

## Achieving the IIF respiratory and inhaler targets A supportive plan for PCNs

### Getting ready

1. Understand the [targets](#) (details in Appendix)
  - a. RESP01 & 02 indicate quality of asthma care – reducing over reliance on SABA (short acting beta agonist) inhalers and increasing regular use of ICS (inhaled corticosteroid)
  - b. ES01 & ES02 deal with choice of inhaler – choosing most suitable environmentally friendly options
2. Be clear why these targets are there
  - a. Poorer asthma outcomes (more admissions and deaths) are found in those over reliant on SABA & underusing ICS inhalers - see [National Review of Asthma Deaths](#).
  - b. There is a huge environmental impact of propellant gasses in [MDI inhalers](#) equivalent to about 4800 metric tons of CO2 each month in Greater Manchester – like having 27,000 cars on the road.
3. Find out where your PCN and practices are by logging into data sources (you need to register from an NHS email address):
  - a. More in depth prescribing data, showing prescribing patterns is [here](#):
4. Get the latest GMMMG guidelines for [COPD](#) and [Asthma](#)
5. Appoint a respiratory lead at your practice and/or PCN, if possible

### Teamwork

1. Get everyone on board – ALL nurses, doctors, pharmacists (practice, PCN, and community), admin involved in repeat prescribing.
2. Ensure relevant team members have access to tableau [data](#).
3. Agree who is going to do what - running searches to identify at risk groups, inviting patients in, carrying out respiratory reviews, following patients up, monitoring tableau.
4. Agree which tools you will use.
  - a. [Greener practice](#) has some great resources, like information, videos, QI project ideas, searches.
  - b. PResQiPP has some [searches](#).
  - c. Eclipse has some searches (linked to some GP systems).

### Review Control

1. Focus on those at risk of worse outcomes. Prioritise those:
  - a. Overusing SABA (>3 a year)
    - i. Start with those using >12 a year, then work down to >6 and finally >3
  - b. One or more oral corticosteroid issued in past year
  - c. 3 or less ICS containing inhalers in past year, but using regular SABA
2. Assess current symptom burden
  - a. Asthma - Asthma control test, FENO (where available), peak flow readings, frequency of use of SABA, one or more hospital admission with asthma
  - b. COPD – Spirometry, CAT [score](#), exacerbations, hospitalisations
3. Review and educate on inhaler technique as a priority. Aim to move patients onto one inhaler device type i.e. same device for preventer & reliever if possible and if not, all devices be either MDI, SMI or DPI, to ensure same inhalation technique for all.

## Reduce Carbon

1. Always consider DPI or soft mist inhaler (SMI) before MDI
  - a. Significantly lower carbon impact (20-30 times)
  - b. Easier to teach
  - c. Have a dose counter
  - a. More convenient for patient (no spacer required)
2. Use GMMMG [guidelines](#) and patient preference to determine inhaler choice
3. Involve the patient in any changes, with proper conversation, instruction, and review
4. For asthma 'Be smart, consider MART' particularly for those under using ICS but over reliant on SABA - if HCP carrying out review confident and trained in MART. Use licensed dry powder inhalers (Fobumix, Symbicort, Fostair, Atecurta)
5. Doing a SABA switch programme: from Ventolin & generic Salbutamol to Salamol or Airomir can have an early carbon impact. It does not however deal with the other issues of improving asthma care, can annoy patients and is quite a bit of work. It is therefore not recommended. Should you decide to do this, please see Appendix 2.

## Return to community pharmacy

1. To ensure proper disposal, please instruct all patients to return *all* inhalers to the community pharmacy (as per national guidance)
  - a. This ensures the destruction of any remaining propellant gases and avoids potential contamination of water supplies with medicines.

## Monitoring

1. Monitoring the patient
  - a. Follow up any changes
  - b. Ask the dispensing community pharmacy to check how the patient is getting on using the [New Medicines Service](#) (or where available the Inhaler technique service).
2. Monitoring progress;
  - a. Decide how often you will monitor and review performance against [IIF indicators](#), at a practice and a PCN level
  - b. Who will do it & how often will they provide feedback to the team?
3. Celebrate success! The GM tableau dashboard can show the [carbon equivalence](#) of your inhaler prescribing. You can work out how many 'car miles' you have saved! Never mind hitting the IIF targets.

## Getting help

1. Look out for training opportunities
2. For further information, support or training requests contact:
  - a. Your locality medicines optimisation team
  - b. Dr David McKelvey (GM Clinical Lead in Primary Care Sustainability)  
[David.mckelvey@nhs.net](mailto:David.mckelvey@nhs.net)
  - c. Dr Murugesan Raja (GM Clinical Lead in Respiratory Medicine)  
[murugesan.raja@nhs.net](mailto:murugesan.raja@nhs.net)

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## Appendix 1: Detail of respiratory targets

Area	Target	Description	Personalised care adjustments/Exclusions
Respiratory care	RESP-01	Percentage of patients on the QOF Asthma Register who received three or more inhaled corticosteroid (ICS, inclusive of ICS/LABA) prescriptions over the previous 12 months	<ol style="list-style-type: none"> <li>1. Patient added to QOF Asthma Register in last 9 months of the financial year.</li> <li>2. Not clinically suitable – as measured by: <ul style="list-style-type: none"> <li>- Presence of 'Inhaled corticosteroid not indicated' SNOMED code.</li> <li>- A recording of mild asthma, without a subsequent recording of moderate or severe asthma.</li> <li>- Fewer than 3 SABA prescriptions in the same 12-month period (fewer than 4 for patients aged under 18)</li> </ul> </li> </ol>
	RESP-02	Percentage of patients on the QOF Asthma Register who received six or more Short Acting Beta-2 Agonist (SABA) inhaler prescriptions over the previous 12 months	Excluding those with dual diagnosis of Asthma and COPD
Environmental sustainability	ES-01	Metered Dose Inhaler (MDI) prescriptions as a percentage of all non-salbutamol inhaler prescriptions issued to patients aged 12 years or over	Prescriptions to patients to whom the "Dry powder inhaler not indicated" SNOMED code has been applied
	ES-02	Mean carbon emissions per salbutamol inhaler prescribed (kg CO <sub>2</sub> e)	None

## Appendix 2 – Advice on doing a SABA switch programme

Should you decide to go ahead with this programme, we recommend the following:

1. Do a search for those on Ventolin evohaler & generic salbutamol MDI.
2. It is wise to check each patient to see if they tried a switch before and if not, if they would be suitable to switch.
3. Message the patient via SMS to explain why the change is being advised, that this is a first step, and further inhaler optimisation, like moving to a DPI will be discussed at the next asthma review. (Greener Practice Asthma Toolkit has good suggested wording)
4. For any who are unhappy with the change, invite in for a review for inhaler optimisation – seeing it as an opportunity to discuss a move to DPIs
5. Inform your community pharmacies so that they can support the switch and ensure they have the right stocks and placebos for inhaler counselling

## Glossary

CO <sub>2</sub> e	Carbon dioxide equivalent to allow comparison for different emissions
DPI	Dry Powder Inhaler
FENO	Fractional Exhaled Nitric Oxide – assists asthma diagnosis
ICS	Inhaled Corticosteroids
IIF	Impact and Investment Fund – PCN incentive scheme
MART	Maintenance and Reliever Therapy
MDI	Metered Dose Inhaler
PCN	Primary Care Networks
SABA	Short Acting Beta-2 Agonist
SMI	Soft Mist Inhaler