

Care Quality Commission

Inspection Evidence Table

Highbury Grange Medical Practice (1-543975260)

Inspection date: 24 October 2019

Date of data download: 1 December 2019

At the previous inspection, on 5 March 2019, we the rated practice as: Inadequate for safe; Good for effective, caring and responsive; and Requires Improvement for well-led. This gave the practice an overall rating of Requires Improvement. Because of the safety concerns we identified, we served a warning notice under Section 29 of the Health and Social Care Act 2008, as the provider was failing to comply with the relevant requirements of Regulation 12, (1), Safe care and treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out a follow up inspection, on 18 July 2019, to assess whether the concerns identified in the warning notice had been addressed by the provider. At that inspection we found that the provider had appropriately addressed all the concerns identified in the warning notice.

This inspection was an announced focussed inspection reviewing the safe and well-led domains. We found all the issues identified previously had been addressed to an appropriate standard. We rated the practice as good for providing safe and well-led services.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Good

At the previous inspection, 5 March 2019, we found that there was unsafe and inappropriate management and monitoring of patients prescribed high-risk medicines, concerns regarding the accuracy of the practice's safeguarding register and there was not a safe system for monitoring patients who had been referred under the two week wait cancer referral service.

At this inspection we were satisfied that the practice had significantly improved and all the previous concerns had been adequately addressed (see below for more details).

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes

Safeguarding	Y/N/Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> At the previous inspection carried out on 5 March 2019, we found that the practice's internal log of patients who were recorded on the child protection register was not accurate and up to date. At this inspection we saw the practice had a new policy to carry out a monthly review of this register to ensure its accuracy. We reviewed the practice's internal log and found it was now up to date and matched the local authority's child protection register. The practice was accredited by the Identification and Referral to Improve Safety (IRIS) service. IRIS is a GP orientated organisation to which the practice can refer patients to when there are concerns about possible domestic violence/abuse and neglect. We spoke to a range of clinical and non-clinical staff; all staff were aware of how to identify and report safeguarding concerns. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed four staff files which contained evidence of medical indemnity and vacation status as required. Appropriate pre-employment checks had taken place. For example, we saw that each staff file had a full record of employment history, references, DBS certificates, proof of identity and qualifications. 	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 19 June 2019	Yes
There was a record of equipment calibration. Date of last calibration: 19 June 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: October 2019	Yes
There was a log of fire drills. Date of last drill: May 2019	Yes
There was a record of fire alarm checks. Date of last check: 23 October 2019	Yes
There was a record of fire training for staff. Date of last training: 14 January 2019	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 14 January 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: October 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2019	Yes

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: October 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	

The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice carried out yearly infection prevention control audits. We saw that the most recent infection control audit had been undertaken by the practice nurse who was the infection control lead. Actions identified in the infection prevention control audit had been carried out. For example, we saw that the risk assessment had identified a toilet seat was broken and two new members of staff needed to undertake their infection prevention control training, and these actions were completed. We saw that annual legionella risk assessment had been undertaken 5 February 2019, and we were provided with evidence that the practice's landlord was carrying out monthly water temperature checks as recommended by the risk assessment. 	

Risks to patients

There were adequate 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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
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.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We saw there was a sepsis protocol and clinicians had access to the necessary clinical equipment to help manage patients with suspected sepsis. We saw evidence that non-clinical staff had received sepsis awareness training and that sepsis awareness posters were displayed in all treatment rooms and in the reception area. The practice evidenced a locum and induction pack which included all the appropriate information. 	

Information to deliver safe care and treatment

Staff had 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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> A 'two week wait' (TWW) referral is a request from a GP to ask the hospital for an urgent appointment for a patient, because the patient has symptoms that might indicate a cancer diagnosis. At the previous inspection on 5 March 2019, we found the practice's policy on TWW referrals was inadequate. When we inspected in March 2019, we found, although GPs made referrals to secondary care providers in a timely manner, there was no process in place to ensure the patient received or attended the referral appointment. During the March 2019 inspection, the practice explained it asked patients to ring the practice if they had not been seen. At this inspection, the practice provided us with evidence that it had changed its policy on TWW referrals. The new policy now required the practice to maintain an internal log which recorded all patients that had been booked for a TWW appointment. The new policy required the practice to follow-up patients after their appointment date to ensure that the patient had been seen. 	

Appropriate and safe use of medicines

The practice had 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) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.60	0.67	0.87	Variation (positive)
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). (01/10/2018 to 30/09/2019) (NHSBSA)	12.5%	10.6%	8.5%	Tending towards variation (negative)
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 (01/04/2019 to 30/09/2019) (NHSBSA)	5.75	5.85	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	1.36	1.66	2.08	No statistical variation

Explanation of any answers and additional evidence:

- The practice was aware 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 was slightly higher than the CCG and England averages. The practice was pro-actively working with their clinical pharmacist to review their policy on antibiotic prescribing.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers,	Yes

Medicines management	Y/N/Partial
and there was regular review of their prescribing practice supported by clinical supervision or peer review.	
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection on 5 March 2019, we found individual patient records for patients prescribed high-risk medicines including Warfarin, Methotrexate, Azathioprine and Lithium were not always managed in a way that kept patients safe. This was because the provider did not have an effective system in place to ensure that blood test results were reviewed prior to prescribing these high-risk medicines to patients. In addition, comprehensive care records were not always maintained for patients who were prescribed high-risk medicines.</p> <p>At the warning notice follow up inspection on 18 July 2019, we saw a new policy had been put in place which ensured patient blood test results were reviewed by the GP and logged on patients clinical records prior to prescribing any high-risk medicine. We also saw all patients who were prescribed high-risk medicines had an alert on their records, which reminded the clinician to review latest blood test results prior to prescribing. The practice had also created an electronic high-risk medicine monitoring checklist. This document was a summary guide outlining important information and checks required prior to prescribing any high-risk medicines. We reviewed 38 records for patients being prescribed high-risk medicine and found that they were all being managed and monitored appropriately.</p>	

Medicines management	Y/N/Partial
At this inspection, we reviewed medical records for eight patients prescribed high risk medicine and found they were managed and monitored appropriately. As a result, we were satisfied that the practice had continued with its new policies to safely manage patients prescribed high risk medicine.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

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

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
CQC inspection on 5 March 2019	The practice treated the findings of the CQC inspection as a significant event. The practice created new policies and procedures and ensured governance around the managing and monitoring of patients on high risk medicines was effective.
The air-conditioning unit located in the server and communications room had broken down.	The practice contacted the landlord and asked for urgent assistance to fix the air-conditioning. In the meantime, staff were re-located to another room, and the doors were left open to allow air flow. The air-conditioned was repaired on the same day.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
Alerts were received electronically and disseminated by the practice management and/or practice pharmacist to all staff. All alerts were recorded on a register, which included the details of the alert and action taken. Staff gave examples of alerts actioned, which had been recorded appropriately. For example, we saw a example of a Medicines & Healthcare Products Regulatory Agency (MHRA) alert in	

respect of prescribing sodium valproate to pregnant women. This is a medicine used primarily to treat epilepsy and bipolar disorder and to prevent migraine headaches, but which exposes babies in the womb to a high risk of serious developmental disorders and/or congenital malformations. A patient record search was carried out and appropriate action was taken with patients to discuss the risks associated with taking this medicine whilst trying to become pregnant.

Well-led

Rating: Good

At the previous inspection, 5 March 2019, we found the practice did not have clear and effective governance processes for managing and monitoring patients being prescribed high risk medicines, patients being referred under the two-week wait cancer referral service and maintaining the internal child safeguarding register.

At this inspection we were satisfied there was now safe and proper policies and governance arrangements in place to address the previous concerns.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">We saw evidence that the practice had policies and governance arrangements in place to ensure patients on high risk-medicines were monitored and managed safely, the internal child safeguarding register was up to date and accurate, and there was a process to ensure patients referred under the two-week wait cancer referral service received and attended appointments.There was a designated lead for each clinical and non-clinical area. For example, there were leads for safeguarding, clinical governance, complaints, performance monitoring, administrative staff and infection control.The practice held clinical and non-clinical meetings regularly. We saw meetings were appropriately minuted, actions were logged and monitored and feedback was sought and noted.We saw evidence of management interacting with its staff and keeping them informed of changes and current issues via email and meetings.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes

Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice informed us their vision was:</p> <ul style="list-style-type: none"> To provide the best possible quality service for patients within a confidential and safe environment by working together irrespective of age, sex, gender, disabilities, health, religious beliefs or ethnic origin. To involve patients in decisions regarding their treatment. To provide patients choice of treatment and services. To provide up to date health promotion and encourage good well-being and lifestyle choices. To involve allied healthcare professionals in the care of our patients where it is in their best interests. To encourage patients to get involved and join the Patient Participation Group. To continually monitor and review patient access and services. To be courteous, caring, respectful and sensitive to patient needs. To ensure and review staff training and skills according to needs of patients, the practice and personal development. 	

Culture

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

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

Explanation of any answers and additional evidence:

- Staff told us the practice promoted continuous learning and encouraged staff to take on different roles and to become leads for different areas to help develop their careers.
- Staff told us if they had any concerns they would raise them with management, with the confidence their concerns would be taken seriously and acted upon.

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

Source	Feedback
Staff interviews.	We spoke with members of staff during the inspection. All stated they felt well supported and that they had access to the equipment, tools and training necessary to enable them to perform their roles well. We were told staff were given protected time to enable them to undertake training and carry out non-clinical duties. Staff reported there were good, effective working relationships between managers and staff and clinical and non-clinical staff.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
The practice had a suite of practice specific policies including, child and adult safeguarding, infection and prevention control and significant events. There was a system for these to be regularly reviewed by the management team.	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Yes

There were effective arrangements for identifying, managing and mitigating risks.		Yes
A major incident plan was in place.		Yes
Staff were trained in preparation for major incidents.		Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.		Yes
Examples of actions taken to address risks identified within the practice		
Medical Emergencies	Staff had received training in basic life support. Emergency medicines and equipment were in place, these were checked regularly, and trained staff knew how to use them.	
Significant events and complaints	Complaints and significant events we reviewed were appropriately acknowledged, investigated and responded to in a timely manner. Learning was shared amongst all staff members (minutes of meetings were seen).	
Infection prevention control	Staff had training in infection prevention and control, and the practice carried out annual infection prevention and control audits. The practice acted on any areas identified for improvement or rectification within the audits.	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

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

Engagement with patients, the public, staff and external partners

The practice involved 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.	Yes
The practice had an active Patient Participation Group.	Yes

Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

Continuous improvement and innovation

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

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

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. 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.