Scottish Government consultation

Quality prescribing for respiratory: a guide for improvement 2024- 2027

Draft guidance

1. Approach to review

We recommend for all patients, medications are reviewed using a person-centred approach using the standardised Polypharmacy 7-Steps guidance.

Do you agree with this recommendation?

RCGP Scotland welcomes the opportunity to respond to this consultation. As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.

We welcome the opportunity to contribute to this consultation for quality prescribing for respiratory illness 24-27. It is important to recognise the high burden of respiratory disease in Scotland, and the huge role that Scottish general practice has in supporting patients with lung conditions.

RCGP Scotland has spearheaded work in the area of sustainable prescribing, with inhaler use as a crucial component to that work. Climate and sustainability have been the selected policy priority area for the current Joint Chairs of RCPG Scotland. In 2021 we produced a joint statement on reducing the environmental harm from prescribing along with the Royal Pharmaceutical Society and Scottish Academy for Medical Royal Colleges. We recognise and endorse the consultations description of the global warming potential of metered dose inhalers (MDIs) and the slow progress in switching to dry powder or soft mist inhalers in Scotland compared to other European countries. We have always stated that this change should take a patient-centred approach, and that patients be "brought along" on the journey. RCGP Scotland states that good care is environmentally sustainable care, and supports the NHS Scotland target to be net zero by 2040 at the latest.

This is excellent prescribing guidance overall in terms of clinical content and we welcome the emphasis on climate sustainability and better outcomes for patients. However, almost all this workload will fall to general practice and the guidance does not discuss where the necessary workforce and resource will come from for implementation. Without an expansion in resource, the Scottish Government will once again be raising expectations in patients, whilst expecting that a falling GP workforce in terms of Whole Time Equivalent (WTE), already working outwith safe limits, can implement guidance which brings a new workload. Raising expectation when practices struggle to deliver may have adverse effects on practice-patient relationships. We would also encourage a greater focus on health inequalities which have such influence on the prevalence, morbidity and mortality of respiratory disease in Scotland.

For adults with asthma
Please tell us more about your views on our recommendations for treatment of adults with asthma:

We consider the above advice for asthma treatment excellent. GPs in Scotland no longer undertake Quality and Outcomes Framework (QOF) working, but our experience is that they do largely continue with the QOF recommendations for core diseases such as COPD and asthma. Much of this advice will currently be being done in these Quality Outcome Framework (QOF)-type reviews, but for some this will be a new or expanded workload, and all the more difficult in the most deprived. We would welcome assurance that the additional workload and resource required for implementation has been considered. It will therefore only be effective in terms of improving patient care if there is the staff to deliver it.

For example, a Deep End practice, which prioritises asthma and COPD care, supported by protocols and training and a very active approach to recall (including after exacerbations) has provided the following figures:

Total population: 12056
QOF Asthma Register on medication in the last 15 months (i.e. "active" asthma): 805
QOF COPD Register: 416
Prescribed 12 or more SABA inhalers in the last 6 months: 211
Those prescribed only a SABA: 311
Those on oral mucolytics for more than 6 months: 18.

For people with bronchiectasis:
Please tell us more about your views on our recommendations for treatment of people with bronchiectasis:

The recommendation states, "Azithromycin 250mg three times a week is recommended for patients with four or more exacerbations in any 12-month period, usually started after advice from secondary care."

We recommend that this should only be started on advice from secondary care, rather than 'usually', and that the specialist be fully responsible for assessing and counselling the patient about the medication.

6. For people with Idiopathic Pulmonary Fibrosis (IPF):
Please tell us more about your views on our recommendations for treatment of people with Idiopathic Pulmonary Fibrosis (IPF):

RCGP Scotland agrees that anti-fibrotics should only be prescribed and monitored by a specialist, but they also need to fully counsel the patient too, and that work should not be delegated to the GP.

7. Wider considerations

The healthcare industry is increasingly asked to account for the negative environmental impact generated through providing medical care. Regular medication reviews to address inappropriate polypharmacy in respiratory conditions and other co-morbidities (when a person has more than one disease or condition at the same time) should ensure that the environmental impact of prescribing is reduced.

Do you agree with these recommendations?

RCGP Scotland has welcomed the Scottish Government's efforts to improve asthma and COPD care and actions seeking to reduce the environmental impact of inhalers. These actions represent an opportunity to both improve respiratory care and bring Scotland in line with the standards of our European neighbours where the majority of inhalers prescribed are lower carbon dry powder inhalers.

The priority for GPs is to support patients to optimise control of their condition. Most patients can use low carbon inhaler devices and many patients find them easier to use. These patients should be offered a choice of inhaler device.

We know that if asthma or COPD is well managed, it can bring the best possible outcome for patients and the environment alike. Patients taking a preventer inhaler every day as prescribed results in fewer symptoms and using fewer reliever inhalers overall. Everyone should be supported to use the right inhaler technique, with an inhaler that suits them, to help keep asthma and COPD symptoms under control.

We are aware that this work is more difficult in deprived populations where there are lower levels of literacy, and health literacy, digital poverty and more people for whom English may not be their first language.. These factors need to be taken into account both when producing educational materials but also when considering the additional workforce required for this work.

Do you feel there are any barriers to implementing the recommendations from this guidance?

The key barrier to implementation is the additional workload it will place on general practice at a time of significant pressures.

Virtually all asthma and COPD, and – following diagnosis - most Idiopathic pulmonary fibrosis (IPF) and bronchiectasis are entirely, or almost entirely, managed in general practice. GPs are already working beyond safe limits, Whole Time Equivalent GP numbers are falling and the workload continues to rise in line with population demographics. This is alongside the fact that some practices are now struggling to retain or recruit Practice Nurses, who undertake most of this work.

GPs in Scotland no longer undertake Quality and Outcomes Framework (QOF) working, but our experience is that they do largely continue with the QOF recommendations for core diseases such as COPD and asthma. We would always want to review patients where treatment was not effective, and especially those with more severe disease and using high dose steroids, for instance, where there is highest risk of medication-related harm too. But, for example, bronchiectasis is not covered by QOF or the QOF funding that was transferred to the core GMS resource, and the recommendation for a twice-yearly requirement to review mucolytics is entirely new work, although numbers for that will be small.

However, the additional work for COPD and asthma is large, and we would be keen to see the business case for this in terms of the extra workforce and resource required to implement this in general practice. We also note that the Scottish GMS contract has not yet been fully implemented – and that includes the Advanced Nurse Practitioners and pharmacotherapists who would have made up a workforce able to take on the additional workloads recommended in this document. The removal of underspend of the Primary Care Improvement Fund also removed the ability to opportunistically employ staff such as this when they became available.
If implemented, and as the majority of these recommendations fall to GPs, we are keen to know what educational time will be made available for GPs and their teams to help them undertake this work.

The College welcomes the 7 steps to appropriate polypharmacy model but believe that this now needs an 8th step – sitting alongside the patient – of a workforce with adequate capacity and training, which is intrinsic to the House of Care model.

Pages 29-31 outline what should be done in a single asthma review (with an additional requirement outlined earlier to review all multimorbidity). This is valuable, but substantial work – we strongly welcome the principles - but struggle to have the capacity to undertake this. We note that “It is estimated that up to 11% of unplanned hospital admissions are attributed to harm from medicines” (page 24) – this is a huge NHS expense – and resourcing upstream general practice to undertake the work outlined in the guidance is likely to bring substantial cost savings, as well as saving the patient cost of distressing and unnecessary admissions (themselves associated with unintended iatrogenic harm). We need resource transfer for that to happen. This also applies to those with poorly controlled disease, where again, emergency admissions, as well as the other associated harms, could be reduced.

We also have concerns about capacity elsewhere in the system, particularly with the recommendation that all those with severe asthma with ongoing symptoms be referred. Scottish prevalences of that are higher than the rest of the UK. We would welcome further data behind this recommendation to ensure we have the secondary care specialists to absorb that workload.

The College would also welcome greater mention of smoking in the guidance. Smoking is a leading cause of respiratory morbidity and mortality with health services having a key

role to play in terms of stopping, and not starting. There is a strong evidence base for smoking cessation approaches. ASH[i] , whose evidence is quoted by NICE, estimates that: in 2017, 37% of all deaths from respiratory diseases in England were estimated to be attributable to smoking, and around a quarter of the excess mortality among smokers is accounted for by lung cancer and COPD. This data has an adverse gradient for socioeconomic deprivation, especially for cancer and COPD. Asthma is also profoundly affected by smoking, with the Royal College of Physicians noting that household smoking increases the risk of asthma in children by about 50%, and that there are 22,000 cases of wheeze and asthma caused by passive smoking in children in the UK each year.[ii]

It is also disappointing to have so little mention of health inequalities which are so pronounced for respiratory disease. We would recommend an epidemiological analysis of health inequalities with reference to respiratory disease, and specific consideration given to this group of people who are also more likely to miss appointments and struggle on multiple fronts. The workload recommended by the consultation will place a hugely disproportionate burden on 'Deep End' general practice. In deprived practices, morbidity will be higher, but it is also time-consuming to explain and change from MDIs to dry powder inhalers with challenges with poor literacy and health literacy, digital poverty and large numbers of patients in some deprived practices unable to speak English.

Covid-19 has also had a profound effect on respiratory health, some of it persistent, with outcomes worse in the deprived. Those living in poverty are less likely to access life-saving flu and Covid vaccines, important factors in our respiratory preventative programme, and also not mentioned. On page 20, we would consider it important to include socio economic deprivation in the statement that "The impact of respiratory conditions can vary depending on many factors," nor is it mentioned in the COPD section. We believe that it in future consultations such as this there needs to be an epidemiological assessment of inequality and that a working GP from a practice serving a deprived population to be included discussions.

While the emphasis is on prescribing, we know that environmental pollution exacerbates respiratory conditions and will itself affect prescribing rates. It is estimated that air pollution accounts for 28-36,000 deaths in the UK annually and we should also be recommending measures to reduce traffic and encourage active travel[iii] – a prescription for better health in other ways too. A key Scottish study has just linked children's hospital admissions for respiratory illness with air pollution.[iv]

What are the key factors that will enable successful implementation of these recommendations?

There is considerable and useful data outlining prescribing trends shown by the different Health Boards. It would be good to see learning from this too, to understand best practice and why certain approaches have worked, to better implement this in all areas. We strongly support the development of formularies (and especially electronic formularies embedded in the GP clinical software) to help adherence to both good clinical and sustainable practice. This was an ask of our joint statement on reducing the

environmental harm from prescribing.[v] The local projects look helpful and should be rolled out. We welcome the use of Scottish Therapeutics Utility (STU) and ScriptSwitch and the facilitation of their use should be encouraged.

Respiratory prescribing is increasingly complex and now undertaken by a wider range of clinicians in general practice as the multi-disciplinary team expands. Protected Learning Time (PLT) allows GPs and their teams to come together for learning and development within their working week. We have long campaigned for the return of central support for this. While we welcomed the Scottish Government provision of funding to Boards for practice PLT, we have concerns about the level of resource and that implementation may be patchy, and ask the Scottish Government to evaluate its progress since the announcement. Our preference remains for PLT arrangements to be easily understood, with support at a national level.

We agree with the aim to raise local public awareness to promote improvements in asthma care and the environmental impact of respiratory prescribing - but this should not fall solely to GPs. We would also welcome more information shared about medicine waste and returning inhalers to pharmacies.

A good interface between primary and secondary care is seen as facilitating good prescribing. The College urges the Scottish Government to mandate an interface group in every Health Board area.

The resources on page 106 are very useful and welcome and we are pleased to see the RCGP green practice toolkit highlighted. We need resources expanded for those who cannot read, and those who do not speak English as a first language.

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[i] https://ash.org.uk/resources/view/smoking-and-respiratory-disease
[ii] https://shop.rcplondon.ac.uk/products/passive-smoking-and-children?variant=6634905477
[iii] Low traffic neighbourhoods and population health | The BMJ
[iv] Respiratory Admissions Linked to Air Pollution in a Medium Sized City of the UK: A Case-crossover Study - Aerosol and Air Quality Research (aaqr.org)
[v] https://www.rcgp.org.uk/getmedia/c3f95668-7892-49a9-be43-1d9468cb56e9/scotland-prescribing-statement.pdf