Acute prescribing Learning Report

Introduction

The Acute Prescribing Learning Network ran from December 2021 – May 2022. This was to allow participating teams to develop and test new tools and processes within the multidisciplinary team and participate in virtual workshops to share and capture the learning. During this six month period, 4 NHS Lanarkshire practices participated in the HIS Acute Prescribing Learning Network with the focus to improve the management of acute prescribing while supporting the development of GP practice and pharmacotherapy teams within primary care.

The aim of the Learning Network was to develop staff skills and test a range of tools and resources for the safe and effective management of acute prescribing processes within primary care. The expected benefits include safer acute prescribing, improved patient experience, more efficient processes and effective team working across the primary care multidisciplinary team.

The overarching aim of the Network was to collaboratively develop a Toolkit to support improvements in acute prescribing efficiency within GP practice. The Acute prescribing toolkit (https://ihub.scot/acuteprescribingtoolkit) was launched in September 2022.

Methodology

Practices were asked to express their interest if they wished to participate in the collaborative, and a Lanarkshire wide application for the 4 practices who indicated a keenness to be involved was jointly submitted, with the support of an improvement manager for the PCIT and advanced clinical pharmacist from PCIP.

GP practice teams across Scotland came together via 3 Workshops on MS Teams to identify improvement areas and ideas, test and provide feedback on resources and supporting documents and to test and implement change ideas at practice level.

The Network created a platform on MS Teams for the sharing of support as well as sharing of existing individual practice processes and policies to improve acute prescribing volume and quality.

Application

The Acute prescribing collaborative provided a wide variety of tools for the practices involved to test, and aid implementing and monitoring changes with the hope of noticing improvement. These tools consisted of –

- Prioritisation tool (Appendix 1)
- Driver Diagram (Appendix 2)
- Project Charter (Appendix 3)
- Change package (Zip file available on request)

Participating NHSL practices primarily used the provided Prioritisation Tool to identify relevant improvement change ideas in acute prescribing and developed processes to implement these at practice level.

STU data reports were run by the pharmacy team in practice and utilised to identify specific relevant prescribing areas/medication groups for individual practices to focus their efforts and will continue to be utilised to measure impact of implementing change ideas on acute prescribing.

Practice	HSCP	List size	No of acutes per 1,000 patients (Nov-21)	% acute prescriptions (Nov-21)	Repeatable acute areas
A	North	5630	437	31.8%	CNS, Gastro, MSK
B	North	7380	285	19.2%	CNS, Gastro, MSK
C	South	8650	371	24%	CNS, Gastro
D	South	8130	572	31.1%	CNS, skin

One practice held a MDT practice meeting and used both a driver diagram and prioritisation tool to inform discussion. This resulted in substantial discussion on a number of acute prescribing areas – processes, sign posting and moving acute prescriptions to repeat.

Another practice held practice meeting and expressed that the prioritisation tool identified areas they already feel are done well/have good understanding of, however led to identifying the following priority change ideas - prescribing plans, medication reviews with intent to link wider MDT and sharing their prescribing policy.

It should be acknowledged that reducing the number/volume of acute prescriptions is not the sole outcome/intention of this work, however a sensible measurement which could be cross-linked with implementing changes in processes and associated workload management.

Key Learning

Throughout the learning network, both PCIT QI support and Advanced Clinical services pharmacist worked together and linked in with the practices to offer support and capture learning.

The practices completed a project summary (Appendix 4) to provide a better understanding of progress being made. From the responses received, it was evident that there is a consistency across the board that the overall aim is to reduce the number of special request prescriptions (specifically targeting anti-depressants, PPIs and skin) whilst improving patient safety, effectiveness and efficiency.

Practices utilised the prioritisation tool which identified areas already being completed effectively and that they had a good understanding of. This tool also identified the following priority change ideas:

Across the four practices, the following change ideas were discussed–

- Implementation of revised antidepressant prescribing, incorporating pharmacist review and move repeat prescribing using appropriate prescribing management functions e.g. forced reauthorisation.
- Implementing SOPs developed to support moving prescribing of specific medications (e.g. PPIs, antidepressants and skin) identified as ‘repeatable acutes’ to repeat prescribing. (Appendix 5 and 6)
- "Think Repeat!" added at top of specials column. All prescribers on board with this and many scripts that have been repeated on acute, sometimes for years, have been added to repeat.
- Changing prescribing processes by all clinicians ensuring clear documented plan for medications in notes including duration timescales and when review is required- both acute and repeat medication
- Create a process map for admin and clinicians for each of the Skin, PPI & Anti-depressant acutes.

- Methotrexate and other DMARDs and lithium. If established on stable dose with three monthly bloods then give a supply to take up to next blood test date. Then, if bloods normal, give a 12 week supply.
- Implementing acute prescribing of annual supply of contraceptives, following appropriate review.
- Implementing prescribing of HRT on repeat; authorised for annual supply following appropriate review.
- Increased adoption of serial prescribing, with 48 week prescriptions issued rather than 24 weeks.

It is clear to see, that by utilising the prioritisation tool and other useful tools, there is a wide variety of change ideas underway.

In order to provide a comprehensive understanding of the learning, the practices were asked to complete a short survey (Appendix 7) to capture responses to allow informative evaluation. The practices kindly provided an update on where things are with testing their changes. (Appendix 8)

Practices are progressing with implemented changes. There have been a few barriers noted around staffing (sickness, retiring), which has postponed discussions around processes, however the aim is to progress again when able. One practice has developed an SOP and is currently auditing the data.

Responses received from GPs, pharmacists and practice managers showed –

- The majority of staff found both the STU tool – dashboard tab and repeatable acutes tab very helpful and quick to use
- The prioritisation tool and process map was fairly helpful
- The change package was fairly helpful
- There was no strong view on the driver diagram, project charter or the huddle checklist

The main influence to participate in the collaborative and explore the toolkit was mainly due to the high volume of acute prescriptions. Other contributing factors according to the survey was ‘clinical area in need of active reviews’, ‘strong views of one or two people’ and ‘desire for a quick win’.

The responses received indicate this is very much collaborative working. A mix between GP and Pharmacists are the main drivers of change with a mix of practice manager and practice administrative staff involved. Time was planned in for practice Pharmacists to actively review patients as per the SOPs and the changes to prescribing allowed them to move items from acute to repeat during their pharmacotherapy time in practice. Collaborative working was essential in the success of the improvement in workload. The SOPs were used as working documents utilising them when working through acute workload every day. It was felt that practices could not complete reviews on every patient identified in the STU data therefore using the SOP to implement the change would become a change to processing acutes when presented. A review of the initial prescribing process of the highlighted therapeutic area, is also key to the success of the collaborative. Documented indication, review date and thought of prescribing length was added to initial consultations to ensure that it was clear when the patient needed a review. This aided in the decision process to actively change the item to repeat.

Data comparison

Practices were asked to submit baseline data at the beginning of the HIS collaborative and again after the pilot timeframe had finished. The data has been compared as a percentage of acute prescribing relative to the total number of prescriptions issued. This percentage of acute issued does not reflect the differences in acutes issued during a consultation vs those issued from a patient prescription request.

Practice	Total number of prescriptions		No of acute prescriptions per 1,000 patients		% acute prescriptions	
	Nov-21	**Jul-22**	**Nov-21**	**July-22**	**Nov-21**	**July-22**
A – North HSCP	19851	17820	437	372	31.8%	30.2%
B – North HSCP	10943	10177	285	260	19.2%	18.9%
C – South HSCP	13352	11876	371	283	24.0%	20.6%
D – South HSCP	14461	13029	572	513	31.1%	32.0%

Comparing the percentage of acute prescriptions at the beginning of the collaborative and at the end, there is a reduction in acute prescribing in 3 out of the 4 practices. There is a reduction in all practices when comparing the acute prescriptions issued per 1,000 patients.

When the practices were asked if the area of improvement work was continuing after the collaborative came to an end, they advised that the improvement is indeed still continuing. They reported an overall reduction in the volume of acute prescriptions and patient feedback is positive. One practice indicated that acute prescriptions still appear to be climbing, however the percentage of all items that are repeats has increased. This indicates that the work that has been done has stemmed the tide of the increase in overall prescribing. It has also been reported that there has been an increase in patient reviews, enhancing overall patient care.

To gain a better understanding of the impact, the practices were asked if the number of daily special requests completed were affected/reduced by the impact of spending more time working on moving appropriate acute requests to repeat prescribing. Of the practices that have responded, they recognised that the question was a relevant point to consider, however they noted that when considering the full wider system there was complexity that would influence this e.g. current increase prevalence of Strep A and associated increase in requests. As such, they advised that they did not recognise a level of increase that was of concern when balanced with the benefits being realised through the implementation of the Acute Prescribing approach.

The practices were also asked what they would do anything differently during the identification and implementation of a new process. The responses are summarised below:

- Include the wider team to ensure everyone is on board and that the change will be embedded.
- Ensure future changes discussed at MDT level and compile a collective strategy.
- Be mindful of current pressures and how these can create difficult barriers, however a collaborative approach is more effective.

Acknowledgements

Strathcalder practice

Craigallian practice

Chapelhall practice

Jamieson Practice

Appendix 1

Question	Answer
Do you:	
1. Know the skill mix, roles and responsibilities and engagement levels of your team?	
2. Have good communication and training within your team?	
3. Collect data and do you understand it?	
4. Document prescribing plans in medical records?	
5. Have a clear process for patients and staff for requesting prescriptions?	
6. Have a safe and efficient medication review process, including for LTC meds?	
7. Use permissible and serial repeats & have an agreed policy?	
8. Have standard procedures so that all prescribers manage common medications the same way?	
9. Use care navigation and promote self care effectively?	

View change ideas

Healthcare Improvement Scotland

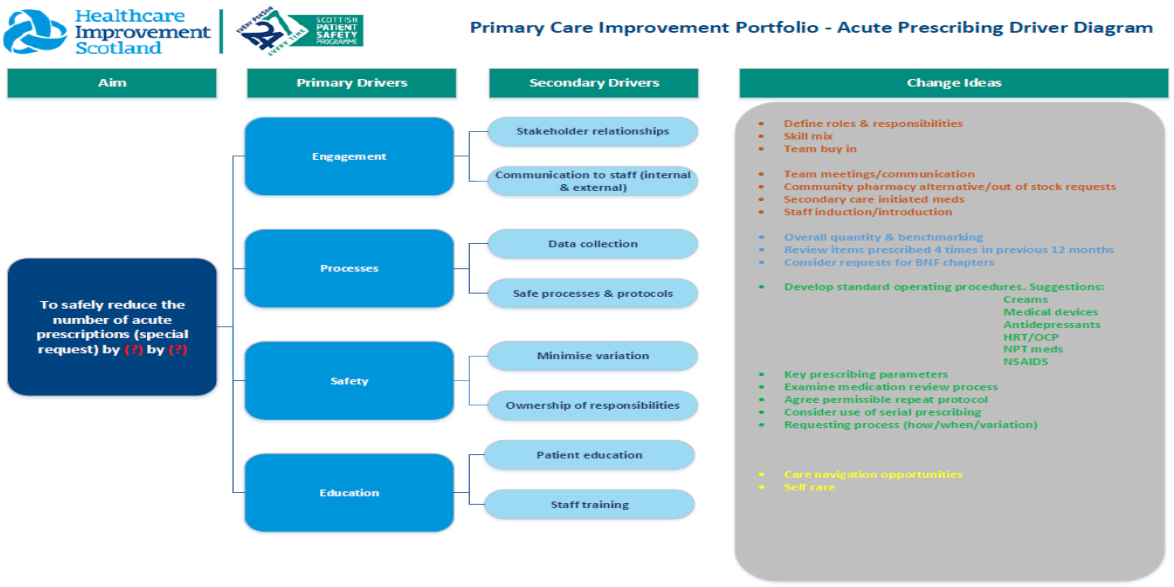
Acute Prescribing - Change ideas

Key
- Priority 1
- Priority 2
- Priority 3
- Priority 4

Change Idea	Rationale	Links
Understand your team	Teams need to be motivated to work together and allocate tasks appropriately in order to improve acute prescribing. Clarity about team make up, skill mix, roles and responsibilities and project aims helps create the conditions for improvement.	For more information click here
Communication	You need to introduce your project to team members so that they understand the aim and their role. Ongoing communication with your team is essential. Projects will also impact on people beyond your practice team. Effective communication will help everyone to understand what you are doing and be involved in shaping any changes or providing feedback as appropriate.	For more information click here
Data understanding	Understanding the total number of acute prescriptions ("acutes") generated within the practice will help understand this workload. It will help you set a baseline and measure improvement. More detailed analysis will enable comparisons, help identify where to focus and may generate change ideas.	For more information click here
Prescribing plan	Recording prescribing plans in patient notes enables other members of the practice multidisciplinary team (MDT) to understand the intentions of the original prescriber. This supports pharmacy teams to move through acute prescriptions safely and quickly and reduces the need to refer back to the prescriber.	For more information click here
Requesting prescriptions	Having a safe, efficient and convenient procedure for requesting medication will be of benefit to both patients and staff. If procedures are followed and workload is directed to the most appropriate person then time and effort is likely to be saved. Increased patient satisfaction with the process is also likely to benefit staff and other stakeholders.	For more information click here
Medication reviews	Ideally, all patients on repeat prescriptions should have an annual review of their medicines. If a robust medication review procedure is in place, it may instil confidence to issue medication on repeat rather than acute.	For more information click here
Prescribing policies	There are different prescribing options available. Many medications may not require a clinical review every time they are issued. However, they do require a guaranteed review within a specific timeframe. In these cases a permissible repeats may be the most appropriate type of prescription. When medications are stable and require minimal monitoring. A serial prescription can reduce the workload related to issuing and dispensing the medication.	For more information click here
Standard operating procedures	Developing a safe and efficient policy for every prescriber to follow for certain types of medication can ensure consistency and good medicines management. This may allow prescriptions to be moved off of acute.	For more information click here
Care navigation and self care	Effective care navigation ensures patients can be seen by the right person, at the right time and in the right place and enables better use of GP practice resources. Using care navigation to signpost appropriate patients to community pharmacies, Pharmacy First services and self-care resources can support safe reduction in the number of acute prescriptions issued.	For more information click here

Return to Questionnaire

Appendix 2


Healthcare Improvement Scotland
Primary Care Improvement Portfolio - Acute Prescribing Driver Diagram
Aim
Primary Drivers
Secondary Drivers
Change Ideas
To safely reduce the number of acute prescriptions (special request) by (?) by (?)
Engagement
Processes
Safety
Education
Stakeholder relationships
Communication to staff (internal & external)
Data collection
Safe processes & protocols
Minimise variation
Ownership of responsibilities
Patient education
Staff training
Define roles & responsibilities
Skill mix
Team buy in
Team meetings/communication
Community pharmacy alternative/out of stock requests
Secondary care initiated meds
Staff induction/introduction
Overall quantity & benchmarking
Review items prescribed 4 times in previous 12 months
Consider requests for BNF chapters
Develop standard operating procedures. Suggestions:
Creams
Medical devices
Antidepressants
HRT/OCP
NPT meds
NSAIDS
Key prescribing parameters
Examine medication review process
Agree permissible repeat protocol
Consider use of serial prescribing
Requesting process (how/when/variation)
Care navigation opportunities
Self care

Appendix 3

A Project Charter is a short document that explains the project in clear, concise wording. It outlines your plan to help teams quickly understand the goals, tasks, timelines, and stakeholders.

Your team name:	
Your practice name:	
QI project team members: (please provide full names and roles)	
Date:	

1. **What are you trying to accomplish?**

Topic or issue you would like to improve (1-2 sentences):

Aim statement (how good do you want to be by when?) (1 sentence):

Why is this an important issue to tackle? Why does it matter to your service users/staff/directorate/organization? How will it help improve acute prescribing? (4-5 sentences)

What is the scope of your project? What specific processes will need to change to achieve your aim/goals? Types and numbers of patients/clients whose outcome will be affected:

Do you have data that can tell you the current performance of the process?

2. **How will you know that a change is an improvement?**

Measures:

How will you monitor your progress toward your goal(s)? List the process measures you plan to track.

- **Process** - how you will know how the parts of the system you need to change (to get you to your improvement aim) are performing and the impact of your changes on these.
- **Balancing** - do you need to keep watch in case your action has an unintended impact on other parts of the system or to see if something unrelated to your project is influencing project success?

3. **What changes can you make that will lead to improvement?**

What change ideas would you like to test (the more the better)? What evidence is out there about what works?

4. **What initial activities do you have planned?**

These are the *tasks* associated with your project (not to be confused with change ideas) e.g. setting up an improvement team, gathering baseline data, and applying improvement tools to help you understand how things are currently working to help identify change ideas.

5. **List any barriers that you can identify to getting this project going**

6. **What ring-fenced time have you agreed for your practice staff to meet?**

(suggestion would be weekly or fortnightly for 30-60 mins with all staff involved in this project present)

Appendix 4

Please complete the form as thoroughly as possible to help us understand what progress network teams have made and which resources should be published as part of our Acute Prescribing toolkit

NB: Please ensure all supporting documents are sent to us along with this completed form.

Practice Name	
List size	
HSCP	
Contact email	
Date	

Aim (*What are you trying to accomplish? Do you have an Aim Statement?)*
Change Ideas (*What changes are you testing?)*
Activity so far (*How did you start? What has been achieved so far? Which tools have you used i.e. prioritisation tool, PDSA cycles, project charter, Pareto chart etc.)*
Activity planned for next 3 months (*What activity is ongoing? What would you like to do next? Which tools do you plan to use?)*
Measurement (*What data or information are you using to the impact of changes? Have you seen any change? How will you know if a change is an improvement?)*
Stakeholder Feedback *(Have you received any planned or ad hoc feedback from staff, service users or other stakeholders?)*

Things to consider/hint & tips for other teams testing this change idea

Risks / issues identified – please highlight any support needed

Key learning/reflections

Attachments

- ☐ Charter
- ☐ PDSA
- ☐ Measurement plan
- ☐ Data
- ☐ Policies/Protocols/procedures
- ☐ Other (please give details below):

Q&A

Being part of the Acute Prescribing Network has:

1. Increased confidence to implement changes to your acute prescribing systems?
   - ☐ Strongly agree
   - ☐ Agree
   - ☐ Neither agree/disagree
   - ☐ Disagree
   - ☐ Strongly disagree

2. Increased collaboration/communication about acute prescribing within your team?
   - ☐ Strongly agree
   - ☐ Agree
   - ☐ Neither agree/disagree
   - ☐ Disagree
   - ☐ Strongly disagree

3. Increased collaboration/communication about acute prescribing beyond your team?

☐ Strongly agree
☐ Agree
☐ Neither agree/disagree
☐ Disagree
☐ Strongly disagree

4. Increased the safety of our acute prescribing systems?

☐ Strongly agree
☐ Agree
☐ Neither agree/disagree
☐ Disagree
☐ Strongly disagree

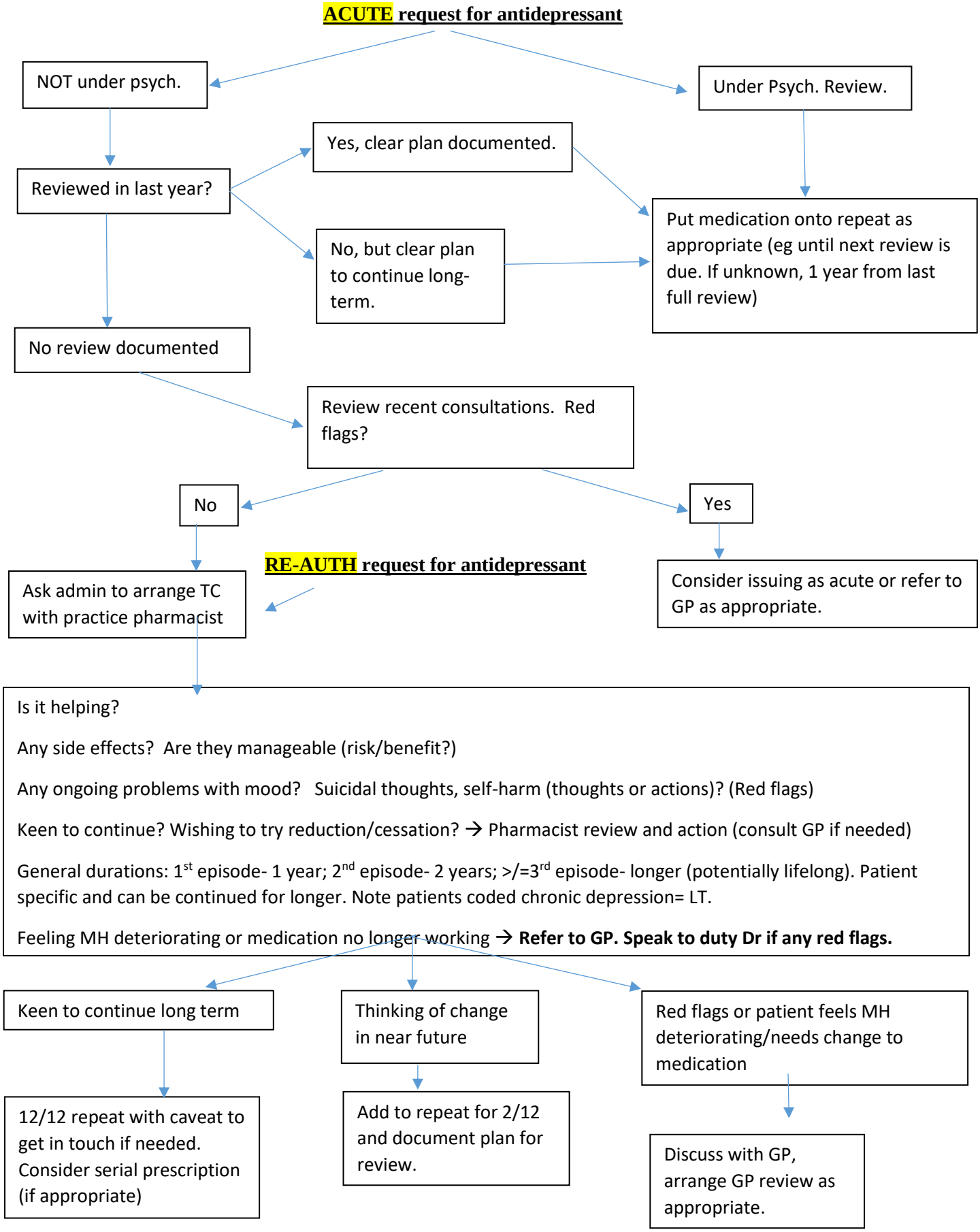
Thank you for completing this form. Please send the form and supporting documents to:

Teams to send: HSCP Team lead

Team lead: HIS Team his.pcpteam@nhs.scot

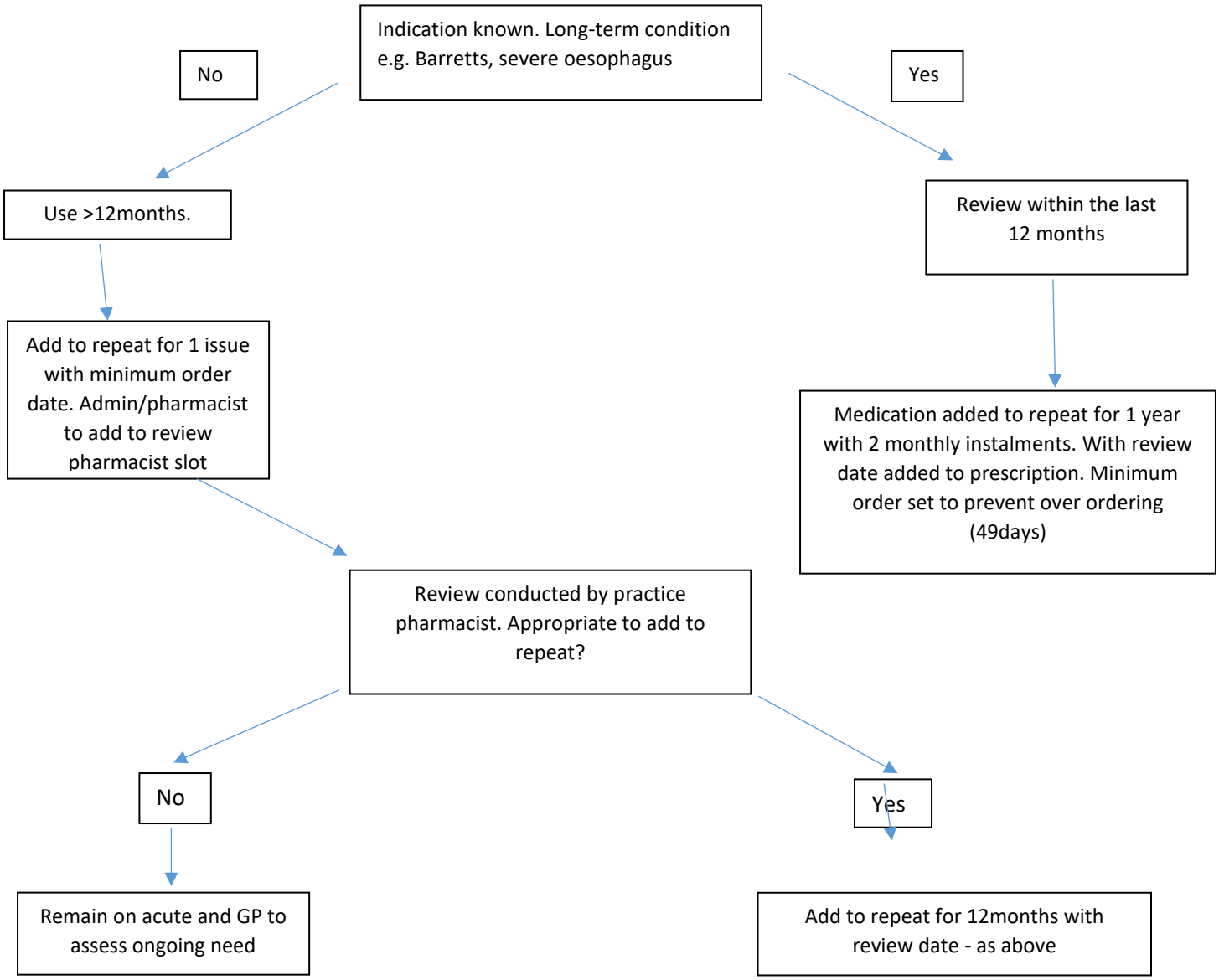
This information will be used to produce a summary of change ideas being worked on and the contact details of teams. This will be shared on the Acute Prescribing Learning network MS Teams channel to facilitate networking and sharing of learning and resources. We hope this will be useful to everyone. If you do not want your team included in the summary please tick the box. We do not want our team details included in the summary.

Appendix 5 - Pharmacist anti-depressant review flow chart



Appendix 6

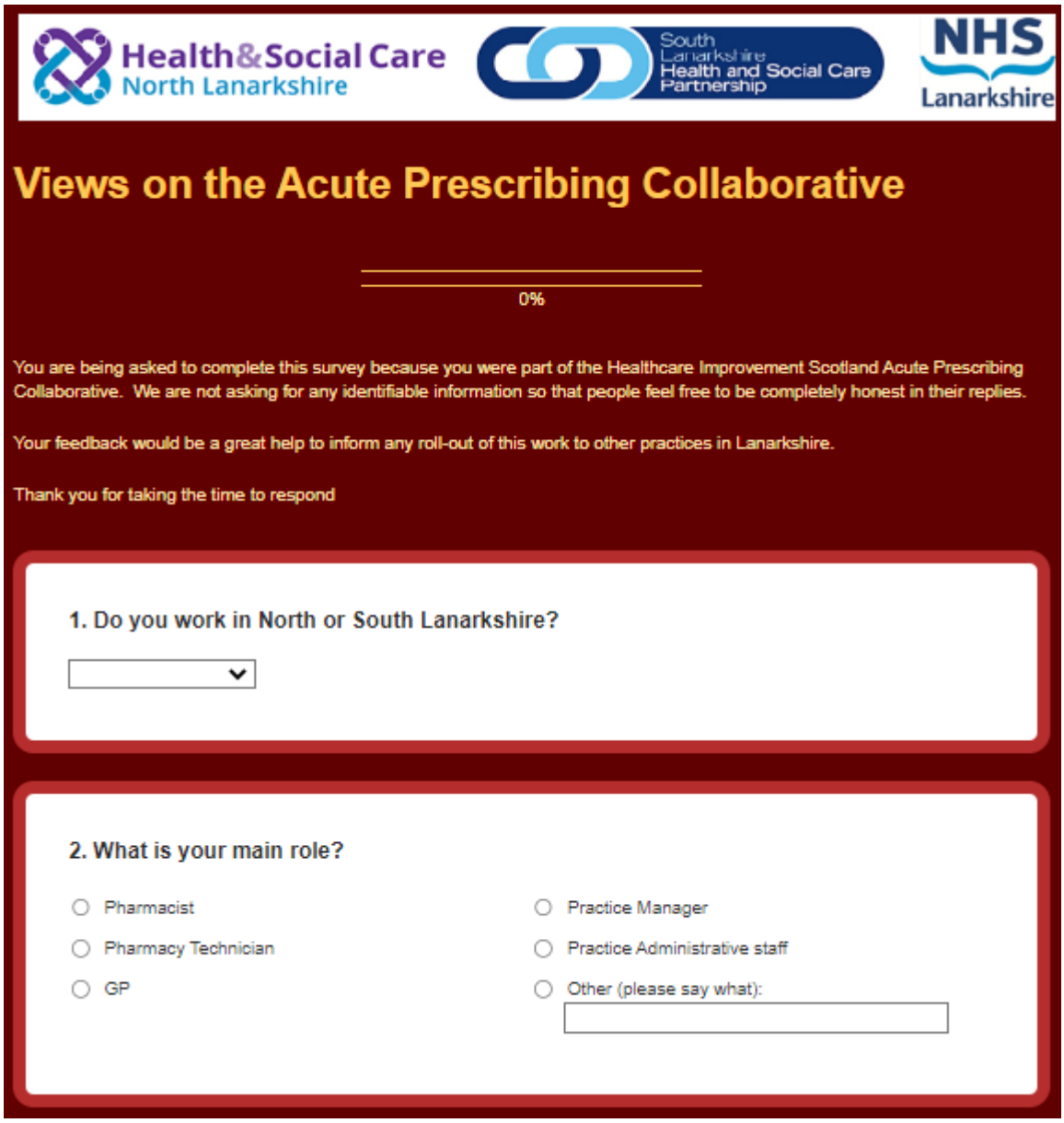
ACUTE request for PPI



Points for Review

- Indication
- Dose appropriate
- Lifestyle interventions – diet, smoking, alcohol, weight
- ?Triggers
- Risks of long-term use.
- Rebound symptoms – Peptac can be issued
- On formulary PPI
- Reference to PPI protocol on First Port

Appendix 7



Health&Social Care North Lanarkshire

South Lanarkshire Health and Social Care Partnership

NHS Lanarkshire

Views on the Acute Prescribing Collaborative

0%

You are being asked to complete this survey because you were part of the Healthcare Improvement Scotland Acute Prescribing Collaborative. We are not asking for any identifiable information so that people feel free to be completely honest in their replies.

Your feedback would be a great help to inform any roll-out of this work to other practices in Lanarkshire.

Thank you for taking the time to respond

1. Do you work in North or South Lanarkshire?

2. What is your main role?

- Pharmacist
- Pharmacy Technician
- GP
- Practice Manager
- Practice Administrative staff
- Other (please say what):

3. If you used any of the following tools during the Acute Prescribing Collaborative, how did you find them?

	Very helpful	Fairly helpful	Not helpful	No strong view	Did not use
STU tool - dashboard tab	○	○	○	○	○
STU tool - repeatable acutes tab	○	○	○	○	○
Prioritisation tool	○	○	○	○	○
Process map	○	○	○	○	○
Driver diagram	○	○	○	○	○
Huddle checklist	○	○	○	○	○
Change package	○	○	○	○	○
Project charter	○	○	○	○	○

4. How would you describe the time taken to use the STU tool dashboard tab and STU tool repeatable acutes tab?

	Quick to use	Time-consuming	No different to how did this before	Did not use
STU tool dashboard tab	○	○	○	○
STU tool repeatable acutes tab	○	○	○	○

Please use this space if you wish to briefly comment on your response:

5. Did any of the following influence what was selected for review during the collaborative? *(Tick as many as apply)*

- ☐ Highest volume of acute prescriptions
- ☐ Clinical area in need of active reviews
- ☐ Strong views of one or two people
- ☐ Desire for a quick win
- ☐ Area of special interest in practice
- ☐ Other (please say what):

6. Which of the following people were involved in driving forward the changes during the collaborative?

	Main driver of change	Very involved	Somewhat involved	Not involved
GP(s)	○	○	○	○
Practice Manager	○	○	○	○
Practice Administrative staff	○	○	○	○
Pharmacist(s)	○	○	○	○
Pharmacy Technician(s)	○	○	○	○
Improvement Manager(s)	○	○	○	○

If others were involved, please say what their role was:

7. Is the area of work selected for the collaborative continuing in the practice now?

- ○ Yes, fully
- ○ Yes, partially
- ○ No
- ○ Not sure
- ○ Other (please describe):

8. Would you say any of the following happened as a result of the acute prescribing collaborative work? *(Tick as many as apply)*

- ☐ Volume of acutes reduced overall
- ☐ Volume of acutes reduced for GPs
- ☐ Volume of acutes reduced for Pharmacist(s)
- ☐ Patients were happy with the changes
- ☐ Volume of patient reviews increased
- ☐ Other (please say what happened):

Appendix 8

Practice Feedback

Practice A

- Discussed at practice meeting with the clinical team the following -
    - During medication reviews if a medicine has been issued >4 times/ year - add to repeats
    - Consider setting review dates for birthday month instead of 1 yearly?
    - Document plan for medications in notes of duration timescales and when review is required- both acute and repeat medication
- Most recently identified specific areas in the patient discharge letters that require training for our admin staff to gain confidence in adding the medication that will be prescribed long term. This was also discussed at a practice meeting with all of the clinicians.
- Utilised the resources within our practice with the help from the practice pharmacist who is happy to provide the material and resources to help our staff gain the confidence in these specific areas during a protected learning event

Practice B

- Analysed our mood review process and used STU to check on serial prescribing numbers
- Focused on anti-depressants, serial prescribing and contraceptives (anti-depressants in particular due to volume of reviews and felt that this could be streamlined and simplified. Admittedly no data collection, but hoping to see results over next 6/12)
- Perhaps too early to see tangible results, but serial prescription numbers are increasing.
- Have not fully discussed forward plans, but think we will try to hammer these ones down before considering other areas to improve on.

Practice C

- Had two practice meetings to discuss the project.
- Started by counting how many specials were issued in a week through columns to give the proportion of acute prescriptions that were specials rather than generated in a consultation (utilised STU data to calculate).
- Identified barriers were sickness and self-isolation and the loss of GP through resignation and another GP going soon.
- Aim to repeat data collection in a month or two and keep momentum up.

Practice D

- Identified a charter based off the template.
- Opted to review skin, PPI & Anti-depressant acute prescribing.
- Practice pharmacist to review Anti-depressant acute prescribing and GP is to action skin acute prescribing.
- To create a SOP for the above groups so that other clinicians can review and move the acutes onto repeats.
- Create a process map for admin and clinicians for each of the acutes above.