Quick Reference Guide: Optimising Prescribing in Respiratory

This quick reference guide consolidates Hertfordshire & West Essex (HWE) ICS medicines optimisation recommendations relating to respiratory care into a single point of care reference tool that can be used when reviewing prescribing in patients with asthma or COPD. Inhalers represent a significant area of prescribing spend across the NHS and it is essential that treatments prescribed support long-term sustainability and deliver best value for our population.

Summary on a page:

Workstream area	Action required (for more detail see following pages)
Brand prescribing for all inhalers	Prescribe **all inhalers by brand**. Generic prescribing creates unintentional variation in devices supplied leading to confusion and poor inhaler technique.
Greener choices - choose lowest-carbon options	**NEW patients: use dry powder inhalers (DPIs) for anyone able to take a quick, deep inhalation.** Consider switching to DPI or low carbon alternatives when reviewing existing patients. Symbicort® First choice DPI for Anti-inflammatory reliever (AIR) and maintenance and reliever therapy (MART) in 12 years and over.
Greener inhalers: Salbutamol	• DPI preferred option is **Salbutamol Easyhaler 100mcg** inhaler • If DPI not suitable, preferred low carbon option is **Salamol 100mcg inhaler**
Greater use of approved formulary inhalers	Local guidance and ScriptSwitch® provides details of approved formulary choices to support use of locally approved cost-effective inhalers. Do not follow Ardens formulary recommendations.
Prescribing of Salbutamol in **12 years and over with asthma**	• **NEW diagnosis – DO NOT prescribe Salbutamol**, use Anti-inflammatory reliever (AIR) or maintenance and reliever therapy (MART) • EXISTING diagnosis + SABA alone; switch to AIR/MART; Stop salbutamol. • EXISTING diagnosis + uncontrolled; switch to MART; Stop salbutamol. • EXISTING diagnosis, well controlled on fixed dose inhaled corticosteroid and little/no use of salbutamol; consider taking Salbutamol off repeat.
Review excessive quantities of rescue therapies e.g. Salbutamol or AIR	• Prioritise for review, follow local guidance on asthma and COPD (age specific) • Consider if overuse or oversupply; if overuse ⇨ optimise treatment, if oversupply ⇨ review prescribing processes
Underuse of inhaled corticosteroids (ICS) in fixed dose regime	• Consider holistically, including diagnosis and use of rescue therapy • Step down ICS if good control for 3-6m
Provide regime specific personalised Asthma Action Plan	• All patients **must be counselled on and have a treatment regime specific PAAP** (AIR/MART/Salbutamol rescue therapy). Asthma and Lung UK provides asthma actions plans and are available in multiple languages.
Cost effective formulary option: Beclometasone + Formoterol MDI 100/6 and 200/6 (≥ 18 yrs)	• **DO NOT prescribe Fostair® for new patients** (non-formulary) • **Bibecfo® MDI is the preferred formulary cost-effective inhaler** and has same active ingredients, propellent and excipients. Consider switching existing patients from Fostair® to Bibecfo®
Increase uptake of ScriptSwitch® inhaler switch offers at point of prescribing	• **For new initiations follow ScriptSwitch recommendations for most cost-effective formulary options** as per local guidance • Consider cost-effective switches for existing patients
Starting inhalers in asthma and COPD	• Consider signposting patient to the community pharmacy New Medicine Service

Workstream area	More Information	Resources
ALL inhalers (greener choices)	Consider **dry powder inhalers (DPIs) as first choice**; most patients who can suck in 'quick and deep' will be able to use a DPI. DPIs offer benefits to patients as generally easier to use than other inhaler types and offer an effective alternative if a patient has poor control and/or technique; they do not require a spacer and most have a dose counter. Other inhaler types e.g. soft mist inhalers (SMIs) or pressurised metered dose inhalers (MDIs) can be considered where clinically appropriate e.g. insufficient inspiratory effort to take a quick deep breath. Local guidance on Asthma and COPD pharmacological management (see resource section) includes formulary inhalers.	Inhaled corticosteroids (ICS) approved formulary choices Salamol – patient letter Salamol – poster NICE Asthma inhalers and climate change Asthma and Lung UK Choosing the right inhaler device for your patients
ALL inhalers (brand prescribing)	Prescribe by preferred formulary brand to support most cost-effective options[1] and prevent unintentional variation in devices supplied to patient; supply of varied devices can confuse patients and result in suboptimal treatment due to poor inhaler technique. **Even small differences in the way a device is primed or activated can cause suboptimal use and poor outcomes.** *[1] for example, if an inhaler containing beclometasone diproprionate/formoterol is prescribed **generically** the NHS pays the community pharmacy the drug tariff reimbursement price of £29.32 (equivalent cost of Fostair®) **regardless** of which brand is supplied and if the cost is lower; however, if prescribed as preferred cost-effective brand Bibecfo® this would cost the NHS less than 50% (£13.98) for every 120 doses supplied. Both devices contain the same active ingredient, excipients and propellant.* **Not all inhalers are interchangeable, and some are more potent than others e.g. those containing extra fine particles. MHRA advice to prescribe beclometasone inhalers by brand name was issued in 2008.**	Guidance on clinically appropriate brand prescribing within Hertfordshire and west Essex ICS RightBreathe.com national resources to find inhalers based on drug class e.g. ICS/LABA, drug name, device type – each monograph contains detailed info on licensed doses, steroid dose etc.
Increased use of approved formulary choices	Start right, it is much better to start a patient on the preferred inhaler from the outset than switch after they have become familiar with a device type e.g. patients familiar with propellant containing devices may resist switch to a DPI regardless of benefits of ease of use and better drug deposition as they associate the sensation of the propellant with effectiveness even though the amount of dose delivered is low even with good technique. Use local guidance to ensure adherence to local formulary approved cost-effective inhalers in asthma and COPD when initiating and reviewing prescribing. In patients on existing therapy, promote switching where there is a	Inhaled corticosteroids (ICS) approved formulary choices Preferred formulary choices are outlined in key guidance documents linked below.

	more cost-effective formulary option. For patients with uncontrolled symptoms review as per local guidance and follow recommended inhaler choices.	
Cost effective inhalers: Beclometasone + Formoterol MDI 100/6 and 200/6 120 dose (licensed for ≥ 18 years)	• **Do not prescribe Fostair® for new patients (non-formulary for new initiations).** • **Bibecfo® MDI** is the preferred formulary cost-effective inhaler for patients requiring an MDI containing beclomethasone and formoterol and not suitable for a DPI. Approved locally and supported by local respiratory specialists - contains the same active ingredients, propellant and excipients as Fostair® MDI. • Switch patients currently prescribed Fostair® to **Bibecfo®** if clinically appropriate and MDI remains device type of choice or consider switch to DPI as per local guidelines.	HERTFORDSHIRE AND WEST ESSEX AREA PRESCRIBING COMMITTEE (HWE APC) Bibecfo® pMDI for treatment of asthma in adults Inhaled corticosteroids (ICS) approved formulary choices
Greener inhalers: Preferred Salbutamol options	• DPI preferred option is **Salbutamol Easyhaler 100mcg inhaler** • If DPI not suitable, preferred low carbon option is **Salamol 100mcg inhaler** For patients remaining on an MDI, a spacer should be provided to optimise drug delivery to the lungs and reduce unnecessary release of harmful green house gases. Dose delivery can be further optimised by using either the single breath and hold technique or tidal breathing technique.	Salamol – patient letter Salamol – poster Asthma and Lung UK How to use a pMDI inhaler with a spacer – single breath and hold Asthma and Lung UK How to use a pMDI inhaler with a spacer – tidal breathing
Excessive quantities of rescue therapies e.g. Salbutamol or AIR	**Prioritise for review, follow local guidance on asthma and COPD (age specific):** • Confirmed diagnosis? (consider alternative diagnoses or co-morbidities contributing to breathlessness symptoms) • Suboptimal Adherence with preventer? (patient reported use supported by quantity and frequency of issues). Patient educated that underlying cause of asthma is inflammation and remains untreated by Salbutamol and recommend move to AIR PRN or from AIR ⇨ MART • Suboptimal inhaler technique? (should be seen and checked). Visit the Asthma + Lung UK website for more information on inhaler devices and videos on correct inhaler technique. Consider a switching inhaler device to one more suitable for the technique demonstrated e.g. quick and deep inhalation is more suited to a DPI, poor inspiratory effort is more suited to an SMI or MDI with spacer. • Non-pharmacological interventions optimised? e.g. smoking (active or passive) • Optimised treatment for co-morbidities contributing to breathlessness?	HWE Asthma guidance: • MART - Asthma Management in over 12 years • Guidelines for the Management of Adults with Confirmed Asthma (18 years and over) • Q&A for reducing over-prescribing of Short Acting Beta Agonists (SABA) ECF • Guidelines for the Management of Children with Confirmed Asthma HWE COPD guidance: • COPD treatment guidance • Optimisation of inhalers and inhaled corticosteroid dose for adults with COPD • COPD Acute exacerbation • Repeat Prescribing Toolkit Q&A ECF 2025/26

	• Other factors considered and discussed? E.g psychosocial (anxiety and depression); seasonal factors; environmental factors (indoor and outdoor air pollution, indoor mould exposure etc • Personalised Asthma Action Plan specific to regime in place? e.g. AIR, MART, Fixed dose ICS plus SABA rescue • Remains uncontrolled despite optimisation in primary care and patient adherence? Refer for specialist review • If oversupply rather than overuse; review repeat prescription and use tools available to limit supply e.g. no. of authorisations, prescription duration intervals, review local policy to prevent oversupply of rescue therapies contributing to poorer outcomes. Who is requesting oversupply – if managed repeat encourage patient to order own medication e.g. via NHS App.	• Medicines Management & Prescribing Self-Assessment Tool
Personalised Asthma Action Plan (PAAP)	All patients should have an up-to-date asthma action plan that relates to the treatment regime they are following e.g. AIR, MART or fixed dose ICS with Salbutamol or other short acting beta agonist rescue therapy. Step through the PAAP and ensure patient understands every point, pausing for feedback and questions – if moving regime to AIR/MART highlight differences in new regime and check patient understanding. Patients following AIR/MART regimes should not be routinely co-prescribed SABA rescue therapy and this can cause confusion and increase risk of non-compliance with AIR/MART and prolong over reliance on Salbutamol. Asthma and Lung UK asthma actions plans are available in multiple languages and in editable downloadable versions which can be integrated into GP systems. PAAPs should be revisited at every review.	• Asthma and Lung UK What is an asthma action plan? • Asthma and Lung UK All health advice resources (Here you'll find our clear and reliable resources for people with lung conditions, including multi-lingual versions. You can download the resources you need for free) • AIR asthma action plan Editable • MART asthma action plan Editable • Adult asthma action plan (Salbutamol rescue) Editable • Child asthma action plan (Salbutamol rescue) Editable
Underuse of preventer therapy on fixed dose ICS or ICS/LABA regime	Consider holistically, including diagnosis and use of rescue therapy. In stable patients with controlled symptoms consider stepping down ICS dose, if using ICS/LABA step down to lower strength device in preference to reducing number of doses of high strength – this ensures only ICS dose reduced while maintaining LABA dose and reduces risk of failed step down. If poor compliance and uncontrolled symptoms review management plan as per local guidance.	See main guidance links above plus: • Step down guidance for controlled asthma in adults(18 years and over)
Prescribing of Salbutamol inhalers in adults and children 12 years and over with asthma	NICE/BTS/SIGN asthma guidelines for 12 years and over recommend SABA free pathways for all new patients with asthma or switching existing patients with	• MART - Asthma Management in over 12 years • Guidelines for the Management of Adults with Confirmed Asthma (18 years and over)

uncontrolled symptoms or treated with SABA alone, this has been adopted within local guidance:

NEW diagnosis	DO NOT prescribe Salbutamol; prescribe anti-inflammatory reliever (AIR) or maintenance reliever therapy (MART).
EXISTING diagnosis + prescribed Salbutamol alone i.e. no inhaled corticosteroid (ICS)	If secure diagnosis, discontinue SABA and prescribe AIR/MART **as per local guidance (SEE LINKS OPP)**. *Note: Ardens Manger provides case finding for patients 12 years and over on SABA monotherapy for review.*
EXISTING diagnosis + prescribed Salbutamol with ICS	If secure diagnosis, review salbutamol use and assess asthma control. If uncontrolled asthma based on guidance, recommendation is to switch to AIR/MART. If well controlled asthma, salbutamol rescue as part of a traditional fixed dose ICS regime (preferably as Salbutamol Easyhaler DPI or Salamol MDI) is recommended if: • NO or very little Salbutamol use (≤ twice a week (4 puffs) and no nighttime use) ☑ • Reported use matches quantity and frequency of issues; ≥ 2 salbutamol inhalers suggests poor control or oversupply ☑ • No severe exacerbations in last 12m; check for any oral corticosteroid use, A&E attendances, hospital admissions related to asthma ☑ • Adherence with ICS; patient reported and verified by quantity and issues including emergency supply. Consider stepping down ICS if stable ☑ • If remaining on traditional fixed dose ICS + rescue salbutamol therapy regime, set max issues and duration so > 2 issues in 12m triggers review ☑

- Q&A for reducing over-prescribing of Short Acting Beta Agonists (SABA) ECF
- Guidelines for the Management of Children with Confirmed Asthma

The Primary Care Respiratory Society provides useful resources to support review of Salbutamol in both asthma and COPD:

- Top Tips for Using the Asthma Right Care Slide Rule
- COPD Exacerbation Risk Slider Aide-Memoire

Starting inhalers in asthma and COPD	Consider signposting patient to the community pharmacy New Medicine Service; this service provides support for people with long-term conditions newly prescribed a medicine and includes prescribing of inhalers for asthma and COPD. Patients receive support with correct inhaler technique, education on their condition, device use, are counselled on potential adverse effects to support reporting of problems and where necessary referral to the prescriber if concerns.	• Community Pharmacy New Medicine Service
Asthma Priorities: what success looks like	• Reducing short-acting beta-agonists (SABAs) over-reliance and over-prescribing • Increasing the use of SABA free pathways with AIR or MART • Adoption of local and national guidance and adherence to local formularies to support cost-effective prescribing • Prioritising lower carbon options (DPIs or lower carbon MDIs) for inhalers, where appropriate and safe to do so, and via shared decision-making • Promoting appropriate inhaler disposal (returning used and expired inhalers to pharmacy for disposal to reduce release of harmful greenhouse gases) Asthma death rates in the UK grew by nearly 24% in the 10 years following the publication of national review of asthma death report in 2014 and over reliance on rescue therapy and under use of preventer still persists. The first joint BTS/NICE/SIGN Asthma guidance represents a significant change in asthma management in patients 12 years and over and should drive sustained change in prescribing behaviour particularly around Salbutamol. This messaging has been further supported by the latest drug safety update highlighting changes in Salbutamol prescribing. Improving the carbon footprint of inhaled therapy remains a national and local priority.	• Drug Safety Update: Short-acting beta 2 agonists (SABA) (salbutamol and terbutaline): reminder of the risks from overuse in asthma and to be aware of changes in the SABA prescribing guidelines • HWE ICS Steps to tackle asthma deaths 4th Sept 2025 • HWE ICS Living with asthma

Version	V1.0
Developed by	Alison Jackson, Lead Pharmaceutical Advisor Pharmacy and Medicines Optimisation Team, Hertfordshire and West Essex ICB
Date Ratified	November 2025, Medicines Optimisation Delivery and Implementation Group
Review date	The recommendations in this document are based upon the information available at the time of publication.