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CLINICAL COMMISSIONING GROUP
DATA PACK GUIDANCE

PRIMARY CARE DATA PACKS AND INSPECTION TEAM

- October 2014 -

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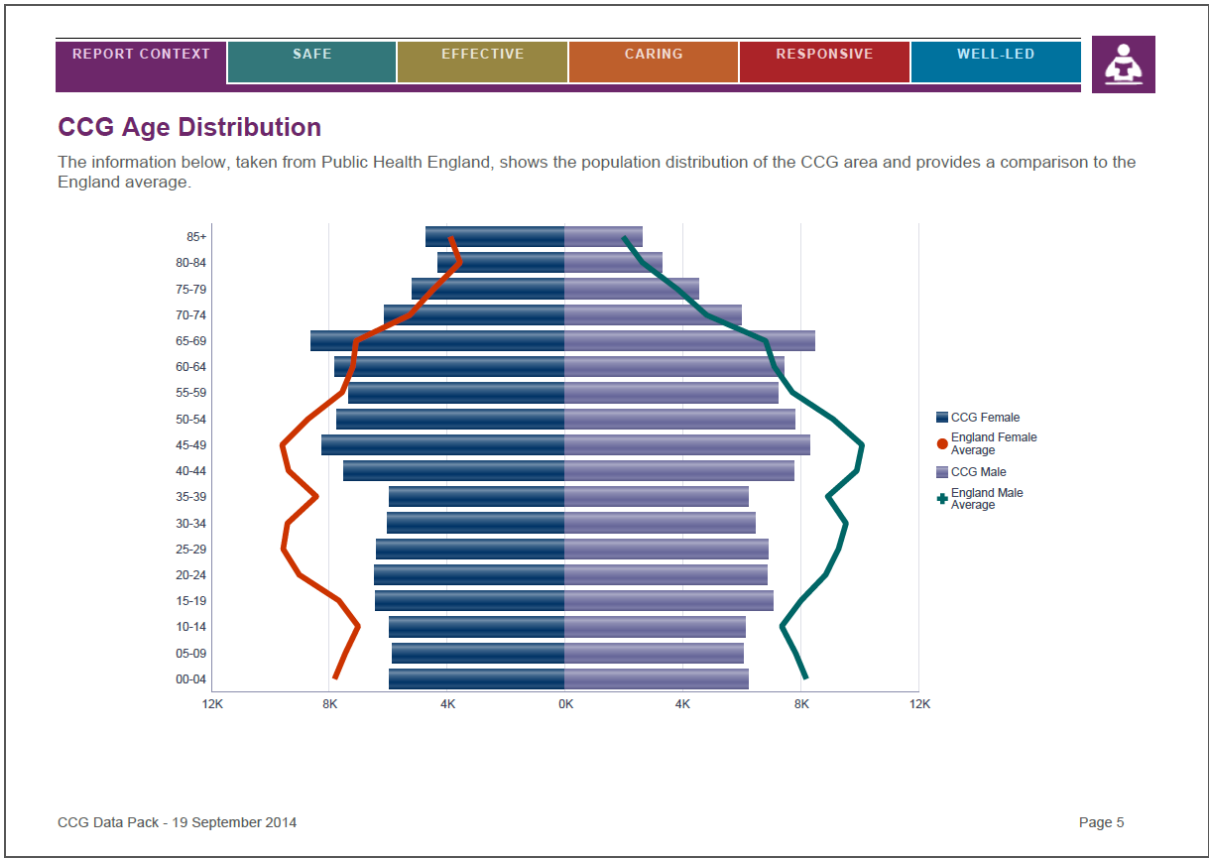
Introduction

The purpose of this guidance is to supplement the information contained in the CCG level data packs and is to be used as an aid in understanding some of the content and terms used the data pack. The CCG packs are primarily used by inspection managers as part of their meetings with CCGs.

This guidance contains screenshots of the relevant sections of the data pack, explains some of the indicators and provides further information regarding some sections of the data pack including hyperlinks to additional sources.

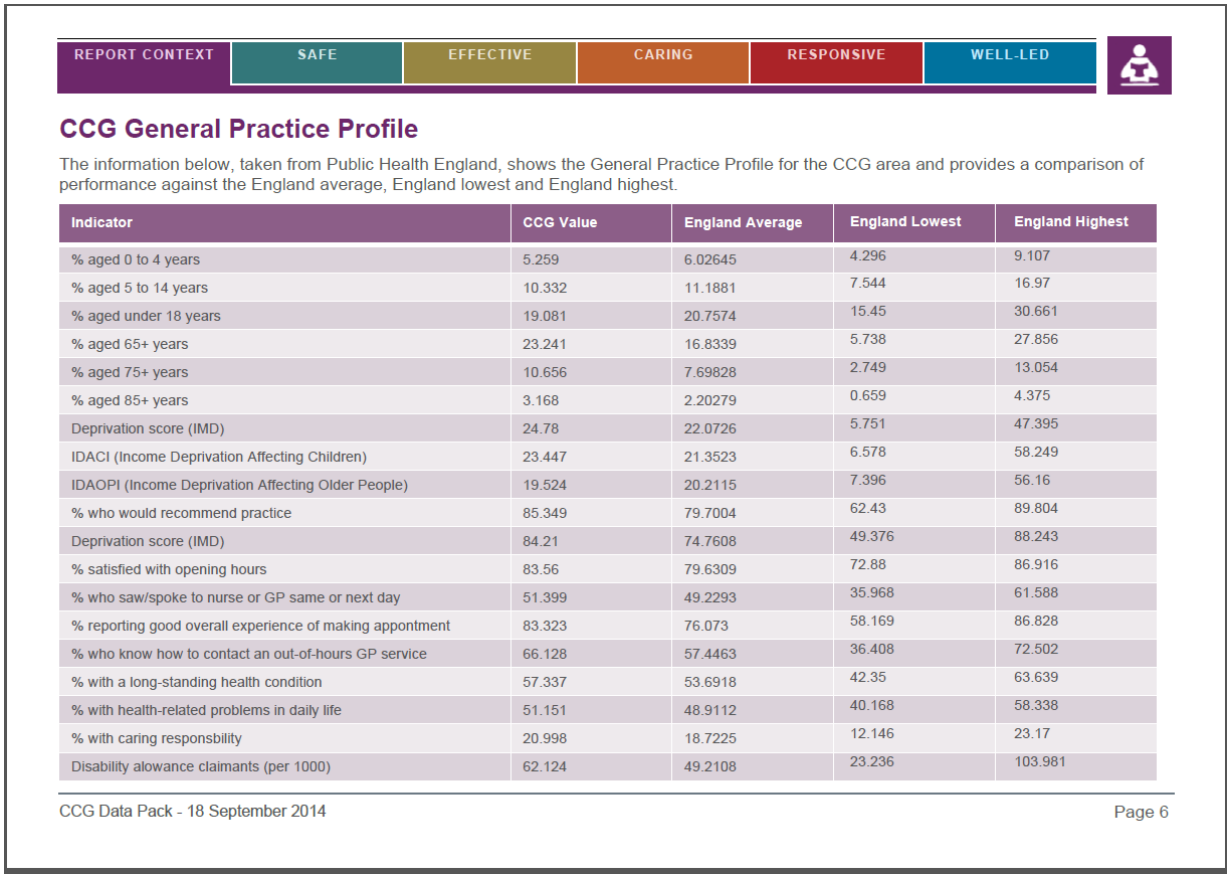
Further guidance will be provided at a future time by means of a webinar (a web-based seminar) and surgeries where members of the PMS Data Pack and Inspection team will be available to assist with any questions or queries regarding the data packs.

CCG Age Distribution



The age distribution graph shows the percentage of males and females registered with a practice, by 5 year age band aggregated to CCG level (April 2013). The percentages for the Clinical Commissioning Group (dark blue, female and purple, male) and the England averages (red line, female and green line, male) are shown to enable the user to see the each age profile of the CCG in comparison to the England average. This information will allow the user to see if the CCG has a young, old or mixed age profile by gender and whether or not this is comparable to the England average. This information provides an insight into the possible health needs of the population that the CCG serves.

CCG General Practice Profile



REPORT CONTEXT | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED

CCG General Practice Profile

The information below, taken from Public Health England, shows the General Practice Profile for the CCG area and provides a comparison of performance against the England average, England lowest and England highest.

Indicator	CCG Value	England Average	England Lowest	England Highest
% aged 0 to 4 years	5.259	6.02645	4.296	9.107
% aged 5 to 14 years	10.332	11.1881	7.544	16.97
% aged under 18 years	19.081	20.7574	15.45	30.661
% aged 65+ years	23.241	16.8339	5.738	27.856
% aged 75+ years	10.656	7.69828	2.749	13.054
% aged 85+ years	3.168	2.20279	0.659	4.375
Deprivation score (IMD)	24.78	22.0726	5.751	47.395
IDACI (Income Deprivation Affecting Children)	23.447	21.3523	6.578	58.249
IDAOPI (Income Deprivation Affecting Older People)	19.524	20.2115	7.396	56.16
% who would recommend practice	85.349	79.7004	62.43	89.804
Deprivation score (IMD)	84.21	74.7608	49.376	88.243
% satisfied with opening hours	83.56	79.6309	72.88	86.916
% who saw/spoke to nurse or GP same or next day	51.399	49.2293	35.968	61.588
% reporting good overall experience of making appontment	83.323	76.073	58.169	86.828
% who know how to contact an out-of-hours GP service	66.128	57.4463	36.408	72.502
% with a long-standing health condition	57.337	53.6918	42.35	63.639
% with health-related problems in daily life	51.151	48.9112	40.168	58.338
% with caring responsbility	20.998	18.7225	12.146	23.17
Disability alowance claimants (per 1000)	62.124	49.2108	23.236	103.981

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Note on interpretation

The age structure and deprivation levels of the population are particularly important in understanding the profiles. The demographic information and other contextual information at the beginning of the profile are essential for interpreting the remaining indicators.

For example, a below average prevalence of diabetes or other long term conditions in a practice may be explained by a much younger than average practice population, such as a practice serving a university.

The prevalence of most of the long term conditions included within QOF is related to both lifestyle behaviours, like smoking, and broader factors, such as level of educational attainment, housing quality, etc. The Index of Multiple Deprivation 2010 is included in the profiles to provide a helpful summary measure because deprivation levels are frequently related to disease prevalence. More deprived practices will generally have a higher prevalence of the common long term conditions.

Deprivation

There are three deprivation indicators in the general practice profile section of the CCG data pack:

Index of Multiple Deprivation (IMD)
https://www.gov.uk/government/statistics/english-indices-of-deprivation-2010

IDACI (Income Deprivation Affecting Children Index)
The proportion of children aged 0–15 years living in income deprived households as a proportion of all children aged 0–15 years.
http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10/

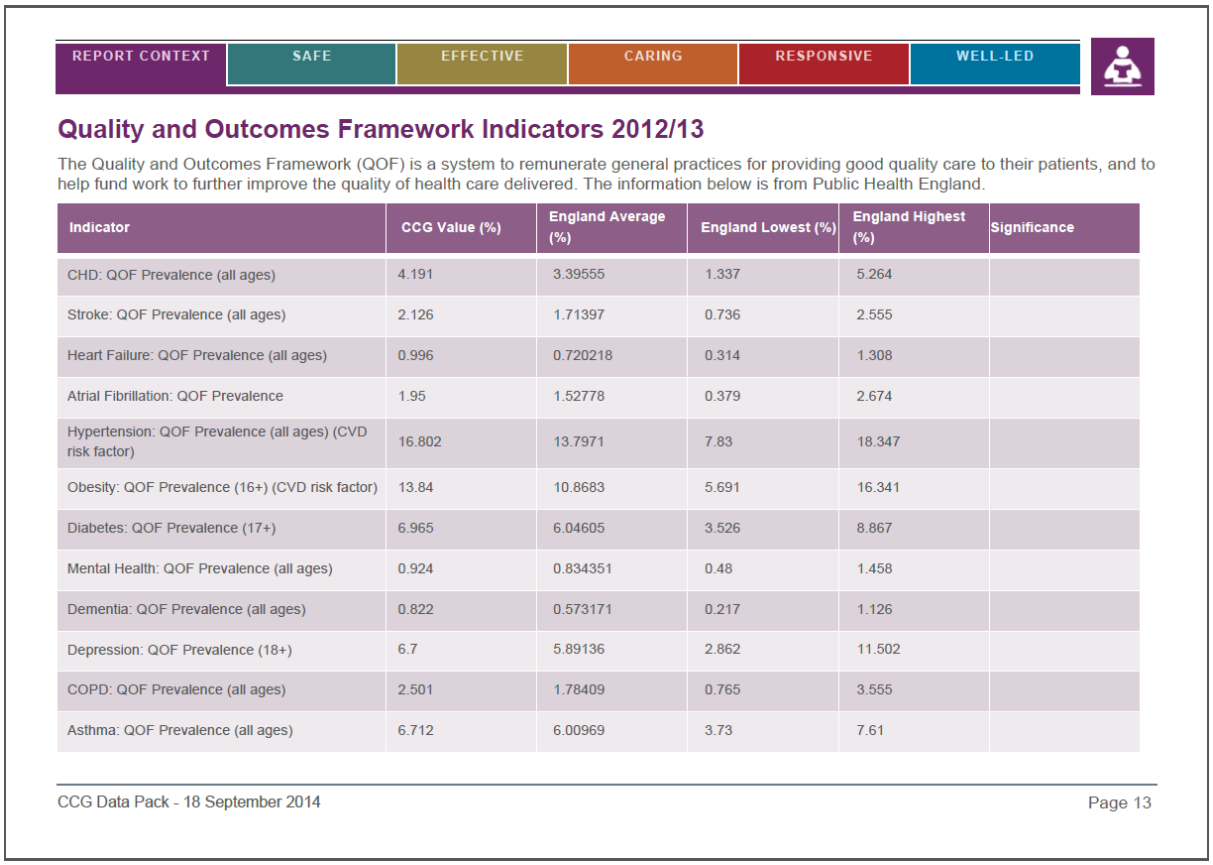
IDAOPI (Income Deprivation Affecting Older People Index)
Adults aged 60 years or over living in pension credit (guarantee) households as a proportion of all those aged 60 years or over.
http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10

People living in more deprived areas tend to have greater need for health services.

Time Periods:

Indicator	Period
% aged 0 to 4 years	2013
% aged 5 to 14 years	2013
% aged under 18 years	2013
% aged 65+ years	2013
% aged 85 + years	2013
Deprivation score (IMD)	2012
IDACI (Income Deprivation Affecting Children)	2012
IDAOPA (Income Deprivation Affecting Older People)	2012
% who would recommend practice	2012/13
% satisfied with phone access	2012/13
% satisfied with opening hours	2012/13
% who saw/spoke to nurse of GP same or next day	2012/13
% reporting good overall experience of making appointment	2012/13
% who know how to contact an out-of-hours GP service	2012/13
% with long-standing health condition	2012/13
% with health-related problems in daily life	2011/12
% with caring responsibility	2012/13
Disability allowance claimants (per 1000)	November 2011
Nursing home patients	2010/11
Working status – Paid work or full-time education	2012/13
Working status – Unemployed	2012/13
Total QOF points	2012/13

Quality and Outcomes Framework Indicators 2012/13



REPORT CONTEXT | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED

Quality and Outcomes Framework Indicators 2012/13

The Quality and Outcomes Framework (QOF) is a system to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. The information below is from Public Health England.

Indicator	CCG Value (%)	England Average (%)	England Lowest (%)	England Highest (%)	Significance
CHD: QOF Prevalence (all ages)	4.191	3.39555	1.337	5.264	
Stroke: QOF Prevalence (all ages)	2.126	1.71397	0.736	2.555	
Heart Failure: QOF Prevalence (all ages)	0.996	0.720218	0.314	1.308	
Atrial Fibrillation: QOF Prevalence	1.95	1.52778	0.379	2.674	
Hypertension: QOF Prevalence (all ages) (CVD risk factor)	16.802	13.7971	7.83	18.347	
Obesity: QOF Prevalence (16+) (CVD risk factor)	13.84	10.8683	5.691	16.341	
Diabetes: QOF Prevalence (17+)	6.965	6.04605	3.526	8.867	
Mental Health: QOF Prevalence (all ages)	0.924	0.834351	0.48	1.458	
Dementia: QOF Prevalence (all ages)	0.822	0.573171	0.217	1.126	
Depression: QOF Prevalence (18+)	6.7	5.89136	2.862	11.502	
COPD: QOF Prevalence (all ages)	2.501	1.78409	0.765	3.555	
Asthma: QOF Prevalence (all ages)	6.712	6.00969	3.73	7.61	

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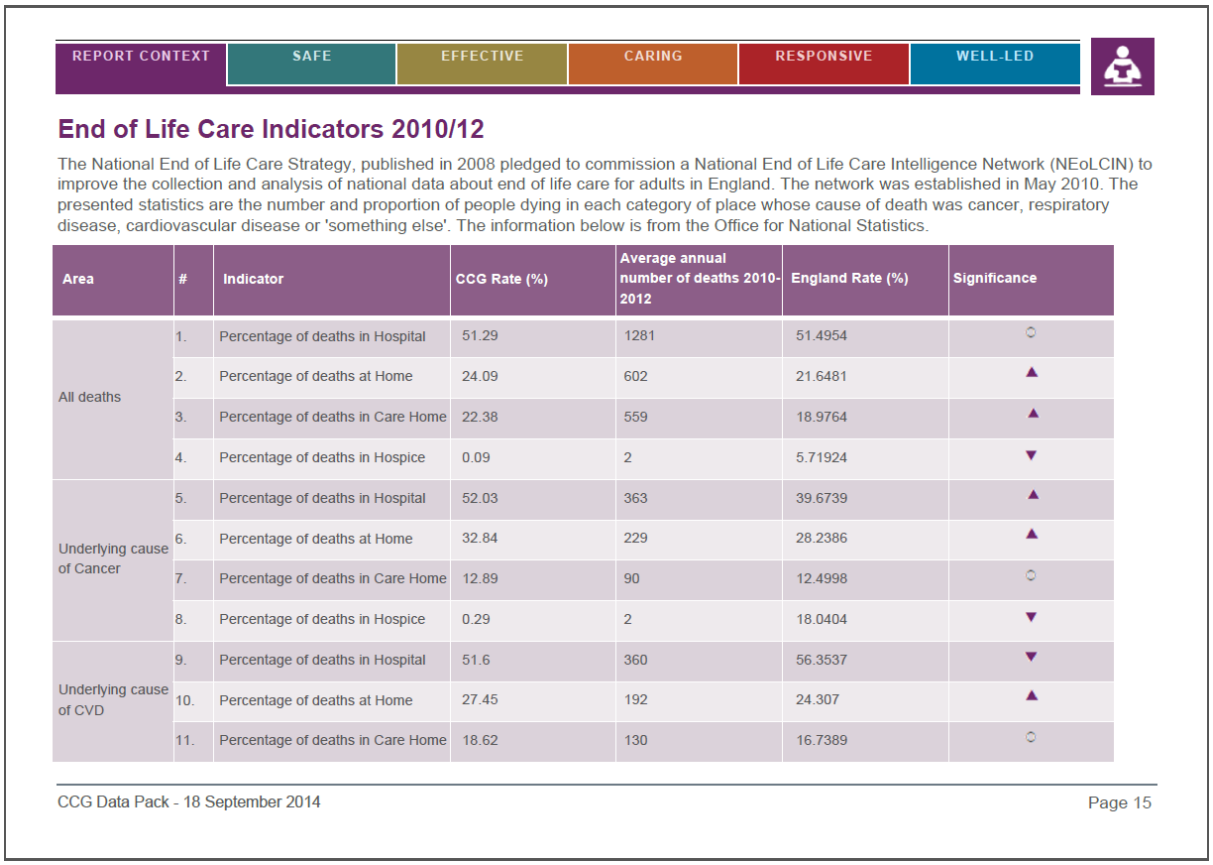
The Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all surgeries in England and was introduced as part of the GP contract in 2004. QOF awards surgeries achievement points for: managing some of the most common chronic diseases e.g. asthma, diabetes, how well the practice is organised, how patients view their experience at the surgery and the amount of extra services offered such as child health and maternity services. As QOF is voluntary it may not be an accurate reflection of the true prevalence of the area.

Prevalence

Prevalence is a measure of the burden of a disease in a population at a particular point in time and is different to incidence (which is a measure of the number of newly diagnosed cases within a particular time period). The QOF prevalence rate is the total number of patients on the register, expressed as a proportion of the total number of patients registered with a practice at one point in time.

http://www.dhsspsni.gov.uk/statistics_and_research-qof-prevalence

End of Life Care Indicators 2010/12



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End of Life Care Indicators 2010/12

The National End of Life Care Strategy, published in 2008 pledged to commission a National End of Life Care Intelligence Network (NEoLCIN) to improve the collection and analysis of national data about end of life care for adults in England. The network was established in May 2010. The presented statistics are the number and proportion of people dying in each category of place whose cause of death was cancer, respiratory disease, cardiovascular disease or 'something else'. The information below is from the Office for National Statistics.

Area	#	Indicator	CCG Rate (%)	Average annual number of deaths 2010-2012	England Rate (%)	Significance
All deaths	1.	Percentage of deaths in Hospital	51.29	1281	51.4954	○
	2.	Percentage of deaths at Home	24.09	602	21.6481	▲
	3.	Percentage of deaths in Care Home	22.38	559	18.9764	▲
	4.	Percentage of deaths in Hospice	0.09	2	5.71924	▼
Underlying cause of Cancer	5.	Percentage of deaths in Hospital	52.03	363	39.6739	▲
	6.	Percentage of deaths at Home	32.84	229	28.2386	▲
	7.	Percentage of deaths in Care Home	12.89	90	12.4998	○
	8.	Percentage of deaths in Hospice	0.29	2	18.0404	▼
Underlying cause of CVD	9.	Percentage of deaths in Hospital	51.6	360	56.3537	▼
	10.	Percentage of deaths at Home	27.45	192	24.307	▲
	11.	Percentage of deaths in Care Home	18.62	130	16.7389	○

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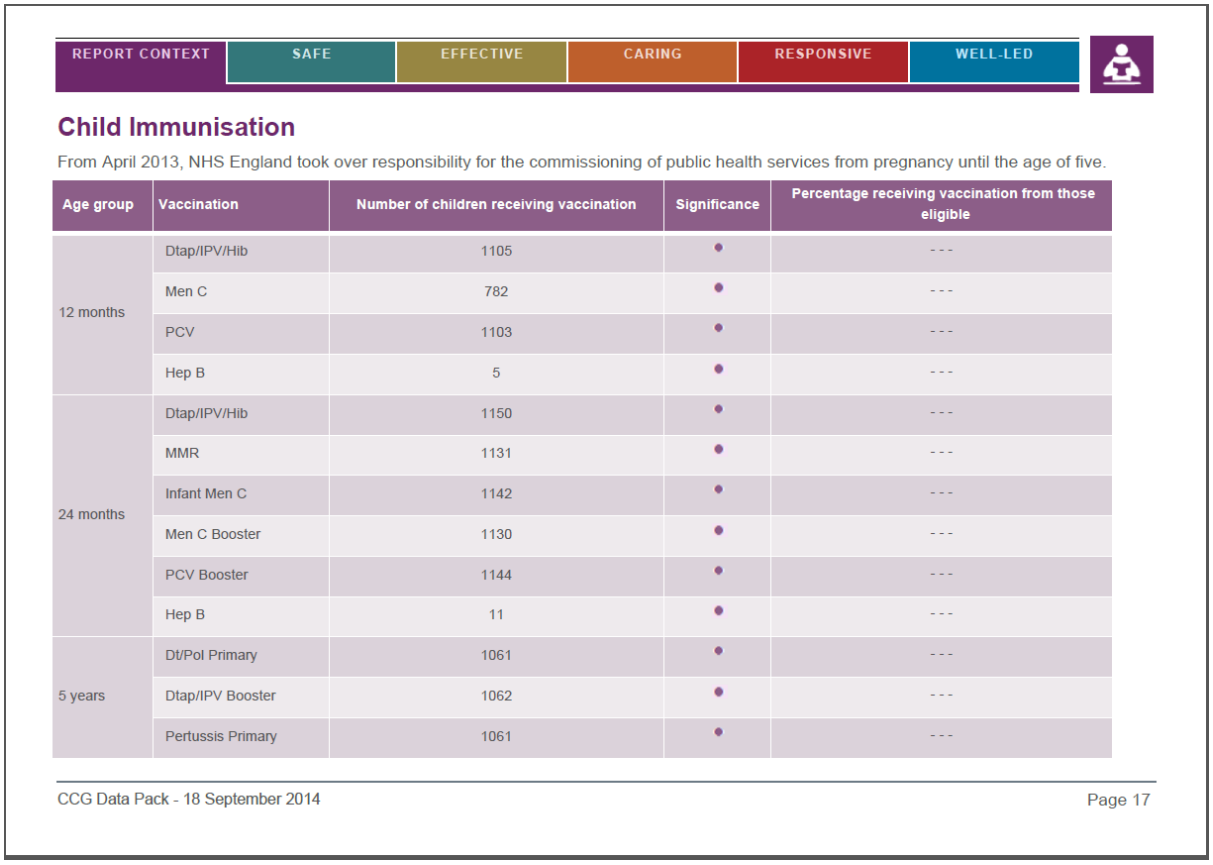
These indicators describe the place of death for residents in each LA.

- Hospital: NHS or non-NHS, acute or community hospitals/units but not psychiatric hospitals.
- Own residence: the death occurred in the place of usual residence where this is not a communal establishment.
- Care home: NHS or private nursing homes, private or Local Authority residential home or specialist nursing homes.
- Hospices: many hospices are “freestanding” but some are found within NHS hospitals. Also, hospices increasingly work in the community. At present ONS classifies the place of death as hospice only when the death occurs in a freestanding hospice premises.

Cause of Death

The “underlying” cause of death is the main cause of death recorded on a death certificate. The “mentions” are either the underlying cause or a contributory cause as recorded on the death certificate. The most common underlying causes and most commonly mentioned contributory causes that are demanding of end of life care were selected.
http://www.endoflifecare-intelligence.org.uk/end_of_life_care_profiles/la_profiles_2012

Child Immunisation



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Child Immunisation

From April 2013, NHS England took over responsibility for the commissioning of public health services from pregnancy until the age of five.

Age group	Vaccination	Number of children receiving vaccination	Significance	Percentage receiving vaccination from those eligible
12 months	Dtap/IPV/Hib	1105		---
	Men C	782		---
	PCV	1103		---
	Hep B	5		---
24 months	Dtap/IPV/Hib	1150		---
	MMR	1131		---
	Infant Men C	1142		---
	Men C Booster	1130		---
	PCV Booster	1144		---
	Hep B	11		---
5 years	Dt/Pol Primary	1061		---
	Dtap/IPV Booster	1062		---
	Pertussis Primary	1061		---

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The child immunisation data is for the time period 1 April 2013 to 31 March 2014.

The number of children receiving a vaccination is an amalgamation of the numbers for each practice in the CCG area and therefore where there are low numbers this is reflective of the practices in the area. Low numbers may indicate that practices may not have submitted data to NHS England.

DTaP/IPV/Hib

The DTaP/IPV/Hib vaccine, also known as the 5-in-1 vaccine, is one of the first vaccines that a baby will have. It's a single injection which protects them against five serious childhood diseases (diphtheria, tetanus, whooping cough (pertussis), polio, and Hib (Haemophilus influenzae type b)). http://www.nhs.uk/conditions/vaccinations/pages/5-in-1-infant-dtapipvhib-vaccine.aspx

Men C

The meningitis C vaccine - better known as Men C - protects against infection by meningococcal group C bacteria, which can cause two very serious illnesses, meningitis and septicaemia. The Men C vaccine does not protect against meningitis caused by meningococcal group B bacteria, therefore it is important to be aware of the symptoms of meningitis.

Which children should have the meningitis C vaccine?

Children are routinely offered the Men C vaccine as part of the NHS childhood vaccination programme at:

- 3 months
- 12 months
- 13-15 years (teenage booster)

Babies have their first Men C vaccination when they are three months old.

Babies then have a second dose of Men C at 12 months. This dose is combined with the Hib (Haemophilus influenzae type b) vaccine and is called the Hib/Men C booster (see the separate section on the Men C booster).

Two doses of Men C vaccine are given to make sure babies develop a good enough immune response to protect them against meningitis C in early childhood.

The Men C vaccine is also routinely available as a teenage booster to children aged 13-15 years. This Men C teenage booster can be given at the same time as the 3-in-1 teenage booster (against tetanus, diphtheria and polio) and will extend the child's protection against meningitis C into early adulthood.
http://www.nhs.uk/Conditions/vaccinations/Pages/men-c-vaccine.aspx

PCV (Pneumococcal vaccine) / PCV Booster

The pneumococcal vaccine (or 'pneumo jab' or pneumonia vaccine as it's also known) protects against pneumococcal infections. Pneumococcal infections are caused by the bacterium Streptococcus pneumoniae and can lead to pneumonia, septicaemia (a kind of blood poisoning) and meningitis.

Who should have the pneumococcal vaccine?

A pneumococcal infection can affect anyone. However, some people need the pneumococcal vaccination because they are at higher risk of complications. These include:

- all children under the age of two
- adults aged 65 or over
- children and adults with certain long-term health conditions, such as a serious heart or kidney condition

http://www.nhs.uk/conditions/vaccinations/pages/pneumococcal-vaccination.aspx

Hepatitis B

Hepatitis B is a type of virus that can infect the liver.

Symptoms can include:

- feeling sick
- being sick
- lack of appetite
- flu-like symptoms, such as tiredness, general aches and pains, and headaches
- yellowing of the skin and eyes (jaundice)

Many people do not realise they have been infected with the virus because the symptoms may not develop immediately, or even at all. It takes between 40 and 160 days for any symptoms to develop after exposure to the virus.

Babies and hepatitis B vaccination

Babies born to mothers infected with hepatitis B need to be given a dose of the hepatitis B vaccine after they are born. This should be given within 24 hours of birth and followed by a further dose of the vaccine at one, two and twelve months after birth.

Some mothers infected with hepatitis B are considered especially high-risk because they are highly infectious. Babies born to these high-risk mothers should also receive an injection of HBIG at birth (in addition to hepatitis B vaccination) to give them rapid protection against infection.

All babies born to mothers infected with hepatitis B should be tested at 12 months of age to check if they have become infected with hepatitis B.
http://www.nhs.uk/conditions/vaccinations/pages/hepatitis-b-vaccine.aspx

MMR (Measles, Mumps & Rubella)

MMR vaccine is given on the NHS as a single injection to babies as part of their routine vaccination schedule, usually within a month of their first birthday. They will then have a second injection of the vaccine before starting school, usually between the ages of three and five.

The MMR vaccine can sometimes be given to babies from six months of age if they may have been exposed to the measles virus, or during a measles outbreak.

Babies under six months old are not routinely given the MMR vaccine. This is because the antibodies to measles, mumps and rubella passed from their mothers at the time of birth are retained and can work against the vaccine, meaning it's not usually effective. However, this means the risk of any side effects is even lower among these younger babies, because the antibodies passed from the mother stop the viruses in the vaccine from growing. These maternal antibodies decline with age and are almost all gone by the time that MMR is normally given – around one year old.

In certain circumstances, for example during a measles outbreak, MMR vaccination is recommended for six- to nine-month-old babies if they are at high risk of becoming infected. However, these children may not have sufficient protection from this early dose, so they will still need the standard MMR doses at 12-13 months and 40 months of age.
http://www.nhs.uk/Conditions/vaccinations/Pages/mmr-vaccine.aspx

Men C Booster

The Hib/Men C vaccine is given as a single injection to boost an infant's protection against two different diseases Haemophilus influenzae type b (Hib) and meningitis C.

Hib and meningitis C infections are serious and potentially fatal and they can both cause meningitis and septicaemia (blood poisoning).

Who should have the Hib/Men C booster?

The Hib/Men C is a booster vaccination given to all babies shortly after their first birthday as part of the NHS childhood vaccination programme. The vaccine boosts the protection the child has already gained from their first course of Hib vaccine which they had in the 5-in-1 vaccine at 8, 12 and 16 weeks old, and the Men C vaccine which they had at 12 weeks.

Once the baby has received the Hib/Men C booster, they will be protected against Hib and meningitis C into adulthood. The brand name of the Hib/Men C vaccine given in the UK is Menitorix.
http://www.nhs.uk/conditions/vaccinations/pages/hib-men-c-booster-vaccine.aspx

Dtap/IPV Booster

Also known as the DTaP/IPV (or dTaP/IPV) vaccine or simply the 'pre-school booster', the 4-in-1 pre-school booster vaccine is given to three-year-old children to boost their protection against:

- diphtheria
- tetanus
- whooping cough
- polio

Children are routinely vaccinated against these illnesses as babies. This booster increases their immunity even further.

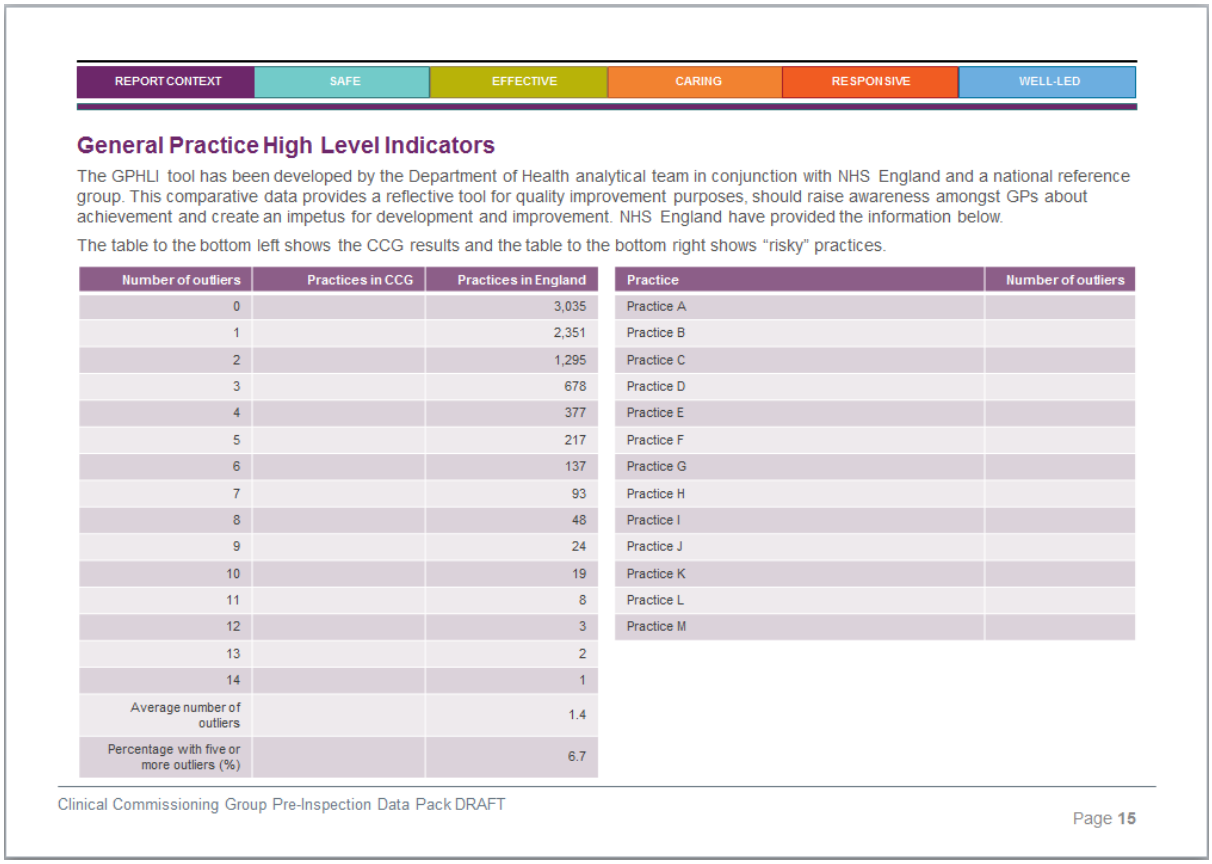
Who should have the 4-in-1 vaccine?

The 4-in-1 booster vaccine is given to pre-school children when they are about three years and four months old. Two different 4-in-1 vaccines are available. One contains higher-strength diphtheria (DTaP/IPV) and has the brand name Infanrix-IPV. The other contains lower-strength diphtheria (dTaP/IPV) and has the brand name Repevax.
http://www.nhs.uk/Conditions/vaccinations/Pages/4-in-1-pre-school-dtap-ipv-booster.aspx

Pertussis Primary

Whooping cough (see Dtap/IPV Booster)

General Practice High Level Indicators



REPORT CONTEXT | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED

General Practice High Level Indicators

The GPHLI tool has been developed by the Department of Health analytical team in conjunction with NHS England and a national reference group. This comparative data provides a reflective tool for quality improvement purposes, should raise awareness amongst GPs about achievement and create an impetus for development and improvement. NHS England have provided the information below.

The table to the bottom left shows the CCG results and the table to the bottom right shows "risky" practices.

Number of outliers	Practices in CCG	Practices in England
0		3,035
1		2,351
2		1,295
3		678
4		377
5		217
6		137
7		93
8		48
9		24
10		19
11		8
12		3
13		2
14		1
Average number of outliers		1.4
Percentage with five or more outliers (%)		6.7

Practice	Number of outliers
Practice A	
Practice B	
Practice C	
Practice D	
Practice E	
Practice F	
Practice G	
Practice H	
Practice I	
Practice J	
Practice K	
Practice L	
Practice M	

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Practices are identified as 'outliers' if they are outside two standard errors from the England average. A practice with five or more outliers is considered to be potentially 'risky'.

The average number of outliers for the practices in the CCG and for all practices in England can be used to determine whether or not the number of outliers in the CCG is higher, lower or in line with the England average.

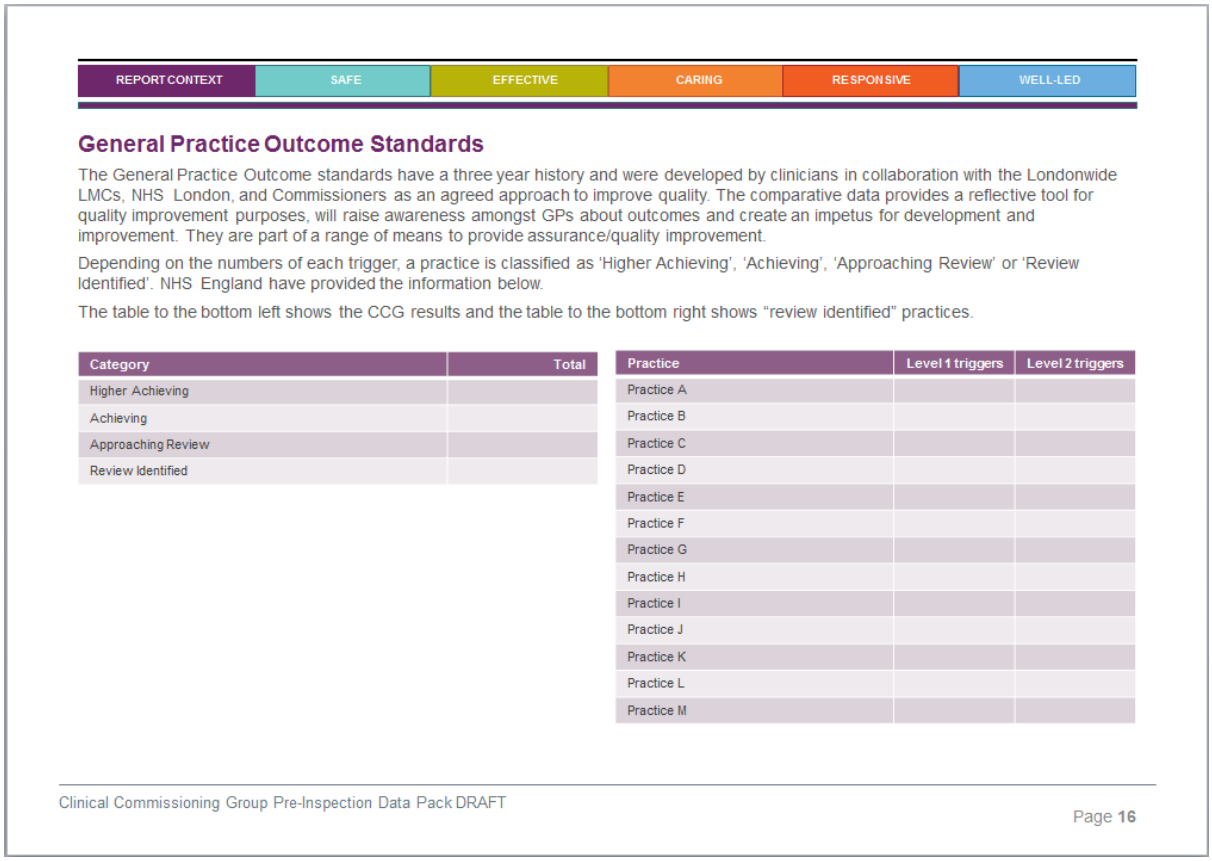
The percentage of practices with five or more outliers for the practices in the CCG and for all practices in England can be used to determine whether or not the number of potentially 'risky' practices in the CCG is higher, lower or in line with the England average.

How are outliers identified?

Funnel plots are used to identify whether a practice is an outlier of interest on each indicator. Funnel plots allow many data points to be plotted and then identify whether or not any individual point is significantly above or below the expected value. In this tool the funnel plots plot points for every practice and compare them to the England Average.

N.B. Some early data packs will not have this information available; this will become available in due course.

General Practice Outcome Standards



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General Practice Outcome Standards

The General Practice Outcome standards have a three year history and were developed by clinicians in collaboration with the Londonwide LMCs, NHS London, and Commissioners as an agreed approach to improve quality. The comparative data provides a reflective tool for quality improvement purposes, will raise awareness amongst GPs about outcomes and create an impetus for development and improvement. They are part of a range of means to provide assurance/quality improvement.

Depending on the numbers of each trigger, a practice is classified as 'Higher Achieving', 'Achieving', 'Approaching Review' or 'Review Identified'. NHS England have provided the information below.

The table to the bottom left shows the CCG results and the table to the bottom right shows "review identified" practices.

Category	Total
Higher Achieving	
Achieving	
Approaching Review	
Review Identified	

Practice	Level 1 triggers	Level 2 triggers
Practice A		
Practice B		
Practice C		
Practice D		
Practice E		
Practice F		
Practice G		
Practice H		
Practice I		
Practice J		
Practice K		
Practice L		
Practice M		

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Depending on the numbers of each trigger, a practice is classified as 'Higher Achieving', 'Achieving', 'Approaching Review' or 'Review Identified':

- Higher Achieving - between zero and one triggers in total and no level two triggers.
- Achieving - between two and five triggers in total or one level two trigger.
- Approaching Review - between six and eight 8 triggers in total or no more than two level two triggers.
- Review Identified - nine or more triggers in total or three or more level two triggers.

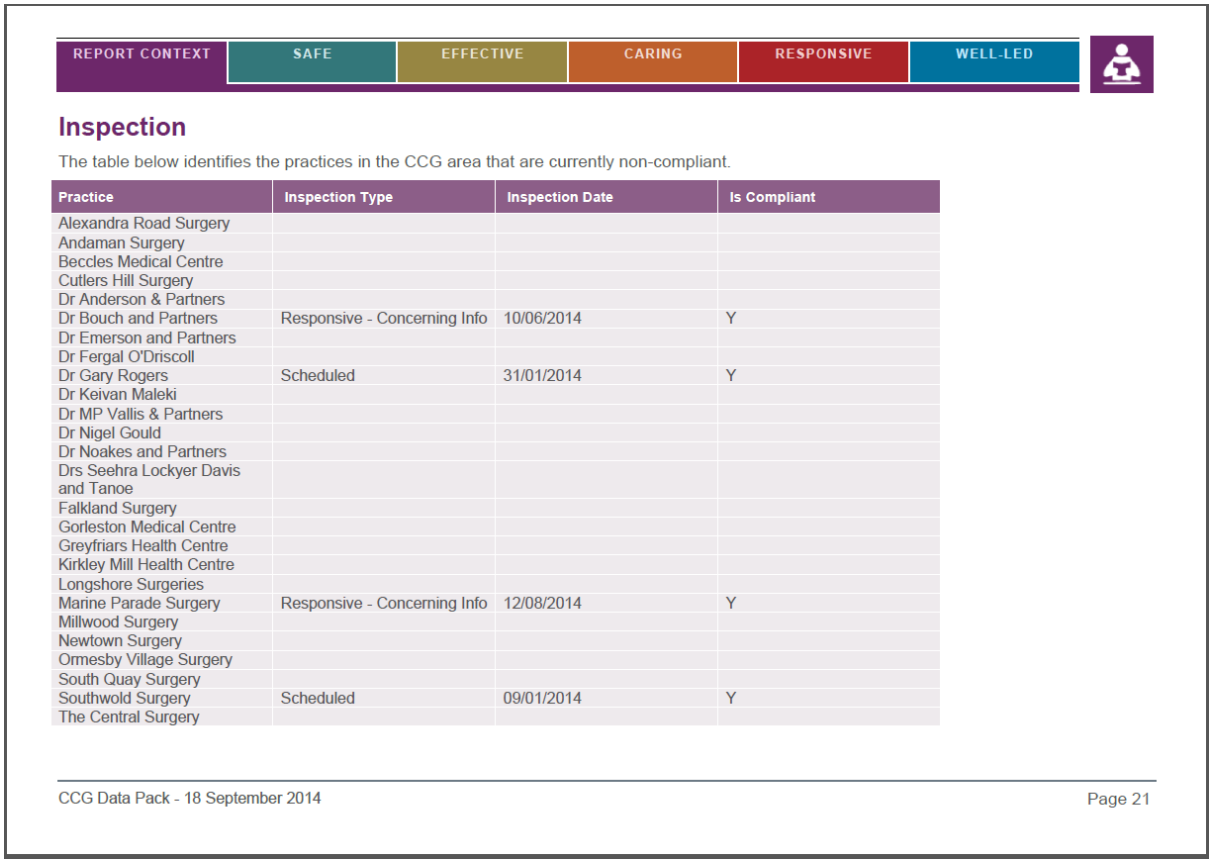
How are 'triggers' identified?

Practices within two standard deviations of the nationally expected threshold will flag a level 1 trigger. Practices greater than two standard deviations from the nationally expected threshold will flag a level 2 trigger.

The level of trigger, alongside an understanding of the local context, provides commissioners and GP practices with an indication of areas that may require improvement.

N.B. Some early data packs will not have this information available; this will become available in due course.

Inspection



REPORT CONTEXT | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED

Inspection

The table below identifies the practices in the CCG area that are currently non-compliant.

Practice	Inspection Type	Inspection Date	Is Compliant
Alexandra Road Surgery			
Andaman Surgery			
Beccles Medical Centre			
Cutlers Hill Surgery			
Dr Anderson & Partners			
Dr Bouch and Partners	Responsive - Concerning Info	10/06/2014	Y
Dr Emerson and Partners			
Dr Fergal O'Driscoll			
Dr Gary Rogers	Scheduled	31/01/2014	Y
Dr Keivan Maleki			
Dr MP Vallis & Partners			
Dr Nigel Gould			
Dr Noakes and Partners			
Drs Seehra Lockyer Davis and Tanoe			
Falkland Surgery			
Gorleston Medical Centre			
Greyfriars Health Centre			
Kirkley Mill Health Centre			
Longshore Surgeries			
Marine Parade Surgery	Responsive - Concerning Info	12/08/2014	Y
Millwood Surgery			
Newtown Surgery			
Ormesby Village Surgery			
South Quay Surgery			
Southwold Surgery	Scheduled	09/01/2014	Y
The Central Surgery			

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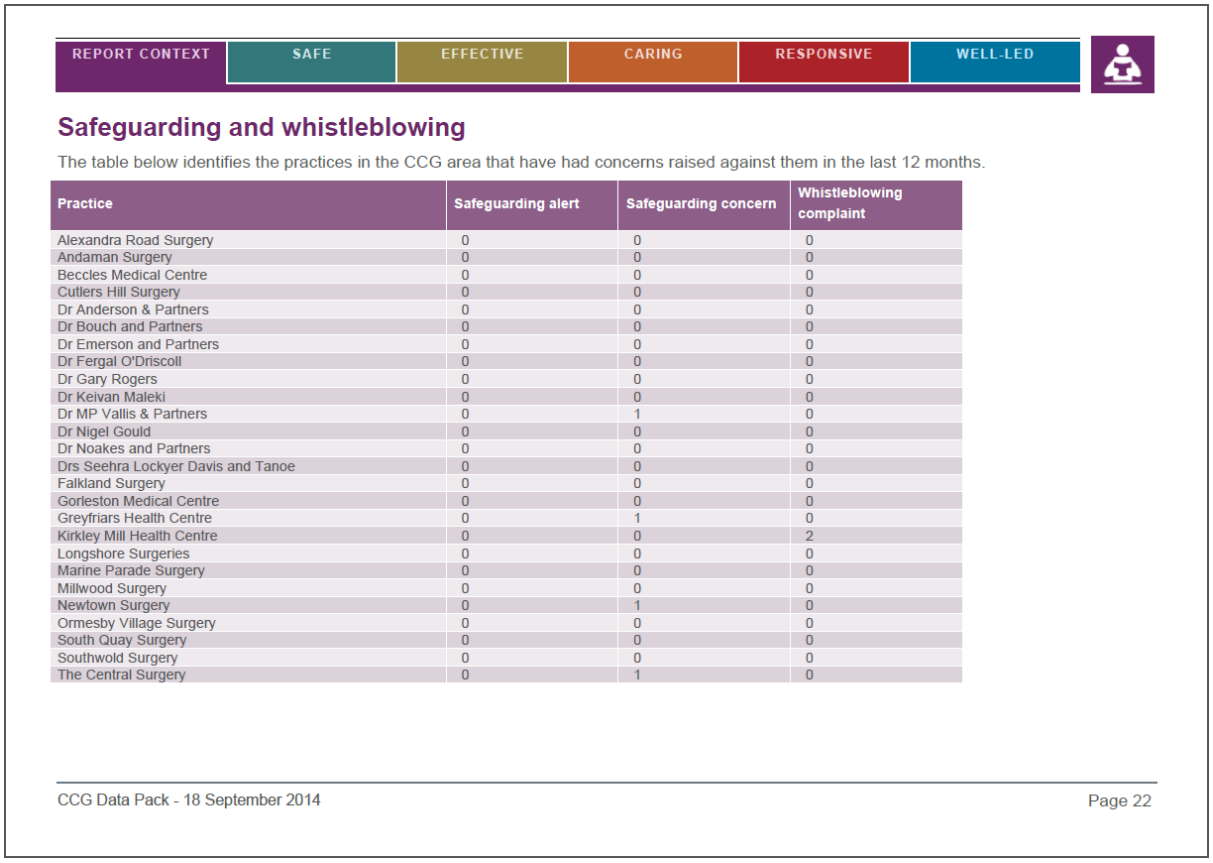
The table in this section identifies the practices in the CCG area and whether the practices are currently compliant or non-compliant. Also shown is the type and date of the inspection. Blank entries denote that the practice is yet to be inspected.

Safeguarding and whistleblowing



REPORT CONTEXT | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED

Safeguarding and whistleblowing

The table below identifies the practices in the CCG area that have had concerns raised against them in the last 12 months.

Practice	Safeguarding alert	Safeguarding concern	Whistleblowing complaint
Alexandra Road Surgery	0	0	0
Andaman Surgery	0	0	0
Beccles Medical Centre	0	0	0
Cutlers Hill Surgery	0	0	0
Dr Anderson & Partners	0	0	0
Dr Bouch and Partners	0	0	0
Dr Emerson and Partners	0	0	0
Dr Fergal O'Driscoll	0	0	0
Dr Gary Rogers	0	0	0
Dr Keivan Maleki	0	0	0
Dr MP Vallis & Partners	0	1	0
Dr Nigel Gould	0	0	0
Dr Noakes and Partners	0	0	0
Drs Seehra Lockyer Davis and Tanoe	0	0	0
Falkland Surgery	0	0	0
Gorleston Medical Centre	0	0	0
Greyfriars Health Centre	0	1	0
Kirkley Mill Health Centre	0	0	2
Longshore Surgeries	0	0	0
Marine Parade Surgery	0	0	0
Millwood Surgery	0	0	0
Newtown Surgery	0	1	0
Ormesby Village Surgery	0	0	0
South Quay Surgery	0	0	0
Southwold Surgery	0	0	0
The Central Surgery	0	1	0

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Safeguarding refers to an organisations responsibility to protect people whose circumstances make them vulnerable to abuse, harm or neglect.

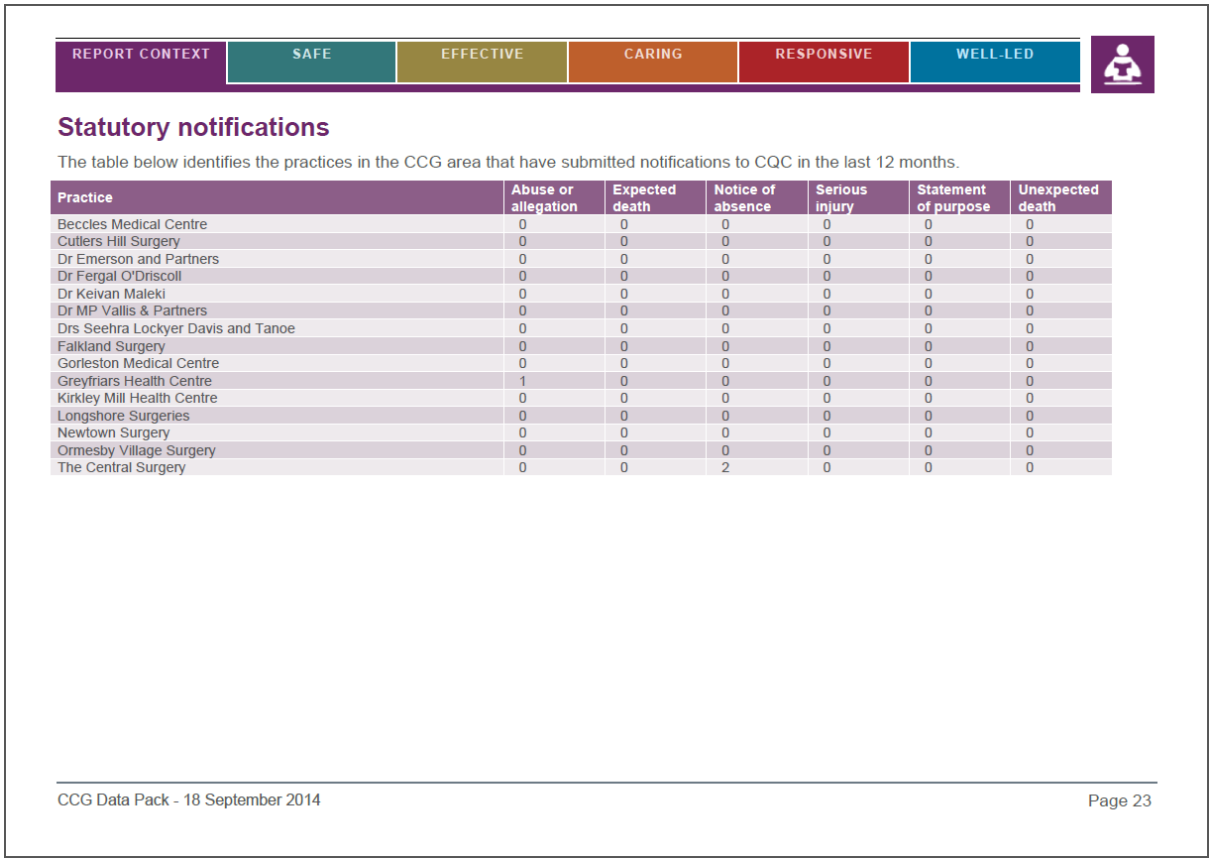
As a regulator, CQC's main responsibility is to ensure that providers of care have adequate systems in place and that these are effectively implemented.

- Vulnerable adult alerts: This is typically where CQC is the first receiver of information about abuse or possible abuse, and where we will need to alert the local safeguarding authority and/or police and/or consider taking regulatory action. The information could also constitute an alert where CQC is not the first receiver of information if CQC is required to take immediate action to ensure that people are safe.

- Vulnerable adult concern: This is typically where CQC is not the first receiver of information about abuse or possible abuse, but will still need to consider the information and whether any regulatory action is needed.

- Whistleblowers are members of staff or suppliers of services to an employer who are raising their concern about abuse.

Statutory notifications



REPORT CONTEXT | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED

Statutory notifications

The table below identifies the practices in the CCG area that have submitted notifications to CQC in the last 12 months.

Practice	Abuse or allegation	Expected death	Notice of absence	Serious injury	Statement of purpose	Unexpected death
Beccles Medical Centre	0	0	0	0	0	0
Cutlers Hill Surgery	0	0	0	0	0	0
Dr Emerson and Partners	0	0	0	0	0	0
Dr Fergal O'Driscoll	0	0	0	0	0	0
Dr Keivan Maleki	0	0	0	0	0	0
Dr MP Vallis & Partners	0	0	0	0	0	0
Drs Seehra Lockyer Davis and Tanoe	0	0	0	0	0	0
Falkland Surgery	0	0	0	0	0	0
Gorleston Medical Centre	0	0	0	0	0	0
Greyfriars Health Centre	1	0	0	0	0	0
Kirkley Mill Health Centre	0	0	0	0	0	0
Longshore Surgeries	0	0	0	0	0	0
Newtown Surgery	0	0	0	0	0	0
Ormesby Village Surgery	0	0	0	0	0	0
The Central Surgery	0	0	2	0	0	0

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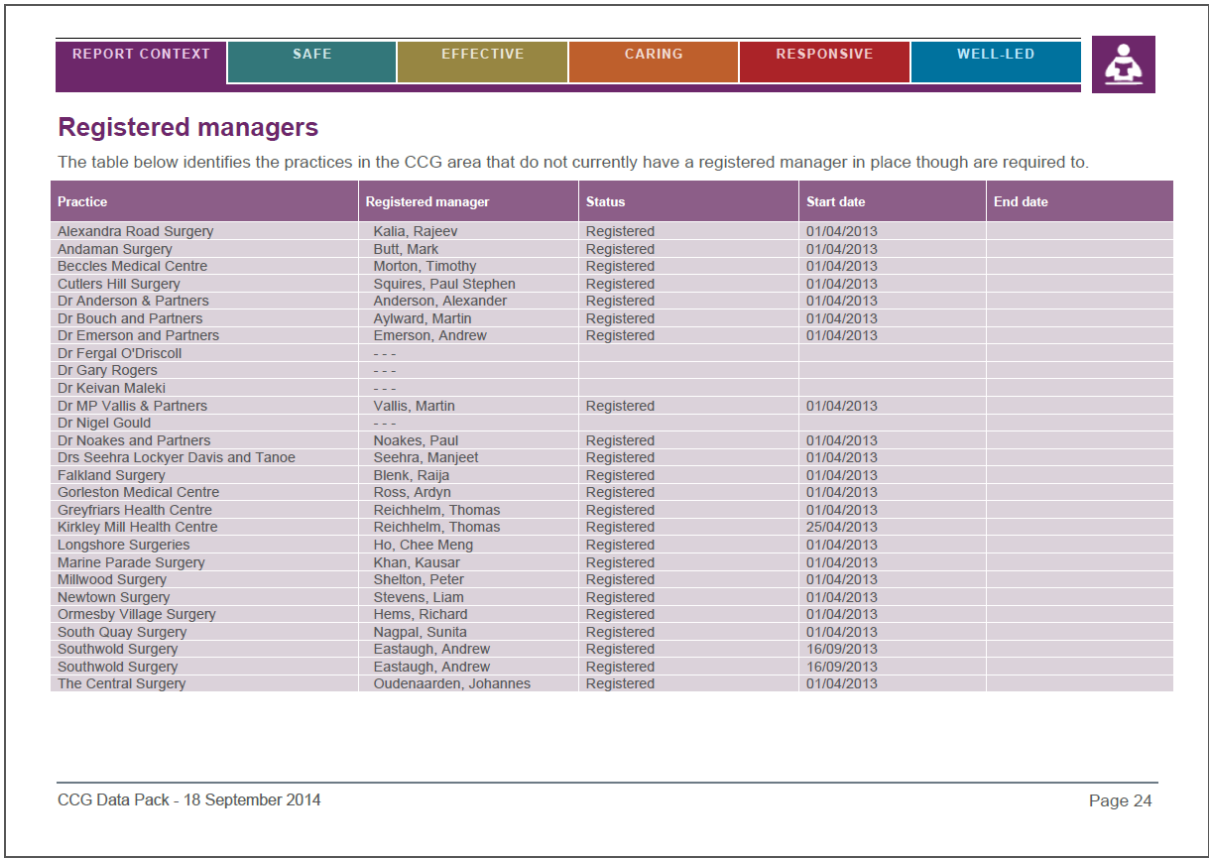
The table in this section shows the practices in the CCG area that have submitted notifications to CQC in the last 12 months and the type of notification received.

Registered providers must notify CQC about a number of changes, events and incidents affecting their service or the people who use it. Notifications to CQC are a requirement under the Health and Social Care Act 2008 (HSCA).

Providers must report the following to CQC:

- Changes to the Statement of Purpose (Regulation 12).
- Absence of registered person (Regulation 14).
- Death of a person who uses the service (Regulation 16).
- Deaths and unauthorised absences of people who are detained or liable to be detained under the Mental Health Act 1983 (Regulation 17).
- Other incidents (Regulation 18): the main ones are:
    - Serious Injuries.
    - Abuse or allegations of abuse.
    - Application to deprive a person of their liberty.
- Death of a woman after termination of pregnancy (Regulation 20).
- Death of a provider (Regulation 21).
- Appointment of liquidators (Regulation 22).

Registered managers



REPORT CONTEXT | SAFE | EFFECTIVE | CARING | RESPONSIVE | WELL-LED

Registered managers

The table below identifies the practices in the CCG area that do not currently have a registered manager in place though are required to.

Practice	Registered manager	Status	Start date	End date
Alexandra Road Surgery	Kalia, Rajeev	Registered	01/04/2013	
Andaman Surgery	Butt, Mark	Registered	01/04/2013	
Beccles Medical Centre	Morton, Timothy	Registered	01/04/2013	
Cutlers Hill Surgery	Squires, Paul Stephen	Registered	01/04/2013	
Dr Anderson & Partners	Anderson, Alexander	Registered	01/04/2013	
Dr Bouch and Partners	Aylward, Martin	Registered	01/04/2013	
Dr Emerson and Partners	Emerson, Andrew	Registered	01/04/2013	
Dr Fergal O'Driscoll	- - -			
Dr Gary Rogers	- - -			
Dr Keivan Maleki	- - -			
Dr MP Vallis & Partners	Vallis, Martin	Registered	01/04/2013	
Dr Nigel Gould	- - -			
Dr Noakes and Partners	Noakes, Paul	Registered	01/04/2013	
Drs Seehra Lockyer Davis and Tanoe	Seehra, Manjeet	Registered	01/04/2013	
Falkland Surgery	Blenk, Raija	Registered	01/04/2013	
Gorleston Medical Centre	Ross, Ardyn	Registered	01/04/2013	
Greyfriars Health Centre	Reichhelm, Thomas	Registered	01/04/2013	
Kirkley Mill Health Centre	Reichhelm, Thomas	Registered	25/04/2013	
Longshore Surgeries	Ho, Chee Meng	Registered	01/04/2013	
Marine Parade Surgery	Khan, Kausar	Registered	01/04/2013	
Millwood Surgery	Shelton, Peter	Registered	01/04/2013	
Newtown Surgery	Stevens, Liam	Registered	01/04/2013	
Ormesby Village Surgery	Hems, Richard	Registered	01/04/2013	
South Quay Surgery	Nagpal, Sunita	Registered	01/04/2013	
Southwold Surgery	Eastaugh, Andrew	Registered	16/09/2013	
Southwold Surgery	Eastaugh, Andrew	Registered	16/09/2013	
The Central Surgery	Oudenaarden, Johannes	Registered	01/04/2013	

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The table in this section identifies the practices in the CCG area that do not currently have a registered manager in place although this is a requirement.

The name of the registered manager is shown and the status of their registration and the date the manager was registered. Where a practice has changed a manager, the end date of the previous manager will be displayed and the details of the new manager would also be included under the practice name.

Where it has been identified that a manager is not in place, series of dashes will be inserted under the ‘Registered manager’ column for each practice identified.

Further Information

For any enquiries regarding the data pack or for further guidance please contact the PMS Data Packs and Inspection team at the following email address: PMS data packs & Inspection Queries