

# Care Quality Commission

## Inspection Evidence Table

### Chelsea Medical Services (1-6654175832)

**Inspection date:** 22 and 29 September 2020

**Date of data download:** 17 September 2020

An announced desk-based focused inspection was carried out on 22 and 29 September 2020 to follow-up on two warning notices in relation to Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) issued to the provider following a comprehensive inspection on 11 November 2019.

As part of this desk-based inspection we spoke with staff by telephone/video conference and reviewed documentary evidence, including photographs, submitted by the provider. In addition, a GP specialist advisor undertook a remote clinical note review with the consent of the provider.

We did not review the ratings at this inspection.

**Safe**

**Rating: Unrated**

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Yes
Explanation of any answers and additional evidence: At the last inspection we found that training for safeguarding vulnerable adults for the practice's safeguarding lead was not up to date. At this inspection the provider submitted evidence of safeguarding vulnerable adults training for the safeguarding lead carried out on 08/02/20.	

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> <p>At the last inspection the provider could not demonstrate they had a safe recruitment system in place. We reviewed five staff records and found gaps in these records. For example, three records did not contain photo ID. There were no induction records for four out of four staff. At this inspection we found that recruitment and induction records were in place for all staff.</p> <p>At the last inspection the provider could not demonstrate that any member of staff in direct clinical contact had a complete record of the requisite blood tests and vaccinations to keep patients safe, or who had certified immunity, in line with current Public Health England (PHE) guidance. At this inspection the provider submitted evidence of the required blood tests and vaccinations for all clinical staff.</p> <p>At the last inspection the provider could not demonstrate they had a system in place to monitor registrations for professional staff on a regular basis. At this inspection the provider submitted evidence of a system to monitor registrations for professional staff on a monthly basis.</p>	

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: 25/02/20	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a record of fire extinguisher checks.	Yes
There was a log of fire drills. Date of last drill: 19/08/20	Yes
There was a record of fire alarm checks. Date of last check: 19/11/20	Yes
There was a record of fire training for staff.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 19/11/19	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection the provider could not demonstrate they had undertaken portable appliance testing (PAT). We reviewed some appliances in the practice premises and saw stickers on those items dated</p>	

September 2013. At this inspection the provider submitted evidence of up to date PAT testing certificates.

At the last inspection the provider submitted evidence of a control of substances hazardous to health (COSHH) risk assessment. However, it did not contain data sheets and did not include all substances held on the practice premises in the COSHH risk assessment. For example, liquid-based cytology. At this inspection the provider submitted evidence of COSHH risk assessments for all hazardous substances stored on the practice premises.

At the last inspection the provider submitted a record of fire extinguisher checks. However, this expired in May 2019. At this inspection the provider submitted evidence of up to date fire extinguisher checks.

At the last inspection we saw in minutes of a practice meeting they had discussed a fire drill. However, the provider could not demonstrate any other evidence regarding this. At this inspection the provider submitted evidence of regular fire drills carried out at the practice.

At the last inspection the provider could not demonstrate that staff had completed fire safety training. At this inspection the provider submitted evidence of fire safety training for all staff.

At the last inspection the provider could not demonstrate they had fire marshals in place who were adequately trained for this role. In addition, there were no contingency plans in place for when this member of staff was away from the practice. At this inspection the provider submitted evidence that all staff had received instruction in the role of a fire marshal and that a nominated fire marshal was available onsite to cover all contingencies.

At the last inspection the provider could not demonstrate they had a fire safety risk assessment in place. At this inspection the provider submitted evidence of a fire risk assessment carried out by a professional company.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 28/02/20	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 28/02/20	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection the provider had an asbestos risk assessment in place. However, this did not meet the standards required in line with national guidance. At this inspection the provider submitted evidence of an appropriate asbestos risk assessment with evidence of regular checks as recommended by the risk assessment.</p> <p>At the last inspection the provider could not demonstrate they had carried out health and safety and premises/security risk assessments. At this inspection the provider submitted evidence of a health and safety risk assessment which also included the premises and security.</p>	

## 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.	Yes
Date of last infection prevention and control audit: external audit 02/09/20, internal audit 17/04/19.	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we found the NHSE Infection Prevention &amp; Control (IPC) unit had undertaken an external IPC audit on 28 August 2019. Action points had been identified and this had mandatory requirements and timescales attached to it. We found some mandatory action points had not been completed within the correct timescale. At this inspection the provider submitted evidence that they had held a meeting with NHS property and the Clinical Commissioning Group (CCG) to organise funding and permission to carry out the outstanding mandatory actions. However, this had been put on hold due to the Covid-19 pandemic. The provider demonstrated they had done all that was reasonably practicable to address the points on the audit and that there were no outstanding risks to patient safety that required immediate attention.</p> <p>At the last inspection, the provider could not demonstrate they had a Legionella risk assessment in place. This had been identified as being a high priority during an NHSE external IPC audit on 28 August 2019. NHSE IPC unit had given a four week time scale for this to be completed. At this inspection the provider submitted evidence that a Legionella risk assessment had been carried out.</p> <p>At the last inspection cleaning equipment was incorrectly stored. Mops were not inverted and buckets were stored close together increasing the risk of cross contamination. At this inspection the provider submitted evidence of appropriate storage of cleaning equipment.</p> <p>At the last inspection the provider could not demonstrate they undertook internal IPC audits. At this inspection the provider submitted evidence of internal IPC audits carried out at regular intervals to ensure compliance with IPC standards.</p>	

## Risks to patients

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

	Y/N/Partial
Comprehensive risk assessments were carried out for patients.	Yes
There was an effective induction system for temporary staff tailored to their role.	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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we reviewed staff employment and recruitment records and found gaps in relation to staff induction records. At this inspection we found induction records were in place for all staff.</p> <p>At the last inspection we found gaps in staff training for basic life support. At this inspection we found all staff had undertaken recent training however not all staff had completed it in the previous 12 months. The practice told us that this was because they had been unable to book face to face training during Covid pandemic therefore some staff were overdue. However, all staff had completed online training and face to face training would be completed as soon as it was available.</p> <p>At the last inspection the provider could not demonstrate they had safety netting systems in place regarding two-week urgent referrals and high-risk medicines. At this inspection the provider demonstrated effective systems in regard to these to ensure patient safety.</p> <p>At the last inspection we found that risk assessments for the practice premises were absent. We found that some risk assessments undertaken to ensure the safety of the premises for patients and staff had not been undertaken, for example fire safety, Legionella, asbestos and COSHH risk assessments. At this inspection the provider submitted evidence of risk assessments for most areas of health and safety.</p> <p>At the last inspection non-clinical staff we interviewed told us what actions they would take if a very unwell patient attended the practice. However, the practice could not demonstrate that all staff had undertaken sepsis or red flag signs training in line with national guidance. At this inspection the provider submitted evidence of sepsis training completed for all staff.</p>	

## 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
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection we saw the practice managed electronic clinical records in line with national guidance and legislation. However, we saw that paper medical records are stored in their reception area and in a 'server room' which is easily accessible to others. In both storage areas, records could easily be removed without a member of staff seeing. At this inspection the provider submitted evidence to show that paper medical records were no longer accessible to people passing by the reception back office area and were now stored in secure filing cabinets.</p> <p>At the last inspection we reviewed the system and process the provider had in place regarding two-week wait urgent referrals. The provider could not demonstrate they operated a fail-safe system. For example, we found ten patients had not been followed up by the practice to check they had attended an appointment with secondary care. At this inspection the provider submitted evidence of a fail-safe system to ensure all patients were followed up by the practice.</p>	

At the last inspection, the provider could not demonstrate they had a failsafe system in place to manage and monitor cervical smear screening. We were not assured regarding patient safety. At this inspection the provider submitted evidence of a fail-safe system in that a record was kept of cervical smears undertaken and a system to cross check all results were returned to the practice.

## Appropriate and safe use of medicines

### The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Medicines management	Y/N/Partial
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 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
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 the last inspection we reviewed the system and process the provider had in place to monitor and manage high-risk medicines. The provider could not demonstrate they operated a safe effective system regarding this. For example, we found evidence that six patients had not undertaken appropriate blood monitoring. We were not assured regarding patient safety. At this inspection we reviewed a selection of patients on high-risk medicines and found they were being monitored appropriately.</p> <p>At the last inspection, the provider did not maintain stock of a medicine used for the treatment of croup in children. The provider had not conducted a risk assessment as to why they did not stock this medicine. At this inspection the provider submitted evidence that they now held a stock of this medicine.</p> <p>At the last inspection we found the vaccine fridges were overstocked. The vaccines were stored to the sides of the fridge which did not facilitate the air circulation system to maintain vaccines at a safe optimum temperature. We found that temperatures had fallen below recommended on several occasions on the vaccine fridge in a consultation room and no remedial actions had been undertaken regarding this. They did not have a system in place to monitor new stock and manage stock rotation. Therefore, we could not be assured that the cold chain was being maintained in accordance the Public Health England guidance. At this inspection we found the practice had rectified the shortfalls. They submitted evidence that a larger vaccine fridge had been purchased to ensure vaccines were not overstocked. A clinical stock handling policy had been introduced and staff trained on stock management and cold chain procedures. The provider submitted evidence of daily temperature checks to ensure vaccines were stored within the appropriate temperature range.</p>	

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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection the practice could not demonstrate a consistent and failsafe system for receiving, recording and acting on patient safety alerts. They could not demonstrate they had captured all alerts; what actions had been taken and by whom; when actions had been completed and that this information was shared with all staff. We were not assured regarding patient safety. We also found that the practice did not undertake clinical meetings. Therefore, there was limited potential for relevant patient safety alerts to be discussed by clinical staff.</p> <p>At this inspection the provider submitted evidence of a detailed spreadsheet for capturing patient safety alerts. Patient safety alerts had been recorded and action taken. The provider had introduced clinical meetings and the minutes of these meetings provided evidence that patient safety alerts were discussed by clinical staff.</p>	



## Effective

Rating: Unrated

### Effective needs assessment, care and treatment

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

	Y/N/Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection staff told us that patients with potentially serious illness were followed up in a timely way. However, they could not demonstrate they had a system and policy in place to manage and monitor this. For example, two-week urgent referrals. At this inspection the provider submitted evidence of fail-safe systems to follow up patients with potentially serious illness. For example, fail-safe systems for two-week urgent referrals and for cervical screening.</p> <p>At the last inspection we found evidence that patients' treatment was not always reviewed regularly. For example, six patients on high-risk medicines did not have appropriate regular monitoring in line with national guidance. At this inspection we reviewed all patients on high-risk medicines and found they were being monitored appropriately.</p>	

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) (01/04/2018 to 31/03/2019) (NHS England)	10	18	55.6%	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) (01/04/2018 to 31/03/2019) (NHS England)	15	31	48.4%	Below 80% uptake
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) (01/04/2018 to 31/03/2019) (NHS England)	17	31	54.8%	Below 80% uptake



The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	16	31	51.6%	Below 80% uptake
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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

At the last inspection we found the practice has not met the minimum 90% target for four of four childhood immunisation uptake indicators (the recommended standard for achieving herd immunity is 95%). We asked clinical staff regarding the deterioration in childhood immunisations rates. They told us that parents took their children to have their immunisations with private providers. However, they did not share data with us to evidence this.

At this inspection the practice submitted evidence of an action plan to improve the low childhood immunisation uptake. This included searches carried out by clinical staff to find the target patients and invite in for an appointment and evidence from clinical meeting minutes of regular discussion to improve uptake. We were unable to confirm if immunisation uptake had improved following these measures as the latest data had not been published by NHS England and the practice were unable to demonstrate improvement through unverified data.

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: 31/03/2020) (Public Health England)	39.1%	N/A	80% Target	Below 70% uptake

### Any additional evidence or comments

At the last inspection Public Health England (PHE) data demonstrated that the achievement rate for eligible women for cervical cancer screening (2018/2019) was 41.5%. This was significantly below the 80% England target. The practice told us that patients receiving smears from private clinics contributed to the low uptake however they could not provide evidence to support this. In addition, the practice did not have an action plan in place to improve the low uptake.

At this inspection the practice submitted evidence of an action plan to improve uptake including searches carried out by clinical staff to find target patients and invite in for an appointment and evidence from clinical meeting minutes of discussions to improve uptake. However, the PHE data above from 31/03/2020 showed no improvement and a slight deterioration in uptake. The practice assured us they were committed to improving uptake and provided evidence from a cervical smear audit that demonstrated that between January and July 2020, 17% of smears were performed at private clinics. They also pointed out that there was a significant reduction in smears performed April to May 2020 due to the Covid-19 pandemic.

## Monitoring care and treatment

**At the last inspection we found there was limited monitoring of the outcomes of care and treatment. At this inspection we found that whilst there was no comprehensive programme of quality improvement activity monitoring of care and treatment had improved.**

	Y/N/Partial
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	No
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Examples of quality improvement:

<p>The practice submitted evidence of some improvement in monitoring care and treatment for patients. For example:</p> <ul style="list-style-type: none"> <li>• An audit of patients on antipsychotic medicines to ensure safe prescribing.</li> <li>• High-risk medicine monitoring audits.</li> <li>• An audit of patients on Nonsteroidal Anti-inflammatory Drugs (NSAIDs) to ensure safe prescribing.</li> <li>• Sodium valporate audit to ensure compliance with MHRA safety alert.</li> <li>• A cervical smear audit to monitor and improve cervical smear uptake.</li> </ul> <p>Although quality improvement activity focused on areas of concern identified at the last inspection it was not a comprehensive program of quality improvement. The practice agreed this was an area that needed further development.</p>
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## Effective staffing

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

	Y/N/Partial
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	No

<p>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.</p>	<p>Yes</p>
<p><b>Explanation of any answers and additional evidence:</b></p> <p>At the last inspection the practice could not demonstrate they assessed the learning and development needs for staff. For example, the practice had not identified that the healthcare assistant was required to undertake Care Certificate training. At this inspection the provider submitted evidence that they had booked the healthcare assistant onto a Care Certificate training workshop however this had been postponed due to the Covid-19 pandemic.</p> <p>At the last inspection the provider could not demonstrate policies/protocols to monitor and manage tasks undertaken by the healthcare assistant. At this inspection the provider submitted evidence of a protocols in place to monitor and manage the tasks undertaken by the healthcare assistant and to ensure they were appropriately supervised to carry out their role safely.</p> <p>At the last inspection the provider could not demonstrate they had an appropriate embedded system of learning and training for staff. For example, they did not have a programme of regular training in place. They could not evidence that any staff had undertaken appropriate training regarding fire safety training and sepsis/red flag signs. At this inspection the provider submitted evidence of a system to monitor staff training and demonstrated that staff had filled the gaps in training identified at the last inspection.</p> <p>At the last inspection we reviewed four staff records and saw that none of them had undertaken an induction programme. We also reviewed five staff records and saw that three out of five did not contain evidence of an annual appraisal. At this inspection the practice demonstrated they had implemented induction training for new staff and a system of appraisal for all staff.</p>	

## Governance arrangements

The provider had reviewed their governance systems and processes and had made improvements to the areas of concern outlined at our previous inspection.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection we found that there was a lack of systems and processes established and operated to ensure compliance with the requirements to demonstrate good governance. At this inspection we found the practice had made improvements to their systems and processes and were able to demonstrate:</p> <ul style="list-style-type: none"> <li>• A fail-safe system regarding two-week wait urgent referrals.</li> <li>• An effective system to monitor and manage patients prescribed high-risk medicines.</li> <li>• A fail-safe system regarding complying with patient safety alerts.</li> <li>• A fail-safe system regarding cervical screening.</li> <li>• A system to monitor and manage regular staff training.</li> <li>• Protocols/policy to monitor and manage the tasks undertaken by the healthcare assistant.</li> <li>• Regular clinical meetings.</li> <li>• Action plans to address low cervical screening and childhood immunisation achievement rates. However, cervical screening and childhood immunisation uptake remained significantly below national targets.</li> <li>• An effective recruitment system.</li> <li>• A system to monitor registrations for clinical staff on an annual basis.</li> <li>• A system in place to monitor, manage and drive quality improvement in patient care. Although this focused on areas of concern identified at the last inspection it was not a comprehensive program of quality improvement. The practice agreed this was an area that needed further development.</li> </ul>	

### 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.