PCPA General Practice Pharmacist Award Showcase

Integrated Care Pathways - Developing the Workforce - Smarter Prescribing

Chair

Helen Kilminster

PCPA National Vice President & Senior Clinical Pharmacist

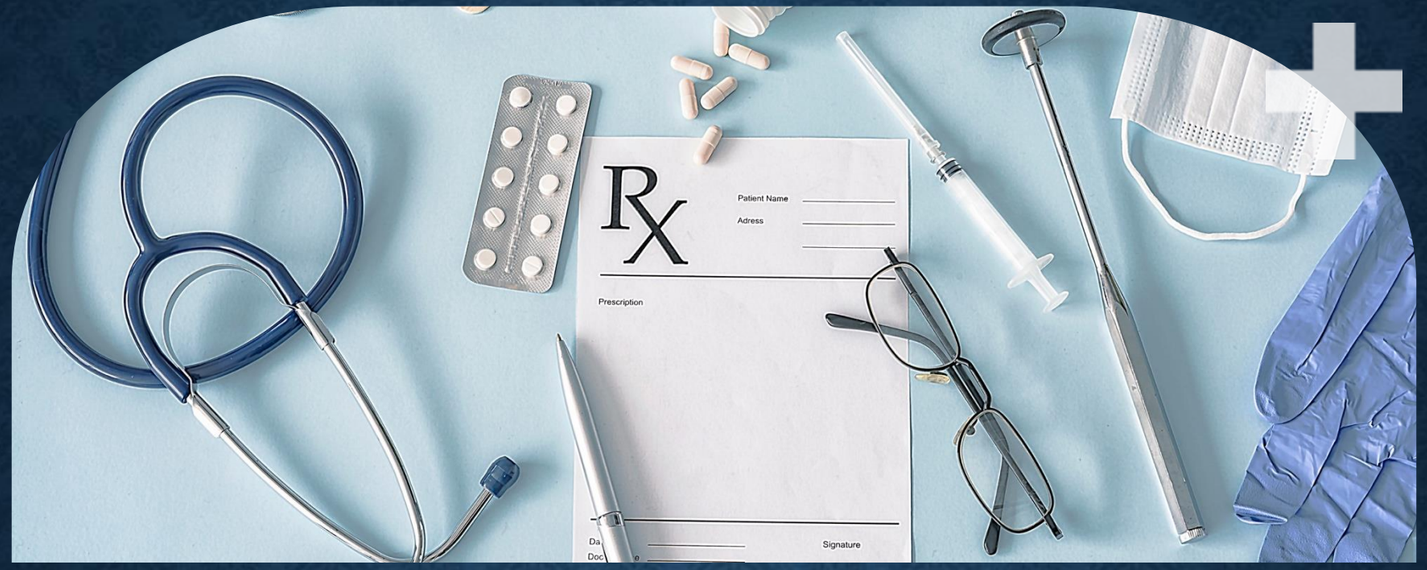
Speakers

Sarah Shaheen Baig

Professional Development and Governance Lead Pharmacist | Associate Professor in Prescribing

Aisha Adnan

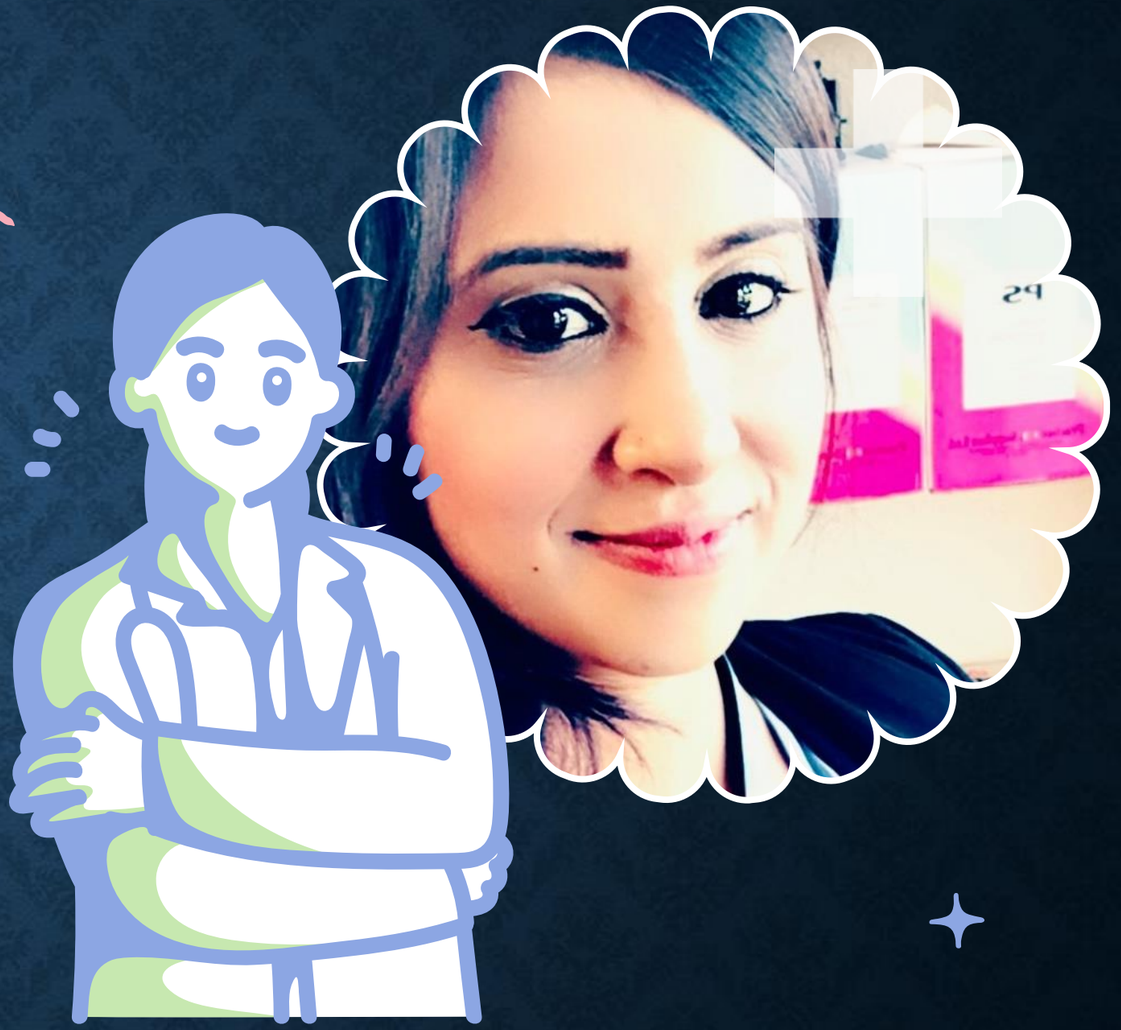
Senior Clinical Pharmacist



Sarah Baig
PCPA General Practice Pharmacist Award 2025

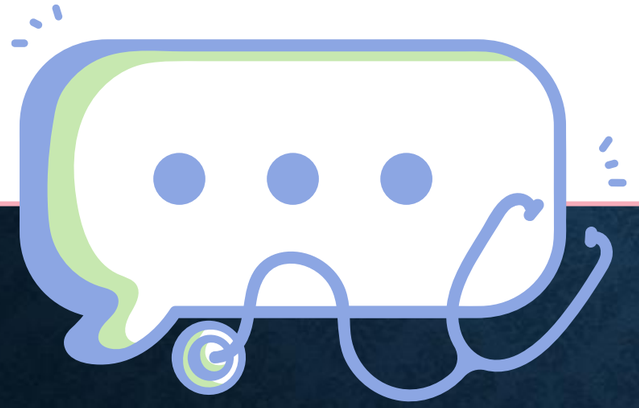
About Me

- Pharmacist for 19 years
- Portfolio Career across Secondary care, Primary care and academia
- Primary care Pharmacist for 10 years
- Academic Pharmacist for 8 years - Programme directorship and prescribing curriculum
- **Innovation , Strategic working and Practical Solution driven work**



My Vision

My work focuses on improving patient care while strengthening the workforce that delivers it.



My Mission

- *Bringing Care to Those the System Often Misses*
- *Developing the Next Generation of Prescribers*
- *Turning Belief Into Action*

Developing our Workforce

Designed and delivered Black Country trainee pharmacist prescribing study days

System Leadership and collaborative work

Supported the development of confident independent prescribers across

learning opportunities shared across organisations

Supported the development of confident independent prescribers across the system

Initiated and delivered workforce development across organisational boundaries

Creating good governance and consistency

Used negotiation, persistence and collaboration to overcome system barriers

Workforce Development

Supporting Foundation Trainees – February 2025

Prescribing Support

Prescribing Safety Assessment Pilot

Integrated Structured Clinical Examinations for Prescribing competence – added quality

Developing an Integrated Care Pathway

- Diabetes and Renal pharmacist by background since 2011.
- CVRM is now fully embedded in care pathways
- NICE guidance – CVRM approach
- Workstream around Three Treatment Targets and 8 Care Processes
- South Asian Population
- Issues with adherence

- Delivered Group consultations in Urdu
- Community engagement
- Partnership with local charity organisation
- Reduce inequalities in diabetes
- Empowering patients
- Population level Integrated work
- Culturally tailored interventions
- Building Trust

SWEET ENOUGH

LIVING WELL WITH (OR WITHOUT) DIABETES

NHS The Dudley Group NHS Foundation Trust

VENUE
Lye Community Centre, Cross Walks Rd, Lye, DY9 8BH

DATE AND TIME
Mon 1st December 11am until 1pm

ATTENDEES
Over 76 people engaged with the event

EVENT AIMS

- Bring together people who have diabetes or are at risk.
- Share practical information and advice for living with diabetes.
- Correct misconceptions and myths about the condition.
- Foster a supportive community approach to managing diabetes.

EVENT HIGHLIGHTS

- Diabetes presentation presented by Sarah Baig Professional Development and Governance Lead Pharmacist providing myth busting facts
- Presentation was translated into different languages including English and Urdu
- Beacon Centre for the Blind and Park Activators from public health attended the event
- Event organisers asked us to return again
- We had an individual express their interest in becoming a Diabetes Champion

Event supported by Chapel Street Surgery.

ACTIVITIES

How confident do you feel about living with diabetes?

Before event

😊	😐	☹️
50%	36.36%	13.64%

After event

😊	😐	☹️
95.24%	2.38%	2.38%

Which celebrities do you think have diabetes?

Halle Berry – 1 vote
Tom Hanks – 1 vote
Salma Hayek – 0 votes
Chaka Khan – 1 vote
Patti LaBelle – 4 votes
Randy Jackson – 1 vote
Sonam Kapoor Ahuja – 3 votes
Samantha Ruth Prabhu – 2 votes
Fawad Khan – 2 votes
Wasim Akram – 12 votes

All of these celebrities have diabetes

TOPICS COVERED IN PRESENTATION

9

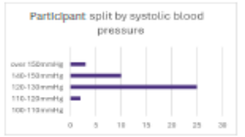
- What diabetes is and the possibility of diabetes remission
- The nine diabetes care processes and why they matter
- Healthy eating adapted to a traditional South Asian diet
- Managing diabetes during Ramadan
- Addressing myths and concerns about diabetes medications
- Information on newer diabetes treatments
- Practical advice on sick day rules

DIABETES TREATMENT TARGETS

- Blood sugar control (HbA1c)
- Blood pressure control
- Cholesterol management

These are essential for reducing long-term complications such as heart and kidney disease

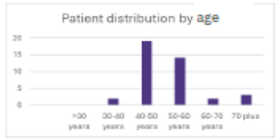
CLINICAL BENEFITS WERE ALSO IDENTIFIED:



13 participants (33%) were found to have raised systolic blood pressure (>140 mmHg)

These individuals were referred for follow-up and review in GP practices, showing the added value of community-based sessions

48%
largest age group was women aged 40–50 years



The majority of patients were from Stourbridge, Lye and Wollescote Primary Care Network followed by Brierley Hill Primary Care Network

ATTENDEE FEEDBACK

"It was great to be supported by the Dudley Group NHS Foundation Trust and wider colleagues in hosting a diabetes workshop in Urdu. Our local ladies appreciated the opportunity to hear first hand about preventative care and how to live well with diabetes and really enjoyed a lively exercise session. We look forward to continuing our work with the Trust and our local practice in Chapel St"

- Women valued explanations that were culturally relevant and easy to understand
- Many reported feeling more confident managing their diabetes
- Participants felt better able to talk to healthcare professionals about their treatment
- The group setting helped to build confidence, shared learning, and peer support

NEXT STEPS

- A follow-up session is planned for March 2026 to assess longer-term impact on understanding, adherence, and clinical outcomes (HbA1c, blood pressure, and cholesterol)
- Exercise classes requested to be held at the centre
- Domestic violence and mental health sessions requested
- Data from practice level review will also identify the impact of the interventions through review of HbA1c, blood pressure and lipids.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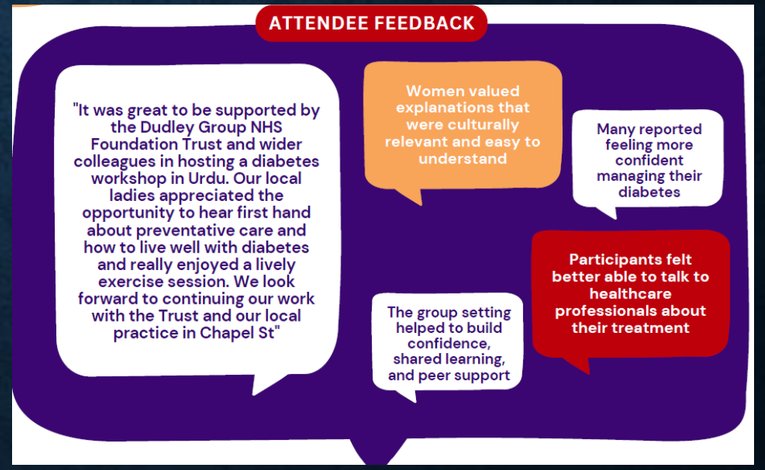
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“If you have an idea to improve patient care ...believe in it”

“Don’t see rejection as failure”

“Believe you can....and you will…”

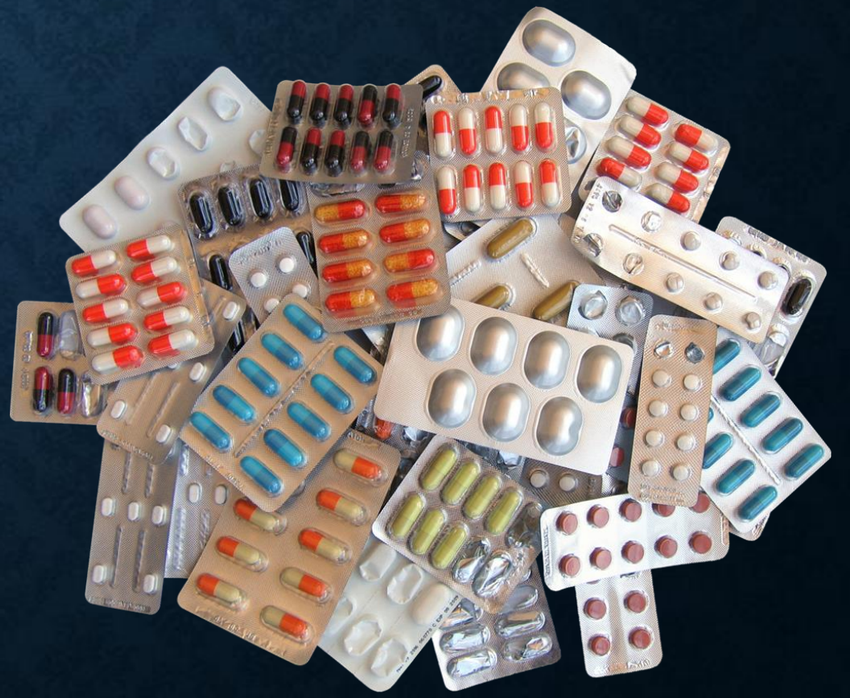
Thank you to PCPA and Thank you for listening

PCPA
AWARDS
SHOWCASE

SMARTER PRESCRIBING

Deprescribing and Prescribing with purpose: A QI Project

Aisha Adnan
Clinical Pharmacist ,IP, DPP



HOW DOES IT START?

Pure Observation : act of perceiving reality directly without judgment or emotional reaction

An element of curiosity paired with critical analysis, ability to interpret the data points and elaborate them

Observations precede QI projects

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PRESCRIBING : WHY IT MATTERED

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Observed problems:

1. Overprescribing (excessive quantity, Tx of side effects, continued unnecessary use)
2. Unsynchronised quantities
3. Medicines not linked to diagnosis
4. Apparent treatment non-compliance
5. High repeat-request burden on staff

System drivers of observed problems:

1. EMIS default quantities
2. COVID monitoring backlog
3. GP contract changes
4. Increased workload, staff strain and decision fatigue.
5. Medication waste through bulk signing

PROCESS MAPPING & ROOT CAUSE ANALYSIS

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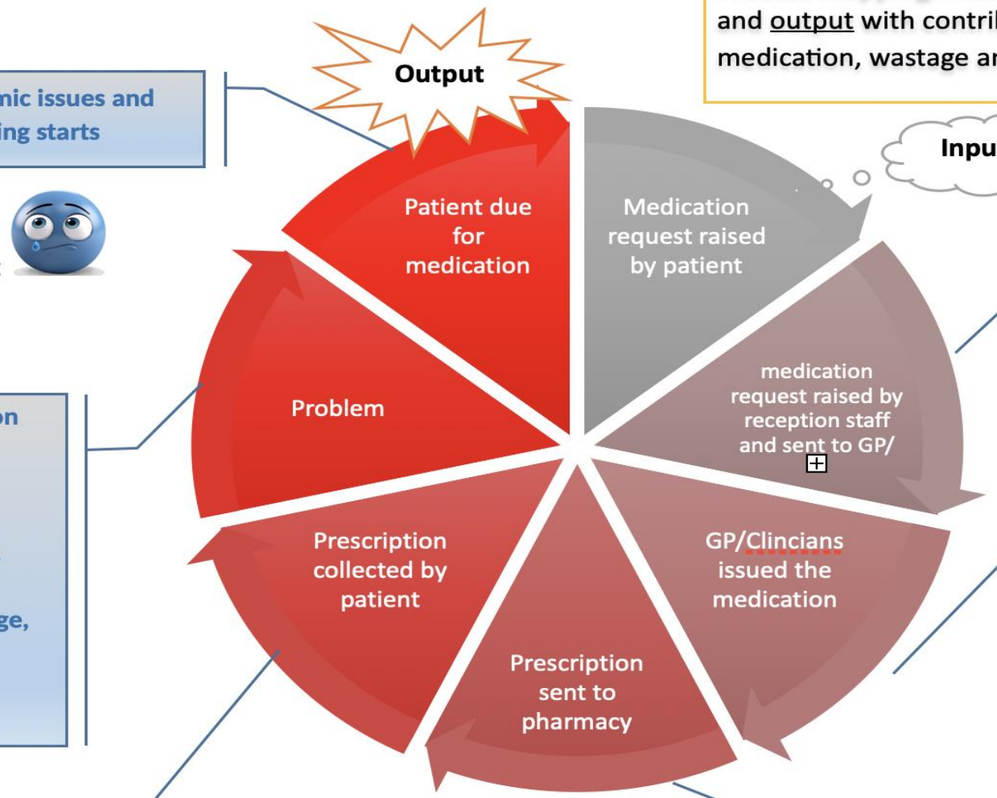
Process Mapping: Illustration of input, handover process of prescription requests and output with contributory factors at every step leading to unsynchronised medication, wastage and system burden **(Supports: outcome 3.4)**



Recycling of systemic issues and over prescribing starts

Impact on patient

Contributory factors: Patient frustration and dissatisfaction, renewed need to order missing/alternative /wrong medicine, extra trips to surgery and pharmacy with environmental impact, system overload on GP, Pharmacy and connected services, medication wastage, medication stolen, drug-addiction, Hospital inpatient stay or specialist review and change of therapy,

Contributory factors: Human errors, wrong patient selection, incomplete request raised by reception staff, untrained staff, errors due to work and personal stress, Hospital/specialist letters, distractions

Contributory factors: Human errors, decision density and decision fatigue, overburden, lone working, late working, locum working, patients stressing for urgent prescriptions, new software, relying on system to choose prescribed quantity, issued Rx's in bulk, lack of time, Covid-19, strained environment, Contract changes, lack of education , distractions

Contributory factors: Patient realises= medicines are dispensed wrong, medicine is missing, ordered wrong medicine, lack of education which one is as-required medicine?, distractions

Contributory factors: Drug shortages, Drugs supplied at different times due to shortages, dispensing errors, staff shortages, Burden of OTC and Specialist services, decision fatigue and decision density, handed out wrong patient's medicines, drug recalls and alerts, distractions

INTERVENTION DESIGN — PDSA APPROACH

- **Plan:** Systematic Stakeholder review and agreement (patients, GPs, nurses, reception, pharmacists).

- **Do:** Systematic prescription reviews =Link indication, Target organ clearance (QT Interval, Serotonin syndrome, Paracetamol poisoning, ESRD), interactions and necessity ; align regimens to 28/56-day cycles; opportunistic and planned SMRs, Education , PRESCRIBING TAKING SHAPE

- **Study & Act:** Weekly outcome reviews, staff education, and iterative PDSA cycles.

DEPRESCRIBING TAKING SHAPE

- **Concrete changes:** Reduced quantities for liquids and high-cost items (examples: Amitriptyline liquid from 150ml → 70ml; Lisinopril solution 150ml → 40ml). **Smaller changes led to approx 4000£ savings over the period of 1yr from 14 patients.**
- **Clinical rationale:** Match supply to actual need; reduce stockpiling and accidental overdosing; improve monitoring.
- **Patient safety:** Fewer excess medicines at home; clearer PRN vs regular guidance.

DRUG Reviewed	INITIAL QUANTITY on Rx for 28 days before QI review	FINAL QUANTITY on Rx for 28 days After QI review adjusted as per dose, need & indication	INITIAL COST (£) of NHS Rx (including other drugs) for 28 days BEFORE QI CHANGES	FINAL COST (£) of NHS Rx (including other drugs) for 28 days AFTER QI CHANGES	TOTA REDUCI Rx per (actual, r dat	
Perindopril 8mg tabs	30	28	19.55 £	19.48 £	-7	
Tamsulosin 400mcg caps	30	28	19.48 £	19.38 £	-10 p	-1.20£
Desmopressin 120mcg lyophilisates	60	56	266.39 £	262.34 £	-4.05 £	-48.60£
Colecalciferol 20,000 U caps	12	2	16.80 £	5.44 £	-11.36 £	-136.32£
Fexofenadine 180mg tablets	30	28	1.82 £	1.70 £	-12 p	-1.44£
Atorvastatin 20mg	56	28	98.90 £	97.64 £	-1.26 £	-15.12£
Lansoprazole 30mg	56	28	97.64 £	96.50 £	-1.14 £	-13.68£
Sukkarto SR 500mg tabs	224	28	77.66 £	65.55 £	-12.11 £	-145.32£
Clobazam oral susp. 5mg/5ml	150ml	90ml	92.87 £	56.89 £	-35.98 £	-431.76£
Canagliflozin 100mg tabs	30	28	130.49 £	127.87 £	-2.62 £	-31.44£
Lisinopril 5mg/5ml solution	150ml	40ml	474.11 £	314.25 £	-159.86 £	-1918.32£
Audmonal 60mg capsules	100	84	28.27 £	25.91 £	-2.36 £	-28.32£
Pramipexole 180mcg tabs.	180	84	41.92 £	20.74 £	-21.18 £	-254.16£
Amitriptyline 10mg/5ml O. sol.	150ml	70ml	126.10 £	58.84 £	-67.25 £	-807.24£

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RESULTS AND COST IMPACT

- **ePACT DATA Analysis- Practice-level Net Ingredient Cost trend: –3.84%** in July–September 2024 and a further **–0.44%** in October–December 2024, showing sustained reduction despite December seasonal pressures on practice and NHS.
- **Per-patient examples:** Large monthly savings from adjusting liquid and high-volume supplies (e.g., Lisinopril and Amitriptyline reductions produced substantial per-patient annual savings when extrapolated). Additionally , reduced patient and staff decision density and fatigue & errors.

CHALLENGES

1. **Coordination:** Ensuring that all medications could be synchronized without causing any issues for the patients was a challenge.
2. **Communication:** Effectively communicating the changes to patients and other stakeholders as not all stake holders were available at the point of review.
3. **Logistics:** Managing the logistics of changing prescription schedules, synchronising medicines and ensuring that the patient understands and agrees with the decision-making process and pharmacy could accommodate these changes.
4. **Competing priorities of MDT** : Stakeholder staff team members were managing their heavy workload which made it difficult for them to fully engage with project
5. **Variation in buy-in**: Not all staff recognised the impact scale
6. **Change fatigue**: Patients and MDT member's reluctance to changes due to previous experiences
7. **Point of view variation:** Clinical and non-clinical staff's point of view made it challenging to conduct root cause analysis.

SYSTEM AND STAKEHOLDER BENEFITS

1. **Operational:** Reduced reception and pharmacy queries; fewer patient pharmacy visits; improved workflow capacity.
2. **Clinical:** Better monitoring, fewer unnecessary medicines, improved prescribing confidence.
3. **Environmental:** Fewer patient trips → lower CO_2 emission and carbon foot print; less drug waste entering waste streams.
4. **System-wide impact:** Project presented to ICB; shared via ICB newsletter and development of Local Quality Incentive Scheme 2025-2026 for implementaion of RPS Repeat prescribing toolkit.

PRESCRIBING REVIEW PROJECTS

1. **Proton pump inhibitors** (resulted in over 50% reduction in harmful prescribing)
2. **Iron** (resulted in over 50% reduction in harmful prescribing)
3. **Dressings** (resulted in reduction in costs)
4. **Topiramate** (resulted in improvement in safe prescribing and Shared Care)
5. **Learning disability** (resulted in improvement in annual care reviews & shared decision making)
6. **Dual antiplatelet therapy** (resulted in reduction in harmful prescribing of DAPT when it was past its Tx phase)
7. **Sodium Valproate** (resulted in improvement in safe prescribing and Shared Care)
8. **High-cost drugs** (resulted in reduction in costs)
9. **Continuous Blood glucose Sensors** (resulted in improved compliance with local guidelines, reduced wastage, signposted patients to appropriate service for tech failures)
10. **MART regimen inhaler** (led to major drive to educate patients about their inhaler regimen, reduce overuse and improve correct inhaler technique)
11. **Cyclizine** (led to stopping harmful over prescribing for idiopathic causes and educating GPs, Nurses & other clinicians about addiction/abuse potential and Courts and Tribunals Judiciary, December 12, 2023: Charlene Roberts: Prevention of future deaths report)

RESEARCH GAPS

- **Methodological Rigor in Social Prescribing:** While social prescribing is growing, much of the evidence is from uncontrolled studies, limiting conclusions about long-term effectiveness, especially for severe mental health problems. More methodologically rigorous, controlled trials and studies with longer follow-up periods are needed. Cochrane : People's Review Project
- **Standardized Metrics for Monitoring:** There is an absence of robust, standardized indicators for monitoring the "stop date" of prescriptions, which is crucial for reducing unnecessary long-term usage

FEEDBACK IS A GIFT

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- I would be extremely grateful for feedback to support my learning and development:
- https://forms.gle/Vj9JBUv4FJjkdBbGA
- Ctrl+click OR copy paste above link in browser