MAJOR CONDITIONS DELIVERY GROUP ADVICE ON CHANGING INHALERS

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Authors	On behalf of the Somerset ICB Respiratory Programme Group: David Long Dawn Bradley Leeann Lintern Steve Holmes Steve Moore Victoria Wright Wendy Tregidgo
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1. There are currently (01.01.2024) 144 inhaler devices and preparations available on the Right Breathe website[1] which can be a challenge for even respiratory interested clinicians to be fully aware of.

2. It is well established that clinicians working in their roles have duties to their patient but also to the overall system in prescribing. Somerset Foundation Trust employees are in general limited to prescribing from their formulary and those in primary care encouraged to use the ICB formulary. Professionally health care professionals have a duty to use the resource available sensibly – and as well as providing the appropriate treatments for our patients, we have duties to be aware of and manage the cost implications of our decisions. This is clearly laid out in the General Medical Council and other professional bodies guidance[2,3].

3. There are also professional responsibilities on clinicians to prescribe treatments that are clinically indicated, that the patient can and is prepared to use (to avoid waste)[2,3].

4. There has been widely discussed cases of people prescribed inhalers without being taught how to use an inhaler who are admitted to hospital because of loss of control of their condition, (though these are rarely formally reported and investigated and the ICB is unaware of any cases within Somerset). Clinicians are also aware that inhalers have been changed without the patient being aware and requiring clinical input to manage this. We would suggest if this does happen, an alert should be raised so the circumstances can be investigated and the health care community learn from the event. This notification would fit in with the duties of all registered health care professionals – all of whom should be aware of how to raise a patient concern.

5. Clinicians are well aware that there are well recognised areas where treatment with inhalers across boundaries are changed but assumptions are made as to who will teach the patient to use the inhaler, with examples of patients reporting the clinician suggesting or prescribing not checking inhaler technique and assumptions that another clinician/community pharmacist will undertake this. Our systems are certainly not perfect at the moment and this will remain a challenge[4].

6. Prescribing costs are one of the areas that a health care system can potentially make easy savings and this can be by prescribing the most cost effective device providing the medications needed but how this is undertaken may make a difference. These costs are important to the overall Somerset ICB budget so that we can maximise the health care provision available to the population.

7. We have described two sorts of switch and recognise that there are variations among these:

   - Forced switch[5]
     When the patient is notified that their medication is being changed and provided with information on the new medication without direct involvement in the change (lack of shared decision making), when a decision is made on formulary changes within an ICB, PCN or practice and this occurs without direct face to face discussion. The Respiratory Programme Group do not feel that any forced switch should take place.

   - Shared treatment change[4,6]
     When the patient and clinician meet and agree a switch in inhaler, having checked that the patient is happy with the changes and is able to use the device competently.

8. The published evidence on this is controversial with a large study published in 2021 involving more than 700,000 people with asthma and COPD in the UK. This identified 69,800 people who had had their medication switched without an associated clinical consultation. The analysis on follow up of these patients suggested that switches (no difference between gender, age, inhaler device or inhaler technique checks) did not impact on consultations, respiratory events and adverse medication events in the electronic medical records. Adherence to treatment improved post switch[7].

9. This same study was included in a review of the literature on asthma which identified 11 papers (with often small numbers and differing methodology)[8]. Six papers of these showed reduced medication adherence and five studies showed unchanged or increased health care utilisation. On this basis the authors suggested that switching has a largely negative impact on asthma and associated outcomes.

10. Advantages of forced switch may be:
    - Able to change at scale and make cost savings rapidly for the ICB which could be used in other health care settings (especially with use of IT).

11. Disadvantages of a forced switch may be:
    - Possible worse control/admissions as a result of not checking device[8].
    - May impact on clinician patient relationship and trust[9].
    - A proportion of patients likely to contact the practice to discuss the change even with the communication (personal communications is that this seems to be at least 5% of those switched though Bloom paper suggests no difference)[7].

12. Advantages of shared treatment change:
    - Clear shared agreement on changes after discussion and checking of inhaler technique.
    - May improve compliance/adherence and clinician patient relationship in longer run term.
    - Allows opportunity to engage person in decision making for their care.

13. Disadvantages of shared treatment change:
    - A proportion of patients on new device may want to return to their previous, familiar device (percentage unknown but could well be less than forced switch).
    - Slower process of change (and less saved budget).
    - Depends on every review assessing inhalers and moving towards agreed changes.

14. Overarching considerations prior to any changes of inhaler:

A. Patient

1. Is the diagnosis correct and are the symptoms being treated by the inhaler caused by the respiratory condition? (remember many people have breathing pattern disorder problems, anxiety or deconditioning contributing to their breathlessness and for many the diagnosis may be more complex)[10].
2. Patients who have been admitted or been to an emergency department in the last year, required an emergency course of oral corticosteroids, used more than six reliever (blue) inhalers, have poor control or other complex medical problems should be considered strongly for face to face review as they are at significantly greater risk (both in asthma and COPD)[11,12].
3. Using an inhaler regularly and effectively (preventer in asthma) may with better control reduce dramatically the number of emergency reliever prescriptions required and reduce exacerbations in COPD[13,14].

B. System

1. Is the change of significant value to the system compared to the workload involved and any risk to patient safety?
2. Is there good documentation and systems in place to implement the change successfully?
3. Is there capacity for any increased workload to be managed within the system?
4. Is there capacity in the system for the proposed change? (Some changes have resulted in shortages or unavailability of medication and high workload to manage).

15. Recommendations for a successful "Forced Switch"

After considerable discussion and with full support from all on the Respiratory Programme Group (across primary/secondary care and from ICB pharmacist, general practice, specialist and general practice nursing support), we are unable to recommend a forced switch as it appears with current evidence to be against good clinical practice and not in keeping with moves to engage people with respiratory disease actively in their care. The only time a forced switch is likely to be needed is when a product is withdrawn from the market when a switch may well be necessary but should involve careful communication with every patient and an opportunity for that patient should they wish to discuss options.

16. Recommendations for a successful "Shared face to face change"

1. Ensure clinicians undertaking reviews are all clear on planned changes for the year in any prescribing changes.
2. Ensure patient alerts are triggered for every patient where a recommended change should be considered.
3. Consider whether a planned text (accurx) message is sent to relevant people to encourage them to book an appointment to discuss this (planning to accommodate amongst other workload).

Conclusions

Our first duty is to ensure patient safety as clinicians, however there are pressures on workload and the NHS which we all have responsibilities to work towards improving when we can. There are complexities around implementing forced switches and in implementing review based changes and there are pros and cons of each method. This document, we hope ,helps practices and PCNs work through the issues. Every prescription has medico legal implications and we should not forget this and be prepared to justify our practice.

We would be grateful for any comments and evidence base that you think makes a difference.

References

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