

Q&A panel questions

National Forum for Respiratory Medicines
Optimisation: NetZero and Sustainability –
How it is being tackled across the UK

10th April 2025



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Do you feel we need a sustainable lead in every PCN to promote the environmental factors. It feels clinicians have so much on their plate?

Yes, I think this is a good idea and there is a sustainable lead in every Scottish Health Board, with a Climate emergency and sustainability board in every health board too. There needs to be support from clinicians and no reason that the sustainable lead cannot be a clinician, but needs dedicated time and resource.

Sometimes, clinicians refer suspected asthma patients to me after prescribing an ICS. How does this affect the FeNO score & its reliability as an objective test?

High FeNO levels show eosinophilic inflammation in the airways so normal or low levels show that there is no untreated inflammation. If an individual has been prescribed an ICS before a diagnostic test, this will affect the results of both the FeNO and reversibility testing for spirometry. A FeNO should not be done in isolation, the clinical history and examination will also contribute and following the pathway of other diagnostic tests if doubt still exists.

What are the current challenges and barriers to implementing sustainable practices in respiratory medicine?

My view is that people perceive time as a barrier, however if those at most risk of poor control are targeted for review and treatment is optimised, this can be beneficial for the person and sustainability e.g. checking inhaler technique, optimising therapy and reducing inappropriate SABA use. Formularies and respiratory pathways need to be updated and include sustainable choices and encourage clinicians to discuss more sustainable inhaled therapy when reviewing choices.

What are your thoughts on only relying on one objective test and patient symptoms in diagnosing asthma?

If the results are clear and the clinical history and examination suggests asthma, then I am happy with that. The BTS/NICE/SIGN guidance on diagnostics is clear, so that if there is diagnostic uncertainty with one objective test but the history suggests asthma, continue along the pathway e.g. spirometry, peak flow readings.

How do you join these various committees and what value has this in promoting current best evidence?

Involvement in any national respiratory committees is beneficial from a self-development point of view, but also for helping to implement the best clinical policy and guidance. Join the groups (e.g. PCRS, BTS) and ask about how to get involved.

Why do we still have 1000 patients a year dying of Asthma?

We have not been able to address the overuse of SABA and the underuse of inhaled corticosteroids. In addition, asthma is often treated in general practice where there may not be asthma interested practitioners, so elements such as inhaler technique checks, optimal treatment pathways based on the new guidance and personalised asthma action plans may not have been implemented. Attendance at reviews for those most at need for review need to be encouraged, including targetting those who don't attend. Education and awareness for both healthcare professionals and patients should help people to understand the challenges and how to reduce the asthma deaths.

Do we lack in patient education and what can we learn from other communities countries in which there are lower deaths due to asthma. How can we sustain this?

Our third sector bodies such as Asthma Lung UK are great at supporting patient education, but that is only if patients seek this out. My concern is misinformation, for example, on social media. We need to continue to have a consistent message about good quality respiratory care across all sectors and correcting misinformation to address this. Our respiratory bodies such as BTS and PCRS can help to support and sustain this.

More work and incentives to get primary care to review under and over use of maintenance inhalers, and support better pt concordance and adherence?

Local schemes and incentives seem to work in optimising therapy and help drive quality improvement projects in respiratory, which I would support. Use of community pharmacies and schemes there would also be advantageous to assist patient education and adherence.

How can pharma help reach your targets and goals?

Pharma can assist by supporting the messages in the guidelines and local pathways/formularies. Also for scaling up quality improvement projects which have worked in areas in which they work. I have found that Pharma can be very helpful with that knowledge and networking across the UK, knowing what has worked well and supporting those projects in areas with resources and information. Helping to educate those generalists also in the updated approach to respiratory care, including sustainability. I also welcome work done by Pharma to reduce their carbon emissions, for example, reducing waste, reducing plastics in packaging, recycling for packaging, low global warming potential propellants etc.

If pharma dropped costs

We will not have these repeat formulary changes!

Each ICB/local formulary group will have to make a judgement on the relative risks and benefits of changes based on cost. We would all welcome lower pricing for essential medicines for our patients, but need to balance this against the risk of poor use of unfamiliar inhalers, and the loss of trust from patients if switches are made outside a shared decision making approach.

New guidance BTS review Saba and switch mdi to dpi do we feel this will create the push we aspire?

The focus of the new guidelines is on optimal clinical care, prioritising SABA-free pathways for many patients. This will reduce CO2e as MDI SABA is a large proportion of UK inhaler prescribing. There is indeed also a prompt to pick DPI as default for patients that can use these devices. The National guidelines influence local guidelines and individual clinician behaviour so we hope will create a push to speed up the change we need. But large scale change is slow and requires local support and systems to make the right thing the easy thing.

How can we link in local authorities who have clean air strategies, to improve outcome?

Reach out to your local clear air team and/or public health team. Partnership working is efficient and effective.

What can be done to address the discourse between asthma management and patient education?

I'm not sure what this question is asking I'm afraid. Is the question asking how we can ensure patient education reaches patients and meets their needs to support best management? There is not one answer to this – we need to use all levers and opportunities. This includes 1 to 1 conversations, written and online materials, national awareness campaigns eg World Asthma Day, as well as opportunities to discuss asthma across traditional media. It is essential that messaging is clear, and empowers patients to understand their own care.

How do you see AI affecting how we manage patients with asthma?

AI is likely to have a very limited impact on how we manage patients with asthma.

What is the latest on digital inhalers to help with adherence?

The digital inhaler which was on the market has been withdrawn and I have no information about future plans as yet.

There are digital add on devices, e.g. SMART asthma monitoring kit, which can be purchased, which has an app associated with the use of a digital device which can attach to an MDI and helps with adherence and monitoring of asthma symptoms. More information on this is through www.smartasthma.com

Leicestershire ran a period where you could recycle inhalers. This seemed very sensible. Are there any plans to reinstate this nationally?

There are aspirations for a national scheme, but there are many hurdles, most significantly funding. Previous pilots including the Leicestershire one were pharma funded and whilst often successful in small areas are not supported over the longterm and are not scalable. The pilot funded by Greener NHS in South East London has been designed as a proof of concept of using existing NHS infrastructure to collect and return inhalers to a specialist recycling firm. Data is being analysed and will be shared as part of ongoing conversations about the possibility of a national scheme.

Why do we only look at global warming potential and not things like the damage of single use plastics?

We don't. We look at all aspects of the environmental impact including single use plastic, but by far the largest contributor is the HFC gases in MDI inhalers so it's appropriate to tackle this as a priority as we'll get the greatest impact from our efforts. All inhalers use single use plastic. This is partly due to medicine regulations which are outside the control of clinicians/healthcare organisations. We promote the use of Respimat inserts to reduce single use plastic in those devices and would welcome innovation from industry on reducing single use plastics across devices.

Are there any plans to help address pollution especially near schools? Education for schools and parents?

There are many groups supporting education on air pollution. You can lend your support, which is always welcomed. For example Mums for Lungs (<https://www.mumsforlungs.org/>) do lots of outreach, education and campaigning for School Streets. You can also support actions and events on Clean Air Day (<https://www.actionforcleanair.org.uk/campaigns/clean-air-day>) each year.

Can nations work with government to compel manufacturers to make inhalers recyclable with household recycling? This would make a huge difference.

Unfortunately there are a number of difficulties with using household recycling at present. Inhalers have a many components; e.g. plastic, traces of medication, metal, and potentially harmful propellants which need to be disposed of safely.

As a starting point I think it is possible to increase and improve access to inhaler recycling schemes and have a joined up approach across the four nations. This would be helped if recycling becomes a higher priority. I would hope, in the future, there will be opportunities to make inhalers easier to recycle and a shared vision will encourage manufacturers to make a change.

No-one's mentioned AI-enabled tools to free up sustainable resources yet. So the panellists thoughts on this would be welcomed.

AI has a many potential applications in healthcare. I see opportunities in identifying and prioritising patients requiring optimisation/review, which would definitely lead to a more efficient use of resource. It is worth noting that AI is currently a demanding resource with a substantial carbon footprint, which must be considered. At present I am not aware of any immediate national plans.

With MDI inhalers, are there any plans to just prescribe the canister and not the plastic chamber?

Spiriva Respimat can be prescribed as the canister alone. For it to work well I think it would require a good level of patient and clinician education. From experience it hasn't worked well and many revert to prescribing the combination as it is simpler.

We are so constrained with acute patients, how do we propose funding should look like to stop neglecting long term prevention and be ahead of the curve?

An option would be to include managing long term risk/prevention in the funding indicators, very often an incentive helps to drive change. However, I do appreciate that securing funding is always challenging. In NI a comprehensive COPD review template has been developed and is in the process of being rolled out with the aim to standardise COPD management at all stages.

It covers a holistic review considering the increased CV risk of COPD patients. This was made possible by industry support.

Would investing in local communities to improve the environment, housing, and job opportunities lower long-term healthcare costs and medication burden?

There are many examples of how these factors can affect outcomes. Anything that can improve the lives and outcomes of patients is always of benefit.

The carbon burden across the globe are: 1 Energy 2. Transport 3. Residential and Commercial 4. Industry. Can you consider healthcare net zero v these factors?

I think it is important to consider the meaning of net zero and worth reading the link below.

“The 'net zero' target is legally binding. In practice, net zero means that total greenhouse gas emissions are equal to the carbon removed from the atmosphere.

<https://commonslibrary.parliament.uk/what-is-net-zero/#:~:text=Net%20zero%20legislation&text=This%20is%20commonly%20known%20as,carbon%20removed%20from%20the%20atmosphere.>

There will always be some form of emission, but in this context the balance is zero and can be demonstrated.

Shouldn't we challenge that the cost of waste/recycling is billed back to pharma instead of the NHS, given pharma's profits? This approach works in Portugal.

- Firstly I believe we need to distinguish the difference in waste and recycling.
- Secondly I do believe that Pharma have a significant role to play in the environmental sustainability associated with medicines use and disposal, I am not convinced however simply billing Pharma for the waste is the answer.
- I believe we all need to work with collaboratively with Pharma to find solutions for 1) manufacture of products that are simpler and easier to dispose of and recycle if appropriate 2) waste management whether this be recycling or disposal in general. Some Pharma companies are already working together to try to address this – see [CiPPPA - Circularity in Primary Pharmaceutical Packaging Accelerator](#).
- Finally we need to get better at not generating waste in the first place – this involves the whole system which would include the role of Pharma.

Regarding waste:

- Waste contracts differ across the UK and are commissioned in very different ways and according to different timelines depending on the country. Metrics around what is collected and disposed of also varies. This would pose a challenge in operational terms to engage with multiple Pharma companies at different levels (national, local e.g ICB etc) to operationalise the cross charging.
- Currently there is already a large amount of medicines waste in the system that could be reduced and yet we do not challenge Pharma to pay for this.

- Addressing the current level of medicines waste will release significant savings and reduce the CO2e associated with disposal of these and efficiencies in processes to organise and dispose of the waste.

Regarding recycling

- As I am sure delegates attending the conference would be aware not all medicines can or should be recycled.
- Recycling yield relatively low CO2e reduction compared with other methods to reduce the carbon associated with medicines. There tends to be an assumption that recycling is the answer but if resources are limited.
- In saying that there is still a need to identify ways to recycle those medicines that can be recycled.
- Studies, some done in the UK and in Wales specifically have identified the complexity of materials involved in the devices of some medicines such as DPI inhalers and the challenges this would bring with recycling these even if Pharma were to pay for this.

How closely are we working together with the third sector to deliver the sustainability and medicines optimisation agenda to patients?

- This is an interesting question and has made me think and question what we are currently doing in Wales.
- I suppose it depends on what we mean by the third sector.
- There are some charities such as Asthma and Lung UK that we work very closely with in Wales to address inhaler use and disposal. Representatives of this charity sit on our national Strategic Network for Respiratory Conditions, our Taks and Finish groups and sub groups established to support implementation of the [Decarbonisation: inhaler prescribing, use and disposal 2023–2030 A national strategy for Wales](#).
- Third sector providers offering social prescribing and run programmes to encourage health wellbeing and prevention interventions would also be another area I feel we have



How ?



very close working with in Wales. By default, close working with these providers will have co-benefits and influence the environmental sustainability and medicines optimisation agenda. Getting people to use less medicines for their ailments / conditions by whatever means and improving their health will affect a number of the core element in what I term Environmentally Sustainable Health & Care. (see embedded slide above).

- In 2024 I chaired a session at [Wales Climate Week](#) which featured just this. The session I refer to was held on day 4 session 30- [WCW 2024 Day 4 Session 5 Health co benefits of climate action](#).
 - Could we do more , should we do more – always!
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Treating tobacco dependency will have a massive impact to the patient and the planet- why not greater emphasis on this?

- I couldn't agree more, in fact supporting all the healthy behaviours ie diet, physical activity, alcohol for example all have huge co-benefits for patients health, wellbeing and the planet. This plays into the prevention agenda that public health colleagues have been pushing for many years.
 - If we can keep people well, they use less medicines, less services and stay out of hospital (whish is the biggest carbon contributor across the NHS).
 - In Wales we have national programmes designed to encourage our citizens in Wales to quit smoking, eat healthy, be more physically active and reduce alcohol use. The co-benefits are realised and programme leads contribute to our Public Health Wales Climate Change Board. Details of many of these programmes can be found on the Public Health Wales internet pages [Promoting healthy behaviours - Public Health Wales](#). Specifically for smoking [Help Me Quit](#)
 - I would include vaping in this basket too as the effects of nicotine plus the devices used are a growing problem.
 - A challenge with realising the impact of these public health interventions are 3 fold from my personal viewpoint:
 - ~ They rely on individual patient behaviours change which is a lot harder to achieve than people realise.
 - ~ For some groups the patient / population numbers are relatively low e.g in Wales, 2022/23 data suggests only 13% (**330,596**) adults still smoke.
 - ~ Public health interventions take a long time to realise the benefits e.g a smoker giving up toady will realise their health benefits in the longer term (maybe 10 years on).
 - ~ Although prevention is recognised and written across the policy landscape, ministerial priorities still feature on waiting times, early diagnosis and core operational NHS issues. As a result prevention interventions may not get the resource required to fully have the impact they could.
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What sustainability measures can be implemented for children under 12 with asthma?

- Best advice would be to follow the national guidelines. NICE, SIGN and AWMMSG guideline are mainly all aligned and provide the same messaging on treatment options and in Wales a greener option often is considered first if the child can use it. This is the best way to effect the best respiratory care and therefore improve the environmental sustainability of treatment to a child under 12.
 - The days of a child having a SABA pMDI at home, in school, in coat pocket, at grandparents etc just in case has long gone BUT we do still see this – it is a hard behavioural habit to break so any opportunity to educate parents and children themselves should be encouraged.
 - Attend reviews and check ups when requested.
 - Make sure inhaler technique is as good as it can be and is checked and advice given on improving technique on a regular basis.
 - [Pembrokeshire asthma project improves lives of 400 children | Milford Mercury](#) check out this project in West Wales by a pharmacist visiting schools – I have listened to some lovely stories from grandparents of children involved in this project and how they are engaging in school activities as a result of the improve care.
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Can community pharmacy play a bigger role?

- I believe community pharmacy already plays a significant role in the environmental sustainability agenda whether as a sector it realises it or not.
 - The contacts it has with our citizens makes it a perfect setting for a range of intervention to improve medicines sustainability and optimisation.
 - Unfortunately the demands on community pharmacies at present makes it really difficult for contractors to consider what is possible over their core contract. Challenges dominating community pharmacy capacity at the moment include medicines sourcing (due to shortages), staff capacity (due to NI contribution hikes), stores closing and increase in patient demand for primary care services.
 - I believe there is a need to increase awareness of the entire community pharmacy workforce (clinical and non clinical staff) on climate change, the health effects and the role medicines and pharmacy can have on this agenda.
 - RPS have embraced this and in Wales we are working on Goals which I am hoping we can embed environmental sustainability across all Goals or have a separate goal in its own right. This is work in progress.
 - Many contractors tell me we need to 'make it meaningful' for them and then they will 'get it'.
 - In saying that there are some fantastic community pharmacy champions champing at the bit with this agenda and doing wonderful thing. We have a number signed up to our [Greener Primary Care Wales Framework & Award Scheme](#). Check out a colleague in [Newport](#) and a [PJ article](#) and another in [Cwm Taf](#).
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Can we have some pressure on better vaping legislation?

- Influencing legislation is a recognised public health intervention. It is however quite complex and does take time for data evidence to be gathered, legislation to be timetabled, written, consulted and laid before government.
 - I believe there are efforts in place across the UK to address vaping, particularly in the younger age group and legislative changes are a part of that ambition. [Tobacco and Vapes Bill 2024: creating a smoke-free generation and tackling youth vaping | GOV.WALES](#)
 - The problem is clearly recognised [Vaping - Public Health Wales](#), the challenge is that the health system is up against a multi-million industry (many vapes are a subsidiary of the tobacco industry) so any regulation or legislation may well be challenged and need to be watertight and future proof.
 - I feel there is a need to educate along side legislate though as the demand is driving the uptake.
 - Could more be done, could it be done quicker. I wouldn't disagree.
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How can we engage with prescribers and practices to deliver green prescribing

- This is a question close to my heart.
- We have been working on this in Wales in the context of green inhalers for over 2 years. The reason we have chosen inhalers is it is one of the larger medicine contributors to the NHS Wales carbon footprint.
- I am very aware that great progress has been made with inhalers but we are not there yet but we need to now look at other medicines and prescribing practice that could be greener. This is a conversation PHW have started with key stakeholders and hope to convene a workshop late summer to bottom what, how, who, when we do this.
- My top tip would be to identify the co-benefits, provide evidence and data and then work on drivers that work for the prescriber community you are trying to engage with. Plus make it as easy as possible. Follow EAST Framework.
- Building on the success of the green inhaler work. A number of key drivers in primary care specifically have seemed to have been successful for us in Wales.

STRATEGY

The [NHS Wales decarbonisation strategic delivery plan](#) sets out a series of steps and targets for NHS Wales to reach net zero carbon emissions by 2030. Specific initiatives detailed in the plan include:

- **Initiative 42** - Take a patient-centric approach to optimise inhaler use, focusing on a reduction in the over reliance of reliever inhalers where possible.
- **Initiative 43** - Transition the existing use of carbon-intensive and high global warming potential (GWP) inhalers to alternative lower GWP inhalers where possible. [The target is a shift to just **20% of inhalers being MDIs** and remaining **80% of inhalers being low GWP alternatives** by 2025].

- Endorsement by AWMSG and publication of the [*Decarbonisation: inhaler prescribing, use and disposal 2023–2030 A national strategy for Wales*](#) in 2023.

GUIDELINES

- AWMSG endorsement of the All Wales Prescribing Guidelines for [COPD](#) and [asthma in adults](#) and [asthma in children](#) developed by the Respiratory National Strategic Clinical Network. First published in 2020.

CONTRACTS

- Inclusion in the GMS contract from October 2021- March 2024
- Inclusion in the community pharmacy contract 2024

NATIONAL KPIS

- Inclusion in the basket of [National Prescribing Indicators](#) for 2022-2025. Also now in NPIs until 2028.

NATIONAL CO-ORDINATION

- Establishment of an Inhaler Task and Finish group in December 2021.

FEEDBACK AND DATA PROVISION (TO PRACTICE LEVEL)

A range of data sources, generated from prescribing data available in Wales and provided by the All Wales Therapeutics and Toxicology Centre.

- [National Prescribing Indicators quarterly reports](#)
 - [NHS Wales inhaler carbon footprint reports](#)
 - [Green Inhaler QI Project dashboard](#)
 - [Inhaler decarbonisation dashboard](#)
 - Bespoke data requests to AW TTC
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Published by Pharman Limited

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