Looking back over the 2016/17 financial year we have every reason to be proud of our efforts to ensure that patients in Suffolk receive the highest quality care for the best possible value.

Satisfaction levels for our GP services are higher than the national average and the Care Quality Commission (CQC) has rated nearly all our practices ‘good’ or ‘outstanding’.

Ipswich Hospital NHS Trust is also rated as ‘good’ by the CQC. In October 2016 the Norfolk and Suffolk NHS Foundation Trust (NSFT), which provides mental health services in our county, improved enough to merit being moved from ‘inadequate’ to ‘requiring improvement’ by the CQC.

Significant improvements have been achieved in a number of key areas. During 2016/17 we have:

- Reduced the number of times when patients could not be discharged from hospital despite them being fit enough to leave from 15% to 3.5%
- Reduced the numbers of people waiting to hear if they are eligible for Continuing Healthcare funding
- Supported more people with learning disabilities to be able to live in the community
- Saved more than £1.8million
- Commissioned the Wellbeing Service from NSFT to help adults and children with common mental health problems overcome anxiety, stress and depression
- Helped the East of England Ambulance Service NHS Trust to increase the number of life-threatening ‘Red 1’ calls it responded to within the eight-minute target from 58% to 69%

In accordance with national guidelines our priorities are to prevent, and improve the health, of people suffering from:

- Cancer
- Diabetes or other long-term conditions
- Mental health issues
- Frailty
- Obesity (particularly in children) and
- Health inequalities (due to being marginalised or vulnerable people).

We believe this can best be achieved by continuing to provide clinical leadership, further developing our relationships with health and social care providers, joining up services in local communities with the help of our member GP practices, our partners at Suffolk County Council and the voluntary and community sector, and forging even stronger partnerships with our patients.

Patients, carers and members of the public have been instrumental in helping the CCG Governing Body and Clinical Executive make good decisions for the future of the services we commission.

Going forward our goals remain the same - to improve partnership working at every level and to remain within our financial means to secure the best possible outcomes, services and experiences for our patients.

Thank you to everyone who has worked with us this year.

Dr. Mark Shenton, Chair of NHS Ipswich and East Suffolk Clinical Commissioning Group

Dr Ed Garratt, Chief Officer of NHS Ipswich and East Suffolk Clinical Commissioning Group
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The Performance Report
Ipswich and East Suffolk CCG has eight clinical priorities. These were chosen with the help of patients and the public, GP member practices, partners and providers. We also reviewed evidence of local needs and national standards.

**Our clinical priorities are to:**

- Ensure high quality local services
- Improve the health of those most in need
- Improve access to mental health services
- Promote self-care
- Improve the health and educational attainment of children and young people
- Improve outcomes for patients with diabetes so they are above the national average
- Improve care for frail elderly individuals, and
- Allow patients to die with dignity and compassion and choose their place of death.

The CCG’s Governing Body includes seven elected GP members. Our Clinical Executive has a further seven appointed GP members, each of whom is linked to a number of GP member practices.

The CCG has engaged members through a variety of means including:

- GP link visits
- Locality meetings
- The ‘contract query line’
- Training and education events
- Practice manager forums, and
- Dedicated forums for prescribing leads, nurses and medical secretaries.

Member practices help identify needs, design services and give feedback on the performance of those services. We have ensured patient involvement on our procurement panels and show publicly how we have listened and what action we have taken as a result using a “You said it, we did it” approach.

The CCG has developed an award winning youth engagement group called YEAH! Part of the group’s role is to ensure that the views of younger people are heard. We have also shown our commitment to working in partnership with patients by appointing patient partnership ‘champions’ across the organisation.

More about our engagement with patients and members of the public can be found later in our report.

During the year we have strengthened our relationships with other commissioning partners through the Health and Wellbeing Board. We have good partnerships with leaders from across local councils, the NHS and local voluntary groups, made better by working on future health and care plans together. Our relationships with the wider clinical community have also been enhanced through our Elective Care Network, Integrated Care Network and prescribing activity.
Performance Overview

Nature, Objectives and Strategies of the CCG

Clinical Commissioning Groups (CCGs) were licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. As of 1 April 2014 CCGs have been licensed without conditions.

All CCGs are obliged to prepare an annual report for the National Health Service Commissioning Board (NHSCB) under the powers conferred on it by the National Health Service Act 2006.

NHS Ipswich and East Suffolk CCG is responsible for planning, buying and monitoring health care services for 403,571 patients.

During 2016/17 our 40 GP member practices have increasingly worked together and on 1 April 2017 11 practices joined together to form Suffolk Primary Care.

We are responsible for community services, secondary care (hospital) and mental health services as well as NHS Continuing Healthcare. We co-commissioned primary medical services with NHS England in 2016/17 but from 1 April 2017 we will have delegated commissioning functions.

The governing body of the CCG includes seven elected GPs, a secondary care doctor, a lay member for patient and public involvement, a lay member for governance, a lay member for conflicts of interest, a chief nursing officer, a chief finance officer and an accountable officer. It also includes four other non-voting chief officers.

Our catchment area includes the Borough of Ipswich, the Suffolk Coastal district, parts of the districts of Mid Suffolk and Babergh and a small part of St Edmundsbury. The area is predominantly rural. There is one major town - Ipswich - and three towns with populations of more than 10,000 people - Felixstowe, Stowmarket and Woodbridge.

The population of east Suffolk is projected to increase by between 16 and 32% from 2008 to 2031. This is projected to include a 49% increase in the number of people aged 65 and over, estimated at 60,800 between 2001 and 2021. This brings with it extra demands for age-related services and support. The population of Ipswich itself is also growing and is projected to increase by 33% between 2008 and 2031.

People living in east Suffolk are relatively healthy compared to those in other parts of the country, although there are still some significant issues to be addressed, including tackling health inequalities in some areas.

Data from 2010-2012 shows that our population has significantly higher healthy life expectancies for both men and women compared to other areas of England.

This data shows that in our area:

- Men have a life expectancy of 80.7 years and a healthy life expectancy of 66.3 years, meaning 82.1% of their lives are spent in ‘good health’, and
- Women have a life expectancy of 84 years and a healthy life expectancy of 67.3 years, meaning 80.1% of their lives are spent in ‘good health’.

However, significant health inequalities exist in our catchment. There is a 5.5 year life expectancy gap for men and a 4.3 year gap for women between those living in the most and least deprived areas of the CCG area.

The main causes of death in Ipswich and east Suffolk mirror those across England, with over three quarters of all deaths caused by cancer, circulatory disease (including coronary heart disease and stroke) and respiratory diseases. Coronary heart disease is the most prevalent cause of health inequalities in Suffolk, and cancer is the leading cause of premature mortality.

Performance Overview

CCG Headquarters and Operational Area

NHS Ipswich and East Suffolk CCG is currently based at Rushbrook House, Paper Mill Lane, Bramford. Rushbrook House is a four-storey building in a rural location, three miles outside the county town of Ipswich, with easy access to the A14 and A12, allowing team members to travel easily. Visitor parking is available and there are disabled parking areas.

The CCG will be moving to new headquarters at Endeavour House in Ipswich in late 2017.

The area covered by the CCG is shown to the right of Stowmarket on the map below.

We work together with our neighbouring CCGs, providers and partners as members of the Suffolk and North East Essex Sustainability and Transformation Plan (STP) group (also known as the Health and Care Plan Group).

Ipswich Practices

1. The Chesterfield Drive Practice
2. Deben Road Surgery
3. The Norwich Road Surgery
4. Ivy Street Medical Street
5. Burlington Road Surgery
6. Barrack Lane Medical Centre
7. The Dr Solway & Dr Mallick Practice
8. Orchard Medical Practice
9. Two Rivers
10. Hawthorn Drive Surgery
11. The Derby Road Practice
12. Felixstowe Road Medical Practice
13. Ravenswood Medical Practice
Performance Overview

Commissioning Activity

We commission services from a range of organisations including acute hospital trusts, GP practices, voluntary organisations and other NHS and non-NHS providers.

The services we commission include:

- **Urgent care services** - including ambulance response services, hospital accident and emergency departments and the NHS111 telephone service
- **Elective care services** - for planned operations and interventions
- **Community services** - including community nursing and therapy services, community hospitals and the provision of community equipment
- **Mental health and learning disability services** - provided both in hospitals and at home or in the community
- **Children’s services** - supporting children with individual health needs and receiving services provided with Suffolk County Council
- **Out of hours GP services** and
- **Non-urgent patient transport**

All contracts with providers are closely managed by a dedicated, highly skilled contracting team. This means services are delivered as set out in the contracts and provide value for money for the people of Suffolk. The contracting team ensures that both the quality and the performance of services are consistently scrutinised.

The team builds strong, collaborative partnerships with our providers. We support our providers, and also challenge them where appropriate. Our aim is to work from a position of trust, respect and active clinical leadership.

All commissioning decisions are based on clinical best practice and data analysis. Service providers are required to show care outcomes and value for money. Each of our services has to measure its impact by outcomes for patients and the feedback patients give on their experiences. Performance and impact is reviewed across each service to ensure it is delivering value of money.
Integrated Care: Our work involves joining up services to make them simpler, so that the public can better access them when in need. What follows are the highlights for 2016/17.

**Integrating Urgent Care services**

Working with North East Essex CCG and West Suffolk CCG, we are creating a model which joins up NHS111, out of hours care and a Single Point of Access for urgent care services. It will mean patients and staff have to make fewer calls to get the help they need. We are looking for one organisation to take on the contract. This change will be implemented in 2017/18.

**Achieving the four hour A&E targets**

A review of how and when people access the Emergency Department was carried out with key groups which regularly use emergency care services. It enabled us to look at how to work together and improve internal A&E processes. This will help patients to access the right service for their needs, relieve pressure on A&E and help ensure achievement of the four-hour target.

**Avoiding unnecessary hospital admissions**

The Crisis Action Team (CAT) has now been embedded into the local health and care system. The CAT supports people in a crisis who need support and reablement to stay in their own homes rather than being taken to A&E or admitted to hospital. This service has been working closely with other admission avoidance services to help people with multiple and complex needs.

**Frailty Assessment Base.**

This service moved into its own dedicated unit at Ipswich Hospital NHS Trust in December 2016. It provides a comprehensive assessment of people who are frail which looks at their medical, pharmaceutical, dietetic and functional needs to enable them to live as independently as possible. The service piloted a seven-day working model during 2016/17 and has committed to implementing this permanently in 2017/18.

**Proactive and Reactive Care.**

An integrated care model has been developed so that people's future physical, psychological, social and mental health needs can be met as closely as possible to their homes. The model takes into account the Suffolk Health and Care Review 2014, which considered the local evidence base and health needs, as well as undertaking extensive engagement with local organisations and individuals.

**Developing Connect.**

During 2015/16 the Connect pilot project set out the best ways of working together in local areas. Using all we learned in east Ipswich teams have been set up across the CCG area. Two implementation managers have been appointed in 2016/17 to build better working relationships between community nurses and therapists, social care and housing teams, the police and voluntary organisations. Integrated Neighbourhood Teams (INTs) and Community Resilience (CR) will deliver this work.

**Delayed Transfers of Care (DTOC).**

Meetings are held regularly to help facilitate the timely discharge of patients once they are deemed medically fit to leave hospital. We have also gathered the views of the Ipswich Hospital User Group and the CCG's Community Engagement Partnership to inform the idea of 'Ticket Home', a patient-held document which sets out clearly who the person, carer and/or family member can discuss care and discharge plans as soon as their care in hospital begins.

**Development of Discharge to Assess (D2A)**

D2A is a pilot scheme which aims to help patients leave hospital to have their ongoing care and support needs assessed in a more relaxed and appropriate environment, rather than on a ward. The scheme has been piloted in Felixstowe where we have been working with Healthwatch Suffolk to closely review outcomes for patients. This has provided us with valuable insight into what has worked well and what can be improved when D2A is rolled out across Suffolk. The pilot may be extended to prevent unnecessary admissions in the future.
Performance Overview

Strategies for Achieving the Objectives continued

Planned Care: Care in hospital or in the community, which is planned after a request from a doctor, nurse or health and care professional, is a major part of our work to meet people’s need. Clinicians take a lead role in setting priorities through Clinical Transformation Groups (CTGs).

Ophthalmology (Eyesight)

A local Ophthalmology Alliance has been formed between the CCG and Ipswich Hospital NHS Trust. The alliance has been working with eye care staff at Ipswich Hospital and community providers to make changes that will help to maximise patients’ eye care experiences. To take this forward, we are looking for a partner to introduce technology so that patients have a treatment plan before seeing a consultant, saving patients’ time.

Musculoskeletal (Limbs)

A new model of musculoskeletal (MSK) care was launched on the 1 October, 2016. The CTG which developed it is made up of professionals from all the organisations providing MSK care and includes service users. Improvements have been made to how people access and experience the service as a result of GP and hospital care clinicians leading on this work.

The Ipswich and East Suffolk Integrated MSK service brought together two providers of MSK care - Allied Health Professionals Suffolk and Ipswich Hospital NHS Trust (IHT).

Access to orthopaedic, rheumatology and pain services is now provided in one place. It means patients are given the right treatment by the right person in the right place. Anyone over the age of 16 can also refer themselves for community physiotherapy.

Improved referral forms have been loaded onto the Map of Medicine, an on-line tool for GPs with information and links to patient advice. It also saves time as it automatically adds details of where the patient is registered as well as age, previous medical history, allergies and current and repeat medication.

A set of outcomes has been developed which the MSK service, working together with the CCG, will use to measure the impact of the new care model. Patients were engaged throughout to ensure that what matters most to the people using the service has been taken onboard.

Gastroenterology (Digestion)

There has been a significant growth in the number of people asking for help for problems with their digestive systems. Three CTG meetings were held to identify how the service could be improved. We have been discussing ways of delivering these changes with the current providers of gastroenterology care, with the aim of ensuring patients are able to access high quality, joined-up services, as close to their home as possible.

Audiology (Hearing)

The CCG has worked with clinicians at IHT to improve access for patients with age-related hearing difficulties affecting both ears. It started with a six-month pilot in 2016 which saw patients who were eligible for a hearing aid attending classes before having a hearing aid fitted. This meant they felt more informed and confident about wearing and using their hearing aids and gave them support.

The pilot has also seen improved partnerships between organisations, improvements in repairs and battery supply, more patients being seen closer to home and the smoother transition of patients back into hospital when needed.
Performance Overview

Strategies for Achieving the Objectives continued

Map of Medicine

The Map of Medicine is an online package for GPs which gives them instant access to information to help them guide patients through their care. There are currently 94 local maps and over 120 referral forms. These provide details of how to access specialist services.

Cancer

One in five people with cancer are diagnosed after being admitted to hospital in an emergency. Survival rates for these patients are considerably lower than for those whose cancer has been diagnosed prior to emergency admission, for example as the result of an urgent referral by their GP. The longer it takes to diagnose and treat cancer in a patient the poorer their medical outcome is likely to be.

As a result a new assessment service has been set up, called the Macmillan Ipswich Diagnostic Assessment Service (MIDAS). (See case study page 37).

NHS Continuing Healthcare

NHS Continuing Healthcare (CHC) is for adult patients who are assessed as having an ongoing 'primary health need' that is arranged and funded solely by the NHS. The CHC team aims to achieve the best possible assessment and care for patients and ensure these are delivered locally in a fair and cost-effective way.

Changes made by the local CHC service in 2016/17 included:

- Improvements to the team to allow an effective, efficient service for patients and their families
- Development of robust monitoring and reporting processes to improve performance and ensure effective governance
- Public engagement events to answer questions about CHC
- Creation of a joint ‘task force’ at IHT to bring together health and social care teams so that more people could be discharged from hospital as soon as they were ready
- Training on the CHC assessment processes for colleagues from IHT, St Elizabeth Hospice and community healthcare teams
- The development of a CHC ‘Equity and Choice’ policy which outlines how the CCG will commission and fund care for individuals who have been assessed as eligible
- Working jointly with NHS North East Essex CCG to ensure a consistent approach in delivering the CHC Framework
- Working with partner organisations to develop the ‘Discharge to Assess’ model where CHC assessments are no longer conducted in acute hospital settings to enable the safe and appropriate discharge of patients (see pages 10 and 35)
- The implementation of a ‘quality and compliance’ self-assessment tool to support the CHC team’s quality improvement work
- Joining the NHS England CHC Strategic Improvement Programme, a country-wide initiative to improve the effectiveness and efficiency of CHC over the next two years, and
- Working with health, social care, care home and domiciliary care providers on the Care Homes Strategic Market Review to meet the care and support needs of people in Suffolk.

For more information on NHS Continuing Healthcare please visit our website.
Primary Care: Another significant focus has been to support member practices. We have created and planned for co-commissioning high quality and resilient primary care services. Our GP Forward View strategy, working with our colleagues in neighbouring West Suffolk CCG and North East Essex CCG, is a major step towards supporting member practices and ensuring patients get good access in the future.

Delegated commissioning

During 2016/17 our GP members indicated that they wanted to move towards delegated commissioning of primary care services. This means the CCG becomes accountable for buying and managing general practice services.

The GPs felt this would enable more primary care decisions to be made at a local level and ensure a better fit with other care services through increased partnership working.

The switch to delegated commissioning involved a significant amount of preparation around the legal and financial implications of the move, as well as consideration of how decisions would be made.

Support for general practice in Ipswich

GP practices in Ipswich tackle additional challenges to those faced by practices elsewhere in Suffolk.

The CCG has worked with practices in Ipswich to build a case for £249,000 additional resources to enable them to adopt different models of service delivery and support them to work together.

Care homes

In 2016 we reviewed our care homes specification, which gives GP practices investment to provide proactive care for care home patients. The review considered lessons learned in other parts of the NHS, including improved medicine reviews, in order to further improve the service.

Local enhanced services

A range of additional services commissioned from GP practices have been reviewed to ensure they provide value for money.

Personal Medical Services contract

A dashboard tool has been developed to help GP practices monitor how they are performing.

Learning disabilities

All GP practices are now signed up to deliver annual health checks for patients with learning disabilities with the aim of improving care. This included updating IT processes with details of how people wanted to be communicated with in order to meet the requirements of the Accessible Information Standard.

Estates

A local estates strategy has been developed with NHS Property Services. The CCG made a range of bids for funds to the national Estates and Technology Transformation Fund. A number of these were approved and work has already begun to deliver projects.

The CCG is involved in an innovative partnership with Ipswich Borough Council which is looking into the possibility of delivering a new GP hub in the town.

Ensuring a resilient primary care system

The CCG has worked with GP practices to address any issues that may impact on their ability to deliver services and has provided support in bids for ‘Vulnerable Practice Support’ and funding for the ‘Practice Resilience Programme’.
Strategies for Achieving the Objectives continued

**Medicine Management:** The CCG has adopted five core medicine management strategies in 2016/17 to ensure safe, high quality, cost-effective prescribing.

1. **Targeted practice engagement**
   Regular prescribing meetings were held with ‘over budget’ practices and increased medicines management training opportunities were offered. Prescribing support software has also been installed in 36 out of the CCG’s 40 practices.

2. **Medicines Management Team support**
   Practices and care homes were provided with monthly benchmarking data to enable effective individual decision making and peer review, with priority given to those that were ‘over budget’.

3. **Contractual requirements and reinvestment scheme**
   The Personal Medical Services Development Framework and the General Medical Services Local Enhanced Service Prescribing Incentive Scheme support GP practices to meet their prescribing budget. A reinvestment scheme has also been developed to enable safe, high quality, cost-effective prescribing, thereby reducing waste of medicines.

4. **Collaborative working**
   We have worked with providers including Ipswich Hospital NHS Trust, Suffolk Community Healthcare and the Local Pharmaceutical Committee to make improvements. A joint formulary has been created to promote cost-effective prescribing in primary and secondary care.

5. **Patient and public engagement**
   Advice was taken from Patient Participation Groups to help reduce medicinal waste and promote healthy living. This informed the two big campaigns below and many smaller ones too.

Every year in east Suffolk, approximately £2.1m is wasted on unused prescription medicine

- £630k worth is left unused in people’s homes
- £780k worth is returned unused to pharmacies
- £350k worth is thrown away unused by care homes
- £350k worth is wasted in other ways, including the cost of safe disposal

Once an unwanted medicine has left the pharmacy, it cannot be used even if it’s not been opened. By reducing the amount of medicines being wasted, we can increase the available funding for other health services.

OPEN THE BAG.
If you don’t need the medicine, hand it back to the pharmacist or delivery driver which means it can be used safely by someone else.

For more information visit: www.ipswichandeastsuffolkccg.nhs.uk

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Ipswich and East Suffolk Clinical Commissioning Group spent £1m on prescribed paracetamol last year. This is the equivalent of:

- 39 MORE community nurses
- 270 MORE hip replacements
- 66 MORE drug treatment courses for breast cancer
- 1,000 MORE drug treatment courses for Alzheimer’s
- 1,040 MORE cataract operations

The NHS belongs to you, use it responsibly.
Key Issues and Risks

The CCG’s Revenue Resource Limit (RRL) for the year ending 31 March, 2017, was £470.2million. This was based on a formula which takes into account factors such as the age and needs of the population served by the CCG as well as market forces.

Resources

The Ipswich and East Suffolk CCG and West Suffolk CCG are overseen by a single management delivery team headed by an Accountable Officer. Both CCGs are also served by a shared Chief Nursing Officer, Chief Finance Officer, Chief Contracts Officer, Chief Corporate Services Officer and Chief Redesign Officer.

Each CCG has its own dedicated Chief Operating Officer.

This structure has enabled the provision of:

- Dedicated support for the specific functions required of each CCG, its governing body, committees and membership
- Expertise in safeguarding, quality and safety, financial management and contracting, and
- Economies of scale through shared functions.

For more information on financial resourcing visit our website.

Risks and uncertainties

The principal risks and uncertainties relevant to the CCG during the course of 2016/17 are recorded and managed by the Governing Body Assurance Framework.

The following risks had not been fully eliminated by the end of the year, although clear plans are being drawn up to do so:

- Reduce cases of Clostridium difficile in line with national targets
- Re-design and commission services covered by the ‘Urgent Care’ and ‘Health and Independence’ reviews within required timescales
- A significant reduction in the capacity of GP services, affecting access times for patients, demand on other services and retention of clinical staff
- Meet the four-hour Accident & Emergency standard, presenting a potential risk to patient safety and experience
- The potential impact of service quality delivered by the Norfolk & Suffolk Foundation Trust (NSFT) - the Care Quality Commission’s re-inspection report of October 2016 gave NSFT an overall rating of ‘requires improvement’, however its ‘Are services safe?’ rating continues to be ‘inadequate’
- Poorly performing mental health services, and
- Comply with the Special Educational Needs and Disability (SEND) reforms.

The Governing Body manages principal risks with Risk Management Strategies and Organisational Frameworks which set out how risks are managed.

To see the Governing Body Assurance Framework visit the website.
The Ipswich & East Suffolk Clinical Commissioning Group delivered its key statutory and administrative financial duties during the financial year ending 31 March 2017 with a surplus of £7.57 million, against an overall Revenue Resource Limit (RRL) of £470.2 million.

This surplus was composed of £4.58 million which NHS England and HM Treasury required the organisation to hold in case of potential deficits elsewhere in the NHS. This requirement, combined with rising demand and costs locally, meant the savings required through Quality, Innovation, Productivity and Prevention (QIPP) schemes were significantly greater than they have been since the CCG was created.

The CCG was able to deliver the level of savings required thanks to a combination of factors including new ways of contracting with Ipswich Hospital NHS Trust and West Suffolk NHS Foundation Trust, improved performance in prescribing, and by managing to offset the anticipated rise in Continuing Healthcare costs, despite a nationally agreed 40% increase in the cost of Funded Nursing Care.

Throughout 2016/17 the challenges posed by the need to meet national performance targets have been even greater than those posed by the financial restraints placed on the NHS.

In spite of the national picture, local performance has remained relatively strong. While there are some targets which have not been met in full, such as the four-hour accident and emergency standard, the CCG continues to perform well and the majority of targets relating to cancer treatment waiting times and 18-week Referral to Treatment continue to be delivered.
**Performance Analysis**

**Sustainable Development**

**What is sustainable development?**

Sustainable development aims to balance the long-term social, environmental and economic needs of the present, without compromising the ability of future generations to meet their own needs. For the CCG, this means paying attention to our impact on the environment, and working to ensure we meet the diverse health and wellbeing needs of our population.

**CCG performance and achievements**

We commission healthcare services to protect and improve the health of current and future generations. We are committed to reducing carbon emissions, minimising waste and pollution, making the best use of scarce resources and nurturing community strengths and assets. Working with our partners we promote sustainability and carbon reduction in a variety of ways, from using teleconferencing and car sharing to developing opportunities for services within local areas.

In 2017/18 we will develop a Sustainable Development Management Plan (SDMP). This will set out our vision for becoming a leading sustainable organisation and explain how we intend to do this. It will determine how we respond to the current and emerging environmental, social and economic challenges posed by climate change to the healthcare estates and on patient health. In recent years these have included heatwaves, prolonged periods of cold, floods and droughts. Our SDMP will include an action to develop an ‘adaptation plan’ aimed at off-setting the future climate change risks which could affect Suffolk.

We will use the Good Corporate Citizenship assessment tool to monitor the less obvious benefits of sustainable development, which will be reviewed annually. We will join the Investors in the Environment Network, which supports organisations to reduce their direct reliance on energy and natural resources, thereby cutting costs and emissions. Based on our commitment to improving our environmental performance we hope to achieve Investors in the Environment ‘Silver Award’ accreditation in 2017/18.

Once our SDMP has been developed, an accompanying action plan will be included that will help us achieve our targets.

**Direct impacts**

We have direct control over our greenhouse gas emissions including building energy consumption, waste, water and sewage. Our employees create indirect emissions as a result of driving to and from work and home. Over the past year we have encouraged our employees to make sustainable travel choices and think about energy efficiency. Next year our Staff Health and Wellbeing Group will recruit ‘green champions’ and seek innovative ideas and feedback on the organisation’s working practices and environment. The group already supports the healthy workforce agenda, which aims to help staff remain healthy by providing access to initiatives that promote healthy lifestyles.

**Indirect impacts**

We aim to increase awareness of the need for carbon management and resource efficiency among our external suppliers and providers by developing sustainable procurement and through low carbon commissioning work. This will reduce the carbon footprint of our supply chain as well as helping to minimise vehicle pollution and reduce environmental damage. We have already taken steps to encourage sustainable transport by our commissioned services in our Procurement Policy. This policy includes the requirement for corporate social responsibility to be one of the key criteria used in assessing the suitability of potential providers.

Our day-to-day sustainability measures include:

- Reminding staff and visitors to turn off lights and to turn off their computers when not in use
- Encouraging staff to work electronically and only print when absolutely necessary
- Setting printers to double-sided
- Uploading papers for training and education events onto our website
- Providing recycling bins for paper and plastic
- Encouraging car sharing and use of public transport
- Promoting web or tele conferencing to reduce the number of cars on the road, lower carbon emissions and reduce the amount of the working day lost in travelling to off-site meetings, and
- Commissioning services that provide care closer to patients’ homes to minimise carbon emissions by reducing the distance that patients have to travel to health and social care appointments.
Performance Analysis

Improving Quality of Services

‘Leading Change, Adding Value (2016)’ is a framework for all nursing, midwifery and care staff which acknowledges the crucial role their professions have in closing the care and quality gap identified in the Five Year Forward View.

We have brought in new processes to monitor the quality of our commissioned services. These range from providing support to our contractors and, if necessary, taking action to hold them to account if and when issues affecting performance are identified.

The review process, led by the Chief Nursing Officer, includes developing and monitoring clinical standards in line with national guidance and best practice, assuring providers’ clinical governance arrangements, verifying quality accounts and reviewing all serious incidents and clinical investigations. Over the past 12 months these processes for monitoring service quality have been standardised across the CCG’s main providers and enhanced for smaller providers.

Where provider organisations are designated as failing, we do more to monitor and support, including:

- Engaging fully with regulatory improvement frameworks
- Offering shared expertise to enhance routine quality monitoring systems and processes within the organisation
- Regularly sharing intelligence with the provider, regulators and associate commissioners
- Constructively challenging existing or potential areas of concern
- Providing active support for the development of improvement plans and offering resources to monitor and test their implementation, and
- Carrying out increasingly frequent quality improvement visits focused on identified areas of concern.

The Chief Nursing Officer is also our lead for safeguarding children and adults.

Through the Transforming Care Programme the CCG has worked to bring individuals who had previously been given placements outside of Suffolk back into the county and to develop system-wide services to support them.

Over the past 12 months the support provided to care homes has been enhanced by a scheduled programme of Quality Improvement Visits (QIVs). These have also taken place at acute, community and mental health service facilities. The outcomes of these visits are made available to the public. Regular meetings take place with both Suffolk County Council and the Care Quality Commission to ensure that intelligence about care home providers is shared across the county. The Chief Nursing Officer and her team have also worked to provide increased support to primary care services regarding safeguarding children and young people. The Chief Operating Officer’s team has provided dedicated support to GP Practices before and after Care Quality Commission inspections as well as through wide-ranging training and education for clinicians and the management teams.
By encouraging the active participation of patients, carers, community groups and their representatives we can achieve better planning, delivery and quality of the services that we commission. This year we have started to create an Engagement Framework and Tool Kit which set out the way we engage with the population of Ipswich and East Suffolk to support our commissioning and makes sure this is appropriate and effective. This takes into account the area’s diverse population and the health inequalities we need to address. It also highlights the need for us to communicate with people from disadvantaged or vulnerable groups, as well as people who struggle to access our services. This will help us understand the impact our decisions have on different groups and individuals.

Our Engagement Framework and Toolkit will set out the need to:

- Clearly determine who we are engaging with, what is being proposed, what can be influenced and what are the likely costs and benefits of any proposal
- Ensure enough time is given to make sure feedback is received and considered as part of the decision making process
- Adapt our engagement activities and methods to meet the specific needs of different patient groups and communities
- Ensure our responses to engagement exercises are analysed, and
- Provide clear feedback to the public, reflecting their input.

We have strengthened our Community Engagement Partnership (CEP), a sub-group of the governing body whose members represent a number of groups and organisations within Ipswich and East Suffolk. The CEP’s aim is to make sure the public’s views are taken into account when we plan and develop services. Its members are also able to share their individual health care experiences. A CEP representative sits as a lay member on the Governing Body and has responsibility for overseeing our public engagement arrangements. This includes responsibility for chairing the Co-Commissioning Group.

During 2016/17 we supported the CEP in organising public discussions about in-vitro fertilisation, marginalised and vulnerable adults, mental health services, personal health budgets and Continuing Health Care.

We have strategic links with Healthwatch Suffolk, the voluntary care sector, the acute sector and Suffolk County Council, which enable us to better understand and respond to the concerns of our population. We work with Suffolk Health Scrutiny Committee to gain advice on areas where we think there will be service changes.

You can read more about how we involve patients, carers, community groups and the public in every stage of our commissioning process in the “Have your say” section of our website, which provides more information on how you can get involved in shaping NHS services. We also publish the results of all our engagement activity within this section of the website, along with an Annual Patient Engagement Report.

Ipswich and East Suffolk Patient Participation Group (PPG) Network meets regularly to give members of each practice’s PPG the chance to learn from each other and discuss important commissioning and local health issues. This helps to ensure the PPGs have the knowledge they need to function effectively, both at practice level and also in representing the views of their wider practice population to service commissioners.

The network has held presentations and discussions on a number of important issues over the year including the future of primary care, the CCG’s equality objectives and local community initiatives such as ‘Warm Homes Healthy People’, as well as organising events to help raise health care awareness. PPGs are always looking for new members, particularly from currently under-represented groups such as young people and those from minority ethnic groups. If you are interested in joining your practice’s PPG contact the practice manager, who will be able to give you more information.

All our stakeholder groups provide patient and public feedback on all aspects of service provision and on governing body decisions, as well as advising us on wider engagement issues.

We attended a number of community events and local forums during the year to obtain feedback from patients and members of the public on different health care related issues. Feedback from these meetings and outreach work in the local community has been used to shape the future of local health services, in particular in-vitro fertilisation and services for marginalised and vulnerable adults.
Specific work:

Care at Christmas - The ‘Stay Well This Christmas & New Year’ campaign was launched in December to provide information for patients on where to go for health advice when their GP practice was closed to help reduce demand on A&E. Leaflets were handed out at supermarkets and during late night town centre shopping evenings as well as being supplied to local pharmacies.

‘Feet on the Street’ - We were at 13 locations in Ipswich and across east Suffolk over the summer to obtain feedback from the public regarding proposed changes to IVF and MVA services.

Partnerships with Patients - Following two workshops involving GPs on the Clinical Executive Committee, chief officers and representatives from local patient participation groups and the Community Engagement Group, the CCG committed to adopting co-production and partnership working with patients across the organisation. To embed this we appointed trained champions within each directorate.

Young people - Our YEAH! (Youth Engagement and Health) group meets regularly to discuss how engagement with young people across the CCG area can be improved. The group has recently recruited a number of new members from local secondary schools and sixth forms within Ipswich and east Suffolk to help.

With support from the CCG the YEAH! group produces a newsletter for each term of the school year which includes help and advice for young people and information about what the group is doing to help improve local health services.

Migrant workers - We continue to work closely with community and voluntary organisations to support non-English speaking people and newly arrived migrant workers. We have visited a number of local groups to help increase their understanding of how to access local health services and to promote the use of pharmacies. We have also produced a number of easy-to-read leaflets to help non-English speakers look after minor injuries and use services wisely.

The CCG is one of eight organisations in the NHS Eastern region invited to send delegates to a three-day conference on migrant health being held in Maastricht, Holland. The conference is part of the European Local Authorities Integration Network (ELAINE), and provides an opportunity to connect with European health and social care organisations from Sweden, Spain, Holland and Denmark to discuss the integration of migrants and refugees.

Careers fairs - We have attended a number of careers fairs at local primary and secondary schools to promote the diverse job opportunities which the NHS offers.

PPG awareness events - We have supported GP patient participation groups in a number of areas in organising health events to raise awareness of local support services and organisations. These have included a ‘Dementia Awareness’ event at the Grove Medical Centre in Felixstowe, an open-to-all ‘International Health Road Show’ hosted by Burlington Road Surgery which focused on supporting people for whom English was not their first language and general health awareness events at Pinewood Surgery and Framfield House. A health day was also organised in Leiston in partnership with the local children’s centre to raise awareness of local support services.

Patient Partnership Conference - In May 2016 we hosted our first Patient Partnership Conference. The event provided the CCG and our partners from Ipswich Hospital NHS Trust, the Norfolk and Suffolk Foundation Trust and Suffolk Community Healthcare to present our forward plans and answer questions from an audience of 120 people. Group discussions led by GPs from our Clinical Executive Committee gave the public the chance to let us know how they would like to engage with the CCG in future and provide their views on finances, resources and management of waste within the NHS.
Local events - We attended a number of big local events including the Suffolk Show, the Indian Summer Mela and the One Big Multicultural Festival. This meant we engaged with large numbers of people about our over the counter, waste medication and ‘Think Pharmacist’ campaigns as well as to gather feedback about local health care services.

Flu clinics - We spoke to patients at flu clinics about our over the counter campaign. Partner organisations, including the Warm Homes Healthy People project, One Life Suffolk and the Ipswich Dementia Action Alliance also attended to provide information about their own services.

Debenham Girls Group - This is a youth group for young ladies aged between 18 and 25 with mild to moderate disabilities. We provided a range of activities promoting health care, independent living and exercise and nutrition, as well as a cookery workshop. One Life gave a presentation on the amount of sugar contained in soft drinks and the girls were encouraged to sit down with their parents and carers to discuss the importance of annual health checks and give feedback on their experiences of the NHS.
Performance Analysis

Reducing Health Inequalities

Our aim is to work with Public Health England to ensure we make high impact, cost effective interventions to combat health inequalities. We commissioned the Wellbeing Service, designed to help people experiencing stress and anxiety, this year. We also supported the Connect project, which aims to identify the causes of health inequality in local communities within Ipswich and east Suffolk and forge sustainable community partnerships. We have senior representation on the Joint Strategic Needs Assessment (JSNA) Steering Group to ensure health inequalities are clearly identified, recorded and acted on.

In recognition of our legal duty to reduce health inequalities we work closely with the Health and Wellbeing Board and Public Health England teams across our catchment area. Our strategic objectives are closely linked to those of the Health and Wellbeing Board, ensuring we contribute directly to the delivery of the Health and Wellbeing Strategy.

Health and Wellbeing Strategy

The Suffolk Health and Wellbeing Board is the key strategic leadership group for health, care and wellbeing. It is the forum where the CCG, together with Suffolk County Council and other partners from the local health economy, including the police, voluntary sector and Healthwatch Suffolk, work together to improve wellbeing outcomes. It is responsible for delivering the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.


The CCG’s strategic objectives are closely linked to the four key outcomes of the Health and Wellbeing Board, ensuring we contribute directly to the delivery of the Health and Wellbeing Strategy.

The four key aims are for every child in Suffolk to have the best possible start in life, to improve independent life for people with physical and learning disabilities, for older people in Suffolk to enjoy a good quality of life and for people in Suffolk have the opportunity to improve their mental health and wellbeing.

The CCG works with health and social care commissioners and statutory providers as key members of the Suffolk Joint Commissioning Group for Mental Health and Learning Disabilities, and the Children’s Joint Commissioning Group. Both report to the Suffolk Health and Wellbeing Board.

In the past year the following actions were identified:

- Improving services for children and young people through a co-produced strategy
- Launching the suicide prevention strategy, Suffolk Lives Matter, at an autumn conference
- Developing dementia services with service users
- Supporting Suffolk Minds Matters, the annual public health report with recommendations for improving people’s mental health
- Launching Wellbeing Suffolk, a service to support those with anxiety and depression, and
- Delivering public campaigns on Stay Well, salt awareness, flu inoculations and breastfeeding.
## Performance Analysis

### National Performance Measures 2016/17

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Reporting Frequency</th>
<th>Contractual Measure</th>
<th>Current Period</th>
<th>Current Period Target</th>
<th>Current Period Actual</th>
<th>Rolling 6 months</th>
<th>Latest Applicable Target</th>
<th>YTD Actual</th>
<th>Comments</th>
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<tbody>
<tr>
<td>EB1</td>
<td>The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>90%</td>
<td>71.2%</td>
<td>90%</td>
<td>76.4%</td>
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<tr>
<td>EB2</td>
<td>The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed non-admitted pathways</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>95%</td>
<td>93.7%</td>
<td>95%</td>
<td>94.8%</td>
<td>IESCCG</td>
<td></td>
</tr>
<tr>
<td>EB3</td>
<td>The percentage of Referral to Treatment (RTT) pathways within 18 weeks for incomplete pathways</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>92%</td>
<td>92.7%</td>
<td>92%</td>
<td>94.3%</td>
<td>IESCCG</td>
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<td>EB4</td>
<td>Diagnostic test waiting times</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>1%</td>
<td>0.4%</td>
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<td>1.8%</td>
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<tr>
<td>EB5</td>
<td>A&amp;E waiting time - total time in the A&amp;E department</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>95%</td>
<td>92.9%</td>
<td>95%</td>
<td>91.3%</td>
<td>IHT</td>
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<td>EB6</td>
<td>All Cancer 2 week waits</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>93%</td>
<td>95.5%</td>
<td>93%</td>
<td>95.3%</td>
<td>IESCCG</td>
<td></td>
</tr>
<tr>
<td>EB7</td>
<td>Two week wait for breast symptoms (where cancer was not initially suspected)</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>91.1%</td>
<td>91.1%</td>
<td>93%</td>
<td>91.5%</td>
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<td>EB8</td>
<td>Cancer day 31 waits: Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>96%</td>
<td>95.7%</td>
<td>96%</td>
<td>96.3%</td>
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<td>EB9</td>
<td>Cancer day 31 waits: 31-day standard for subsequent cancer treatments-surgery</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>94%</td>
<td>94.6%</td>
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<td>EB10</td>
<td>Cancer day 31 waits: 31-day standard for subsequent cancer treatments-anti cancer drug regimens</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>98%</td>
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<td>EB11</td>
<td>Cancer day 31 waits: 31-day standard for subsequent cancer treatments-radiotherapy</td>
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<td>EB12</td>
<td>Cancer day 31 waits: Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer</td>
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<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>85%</td>
<td>81.9%</td>
<td>85%</td>
<td>83.3%</td>
<td>IESCCG</td>
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<td>EB13</td>
<td>Cancer day 31 waits: Percentage of patients receiving first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service</td>
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<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>90%</td>
<td>100.0%</td>
<td>90%</td>
<td>94.6%</td>
<td>IESCCG</td>
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<td>EB14</td>
<td>Cancer day 31 waits: Percentage of patients receiving first definitive treatment for cancer within 62-days of a consultant decision to upgrade their priority status</td>
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<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>89%</td>
<td>92.2%</td>
<td>94%</td>
<td>95.7%</td>
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<td>EB51</td>
<td>Mixed Sex Accommodation (MSA) Breaches</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
<td>Mar-17</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>6</td>
<td>IESCCG</td>
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<td>EB52</td>
<td>Cancelled Operations</td>
<td>Monthly Mar-17</td>
<td>NHS EC Annex  B Measure</td>
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<td>0</td>
<td>4</td>
<td>0</td>
<td>78</td>
<td>IHT</td>
<td></td>
</tr>
</tbody>
</table>
Performance Analysis

Environmental and Social Sustainability Report

Information Technology

Through our involvement with the Suffolk Informatics Partnership we are improving partnership working, information sharing, governance and infrastructure.

This means:

• Our patients can receive the care and support they need to live healthier, happier lives
• We are able to provide the information and tools they require to take responsibility for their own health and wellbeing
• Our professionals are supported in delivering that care
• We work with partner organisations to provide joined-up health care for our patients
• We deliver safe, high quality and sustainable services regardless of location, organisation or care setting, and
• We continually challenge ourselves to find smart solutions to improve health and wellbeing in our communities.

The Information and Communications Technology (ICT) team has worked with a small number of GP Practices to trial new ‘e-consultation’ technology designed to improve patient access and support primary care (see case study on page 30). It will be working with more practices over the coming months.

The team has also worked with clinicians to introduce a tool to help them make decisions and continues to produce and launch new methods of working with healthcare providers. This has helped improve use of new communication tools, increased use of the Electronic Referral System (ERS) and increased the quality, accuracy and consistency of referrals across Suffolk.

GP practices, health care and social care teams share personal information across partner organisations safely and securely with patient consent in line with the Caldicott Principles. They can now view the medical records of temporary patients via the Summary Care Record, enabling simple and effective information sharing.

We have also begun working with other health and care organisations to prepare the ground for clinicians and practitioners to be able to work effectively from each other’s offices and buildings and on improved processes to free up their time. Clinical safety networks, technology networks and information sharing/governance networks have been created to support these new ways of working.
Performance Analysis

Equality and Diversity Report

While we are confident the NHS services we commission are fair and accessible to all, a person’s gender, age, race, disability, sexual orientation and religious beliefs will be a factor in their care.

In line with the Equality Act 2012 we use the national Equality Delivery System (EDS2) to ensure we and our providers deliver better outcomes for the people of Suffolk. This obliges us to make effective use of accurate data, communicate with our local population and to provide consistency and leadership in our equality agenda. Our actions are overseen by the lay member for patient and public involvement, two GP equality and diversity champions and a GP health inequalities lead.

Objective 1

Changes across services for individual patients are discussed with them, and transitions are made smoothly.

Score: Achieving

We have:

- Adopted a ‘Translation Policy’
- Maintained the Youth Engagement and Health (YEAH!) group
- Ensured GP practices have ways to record patients who require more help with communication, adhering to the Information Access Standard
- Sought patient feedback via our website and social media platforms, and through direct engagement and involvement with the public, and
- Toughened our Equality Impact Assessment tools and framework, which saw us actively find people using the Marginalised and Vulnerable Adults services for our engagement exercise in summer 2016.

Objective 2

Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds.

Score: Developing

We have:

- Focused on joining-up health and social care services
- Improved patients’ direct access to their records
- Learned lessons from public inquiries, Care Quality Commission reports and serious case reviews and put systems in place to make improvements
- Maintained clinical representation on the Suffolk Safeguarding Board, and
- Ensured that any complaints we have received have been dealt with fairly.

Objective 3

Senior* and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination

*this was previously ‘middle’

Score: Achieving

We have:

- Overseen the completion of equality and diversity training by all staff
- Ensured our employees have equality and diversity objectives in their personal development plans, and
- Ensured a patient story is heard at governing body level and broader GP surgery staff training events.
Dr David Egan
Lead for prescribing
Dr John Oates - Lead for integrated care and dementia

Dr John Flather
Lead for end of life, care homes and diabetes

Dr Christopher Rufford
Lead for self-care and prevention

Dr Ben Solway
Lead for children and young people, safeguarding, alcohol and substance abuse and marginalised vulnerable adults (MVAs)

Dr Peter Holloway
Lead for planned care and cancer

Dr Juno Jesuthasan
Lead for map of medicine, communications and website, IT and strategy, training and education and black & minority ethnic (BME)
Case Studies

Continuous Improvement

Care homes - working in partnership

Like the rest of the country, Suffolk has an ageing population and is seeing more people diagnosed with more than one condition which they are likely to have for the rest of their lives.

Charged with improving the health and wellbeing of residents in the area’s 104 care homes, the East Suffolk Care Homes Forum was formed in 2016. The forum brings together the CCG and Suffolk County Council, care home representatives, Ipswich Hospital NHS Trust, Suffolk Community Healthcare and out-of-hours service providers.

The care home sector already does a lot of good work in east Suffolk. The forum has built on this by meeting regularly to share ideas, support care providers and promote greater levels of partnership working so that we can tackle any issues that arise collectively.

Another key aim is to reduce the number of avoidable, unplanned hospital admissions of care home residents by encouraging greater independence among residents and letting them have a greater say in how and where they are treated. This often sees more appropriate care out of hospital and it also reduces the number of 999 calls.

‘My Care Wishes’ documents hold all decisions residents make about their end-of-life care, including their preferred choice of treatment and where they wish to die. We are working with a number of care home providers, GP practices and local hospices to develop this further.

The forum, which runs bi-monthly and is facilitated by the CCG, is hosted by care homes and held at different locations across the CCG area. This collaborative approach encourages a shared ownership of the work projects which emerge from forum meetings. Part of the CCG’s role is to be responsive to the needs of the care home sector so they can provide high quality compassionate care.

To date more than 20 care home providers responsible for around 70% of homes in east Suffolk are represented through the forum, including the three largest providers. A similar forum is being launched in west Suffolk following the successful conclusion of a pilot project in June.

Current projects being undertaken by the east forum include:

- co-design of the discharge template to aid speedier discharge
- a ‘falls post-action protocol’ to support decision making
- consultation with providers on ‘do not resuscitate’ best practice guidance
- a pilot project on ‘education in continence care’
- a study of antibiotic usage in care homes, and
- support for the prescribing of homely remedies.

Dr John Flather, care homes lead for NHS Ipswich and East Suffolk CCG, said:

“By bringing together this mix of skills, experience and ideas the East Suffolk Care Homes Forum is another step forward in delivering better care for our elderly population and making sure their later years are as happy and healthy as possible.”
Pharmacies are well placed to give advice on the treatment of minor illnesses, and many medicines are available to buy without the need for a prescription.

To increase public awareness about the services pharmacies can offer a publicity campaign was launched to explain how people could best look after themselves without putting more strain on NHS resources.

We reached a wide audience by using social media, a film, leaflets and posters which were handed out at events such as the Suffolk Show. GP practices helped direct patients with minor ailments to their local pharmacies as well as displaying campaign posters and leaflets in their waiting rooms. Business cards with the contact details of the Patient Advice and Liaison Service were also distributed to all GP practices to further support the campaign and gather patient feedback.

Seeing their local pharmacist can help patients because:

- There is no need to make an appointment to speak to a community pharmacist, and many open for extended hours, improving access to healthcare advice.
- GP practices are able to use their appointments for seeing patients who are very ill or have long-term conditions, thus improving the health of the local community, and
- The savings made as a result of patients purchasing their own medication for minor ailments can be ploughed back into local NHS services.

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Dr David Egan, a GP in Debenham and prescribing lead for NHS Ipswich and East Suffolk CCG, said:

“We are actively encouraging people to take greater control over their own health care more. We’ve worked with GPs to promote more effective prescribing and highlighted that patients visiting their local pharmacy, rather than the GP, can mean getting better sooner.”
NHS Continuing Healthcare (CHC)

The NHS Continuing Healthcare (CHC) team in Suffolk is responsible for commissioning care for nearly 600 patients across Suffolk.

People who are eligible for CHC usually have complex, intense and unpredictable health needs which means the NHS funds their entire care package or care home placement.

The CHC clinical team consists of one team of nurses who visit people to assess their eligibility for CHC funding, and another who carry out case management work with patients and their families to commission, oversee and monitor their care packages or the placements the CCG has commissioned for them.

For example, a man in his 70s with terminal Motor Neurone Disease (MND) who had been assessed and deemed eligible for CHC, asked to be looked after at home.

People with MND often have very complex health needs, particularly in relation to their breathing. Concerns were raised with him about how this could be managed safely at home and he agreed that he might need to consider being cared for in a nursing home. The CHC team approached several nursing homes to find a placement for him but this proved difficult as none of them were close enough to his family.

Eventually the team were able to commission a home care package that addressed his needs and was clinically safe so that he could live with his wife and be looked after at home. The man has repeatedly told the CHC team that his care package is working very well for him and his family.

Question Time

Between April and December 2016 a series of events were held across the CCG’s area to give members of the public the opportunity to find out more about CHC and personal health budgets (PCBs).

Experts from the CCG team gave an overview of application procedures and explained how an individual’s eligibility for funding is assessed. They were also on hand to answer any questions from the audience.

It is hoped such events will increase understanding and awareness around CHC and PCBs so that more long-term care commissioning plans can be planned with patients and their families.

Dr Imran Qureshi, a GP in Leiston and NHS Continuing Healthcare Lead for NHS Ipswich and East Suffolk CCG said:

“Over the last year we have worked hard to raise awareness of NHS Continuing Healthcare and personal health budgets. We want people to know what help and support is available and make it as easy as possible to access. A personal health budget makes healthcare much more patient focused and delivers extra patient choice, as well as enabling health professionals to work more closely with patients, resulting in improved health outcomes.”
Case Studies

Collaboration

Electronic Consulting in Primary Care

The CCG has been exploring the possible benefits of using technology in primary care to help people get appropriate help.

Electronic consulting allows patients to describe their symptoms to their own practice securely using their smartphone or home computer. The information can then be reviewed by a clinician who decides what action to take. This can include offering patients prescriptions or arranging a telephone or face-to-face consultation.

Early work has shown that patients are guaranteed a response from their GP practice within a defined time and, if necessary, are usually offered a telephone or face-to-face consultation the same day. GP practices are able to manage patients more easily and quickly as a result.

The cost of providing electronic consulting is about £1 per patient per year.

Two GP practices began piloting the use of two alternative electronic systems - eConsult and askmyGP - in early March. Two more are due to join the pilot in April. The pilots will be regularly assessed to monitor patient experience.

Dr Juno Jesuthasan, senior partner at Barrack Lane Medical Centre and communications lead, said electronic consulting had potential. He said:

"Technology can do a great deal to make sure that patients are still getting advice and support for their symptoms from the right member of the team, without necessarily the need to come into the practice. While this is early days, our CCG wants to explore every possible avenue of improving online services for patients for the future."
Case Studies

Collaboration

Crisis Action Team

When people come into hospital, some of them can go home much earlier if they get more support.

With that in mind, the Crisis Action Team (CAT) offers support and treatment to people in their homes with regular visits.

One such patient was a 96-year-old lady who came into Ipswich Hospital NHS Trust’s A&E Department. She was not eating well and this had led to a gradual loss of strength.

The lady was referred by the Lead Integration Nurse to CAT, and was visited two hours after getting home. She was booked in for a medical review with a team that assesses frailty and capability at a unit in the hospital. Arrangements were made with a geriatrician for a further eight-week follow-up appointment at that unit.

The CAT team visited the patient twice a day to supplement her existing daily care package and help her back to independence, and British Red Cross visited her at meal times to help her learn how to cook for herself again. After four days she declared herself happy to be discharged from CAT’s care. At the eight-week Frailty Assessment Base (FAB) review she had made significant improvement and reported that she was feeling well and able to live fully independently again.

Feedback received from CAT patient carer (Jan 2017):

“Everything was very well organised, supportive and fashioned to our need. Every staff member has been sensitive to her needs and treated her with love and compassion. I have been completely comfortable with the care and have appreciated all the help.

“They have shown care and professionalism. They are always cheerful and have helped me to come to terms with the difficulties I have suffered caring for my wife. Anyone relying on the CAT service won’t go far wrong. I would recommend them to anyone.”

Dr John Oates, a GP at Saxmundham Health and integrated care lead for NHS Ipswich and East Suffolk CCG said:

“The Crisis Action Team is a really positive initiative which is enabling better working between health and social care services. More people are being given the help they need to live independently for longer which is reducing the number of unnecessary hospital admissions.”
**Case Studies**

**Collaboration**

**Police Triage Service Collaboration**

**Case Study 1:**

A young woman who had stopped taking her medicine to manage her mental health started leaving lit candles and cans of beer on other people’s doorsteps.

Suffolk Police control room contacted the Police Triage Service (PTS) as members of the public were concerned for her welfare. The triage nurse had concerns that this behavior could be an early warning sign of deteriorating mental health.

The triage nurse was able to work through the police control room to contact a member of the woman’s extended family to ask about her current state of mind and establish whether or not she presented a risk of danger to herself or others. They informed her that she had been prescribed medication but told her that she no longer needed it. The nurse was able to contact mental health services and to arrange a ‘transfer of care’ to Suffolk.

The triage nurse arranged an urgent appointment with a psychiatrist from the mental health team for the woman. Her condition is now being well managed and she is in contact with all relevant services.

**Case Study 2:**

A man who had previously been known to mental health services was reported missing from home by his social services support team.

They were worried as the man, who had been assessed on several occasions but showed no evidence of mental illness, had contacted NHS 111 stating that he intended to harm himself.

The triage nurse was able to provide support, advice and guidance to assist officers in their dealings with the man, thereby reducing the amount of time they spent looking for him. The man often contacted the health services throughout the day to inform them of his whereabouts and what he was doing.

Later the same day members of the public called police to say the man was at an increased risk of harm.

The triage nurse in the control room was made aware and continued to provide support, advice and guidance to officers, as well as advising on the best use of their Mental Health Triage (MHT) car. The police despatched the MHT car so the nurse could check that there had been no significant change to his health. The nurse was able to establish that his claims to want to harm himself were down to frustration at his current social circumstances and did not indicate a real intention to do so.

As a result the police did not have to use their powers under Section 136 of the Mental Health Act to deal with the man, as they had felt compelled to do repeatedly on previous occasions. Instead he was supported to explore better ways of having his social needs met.
**Case Studies**

**Collaboration**

**Procurement**

The CCG ensures that patient representatives are engaged during all procurement exercises.

Patients and carers provide valuable insight which, when considered alongside that of experienced professionals, gives a more rounded view of what constitutes a good service.

Following a very wide engagement programme to develop our dementia services, two patients were then invited to help select the service provider - the carer to an individual with dementia and a representative with the early stages of dementia themselves. Both played a full part in evaluating the service’s proposals which influenced the final outcome.

The new service was launched in March 2017 (see page 39).

**Care Homes Strategy Development**

The CCG, working in partnership with Suffolk County Council, is developing a five-year strategy for the commissioning of care homes (residential and nursing homes).

This began with an independent market research organisation being tasked to undertake a wide-ranging review of available data, evidence and opinion.

Patients and carers, as well as organisations which represent both, were engaged extensively and identified the need for comprehensive but straightforward guidance for individuals on their rights regarding care options.

A working group, which includes representation from Healthwatch Suffolk and the voluntary sector, has been set up to develop information for carers and service users, whose input will be requested and considered prior to publication.
Case Studies

Collaboration

Sustainability and Transformation Plan

Some 26 public organisations and GP representatives from across Suffolk and north east Essex helped put together the Sustainability and Transformation Plan (STP), a range of proposals aimed at maintaining services and improving clinical quality within the CCGs' budget for the next five years.

Members of the public made clear during the engagement process their wish for public sector services to be made simpler and, where possible and practical, delivered closer to their homes. Their views were used to help create more than 40 different cost saving plans.

Our STP has replaced competition with collaboration. By working more closely with partner organisations we want to ensure that the one million people in our catchment area will be living healthier, happier lives by 2021, and that they are better supported to take responsibility for their own wellbeing.

Under the joint-leadership of Isabel Cockayne, our Head of Communications, and Healthwatch Essex Chief Executive Tom Nutt, we launched our proposals on 20 November 2016. This consisted of a four-page summary and an 18-page guide which included case studies supplied by our partners. These can be found on the Healthwatch Suffolk, NHS Ipswich & East Suffolk CCG and North East Essex CCG websites.

A film explaining our STP can be found at: http://www.healthwatchessex.org.uk/news/healthwatch-harriet-grills-nhs-bosses/

Dr. Mark Shenton, Chairman of Ipswich and East Suffolk CCG and GP at Stowhealth, said:

“It is crucial that we plan for the future of health and care services. Nationally and locally we are seeing the signs of rising numbers of people asking for appointments and further treatment, with fewer doctors and nurses able to deliver. Our work has built trusting relationships to help us create better quality services and which will be more sustainable in the future.”
Collaboration

Discharge to Assess (D2A)

In a bid to help improve and support patients to leave hospital safely, Healthwatch Suffolk gathered feedback from patients, front line health and social care staff providers, care homes, care agencies, equipment suppliers and transport providers.

This partnership approach was set up to check out the quality of the Discharge to Assess (D2A) pilot.

Healthwatch Suffolk then carefully examined a small number of cases where patients met the criteria for the D2A pilot to evaluate the quality of their care provision.

Patients were asked about their experiences of D2A, whether their care felt coordinated, whether they and their carers or families felt involved in the decision making process and whether they were able to recover and retain their independence within their own homes.

The lessons learned during this exercise are currently being collated and will be used to shape future good practice to enable services to be tailored to meet the needs of individual patients and carers.

Dr Selina Lim, consultant interface geriatrician with the Ipswich Hospital NHS Trust, said:

“It’s good to be working on a project where collaboration and integration have already made a real difference and are not just buzz words.”
Case Studies

One Clinical Community

Safe, Sustainable, Inspiring

In the autumn of 2016 the CCG took the next step in bringing together clinicians from primary and secondary care as part of the ‘One Clinical Community’.

In November GPs from across Ipswich and east Suffolk met with secondary care consultants from Ipswich Hospital NHS Trust to consider what a successful ‘clinical community’ should look like, what outcomes they wanted to see for both staff and patients, and how transformation could be achieved by working together. Approximately 180 clinicians took part in the summit and the issues raised will form the basis for future work on the project.

Clinicians agreed to:

• Take control of their work to be as efficient and effective as possible
• Focus on how to achieve the best outcomes for patients by understanding what is achievable for them and setting priorities
• Ensure they worked together to consider what is best for their patients and colleagues as well as themselves
• Empower patients to better understand their condition and what they can do to help themselves
• Make time to improve what they did and how they did it.

One of the biggest themes to arise from the first summit was communication, which was identified as a key element in improving patient care and patient experience.

Dr Juno Jesuthasan, GP lead for communications and website, IT and strategy and training and education said:

“GPs engaging more closely with hospital consultants is vital to delivering great patient care and attracting new clinicians to our area. It was really good to meet the consultants and share ideas. The patient is at the centre of all that we do.”
Case Studies

One Clinical Community

Macmillan Ipswich Diagnostic Assessment Service (MIDAS)

A local Cancer Diagnosis in the Acute Setting (CADIAS) survey identified a significant number of cancer patients who had repeatedly attended their GP practice complaining of non-specific, vague symptoms prior to being diagnosed.

In response to this a new assessment service has been set up at Ipswich Hospital NHS Trust. MIDAS offers a route to treatment for patients who have symptoms that may indicate cancer. The service is run by a GP working in partnership with a hospital-based oncologist. Public engagement took place regarding development of the service which considered the type of information patients who are referred to it should receive, as well as how the advantages of early and direct access to diagnostic tests should be communicated.

For example a 73-year-old who was suffering from breathlessness was diagnosed with cancer after undergoing a precautionary CT scan.

The scan was arranged despite no concerns being raised after the patient underwent a routine x-ray.

Dr Peter Holloway, a GP in Mendlesham and cancer lead for NHS Ipswich and East Suffolk Clinical Commissioning Group said:

“The introduction of this service is a really positive step forward in improving the rate of early cancer diagnosis, meaning patients can start treatment as quickly as possible and have the best chance of making a good recovery. The tests can equally rule out a diagnosis of cancer, relieving the burden of worry on the patient.”

Musculoskeletal Care

A patient referred themselves to community physiotherapy complaining of a long history of pain and pins and needles in their right hand following a wrist fracture. They were seen by a physiotherapist at the Riverside Clinic in Ipswich as an urgent appointment because the patient had started to feel weakness in the wrist.

During the assessment, the physiotherapist suspected it was a problem with a pinched nerve, called Carpal Tunnel Syndrome. An appointment was booked for two weeks later at Ipswich Hospital with an Enhanced Scope Practitioner (ESP).

When the practitioner saw the patient, they asked a consultant to check the symptoms at the clinic. This meant the patient did not have to wait for nerve conduction studies and instead was scheduled for a Carpel tunnel release later that same week. Feedback from patient was really positive, with staff being described as “very friendly and supportive”.

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Case Studies

Co-production / A partnership with patients

Patient Participation Groups

Our twice monthly network meetings are attended by representatives from GP practice Patient Participation Groups (PPGs) across Ipswich and east Suffolk.

These provide the opportunity to share experiences and ideas on how patients can support their local GP practices and get involved in commissioning and local health issues.

Throughout 2016 we supported several PPGs to host a number of health awareness events, including an ‘International Health Road Show’ at Burlington Road, a dementia awareness event at The Grove and health awareness days at both Framfield and Pinewood practices.

An event was also held to mark the official opening of the new Two Rivers practice which included tours of the new building, the opportunity to meet some of the centre’s healthcare professionals - including GPs and practice nurses - and the chance for local people to learn more about the work the practice staff do to help its 25,000 registered patients stay well.

At all of the events local voluntary and community organisations, including One Life Suffolk, Suffolk Family Carers, Healthwatch Suffolk and ActivLives, were on hand to provide advice about the local services available to support patients and local communities and enable and encourage them to live healthier and more active lives.

Pauline Quinn, IESCCG patient and public involvement lay member, said:

“The CCG aims to be patient-focused. Involving, listening to and working alongside patients is a significant ambition. Important steps have been taken this year, with patients and the public willingly contributing to partnership working.”
Case Studies

Co-production / A partnership with patients

Dementia

A new service called ‘Dementia Together’ has been co-designed with service users in a bid to simplify the current dementia pathway.

The service aims to help people with dementia and their carers identify and access the support they need more easily, to help them plan for their future, avoid crises and be supported to live well for as long as possible in their own homes.

Dementia Together is for anyone diagnosed with, or suspected of having dementia, those who are worried about associated communication, comprehension or memory issues, and their family carers. A helpline operates seven days a week to provide a single point of access to the service.

The service aims to help people understand dementia and make them aware of the preventative steps that can be taken to minimise its impact, as well as raising awareness of the needs of dementia sufferers to help them stay connected with their local communities and friend and family networks.

Dementia Together will be delivered by Sue Ryder in partnership with the Norfolk and Suffolk Dementia Alliance, the University of Suffolk and Purple Tuesday, who will be developing a dedicated user-friendly website linked to the service.

The new service will replace the existing post-diagnostic dementia support service for Suffolk, which is due to end on 31 March.

Jo Marshall, Sue Ryder’s Neurological Centre Director, said:

“We are very excited to be working together with such a range of organisations. What unites us is a shared passion to make a positive difference to the lives of people who are affected by dementia, including family carers.”

Dr John Hague, GP lead for dementia and governing body member, said:

“This new service will bring together a huge amount of information about the services and support available to people affected by dementia into one place, making it easier for them to get the right help to meet their needs.

“We hope that by empowering patients and their families, and giving them the right information and support, we can help them live well with dementia and stay independent for longer.”
Case Studies

Co-production / A partnership with patients

Public engagement

The CCG announced in June that it was in danger of failing to meet its financial targets for 2016/17 unless it acted decisively to reduce its costs.

A huge amount of work took place to identify where savings could be made across every single contract. At the same time a wide-ranging engagement exercise took place to find out what the public thought about the CCG’s provision of fertility services, outreach clinics for vulnerable people with chaotic lifestyles, and how the NHS could save money.

Between 19 July and 9 September, 2016, 22 events were held involving CCG employees, GPs and Healthwatch Suffolk, which resulted in 1,400 public responses. The Health Scrutiny Committee and Health and Wellbeing Board also involved in these events.

The CCG’s communications and engagement teams carried out regular reviews of the information gathered and identified that more responses were required from people who had actually used these services. As a result, focus groups were set up and outreach clinic visits arranged to gain further insight.

An independent assessment of the engagement exercise was commissioned to help structure the public responses into themes and the feedback gathered reported back to enable the governing body to make its final decisions regarding funding of these services at its meeting in January this year.

The CCG subsequently decided to continue offering two cycles of in-vitro fertilisation to women aged between 23 and 40, and to adopt a strategic approach to supporting marginalised and vulnerable adults such as the homeless and refugees.

What would you do to save money in the NHS?

The public’s response to being asked this question ranged from encouraging people to purchase medication from pharmacies at their own expense more often, to suggesting ways in which the organisation of the NHS itself could be changed. Regarding the latter, taking action to reduce waste was a subject people seemed particularly keen the NHS should address.

These are a few of the examples of our campaigns to reduce waste:

- Every year in east Suffolk, approximately £2.1m is wasted on unused prescription medicine
  - £430k worth is left unused in people’s homes
  - £760k worth is returned unused to pharmacies
  - £135k worth is wasted in the cost of safe disposal

Once an unwanted medicine has left the pharmacy, it cannot be used even if it’s not been opened. By reducing the amount of medicines being wasted each year, we could increase the available funding for other health services.

Paracetamol

Please don’t request paracetamol on prescription

Ipswich and East Suffolk Clinical Commissioning Group spent £1m on prescribed paracetamol last year. This is the equivalent of:

- 39 MORE community nurses
- 270 MORE hip replacements
- 66 MORE drug treatment courses for breast cancer
- 1,000 MORE drug treatment courses for Alzheimer’s
- 1,040 MORE cataract operations

The NHS belongs to you, use it responsibly.
Section 2
The Accountability Report
In partnership with member practices the CCG has developed a strategy to guide the development of primary care.

The key elements of the strategy include:

- Developing a new Model of Care to encourage primary care partnership working and deliver joined up care across Suffolk
- Reducing workload and optimising patient care
- Caring for every professional and every patient
- Improving patient access to GP-led services to support patients and promote self-care
- Creating environments for future care needs by enabling digital connectivity for patients and professionals
- Stimulating transformation by delivering high impact changes, and
- Co-producing strategy and plans with clinical leaders, patients, members of the public and our partners to enable excellence in delivery with management support.

This strategy has been further developed through our GP Forward View Operational Plan, which NHS England has rated as “green”.

Every year the CCG takes part in a national ‘360 stakeholder survey’ which is run by IPSOS Mori. The survey helps the CCG develop internally and improve its relationships with others. Some 78% of stakeholder groups responded to the survey.

Of those stakeholders who responded:

- 85% reported a good working relationship with the CCG
- 94% said they had been engaged ‘a great deal’ or ‘a fair amount’, up 10% on the previous year
- 71% were confident the CCG had acted on feedback it had been given about the quality of services
- 68% had confidence in the CCG to commission high quality services for the local population
- 61% knew of the CCG’s plans and priorities and almost half said they had been given the opportunity to influence them
- 65% felt there was clear and visible leadership from the CCG, and
- 84% said that if they had concerns about the quality of local services they would feel able to raise their concerns with the CCG.

While the results of the 2016/17 survey are encouraging we know we still need to do more and will draw up an action plan to make sure that we deliver on this.

Specific focus will be placed upon clearly demonstrating where action has been taken in response to queries or concerns, enhancing engagement in the development of plans and priorities, and ensuring the visibility and accessibility of the whole leadership team.

Dr Ed Garratt
Accountable Officer,
Ipswich and East Suffolk
Clinical Commissioning Group
23 May 2017
This section sets out details of the member practices of the CCG, together with the composition of each of the Membership Bodies.

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NHS Ipswich and East Suffolk Clinical Commissioning Group - Annual Report 2016/17

Corporate Governance Report - Members’ Report

Composition of Governing Body

The Governing Body Membership is made up of 9 men and 7 women.

Dr Mark Shenton
GP in Stowmarket, Chairman

Dr Mark Shenton, a GP at StowHealth in Stowmarket, is the Chairman of the Governing Body of NHS Ipswich and East Suffolk CCG and Clinical Lead. He is the Clinical Lead for ensuring high quality services, a thread through all of our programmes. Dr Shenton has been involved with practice-based commissioning since 2005, which has given him a valuable insight into the process of commissioning services which meet the needs of local people. He also has experience of working at both Ipswich and West Suffolk hospitals.

Dr Michael McCullagh
Clinical Executive Member

Dr Michael McCullagh is a GP at Orchard Medical Practice in Ipswich and has been a GP for 25 years. Dr McCullagh has previously been the children and young people (CYP) lead member of the Clinical Executive as well as the clinical governance lead of Ipswich Primary Care Trust. His other related interests include medical education, health economics and research.

Dr John Hague
GP in Ipswich

Dr John Hague is a GP at Derby Road Practice in Ipswich and he is a member of the Governing Body and Clinical Executive. He is the clinical lead for mental health and learning disabilities.

Dr Billy McKee
GP in Felixstowe

Dr Billy McKee is a GP at Walton Surgery in Felixstowe. He is a member of the Governing Body and Clinical Executive and is lead for improving stroke services.

Dr Ed Garratt
Accountable Officer

Dr Ed Garratt is Chief Officer for both the NHS Ipswich & East Suffolk and NHS West Suffolk Clinical Commissioning Groups. He was previously Chief Operating Officer of the NHS West Suffolk CCG and has worked in the NHS for more than 10 years, both at a regional level in commissioning and helping to develop the NHS Constitution. He also worked on the policy development associated with the government’s NHS reforms of 2012. Dr Garratt holds a Doctorate from the University of Cambridge.
**Corporate Governance Report - Members’ Report**

**Composition of Governing Body continued**

### Dr Imran Qureshi
GP in Leiston, Clinical Executive Chair

Dr Imran Qureshi is a GP at Leiston Surgery. He is a member of the Governing Body and Chair of the Clinical Executive. He is the black and minority ethnic lead for the CCG and also works to improve both planned and integrated care. Dr Qureshi is the Lead Governing Body member for sustainability.

### Barbara McLean
Chief Nurse

Barbara McLean is Chief Nurse, with responsibility for improving quality and patient experience. A qualified nurse, she has also served as Chief Executive Officer and Executive Nurse for the Cambridge and Peterborough NHS Foundation Trust and as Director of Nursing for the Suffolk Mental Health Partnership.

### Lesley Macleod
Chief Finance Officer

Lesley Macleod is Chief Finance Officer for both the NHS Ipswich and East Suffolk and NHS West Suffolk Clinical Commissioning Groups. She joined the CCGs in May 2016 on a fixed-term contract, reprising a role she performed in 2012 prior to authorisation. Prior to re-joining us Lesley worked for a number of other CCGs across the country.

### Dr Lorna Kerr
Secondary Care Doctor

Dr Lorna Kerr is the secondary care doctor member of the Governing Body. Dr Kerr is a full time anaesthetic consultant at the Norfolk and Norwich Hospital (with a special interest in paediatric and spinal anaesthesia) since 1993. She has a broad knowledge of secondary care having been a Clinical Director and Chairman of Consultant Staff Committee.

### Maddie Baker-Woods
Chief Operating Officer

Maddie Baker-Woods joined NHS Suffolk in 2009 as Head of Corporate Policy and subsequently as Deputy Director of Primary Care before taking up the position of Chief Operating Officer for the CCG in April 2013. Prior to joining the NHS, Maddie spent ten years working with business and Government on welfare reform as Director of the London Employers Coalition and Director of Policy for the National Employment Panel. Prior to this, Maddie was Associate Director for Economic Development of an international consultancy firm.
Amanda Lyes is the Chief Corporate Services Officer and has a NHS career spanning 20 years. Although professionally qualified in Human Resources, her profile now encompasses IM&T, corporate governance, information governance as well as HR. Amanda’s strengths lay in the field of change management, organisational development and employee relations. She is passionate about delivering a high standard of service. She is an experienced Board member having held Board level positions in two other NHS organisations, is a Fellow of the Chartered Institute of Personnel and Development and holds a MSc in Human Resource Management.

Amanda Lyes
Chief Corporate Services Officer

Jan Thomas is the Chief Contracts Officer for Ipswich and East Suffolk CCG and West Suffolk CCG. Jan has over 20 years’ experience working in and with the NHS. Starting her career as a nurse, she has worked in acute NHS hospitals and senior roles in the private sector healthcare. Jan is focused on ensuring that the care received by the people in Suffolk is the best care possible and that service users are put at the centre of decisions made by the CCGs.

Jan Thomas
Chief Contracts Officer and Deputy Accountable Officer

Richard Watson joined the CCG in January 2015 as the Chief Redesign Officer for Ipswich and East Suffolk CCG. He has worked across the NHS and local government in a variety of roles most recently at NHS Enfield CCG where he led on the redesign of clinical services across the borough. He has also been an elected local councillor and cabinet member within a London borough where he led on community safety, leisure and libraries. He is passionate about improving outcomes and his strength lays in managing complex service redesign in partnership with other stakeholders.

Richard Watson
Chief Redesign Officer

Graham Leaf was previously a Non-Executive Director of NHS Suffolk. He is Vice Chair of the Governing Body and Chair of the Audit Committee and the Remuneration and Human Resources Committee. His background is in Industrial Engineering and Business Management. He has been responsible for the overall management, strategic direction and financial performance of numerous private sector companies since 1991.

Graham Leaf
Vice Chair and Audit and Governance Lay Member

Composition of Governing Body continued
Pauline Quinn has an extensive background of Nursing at Ipswich Hospital, the Royal College of Nursing and the Ombudsman’s Office. Her personal experiences of community and hospital services have allowed her to call on her knowledge and expertise to have a distinctive perspective on the quality and impact of health care provision in the area. Pauline has a particular interest in the needs of older people and vulnerable groups and would like to ensure that they have equal access to healthcare. As a nurse she was a proponent of partnership working to ensure maximisation of potential, dignity and that the voices of the service user is at the centre of development of services. Pauline is a member of the Patient Participation Group at her local practice and was also a lay member at the West Essex Clinical Commissioning Group.

Steve Chicken has held senior roles in a number of global manufacturing businesses and is a specialist in continuous improvement. He and his family have lived in Suffolk for 17 years.
## Key Committees

### Clinical Scrutiny Committee
Maddie Baker-Woods  
Steve Chicken  
Dr David Egan  
Dr John Flather  
Dr Ed Garratt  
Dr John Hague  
Dr Peter Holloway  
Dr Juno Jesuthasan  
David Kanka  
Dr Lorna Kerr  
Graham Leaf  
Amanda Lyes  
Dr Michael McCullagh  
Dr William McKee  
Barbara McLean  
Lesley MacLeod  
Dr John Oates  
Pauline Quinn  
Dr Imran Qureshi (Chair)  
Dr Christopher Rufford  
Dr Mark Shenton  
Dr Ben Solway  
Jan Thomas  
Richard Watson

### Commissioning Governance Committee
Dr Ed Garratt  
Dr Lorna Kerr  
Graham Leaf  
Lesley MacLeod  
Pauline Quinn  
Jan Thomas

### Remuneration and Human Resources (HR) Committee
Graham Leaf  
Dr Michael McCullagh  
Pauline Quinn (Reserve)

### Joint Suffolk CCG Group
(Committee of West Suffolk CCG and Ipswich and East Suffolk CCG)
- Bill Banks  
- Dr Christopher Browning  
- Dr Ed Garratt  
- Graham Leaf  
- Dr Mark Shenton  
- Martin Smith (Independent Chair)

### Financial Performance Committee
Dr Ed Garratt  
Steve Chicken (Chair)  
Graham Leaf  
Lesley MacLeod  
Dr Michael McCullagh  
Dr Imran Qureshi  
Dr Mark Shenton

### Community Engagement Partnership
Anthony Bone  
Lynda Cooper  
Linda Hoggarth  
Mike Hope  
Gill Jones (Healthwatch Suffolk)  
Jo Marshall (Suffolk Congress)  
Susie Mills  
Gillian Orves (co-chair)  
Pauline Quinn  
Vicky Thompson-Carr (co-chair)  
Richard Squirrel  
Caroline Webb

### Audit Committee
Graham Leaf (Chair)  
Steve Chicken  
Dr Michael McCullagh  
Pauline Quinn (Reserve)

The following are in attendance at the Audit Committee:
- Representatives from Finance  
- Representatives from External Audit  
- Representatives from Internal Audit  
- Representatives from Counter Fraud

### NHSE-IESCCG Joint Commissioning Committee
Pauline Quinn (Chair)  
Cllr Tony Goldson  
Maddie Baker-Woods  
Dr Ed Garratt  
Dr Lorna Kerr  
Graham Leaf  
Lesley MacLeod  
Andrea Patman  
Carole Theobald  
Jan Thomas  
Matthew Thorpe  
Andy Yacoub
Corporate Governance Report - Members’ Report

Register of Interests 2016/17

The Register of Interests document can be found on the Ipswich and East Suffolk CCG website here.

Ipswich and East Suffolk CCG
CCG>Home>About Us>Our Constitution>Conflicts of Interest

Personal Data Related Incidents

There were no Serious Untoward Incidents relating to data security breaches, and therefore none reported to the Information Commissioner.

Statement of Disclosure to Auditors

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

- So far as the member is aware, there is no relevant audit information of which the CCG’s auditor is unaware that would be relevant for the purposes of their audit report
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG’s auditor is aware of it.

Modern Slavery Act

NHS Ipswich and East Suffolk 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.

External Audit and Complaints

External Audit

The CCG’s external auditor is Ernst and Young and the cost of services provided by them in 2016/17 was £76,505. Work undertaken was purely in the provision of statutory audit services. Please note the figure of £69k in the CCGs 2016-17 accounts includes a rebate from the Audit Commission reserves of £7,600.

Principles for Remedy

The Parliamentary and Health Service Ombudsman has issued six Principles for Remedy when handling complaints. These principles set out for complainants and bodies within the Parliamentary and Health Ombudsman’s jurisdiction how they think public bodies should put things right when they have gone wrong - as well as its approach to recommending remedies.

The Principles for Remedy are:

1. Getting it right.
2. Being customer focused.
4. Acting fairly and proportionately.
5. Putting things right.
6. Seeking continuous improvement.
Patient Advice & Liaison Service (PALS)

The Patient Advice & Liaison Service (PALS) provides information and advice on NHS services, non-emergency hospital transport and all other community health services within the NHS Ipswich and East Suffolk Clinical Commissioning Group area.

The main aim of PALS is to quickly resolve problems and concerns for people using NHS services before they become a major issue. It also acts as an early warning system by monitoring and highlighting any problems or gaps in service provision.

As of 1 September 2016 PALS ceased to manage the Emergency Dental Line for Suffolk and patients are now referred to NHS111 which has taken over responsibility for the service.

The total number of contacts dealt with by PALS between April 2016 and March 2017 was 4,492.

Complaints

PALS received 79 complaints between April 2016 and March 2017.

The Patient Experience Team (PET) now coordinates responses to all letters received by the CCG from Members of Parliament. Thirty two such letters were received during this same period.

Patient Involvement

The Patient Experience Team (PET) conducted a two-week survey on patients calling its freephone number to record how people had heard about the service, how they felt awareness of the service could be raised (i.e. social media, leaflets, posters etc) and how it could be improved.

Their responses suggested a preference for accessing services online, but leaflets were also felt to be helpful as several comments were made regarding the difficulty of finding the freephone number when not on the internet. Freephone users also valued the ability to meet face-to-face with members of the PET to discuss concerns. This will be addressed in the new financial year.
Corporate Governance Report

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 Officer to be the Accountable Officer of Ipswich and East Suffolk 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 financial statements in the form and on the basis set out in the Accounts Direction. The financial statements 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 net expenditure, changes in taxpayers’ equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health 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 Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Prepare the financial statements on a going concern basis.

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.

I also confirm that:

- As far as I am aware, there is no relevant audit information of which the CCG’s auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG’s auditors are aware of that information.
- That the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Dr Ed Garratt
Accountable Officer, Ipswich and East Suffolk Clinical Commissioning Group

23 May 2017
### Salaries and Allowances 2016/17

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Yes / No</th>
<th>From</th>
<th>To</th>
<th>Salary (bands of £5,000)</th>
<th>Expense Payments (taxable to nearest £100)</th>
<th>Performance Pay and Bonuses (bands of £5,000)</th>
<th>Long term performance pay and bonuses (bands of £5,000)</th>
<th>All Pension Related Benefits (bands of £2,500)</th>
<th>Total (bands of £5,000)</th>
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<td>Dr Edmund Garratt</td>
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<td>01/04/2016</td>
<td>31/03/2017</td>
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<td>30/04/2016</td>
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<td>31/03/2017</td>
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<td>Clinical Executive Chair</td>
<td>No</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
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<td>Mental Health Lead</td>
<td>No</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
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<td>30 - 35</td>
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<td>Dr Mike McCullagh</td>
<td>Children, Young People and Maternity Lead</td>
<td>No</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
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<tr>
<td>Graham Leaf</td>
<td>Governing Body Vice Chair and Audit</td>
<td>No</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
<td>10 - 15</td>
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<td>Stephen Chicken</td>
<td>Lay Member - Conflicts of Interest</td>
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<td>17/01/2017</td>
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<td>Pauline Quinn</td>
<td>Patient and Public Involvement - Lay Member</td>
<td>No</td>
<td>01/04/2016</td>
<td>31/03/2017</td>
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<td>Dr Lorna Kerr</td>
<td>Secondary Care Doctor</td>
<td>No</td>
<td>01/04/2016</td>
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</table>
Remuneration and Staff Report

Senior Management Remuneration Report Tables

The below relates to the 2016/17 Salaries and Allowances.

Changes to the Governing Body Membership

Management Delivery Team:

Chief Officer - Julian Herbert relinquished his duties on 18 March 2016 and left the CCG on 30 April 2016. Dr Edmund Garratt was appointed to the role on 21 March 2016.

Chief Finance Officer - Carl Goulton left the CCG on 31 May 2016. Lesley Macleod was appointed as Interim Chief Finance Officer on 31 May 2016 and then as Chief Finance Officer on 9 December 2016. Lesley left the CCG on 31 March 2017.

Lay Members:

Stephen Chicken joined the CCG as a Lay Member on 17th January 2017.

Note 1 - Management Delivery Team

West Suffolk CCG host the Management Delivery Team that provides management support to both West Suffolk CCG and Ipswich and East Suffolk CCG. The cost of the Management Delivery Team is shared between both CCG’s in the proportion: - Ipswich and East Suffolk CCG 62.10% (2015/16 - 62.80%) - West Suffolk CCG 37.90% (2015/165 - 37.20%). The Management Delivery Team includes the above highlighted Chief Officers. In addition to showing the salary and fees charged to Ipswich and East Suffolk CCG, the table also records the Chief Officer’s total salary and fees. As West Suffolk CCG host the Management Delivery Team the Ipswich and East Suffolk CCG share of these pay costs is shown as a charge from West Suffolk CCG in the Ipswich and East Suffolk CCG’s accounts and not as payroll costs.

Note 2 - All Pension Related Benefits

The amount included here is the annual increase in pension entitlement determined in accordance with the ‘HMRC’ method for defined benefit pension schemes. In summary, this is as follows:

Increase in pension entitlement = ((20 x PE) + LSE) - ((20 x PB) + LSB), where:

- PE is the annual rate of pension that would be payable to the officer if they became entitled to it at the end of the financial year.
- PB is the annual rate of pension, adjusted for inflation, that would be payable to the officer if they became entitled to it at the beginning of the financial year.
- LSE is the amount of lump sum that would be payable to the officer if they became entitled to it at the end of the financial year.
- LSB is the amount of lump sum, adjusted for inflation, that would be payable to the officer if they became entitled to it at the beginning of the financial year.

The amount included is not a sum paid to the officer by the CCG. It merely represents the increase in pension entitlement that occurred during the year and is derived from data received from NHS Pensions.

Where N/A is shown in the table there is no requirement to disclose as the pensions data received includes contributions from other employment sources.
### Salaries and Allowances 2015/16

(subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Management Delivery Team</th>
<th>Period in Office:</th>
<th>Salary (bands of £5,000)</th>
<th>Expense Payments (taxable to nearest £100)</th>
<th>Performance Pay and Bonuses (bands of £5,000)</th>
<th>Long term performance pay and bonuses (bands of £5,000)</th>
<th>All Pension Related Benefits (bands of £2,500)</th>
<th>Total (bands of £5,000)</th>
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<tr>
<td>Madeleine Baker-Woods</td>
<td>Chief Operating Officer</td>
<td>No</td>
<td>01/04/2015</td>
<td>80 - 85</td>
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<td>01/04/2015</td>
<td>90 - 95</td>
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<td>18/03/2016</td>
<td>85 - 90</td>
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<td>Jon Reynolds</td>
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<td>0</td>
<td>30 - 35</td>
<td>N/A</td>
</tr>
<tr>
<td>Dr Paul Kaiser</td>
<td>End of Life and Governance / Audit Committee Lead</td>
<td>No</td>
<td>01/04/2015</td>
<td>30 - 35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30 - 35</td>
<td>N/A</td>
</tr>
<tr>
<td>Dr Mike McCullagh</td>
<td>Children, Young People and Maternity Lead</td>
<td>No</td>
<td>01/04/2015</td>
<td>30 - 35</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>30 - 35</td>
<td>N/A</td>
</tr>
<tr>
<td>Graham Leaf</td>
<td>Governing Body Vice Chair and Audit and Governance Lay Member</td>
<td>No</td>
<td>01/04/2015</td>
<td>10 - 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10 - 15</td>
<td>N/A</td>
</tr>
<tr>
<td>Gulshan Kayembe</td>
<td>Lay Member - Patient and Public Involvement</td>
<td>No</td>
<td>01/04/2015</td>
<td>0 - 5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0 - 5</td>
<td>N/A</td>
</tr>
<tr>
<td>Pauline Quinn</td>
<td>Lay Member - Patient and Public Involvement</td>
<td>No</td>
<td>01/05/2015</td>
<td>10 - 15</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10 - 15</td>
<td>N/A</td>
</tr>
<tr>
<td>Dr Lorna Kerr</td>
<td>Secondary Care Doctor</td>
<td>No</td>
<td>01/04/2015</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>
The below relates to the 2015/16 Salaries and Allowances.

Changes to the Governing Body Membership

Management Delivery Team:

Chief Officer: - During the year Julian Herbert left the CCG and was replaced by Dr Edmund Garratt.

Chief Contracts Officer: - During the year Wendy Tankard left the CCG and was replaced by Jan Thomas. Jon Reynolds acted-up into the role for a brief period prior to Jan starting with the CCG.

GP Membership:

Dr John Flather resigned from his Governing Body role at the end of last year and was replaced by Dr Mike McCullagh. Dr Paul Bethell left the CCG at the end of February 2016.

Lay Members:

Patient and Public Involvement Lay Member - During the year Gulshan Kayembe left the CCG and was replaced by Pauline Quinn.

Note 1 - Management Delivery Team

West Suffolk CCG host the Management Delivery Team that provides management support to both West Suffolk CCG and Ipswich and East Suffolk CCG. The cost of the Management Delivery Team is shared between both CCG’s in the proportion:- Ipswich and East Suffolk CCG 62.80% (2014/15 - 61.72%) - West Suffolk CCG 37.20% (2014/15 - 38.28%). The Management Delivery Team includes the above highlighted Chief Officers. In addition to showing the salary and fees charged to Ipswich and East Suffolk CCG, the table also records the Chief Officer’s total salary and fees. As West Suffolk CCG host the Management Delivery Team the Ipswich and East Suffolk CCG share of these pay costs is shown as a charge from West Suffolk CCG in the Ipswich and East Suffolk CCG’s accounts and not as payroll costs.

Note 2 - All Pension Related Benefits

The amount included here is the annual increase in pension entitlement determined in accordance with the ‘HMRC’ method for defined benefit pension schemes. In summary, this is as follows:

Increase in pension entitlement = ((20 x PE) + LSE) - ((20 x PB) + LSB), where:

- PE is the annual rate of pension that would be payable to the officer if they became entitled to it at the end of the financial year.
- PB is the annual rate of pension, adjusted for inflation, that would be payable to the officer if they became entitled to it at the beginning of the financial year.
- LSE is the amount of lump sum that would be payable to the officer if they became entitled to it at the end of the financial year.
- LSB is the amount of lump sum, adjusted for inflation, that would be payable to the officer if they became entitled to it at the beginning of the financial year.

The amount included is not a sum paid to the officer by the CCG. It merely represents the increase in pension entitlement that occurred during the year and is derived from data received from NHS Pensions.

Where N/A is shown in the table there is no requirement to disclose as the pensions data received includes contributions from other employment sources.
### Pension Benefits 2016/17
(subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Period in Office:</th>
<th>Real increase / decrease in pension at age 60 (bands of £2,500)</th>
<th>Real increase / decrease in pension lump sum at aged 60 (bands of £2,500)</th>
<th>Total accrued pension at 31 March 2016 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 1 April 2016</th>
<th>Cash Equivalent Transfer Value at 31 March 2017</th>
<th>Real increase / decrease in Cash Equivalent Transfer Value</th>
<th>Employer’s contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Edmund Garratt</td>
<td>Chief Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>2.5 - 5</td>
<td>5 - 7.5</td>
<td>20 - 25</td>
<td>45 - 50</td>
<td>194</td>
<td>249</td>
<td>55</td>
<td>0</td>
</tr>
<tr>
<td>Julian Herbert</td>
<td>Chief Officer</td>
<td>01/04/2016 - 30/04/2016</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>20 - 25</td>
<td>60 - 65</td>
<td>362</td>
<td>375</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Madeleine Baker-Woods</td>
<td>Chief Operating Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>10 - 15</td>
<td>0 - 5</td>
<td>90</td>
<td>109</td>
<td>19</td>
<td>0</td>
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<tr>
<td>Barbara McLean</td>
<td>Chief Nursing Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>35 - 40</td>
<td>110 - 115</td>
<td>719</td>
<td>770</td>
<td>51</td>
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<tr>
<td>Amanda Lyes</td>
<td>Chief Corporate Services Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>35 - 40</td>
<td>100 - 105</td>
<td>541</td>
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<td>39</td>
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<tr>
<td>Carl Goulton</td>
<td>Chief Finance Officer</td>
<td>01/04/2016 - 31/05/2016</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>5 - 10</td>
<td>0 - 5</td>
<td>60</td>
<td>67</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Jan Thomas</td>
<td>Chief Contracts Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>5 - 10</td>
<td>15 - 20</td>
<td>103</td>
<td>133</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Richard Watson</td>
<td>Chief Redesign Officer</td>
<td>01/04/2016 - 31/03/2017</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>10 - 15</td>
<td>0 - 5</td>
<td>85</td>
<td>99</td>
<td>15</td>
<td>0</td>
</tr>
</tbody>
</table>

No pension contributions were made in respect of the following Governing Body Members.

- Dr Mark Shenton
- Dr Imran Qureshi
- Dr John Hague
- Dr William McKee
- Dr Mike McCullagh
- Lesley Macleod
- Graham Leaf
- Stephen Chicken
- Pauline Quinn
- Dr Lorna Kerr

## Pension Benefits 2015/16

(subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>From</th>
<th>To</th>
<th>Period in Office</th>
<th>Real increase / decrease in pension at age 60 (bands of £2,500)</th>
<th>Real increase / decrease in pension lump sum at aged 60 (bands of £2,500)</th>
<th>Total accrued pension at 31 March 2016 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 1 April 2015</th>
<th>Cash Equivalent Transfer Value at 31 March 2016</th>
<th>Real increase/ decrease in Cash Equivalent Transfer Value</th>
<th>Employer’s contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madeleine Baker-Woods</td>
<td>Chief Operating Officer</td>
<td>01/04/2015</td>
<td>31/03/2016</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>5 - 10</td>
<td>0 - 5</td>
<td>74</td>
<td>90</td>
<td>15</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Richard Watson</td>
<td>Chief Redesign Officer</td>
<td>01/04/2015</td>
<td>31/03/2016</td>
<td>2.5 - 5</td>
<td>0 - 2.5</td>
<td>10 - 15</td>
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<td>85</td>
<td>18</td>
<td>0</td>
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</tr>
<tr>
<td>Julian Herbert</td>
<td>Chief Officer</td>
<td>01/04/2015</td>
<td>18/03/2016</td>
<td>0 - 2.5</td>
<td>2.5 - 0</td>
<td>20 - 25</td>
<td>60 - 65</td>
<td>334</td>
<td>362</td>
<td>23</td>
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</tr>
<tr>
<td>Dr Edmund Garratt</td>
<td>Chief Officer</td>
<td>21/03/2016</td>
<td>31/03/2016</td>
<td>0 - 2.5</td>
<td>2.5 - 0</td>
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<td>179</td>
<td>194</td>
<td>13</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Barbara McLean</td>
<td>Chief Nursing Officer</td>
<td>01/04/2015</td>
<td>31/03/2016</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>35 - 40</td>
<td>110 - 115</td>
<td>690</td>
<td>719</td>
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<tr>
<td>Amanda Lyes</td>
<td>Chief Corporate Services Officer</td>
<td>01/04/2015</td>
<td>31/03/2016</td>
<td>0 - 2.5</td>
<td>2.5 - 0</td>
<td>35 - 40</td>
<td>95 - 100</td>
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<td>541</td>
<td>14</td>
<td>0</td>
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</tr>
<tr>
<td>Carl Goulton</td>
<td>Chief Finance Officer</td>
<td>01/04/2015</td>
<td>31/03/2016</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>5 - 10</td>
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<td>41</td>
<td>60</td>
<td>18</td>
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<tr>
<td>Wendy Tankard</td>
<td>Chief Contracts Officer</td>
<td>01/04/2015</td>
<td>31/08/2015</td>
<td>2.5 - 5</td>
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</tr>
<tr>
<td>Jan Thomas</td>
<td>Chief Contracts Officer</td>
<td>05/10/2016</td>
<td>31/03/2016</td>
<td>0 - 2.5</td>
<td>2.5 - 0</td>
<td>5 - 10</td>
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<td>91</td>
<td>103</td>
<td>11</td>
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<tr>
<td>Jon Reynolds</td>
<td>Acting Chief Contracts Officer</td>
<td>28/08/2015</td>
<td>02/10/2015</td>
<td>0 - 2.5</td>
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<td>169</td>
<td>2</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

No pension contributions were made in respect of the following Governing Body Members.

- Dr Mark Shenton
- Dr Imran Qureshi
- Dr Paul Bethell
- Dr John Hague
- Dr William McKee
- Dr Paul Kaiser
- Dr Mike McCullagh
- Graham Leaf
- Gulshan Kayembe
- Pauline Quinn
- Dr Lorna Kerr

Changes in SCAPE Discount Rate for Pensions

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%.

This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.
Remuneration Policy

Policy on remuneration of senior managers
(not subject to audit)

The policy for the remuneration of senior managers was operated in accordance with Agenda for Change and it is intended to continue with this policy for future years. The pay for both the Chief Officer and the Chief Finance Officer was in accordance with recently published national guidance. The remainder of the senior managers are paid on the VSM (very senior manager) grade, all salaries having been nationally benchmarked.

Senior managers’ performance related pay
(not subject to audit)

There is no element of pay that is performance related.

Policy on senior managers’ contracts
(not subject to audit)

All staff including senior managers (up to and including Band 9) follow the national terms and conditions of service pertaining to notice periods. The maximum period of notice under Agenda for Change is 3 months. Chief Officers are appointed in accordance with the VSM framework and have a notice period built into their contract of employment for six months.

Compensation on Early Retirement or for Loss of Office

(not subject to audit)

None.

Payments to Past Members

(not subject to audit)

There were no payments to past directors.

Pay Multiples

(subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director / member in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid member of the Governing Body in the financial year 2016/17 was £90,000 to £95,000 (2015/16 - £90,000 to £95,000). This was 2.20 (2015/16 - 2.07) times the median remuneration of the workforce, which was £40,000 to £45,000 (2015/16 - £40,000 to £45,000).

In 2016/17 no employee received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £15,000 to £20,000 to £90,000 to £95,000 (2015/16 - from £15,000 to £20,000 to £90,000 to £95,000).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.
## Staff Costs 2016-17

### Employee Benefits

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Admin</th>
<th>Programme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total £’000</td>
<td>Permanent Employees £’000</td>
<td>Other £’000</td>
</tr>
<tr>
<td></td>
<td>Permanent</td>
<td>Other</td>
<td>Total £’000</td>
</tr>
<tr>
<td>Salaries and wages</td>
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<td>43</td>
</tr>
<tr>
<td>Social security costs</td>
<td>185</td>
<td>185</td>
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</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
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<td>238</td>
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</tr>
<tr>
<td>Other pension costs</td>
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<tr>
<td>Other post-employment benefits</td>
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</tr>
<tr>
<td>Other employment benefits</td>
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</tr>
<tr>
<td>Termination benefits</td>
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<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>2,180</td>
<td>2,137</td>
<td>43</td>
</tr>
<tr>
<td>Less recoveries in respect of employee benefits</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>2,180</td>
<td>2,137</td>
<td>43</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>2,180</td>
<td>2,137</td>
<td>43</td>
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</tbody>
</table>

## Staff Costs 2015-16

### Employee Benefits

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Admin</th>
<th>Programme</th>
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<tbody>
<tr>
<td></td>
<td>Total £’000</td>
<td>Permanent Employees £’000</td>
<td>Other £’000</td>
</tr>
<tr>
<td></td>
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<td>Other</td>
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<tr>
<td>Salaries and wages</td>
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<td>Social security costs</td>
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<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>268</td>
<td>268</td>
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<td>Other pension costs</td>
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<td>Other post-employment benefits</td>
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<tr>
<td>Termination benefits</td>
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<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td>2,622</td>
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<td>(34)</td>
<td>(34)</td>
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<tr>
<td><strong>Total - Net admin employee benefits including capitalised costs</strong></td>
<td>2,588</td>
<td>2,298</td>
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<td>Less: Employee costs capitalised</td>
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</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td>2,588</td>
<td>2,298</td>
<td>290</td>
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</table>
Remuneration and Staff Report - Remuneration Report

Staff Composition

IESCCG Gender by Banding

<table>
<thead>
<tr>
<th>Band</th>
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<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
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</tr>
<tr>
<td>4</td>
<td>2</td>
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</tr>
<tr>
<td>5</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>6</td>
<td>9</td>
<td>28</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>11</td>
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<td>8a</td>
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<td>11</td>
</tr>
<tr>
<td>8b</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8c</td>
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<tr>
<td>8d</td>
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</table>

Management Delivery Team Gender by Banding

<table>
<thead>
<tr>
<th>Band</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
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<td>3</td>
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<tr>
<td>VSM</td>
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</table>

Staff Policies applied during the Financial Year

None.
Sickness absence rates for the CCG and the Shared Management Delivery Team increased slightly during the third and fourth quarters of 2016 and were both above the 2% target. The three main causes of sickness absence were ‘colds, coughs and flu’, ‘gastro-intestinal problems’ and ‘headache and migraines’.

Return to work interviews and early referrals to occupational health by line managers have helped reduce and manage the level of sickness absence. We have begun working with employee wellbeing experts CiC to provide staff with an independent, free and confidential advice service. All CiC counsellors are either accredited by or registered with the British Association for Counselling and Psychotherapy or an equivalent professional body. They offer practical advice and emotional support with work and personal issues.

All of our employees have access to a Stress Management Toolkit which helps them identify the causes of stress and are able to discuss any issues they may have with line managers and the occupational health team. The CCG has also relaunched its staff health and wellbeing group and a number of health and wellbeing champions have been appointed.

The health and wellbeing initiatives we have introduced have included:

- ‘Fruit of the month’ boxes
- Access to Suffolk Wellbeing workshops.
- Flexible working opportunities, and
- Monthly activities such as charity collections
- Flu jabs for all

Following inspection visits in March 2016 the CCG secured accreditation for three awards - the Investors in People (IiP) gold assessment, the ‘Health and Wellbeing’ award and the ‘Staying Healthy at Work’ award. Along with West Suffolk CCG we are the only organisations to secure all three awards. During assessment for the IiP gold award 193 requirements were evidenced, well over the 165 needed. The executive summary in the IiP report praised the CCGs for “very clear direction and objectives”, “clear, high standards and procedures to enable people to perform well” and “great encouragement and support of ideas for improvement”.

---

**Staff Numbers**

**Remuneration and Staff Report - Remuneration Report**

**Sickness Absence Data**

<table>
<thead>
<tr>
<th>Ipswich and East Suffolk CCG</th>
<th>Chief Operating Office, Ipswich and East Suffolk CCG</th>
<th>2016-17</th>
<th>Overall Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chief Redesign Office, Ipswich and East Suffolk CCG</td>
<td></td>
<td>2.06%</td>
</tr>
<tr>
<td></td>
<td>Overall rate</td>
<td></td>
<td>2.69%</td>
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<table>
<thead>
<tr>
<th>Management Delivery Team</th>
<th>Chief Corporate Office</th>
<th>2016-17</th>
<th>Overall Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chief Contracts Office</td>
<td></td>
<td>5.82%</td>
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<td>Chief Finance Office</td>
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<td>3.27%</td>
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<tr>
<td></td>
<td>Chief Nursing Office</td>
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<td>1.69%</td>
</tr>
<tr>
<td></td>
<td>Communications and external relations</td>
<td></td>
<td>3.78%</td>
</tr>
<tr>
<td></td>
<td>Office of the Accountable Officer</td>
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<td>0.68%</td>
</tr>
<tr>
<td></td>
<td>Overall Rate</td>
<td></td>
<td>3.33%</td>
</tr>
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</table>
Staff Engagement

A variety of means are used to keep employees informed about workplace developments, including:

- Regular one-to-one meetings with line managers during which they are encouraged to raise any concerns or issues
- Monthly team briefings hosted by the Chief Officer during which questions from the floor are encouraged or can be tabled anonymously in advance
- The Buzz, a bi-weekly electronic newsletter and
- Headlines - an all staff email to alert people to key business and building updates

Any issues concerning staff are reported to the Remuneration and HR Committee and the Staff Partnership Forum for discussion and CCG performance data is posted on the staff intranet on a monthly basis.

The CCG’s values and behaviours are included in the personal development plans of all employees and regular reviews are conducted by line managers to ensure these are being adhered to by staff. Regular employee surveys are also undertaken.

Disabled employees

The CCG promotes equality of opportunity in all it does, including the recruitment and selection of its workforce. It has ‘Positive about Disability’ accreditation and holds the Investors in People gold award. Its recruitment and selection policy which highlights the steps recruiting managers need to take if an applicant declares themselves as disabled. Reasonable steps are taken to ensure all disabled applicants are treated fairly, which includes being flexible about interviewing venues, selection procedures and aptitude tests.

Occupational health advice and support is offered to all staff and specialist advice is sought for disabled employees.

Meetings with occupational health advisers are held every three months to review how the CCG can actively support staff health and wellbeing. All employees undergo an annual appraisal and personal development plans are drawn up on an equal opportunities basis. Key Performance Indicators regarding equal opportunities are regularly reported to the Remuneration and HR Committee.

Joint Staff Partnership

The CCG works closely with trade union colleagues including Unison, the Royal College of Nursing and Managers in Partnership as part of the Joint Staff Partnership. Meetings occur bi-monthly and details of matters discussed and decisions taken are communicated to staff.

During the year the Joint Staff Partnership also reviewed and signed off a new staff sickness absence policy and sponsored a ‘lunch and learn’ event on infection control.

Expenditure on Consultancy

The CCG spent £55k during 2016/17 (£250k in 2015/16) on consultancy. The majority of 2016/17 spend was in relation to business management services to support the CCG with managing its financial turnaround.
Off-Payroll Engagements (not subject to audit)

For all off-payroll engagements as at 31 March 2017, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of existing engagements as of 31 March 2017</td>
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</tr>
<tr>
<td>Of which, the number that have existed:</td>
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<tr>
<td>- for less than one year at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>- for between one and two years at the time of reporting</td>
<td>0</td>
</tr>
<tr>
<td>- for between 2 and 3 years at the time of reporting</td>
<td>1</td>
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<tr>
<td>- for between 3 and 4 years at the time of reporting</td>
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<tr>
<td>- for 4 or more years at the time of reporting</td>
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</table>

For all new off-payroll engagements between 01 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017</td>
<td>0</td>
</tr>
<tr>
<td>Number of new engagements which include contractual clauses giving NHS West Suffolk CCG the right to request assurance in relation to income tax and National Insurance obligations</td>
<td>0</td>
</tr>
<tr>
<td>Number for whom assurance has been requested</td>
<td>0</td>
</tr>
<tr>
<td>Of which:</td>
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<tr>
<td>- assurance has been received</td>
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</tr>
<tr>
<td>- assurance has not been received</td>
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</tr>
<tr>
<td>- engagements terminated as a result of assurance not being received</td>
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</table>

The CCG has robust contractual arrangement with all of its off-payroll engagements that minimises any risk to the CCG. The contractual arrangements require all off-payroll engagements to provide assurance that the correct amount of tax is being paid.

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 01 April 2016 and 31 March 2017:

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year</td>
<td>1</td>
</tr>
<tr>
<td>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.</td>
<td>14</td>
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</tbody>
</table>
Exit Packages

Please refer to note 4.4. in the Financial Statement and Notes (section 3) for details of exit packages agreed in the financial year.

Health and Safety

The Health & Safety and Risk Committee meets every quarter to review health and safety and risk issues relating to NHS Ipswich and East Suffolk CCG.

The committee is chaired by the Chief Corporate Services Officer and draws members from both CCGs, property services, the CCG Health and Safety services provider (Safetyboss) and the management delivery team. The committee reports activities to the remuneration and HR committee for their information and comment.

During the year class room health and safety training has been provided in-house by the Information Governance and Risk Manager (holder of NEBOSH qualification in general health and safety). The provision of training will be changing again and from April 2017 will be provided via a web-based training tool. The three mandatory modules will cover the required areas of health and safety for a low risk office environment and each includes an assessment which must be passed by staff.

During the past year the committee has investigated and acted on a risk identified by NHS Property Services relating to the risk of a member of staff or a visitor to the building falling from windows on the upper floors (particularly where the sill heights are very low). A simple low cost solution (window bars) has been installed reducing the risk of falls.

The committee has also arranged for additional signage at Rushbrook House to advise vehicles of the presence of vehicles turning into the farm car park and the presence of pedestrians.

The committee has continued to provide advice to staff on their safety within the office and continues to work with them to maintain a safe environment for staff and visitors.

Parliamentary Accountability and Audit Report

Ipswich and East Suffolk Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.

Dr Ed Garratt
Accountable Officer,
Ipswich and East Suffolk Clinical Commissioning Group

23 May 2017
Section 2; Appendix 1
Annual Governance Statement
Introduction and Context

Ipswich and East Suffolk Clinical Commissioning Group is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

As at 1 April 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

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.

UK Corporate Governance Code

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

However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including the aspects of the UK Corporate Governance Code in respect of leadership, effectiveness and accountability that we consider to be relevant to the Clinical Commissioning Group and best practice.
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 Governance Framework of the Clinical Commissioning Group is the system by which the Clinical Commissioning Group is directed and controlled in order to achieve its objectives and meet the necessary standards of accountability and probity. Effective corporate governance, along with clinical governance, is essential for a Clinical Commissioning Group to achieve its clinical, quality and financial objectives.

The NHS Act 2006, together with the Health & Social Care Act 2012 and associated legislation, sets out the legal framework within which the Clinical Commissioning Group operates. It is a statutory requirement that the Clinical Commissioning Group Governing Body specify their terms of reference, schedule of reservation and delegation of powers, and the financial framework within which the organisation operates. These key documents comprise the Clinical Commissioning Group’s corporate governance arrangements and include:

- The Constitution - as a framework for Governing Body governance
- The Detailed Financial Policies - as a framework for financial governance
- The Scheme of Reservation and Delegation - as a framework for internal governance

It is essential that the public and all employees know of the existence of these documents and for staff, that they are aware of their responsibilities as set out within. They are therefore reviewed, updated and approved each year at a meeting of the Governing Body in public and made available on the Clinical Commissioning Group web site and intranet.

The Clinical Commissioning Group’s Membership Body includes 40 member practices that make up four localities. These localities are:

- Suffolk Brett Stour
- Commissioning Ideals Alliance
- Deben Health Group
- Ipswich
<table>
<thead>
<tr>
<th>Suffolk Brett Stour</th>
<th>Ipswich</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bilstedon Health Centre</td>
<td>• Barrack Lane Medical Centre</td>
</tr>
<tr>
<td>• Combs Ford Surgery</td>
<td>• Burlington Primary Care</td>
</tr>
<tr>
<td>• Constable Country Rural Medical Practice</td>
<td>• Deben Road Surgery</td>
</tr>
<tr>
<td>• Eye Health Centre</td>
<td>• Felixstowe Road Medical Practice</td>
</tr>
<tr>
<td>• Fressingfield Medical Centre</td>
<td>• Hawthorn Drive Surgery</td>
</tr>
<tr>
<td>• The Barham &amp; Claydon Surgery</td>
<td>• Ivry Street Medical Practice</td>
</tr>
<tr>
<td>• Hadleigh Health Centre</td>
<td>• Orchard Medical Practice</td>
</tr>
<tr>
<td>• Ixworth Surgery</td>
<td>• Ravenswood Medical Practice</td>
</tr>
<tr>
<td>• Mendlesham Health Centre</td>
<td>• The Chesterfield Drive Practice</td>
</tr>
<tr>
<td>• Needham Market Country Practice</td>
<td>• The Derby Road Practice</td>
</tr>
<tr>
<td>• Stow Health</td>
<td>• The Dr Solway &amp; Dr Whale Practice</td>
</tr>
<tr>
<td>• The Holbrook and Shotley Practice</td>
<td>• The Norwich Road Surgery</td>
</tr>
<tr>
<td></td>
<td>• Two Rivers Medical Centre</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Deben Health Group</th>
<th>Commissioning Ideals Alliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Church Farm Surgery</td>
<td>• The Grove Medical Centre</td>
</tr>
<tr>
<td>• Debenham Surgery</td>
<td>• Haven Health</td>
</tr>
<tr>
<td>• Framfield House</td>
<td>• Howard House Surgery</td>
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<td>• Framlingham Surgery</td>
<td>• Martlesham Surgery</td>
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<tr>
<td>• Leiston Surgery</td>
<td>• The Birches Medical Centre</td>
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<tr>
<td>• Little St John’s Street Surgery</td>
<td>• Walton Surgery</td>
</tr>
<tr>
<td>• Saxmundham Health</td>
<td></td>
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<tr>
<td>• The Peninsula Practice</td>
<td></td>
</tr>
<tr>
<td>• Wickham Market Medical Centre</td>
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</tbody>
</table>
The Clinical Commissioning Group’s Governing Body includes 13 voting members: 7 GPs elected by their peers, a lay member for governance, a lay member for patient and public involvement, a third lay member appointed in 2016 (in accordance with the NHS England statutory guidance on the management of conflicts of interest), an Accountable Officer, a Chief Nursing Officer, a secondary care doctor and a Chief Finance Officer. The Governing Body also includes 4 non-voting Chief Officers.

Governing Body meetings focus on strategy, clinical and service development, finance, performance and scrutiny and governance and corporate business.

Some of the key items considered by the Governing Body at meetings during the year included:

- Maternity Services
- The Transforming Care Programme
- STP Planning
- Delegated Commissioning
- The Future of IVF and MVA Services
- Integrated Community Health and Care Services
- The Pathology Partnership
- Communication, Engagement and Involvement Strategy
- MSK Service Redesign

The Price Waterhouse Coopers (PWC) CCG Capability and Capacity Review commissioned by NHS England in June 2016 concluded that the CCG Governing Body did not take corrective action in 2015-16 to address underlying financial issues as they were reported. The report identified weaknesses in a lack of consistent corporate collective responsibility as contributing factors, and recommended that the Governing Bodies undertake a self-assessment to further understand the reasons.

Given the dynamic environment within which CCGs undertake their activities even the most experienced Governing Body Members benefit from on-going training and support. New Members also need robust orientation, allowing them to understand their role and the organisations governance processes. Further to the findings of the self-assessment, training needs analysis and recommendations from PWC, update training has been
provided for Governing Body Members with a particular focus on scrutiny and challenge. As a consequence, the Governing Body now considers that it has been effective in the discharge of its duties and has been assured by NHS England at subsequent quarterly review meetings.

The table below shows the Governing Body attendance for 2016-17:

<table>
<thead>
<tr>
<th>Governing Body Member</th>
<th>26 Apr 16 (Part 2)</th>
<th>17 May 16</th>
<th>24 May 16 (Part 2)</th>
<th>26 Jul 16 (Part 1 &amp; 2)</th>
<th>27 Sep 16</th>
<th>22 Nov 16 (Part 1 &amp; 2)</th>
<th>20 Dec 17 (Part 2)</th>
<th>24 Jan 17 (Part 1 &amp; 2)</th>
<th>28 Mar 17 (Part 1 &amp; 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Armitt Chris</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>(Deputy Chief Finance Officer)</td>
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<td>(Deputy Chief Nursing Officer)</td>
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<td>McLean Barbara</td>
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<td>(Chief Nursing Officer)</td>
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The formal sub-committees established by the Clinical Commissioning Group Governing Body include:

**The Audit Committee**

The purpose and key functions of the Audit Committee include reviewing the adequacy of:

(i) All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Governing Body;

(ii) The structures, processes and responsibilities for identifying and managing key risks facing the organisation through the oversight of risk management and information governance strategies;

(iii) The operational effectiveness of policies and procedures relating to internal control and risk management including the Governing Body Assurance Framework; and

(iv) The policies and procedures for all work related to fraud and corruption required under the terms of the Standard NHS Contract and in accordance with the NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption

Highlights of the Committee’s work included:

- Consideration and oversight of the work plans for External Audit, Internal Audit and Counter Fraud
- Data/Cyber Security
- Individual Funding Requests

Internal Audit reporting including reports on the following:

- Safeguarding Vulnerable Adults
- NICE Guidance
- GP Payments
- Continuing Healthcare
- Governing Body Assurance Framework (GBAF)
- Financial Reporting and Budgetary Control
- Key Financial Assurance
The Remuneration and Human Resources Committee

The purpose of the Remuneration and Human Resources Committee is to:

(i) Advise the Governing Body about the appropriate remuneration and terms of service for the Accountable Officer, Chief Officers and senior managers of the Clinical Commissioning Group.

(ii) Under delegated powers from the Governing Body, make decisions on all aspects of the Accountable Officers’, Chief Officers’ and senior managers’ salary (including any performance-related elements and any allowances) within the provisions of relevant national frameworks, provisions for other benefits, as well as the arrangements for termination of employment and other contractual terms.

(iii) Advise on all Human Resources policies and procedures and issues that may impact on the terms and conditions of employment for all staff.

(iv) Advise on all matters of health and safety.

Highlights of the Committee’s work included:

- Human resources/workforce performance
- Health and safety/risk management
- Changes to the NHS Agency Framework
- Apprentices
- Gender Pay Issues
- Public Sector Exit Packages
- IR35 – HMRC New Off-Payroll Rules

### Remuneration and HR Committee – Ipswich and East Suffolk CCG – 2016/17

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<tr>
<th>Remuneration &amp; HR Committee Member</th>
<th>5 Apr 16 (Extraordinary P2)</th>
<th>19 Apr 16</th>
<th>19 Jul 16 (Inquorate)</th>
<th>18 Oct 16</th>
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<td>Others in attendance to advise:</td>
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<td>Finance Accounting Manager</td>
<td>Chief Corporate Services Officer</td>
<td>Chief Corporate Services Officer</td>
<td>HR Business Manager</td>
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### The Clinical Scrutiny Committee

The purpose of the Clinical Scrutiny Committee is to:

(i) Provide a dedicated forum for the oversight of clinical governance.

(ii) Provide assurance to the Governing Body and Audit Committee that the Clinical Commissioning Group has the necessary clinical governance arrangements in place to meet its objectives.

(iii) Ensure effective clinical engagement in clinical governance processes, utilising clinicians’ specific expertise and knowledge of local communities and public/patient involvement.

(iv) Facilitate a culture where clinical quality, patient experience and patient safety are of the highest priority.

### Clinical Scrutiny Committee – Ipswich and East Suffolk CCG – 2016/17

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<tr>
<th>Clinical Scrutiny Committee Member</th>
<th>26 Apr 16</th>
<th>23 Aug 16</th>
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The Commissioning Governance Committee

The purpose of the Commissioning Governance Committee is to:

(i) Provide a forum, with delegated decision making powers, for approval of commissioning intentions where the recommended providers are GP practices.

(ii) Provide assurance to the Governing Body, Audit Committee, NHS England and general public that the Clinical Commissioning Group has the necessary governance
arrangements in place to manage conflict of interest in regard to the procurement of services provided by GP practices.

(iii) Facilitate a culture of openness and probity around the local commissioning of GP services.

(iv) Demonstrate that the Clinical Commissioning Group and member practices are acting fairly and transparently and that final commissioning decisions are made in ways that preserve the integrity of the decision making process.

The Joint Commissioning Committee

This is a joint committee with NHS England with the primary purpose of jointly commissioning primary medical services for the people of Ipswich and East Suffolk.

The role of the Joint Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act except those relating to individual GP performance management, which have been reserved to NHS England.
The Financial Performance Committee

The purpose of the Financial Performance Committee is to:

(i) Establish a financial performance framework which enables the CCG to proactively manage its financial, performance and quality, innovation, productivity and prevention (QIPP) agenda

(ii) Provide assurance about financial performance to the Governing Body by reviewing and scrutinising performance reports and remedial action plans in detail prior to submission to Governing Body meetings

(iii) Ensure that the CCG operates within agreed budgets and proposing plans and necessary actions to maintain financial balance

(iv) Demonstrate the achievement of value for money and provide confidence to the Governing Body and wider public that the CCGs resources are being used effectively and efficiently

(v) Facilitate a culture of openness and probity around the delivery of effective financial and performance management

(vi) Hold to account the relevant Chief Officers and appropriate GPs for delivery of agreed plans within their areas of responsibility
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**Discharge of Statutory Functions**

Arrangements put in place by the clinical commissioning group and explained within the Corporate Governance Framework have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the 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**

During the course of 2016-17, the organisation's processes for effective risk management were managed in line with the Clinical Commissioning Group Risk Management Strategy and Organisational Framework 2016-2019 and the Governing Body Assurance Framework with this being reviewed monthly by the Chief Officer Team and Clinical Scrutiny Committee, and also reviewed by the Governing Body and the Audit Committee at each of their meetings.

The Chief Corporate Services Officer is the designated lead for overseeing the day to day coordination of risk management reporting arrangements, including training and is a resource for all risk related issues. The Governance Advisor supports Chief Officers, Heads of Department and Line Managers, whilst also scrutinising all identified risk and incident data. As the designated lead, the Chief Corporate Services Officer works in partnership with:

- The contract Health and Safety Advisers who act as the Clinical Commissioning Group’s ‘Competent Person’
- The Chief Nursing Officer with respect to risk management requirements set out in the Care Quality Commission standards
- The Information Governance and Risk Manager

Equality Impact Assessments are conducted at the outset of setting strategy and delivering services across the commissioning cycle and in assuring a control and assurance culture through risk, incident and complaints management which ensures a clearly defined culture of equality across the Clinical Commissioning Group’s activities.

**Risk Assessment**

The Governing Body Assurance Framework (GBAF) provides the Clinical Commissioning Group with a simple but comprehensive method for the effective and focused management
of risk. Through the GBAF the Governing Body gains assurance from the Chief Officers that all risks are being appropriately managed throughout the organisation.

The GBAF identifies which of the organisation’s strategic goals may be at risk because of inadequacies in the operation of controls, or where the Clinical Commissioning Group has insufficient assurance. At the same time it encompasses the control of risk, provides structured assurances about where risks are being managed and ensures that objectives are being delivered. This allows the Governing Body to determine how to make the most efficient use of resources and address the issues identified in order to continuously improve the quality and safety of healthcare commissioning.

In order to ensure consistency in the risk assessment process, the likelihood and consequences of all risks on the Clinical Commissioning Group Risk Register are assessed against an agreed 5x5 risk matrix. Risks which are deemed to be of sufficient concern to the organisation as a whole are considered for being migrated to the GBAF and thereby inform the Governing Body agenda. The risk matrix and subsequent red, amber, green (RAG) score identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action and determines whether risks are to be accepted on the basis of the colour bandings and risk ratings. In evaluating effectiveness, the RAG rating system is also used to present how well the agreed controls are operating.

A summary of the key strategic risks affecting the Clinical Commissioning Group during the course of 2016-17 (including those carried forward into future years) and the actions taken to eliminate or mitigate them have included:
<table>
<thead>
<tr>
<th>Risk</th>
<th>Actions Taken to Eliminate or Mitigate</th>
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</table>
| 3. Failure to achieve financial balance in 2016-17 | • Project management approach to delivery of the QIPP plans  
• Focus on activity levels at acute providers with clear actions to mitigate against over performance  
• Close monitoring of the delivery of QIPP initiatives through KPI’s  
• Encourage innovative changes principally via CCGs to improve efficiency  
• Active scrutiny and challenge of specialist costs through meetings with the Specialised Commissioning team  
• Clinical Executive and Governing Body review of all significant investment.  
• Holding new investments that don’t generate in year savings until QIPP delivery on track  
• Participation in regional and national discussions  
• Prioritisation process for QIPP initiative investments and transformational change at Clinical Executive  
• CHC Project Board |
| 13a. Failure to comply with NHS continuing Health care Framework  
**Removed from the GBAF December 2016** | • Investment of clinical and administration personnel  
• High attrition, retention of staff through training and on-going support framework in development  
• Review of operating processes established to target backlog which will not effect on going business continuity  
• Policies and processes to be established and agreed by the CCG |
| 16. Failure to evidence the national drive of zero tolerance on MRSA bacteraemia  
**Removed from the GBAF June 2016** | • All MRSA bacteraemia cases to be subjected to NHS England Post Infection Review (PIR)  
• CCG will lead PIR pre 48hr cases. Acute provider where case occurred will lead post 48hr cases  
• Review of all audits and contract monitoring information against CQC recommended IC standards (to include antibiotic prescribing) in all CCG commissioned services  
• Review of compliance against national and locally agreed MRSA screening standards |
| 18. Failure to achieve the local reduction trajectories for Clostridium difficile | • Robust RCA process for each provider case and submitted to CCG for assessment.  
• Audit programme of CQC recommended IC standards (to include antibiotic prescribing) in all CCG commissioned services  
• CCG attendance at PIR reviews and IP&C Committee meetings  
• Provider delivery of targeted infection control education and audit in all CCG commissioned services.  
• 15/16 trajectory agreed in SLA – ceiling for 18 Acute cases and 89 non-acute cases |
| 20. Failure to redesign and commission services covered by the Urgent Care and Health and Independence reviews within required timescales | • Programme structure put in place for Health and Care Review Mapping of all existing services to ensure full coverage of newly commissioned services  
• Regular review with SCC to ensure smooth running of programmes  
• Each programme has set out timelines to ensure commissioned redesigned services in 2015. These have been reviewed by the Clinical Executive. |
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<tr>
<th>Risk</th>
<th>Actions Taken to Eliminate or Mitigate</th>
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| 24. Significant reduction in the capacity of GP services in Ipswich as a whole and some individual East Suffolk practices, affecting access times for patients and demand for other services | - CCG Primary care strategy and support team in daily contact with practices  
- Ipswich and other locality meetings  
- Bi-monthly Practice Manager meetings  
- LMC/CCG/PM meetings  
- Weekly Clinical Executive meetings Bi-monthly Governing Body meetings                                                                                                                                               |
| 26a Potential impact of service quality delivered by NSFT               | - Regular quality review meetings to review performance against defined key performance indicators  
- Support NSFT to develop a visual quality dashboard promoting visual assessment of performance against agreed thresholds and allowing trends to be identified.  
- CCG attendance at monthly stakeholder assurance meetings to review and challenge progress to deliver quality improvements  
- Review of progress against quality improvement plans (Trust / Local) prior to each quality review meeting  
- Schedule quality improvement visits to Suffolk based NSFT services organised and currently taking place  
- Schedule meeting to gain assurance of robust process to sign off CIPs and to review QIAs associated with the CIPs to assess potential negative impact on quality – outstanding. Waiting for NSFT to confirm date  
- Provide clarity of CCG Mental health / Learning disabilities commissioning strategy  
- Support NSFTs week of mock CQC inspections planned for November / December.  
- Alignment of quality and SLA meetings to allow lead GP attendance  
- Gain assurance that the Trust has robust plans to improve the concerns identified through the mock CQC inspections, in a time frame to ensure confidence before the next quarterly GBAF. |
| 26b Poor performance of mental health services                        | - Completion of RAPs  
- Consideration of issuing further Contractual Notices  
- 4 remedial action plans in place  
- 7 day CPA follow up                                                                                                                                                                                                 |
| 27 A&E failing to meet 4 hour standard presenting a potential risk to patient safety and experience. | - Daily reporting of performance.  
- Internal escalation process has been re-circulated and updated with short term on the day forward demand planning to anticipate peaks  
- 111 targets to reduce inappropriate referrals to A+E  
- A+E referral pathway in place to re-direct appropriate patients to GP+ service.  
- Implementation of new A&E Board as per NHSE guidance starting w/c 12/9/16  
- Doctor productivity being recorded manually whilst electronic option is resolved  
- Assess and address staff shortages in medical and nursing rotas 10 days in advance                                                                                                                                  |
| Risk added to GBAF September 2016                                     |                                                                                                                                                                                                                                     |
Risk | Actions Taken to Eliminate or Mitigate
---|---
28 | Significant issues identified with the blood transfusion service at West Suffolk Hospital (WSH) run by TPP during an inspection by the MHRA – January 2017
| Trust / TPP improvement plan
| Weekly Trust / TPP updates on progress against plan to MHRA / NHSI
| Serious Incident Reporting
| Risk added to GBAF March 2017

29 | Failure to comply with SEND Reforms
| Written statement detailing implementation actions to achieve compliance
| Send Strategy Group (& associated sub-groups) established to provide strategic leadership and governance overseeing implementation of improvement actions
| Appointment of programme manager to deliver implementation of improvements
| Appointment of band 7 SEND support worker to operationally deliver SEND reforms
| Risk added to GBAF March 2017

Further to monthly scrutiny, the risk ratings for each of the Clinical Commissioning Group’s key strategic risks have changed over the course of the year as follows:

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<tr>
<th>Risk No</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
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The risk rating matrix used:

<table>
<thead>
<tr>
<th>Likelihood score →</th>
<th>1: Rare</th>
<th>2: Unlikely</th>
<th>3: Possible</th>
<th>4: Likely</th>
<th>5: Almost Certain</th>
</tr>
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<tbody>
<tr>
<td>Consequence score ↓</td>
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<tr>
<td>5: Catastrophic</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
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<tr>
<td>4: Major</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
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<tr>
<td>3: Moderate</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>2: Minor</td>
<td>2</td>
<td>4</td>
<td>6</td>
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<td>10</td>
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<tr>
<td>1: Negligible</td>
<td>1</td>
<td>2</td>
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</table>

The subsequent red, amber, green (RAG) scores identify the level at which identified risks will be managed within the organisation. It also assigns priorities for remedial action, and determines whether risks are to be accepted on the basis of the colour bandings and risk ratings. In terms of evaluation of effectiveness, the RAG rating system is also used to present how well the agreed controls are operating within the following classifications:
<table>
<thead>
<tr>
<th>RAG Score</th>
<th>Progress</th>
<th>Risk Assessment</th>
<th>Revising Risk Ratings</th>
</tr>
</thead>
</table>
| **CRITICAL** (15-25) |  - There may be significant gaps in controls to ensure effective management.  
  - Controls are in place but insufficient resources  
  - Controls are in place but external forces may be preventing progress. |  - There are insufficient controls in place to address the cause or source of the risk  
  - Controls are considered insubstantial or ineffective  
  - Controls are being implemented but are not yet in place  
  - If this risk were to materialise, the situation could be irrecoverable in terms of the Clinical Commissioning Groups reputational/financial well-being and or service continuity. |  If controls are inadequate then the revised risk rating increases |
| **CHALLENGING** (8-12) | Progress is being made but there is concern that the objective may not be achieved. Additional controls or management action is being taken to improve the likelihood of success. | There are few controls in place, which are considered substantial and/or effective and address the cause of the risk. The consequences of the risk materialising, though severe, can be managed to some extent via contingency plans. | If controls are uncertain, the revised risk rating stays the same as the original risk rating |
| **MANAGEABLE** (1-6) | Progress is being made in accordance with plans. There are no significant concerns. | The risk is considered to be small and there are sufficient controls in place which address or substantially effective the cause of the risk. The consequences of the risk materialising can be managed via contingency plans. | If they are perceived as adequate, then the revised risk rating decreases |
None of the principal risks relate to compliance with the Clinical Commissioning Group licence. In addition, the Governing Body reviews the GBAF at each of its meetings thus ensuring a high degree and rigour over the Clinical Commissioning Group’s performance.

**Capacity to Handle Risk**

All actions contain inherent risks and risk management is central to the effective running of any organisation. The Clinical Commissioning Group therefore ensures that decisions made on behalf of the organisation are taken with due consideration to the management of risks.

To achieve this, the Governing Body must be confident that the systems, policies and people it has put in place are operating in a way that is effective, are focused on key risks and driving the delivery of the organisations objectives. The Governing Body must also demonstrate that it has been properly informed, through evidence from the Governing Body Assurance Framework (GBAF), that it is aware of the totality of risk facing the organisation, and that it has made decisions on the management of that risk based on all of the available evidence. The Clinical Commissioning Group’s risk and control mechanism is described diagrammatically below:
The GBAF is built around the Risk Register and from which the relevant strategic risks are drawn. Whilst appropriately rated strategic risks will automatically migrate to the GBAF, the Governing Body, with additional oversight provided by the Audit Committee, determines whether or not any other risks from the Risk Register should be transferred to the GBAF when considered strategically significant.
Incident and risk reporting is actively encouraged across the Clinical Commissioning Group and relevant reports are recorded on an integrated risk reporting system called ‘Sentinel’, this being managed within the Chief Corporate Services Officer’s department.

As a working document, the GBAF is updated monthly by the Chief Officers and reviewed by the Governing Body, the Clinical Scrutiny Committee and the Audit Committee at each of their meetings, the former in public.

Risks arising from the Clinical Commissioning Group’s daily operations can result in less than optimum quality of service, financial loss, disruption of normal operations, accidents and injuries or adverse publicity. The likelihood of these events occurring and the potential extent of their impact depend on the Clinical Commissioning Group’s practices, processes and culture as well as external influences.

A key aim of the Clinical Commissioning Group’s risk management arrangements is the continued reduction of risk through the greater understanding and involvement of staff at all levels of the organisation. In order to support this, anybody who identifies a potential or actual risk can report their concerns directly to their line manager, a Chief Officer or the Information Governance and Risk Manager by submitting a completed Risk Report Form; indeed all employees have a duty to do so.

**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. How we achieve this is described in the preceding sections.
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 first annual audit was undertaken in January 2017 with an overall assurance assessment of reasonable assurance. There were two important and three routine action points arising from the audit, the majority of which have already been addressed.

Data Quality

Data security risks are reported through the Information Governance and Risk Manager to the Chief Corporate Services Officer. The Information Governance Group that reports to the Audit Committee monitors a detailed action plan, linked to the requirements of the National Information Governance Toolkit. Level-two compliance has been achieved for all of the toolkit requirements giving an overall rating of ‘satisfactory’. No strategic data security risks have been included in the Governing Body Assurance Framework (GBAF) during the course of 2016-17 although the CCG is aware of the increased risk from so called Cyber Security attacks and has as a matter of caution included this risk in the Chief Corporate Services Officer’s local risk register.

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are
developing information governance processes and procedures in line with the information governance toolkit. We have ensured that all staff under-take annual information governance training so that they are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

**Business Critical Models**

An appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report. Quality assurance is vital to ensure that business critical models are robust. The Clinical Commissioning Group ensures as part of its quality assurance that the appropriate governance is applied to its business critical models and that NHS quality assurance guidelines and checklists are also applied.

**Control Issues**

The Clinical Commissioning Group is not aware of any current significant control issues which would potentially:

- Prejudice the achievement of priorities or undermine the integrity or reputation of the CCG and/or wider NHS
- Put delivery of the standards expected of the Accounting Officer at risk
- Make it harder to resist fraud or other misuse of resources, or divert resources from another significant aspect of the business
- Have a material impact on the accounts
- Put national security of data integrity at risk

**Review of Economy, Efficiency & Effectiveness of the Use of Resources**

The CCG has systems and processes for managing its resources including the following:
• Standing Orders.

• Scheme of Reservation and Delegation.

• Financial Policies.

• Strict controls on vacancy management, recruitment and use of agency staff

• Devolved budget management throughout the CCG.

• QIPP Delivery

The Governing Body gains assurance on the delivery of its financial duties from the Financial Performance Committee on a monthly basis following their review of detailed financial information including financial planning and QIPP delivery.

The monthly Integrated Performance Report which is submitted to the Governing Body and Clinical Scrutiny Committee provides performance updates on Constitutional Standards, Clinical Quality and Patient Safety, Contractual Performance, Redesign programmes and the Programme Management Office.

The Programme Management Office (PMO) provides a weekly update of progress against key milestones and financial delivery to the organisation and more formal monthly reports to the Financial Performance Committee and as part of the Integrated Performance Report.

Assurance is also provided to the Governing Body via the Audit Committee, which receives regular reports from both Internal and External Audit to ensure that controls are operating effectively and to advise on areas for improvement. The internal audit plan has been designed to deliver assurance against constitutional duties and gave useful insight into any gaps in controls, as outlined in the work of Internal Audit.

Delegation of Functions
The CCG has not delegated any of its functions.

Counter Fraud Arrangements
The CCG is required under the terms of the Standard NHS Contract and in accordance with the NHS Protect Standards for Commissioners: Fraud, Bribery and Corruption to ensure that appropriate counter fraud measures are in place.
There was a robust programme of counter fraud and anti-bribery activity, supported by the accredited Local Counter Fraud Specialist (LCFS) whose annual proportionate proactive work plan to address identified risks, was monitored by the Chief Finance Officer, the Head of Accounting and Control and the Audit Committee. Face to face training was provided to various staff groups at team meetings during 2016/17, including the Chief Operating Office, Corporate Services, the Contracting Team and the Chief Redesign Office.

Counter fraud material was disseminated to staff regularly through the intranet, posters and leaflet, as well as fraud awareness publicity being provided to staff at training sessions. The LCFS input to the review of policies, including the Counter Fraud and Anti-Corruption Policy, Management of Serious Incidents Policy and Procedure, Personal Health Budget and Integrated Personal Budget Policy and the Revalidation Policy (and Procedure) to ensure that the policies were up-to-date and accurate. Policies are reviewed in line with current legislation, from a best practice and counter fraud perspective.

The LCFS attends CCG Audit Committee regularly to provide progress reports and updates, as well as providing an annual NHS Protect Report against each of the Standards for Commissioners. Appropriate action would be taken regarding any NHS Protect quality assurance recommendations.

The LCFS issued 15 Fraud Alerts/Bulletins during 2016/17 relating to subjects such as mandate fraud, increased threats from cyber-attacks, potential telephone fraud, tax refund scams, identity fraud, phishing emails, charitable fraud and IT support fraud, which are ongoing fraud issues nationally within the NHS and the wider public sector.
Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Board’s own assessment of the effectiveness of the organisation’s system of internal control. This Opinion will in turn assist the Board in the completion of its Annual Governance Statement (AGS).

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion; and
3. Commentary.

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

The basis for forming my opinion is as follows:

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

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

1. Commentary – the key issues arising from audits with limited or no assurance are set out below.

Financial Reporting & Budgetary Control

- The CCG had an unidentified QIPP of £0.7m as at the end of month 4. The CCG also had an underlying deficit of £2.9m. A financial recovery plan was drafted and sent to NHSE in August 2016. The plan included QIPP schemes to cover unidentified QIPP for the CCG. At the time of the audit, detailed project plans as to how the Financial Recovery Plan is to be achieved were not available.

- A follow up audit was undertaken in February 2017 which found that a new PMO team had improved the CCG’s approach to the QIPP programme and project development, monitoring and management processes. Work remained on-going to address the 2016/17 shortfall and approve QIPP projects for 2017/18. The reported forecast position for the CCG is break-even which is in line with its plans.

Continuing Healthcare

- There are significant risks in respect of access to social workers, a growing backlog of reviews, and forthcoming PUPoC cases. The backlog of reviews has grown due to
other priorities and risks being consciously managed by the CCGs, but the numbers overdue mean that these need to be addressed.

THIRD PARTY ASSURANCE

Reliance has been placed on the NHS Business Service Authority and Shared Business Services Service Auditor reports ISAE3402 from their independent auditor PricewaterhouseCoopers for Prescription payments and Finance and Accounting Services. The reports cover the period 1st April 2016 to 31st March 2017 and provide the following opinion for both systems:

- the controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2016 to 31 March 2017 and customers applied the complementary user entity controls referred to in the scope paragraph of this assurance report; and

- the controls tested which, together with the complementary user entity controls referred to in the scope paragraph of this assurance report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2016 to 31 March 2017.

Reliance has also been placed on the Serco Service Auditor report ISAE3402 from their independent auditor PricewaterhouseCoopers for Payroll and Pension Services. The report covers the period 1st April 2016 to 31st March 2017 and provides the following basis for a qualified opinion:

- Control design deficiencies have been identified by Serco ASP in relation to IT change controls in respect of control objective “Controls provide reasonable assurance that production environment changes are tested and approved by management prior to implementation in accordance with documented policies and procedures”.

Apart from the matter described above, the opinion states:

- The controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2016 to 31 March 2017 and customers applied the complementary customer controls referred to in the scope paragraph of this assurance report; and,

- the controls tested, which together with the complementary customer controls referred to in the scope paragraph of this report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2016 to 31 March 2017.

With regards to Payroll and Pension services one exception was noted out of 11 controls tested.
Review of the Effectiveness of Governance, Risk Management and Internal Control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

My review was informed in a number of ways:

- Chief Officers within the organisation who have responsibility for the development and maintenance of the system of internal control provided me with assurance.

- The GBAF itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.
• The work of Governing Body committees, particularly the Audit Committee, which scrutinises and challenges governance and risk activities and seeks assurances on the effectiveness of controls

• The Clinical Scrutiny Committee, as a committee of the Governing Body, provides strategic clinical leadership, expertise and advice whilst ensuring effective clinical engagement, utilising clinician’s knowledge of local communities and public and patient involvement

• The work of the Chief Nursing Officers team in carrying out quality visits, inspections and monitoring provider serious incidents and risks

• Contract meetings with providers which hold them to account for the quality of the services commissioned

• The Health & Safety and Risk Committee reviews health & safety risks and ensures the health & safety of the workforce and any persons working or visiting the premises

• The Information Governance Committee reviews information governance risks and issues, including data losses, IT security, the Clinical Commissioning Group’s obligations under the Data Protection Act 1998 and progress with the IG Toolkit assessment, action plan and submission. The latter also monitored by the Audit Committee.

• The work of regulatory bodies such as Monitor and the Care Quality Commission - their inspection reports provided assurance on the quality and governance of our provider organisations and services and help triangulate local information.

• The work of the Local Counter Fraud Specialist.

• The Serious Incident (SI) process for reporting and investigating serious incidents and robust monitoring of action plans to ensure recommendations are put into practice and risk mitigated.

• Internal Audit provides an independent, objective opinion on the degree to which governance and risk management supports the achievement of the
organisation’s objectives. The Head of Internal Audit, in accordance with NHS Internal Audit Standards, was required to provide an annual opinion of the overall adequacy and effectiveness of the organisation’s system of internal control, covering the whole financial year. For 2016-17 the opinion stated that reasonable assurance could be given, as a generally sound system of internal control is in place, designed to meet the organisation’s objectives, and controls are generally being applied consistently and effectively, with only minor areas for improvement identified.

- Within the Clinical Commissioning Group information risk management forms part of the wider information governance agenda. Ultimate responsibility rests with me as Chief Officer and I am supported by the Senior Information Risk Owner (SIRO), a member of the Governing Body. The SIRO in turn is supported on a daily basis by the Information Governance and Risk Manager who has responsibility for following up on issues in this area.

- An Information Governance Group, chaired by the SIRO and attended by staff from all areas, meets every quarter. This group discusses all information related issues and makes recommendations of actions to address them. The group provides updates into the Audit Committee on a regular basis.

To support this, the Clinical Commissioning Group has approved a number of polices including Information Governance Policy, IT Security Policy and a Data Protection Policy, which guide staff on their responsibilities.

**Conclusion**

The Governance Statement highlights the Clinical Commissioning Group’s key strategic risks that include the risk of failure to achieve financial balance, the risk of failure to comply with the NHS Continuing Healthcare framework and the on-going performance issues with mental health services. An additional key issue facing the Clinical Commissioning Group and highlighted in the Governance Statement for 2015-16 relates to Delayed Transfers of Care (DTOC).

The system recognised an expediential rise in DTOC’s in 2015-16. In response a number of streams of work have been established through a fortnightly group
attended by representatives from system partners. Collaborative working forms the core ethos of these groups, seeking to identify opportunities across systems and processes. The main issues contributing to DTOC’s was care provision, both placement and domiciliary. Health continues to work with social care to re-stabilise the domiciliary market and a full strategic market review was undertaken in addition to a care home procurement process. We are therefore pleased to report that these measures have had a tangible impact on the position, which has seen the number of DToC’s significantly reduced.

During 2016-17 the Clinical Commissioning Group has worked hard to address the Continuing Healthcare (CHC) issues highlighted in last year’s Governance Statement. The Clinical Commissioning Group has significantly reduced the number of back-log cases that are awaiting review and is now consistently achieving the 28 day framework target for assessment of CHC claims. Controls within the CHC IT system have been improved which has led to improved data quality and the provision of greater assurance on the quality of information provided. As such, we are pleased to report that this issue was removed from the CCGs Governing Body Assurance Framework (GBAF) as a strategic risk in December 2016.

One of the Clinical Commissioning Groups key priorities is to improve access to mental health services across Suffolk. Norfolk and Suffolk NHS Foundation Trust is the main provider of mental health services commissioned by the Clinical Commissioning Group. The Trusts CQC Inspection report in February 2015 highlighted serious concerns in service quality and rated the Trust inadequate overall. The Clinical Commissioning Group has therefore continued to been work closely with the Trust during 2016-17 to ensure it delivers the required quality improvements.

2016/17 was an important year for the CCG in continuing to transform health and care services within the local CCG area and as part of a wider geographic footprint through the Suffolk and North East Essex Sustainability and Transformation Plan (STP) area. Specific work commenced with our major acute provider, Ipswich Hospital to transform services and reduce unnecessary costs, together with redesign initiatives underway around services for which the CCG had extended and awarded
contracts until October 2017 (111, Out of Hours and Community Services). Overall, the CCGs plans for transforming care are ahead of trajectory.

Dr Ed Garratt

Accountable Officer

23 May 2017
Section 3
Annual Accounts
CONTENTS

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Statement of Financial Position as at 31st March 2017 3
Statement of Changes in Taxpayers' Equity for the year ended 31st March 2017 4
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## Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Description</th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from sale of goods and services</td>
<td>(28,942)</td>
<td>(17,173)</td>
</tr>
<tr>
<td>Other operating income</td>
<td>(54)</td>
<td>(146)</td>
</tr>
<tr>
<td><strong>Total operating income</strong></td>
<td>(28,996)</td>
<td>(17,319)</td>
</tr>
<tr>
<td>Staff costs</td>
<td>2,180</td>
<td>2,622</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td>492,245</td>
<td>466,065</td>
</tr>
<tr>
<td>Depreciation and impairment charges</td>
<td>74</td>
<td>41</td>
</tr>
<tr>
<td>Provision expense</td>
<td>183</td>
<td>(2,127)</td>
</tr>
<tr>
<td>Other Operating Expenditure</td>
<td>510</td>
<td>544</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td>495,192</td>
<td>467,145</td>
</tr>
<tr>
<td>Net Operating Expenditure</td>
<td>466,196</td>
<td>449,826</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the year</strong></td>
<td>466,196</td>
<td>449,826</td>
</tr>
<tr>
<td>Other Comprehensive Expenditure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub total</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Comprehensive Expenditure for the year ended 31 March 2017</strong></td>
<td><strong>466,196</strong></td>
<td><strong>449,826</strong></td>
</tr>
</tbody>
</table>
### Statement of Financial Position as at 31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Non-current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>8</td>
<td>139</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td></td>
<td>139</td>
</tr>
<tr>
<td><strong>Current assets:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>9</td>
<td>2,592</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>10</td>
<td>190</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td>2,782</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td>2,921</td>
</tr>
<tr>
<td><strong>Current liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>11</td>
<td>(28,002)</td>
</tr>
<tr>
<td>Provisions</td>
<td>12</td>
<td>(1,821)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td></td>
<td>(29,823)</td>
</tr>
<tr>
<td><strong>Non-Current Assets plus/less Net Current Assets/Liabilities</strong></td>
<td></td>
<td>(26,902)</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td></td>
<td>(26,902)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers’ Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td></td>
<td>(26,906)</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity:</strong></td>
<td></td>
<td>(26,902)</td>
</tr>
</tbody>
</table>

The notes on pages 6 to 32 form part of this statement.

The financial statements on pages 2 to 32 were approved by the Governing Body on 23 May 2017 and signed on its behalf by:

Dr Ed Garratt  
Chief Accountable Officer  
23 May 2017
Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

<table>
<thead>
<tr>
<th>Changes in taxpayers’ equity for 2016-17</th>
<th>General fund £'000</th>
<th>Revaluation reserve £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2016</td>
<td>(21,769)</td>
<td>4</td>
<td>(21,765)</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 31 March 2017</td>
<td>(21,769)</td>
<td>4</td>
<td>(21,765)</td>
</tr>
<tr>
<td>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2016-17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(466,196)</td>
<td></td>
<td>(466,196)</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>0</td>
<td>(0)</td>
<td>0</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(466,196)</td>
<td>(0)</td>
<td>(466,196)</td>
</tr>
<tr>
<td>Net funding</td>
<td>461,059</td>
<td>0</td>
<td>461,059</td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>(26,906)</td>
<td>4</td>
<td>(26,902)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in taxpayers’ equity for 2015-16</th>
<th>General fund £'000</th>
<th>Revaluation reserve £'000</th>
<th>Total reserves £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2015</td>
<td>(22,465)</td>
<td>4</td>
<td>(22,461)</td>
</tr>
<tr>
<td>Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adjusted NHS Clinical Commissioning Group balance at 31 March 2016</td>
<td>(22,465)</td>
<td>4</td>
<td>(22,461)</td>
</tr>
<tr>
<td>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2015-16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(449,826)</td>
<td></td>
<td>(449,826)</td>
</tr>
<tr>
<td>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</td>
<td>(449,826)</td>
<td>0</td>
<td>(449,826)</td>
</tr>
<tr>
<td>Net funding</td>
<td>450,522</td>
<td>0</td>
<td>450,522</td>
</tr>
<tr>
<td>Balance at 31 March 2016</td>
<td>(21,769)</td>
<td>4</td>
<td>(21,765)</td>
</tr>
</tbody>
</table>

NOTE:

Under the NHS reforms that came into effect in April 2013, most of the material high value assets previously carried by Primary Care Trusts such as land and buildings were transferred to non-CCG bodies, e.g. NHS Property Services Ltd. Consequently CCGs in general do not carry material non-current assets on their balance sheets. Therefore net assets/liabilities equate to the difference between actual net operating costs incurred (accounted for on an accruals basis) and the cash funding drawn down from NHS England to finance this expenditure.

The notes on pages 6 to 32 form part of this statement
NHS Ipswich and East Suffolk Clinical Commissioning Group - Annual Accounts 2016-17

Statement of Cash Flows for the year ended
31 March 2017

<table>
<thead>
<tr>
<th>Note</th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(466,196)</td>
<td>(449,826)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>5</td>
<td>74</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>9</td>
<td>1,820</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>11</td>
<td>3,483</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>12</td>
<td>(552)</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>12</td>
<td>183</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(461,188)</td>
<td>(450,255)</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) before Financing</strong></td>
<td>(461,188)</td>
<td>(450,255)</td>
</tr>
<tr>
<td><strong>Cash Flows from Financing Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grant in Aid Funding Received</td>
<td></td>
<td>461,059</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Financing Activities</strong></td>
<td></td>
<td>461,059</td>
</tr>
<tr>
<td><strong>Net Increase (Decrease) in Cash &amp; Cash Equivalents</strong></td>
<td>10</td>
<td>(129)</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents at the Beginning of the Financial Year</strong></td>
<td></td>
<td>319</td>
</tr>
<tr>
<td>Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td><strong>Cash &amp; Cash Equivalents (including bank overdrafts) at the End of the Financial Year</strong></td>
<td></td>
<td>190</td>
</tr>
</tbody>
</table>

The notes on pages 6 to 32 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 shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014). 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. Where a clinical commissioning group 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.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget.

If the clinical commissioning group is in a “jointly controlled operation”, the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group’s share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a “jointly controlled assets” arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group’s share of any liabilities incurred jointly; and,
- The clinical commissioning group’s share of the expenses jointly incurred.

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

In the application of the clinical commissioning group’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.

1.4.1 Critical Judgements in Applying Accounting Policies

Better Care Fund:

The CCG has entered into a pooled budget arrangement with Suffolk County Council in respect of the Better Care Fund. This is a national policy initiative and the funds involved are material in the CCG accounts. Having reviewed the terms of the agreement, the Department of Health manual for accounts and the appropriate financial reporting standards, the CCG has determined that there are two elements to the Better Care Fund and they are accounted for as follows:

(1) The first part is controlled by 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. The CCG accounts for these costs as healthcare purchased from NHS and non-NHS providers.

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

1.4.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the clinical commissioning group’s accounting policies that have the most significant effect on the amounts recognised in the financial statements:
Notes to the financial statements

Prescription Services:
The CCG receives financial information from NHS Business Services Authority relating to the cost of drugs prescribed by independent GPs, CCG run practices and other CCG services. The total expenditure for the year includes an estimate March, based on the estimated profile of spend. The estimate for March 2017 is £5.0m (2015-16 £4.9m).

Secondary Healthcare:
Secondary activity reports are received from providers monthly, but activity information for the final month of the year is not available in time for the accounts, so estimates are made in agreement with providers. A full reconciliation is undertaken once actual activity is agreed which is at the end of the first quarter of the following year. Any increase or decrease in activity (if any) becomes a charge or credit in the next financial year. Historically, when these estimates have been compared to the subsequent actual data, they have not been materially different. Estimate techniques are used to ensure that the correct levels of income and expenditure due relating to the current year are included through the inclusion of accruals based on known commitments and local knowledge.

Partially Completed Spells:
Expenditure relating to patient care spells that are part-completed at the year-end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. The CCG agrees to use the figures calculated by the local provider Trusts. The closing partially completed spells accruals, as notified by the provider Trusts, have been netted off with the equivalent balances from the prior year, with any resulting difference charged to operating expenses. The value of the accrual as at 31 March 2017 is £1,350k (31 March 2016 £1,056k).

Maternity Pathways:
Expenditure relating to all ante-natal maternity care is made at the start of a pathway. As a result, at the year-end part completed pathways are treated as a prepayment. The CCG agreed the methodology to be used for the calculation with the local provider Trusts. The value of the prepayment as at 31 March 2017 is £1,019k (31 March 2016 £1,114k).

Continuing Healthcare Accruals:
The CCG commissions a large number of Continuing Healthcare (CHC) packages from a variety of providers, and administers these packages using the Broadcare system. At the end of any accounting period there will be a number of liabilities that have not been invoiced by providers, and so an accrual is calculated to ensure that the financial ledger is consistent with the information reported on Broadcare. The value of the accrual as at 31 March 2017 is £1,334k (31 March 2016 £1,212k).

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 Services Authority as part of the estimate for full year expenditure. The value of the accrual as at 31 March 2017 is £5.0m (31 March 2016 £4.9m).

Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Employee Benefits

1.6.1 Short-term Employee Benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement Benefit Costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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 scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period. 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 clinical commissioning group commits itself to the retirement, regardless of the method of payment.
Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group’s accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

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.
Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.
Notes to the financial statements

1.8 Property, Plant & Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:
- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The item has a cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the clinical commissioning group’s services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:
- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value.

Assets are re-valued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Depreciation, Amortisation & Impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical service potential of the assets. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 Leases

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

1.10.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group’s surplus/deficit.

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

Contingent rentals are recognised as an expense in the period in which they are incurred. Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.11 **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 clinical commissioning group’s cash management.

1.12 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group 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. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury’s discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (previously: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.1%)
- Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 **Clinical Negligence Costs**

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.14 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning group contribute annually to a pooled fund, which is used to settle the claims.

1.16 **Financial Assets**

Financial assets are recognised when the clinical commissioning group 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.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.1 **Financial Assets at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group’s surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.16.2 **Held to Maturity Assets**

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.16.3 **Available For Sale Financial Assets**

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.16.4 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
Notes to the financial statements

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset. At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group 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.

1.17.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.17.2 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group’s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.17.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, 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.

1.18 Value Added Tax

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 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.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.
NHS Ipswich and East Suffolk Clinical Commissioning Group - Annual Accounts 2016-17

2 Other Operating Revenue

<table>
<thead>
<tr>
<th>2016-17</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
</tr>
<tr>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Recoveries in respect of employee benefits</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>30</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>28,912</td>
<td>82</td>
<td>28,830</td>
</tr>
<tr>
<td>Other revenue</td>
<td>54</td>
<td>20</td>
<td>34</td>
</tr>
<tr>
<td><strong>Total other operating revenue</strong></td>
<td><strong>28,996</strong></td>
<td><strong>132</strong></td>
<td><strong>28,864</strong></td>
</tr>
</tbody>
</table>

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

**NOTE:** The increase in 'Non-patient care services to other bodies' income is due to lead commissioning arrangements in respect of the Community Services contract. From 1 October 2015 Ipswich and East Suffolk CCG became the lead commissioner for the Community Services contract and recharges West Suffolk CCG for their share of the contract. The part year effect of this arrangement was reflected in the 2015-16 accounts compared to the full year effect in the 2016-17 accounts. This equates to £1,938k per month.

3 Revenue

<table>
<thead>
<tr>
<th>2016-17</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
</tr>
<tr>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>From rendering of services</td>
<td>28,996</td>
<td>132</td>
<td>28,864</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28,996</strong></td>
<td><strong>132</strong></td>
<td><strong>28,864</strong></td>
</tr>
</tbody>
</table>

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.
NHS Ipswich and East Suffolk Clinical Commissioning Group - Annual Accounts 2016-17

4. Employee benefits and staff numbers

### 4.1.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>Permanent Employees</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Employee Benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>1,757</td>
<td>1,714</td>
<td>43</td>
</tr>
<tr>
<td>Social security costs</td>
<td>185</td>
<td>185</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>238</td>
<td>238</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>2,180</strong></td>
<td><strong>2,137</strong></td>
<td><strong>43</strong></td>
</tr>
<tr>
<td><strong>Total - Net employee benefits including capitalised costs</strong></td>
<td><strong>2,180</strong></td>
<td><strong>2,137</strong></td>
<td><strong>43</strong></td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td><strong>2,180</strong></td>
<td><strong>2,137</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

**NOTE:**

West Suffolk CCG hosts the Management Delivery Team that provides management support to both West Suffolk CCG and Ipswich and East Suffolk CCG. The cost of the Management Delivery Team is shared between both CCGs in the following proportion:

- Ipswich and East Suffolk CCG 62.8%
- West Suffolk CCG 37.2%

The Ipswich and East Suffolk CCG share of these pay costs is shown as a charge from West Suffolk CCG in the Ipswich and East Suffolk CCG accounts and not as employee benefits. Likewise the income from the charge is shown as income from Ipswich and East Suffolk CCG in the West Suffolk CCG accounts and is not netted-off against employee benefits.

### 4.1.2 Recoveries in respect of employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>Permanent</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Employee Benefits - Revenue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>2,188</td>
<td>1,898</td>
<td>290</td>
</tr>
<tr>
<td>Social security costs</td>
<td>166</td>
<td>166</td>
<td>0</td>
</tr>
<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>268</td>
<td>268</td>
<td>0</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>2,622</strong></td>
<td><strong>2,332</strong></td>
<td><strong>290</strong></td>
</tr>
<tr>
<td><strong>Less recoveries in respect of employee benefits (note 4.1.2)</strong></td>
<td><strong>(34)</strong></td>
<td><strong>(34)</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Total - Net employee benefits including capitalised costs</strong></td>
<td><strong>2,588</strong></td>
<td><strong>2,298</strong></td>
<td><strong>290</strong></td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td><strong>2,588</strong></td>
<td><strong>2,298</strong></td>
<td><strong>290</strong></td>
</tr>
</tbody>
</table>

### 4.1.2 Recoveries in respect of employee benefits

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>Permanent</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Employee Benefits - Revenue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employer contributions to the NHS Pension Scheme</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total recoveries in respect of employee benefits</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2015-16</th>
<th>Permanent</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Employee Benefits - Revenue</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social security costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Employer contributions to the NHS Pension Scheme</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total recoveries in respect of employee benefits</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>
4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanently employed</td>
<td>Other</td>
</tr>
<tr>
<td>Total Number</td>
<td>42.6</td>
<td>42.4</td>
</tr>
</tbody>
</table>

Of the above:

- Number of whole time equivalent people engaged on capital projects: 0

4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th></th>
<th>2016-17</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Days Lost</td>
<td>337.0</td>
<td>224.0</td>
</tr>
<tr>
<td>Total Staff Years</td>
<td>44.5</td>
<td>42.7</td>
</tr>
<tr>
<td>Average working Days Lost</td>
<td>7.6</td>
<td>5.2</td>
</tr>
</tbody>
</table>

- Number of persons retired early on ill health grounds: 0
- Total additional Pensions liabilities accrued in the year: £000

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

4.4 Exit packages agreed in the financial year

The CCG did not agree any exit packages during 2016-17 (2015-16 £nil).

**NOTE:** West Suffolk CCG agreed an exit package of £96,124 which related to a Management Delivery Team member who was performing a shared role split between West Suffolk CCG and Ipswich and East Suffolk CCG. Due to the fact that West Suffolk CCG hosts the Management Delivery Team, the exit package was paid in full through the host organisation. Therefore the full amount of the exit package is shown in the West Suffolk CCG accounts with income from Ipswich and East Suffolk CCG being accounted for as ‘Non-patient care services to other bodies’. Ipswich and East Suffolk CCG were charged 62.8% of the total settlement by West Suffolk CCG. This equated to £60,366 and was accounted for by Ipswich and East Suffolk CCG as ‘Services from other CCGs and NHS England’ (see Note 5).
4.5 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 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:

4.5.1 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this ‘employer cost cap’ assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.
5. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2016-17 Admin</th>
<th>2016-17 Programme</th>
<th>2015-16 Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>1,907</td>
<td>1,907</td>
<td>2,396</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>224</td>
<td>224</td>
<td>226</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>2,131</td>
<td>49</td>
<td>2,622</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>7,927</td>
<td>4,225</td>
<td>3,702</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>137,913</td>
<td>5</td>
<td>137,908</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>206,426</td>
<td>8</td>
<td>206,418</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>73,156</td>
<td>0</td>
<td>73,156</td>
</tr>
<tr>
<td>Chair and Non Executive Members</td>
<td>502</td>
<td>502</td>
<td>0</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>69</td>
<td>0</td>
<td>69</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>2</td>
<td>(21)</td>
<td>23</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>55</td>
<td>49</td>
<td>6</td>
</tr>
<tr>
<td>Establishment</td>
<td>427</td>
<td>274</td>
<td>153</td>
</tr>
<tr>
<td>Premises</td>
<td>2,090</td>
<td>46</td>
<td>2,044</td>
</tr>
<tr>
<td>Depreciation</td>
<td>74</td>
<td>74</td>
<td>0</td>
</tr>
<tr>
<td>Audit fees</td>
<td>69</td>
<td>69</td>
<td>0</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>61,159</td>
<td>0</td>
<td>61,159</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>1,664</td>
<td>0</td>
<td>1,664</td>
</tr>
<tr>
<td>Other professional fees excl. audit</td>
<td>24</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Education and training</td>
<td>178</td>
<td>132</td>
<td>46</td>
</tr>
<tr>
<td>Provisions</td>
<td>163</td>
<td>209</td>
<td>(26)</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>1,086</td>
<td>0</td>
<td>1,086</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>493,012</td>
<td>5,604</td>
<td>487,408</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>495,192</td>
<td>7,735</td>
<td>487,457</td>
</tr>
</tbody>
</table>

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

**NOTE:** The increase in ‘Services from foundation trusts’ expenditure is due to lead commissioning arrangements in respect of the Community Services contract. From 1 October 2015 Ipswich and East Suffolk CCG became the lead commissioner for the Community Services contract which transferred from a non-NHS provider to a foundation trust. The part year effect of this arrangement was reflected in the 2015-16 accounts compared to the full year effect in the 2016-17 accounts. This equates to £4.94m per month. The income generated from recharging West Suffolk CCG is shown in Note 2.
6.1 Better Payment Practice Code

<table>
<thead>
<tr>
<th>Measure of compliance</th>
<th>2016-17</th>
<th>2016-17</th>
<th>2015-16</th>
<th>2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£'000</td>
<td>Number</td>
<td>£'000</td>
</tr>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade invoices paid in the Year</td>
<td>12,481</td>
<td>91,988</td>
<td>11,308</td>
<td>100,383</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices paid within target</td>
<td>12,063</td>
<td>89,020</td>
<td>11,068</td>
<td>98,601</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>96.65%</td>
<td>96.77%</td>
<td>97.88%</td>
<td>98.22%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Year</td>
<td>2,923</td>
<td>359,040</td>
<td>2,368</td>
<td>285,639</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid within target</td>
<td>2,842</td>
<td>355,753</td>
<td>2,298</td>
<td>280,640</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices paid within target</td>
<td>97.23%</td>
<td>99.08%</td>
<td>97.04%</td>
<td>98.25%</td>
</tr>
</tbody>
</table>

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipts of a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

<table>
<thead>
<tr>
<th>Amounts included in finance costs from claims made under this legislation</th>
<th>£'000</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Compensation paid to cover debt recovery costs under this legislation</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
NHS Ipswich and East Suffolk Clinical Commissioning Group - Annual Accounts 2016-17

7. Operating Leases

7.1 As lessee

The clinical commissioning group occupies property owned and managed by NHS Property Services Limited.

### 7.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>Buildings £'000</th>
<th>2016-17 Total £'000</th>
<th>2015-16 Buildings £'000</th>
<th>2015-16 Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td>2,059</td>
<td>2,059</td>
<td>(197)</td>
<td>(197)</td>
</tr>
<tr>
<td>Total</td>
<td>2,059</td>
<td>2,059</td>
<td>(197)</td>
<td>(197)</td>
</tr>
</tbody>
</table>

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for these arrangements.
8 Property, plant and equipment

<table>
<thead>
<tr>
<th></th>
<th>Plant &amp; machinery</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-17</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Cost or valuation at 01 April 2016</td>
<td>3</td>
<td>337</td>
<td>340</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>0</td>
<td>(4)</td>
<td>(4)</td>
</tr>
<tr>
<td>Cost/Valuation at 31 March 2017</td>
<td>3</td>
<td>333</td>
<td>336</td>
</tr>
<tr>
<td>Depreciation 01 April 2016</td>
<td>3</td>
<td>124</td>
<td>126</td>
</tr>
<tr>
<td>Disposals other than by sale</td>
<td>0</td>
<td>(4)</td>
<td>(4)</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>0</td>
<td>74</td>
<td>74</td>
</tr>
<tr>
<td>Depreciation at 31 March 2017</td>
<td>3</td>
<td>194</td>
<td>197</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2017</td>
<td>0</td>
<td>139</td>
<td>139</td>
</tr>
<tr>
<td>Purchased</td>
<td>0</td>
<td>139</td>
<td>139</td>
</tr>
<tr>
<td>Total at 31 March 2017</td>
<td>0</td>
<td>139</td>
<td>139</td>
</tr>
</tbody>
</table>

Asset financing:

<table>
<thead>
<tr>
<th></th>
<th>Plant &amp; machinery</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owned</td>
<td>0</td>
<td>139</td>
<td>139</td>
</tr>
<tr>
<td>Total at 31 March 2017</td>
<td>0</td>
<td>139</td>
<td>139</td>
</tr>
</tbody>
</table>

Revaluation Reserve Balance for Property, Plant & Equipment

<table>
<thead>
<tr>
<th></th>
<th>Plant &amp; machinery</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2016</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Balance at 31 March 2017</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

2015-16

<table>
<thead>
<tr>
<th></th>
<th>Plant &amp; machinery</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost or valuation at 01 April 2015</td>
<td>3</td>
<td>337</td>
<td>340</td>
</tr>
<tr>
<td>Cost/Valuation At 31 March 2016</td>
<td>3</td>
<td>337</td>
<td>340</td>
</tr>
<tr>
<td>Depreciation 01 April 2015</td>
<td>3</td>
<td>83</td>
<td>86</td>
</tr>
<tr>
<td>Charged during the year</td>
<td>0</td>
<td>41</td>
<td>41</td>
</tr>
<tr>
<td>Depreciation at 31 March 2016</td>
<td>3</td>
<td>124</td>
<td>127</td>
</tr>
<tr>
<td>Net Book Value at 31 March 2016</td>
<td>0</td>
<td>213</td>
<td>213</td>
</tr>
<tr>
<td>Purchased</td>
<td>0</td>
<td>213</td>
<td>213</td>
</tr>
<tr>
<td>Total at 31 March 2016</td>
<td>0</td>
<td>213</td>
<td>213</td>
</tr>
</tbody>
</table>

Asset financing:

<table>
<thead>
<tr>
<th></th>
<th>Plant &amp; machinery</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owned</td>
<td>0</td>
<td>213</td>
<td>213</td>
</tr>
<tr>
<td>Total at 31 March 2016</td>
<td>0</td>
<td>213</td>
<td>213</td>
</tr>
</tbody>
</table>

Revaluation Reserve Balance for Property, Plant & Equipment

<table>
<thead>
<tr>
<th></th>
<th>Plant &amp; machinery</th>
<th>Furniture &amp; fittings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 01 April 2015</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>At 31 March 2016</td>
<td>0</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>
8 Property, plant and equipment cont’d

8.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plant &amp; machinery</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Furniture &amp; fittings</td>
<td>47</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>7</td>
</tr>
</tbody>
</table>

8.2 Economic lives

<table>
<thead>
<tr>
<th></th>
<th>Minimum Life (years)</th>
<th>Maximum Life (Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Furniture &amp; fittings</td>
<td>5</td>
<td>15</td>
</tr>
</tbody>
</table>
### 9 Trade and other receivables

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17 £'000</th>
<th>Non-current 2016-17 £'000</th>
<th>Current 2015-16 £'000</th>
<th>Non-current 2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>1,143</td>
<td>0</td>
<td>2,887</td>
<td>0</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>1,061</td>
<td>0</td>
<td>1,056</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA receivables: Revenue</td>
<td>240</td>
<td>0</td>
<td>337</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA prepayments</td>
<td>61</td>
<td>0</td>
<td>72</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accrued income</td>
<td>4</td>
<td>0</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>VAT</td>
<td>83</td>
<td>0</td>
<td>46</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Trade &amp; other receivables</strong></td>
<td><strong>2,592</strong></td>
<td><strong>0</strong></td>
<td><strong>4,412</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Total current and non current</strong></td>
<td><strong>2,592</strong></td>
<td><strong>0</strong></td>
<td><strong>4,412</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

Included above:
- Prepaid pensions contributions 0 0

The great majority of trade is with NHS bodies and Local Authorities therefore no credit scoring is considered necessary.

#### 9.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>By three to six months</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>By more than six months</td>
<td>74</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>85</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

£nil of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2017.
### 10 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2016-17 £'000</th>
<th>2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 01 April 2016</strong></td>
<td>319</td>
<td>52</td>
</tr>
<tr>
<td><strong>Net change in year</strong></td>
<td>(129)</td>
<td>267</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2017</strong></td>
<td>190</td>
<td>319</td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service
  - 2016-17 £'000: 190
  - 2015-16 £'000: 319
- Cash in hand
  - 2016-17 £'000: 0
  - 2015-16 £'000: 0
- Cash and cash equivalents as in statement of financial position
  - 2016-17 £'000: 190
  - 2015-16 £'000: 319

**Balance at 31 March 2017**: 190 £'000
### NHS Ipswich and East Suffolk Clinical Commissioning Group - Annual Accounts 2016-17

#### 11 Trade and other payables

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17</th>
<th>Non-current 2016-17</th>
<th>Current 2015-16</th>
<th>Non-current 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS payables: revenue</td>
<td>6,419</td>
<td>0</td>
<td>5,104</td>
<td>0</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>1,350</td>
<td>0</td>
<td>1,114</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA payables: Revenue</td>
<td>3,539</td>
<td>0</td>
<td>4,623</td>
<td>0</td>
</tr>
<tr>
<td>Non-NHS and Other WGA accruals</td>
<td>16,425</td>
<td>0</td>
<td>13,620</td>
<td>0</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>269</td>
<td>0</td>
<td>58</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Trade &amp; Other Payables</strong></td>
<td><strong>28,002</strong></td>
<td>0</td>
<td><strong>24,519</strong></td>
<td>0</td>
</tr>
<tr>
<td><strong>Total current and non-current</strong></td>
<td><strong>28,002</strong></td>
<td><strong>24,519</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Included above are liabilities of £Nil due in future years under arrangements to buy out the liability for early retirement over 5 years.

Other payables include £Nil outstanding pension contributions at 31 March 2017.
### 12 Provisions

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17 £'000</th>
<th>Non-current 2016-17 £'000</th>
<th>Current 2015-16 £'000</th>
<th>Non-current 2015-16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing care</td>
<td>310</td>
<td>0</td>
<td>2,190</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1,511</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,821</strong></td>
<td><strong>0</strong></td>
<td><strong>2,190</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**Total current and non-current**

<table>
<thead>
<tr>
<th></th>
<th>Current 2016-17 £'000</th>
<th>Non-current 2016-17 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,821</strong></td>
<td><strong>2,190</strong></td>
</tr>
</tbody>
</table>

#### Continuing Care

- **Balance at 01 April 2016**: 2,190 £'000
- **Arising during the year**: 719 £'000, 1,511 £'000
- **Utilised during the year**: (552) £'000
- **Reversed unused**: (2,047) £'000
- **Balance at 31 March 2017**: 310 £'000, 1,511 £'000

#### Other

- **Balance at 31 March 2017**: 310 £'000, 1,511 £'000

#### Expected timing of cash flows:

- **Within one year**: 310 £'000, 1,511 £'000
- **Balance at 31 March 2017**: 310 £'000, 1,511 £'000

The Continuing Care provision consists of the likely costs associated with the backlog of business as usual cases still to be assessed and appeals as at 31 March 2017. The provision has been calculated on a cases by case basis using both average weekly costs and conversion rates.

The Other provision relates to potential one-off property costs and a dispute in respect of property costs which has been referred to arbitration.

Nil is included in the provisions of the NHS Litigation Authority as at 31 March 2017 in respect of clinical negligence liabilities of the Clinical Commissioning Group.
Financial instruments

13.1 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 NHS Clinical Commissioning Group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. 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 clinical commissioning group 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 clinical commissioning group 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 Clinical Commissioning Group and internal auditors.

13.1.1 Currency risk

The NHS Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

13.1.2 Interest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

13.1.3 Credit risk

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

13.1.4 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.
### 13.2 Financial assets

<table>
<thead>
<tr>
<th>Loans and Receivables</th>
<th>Total 2016-17</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>1,143</td>
<td>1,143</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>243</td>
<td>243</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>190</td>
<td>190</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td><strong>1,576</strong></td>
<td><strong>1,576</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Loans and Receivables</th>
<th>Total 2015-16</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Receivables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>2,887</td>
<td>2,887</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>351</td>
<td>351</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>319</td>
<td>319</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td><strong>3,557</strong></td>
<td><strong>3,557</strong></td>
</tr>
</tbody>
</table>

### 13.3 Financial liabilities

<table>
<thead>
<tr>
<th>Other</th>
<th>Total 2016-17</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>7,769</td>
<td>7,769</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>20,233</td>
<td>20,233</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td><strong>28,002</strong></td>
<td><strong>28,002</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>Total 2015-16</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Payables:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>· NHS</td>
<td>6,218</td>
<td>6,218</td>
</tr>
<tr>
<td>· Non-NHS</td>
<td>18,301</td>
<td>18,301</td>
</tr>
<tr>
<td><strong>Total at 31 March 2017</strong></td>
<td><strong>24,519</strong></td>
<td><strong>24,519</strong></td>
</tr>
</tbody>
</table>
14 Operating segments

The Clinical Commissioning Group consider they have only one segment: commissioning of healthcare services.

The Clinical Commissioning Group has income totalling £28,996k from external customers. Only one customer generated income greater than 10% of the total sum - NHS West Suffolk CCG (£24,283k). The majority of this income is derived from the hosting and lead commissioning arrangements.

15 Pooled budgets

15.1 Mental Health Pooled Fund

The Clinical Commissioning Group has entered into a pooled funding arrangement under section 75 of the NHS Act 2006, in which the Clinical Commissioning Group made a total contribution of £684,458 (2015-16 - £693,732). This is a jointly controlled operation under IAS 31.

The pool is hosted by Suffolk County Council. As a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pool, which are then used to purchase Mental Health services.


The CCG’s share of this surplus is £17,064 (2015-16 - £19,933).

15.2 Better Care Fund

From 1 April 2015, the Clinical Commissioning Group entered into a Section 75 pooled fund arrangement with Suffolk County Council for the Better Care Fund. The Better Care Fund (BCF) is a policy initiative between local authorities, CCGs and NHS providers which has resulted in pooled funds being used to jointly commission or deliver health and social care. Suffolk County Council act as the Host Partner for the pooled fund and provides the financial management for the fund.

Strategic oversight of the Better Care Fund is provided by the Health and Wellbeing Board. The Clinical Commissioning Group and Suffolk County Council have agreed that the already established Suffolk Commissioners’ Group should act as the Partnership Board for the fund. The Partnership Board is responsible for the overall approval of the individual schemes, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

Each partner to the Better Care Fund manages the contracts with their own providers of Better Care Fund services and each partner retains any financial risk relating to those contracts. The Clinical Commissioning Group made a total Better Care Fund contribution of £23.743m in 2016-17 (£22.885m 2015-16), this consisted of direct contributions to the pooled fund totalling £9.147m (£8.939m 2015-16) with the balance spent on a lead commissioning basis by the CCG.
16 Related party transactions (2016-17)

Ipswich and East Suffolk CCG has a governing body consisting of five GPs from across four localities; one secondary care lead; three lay members responsible for patient and public engagement, governance and conflicts of interest and seven chief officers. All of the GPs on the governing body are Partners in Practices that supply general or personal medical services commissioned by Ipswich and East Suffolk CCG. The value of transactions with these Practices is set out in the table below and largely consists of payments for local enhanced services supplied under contract to the CCG.

### Governing Body Members:

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Payments to Related Party</th>
<th>Receipts from Related Party</th>
<th>Amounts owed to Related Party</th>
<th>Amounts due from Related Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Mark Shenton - Partner - Stowhealth</td>
<td>£56</td>
<td>£1</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr Imran Qureshi - Partner - The Leiston Surgery</td>
<td>£42</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr Michael McCullagh - Partner - Orchard Medical Practice</td>
<td>£60</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr John Hague - Partner - The Derby Road Practice</td>
<td>£67</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr Billy McKee - Partner - Walton Surgery</td>
<td>£9</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

Dr Carrie Everitt, the spouse of Dr Mark Shenton, is a GP Partner of Hadleigh Health Centre. The CCG’s transactions with Hadleigh Health Centre were as follows:

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Payments to Related Party</th>
<th>Receipts from Related Party</th>
<th>Amounts owed to Related Party</th>
<th>Amounts due from Related Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hadleigh Health Centre</td>
<td>£81</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>

Ipswich and East Suffolk CCG also has a Clinical Executive Committee comprising the full membership of the governing body together with a further six GPs from Ipswich and East Suffolk. All of the GPs on the Clinical Executive Committee are Partners in Practices that supply general or personal medical services commissioned by Ipswich and East Suffolk CCG. The value of transactions with these Practices, not otherwise disclosed above is set out in the table below and largely consists of payments for local enhanced services supplied under contract to the CCG.

### Clinical Executive Committee Members:

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Payments to Related Party</th>
<th>Receipts from Related Party</th>
<th>Amounts owed to Related Party</th>
<th>Amounts due from Related Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr David Egan - Partner - Debenham Group Practice</td>
<td>£34</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr John Flather - Partner - Hadleigh Health Centre</td>
<td>£81</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr Peter Holloway - Partner - Mendlesham and Bacton Practices</td>
<td>£49</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr Juno Jesuthasan - Partner - Barrack Lane Medical Centre</td>
<td>£77</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr John Oates - Partner - Saxmundham Health Centre</td>
<td>£60</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td>Dr Benjamin Solway - Partner - Dr Solway, Whale and Mallich Practice</td>
<td>£50</td>
<td>£0</td>
<td>£0</td>
<td>£0</td>
</tr>
</tbody>
</table>
16 Related party transactions (2016-17) - continued

The Department of Health is regarded as a related party. During the year Ipswich and East Suffolk CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The entities with whom the value of transactions exceeded £250,000 are listed below:-

2016/17 Entities with whom the value of transactions exceeded £250k

- Barts Health NHS Trust
- Cambridge University Hospital NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Guy's And St Thomas' NHS Foundation Trust
- Ipswich Hospital NHS Trust
- James Paget University Hospitals NHS Foundation Trust
- Mid Essex Hospital Services NHS Trust
- NHS Bedfordshire CCG
- NHS Cambridgeshire and Peterborough CCG
- NHS England
- NHS Great Yarmouth and Waveney CCG
- NHS Luton CCG
- NHS North and East London CSU
- NHS Property Services Ltd
- NHS South Norfolk CCG
- NHS West Suffolk CCG
- Norfolk & Norwich University Hospitals NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health And Care NHS Trust
- North Essex Partnership NHS Foundation Trust
- Papworth Hospital NHS Foundation Trust
- The Royal National Orthopaedic Hospital NHS Trust
- University College London Hospitals NHS Foundation Trust
- West Suffolk NHS Foundation Trust

In addition, Ipswich and East Suffolk CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Suffolk County Council.
16 Related party transactions (2015-16)

Ipswich and East Suffolk CCG has a governing body consisting of seven GPs from across five localities; one secondary care lead; two lay members responsible for patient and public engagement and governance and seven chief officers. All of the GPs on the governing body are Partners in Practices that supply general or personal medical services commissioned by Ipswich and East Suffolk CCG. The value of transactions with these Practices is set out in the table below and largely consists of payments for local enhanced services supplied under contract to the CCG.

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Mark Shenton - Partner - Stowhealth</td>
<td>67</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr Imran Qureshi - Partner - The Leiston Surgery</td>
<td>36</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr Michael McCullagh - Partner - Orchard Medical Practice</td>
<td>63</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr Paul Bethell - Partner - Lattice Barn Surgery</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr John Hague - Partner - The Derby Road Practice</td>
<td>83</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Dr Billy McKee - Partner - Walton Surgery</td>
<td>28</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr Paul Kaiser - Partner - Wickham Market Medical Centre</td>
<td>62</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Dr Carrie Everitt, the spouse of Dr Mark Shenton, is a GP Partner of Hadleigh Health Centre. The CCG’s transactions with Hadleigh Health Centre were as follows:

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Carrie Everitt</td>
<td>71</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Dr Mark Shenton is a director of Stowhealth Limited. The CCG’s transactions with Stowhealth Limited were as follows:

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stowhealth Limited</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Mrs Dawn Herbert, the spouse of Julian Herbert, Chief Officer of the Management Delivery Team and Governing Body Member, is an employee of Suffolk County Council. The CCG’s transactions with Local Authorities are referred to at the end of this note.
16 Related party transactions (2015-16) - continued

Ipswich and East Suffolk CCG also has a Clinical Executive Committee comprising the full membership of the governing body together with a further seven GPs from Ipswich and East Suffolk. All of the GPs on the Clinical Executive Committee are Partners in Practices that supply general or personal medical services commissioned by Ipswich and East Suffolk CCG. The value of transactions with these Practices, not otherwise disclosed above is set out in the table below and largely consists of payments for local enhanced services supplied under contract to the CCG.

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Executive Committee Members:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr David Egan - Partner - Debenham Group Practice</td>
<td>30</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr John Flather - Partner - Hadleigh Health Centre</td>
<td>71</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr Peter Holloway - Partner - Mendlesham and Bacton Practices</td>
<td>55</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr Juno Jesuthasan - Partner - Barrack Lane Medical Centre</td>
<td>76</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Dr John Oates - Partner - Saxmundham Health Centre</td>
<td>60</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr Benjamin Solway - Partner - Dr Solway, Whale and Mallich Practice</td>
<td>32</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dr Christopher Rufford</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Dr Virginia Hubbard, the spouse of Dr Christopher Rufford, is a Consultant in Dermatology at Ipswich Hospital NHS Trust. The CCG’s transactions with Ipswich Hospital NHS Trust are referred to in the section below. Dr Virginia Hubbard is also a Consultant in Dermatology at The Nuffield Hospital Ipswich.

The CCG’s transactions with the Nuffield Health Group were as follows:

<table>
<thead>
<tr>
<th>Name of Related Party</th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuffield Health</td>
<td>2,776</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

The Department of Health is regarded as a related party. During the year Ipswich and East Suffolk CCG has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The entities with whom the value of transactions exceeded £250,000 are listed below:-

2015/16 Entities with whom the value of transactions exceeded £250k:

- Cambridge University Hospital NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Guy’s And St Thomas’ NHS Foundation Trust
- Ipswich Hospital NHS Trust
- James Paget University Hospital NHS Foundation Trust
- Mid Essex Hospital Services NHS Trust
- NHS Bedfordshire CCG
- NHS Cambridgeshire and Peterborough CCG
- NHS England
- NHS Great Yarmouth and Waveney CCG
- NHS Luton CCG
- NHS North and East London CSU
- NHS Norwich CCG
- NHS Property Services Ltd
- NHS South Norfolk CCG
- NHS West Suffolk CCG
- Norfolk & Norwich University Hospitals NHS Foundation Trust
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Community Health And Care NHS Trust
- North Essex Partnership NHS Foundation Trust
- Papworth Hospital NHS Foundation Trust
- The Royal National Orthopaedic Hospital NHS Trust
- University College London Hospitals NHS Foundation Trust
- West Suffolk NHS Foundation Trust

In addition, Ipswich and East Suffolk CCG has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Suffolk County Council.
17 Events after the end of the reporting period

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2017. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View.

NHS Ipswich and East Suffolk CCG has been approved under delegated commissioning arrangements which mean that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2017.

The financial impact of the CCG taking on this delegated responsibility is an increase in both funding (and associated expenditure) for 2017-18 of £54.7M.

18 Losses and special payments

18.1 Losses

The Clinical Commissioning Group made no losses during 2016-17.

18.2 Special payments

The Clinical Commissioning Group made no special payments during 2016-17.
NHS Ipswich and East Suffolk Clinical Commissioning Group - Annual Accounts 2016-17

19 Financial performance targets

NHS Ipswich and East Suffolk Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Ipswich and East Suffolk Clinical Commissioning Group performance against those duties was as follows:

<table>
<thead>
<tr>
<th>NHS Act Section</th>
<th>2016-17 Target £’000</th>
<th>2016-17 Performance £’000</th>
<th>2015-16 Target £’000</th>
<th>2015-16 Performance £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>223H(1) 502,762</td>
<td>495,192</td>
<td>470,118</td>
<td>467,145</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>223I(2) 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>223I(3) 473,766</td>
<td>466,196</td>
<td>452,799</td>
<td>449,826</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>223J(1) 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>223J(2) 0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>223J(3) 8,547</td>
<td>7,604</td>
<td>9,471</td>
<td>7,066</td>
</tr>
</tbody>
</table>

Note: For the purposes of Section 223H(1), expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year, and income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs’ 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS Ipswich and East Suffolk Clinical Commissioning Group has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £4,580k. This additional surplus will be carried forward for drawdown in future years.

The Clinical Commissioning Group achieved a surplus of £7,570k for the year ended 31 March 2017 (£2,973k 2015-16) - shown by line 223I(3) in the table above. This surplus includes £4,580k generated by not spending the 1% non-recurrent monies referred to above.

The financial performance targets above are produced on a cumulative basis. The in-year targets, which exclude the CCG’s surplus brought forward from 2015-16, are shown below:

<table>
<thead>
<tr>
<th>In-year target expenditure not to exceed income</th>
<th>2016-17 Target £’000</th>
<th>2016-17 Performance £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-year target revenue resource use does not exceed the amount specified in Directions</td>
<td>470,792</td>
<td>466,196</td>
</tr>
</tbody>
</table>

The reconciliation of the cumulative and in-year target figures is shown below:

<table>
<thead>
<tr>
<th>In-year target expenditure not to exceed income</th>
<th>499,788</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus brought forward from 2015-16</td>
<td>2,974</td>
</tr>
<tr>
<td>Cumulative target expenditure not to exceed income</td>
<td>502,762</td>
</tr>
<tr>
<td>In-year target revenue resource use does not exceed the amount specified in Directions</td>
<td>470,792</td>
</tr>
<tr>
<td>Surplus brought forward from 2015-16</td>
<td>2,974</td>
</tr>
<tr>
<td>Cumulative target revenue resource use does not exceed the amount specified in Directions</td>
<td>473,766</td>
</tr>
</tbody>
</table>
INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF
NHS IPSWICH AND EAST SUFFOLK CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Ipswich and East Suffolk Clinical Commissioning Group (CCG) for the year ended 31 March 2017 under the Local Audit and Accountability Act 2014. The financial statements 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 19. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2016/17 HM Treasury’s Financial Reporting Manual (the 2016/17 FReM) as contained in the Department of Health Group Accounting Manual 2016/17 and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes on page 52;
- the table of pension benefits of senior managers and related narrative notes on page 56;
- disclosure of payments for loss of office on page 58;
- disclosure of payments to past senior managers on page 58;
- the tables of exit packages on page 64;
- the analysis of staff numbers and costs and related notes on page 59; and
- the disclosure of pay multiples on page 58.

This report is made solely to the members of the Governing Body of NHS Ipswich and East Suffolk CCG in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the members as a body, for our audit work, for this report, or for the opinions we have formed.
Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities set out on page 51, 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 is also responsible for ensuring the regularity of expenditure and income.
Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors. We are also 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 (the "Code of Audit Practice").

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. We are required under Section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the CCG’s circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the Accountable Officer; and
- the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.
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 by the NHS Commissioning Board; or

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 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 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or

- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of NHS Ipswich and East Suffolk CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Mark Hodgson
for and on behalf of Ernst & Young LLP
Cambridge

Date: 25 May 2017

The maintenance and integrity of the NHS Ipswich and East Suffolk CCG web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.