Inhaled corticosteroids

High dose ICS Prescribing PMOT ECF FAQs

The Pharmacy and Medicines Optimisation Team (PMOT) Medicines Optimisation Enhanced Commissioning Framework (ECF) Quality Scheme 2023-2024 will include an element focused on reducing the prescribing of inappropriate high dose inhaled corticosteroids.

Why has HWE chosen this to be the MO ECF?

- OpenPrescribing shows that HWE ICB is the highest prescriber of high dose inhaled Corticosteroids (ICS) in England; rates of prescribing have been steadily declining and HWE ICB is following this trend but remains significantly higher the national average. In line with BTS/SIGN/NICE, HWE ICB Management of Chronic Asthma in Adults guidelines recommend that reductions should be considered every three months in patients with complete asthma control.
- COPD associated inflammation has limited responsiveness to corticosteroids. According to GOLD 2023 the treatment effect of ICS regimens is higher in patients with high exacerbation risk (≥ 2 exacerbations and / or 1 hospitalization in the previous year). Thus, the use of blood eosinophil counts to predict steroid responsiveness should always be combined with clinical assessment of exacerbation risk (as indicated by the previous history of exacerbations). Long-term ICS use is associated with a significant risk of pneumonia and is not advised in patients with repeated pneumonia events or blood eosinophil <100 cells/µL.
- The National Patient Safety Alert - Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults August 2020 advised that patients taking inhaled beclomethasone >1000 mcg/ day or fluticasone >500 mcg/day were at risk of adrenal insufficiency due to hypothalmic-pituitary-adrenal axis (HPA) suppression and should be issued with an NHS Steroid Emergency Card. HPA suppression occurs more commonly at high doses and in a dose-dependent manner. Long-term use of high dose ICS is associated with an increased risk of local and systemic side-effects e.g., oral thrush, glaucoma, osteoporosis, diabetes. Most patients with asthma do not need higher doses of ICS, because at a group level, most of the benefit including prevention of exacerbations is obtained at low doses (GINA 2022).
- The British Thoracic Society Asthma Care Bundle recommends that all patients should have their medications assessed following an acute exacerbation or asthma attack including a review of medication classes and doses – increasing or decreasing as necessary.

Will this increase my workload?

Patients on the Asthma and COPD registers are already reviewed annually as part of QOF. Review of inhaled therapies, including high dose ICS, should occur as part of this annual review and treatment assessed in terms of symptom control and exacerbation rates. Patients prescribed high dose ICS can be prioritised for review - prioritisation of patients already occurs, for example high short acting beta agonist (ABA) prescribing rates and/or low ICS prescribing rates in asthma. Patients who have been stepped down will need an updated self-management plan and follow up appointment to review changes to treatment.

What are the strategies and how can they help?

Asthma

- Patients with controlled asthma symptoms prescribed fixed high dose maintenance ICS/ICS-LABA and not requiring reliever therapy with SABA can be considered for step down to low or medium dose ICS/ICS-LABA therapy in line with local guidance on the Management of Chronic Asthma. Current local and national Asthma guidance recommends reviewing ICS dose every 3 months with a view to stepping down by 25%-50% for patients with controlled asthma. GINA 2022 recommends starting the patient on a fixed dose regimen as they may be exposed to SABA only reliever therapy and a higher risk of exacerbations.
- Patients with uncontrolled asthma (using SABA more than 3x a week for daytime symptoms or once a week for night symptoms) can be considered for maintenance and reliever therapy (MART) as an alternative to prescribing long-term fixed high dose ICS/ICS-LABA plus reliever SABA.
- MART regimes specifically use ICS-formoterol; onset of action of formoterol is as rapid as salbutamol but has the advantage of a longer duration of action and removes the need for use of separate SABA reliever. MART regimes contain low or medium dose ICS and titrate additional ICS together with additional formoterol to improve asthma control and reduce the risk of severe exacerbations. MART is clinically appropriate for most people with asthma and included in NICE, BTS and GINA guidelines and Herts and West Essex ICB Asthma and MART guidelines.
- Symbicort trials demonstrated decreases in ICS burden (ICS-LABA MART regimens used 25% less ICS than that administered in other treatment groups) and total amount of oral steroid.

COPD:

- Only COPD patients with ≥2 exacerbations per year, or one or more exacerbations requiring hospitalisation and mMRC≥ 2 or CAT≥ 10, or with

asthmatic features (a blood eosinophil count ≥ 300 cells/µL or 0.3 $10x^9$/L) are at the greatest likelihood to benefit from ICS in addition to maximal bronchodilation with LAMA/LABA.

- High ICS doses are not licensed in COPD and HWE ICB COPD guidance recommends high strength ICS use should be reviewed regularly. Local and national guidance recommends reviewing and where clinically appropriate switching patients prescribed open triple inhaler combination (2 devices) to a closed triple system single inhaler. Current NICE and GOLD guidelines suggest single inhalers may be more convenient and effective for patients. All single triple therapy inhalers licensed for COPD contain medium dose ICS and provide an opportunity to step patients down from unlicensed high ICS doses. Use of closed triple inhalers also offers the advantage of reducing the carbon footprint of inhaled therapy.
- For COPD patients who do not meet the above clinical criteria for ICS therapy and who do not have co-morbid asthma diagnosis, reassess need for ICS therapy and consider stepping down to a lower dose ICS and then stopping if not clinically indicated. See link for guidance on page 3.

COPD and Asthma Overlap

- Patients with co-morbid COPD and asthma diagnoses should be managed according to HWE ICB Asthma guidelines. See link to guidance on page 3.

What happens if the target reduction is not met?

Payment for achieving this quality target will be 20p per PNW patient and achievement will be assessed at the end of Q4 once ePACT2 data is available. High dose ICS prescribing rates of 20% or less will be eligible for full payment relating to this indicator. Payment will be made proportionally with movement towards target, from baseline, for practices not achieving the full target. Practices who start 23/24 with a baseline of 20% or less of high dose inhaled corticosteroids compared to all inhaled corticosteroids prescribed, retrieved using the method described above from ePACT2 data, will not be expected to reduce their high dose ICS prescribing further but will be expected to maintain this threshold to achieve full payment relating to this indicator.

How will the reduction be monitored by PMOT?

Using ePACT2 data, prescribing rates for high dose ICS devices will be measured as a percentage of all ICS/ICS-LABA prescribing. The RightBreathewebsite provides monographs for every licensed inhaler device for COPD and asthma, which provide details of ICS dose (low/medium/high), some devices can be classed medium or high dose dependent on the number of puffs prescribed. ePACT2 data cannot differentiate between doses, only by device.

What is the baseline and what was its source?

Baseline will be reported as an average monthly percentage collected using 6 months of rolling data from ePACT2 between July to Dec 2022. Final monthly achievement will be assessed using an average of 6 months rolling data up to March 2024. Prescribing data will be retrieved from ePACT2 and will be reported as a percentage of baseline with updated data provided on a monthly basis in the MO ECF dashboard. The target includes all high dose ICS device prescribing. It excludes nasal solutions and nebulisers.

What resources are available/Where can I find the guidelines?

HWE ICB wide Guidance

Respiratory system (hweclinicalguidance.nhs.uk)

National Guidance

NHSE Guidance for Healthcare Professionals on Inhaled Corticosteroids in Adults

RightBreathe.com

2023 GOLD Report

2022 GINA Report

BTS/SIGN British Guideline on the Management of Asthma

NICE Asthma NG80

NICE COPD NG115

Patient Decision Aid: Asthma inhalers and climate change

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