value at 1 April 2022	(f) Real Increase in Cash Equivalent Transfer Value	(g) ** Cash Equiv-alent Transfer Value at 31 March 2023	(h) Employers Contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Tracy Bleakley - Chief Executive Officer	0-2.5	0-2.5	0-5	0-5	10	4	54	0
Cath Byford - Chief Nurse to 8th May 2022	0-2.5	0-2.5	35-40	55-60	565	0	600	0
Howard Martin - Director for Population Health Management & Health Inequalities	0-2.5	0-2.5	15-20	15-20	263	3	296	0
Mark Lim - Interim Director of Clinical Services & Clinical Transformation to 30th June 2022	0-2.5	0-2.5	25-30	40-45	360	0	376	0
Mark Burgis - Director of Primary & Community Care	0-2.5	0-2.5	25-30	0-5	287	7	341	0
John Ingham - Chief Finance Officer to 31st July 2022	0-2.5	0-2.5	55-60	140-145	1093	2	1155	0

Jocelyn Pike - Director of Place Development & System Support	0-2.5	0-2.5	30-35	50-55	458	10	527	0
Karen Barker - Director of Corporate Affairs & ICS Development from 1st April 2022	0-2.5	0-2.5	20-25	0-5	192	3	224	0
Andrew Palmer - Director of System-Wide Planning & Transformation Delivery	0-2.5	0-2.5	40-45	75-80	617	9	690	0
Tracy Williams - Governing Body Member	0-2.5	0-2.5	30-35	45-50	512	9	575	0

* Total in (a), (b) and (f) for all are for part year as per dates in Executive Directors in post 2022 table. All have continued to accrue pensionable membership since their role end dates.

** (c), (d) and (g) are Greenbury provided figures that relate to the full year.

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

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023 to 24 CETV figures.

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 where:

- 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)

Percentage change in remuneration of highest paid director

	Salary and allowances	**Performance pay and bonuses**
The percentage change from the previous financial year in respect of the highest paid director	3%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	-1.4%	0%

The average percentage change is mainly due to appointments during the reporting period of 65% lower banded appointments and 35% higher banded, also new appointments are often to the bottom of the AfC PayScale whereas leavers tend to be on a higher spine point of the AfC PayScale, both reducing the average."

No performance pay or bonuses were paid during the reporting period (None paid in 2021/22)

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 reporting period 1 April 2022 and 30 June 2022 was 4.7 times the median remuneration of the workforce. (In 2021/22 this was 4.2 times).
(2) The banded remuneration of the highest paid director/Member in Norfolk and Waveney CCG in the reporting period 1 April 2022 and 30 June 2022 was 6.0 times the 25th Percentile (lowest quarter) remuneration of the workforce. (In 2021/22 this was 6.0 times).
(3) The banded remuneration of the highest paid director/Member in Norfolk and Waveney CCG in the reporting period 1 April 2022 and 30 June 2022 was 3.5 times the 75th Percentile (highest quarter) remuneration of the workforce. (In 2021/22 this was 3.1 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 reporting period 1 April 2022 and 30 June 2022 was £195,000-200,000 (2021-22, £190,000-195,000).

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

Period to 30 June 2022	25th percentile	Median	75th Percentile
Total remuneration (£)	32,934	41,659	56,164
Salary component of total remuneration (£)	32,934	41,659	56,164
Pay ratio information	6.0:1	4.7:1	3.5:1

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

* Note 2021-22 calculations based on actual remuneration paid rather than FTE salary as per 2022-23 GAM

In the reporting period 1 April and 30 June 2022, no employees (2021/22 no employees) received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £21,730 to £195,700 (2021/22: £20,330 to £190,000). The increase from 2021/22 to the reporting period 1 April and 30 June 2022 is the result of the AfC pay award.

* 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 had a highly skilled, motivated and experienced workforce of commissioning managers and support staff. During the reporting period the average workforce was 580.0 WTE (whole time equivalent), (503.7 WTE in 2021-22). 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 was 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 the CCG adopted 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 30 June 2022.

Staff Composition by Occupational Code (headcount)	Female	Male	Total
Chair, Lay, Non-Exec & Governing Body Members	3	4	7
Clinical Member	21	16	37
Senior Managers	11	10	21
Managers	88	46	134
Nursing Professionals	97	9	106
Clerical and Administrative	244	53	297
Scientific, Therapeutic & Technical Professionals	12	2	14
Other - Seconded in staff	30	11	41
Other - Non AfC non-CCG shared posts	10	4	14
Total	516	155	671

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	55	3	58
Band 4	52	6	58
Band 5	41	11	52
Band 6	86	15	101
Band 7	90	24	114
Band 8a	52	18	70
Band 8b	48	18	66
Band 8c	29	12	41
Band 8d	15	16	31
Band 9	7	2	9
VSM	5	7	12
Non-Executives & Governing Body Members (Including Clinical Members)	6	4	10
Other - Non AfC CCG members	20	15	35
Other - Non AfC non-CCG shared posts	10	4	14
Total	516	155	671

Whilst these tables detail the breakdown of staffing by banding from a gender perspective, other metrics were 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 were reviewed by both the workforce team and the staff Equality, Diversity and Inclusion Group.

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

Employee benefits

For reporting period 1 April to 30 June 2022 Employee benefits	Permanent Employees £'000	Other £'000	2022-23 Total £'000
Salaries and wages	6,226	631	6,857
Social security costs	725	50	775
Employer Contributions to NHS Pension scheme	1,103	59	1,162
Other pension costs	3	0	3
Apprenticeship Levy	27	0	27
Termination benefits	0	0	0
Gross employee benefits expenditure	**8,084**	**740**	**8,824**

PY comparison Employee benefits	Permanent Employees £'000	Other £'000	2021-22 Total £'000
Salaries and wages	23,488	1,019	24,507
Social security costs	2,539	6	2,545
Employer Contributions to NHS Pension scheme	4,036	7	4,042
Other pension costs	13	0	13
Apprenticeship Levy	104	0	104
Termination benefits	19	0	19
Gross employee benefits expenditure	**30,199**	**1,032**	**31,230**

The 2022-23 3-month period extrapolated to full year effect equates to £35,296 and relative increase of 13% from 2021-22.

2022-23 employee benefits expenditure has increased due to 3% AfC pay award, 1.5% NI social care element and 2021-22 in housing mid-year of teams having a full year effect in 2022-23.

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:

NHS Sickness Absence Rates, April 2022 to June 2022, Provisional Statistics - NDRS (digital.nhs.uk)

Staff turnover

As at 30 June 2022 the staff turnover for NWCCG stood at 5.44% (Based on figures for the 3 month period). As at 31 March 2022 the CCG reported 2.84% staff turnover (Based on figures for a rolling 12-months).

Staff engagement percentages

The CCG is committed to improving staff experiences across the NHS and takes part in the National Staff Survey (NSS) annually. Due to its cessation 30th June 2022 it did not participate in the 2022 NSS.

The ICB did participate in the NSS in October 2022. This results of this will be published in the ICB's 2022-23 Staff Report.

Staff policies

The CCG contracted 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 were based on NHS Business Services Authority policies and as such have been agreed by Trade Unions. HR policies were also reviewed by a Staff Involvement Group (SIG) which was established to ensure that the CCG had the opportunity to engage with and listen to the views of staff to help inform organisational decision making and planning. The CCG had a member of staff who was also a trade union representative who sat on the SIG and reviewed and commented on policies to support their development and review. Where relevant HR personnel engaged with trade unions to support good working relationships.

The CCG followed an Equality, Diversity and Inclusion Policy and was 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 gave full and fair consideration to applications for employment made by disabled persons and promoted the provision of training and guidance and the impartial application of all employment policies and procedures. Occupational health advice and support was available to all staff and specialist advice sought for disabled employees. More information on how the CCG approached equality and inclusion can be found under 'Other employee matters' below.

Trade Union Facility Time Reporting Requirements

This section has not been completed in line with Group Accounting Manual 2022-23 as the reporting period of the annual report is less than seven months.

Other employee matters

Staff Consultation

As mentioned at the start of the Remuneration Report, this is the final Remuneration and Staff Report as the CCG was abolished on 30 June 2022. Staff transferred 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 was a transfer scheme. The process that the CCG followed was 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 had 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 established an Equality, Inclusion and Diversity Group to ensure that the CCG continued to develop opportunities for all employees. A key aim of the CCG was to ensure that diversity was 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 was appointed by the CCG and an Equality, Inclusion and Diversity Policy and Strategy produced.

Health and Safety

The CCG was committed to ensuring the health, safety and welfare of its employees and of course others who may be affected by CCG activities. The CCG took 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 was provided via e-learning for all staff. This mandatory training covered the core requirements for a low risk office environment and each module contained an assessment that must be passed by staff.

Pension

Employees of the CCG were 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 were disclosed within this Remuneration Report.

Expenditure on consultancy

Where the CCG did 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 relied on external organisations and individuals to provide those skills or capacity.

During the reporting period the CCG spent £49,500 on consultancy services as outlined below (2021/22 £647,414).

Consultancy service	Cost £
Strategy Consultancy	£8,700
Organisation & Change Management Consultancy	£40,800
Total	**£49,500**

Off-payroll engagements

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245[1] per day

	Number
Number of existing engagements as of 30 June 2022	8
Of which, the number that have existed:	
for less than one year at the time of reporting	2
for between one and two years at the time of reporting	6
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

The CCG can provide assurance that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary.

Table 2: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2022 and 30 June 2022, for more than £245[1] per day:

	Number
No. of temporary off-payroll workers engaged between 1 April 2022 and 30 June 2022	16
Of which:	
No. not subject to off-payroll legislation[2]	14
No. subject to off-payroll legislation and determined as in-scope of IR35[2]	0
No. subject to off-payroll legislation and determined as out of scope of IR35[2]	2

the number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: no. of engagements that saw a change to IR35 status following review	0

(2) A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

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 2022 and 30 June 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.	2

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

Table 1: Exit Packages

There were no exit packages agreed in the CCG's reporting period 1 April – 30 June 2022

Redundancy and other departure costs are 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 29 June 2023

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 133.

ANNUAL ACCOUNTS

Financial Statement and Notes

NHS Norfolk & Waveney CCG - Accounts for the period ended 30 June 2022

Statement of Comprehensive Net Expenditure for the period ended 30 June 2022

	Note	30 June 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	(3,723)	(16,719)
Other operating income	2	-	(34)
Total operating income		**(3,723)**	**(16,753)**
Staff costs	3	8,824	31,230
Purchase of goods and services	4	516,727	2,088,991
Depreciation and impairment charges	4	13	21
Provision expense	4	2,476	4,139
Other operating expenditure	4	208	1,922
Total operating expenditure		**528,248**	**2,126,303**
Net operating expenditure		**524,525**	**2,109,550**
Finance expense	6 & 7	1	10
Net expenditure for the period		**524,526**	**2,109,560**
Comprehensive expenditure for the period		**524,526**	**2,109,560**

Notes on pages 108 to 132 form part of this statement.

Statement of Financial Position as at 30 June 2022

	Note	30 June 2022 £'000	2021-22 £'000
Non-current assets:			
Right-of-use assets	8	53	-
Total non-current assets		**53**	**-**
Current assets:			
Trade and other receivables	9	5,236	9,552
Cash and cash equivalents	10	395	1,481
Total current assets		**5,631**	**11,033**
Total assets		**5,684**	**11,033**
Current liabilities:			
Trade and other payables	11	(163,750)	(195,365)
Lease liabilities	8	(53)	-
Provisions	12	(7,454)	(4,978)
Total current liabilities		**(171,257)**	**(200,343)**
Total assets less current liabilities		**(165,573)**	**(189,310)**
Non-current liabilities:			
Trade and other payables	11	(612)	(612)
Provisions	12	(216)	(216)
Total non-current liabilities		**(828)**	**(828)**
Assets less Liabilities		**(166,401)**	**(190,138)**
Financed by taxpayers' equity:			
General fund		(166,401)	(190,138)
Total taxpayers' equity:		**(166,401)**	**(190,138)**

The notes on pages 108 to 132 form part of this statement
The financial statements on pages 104 to 107 were approved by the Board on 27 June 2023 and signed on its behalf by:

SIGNED

Tracey Bleakley Chief Executive Officer 29 June 2023

Statement of Changes In Taxpayers Equity for the period ended 30 June 2022

	Note	30 June 2022 General fund £'000	2021/22 General fund £'000
Changes in taxpayers' equity for 30 June 2022			
Balance at 01 April 2022		(190,138)	(138,283)
Changes in NHS CCG taxpayers' equity for 30 June 2022			
Net operating expenditure for the financial period	SoCNE	(524,526)	(2,109,560)
Net recognised NHS CCG expenditure for the financial period		**(524,526)**	**(2,109,560)**
Net funding	SoCF	548,263	2,057,705
Balance at 30 June 2022		**(166,401)**	**(190,138)**

The notes on pages 108 to 132 form part of this statement

Statement of Cash Flows for the period ended 30 June 2022

	Note	30 June 2022 £'000	2021-22 £'000
Cash flows from operating activities			
Net operating expenditure for the financial period		(524,526)	(2,109,560)
Depreciation & amortisation	4	13	21
Other gains & losses		0	10
(Increase)/decrease in trade & other receivables	9	4,316	18,139
Increase/(decrease) in trade & other payables	11	(31,615)	29,583
Increase/(decrease) in provisions	12	2,476	4,139
Net cash inflow (outflow) from operating activities		**(549,336)**	**(2,057,668)**
Cash flows from financing activities			
Net funding received		548,263	2,057,705
Repayment of lease liabilities		(13)	-
Net cash inflow (outflow) from financing activities		**548,250**	**2,057,705**
Net increase (decrease) in cash & cash equivalents	10	**(1,086)**	**37**
Cash & cash equivalents at the beginning of the financial period		**1,481**	**1,444**
Cash & cash equivalents at the end of the financial period		**395**	**1,481**

The notes on pages 108 to 132 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 2022-23 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 CCG 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 the 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, CCGs 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 pools are 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.

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 period. 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 period.
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 period expenditure. For the period ended 30 June 2022 an accrual of £32,372,647 (2021-22: £33,724,026) was included for May and June 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 Standard and Interpretation to be applied for the period ended 30 June 2022. This Standard is still subject to HM Treasury FReM adoption, with the government implementation date for IFRS 17 still subject to HM Treasury consideration.
• IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2023: early adoption is not therefore permitted.
The application of 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

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The CCG assesses whether a contract is or contains a lease, at inception of the contract.

1.14.1 The CCG as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.
The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.
The HM Treasury incremental borrowing rate of 0.95% is applied for leases commencing, transitioning, or being remeasured in the 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy.
Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

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 the period ended 30 June 2022 a value of £36,387 (2021-22: £13,861) 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.

1.16 **Adoption of new standards**

On 1 April 2022, the CCG adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.
Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.
In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset.

Impact assessment

The CCG has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the opening retained earnings with no restatement of comparative balances.
IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.
The group has utilised three further practical expedients under the transition approach adopted:
a) The election to not make an adjustment for leases for which the underlying asset is of low value.
b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.
c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease.
The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.
As of 1 April 2022, the group recognised £0.1m or right-of-use assets and lease liabilities of £0.1m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was no significant impact to tax payers' equity.
The group has assessed that there is no significant impact on its current finance leases due to the immaterial value on the statement of financial position and no significant impact on the limited transactions it undertakes as a lessor because IFRS 16 has not substantially changed the accounting arrangements for lessors.
The following table reconciles the group's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

Total

	£000
Operating lease commitments at 31 March 2022	-2,181
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	0.95%
Operating lease commitments discounted used weighted average IBR	-2,161
Less: Short term leases and non capitalised lease costs (including those with <12 months at application date)	2,095
Lease liability at 1 April 2022	-66

2. Other operating revenue

	30 June 2022 Total	2021-22 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	1,322	4,237
Other contract income	2,401	12,482
Total Income from sale of goods and services	**3,723**	**16,719**
Other operating income		
Charitable and other contributions to revenue expenditure: non-NHS	-	34
Total other operating income	**-**	**34**
Total operating income	**3,723**	**16,753**

3. Employee benefits and staff numbers

3.1 Employee benefits	Total		30 June 2022		Total	2021-22
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee benefits						
Salaries and wages	6,226	631	6,857	23,488	1,019	24,507
Social security costs	725	50	775	2,539	6	2,545
Employer contributions to NHS Pension scheme	1,103	59	1,162	4,036	6	4,042
Other pension costs	3	-	3	13	-	13
Apprenticeship levy	27	-	27	104	-	104
Termination benefits	-	-	-	19	-	19
Total employee benefits excluding capitalised costs *	**8,084**	**740**	**8,824**	**30,199**	**1,031**	**31,230**

* Employee benefit cost increases include application of the anticipated 3% National pay award, and the inhousing 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 85 to 101.

3.2 Average number of people employed

	30 June 2022			2021-22		
	Permanently Employed Number	Other Number	Total Number	Permanently Employed Number	Other Number	Total Number
Total	**528**	**52**	**580**	**474**	**29**	**503**

Of the above:

Further information in respect of staff numbers is included from page 95 of the annual report

3.3 Exit packages agreed in the financial period

There were no exit packages in the period ended 30 June 2022.

	2021-22 Compulsory redundancies	
	Number	£
£10,001 to £25,000	1	18,945
Total	**1**	**18,945**

This table reports the number and value of exit packages agreed in the financial year. The expense associated with this departure 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". An outline of these follows:

The employer contribution rate remained at 20.6% in line with 2021-22. The rate increased 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 have 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 30 June 2022, is based on valuation data as 31 March 2022, updated to 30 June 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 the period ended 30 June 2022, employers' contributions of £1,162,000 (2021-22: £4,042,000) were payable to the NHS Pensions Scheme at the rate of 20.6% of pensionable pay.

4. Operating expenses

	30 June 2022 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	2,271	10,495
Services from foundation trusts	296,035	1,165,945
Services from other NHS trusts	44,155	161,994
Services from Other WGA bodies	29	82
Purchase of healthcare from non-NHS bodies	61,977	295,130
Purchase of social care	2,876	11,283
Prescribing costs	48,600	189,583
GPMS/APMS and PCTMS	50,961	196,465
Supplies and services – clinical	319	91
Supplies and services – general	3,924	34,021
Consultancy services	50	642
Establishment	1,375	6,732
Transport	2,994	10,069
Premises	673	2,905
Audit fees	78	209
Other professional fees	193	2,200
Legal fees	104	419
Education, training and conferences	113	726
Total purchase of goods and services	**516,727**	**2,088,991**
Depreciation and impairment charges		
Depreciation	13	21
Total depreciation and impairment charges	**13**	**21**
Provision expense		
Provisions	2,476	4,139
Total provision expense	**2,476**	**4,139**
Other operating expenditure		
Chair and Non Executive Members	135	551
Research and development (excluding staff costs)	30	1,337
Expected credit loss on receivables	36	14
Other expenditure	7	20
Total other operating expenditure	**208**	**1,922**
Total operating expenditure	**519,424**	**2,095,073**

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

5.1 Measure of compliance	30 June 2022 Number	30 June 2022 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the period	15,792	153,555	59,351	564,174
Total Non-NHS trade Invoices paid within target	15,561	149,806	58,153	549,664
Percentage of Non-NHS trade invoices paid within target	**98.54%**	**97.56%**	**97.98%**	**97.43%**
NHS Payables				
Total NHS trade invoices paid in the period	358	348,344	1,419	1,333,192
Total NHS trade invoices paid within target	336	347,619	1,372	1,328,558
Percentage of NHS trade invoices paid within target	**93.85%**	**99.79%**	**96.69%**	**99.65%**
Total Payables				
Total trade invoices paid in the period	16,150	501,899	60,770	1,897,366
Total trade invoices paid within target	15,897	497,425	59,525	1,878,222
Percentage of all trade invoices paid within target	**98.43%**	**99.11%**	**97.95%**	**98.99%**

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 the period ended 30 June 2022 this target delivery was achieved in all categories with the exception of the number of NHS trade invoices which achieved 94%.

6. Other gains and losses

	30 June 2022 £'000	2021-22 £'000
Loss on disposal of property, plant and equipment assets other than by sale	-	10
Total	**-**	**10**

7. Finance costs

	30 June 2022 £'000	2021-22 £'000
Interest		
Interest on late payment of commercial debt	1	-
Total interest	**1**	**-**
Total finance costs	**1**	**-**

8. Leases

8.1 Right-of-use assets

	30 June 2022 Buildings (excluding dwellings) £'000
Cost or valuation at 01 April 2022	-
IFRS 16 transition adjustment	66
Cost/Valuation at 30 June 2022	**66**
Depreciation 01 April 2022	-
Charged during the period	13
Depreciation at 30 June 2022	**13**
Net Book Value at 30 June 2022	**53**

8. Leases cont'd

8.2 Lease liabilities

	30 June 2022 £'000
Lease liabilities at 01 April 2022	-
IFRS 16 transition adjustment	66
Repayment of lease liabilities (including interest)	(13)
Lease liabilities at 30 June 2022	**53**

8.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	30 June 2022 £'000
Within one year	(53)
Balance at 30 June 2022	**(53)**
Included in:	
Current lease liabilities	(53)
Balance at 30 June 2022	**(53)**

8.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	30 June 2022 £'000
Depreciation expense on right-of-use assets	13
	13

8.5 Amounts recognised in Statement of Cash Flows

	30 June 2022 £'000
Total cash outflow on leases under IFRS 16	(13)
	(13)

8.6 Nature of lessee's leasing activities

The CCG has disclosed all lease liabilities under IFRS 16 in Note 8.1. This is for a property that the organisation occupies in order to carry out it's provision of Healthcare Commissioning. The CCG has entered into no further leases which would have been capitalised under IFRS 16, however there are two properties which the CCG occupies which have been treated as rental agreements which are owned by NHS Property Services.

9.1 Trade and other receivables	Current 30 June 2022 £'000	Current 2021-22 £'000
NHS receivables: Revenue	1,905	7,261
NHS prepayments	817	654
NHS accrued income	888	394
Non-NHS and Other WGA receivables: Revenue	2,599	2,823
Non-NHS and Other WGA prepayments	1,189	293
Non-NHS and Other WGA accrued income	390	140
Expected credit loss allowance-receivables	(2,555)	(2,765)
VAT	-	752
Other receivables and accruals	3	-
Total trade & other receivables	**5,236**	**9,552**

9.2 Receivables past their due date but not impaired	30 June 2022 DHSC Group Bodies £'000	30 June 2022 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	1,392	175	484	31
By three to six months	-	10	172	32
By more than six months	-	2,201	-	2,190
Total	**1,392**	**2,386**	**656**	**2,253**

9.3 Loss allowance on asset classes	30 June 2022 Non DHSC Group Bodies £'000
Balance at 01 April 2022	(2,765)
Lifetime expected credit losses on trade and other receivables-Stage 2	210
Lifetime expected credit losses on trade and other receivables-Stage 3	(36)
Amounts written off	36
Total	**(2,555)**

10. Cash and cash equivalents

	30 June 2022 £'000	2021-22 £'000
Balance at 01 April 2022	1,481	1,444
Net change in period	(1,086)	37
Balance at 30 June 2022	**395**	**1,481**
Made up of:		
Cash with the Government Banking Service	395	1,481
Balance at 30 June 2022	**395**	**1,481**

11. Trade and other payables	Current 30 June 2022 £'000	Non-current 30 June 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS payables: Revenue	1,487	-	13,872	-
NHS accruals	6,913	-	1,327	-
NHS deferred income	110	-	191	-
Non-NHS and Other WGA payables: Revenue	22,089	-	29,860	-
Non-NHS and Other WGA accruals	120,356	-	133,850	-
Non-NHS and Other WGA deferred income	8,394	612	10,764	612
Social security costs	421	-	377	-
VAT	66	-	-	-
Tax	339	-	330	-
Other payables and accruals*	3,575	-	4,794	-
Total trade & other payables	**163,750**	**612**	**195,365**	**612**
Total current and non-current	**164,362**		**195,977**	

*Other payables include £1,798,000 outstanding pension contributions at 30 June 2022 (31 March 2022: £1,730,000).

12. Provisions

	Current 30 June 2022 £'000	Non-current 30 June 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
Redundancy	429	-	399	-
Legal claims	453	-	453	-
Other	6,572	216	4,126	216
Total	**7,454**	**216**	**4,978**	**216**
Total current and non-current	**7,670**		**5,194**	

	Redundancy £'000	Legal Claims £'000	Other * £'000	Total £'000
Balance at 01 April 2022	**399**	**453**	**4,342**	**5,194**
Arising during the period	30	-	2,802	2,832
Reversed unused	-	-	(356)	(356)
Balance at 30 June 2022	**429**	**453**	**6,788**	**7,670**
Expected timing of cash flows:				
Within one year	429	453	6,572	7,454
Between one and five years	-	-	216	216
Balance at 30 June 2022	**429**	**453**	**6,788**	**7,670**

* Other Provisions include estates, prescribing costs, 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

	30 June 2022 £'000	2021-22 £'000
Contingent liabilities		
Legal Claim	200	200
Net value of contingent liabilities	**200**	**200**

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 NHS 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 NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS CCG and internal auditors.

14.1.1 Credit risk

Because the majority of the CCG revenue comes from parliamentary funding, CCG has low exposure to credit risk. The maximum exposures as at the end of the financial period are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.2 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.

14.1.3 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 30 June 2022 £'000	Financial Assets measured at amortised cost 2021-22 £'000
Trade and other receivables with NHSE bodies	1,698	4,465
Trade and other receivables with other DHSC group bodies	1,492	3,802
Trade and other receivables with external bodies	2,596	2,351
Cash and cash equivalents	395	1,481
Total at 30 June 2022	**6,181**	**12,099**

14.3 Financial liabilities

	Financial Liabilities measured at amortised cost 30 June 2022 £'000	Financial Liabilities measured at amortised cost 2021-22 £'000
Trade and other payables with NHSE bodies	66	4,601
Trade and other payables with other DHSC group bodies	8,378	14,674
Trade and other payables with external bodies	146,029	164,428
Total at 30 June 2022	**154,473**	**183,703**

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 30 June 2022				Amounts recognised in Entities books ONLY 2021-22			
			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	-	-	-	18,686	-	-	-	69,120
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	-	766	-	2,331	-	815	-	9,927
Suffolk County Council Mental Health Services	NHS Norfolk and Waveney CCG and Suffolk County Council	Joint provision of mental health services	-	-	-	51	-	-	-	199

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.	-	-	338	650	-	-	1,011	2,555

17. Related party transactions

Details of related party transactions with individuals are as follows:

	30 June 2022				2021-22			
	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
Governing Body Members (including General Practitioner Practice Payments)								
Dr Anoop Dhesi, The Staithe Surgery	394	-	-	-	1,470	-	-	-
Dr Hilary Byrne, Attleborough Surgery	735	-	-	-	2,931	-	-	-
Dr Clare Hambling, Bridge Street Surgery	381	-	-	-	1,414	-	-	-
Dr Ardyn Ross, Millwood and Falkland Surgery	850	-	-	-	3,099	-	-	-
Tracy Williams, Bacon Road Partnership	163	-	-	-	652	-	-	-
Tracy Williams, Castle Partnership	655	-	2	-	2,410	-	-	1

The Department of Health and Social Care is regarded as a related party. During the period 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 £200k are listed below:

- Bedfordshire Hospital NHS Foundation Trust
- Cambridge University Hospital NHS Foundation Trust
- Cambridge & Peterborough NHS Foundation Trust
- Community Health Partnerships
- East of England Ambulance Service NHS Trust
- East Suffolk and North East Essex NHS Foundation Trust

- Guys & 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 England
- NHS North West London CCG
- 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 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 have been abolished and the functions, assets and liabilities of NHS Norfolk & Waveney CCG have transferred 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 as the services of the clinical commissioning group(s) continue to be provided using the same assets by another public sector entity.

19. Financial performance targets

NHS Norfolk & Waveney CCG has a number of financial duties under the NHS Act 2006 (as amended). Performance against those duties was as follows:

	NHS Act Section	Duty Achieved ?	30 June 2022 Target £'000	30 June 2022 Performance £'000	2021-22 Target £'000	2021-22 Performance £'000
Expenditure not to exceed income	223H(1)	Yes	528,249	528,249	2,126,873	2,126,314
Revenue resource use does not exceed the amount specified in Directions	223I(3)	Yes	524,526	524,526	2,110,119	2,109,560
Revenue administration resource use does not exceed the amount specified in Directions	223J(3)	Yes	5,156	5,155	20,621	20,510

20. Losses and special payments

20.1 Losses

The total number of CCG losses and their total value, was as follows:

	Total Number of Cases 30 June 2022 Number	Total Value of Cases 30 June 2022 £'000	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Administrative write-offs in relation to Bad Debts	35	36	21	14
Total	**35**	**36**	**21**	**14**

There were no individual cases over £300,000.
These amounts are reported on an accruals basis but exclude provisions for future losses.

20.2 Special payments

There were no Special payments made during the period ended 30 June 2022 or 2021-22.

Building a better working world

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS NORFOLK & WAVENEY INTEGRATED CARE BOARD

Opinion

We have audited the financial statements of NHS Norfolk & Waveney Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 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 2022/23 HM Treasury's Financial Reporting Manual (the 2022/23 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2022 to 2023 and the Accounts Direction issued by NHS England with the approval of the Secretary of State.

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 30 June 2022 and of its net expenditure for the three-month period then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023; and
- have been properly prepared in accordance with the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

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 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 CCG's, or the successor body's, ability to continue as a going concern for a period to 30 June 2024.

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 other matters prescribed by the Code of Audit Practice

In our opinion:

- other information published together with the audited financial statements is consistent with the financial statements; and
- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2022 to 2023.

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 2022 to 2023; 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 three-month period ended 30 June 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 55 and 56, 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

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 National Health Service Act 2006, the Health and Social Care Act 2012, the Health and Care Act 2022 and other legislation governing NHS CCGs, 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 [illegible]. 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 January 2023 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 three-month period ended 30 June 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. The Code of Audit Practice does not require us to refer to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resource 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 Integrated Care Board (ICB) 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 ICB 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: 29th June 2023

Mark Hodgson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
Cambridge