

Care Quality Commission

Inspection Evidence Table

Manchester Road Surgery (1-551290736)

Inspection date: 08/08/2019

Date of data download: 16 July 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/1

Effective

Rating: Good

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

| | Y/N/Partial |
|---|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | Y |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Y |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Y |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. | Y |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Y |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Y |
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y |
| Explanation of any answers and additional evidence: Meetings were held that included a standard agenda item for clinical matters. However, the minutes of these meetings did not include any detail as to the matters discussed. The practice manager told us that paper copies of clinical updates were provided to the GPs at the meetings. to paper. All members of the staff team had undertaken sepsis awareness training. Emergency medicines included those required to treat patients presenting with sepsis. | |
| | |

| Prescribing | Practice performance | CCG average | England average | England comparison |
|--|----------------------|-------------|-----------------|--------------------------|
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) (NHSBSA) | 0.74 | 1.06 | 0.77 | No statistical variation |

Older people

Population group rating: Good

Findings

- The practice kept up to date registers of patients with a range of health conditions (including conditions common in older people) and used this information to plan reviews of health care and to offer services such as vaccinations for flu.
- Nationally reported data showed that outcomes for patients with conditions commonly found in older people at this practice were generally comparable to outcomes for patients locally and nationally.
- The practice carried out structured annual medication reviews for older patients.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- On the day appointments allowed for rapid access to meet the needs of older patients with co-morbidities.
- The practice used the 'Gold Standard Framework' (this is a systematic evidence-based approach to improving the support and palliative care of patients nearing the end of their life) to ensure patients received appropriate care.
- The practice followed up on older patients discharged from hospital. A dedicated GP was responsible for this and it ensured that their treatment and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions

Population group rating: Good

Findings

Add findings here (for example):

- The practice held information about the prevalence of specific long-term conditions within its patient population. This included conditions such as diabetes, chronic obstructive pulmonary disease (COPD), cardio vascular disease and hypertension. The information was used to target service provision, for example to ensure patients who required immunisations received these.
- The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening their clinical record.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. Patients with multiple conditions were reviewed in one visit where possible. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Home visits were provided to patients who had difficulty getting to the practice.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Data from 2017 to 2018 showed that the practice was performing comparably to practices locally and nationally for the care and treatment of people with chronic health conditions.
- Patients were provided with advice and guidance about prevention and management of their health conditions and were signposted to support services.

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| Diabetes Indicators | Practice | CCG average | England average | England comparison |
|---|------------|-------------|-----------------|--------------------------------------|
| The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 94.3% | 81.7% | 78.8% | Variation (positive) |
| Exception rate (number of exceptions). | 24.5% (40) | 16.4% | 13.2% | N/A |
| The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 90.3% | 79.7% | 77.7% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 23.9% (39) | 12.0% | 9.8% | N/A |

| | Practice | CCG average | England average | England comparison |
|--|------------|-------------|-----------------|--------------------------------------|
| The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 90.3% | 79.5% | 80.1% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 23.9% (39) | 18.3% | 13.5% | N/A |

| Other long-term conditions | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------------------|
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 85.5% | 78.8% | 76.0% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 1.1% (3) | 13.9% | 7.7% | N/A |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 95.7% | 90.2% | 89.7% | No statistical variation |
| Exception rate (number of exceptions). | 2.1% (2) | 14.5% | 11.5% | N/A |

| Indicator | Practice | CCG | England | England |
|-----------|----------|-----|---------|---------|
|-----------|----------|-----|---------|---------|

| | | average | average | comparison |
|---|-----------|---------|---------|--------------------------|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF) | 87.2% | 81.3% | 82.6% | No statistical variation |
| Exception rate (number of exceptions). | 4.6% (18) | 4.4% | 4.2% | N/A |
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF) | 92.9% | 91.7% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 6.7% (3) | 7.1% | 6.7% | N/A |

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- There were systems in place to identify and follow up children who were at risk.
- A designated lead was in place for safeguarding.
- Staff had undergone regular safeguarding training and those we spoke with had appropriate knowledge about child protection and had ready access to safeguarding policies and procedures

| Child Immunisation | Numerator | Denominator | Practice % | Comparison to WHO target of 95% |
|--|-----------|-------------|------------|---------------------------------|
| The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England) | 36 | 36 | 100.0% | Met 95% WHO based target |

| | | | | |
|---|----|----|-------|--------------------------|
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England) | 47 | 48 | 97.9% | Met 95% WHO based target |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England) | 47 | 48 | 97.9% | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England) | 47 | 48 | 97.9% | Met 95% WHO based target |

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- The practice's encouraged cancer screening uptake for patients in this age group. Uptake rates were comparable to local and national averages.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients were able to use request a telephone consultation and therefore did not always have to attend the practice in person to seek advice, and care and treatment.

| Cancer Indicators | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------|
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England) | 77.8% | 74.0% | 71.7% | No statistical variation |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE) | 77.0% | 73.3% | 69.9% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE) | 56.8% | 57.0% | 54.4% | N/A |

| | | | | |
|---|-------|-------|-------|--------------------------|
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) ^(PHE) | 66.7% | 72.4% | 70.2% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) ^(PHE) | 42.9% | 47.2% | 51.9% | No statistical variation |

Any additional evidence or comments

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- The practice held a register of patients living in vulnerable circumstances in order to provide the services patients required.
- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a co-ordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- Staff had been provided with training in the forms of abuse and how to recognise it in vulnerable adults.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Information and advice were available about how patients could access a range of support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

- The practice held a register of patients experiencing poor mental health and these patients were offered an annual review of their physical and mental health.
- Data about how people with mental health needs were supported showed that outcomes for patients using this practice were comparable with local and national averages.
- A system was in place to prompt patients for medicines reviews at intervals suitable to the

medicines they were prescribed.

- There was a system for following up patients who failed to attend for administration of long-term medication.
- Same day and longer appointments were offered when required.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

| Mental Health Indicators | Practice | CCG average | England average | England comparison |
|---|----------|-------------|-----------------|--------------------------|
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 89.7% | 92.7% | 89.5% | No statistical variation |
| Exception rate (number of exceptions). | 0.0% (0) | 11.0% | 12.7% | N/A |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 93.1% | 91.8% | 90.0% | No statistical variation |
| Exception rate (number of exceptions). | 0.0% (0) | 9.8% | 10.5% | N/A |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small> | 87.0% | 87.5% | 83.0% | No statistical variation |
| Exception rate (number of exceptions). | 4.2% (1) | 6.3% | 6.6% | N/A |

Monitoring care and treatment

The practice had a programme of quality improvement activity and reviewed the effectiveness and appropriateness of the care provided.

| Indicator | Practice | CCG average | England average |
|--|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 544.4 | 542.7 | 537.5 |
| Overall QOF score (as a percentage of maximum) | 97.4% | 97.1% | 96.2% |
| Overall QOF exception reporting (all domains) | 6.4% | 6.4% | 5.8% |

Y/N/Partial

| | |
|---|---|
| Clinicians took part in national and local quality improvement initiatives. | Y |
| The practice had a programme of quality improvement and used information about care and treatment to make improvements. | Y |
| Quality improvement activity was targeted at the areas where there were concerns. | Y |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Y |

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

- An improvement in microalbumin testing for diabetic patients has provided more targeted care for patients who have less controlled diabetes.
- Medicines related audits have been carried out to improve outcomes in patient treatment.

Any additional evidence or comments

Effective staffing

The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.

| | Y/N/Partial |
|--|-------------|
| Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme. | Y |
| The learning and development needs of staff were assessed. | Y |
| The practice had a programme of learning and development. | Y |
| Staff had protected time for learning and development. | Y |
| There was an induction programme for new staff. | Y |
| Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015. | N/A |
| Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation. | Y |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | N/A |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Y |

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

| Indicator | Y/N/Partial |
|---|-------------|
| The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF) | Y |
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Y |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Y |
| For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services. | N/A |

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

| | Y/N/Partial |
|---|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Y |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Y |
| Patients had access to appropriate health assessments and checks. | Y |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Y |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity. | Y |

| Smoking Indicator | Practice | CCG average | England average | England comparison |
|--|----------|-------------|-----------------|--------------------------------------|
| The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF) | 98.3% | 94.8% | 95.1% | Tending towards variation (positive) |
| Exception rate (number of exceptions). | 0.1% (1) | 1.0% | 0.8% | N/A |

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

| | Y/N/Partial |
|--|-------------|
| Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented. | Y |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | Y |
| Policies for any online services offered were in line with national guidance. | Y |

Well-led

Rating: Good

Leadership capacity and capability

Leaders had the capacity and skills to deliver good quality sustainable care.

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Y |
| They had identified the actions necessary to address these challenges. | Y |
| Staff reported that leaders were visible and approachable. | Y |
| There was a leadership development programme, including a succession plan. | Y |

Vision and strategy

The practice had a vision and strategy to provide good quality sustainable care.

| | Y/N/Partial |
|---|-------------|
| The practice had a clear vision and set of values that prioritised quality and sustainability. | Y |
| There was a realistic strategy to achieve their priorities. | Y |
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Y |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | Y |

Culture

The practice had a culture which drove good quality sustainable care.

| | Y/N/Partial |
|--|-------------|
| There were arrangements to deal with any behaviour inconsistent with the vision and values. | Y |
| Staff reported that they felt able to raise concerns without fear of retribution. | Y |
| There was a strong emphasis on the safety and well-being of staff. | Y |
| There were systems to ensure compliance with the requirements of the duty of candour. | Y |
| When people were affected by things that went wrong they were given an apology and informed of any resulting action. | Y |
| The practice encouraged candour, openness and honesty. | Y |
| The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | Y |

Examples of feedback from staff or other evidence about working at the practice

| Source | Feedback |
|-------------|---|
| Discussions | <ul style="list-style-type: none"> • Staff told us they felt well supported and valued. • They told us there were positive relationships across the staff team. • Staff we spoke with demonstrated the values of openness. • Staff spoke about the person-centred care and treatment they provided to patients. |

Governance arrangements

The overall governance arrangements were effective.

| | Y/N/Partial |
|---|-------------|
| There were governance structures and systems which were regularly reviewed. | Y |
| Staff were clear about their roles and responsibilities. | Y |
| There were appropriate governance arrangements with third parties. | Y |

Managing risks, issues and performance

There were effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|--|-------------|
| There were effective assurance systems. | Y |
| There were processes to manage performance. | Y |
| There was a programme of clinical and internal audit. | Y |
| There were arrangements for identifying, managing and mitigating risks. | Y |
| A major incident plan was in place. | Y |
| Staff were trained in preparation for major incidents. | Y |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | Y |

Appropriate and accurate information

The practice acted on appropriate and accurate information.

| | Y/N/Partial |
|---|-------------|
| Staff used data to adjust and improve performance. | Y |
| Performance information was used to hold staff and management to account. | Y |
| Our inspection indicated that information was accurate, valid, reliable and timely. | Y |
| There were effective arrangements for identifying, managing and mitigating risks. | Y |
| Staff whose responsibilities included making statutory notifications understood what this | Y |

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|----------|--|
| entails. | |
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If the practice offered online services:

| | Y/N/Partial |
|--|-------------|
| The provider was registered as a data controller with the Information Commissioner's Office. | Y |
| Patient records were held in line with guidance and requirements. | Partial |
| Any unusual access was identified and followed up. | Y |
| Explanation of any answers and additional evidence: Patients records were stored and maintained appropriately. However, we observed an incident whereby patient confidentiality could have compromised. The details of this were discussed with the practice manager at the time of the inspection visit. | |

Engagement with patients, the public, staff and external partners

The practice involved staff and external partners to sustain good quality and sustainable care.

| | Y/N/Partial |
|--|-------------|
| Patient views were acted on to improve services and culture. | Y |
| The practice had an active Patient Participation Group. | Y |
| Staff views were reflected in the planning and delivery of services. | Y |
| The practice worked with stakeholders to build a shared view of challenges and of the needs of the population. | Y |

Feedback from Patient Participation Group.

| Feedback |
|--|
| We did not meet with members of the Patient Participation Group. However, we did receive CQC patient comment cards from fifty patients. These provided highly positive feedback about patient's experiences of the practice and of the care and treatment provided by all members of the staff team. |

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

| | Y/N/Partial |
|---|-------------|
| There was a focus on continuous learning and improvement. | Y |

| | |
|---|---|
| Learning was shared effectively and used to make improvements. | Y |
| <p>Explanation of any answers and additional evidence:</p> <p>Regular meetings were held across the staff team. However, the record of these did not detail the areas discussed, agreements made, and actions required.</p> <p>The practice was part of a Primary Care Network and developments and improvements to the service were being discussed as part of this.</p> | |

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

| Variation Bands | Z-score threshold |
|--------------------------------------|------------------------|
| Significant variation (positive) | ≤ -3 |
| Variation (positive) | > -3 and ≤ -2 |
| Tending towards variation (positive) | > -2 and ≤ -1.5 |
| No statistical variation | < 1.5 and > -1.5 |
| Tending towards variation (negative) | ≥ 1.5 and < 2 |
| Variation (negative) | ≥ 2 and < 3 |
| Significant variation (negative) | ≥ 3 |

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.