FAQs Prescribing assessment

This document is broken down into five sections to help signpost to the relevant section to answer questions regarding the new prescribing assessment.

Section A: The mandatory prescribing assessment
Section B: The assessment process
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Section A: The mandatory prescribing assessment

Why complete a Prescribing assessment?

The prescribing assessment allows the trainee to raise their awareness of good, safe prescribing, and reflect on their clinical practice. It provides a structured, evidenced based review of their prescribing to help them demonstrate their prescribing competences as set out by the GMC and RCGP. It is now a mandatory requirement by the GMC that all trainees are assessed on their prescribing.

Prescribing is a key element of General Practice. The PRACtICe study found that 5% of prescriptions from UK general practices contained an error: GP trainees were highlighted as a cohort of prescribers who may benefit from greater support. The REVISiT study explored the feasibility of using a pharmacist-led review of prescribing for GP trainees. This study reported an error rate of 9% and a suboptimal prescribing rate of 35% among the GPs in training who were recruited. The GMC are keen, as are patients, to see improved prescribing habits by all clinicians and the assessment of this cohort of trainees is a key part of formalising prescribing reviews and learning. This is fundamental to improving patient safety.

Which trainees are required to complete the mandatory assessment from August 2020?

All trainees who start their ST3 year from August 2020 must complete the assessment. This is now a GMC approved assessment.

Less than full time (LTFT) ST3 trainees are required, to complete this if they started ST3 after August 2020.

Those ST3 trainees that are out of synch, already started ST3 prior to August 2020 or have planned to take a break from their GP training, can still undertake the assessment, however they are not required to they can remain on the old WPBA assessment requirements. All trainees however must move to the new assessment package by Aug 2022.

How is the time taken to complete the prescribing assessment taken into consideration within the WPBA requirements?

There is a reduction in the assessment requirements as part of the new WPBA package which takes into account the time required to complete this new assessment. The minimum number of CbDs for example has been reduced from 12 to 5 in the year.

What is the time frame to complete the assessment?

The assessment must be completed by the end of the ST3 year but it is expected to be completed in the first half of the ST3 year.

Is there any reduction of other WPBA to balance undertaking the Prescribing Assessment?

The new WPBA package has a reduction in many of the assessments to account for the new additional assessments and this has been approved by the GMC. The number of prescriptions to be reviewed has been reduced from 60 to 50 to reduce the time involved but not quality of this assessment in line with GMC recommendations from review of the Prescribing Assessment Pilot feedback undertaken in 2019/2020 and their final approval in 2021.

Can ST1/2 trainees do the prescribing assessment?

Any trainee can complete the assessment to improve their prescribing. However, ST1/2 trainees are not required to complete it.

Section B: The assessment process

How long will it take to collect the data?

In the pilot of 60 prescriptions trainees who manually undertook data collection took longer than those who did the data collection using computer search. A total of 78% of those using computer searches reported this taking up to 2 hours to complete in comparison to 38.6% for those using manual searches. The number of prescriptions has been reduced to 50 to reduce the time commitment as a result of the pilot and the searches improved so that hopefully all trainees will be able to use computer-searches to generate the data collection. The time taken to review the 50 was statistically significantly lower in the post implementation survey.

60 prescriptions for an ST3 GP trainee in the first six months represents about 8 surgeries allowing for 15-minute appointments and about 2 out of 3 consultations resulting in a prescription of some kind. Given that some consultations will result in more than one prescription it is probably less than this. If a GP trainee is working at 50% this is probably just over two weeks' work. With the number of prescriptions to review reduced to 50 then 2 weeks should provide enough experience.

How will the prescribing assessment be assessed in a summative way?

The only summative element is completing it with all parts including the questionnaire. It will be part of the information gathered by the trainer about the trainee's prescribing on which a global judgement will be made like with the 13 competencies and signed off in the ESR.

Is it possible to fail?

Only by not completing all elements including the questionnaire or finding no errors/sub-optimal prescribing or not reflecting and describing learning. Lack of completion will be the only way to fail this assessment.

Are the prescriptions acute medications that have been initiated or do they also include medications that have been re-prescribed that were initially issued by another prescriber?

The search will include all medications the trainee has prescribed. This will include acute and repeat medication, even if someone else originally initiated the item as the trainees' signature is at the bottom of this legal document. If the EMIS computer search is used reissues of repeats may not be picked up but this could be reviewed through consultation review if required.

On reviewing the prescription issued, the medication initiated by another prescriber is not optimal, what happens then?

Some computer systems such as EMIS will not pick up medication that was initiated by a colleague in the searches, but other systems will. Within the reflection form there is an opportunity for the trainee to reflect on their prescribing and this will include medication that you issued that you would not necessarily have initiated. Ultimately whoever signed the prescription is responsible for it.

Am I just recording instances when my prescribing wasn't appropriate?

We really think it is important for you to identify areas of good prescribing practice as well as where there could be room for improvement There might have been an occasion where you correctly identified that a dose change was required on a patient's medication, as a result in a reduced renal function, for example, or you might have been meticulous in your documentation of a particularly complex dosing regimen. We appreciate that the celebration of 'good practice' could be a more subjective process and could be more readily highlighted by a third-party

review, but we believe it is beneficial to approach this self-review with the expectation that you will highlight elements of good practice as well as find areas for improvement.

Is a practice pharmacist allowed to be involved in the assessment?

Yes, pharmacists can be used to review the 20 prescriptions on behalf of the trainer. Pharmacists were used in the original REVISiT study, that this assessment is based on. It is important that the trainee reviews their own prescribing to enhance learning, but the pharmacist can review the trainee's scripts on behalf of the trainer. It would be expected that both the pharmacist and the supervisor would be involved in the discussion tutorial though and the supervisor should complete the survey and assessment form.

Who can complete the assessment from a supervisor perspective?

In ST3 the Clinical Supervisor is usually the Educational Supervisor as well but if not the GP educator in the practice with the trainee would be expected to complete the assessment.

Would any part of the process be repeated if there has not been any learning?

If the trainee finds no errors or suboptimal prescribing and does not reflect on their prescribing they would be expected to go back and review their 50 scripts again before discussion in the tutorial.

How can the trainee be assured that the assessment is "fair" to all trainees?

The purpose of the mandatory prescribing assessment pilot (2019/2020) was to gather data regarding the acceptability and utility for all trainees. The analysis of the pilot questionnaire data completed by over 1700 trainees, found that it was a fair assessment. There was no evidence that the prescribing review adversely affected non-white participants. There was no evidence that people with a declared disability were at a disadvantage in completing the task. There was no evidence that people who trained outside the UK were at a disadvantage. There was no relationship between the type of practice, ARCP outcome and of the outcomes measured in the questionnaire. There was a slightly higher number of trainees from Scotland, Wales and NI combined that found the review not as easy to complete, when compared with trainees' experiences in England but this was a pretty small correlation. Most trainees (and trainers) reported that the prescribing review was helpful for assessing and learning about prescribing both in the initial pilot and follow up questionnaire. The original REVISiT study also evaluated favorably with trainers and trainees.

What happens to the various documents once completed?

Any identifiable patient information should be removed from the spreadsheet. The spread sheet should be scanned into the portfolio and attached to the prescribing review learning log in which the trainee reflects. The summary of errors should be added to the supervisor prescribing

assessment form and recorded along with the supervisor's review. These are both present in the live portfolio already and can be accessed for information.

Section C: Trainee specific questions

What is the standard we are expecting from the trainees?

We expect all trainees to have made errors and have some suboptimal prescribing. The standards against which the trainee should be assessed are those indicated in the training manual and that show safe effective prescribing as per BNF and local guidelines. We know in the REVISIT study that 9% of prescriptions issued by the GP trainees were found to have errors and that 35% of prescriptions were suboptimal, so we expect similar levels of errors and suboptimal prescribing to be highlighted by the Prescribing Assessment. In the Prescribing Assessment Pilot (2019-2020) the mean prescribing error rate and suboptimal prescribing rate calculated was 8.3% and 40.6% respectively with 71.5% of trainees uncovering a prescribing error and 98.5% finding at least one incident of sub optimal prescribing. To give you further context, the error rate reported in the Prescribing Assessment Pilot is the same as that reported among Hospital Specialty trainee doctors in the EQUIP study (8.3%), and similar to that reported by a US study involving Family Medicine trainees (11%).

What happens if the trainee has not reviewed 50 prescriptions?

The trainee should be requested to go back and review sufficient numbers to make 50 before the assessment is completed.

If the trainee doesn't identify any errors do they need to keep looking?

Yes; it would be very unusual for this to happen as it never occurred in the REVISIT study. The trainee should be encouraged to review their prescribing again using local guidelines, the guidance manual and the BNF to ensure they check things accurately.

How long is it expected to take to complete the prescribing assessment?

On average it has taken 2-3 hours to complete a review of 60 items. All full time ST3 trainees have 4 hours of personal study per week as part of their GP training. It is expected the trainee will prepare the data collection, review the prescriptions, complete their self-reflection and produce a PDP within this time.

In the pilot of 60 prescriptions trainees who manually undertook data collection took longer than those who did the data collection using computer search. A total of 78% of those using computer searches reported this taking up to 2 hours to complete in comparison to 38.6% for those using manual searches. The number of prescriptions has been reduced to 50 to reduce the time

commitment as a result of the pilot and the searches improved so that hopefully all trainees will be able to use computer-searches to generate the data collection.
The follow up evaluation showed that it took less time to complete 50 prescriptions than the 60 in the pilot without reducing the validity of the results.

Does the collection of prescriptions need to be consecutive?

Yes. A date is agreed between trainee and supervisor and then a search for 50 items prior to this date should take place. One patient may have been prescribed more than one item per prescription. 50 items are reviewed, not 50 prescriptions.

Section D: Supervisor (trainer) specific questions

How should a supervisor find time to complete the assessment when often they are already struggling to find enough time for training?

Many trainers are already assessing prescribing, and all are completing the full CbDs requirement currently; completing the prescribing assessment will save the time on these. Improving prescribing will reduce time in debriefs and reviews and in the practice prescribing budgets as well as, more importantly, improving patient care.

The review is expected to take the same time as a tutorial and prep time so no more time than is already assigned to training. As with any new assessment, it will take time to become familiar with it, but using the computer systems such as script switch will help. The overall WPBA package of assessments has been reduced to ensure that overall the burden of assessment has been reduced.

How many prescriptions does the trainer need to review?

We have stated that the trainer needs to review at least 20 of their trainee's prescriptions. If the results they get from these 20 matches well with the results of the trainee then no further scripts need reviewing. If, however several errors or good prescribing have been missed then it is expected that further scripts will be reviewed so that an accurate comparison of trainer and trainee results can be made.

In the Prescribing Assessment Pilot (2019-20), the majority of trainers (1302/1576: 83%) reported that reviewing 20 prescriptions was sufficient in order to adequately assess their trainee's prescribing. Of the trainers who thought the review of 20 prescriptions was an inappropriate number, 10% (160/1576) thought that 20 prescriptions was too few, and 7% (114/1576) thought that this was too many.

What is the appropriate way to respond if the trainee has prescribed appropriately but outside of local guidelines?

This would be a discussion point. The trainee should be encouraged to use local guidelines as well as the consultation records and BNF etc. when reviewing their prescribing, this is expected of the trainer also.

Does the prescribing assessment process take any consideration of there being a pharmacist involved in dispensing the medication?

Ultimately the responsibility of prescribing an item lies with whoever signs the prescription. Although Pharmacists have responsibilities too these do not negate the doctors'. Some medications are issued by dispensers who have not had as much training as a pharmacist, but this requires the scripts to have all appropriate details on the prescriptions.

Trainees should be encouraged to supply as much information as possible to ensure the medication is both safely taken and effective.

Are we expecting all GPs to prescribe to the 'best practice' level e.g. writing the indication for 'when required' medication etc.?

This would be best practice and ensure the medication is both safely taken and effective. It is hoped that assessing prescribing will drive learning both in trainees and trainers and that this will be shared with the team and improve prescribing across the board.

Perfect prescribing is not expected in either trainer or trainee as this assessment is designed to generate discussion and learning and no prescriber had no errors in the PRACtICE and REVISiT studies.

Might the assessment make a trainee more anxious about prescribing?

It is expected that as it is a formative, self-assessment, exercise based around learning it will actually support trainees and reassure them about their prescribing rather than making them anxious.

What should the trainee do if the practice can't get a search generated from the computer system?

Most GP practice computer systems have generated searches however, if this is not available, a retrospective review of sufficient consultations from a set date is recommended to collect the data of 50 prescriptions. The trainee will analyse the prescriptions as they work through them and record them on the spreadsheet in the same way. The trainer (or pharmacist if applicable) will then randomly review 20 or more consultations using the spread sheet the trainee has completed and review the records, until at least 20 prescriptions have been analysed. This was the basis on which the REVISiT study was done. The computer searches have been created to

help with this assessment where they are available but are not needed to complete the assessment.

What should be done if the trainee needs to do the assessment as a manual search for the retrospective review of consultations rather than as a computer search and misses out some prescriptions?

The random review completed by the trainer would hopefully pick this up and they should discuss them with the trainee including why this happened and discussing probity issues this may raise as well. If they missed out ones deliberately, they would have missed out ones containing errors, which means they have identified the error, which is part of the assessment process. The trainee should be asked to write a log reflecting on the issues identified from this.

Will the trainee need to ensure that a prescription is done for each of the patient experience groups to be signed up as satisfactory and if so, how many is enough?

Trainees will be expected to include a range of prescriptions and are asked to add further prescriptions that demonstrate competence in prescribing across all the patient experience groups. Ideally all should be covered but if areas are missed these can be requested as part of further learning needs and reviewed in a tutorial after completion of the prescribing assessment. It will not affect satisfactory completion of the assessment but may mean the ES feels it is important to review prescribing further before signing off elements of the ESR.

Are there areas that may not be picked up but are also important like palliative care, controlled drugs etc?

These can be requested by the supervisor and assessed in a follow up tutorial or through learning logs, joint surgeries, random reviews and debriefs. The supervisor needs to make a judgement based on the evidence the trainee has presented and what further information should be reviewed should be detailed in the summary of the prescribing tutorial outlined by the trainer.

Is it important to get a breadth of difficulty of prescribing items? E.g. if 95% of the prescriptions are low-level/trivial consultations or repeat prescriptions, will this be acceptable?

The original 'case law' for what would constitute a 'prescribing error' or suboptimal prescribing was developed in the PRACtICe study. The original REVISiT pilot study looked at a minimum of 100 consecutive retrospective prescriptions prescribed by GP trainees. There was no sampling of prescriptions for specific drug categories, but multiple errors were still uncovered. We are also keen to keep as close as possible to the methodology used by the team in the REVISiT study because this will add weight to the validity of this assessment, taking into consideration the implications of reduced numbers of prescriptions being looked at. As long as errors are identified and reflected upon, with suggestions for change, the assessment will have been satisfactorily completed. The review of prescribing may suggest to you that there could be areas of prescribing

practice your trainee is not getting a lot of experience in – and could therefore be a useful triangulation point to discuss further learning exercises or targeted experience.

What number or percentage of errors would be expected from a trainee?

The Prescribing assessment focuses on feedback, reflection and learning about prescribing to improve trainees' prescribing, the number of errors is not important but needs to be detailed in the mandatory questionnaire completed after the assessment to help with research. Clearly, if a trainee reviewed 50 prescriptions and couldn't find a single error this would be a concern as this never occurred in the PRACtICe or REVISiT studies.

How many missed errors would lead to the trainee needing to repeat the assessment?

If in the review the supervisor finds several errors missed, the trainee and supervisor should read through the supporting documentation and discuss the definitions of each error type so that they agree on how to assess prescribing. The trainee should then relook at their 50 prescriptions and write a further learning log on the findings before completing the prescribing assessment.

If the trainee has made several errors but reflected well on them, is this is good enough to pass the trainee for this assessment?

This assessment is designed to be formative so if there is good reflection on errors across the range of population groups and through a range of conditions and types of drugs then the trainee should be acceptable. It is not a pass-fail assessment. If repeated errors were made in set areas, then further evidence may be requested and documented in the assessment but won't affect satisfactory completion of the assessment.

Section E: General information on the prescribing assessment

How many people were involved in the PRACtICe study?

6048 prescription items were reviewed from prescriptions relating to 1777 patients

How many people were involved in the REVISiT study?

1028 prescription items were reviewed, that had been generated by 10 GP trainees.

How many people were involved in the RCGP Pilot?

1576 GP trainers and 1741 GP trainees fed back on the Prescribing Assessment Pilot

Will prescribing become another competency/ capability?

No, there is no plan to change the current 13 capabilities. Prescribing is covered in many of the current capabilities already. N.B. Terminology has changed with the new GP curriculum and

competencies have become capabilities reflecting the expectation that the competency will be demonstrated in a range of settings.

Have the numbers changed after the pilot?

Yes, the idea of the pilot was to ensure the assessment was fair and as effective and acceptable as it could be. Feedback regarding the numbers of prescriptions for both the trainee and the supervisor were requested and the numbers reviewed in light of these results such that now only 50 prescriptions need to be reviewed by the trainee. The majority of trainers found that 20 was the right number for them to review and adequately assess prescribing.

Are there any plans to evaluate trainees' investigations?

In the future CbDs will be expanded to become CATs (Care Assessment Tools) of which CbDs will be a type. Referrals analysis and investigations analysis can all be assessed and recorded using the CAT format. With the new curriculum being implemented there is a required Quality Improvement Project, and a leadership activity required as well as a range of other changes to assessment expectations.

Is there an aspiration to compare trainees to a database mean/ median? If so, is there any evidence to support such comparisons?

Data was gathered in the pilot and subsequent questionnaire about numbers of errors and suboptimal prescribing to compare with the rates in the PRACtICe and REVISiT studies. This was to allow an assessment of validity of the new assessment to be made. As we are encouraging identification of errors and some conscientious trainees may find more than many supervisors would, there is no agreed rate or number of errors that is norm or acceptable.

What is the time frame for the prescribing assessment?

It is expected to be completed in the first half of ST3 after 4 months of usual consulting to ensure a sufficient variety and number of prescriptions have been issued.

References

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