# Care Quality Commission

## Inspection Evidence Table

## Lever Chambers 2 (1-11337529499)

**Inspection date: 7 April 2022**

**Date of data download: 31 March 2022**

# Overall rating: Inadequate

We have rated the practice as inadequate overall because;

- The provider failed to demonstrate they delivered safe and effective care to all their patients.
- The practice did not have systems and processes in place to ensure good governance to protect patients and staff from the risk of harm.
- The provider did not ensure that there were sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed to meet the fundamental standards of care and treatment
- The provider did not ensure that persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- The provider did not ensure that recruitment procedures were established and operated effectively to ensure only fit and proper persons were employed.
- We found the leadership within the practice had not been cohesive and comprehensive to ensure the practice delivered high quality care

# Safe Rating: Inadequate

At this inspection, we rated the practice as Inadequate for providing safe care and treatment because;

- The practice did not have oversight to ensure that staff had received appropriate training including Safeguarding and Infection Prevention and Control (IPC).
- There were significant gaps in the practice systems to assess, mitigate, monitor and manage risks to patient safety.
- The practice did not evidence that all medicines were prescribed safely to patients.
- The practice did not follow its recruitment policy and did not ensure staff had been recruited safely.
- The practice did not have an adequate system to learn and make improvements when things went wrong. The practice did not have an effective system to ensure that learning was shared.

**Safety systems and processes**

## The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

| Safeguarding | Y/N/Partial |
|---|---|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | N |
| Partners and staff were trained to appropriate levels for their role. | Partial |
| There was active and appropriate engagement in local safeguarding processes. | N |
| The Out of Hours service was informed of relevant safeguarding information. | Y |
| There were systems to identify vulnerable patients on record. | Y |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | N |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Partial |

Explanation of any answers and additional evidence:

- The lead GP and the GP Safeguarding lead had not had safeguarding training since 2018 and 2017 respectively. The safeguarding lead was unable to give an example of a safeguarding concern.
- There was no evidence to show that all staff had received appropriate safeguarding training.
- The practice did not routinely undertake DBS checks or risk assessments. They accepted photocopies of DBS checks undertaken by other providers.
- The safeguarding lead told us that there were children's safeguarding meetings held with the practice manager and a health visitor but not attended by a school nurse. There was no documentation of these meetings.
- There was no regular adult safeguarding meetings.

| Recruitment systems | Y/N/Partial |
|---|---|
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | N |
| Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role. | Partial |

Explanation of any answers and additional evidence:

- The practice's own recruitment procedures were not followed. As part of the inspection we reviewed 10 staff files. The practice system and process in place had failed to ensure all appropriate checks had been undertaken for all staff to ensure safe recruitment. We found an inconsistency in the documents available within the files and in the checks that had been undertaken. We found that staff, who had been working independently and with patient contact, had not had DBS checks or personal risk assessments undertaken before working alone.
- Although in some files we saw evidence of the immunisation status of clinical staff, this was not consistent for all clinical staff and the practice did not have clear oversight of staff immunisation status to ensure the safety of patients and staff.
- The practice did not hold any records for locum GPs to show ID, qualifications or DBS checks.

| Safety systems and records | Y/N/Partial |
|---|---|
| Health and safety risk assessments had been carried out and appropriate actions taken.<br>Date of last assessment: July 2019 | N |
| There was a fire procedure. | Y |
| Date of fire risk assessment: July 2019<br>Actions from fire risk assessment were identified and completed. | N |
| Explanation of any answers and additional evidence:<br>• Although NHS Property Services had responsibility for some aspects of building safety the provider did not provide evidence of any up to date fire or health and safety risk assessments for their specific area of the building. The most recent risk assessments were carried out in July 2019. Seven weeks after the inspection the practice provided a handwritten fire risk assessment and a health and safety risk assessment both dated 25 March 2022. | |

**Infection prevention and control**

## Appropriate standards of cleanliness and hygiene were not met.

| | Y/N/Partial |
|---|---|
| Staff had received effective training on infection prevention and control. | N |
| Infection prevention and control audits were carried out.<br>Date of last infection prevention and control audit: July 2019 | Y |
| The practice had acted on any issues identified in infection prevention and control audits. | N |
| The arrangements for managing waste and clinical specimens kept people safe. | Y |
| Explanation of any answers and additional evidence:<br>• There was no evidence to show that staff had received appropriate training for infection prevention and control.<br>• An up to date infection control audit was not available on the inspection however a handwritten one was submitted seven weeks after the inspection and did not include anything relating to national guidance and the prevention of the spread of COVID.<br>• It was unclear to some staff if there was an infection control lead and who it was. Nobody appeared to have this responsibility. | |

**Risks to patients**

## There were gaps in systems to assess, monitor and manage risks to patient safety.

| | Y/N/Partial |
|---|---|

| | |
|---|---|
| There was an effective approach to managing staff absences and busy periods. | N |
| There was an effective induction system for temporary staff tailored to their role. | N |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | N |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Y |
| There were enough staff to provide appointments and prevent staff from working excessive hours | N |

Explanation of any answers and additional evidence:

- Some staff we spoke with and some of those who completed a questionnaire told us they often worked short staffed and they felt this had affected the safe and effective delivery of safe care and the well-being of staff. They would work extra hours to cover annual leave and short term sickness.
- There was no evidence to show that there was an induction policy and that staff had received an induction with relevant training. Some staff told us that they had not gone through an induction process on starting with the practice.
- There were posters throughout the practice with instructions about sepsis and what to do if it was suspected, however staff had not received appropriate training or training in other emergency procedures.
- Staff told us they would alert the GP on duty if they were concerned that there was a deteriorating or acutely unwell patient.
- There were two receptionists on duty for both the morning and the afternoon sessions. Whilst answering the telephone and seeing to patients at the reception desk they were expected to carry out other duties such as prescription requests, urgent and routine referrals and other administration duties, leaving staff feeling pressured to carry out all the tasks correctly and on time.

**Information to deliver safe care and treatment**

## Staff did not have the information they needed to deliver safe care and treatment.

| | Y/N/Partial |
|---|---|
| Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation. | Partial |
| There was a system for processing information relating to new patients including the summarising of new patient notes. | Partial |
| There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. | Y |
| Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals. | Partial |

| | |
|---|---|
| There was a documented approach to the management of test results and this was managed in a timely manner. | Partial |
| There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff. | N/A |

Explanation of any answers and additional evidence:

- Five patient records were checked in detail and showed that consultations were not documented fully, for example diagnosis was not always documented, incomplete examination, limited history, some had no follow up and no safety netting and two had inappropriate prescribing.
- Staff told us that dedicated time was not given to reception staff carrying out administration duties. Duties such as summarising new patient records and processing referrals were carried out whilst seeing patients at the reception desk and answering the telephone. Not all staff were trained in all aspects of the role and there was no procedure documentation to follow. Whilst reviewing a sample of clinical records, the CQC GP specialist advisor saw evidence of a two week wait referral where the patient was seen, and the referral was not made until the following week.
- We were told that normal test results were filed by the practice nurses, however there was no nurse on duty on two days each week resulting in a delay each week. One of the GPs actioned the abnormal results daily.

**Appropriate and safe use of medicines**

## The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA) | 0.86 | 0.83 | 0.76 | No statistical variation |
| The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2021 to 31/12/2021) (NHSBSA) | 7.4% | 7.0% | 9.2% | No statistical variation |
| Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2021 to 31/12/2021) (NHSBSA) | 7.36 | 5.29 | 5.28 | Variation (negative) |

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA) | 228.8‰ | 166.0‰ | 129.2‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA) | 1.88 | 0.73 | 0.62 | Variation (negative) |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA) | 12.0‰ | 10.2‰ | 6.8‰ | Tending towards variation (negative) |

Note: ‰ means *per 1,000* and it is **not** a percentage.

| Medicines management | Y/N/Partial |
|---|---|
| The practice ensured medicines were stored safely and securely with access restricted to authorised staff. | Y |
| Blank prescriptions were kept securely, and their use monitored in line with national guidance. | Y |
| Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions). | Y |
| The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review. | N/A |
| There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. | N |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | N |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | N/A |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Y |
| If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance. | N/A |
| The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance. | Partial |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Y |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Partial |

| Medicines management | Y/N/Partial |
|---|---|
| Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective. | Y |

Explanation of any answers and additional evidence:

- As part of the inspection a number of set clinical record searches are undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches are visible to the practice. Following these searches, we reviewed some patient's records. We found that:
    - One of four records checked of patients who were prescribed Warfarin had no record of monitoring and had no record of an INR blood result.
    - Four of five records checked of patients who were prescribed an Ace Inhibitor or Angiotensin II Receptor Blocker (used to treat high blood pressure, heart and kidney problems) showed that monitoring was not taking place.
    - There were seven patients with hypothyroidism who had not had thyroid function test (TFT) monitoring in the last 18 months, four of the five checked in detail showed that monitoring had not taken place for over two years but were being prescribed medication up to date.
    - Two patients prescribed Azathioprine (an immunosuppressant) were prescribed medication one for over two years and one for over seven months with no monitoring of bloods.
    - Patients with diabetic retinopathy showed that four of the five records checked showed there was no apparent system of review. One patient was under the care of the hospital but had not attended and not followed up by the practice for the reason of DNA.
    - We saw that medicine reviews had been noted as being completed, but a record of what the reviews consisted of was not routinely recorded.

- There was a record of signed PGDs, however a locum practice nurse's name had been added without being countersigned by the GP. This was rectified at the inspection.
- There was a CCG pharmacist to support medicines management in the practice, however we were told that the practice had not received any prescribing data in the last two years. We were told that one of the GPs carried out drug monitoring searches and actioned them appropriately.
- There was an oxygen supply held at the practice. The practice did not have a defibrillator, we were told that they had an agreement with another GP in the same building to have access to their defibrillator if required. There was a defibrillator which belonged to the building which was also accessible to the practice.

**Track record on safety and lessons learned and improvements made**

## The practice did not have a system to learn and make improvements when things went wrong.

| Significant events | Y/N/Partial |
|---|---|
| The practice monitored and reviewed safety using information from a variety of sources. | N |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Partial |
| There was a system for recording and acting on significant events. | Partial |
| Staff understood how to raise concerns and report incidents both internally and externally. | Partial |
| There was evidence of learning and dissemination of information. | N |
| Number of events recorded in last 12 months: | 6 |
| Number of events that required action: | unclear |

Explanation of any answers and additional evidence:

- The practice manager had recently introduced a system for reporting significant events, in which we found the monitoring and reviewing was inadequate. The practice did not have a consistent approach or documentation for staff to report incidents. The details of any investigation, discussion, actions and learning outcomes were not documented in a way that would allow full and complete review, shared learning or monitoring. For example, we found some incidents had been reported, but there was insufficient detail to be clear what had gone wrong, who was responsible for investigating and the learning outcome. We could not be assured that the practice had encouraged duty of candour as there were no details of patients being involved.

| Safety alerts | Y/N/Partial |
|---|---|
| There was a system for recording and acting on safety alerts. | Partial |
| Staff understood how to deal with alerts. | N |

Explanation of any answers and additional evidence:

- As part of our clinical searches, we reviewed a safety alert which related to patients taking a combination of medicines where there are risks of harm. The search identified six patients that could be affected by the risk factors. We found the practice had, since the announcement of our inspection, undertaken to change the patients' medicine. However, this had not been done in discussion with the patient.
- The practice manager had introduced a new system to ensure all alerts were dealt with appropriately.

# Effective Rating: Inadequate

At this inspection, we rated the practice as Inadequate for providing effective care because;

- Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance.
- During the COVID-19 pandemic, the practice had paused long-term conditions clinics. We found as part of this inspection, some patients on long term medicines had not been monitored or reviewed appropriately.
- The practice was unable to demonstrate that staff had all the skills, knowledge and experience to carry out their roles.
- There was limited monitoring of the outcomes of care and treatment. The practice did not have a programme of quality improvement to monitor and ensure care was delivered in a safe and effective way

*QOF requirements were modified by NHS England for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

**Effective needs assessment, care and treatment**

## Patients' needs were not assessed, and care and treatment was not 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. | Partial |
| Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. | Partial |
| Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. | Partial |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Y |
| Patients' treatment was regularly reviewed and updated. | N |
| 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. | Partial |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic | N |

Explanation of any answers and additional evidence:

- Staff we spoke with told us they kept up to date with current evidence-based practice which was accessible from their desktop. We did not see evidence that this was shared and monitored. For example, we found changes to prescribing as a result of a historical safety alert which should have been incorporated into usual practice for safe prescribing had not been made in a timely way.
- During the inspection we identified shortfalls and errors in the practice medical record keeping, therefore we could not be fully assured that patients' needs were always fully assessed.
- As part of this inspection we carried out clinical searches. During the review of some patients' records, we found the practice had not always undertaken comprehensive medicines reviews. We found the information in the records lacked sufficient detail to be assured all medicines prescribed had been assessed and the patients' on going needs had been managed safely.

## Effective care for the practice population

**Findings**

- The practice did not routinely offer health checks, including frailty assessments, to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- End of life care was not delivered in a way which took into account the needs of those whose circumstances may make them vulnerable. Of eleven patients receiving palliative care, two had a DNACPR recorded in their clinical record. One form was not available to view and one form was poorly completed with little information.
- Although the practice had a computer system which identified patients due for vaccination and review, it did not have a system for routinely inviting patients to these appointments.
- There was no evidence of mental capacity assessments seen in patient records so it was unclear whether they were referred to appropriate services.

## Management of people with long term conditions

**Findings**

- Patients with long-term conditions were not offered a structured annual review to check their health and medicines needs were being met.
- We were told that the practice were starting to introduce recall dates as a way to invite patients in for required monitoring and reviews.
- It was unclear if staff who were responsible for reviews of patients with long-term conditions had received specific training. The practice did not have a record of training and qualifications of the staff concerned.
- Our clinical searches found that, of the clinical records checked, GPs did not follow up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. We were told that the GP would contact patients particularly those with chronic obstructive pulmonary disease (COPD), heart failure and cancer for monitoring and follow up, however there was no evidence of this.

- The practice could not demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with COPD were not always offered rescue packs.
- Patients with asthma were offered an asthma management plan.

| 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), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England) | 37 | 48 | 77.1% | Below 80% uptake |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England) | 30 | 34 | 88.2% | Below 90% minimum |
| 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) (01/04/2020 to 31/03/2021) (NHS England) | 29 | 34 | 85.3% | Below 90% minimum |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England) | 29 | 34 | 85.3% | Below 90% minimum |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England) | 36 | 54 | 66.7% | Below 80% uptake |

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

**Any additional evidence or comments**

- The practice did not have a system in place to improve the uptake of childhood immunisations.
- We were told the practice manager was going to liaise with the health visitors to improve uptake and that patients were still afraid to attend the surgery because of COVID.

| 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). (Snapshot date: 30/09/2021) (Public Health England) | 58.3% | N/A | 80% Target | Below 70% uptake |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) **(PHE)** | 56.2% | 67.8% | 61.3% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) **(PHE)** | 51.3% | 58.8% | 66.8% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE) | 36.8% | 53.3% | 55.4% | No statistical variation |

| Any additional evidence or comments |
|---|
| • The practice did not have a plan to improve uptake. They told us that patients do not want to attend the surgery due to COVID. |

**Monitoring care and treatment**

## There was limited monitoring of the outcomes of care and treatment.

| | Y/N/Partial |
|---|---|
| Clinicians took part in national and local quality improvement initiatives. | N |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | N |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | N |

| Any additional evidence or comments |
|---|
| • The practice had not taken part in any quality improvement or carried out any clinical audits in the last two years. It did not have a documented plan in place to start any. |

**Effective staffing**

## The practice was unable 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. | Partial |
| The practice had a programme of learning and development. | N |
| Staff had protected time for learning and development. | N |
| There was an induction programme for new staff. | N |
| 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. | N |
| 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 |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | N |
| Explanation of any answers and additional evidence:<br>• There was no evidence of GP and staff training or record of qualifications.<br>• There was no oversight of training or support to staff.<br>• Staff had access to on-line training but not all staff completed the training as they were not given time during the working day to complete it. Some staff told us they did the training in their own time.<br>• There was no evidence of an induction programme for new or locum staff.<br>• Staff told us there was no comprehensive training offered on starting at the practice.<br>• Although we were told that nurse consultations were randomly selected for review as part of their clinical supervision, this was not documented.<br>• There was no formal supervision of the locum GP or the practice nurses by the lead GP.<br>• On inspection ten personnel files were checked, all of which had no appraisals documented. | |

**Coordinating care and treatment**

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

| Indicator | Y/N/Partial |
|---|---|
| Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved. | Yes |
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |

**Helping patients to live healthier lives**

## Staff were not 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. | Partial |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Partial |
| Patients had access to appropriate health assessments and checks. | Partial |
| 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 and tackling obesity. | Y |

Explanation of any answers and additional evidence:

- We found examples of potentially undiagnosed long term conditions such as diabetes during our clinical searches. This meant the patients were at risk of not being referred to support or education, able to access appropriate health assessments and checks.
- Patients were not routinely invited for health checks or monitoring of long term conditions, the practice told us that this was due to COVID.
- Staff could refer patients to a social prescribing scheme in the area. The scheme identified community services to help with patients' needs.

**Consent to care and treatment**

## The practice was unable to demonstrate that it always 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. | N |
| Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision. | N |
| Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. | N |

Explanation of any answers and additional evidence:

- Although the GPs were aware of consent and mental capacity, no consent forms were used.
- There was no evidence of mental capacity assessments seen in clinical records.
- Of eleven patients receiving palliative care only two had a DNACPR entry in their clinical records.
- One showed that a McMillan nurse had completed a DNACPR but there was no form in the record. The second showed a DNACPR put in place by a GP without evidence of a consultation, poor completion of the form. There was no clear, documented decision and reason for the decision, no record of a discussion with the person and/or representative, no reason why there

was no discussion, no evidence of an MDT approach, no decision about mental capacity recorded and no evidence of a review of the DNACPR recorded.

# Caring Rating: Good

**Kindness, respect and compassion**

## Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

| | Y/N/Partial |
|---|---|
| Staff understood and respected the personal, cultural, social and religious needs of patients. | Y |
| Staff displayed understanding and a non-judgemental attitude towards patients. | Y |
| Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition. | Partial |
| Explanation of any answers and additional evidence:<br>• GPs and staff were able to speak a variety of languages from South Asia.<br>• One member of staff was unaware that the practice had access to Language line for other languages.<br>• We were told that verbal information and advice would be offered to patients during consultations, but this was not always documented in clinical records. | |

| Patient feedback | |
|---|---|
| **Source** | **Feedback** |
| Friends and Family forms | We looked at 20 friends and family forms, all were positive about the GPs and staff and the service provided. |

**National GP Patient Survey results**

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021) | 80.2% | 88.1% | 89.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2021 to 31/03/2021) | 77.5% | 86.8% | 88.4% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021) | 85.9% | 94.2% | 95.6% | Tending towards variation (negative) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021) | 73.6% | 82.2% | 83.0% | No statistical variation |

| Any additional evidence or comments |
|---|
| • The practice did not analyse the GP survey results as a way of improving the service provided. |

| Question | Y/N |
|---|---|
| The practice carries out its own patient survey/patient feedback exercises. | Partial |

| Any additional evidence or comments |
|---|
| • The practice last carried out its own patient survey in 2019, currently there is a plan but no date to carry out an up to date survey. The results of last surveys carried out by the practice are on the website.<br>• We were told that the practice had sent an invite out to all patients inviting them to join a patient group which the practice wanted to start up again after the pandemic. |

**Involvement in decisions about care and treatment**

## Staff helped patients to be involved in decisions about care and treatment

| | Y/N/Partial |
|---|---|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Partial |
| Staff helped patients and their carers find further information and access community and advocacy services. | Y |
| Explanation of any answers and additional evidence:<br>• Some of the clinical staff were able to speak to patients in their own language.<br>• Information was not available in languages other than English<br>• Patients were referred to the social prescriber who would signpost patients to other organisations for health and social care assistance | |

**National GP Patient Survey results**

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021) | 86.5% | 91.2% | 92.9% | No statistical variation |

| | Y/N/Partial |
|---|---|
| Interpretation services were available for patients who did not have English as a first language. | Y |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Y |
| Information leaflets were available in other languages and in easy read format. | N |
| Information about support groups was available on the practice website. | Y |
| Explanation of any answers and additional evidence:<br>• The practice had access to Language line but not all staff were aware of this. | |

| Carers | Narrative |
|---|---|
| Percentage and number of carers identified. | 76 carers 2% of list |
| How the practice supported carers (including young carers). | Carers were invited for health checks and flu jabs and given information from the Carers team. |
| How the practice supported recently bereaved patients. | Bereaved patients are given information about the support offered. |

**Privacy and dignity**

## The practice mostly respected patients' privacy and dignity.

| | Y/N/Partial |
|---|---|
| A private room was available if patients were distressed or wanted to discuss sensitive issues. | Y |
| There were arrangements to ensure confidentiality at the reception desk. | Partial |
| Explanation of any answers and additional evidence:<br>• Staff took telephone calls while dealing with patients at the reception desk where there was a screen. Patients in the waiting area could not hear conversations but those at the reception desk could hear the telephone conversation. | |

# Responsive Rating: Good

**Responding to and meeting people's needs**

## The practice organised and delivered services to meet patients' needs

| | Y/N/Partial |
|---|---|
| The practice understood the needs of its local population and had developed services in response to those needs. | N |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Y |
| The facilities and premises were appropriate for the services being delivered. | Y |
| The practice made reasonable adjustments when patients found it hard to access services. | Y |
| There were arrangements in place for people who need translation services. | Y |
| The practice complied with the Accessible Information Standard. | Y |

Explanation of any answers and additional evidence:

- The practice had a female locum GP available one day each week for patients who preferred this.
- The practice offered telephone consultations for those patients that requested them.
- Home visits were offered to patients who were unable to leave their home.
- The practice had access to language line but not all staff were aware of this.

| Practice Opening Times | |
|---|---|
| **Day** | **Time** |
| Opening times: Lever Chambers Centre for Health | |
| Monday | 8.30am to 6.30pm |
| Tuesday | 8.30am to 6.30pm |
| Wednesday | 8.30am to 1pm |
| Thursday | 8.30am to 1pm |
| Friday | 8.30am to 6.30pm |
| | Appointments are available until 12pm every day |
| Opening times: Great Lever Health Centre | |
| Monday | 8am to 6.30pm |
| Tuesday | 8am to 6.30pm |
| Wednesday | 8am to 6.30pm |
| Thursday | 8am to 6.30pm |
| Friday | 8am to 6.30pm |
| | Appointments are available throughout the day |
| | |

**Further information about how the practice is responding to the needs of their population**

- Patients had a named GP who supported them at home if they required it.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- There weren't any early or late appointments available for school age children so that they did not need to miss school. The practice had two locum nurses who covered three days a week.
- Children under 16 were seen the same day if required.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- Patients with a learning disability or those with anxiety could book an appointment at quieter times of the day.

**Access to the service**

## People were able to access care and treatment in a timely way.

*The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.*

| | Y/N/Partial |
|---|---|
| Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice | Y |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online) | Partial |
| Patients were able to make appointments in a way which met their needs | Y |
| There were systems in place to support patients who face communication barriers to access treatment | Y |
| Patients with most urgent needs had their care and treatment prioritised | Y |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages) | Partial |

Explanation of any answers and additional evidence:

- On-line appointments were not offered by the practice.
- Patients could book appointments in person, by telephone or on-line.
- Most staff were able to speak other languages. Language line was accessible but not all staff were aware of this.

**National GP Patient Survey results**

| Indicator | Practice | CCG average | England average | England comparison |
|---|---|---|---|---|
| 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 (01/01/2021 to 31/03/2021) | 54.1% | N/A | 67.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021) | 53.9% | 70.1% | 70.6% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021) | 61.8% | 67.4% | 67.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021) | 60.5% | 78.1% | 81.7% | Variation (negative) |

| Source | Feedback |
|---|---|
| NHS Choices | • At the time of inspection, no feedback had been left on NHS Choices. |
| Friends and Family | • We looked at 20 random feedback forms. All were positive about the GPs, staff and the service provided. |

**Listening and learning from concerns and complaints**

## Complaints were not used to improve the quality of care.

| Complaints | |
|---|---|
| Number of complaints received in the last year. | 0 |
| Number of complaints we examined. | N/A |
| Number of complaints we examined that were satisfactorily handled in a timely way. | N/A |
| Number of complaints referred to the Parliamentary and Health Service Ombudsman. | N/A |

| | Y/N/Partial |
|---|---|
| Information about how to complain was readily available. | Y |
| There was evidence that complaints were used to drive continuous improvement. | N |
| Explanation of any answers and additional evidence:<br>• There had been no complaints recorded by the practice. | |

# Well-led Rating: Inadequate

Following this inspection, we have rated the practice inadequate for providing well-led services because:

- There was no leadership development programme in place at the time of inspection.
- There were no processes in place to manage performance of clinical or non-clinical staff.
- Clinical oversight was not effective.
- There was no appraisal system in place.
- Recruitment procedures weren't followed and very few pre-recruitment checks carried out
- There was not a system or oversight to ensure training had taken place
- Governance structures and systems were not always in place or regularly reviewed.
- There were no effective arrangements for identifying, managing and mitigating risks;
- There was little evidence of a system to share learning with staff
- The lead GP and long term locum had not had recent safeguarding training as required
- There was no quality improvement or clinical audit plan in place.

**Leadership capacity and capability**

## Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

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

Explanation of any answers and additional evidence:

- We were told that staffing levels were the main challenge to quality and sustainability. There were no permanent GPs or practice nurses employed by the practice. All were locums with only one of the GPs long term.
- The reception/administration team consisted of one receptionist at Lever Chamber Centre for Health and four receptionists at Great Lever Health Centre. Some staff told us that this was not enough to cover all the duties expected in a safe and timely way.
- Not all staff felt that leaders were approachable.

**Vision and strategy**

## The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

| | Y/N/Partial |
|---|---|

| | |
|---|---|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | N |
| Staff knew and understood the vision, values and strategy and their role in achieving them. | N |
| Progress against delivery of the strategy was monitored. | N |

Explanation of any answers and additional evidence:

- The staff vision and values were displayed throughout the surgery, however staff told us that they had not been a part of its development.
- There was no strategy to monitor its progress.

**Culture**

## The practice culture did not effectively support high 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. | Partial |
| There was a strong emphasis on the safety and well-being of staff. | N |
| There were systems to ensure compliance with the requirements of the duty of candour. | N |
| When people were affected by things that went wrong, they were given an apology and informed of any resulting action. | N |
| The practice encouraged candour, openness and honesty. | Y |
| The practice had access to a Freedom to Speak Up Guardian. | Y |
| Staff had undertaken equality and diversity training. | N |

Explanation of any answers and additional evidence:

- We were told the practice had an open door policy, however there were inconsistencies in how staff felt in being able to raise concerns. Some staff told us that practice meetings had now started but they did not always feel confident that they could raise issues or concerns. We were given examples of where concerns had not been dealt with appropriately.
- Staff covered for each other for annual leave and sickness.
- Staff were not given dedicated time and did not have time to carry out training. Some staff carried out their training in their own time at home.
- There was no induction process so all reception/administration staff were not fully trained for their role. This led to trained staff feeling pressured.
- Staff had access to a Freedom to Speak Up Guardian but staff were unaware of this.
- It was unclear which staff, if any had undertaken equality and diversity training as there was no oversight and monitoring of training in the practice.

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

| Source | Feedback |
|---|---|
| Staff questionnaires, interviews (telephone and face to face) | Feedback from staff was varied, for example some staff told us recruitment is needed and that staff do not have time for a break. Some staff also told us they felt supported, whilst other reported they did not. |

**Governance arrangements**

## The overall governance arrangements were ineffective.

| | Y/N/Partial |
|---|---|

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

Explanation of any answers and additional evidence:

- The practice had a safeguarding lead, however they had not completed training since 2017. As part of the role they attended two monthly safeguarding meetings.
- There was a lack of clinical oversight at the practice. We were told that the lead GP would randomly look at practice nurse consultations, however there was no evidence that this took place.
- It was unclear if there were any policies and procedures accessible to staff. Prior to the inspection we were told that there weren't any on the computer and told they were in files. On the inspection there were no files but after the inspection we were told that they were on a legacy file. We did not see evidence of this.

**Managing risks, issues and performance**

## The practice did not have clear and effective processes for managing risks, issues and performance.

| | Y/N/Partial |
|---|---|
| There were comprehensive assurance systems which were regularly reviewed and improved. | N |
| There were processes to manage performance. | N |
| There was a quality improvement programme in place. | N |
| There were effective arrangements for identifying, managing and mitigating risks. | N |
| A major incident plan was in place. | N |
| Staff were trained in preparation for major incidents. | N |
| When considering service developments or changes, the impact on quality and sustainability was assessed. | N |
| Explanation of any answers and additional evidence:<br>• There were no processes in place to manage performance of clinical staff.<br>• There were no formal arrangements for identifying, managing and mitigating risks such as health and safety, fire safety or infection control risk assessments.<br>• There was no appraisal programme in place for staff or GPs.<br>• Recruitment procedures including DBS checks were not followed.<br>• There were no comprehensive assurance systems in place. For example, there was a lack of oversight in monitoring care, such as Medicines and Healthcare products Regulatory Agency (MHRA) alerts, medication reviews and coding of diabetic patients.<br>• There was no quality improvement or clinical audit plan in place.<br>• There was no oversight of the training for GPs, nurses or administration staff. | |

## The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

| | Y/N/Partial |
|---|---|
| The practice had adapted how it offered appointments to meet the needs of patients during the pandemic. | Y |
| The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access. | Y |
| There were systems in place to identify and manage patients who needed a face-to-face appointment. | Y |
| The practice actively monitored the quality of access and made improvements in response to findings. | Partial |

| | |
|---|---|
| There were recovery plans in place to manage backlogs of activity and delays to treatment. | N |
| Changes had been made to infection control arrangements to protect staff and patients using the service. | Y |

Explanation of any answers and additional evidence:

- Staff didn't actively monitor access but if more appointments were required, they would be added on the day according to need.
- There were informal processes to check that patients had attended for treatment but there were no documented plans in place to manage this.
- Staff had access to personal protective equipment (PPE) since the pandemic.

**Appropriate and accurate information**

## The practice did not always act on appropriate and accurate information.

| | Y/N/Partial |
|---|---|
| Staff used data to monitor and improve performance. | N |
| Performance information was used to hold staff and management to account. | N |
| Staff whose responsibilities included making statutory notifications understood what this entailed. | Y |
| Explanation of any answers and additional evidence:<br>• There was no evidence to show that data was used to monitor and improve performance.<br>• There were no processes such as an appraisal system in place to manage performance of clinical staff. | |

## Governance and oversight of remote services

| | Y/N/Partial |
|---|---|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Y |
| 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. | Y |
| Patients were informed and consent obtained if interactions were recorded. | Y |
| The practice ensured patients were informed how their records were stored and managed. | Y |
| Patients were made aware of the information sharing protocol before online services were delivered. | Y |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Y |
| Online consultations took place in appropriate environments to ensure confidentiality. | N/A |
| The practice advised patients on how to protect their online information. | Y |
| Explanation of any answers and additional evidence:<br>• Information was available in leaflet form and on the practice website regarding conditions and treatments and other health services available. | |

**Engagement with patients, the public, staff and external partners**

## The practice did not involve the public, staff and external partners to sustain high quality and sustainable care.

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

Explanation of any answers and additional evidence:

- The practice manager told us that they were currently recruiting to the PPG which had stopped meeting during the pandemic.
- The practice did not carry out any survey of its own to ask patients for their views. They did however gather the Friends and Family feedback.
- The practice attended primary care network (PCN) meetings and local practice manager meetings

**Continuous improvement and innovation**

## There was little evidence of systems and processes for learning, continuous improvement and innovation.

| | Y/N/Partial |
|---|---|
| There was a strong focus on continuous learning and improvement. | N |
| Learning was shared effectively and used to make improvements. | N |

Explanation of any answers and additional evidence:

- There was no quality improvement plan in place.
- The practice manager had newly introduced a system for reporting significant events in which we found the monitoring and reviewing was inadequate. The practice did not have a consistent approach or documentation for staff to report incidents. The details of any investigation, discussion, actions and learning outcomes were not documented in a way that would allow full and complete review, shared learning or monitoring. For example, we found some incidents had been reported, but there was insufficient detail to be clear what had gone wrong, who was responsible for investigating and the learning outcome. We could not be assured that the practice had encouraged duty of candour as there were no details of patients being involved.

**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 practices 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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- 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.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

**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.
- 
- ‰ = per thousand.