NHS
Central East
Integrated Care Board

Areas of Focus for 2026/27 ECF Target - Summary Document

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1. Overview

This guide has been prepared to support Hertfordshire practices to work towards achieving medicines efficiency targets in 26/27.

How will focussing on these areas support the ECF 2026/27 requirements?

As part of the 2026/27 ECF, practices are required to deliver medicines efficiencies through an agreed practice-level efficiency plan. The ECF supports GP practices in optimising the use of NHS resources through value-based prescribing providing financial sustainability across the NHS. These areas of focus will aid achievement of the efficiency plan while supporting consistent and equitable patient care.

What data is available to support these areas of focus and to review the prescribing and spending?

The NHS Business Services Authority (NHSBSA) provides ePACT2 data on key prescribing comparators in England, including practice-level information on items considered not suitable for routine prescribing, covering both spend and item volumes. In addition, the ePACT2 potential generic savings dashboard highlights opportunities to reduce costs by switching from branded medicines to generic equivalents, focusing on 20 nationally identified medicines with the greatest potential to release resources PCNs, practices and prescribers can register for access to ePACT2 reporting and book onto ePACT2 training directly on the NHSBSA hub.

2. Over The Counter (OTC) Primary Care Resources

Central East ICB follow the NHS England national guidance on conditions for which over the counter items should not be routinely prescribed in primary care. This policy guidance aims to reduce unwarranted variation, improve patient outcomes and provide value for money for the NHS. It provides recommendations for items that are available OTC and should not be routinely prescribed because:

- there is limited evidence of clinical effectiveness for the item
- the item would be prescribed for a condition that is self-limiting and will clear up on its own without the need for treatment
- the item would be prescribed for a condition that is appropriate for self-care.

What are the highest areas of OTC prescribing and available OTC resources?

Mild Dry Skin/Sunburn

NHS England advises that mild dry skin and sunburn can be safely managed with over-the-counter emollients. Please see following links for guidance including treatment guidelines and patient information leaflets:

Adult Emollient Prescribing and Treatment Guideline

Patient Guide: How to Use Emollients Effectively

Patient Leaflet: Managing Mild Dry Skin with OTC Emollients

Care Home Guidance for Safe and Appropriate Use of Emollients

Sunscreen products should be prescribed in accordance with Advisory Committee on Borderline Substances (ACBS) approved indications. Sunscreens with ACBS approval are regarded as drugs when prescribed for skin protection against ultraviolet radiation and/or visible light in cases of abnormal cutaneous photosensitivity causing severe reactions. This includes genetic disorders (e.g. xeroderma pigmentosum and porphyrias), severe photodermatoses (both idiopathic and acquired), and patients at increased risk of ultraviolet-related adverse effects due to chronic disease (such as haematological malignancies), medical therapies, or procedures.

Products with ACBS approval include: Anthelios® Sunscreen Lotion SPF 50+, Uvistat® Lipscreen SPF 50, Uvistat® Suncream SPF 30, and Uvistat® Suncream SPF 50. Please see following link for further information: Sunscreen | Treatment summaries | BNF | NICE.

Dry Eyes/Sore tired Eyes

For dry eye preparations, patients with **mild/moderate dry eyes**, are suitable for self-care treatment as per NHSE guidance. Only patients with severe dry eyes should require a prescription. Please see links to the local guidance available:

Dry Eye Disease Treatment Guideline

FAQ for Prescribing Dry Eye Lubrication Drops and Gels

Vitamins and minerals

Vitamin supplements and minerals should not be routinely prescribed in primary care due to limited evidence of clinical effectiveness. Please see following links for guidance:

Position statement - Vitamin D prescribing in adults

Position Statement: Vitamin D Supplementation in Care Homes

British Dietetic Association Food Fact Sheet: Dietary Sources of Vitamin D

Lutein and Antioxidants Patient Information Leaflet

GP Guidance for Patients Planning Privately Funded Bariatric Surgery (SW Herts)

Patient Leaflet: Planning for Private Bariatric Surgery (SW Herts)

Mild to Moderate Hay fever/Allergic Rhinitis

Most people with mild to moderate symptoms for hayfever/allergic rhinitis are able to relieve these with OTC medicines. Please see following links to guidelines which support national guidance:

Treatment Guideline for Seasonal Allergic Rhinitis

Patient Leaflet: Treating Hay Fever with OTC Medicines

Is there an OTC directory for clinicians to see availability of products?

Yes, CI Plus, previously the home of The OTC Directory. Please see link:
https://www.otcdirectory.co.uk

This OTC directory provides you with detailed information on the products available from key suppliers in the OTC market. It is intended to help improve product knowledge and assist in making suitable recommendations, encouraging self-care and providing information on how to use OTC products safely.

You can search by Category, Product or Ingredient.

Note: Availability varies by pharmacy; own-brand alternatives with the same active ingredient may be supplied

What other local resources are available on OTC?

A recently developed patient information leaflet on treating heartburn and indigestion provides practical advice on recognising symptoms and managing them effectively with OTC medicines. It also highlights when further medical advice should be sought. Please see following link:
Patient Information Leaflet - Treating your Heartburn and Indigestion with Over The Counter (OTC) Medicines

What information can be shared with patients?

Over the counter medicines for minor health conditions – Information for patients. All local NHS services should be supporting the OTC guidance. If patients require advice for one of the minor conditions listed, they should visit a local pharmacy first and not attend out of hours or A&E services to obtain OTC medicines.

Local councils are supporting the OTC guidance and a Medicines in School - Questions and Answers Guide has been developed which includes information on OTC products in schools.

3. Low Clinical Value Medicines Efficiency Plan

How does low clinical value prescribing support the ECF 2026/27 requirements?

Practices are required to develop and implement a **medicines efficiency plan** which can include reducing the prescribing of low clinical value items, while maintaining high standards of patient care.

Items which should not routinely be prescribed in primary care policy guidance provides suitable recommendations because they are unsafe, ineffective for some or all patients, or are not cost-effective.

Why is reducing low clinical value prescribing important?

This work aligns with national guidance from NHS England on items which should not routinely be prescribed in primary care because:

- there are significant safety concerns with the item
- there is a lack of robust evidence of clinical effectiveness for the item
- the item is clinically effective but more cost-effective interventions are available
- the item is clinically effective but deemed a low priority for NHS funding.

What data is available to support low clinical value prescribing and spending?

Fig 1 ePACT2 data for months Nov25, Dec25 and Jan26 - Items not for Routine Prescribing in Hertfordshire:

Medicine Category	Items	Actual Cost (£)	No. of identifiable patients
Amiodarone [NEW 2019]	2042	17,169	585
Bath and shower preparations for dry and pruritic skin conditions [NEW 2019]	1989	12,396	1137
Co-Proxamol	6	2,738	2
Dosulepin	1025	10,159	307
Dronedarone [NEW 2019]	65	4,510	26
Herbal Medicines	79	5,501	24
Homeopathy	2	6	2
Immediate Release Fentanyl	71	17,124	12
Lidocaine Plasters	916	70,225	463
Liothyronine	290	33,406	127
Lutein and Antioxidants	144	1,525	53
Minocycline for acne [NEW 2019]	22	354	10
Needles five pounds or more per 100 [NEW 2019]	1676	35,787	902
Omega-3 Fatty Acid Compounds	293	7,608	97
Oxycodone and Naloxone Combination Product	61	3,061	13
Paracetamol and Tramadol Combination Product	117	1,108	55
Perindopril Arginine	178	2,203	88
Prolonged-release Doxazosin	1407	12,237	488
Rubefacients (excluding topical NSAIDs)	302	2,101	149
Silk garments [NEW 2019]	21	2,659	11
Travel Vaccines	267	3,146	16
Trimipramine	34	12,268	12

What actions can practices take to support low clinical value prescribing?

Practices should:

- Avoid initiating items identified as low clinical value
- Review and deprescribe existing prescriptions where clinically appropriate
- Switch to clinically suitable, cost-effective alternatives
- Advise patients on OTC options where appropriate following shared decision-making.

Which items should not be prescribed in primary care?

Co-proxamol; glucosamine & chondroitin; herbal/natural products; homeopathy; minocycline (acne); omega-3 fatty acid compounds (excluding icosapent ethyl [Vazkepa®]); silk garments.

Which items are restricted for use in limited circumstances only?

Aliskerin, bath and shower preparations for dry/pruritic skin conditions; dosulepin; doxazosin (prolonged release); lutein and antioxidants; oxycodone/naloxone combinations; paracetamol/tramadol combinations; perindopril arginine; rubefacients, benzydamine, mucopolysaccharide and cooling products (excluding NSAIDs and capsaicin); trimipramine; amiodarone; dronedarone; immediate release fentanyl; lidocaine plasters; liothyronine; travel vaccines; needles for pre-filled and reusable insulin pens (>£5 per 100 needles) .

What system approaches can practices use to support this work?

To support delivery, practices can:

- Utilise ScriptSwitch to prompt cost-effective prescribing
- Use available prescribing reports ie epact2, open prescribing to identify variation and high-cost opportunities to help develop and deliver the agreed efficiency plan e.g. prioritise high-spend, low-value areas such as trimipramine, lidocaine, liothyronine, and emollients.

What resources are available to support low clinical value prescribing?

Practices should utilise national and local resources to support implementation of low clinical value prescribing guidance.

Resource	Purpose
NHS England Policy	Framework for items which should not routinely be prescribed in primary care
PrescQIPP Bulletin 339	Clinical rationale, cost data, and alternatives to support deprescribing
HWE Clinical Website	Local guidance: • Trimipramine - stopping and switching guidance • Liothyronine - Position Statement • Lidocaine plasters deprescribing guide
OpenPrescribing.net	Prescribing data to support review and benchmarking

These resources should be used alongside prescribing data and clinical judgement to ensure safe, evidence-based, and cost-effective prescribing.

How should practices monitor and review progress?

Practices should:

- Nominate a clinical lead for low clinical value prescribing
- Review progress regularly at practice meetings
- Incorporate guidance into induction and training for new staff and locums
- Audit prescribing data to monitor improvement and identify further opportunities
- Ensure patients are appropriately reviewed following any medication changes

4. Switching from Fostair® to Bibecfo®

How does switching from Fostair® to Bibecfo® support the ECF 2026/27 efficiency requirements?

For adult patients not suitable for a dry powder inhaler and requiring a pMDI (pressurised meter dose inhaler) containing beclometasone/formoterol, Bibecfo® is the preferred formulary option across Hertfordshire. Switching appropriate patients from Fostair® to Bibecfo® supports financial sustainability and delivery of ECF efficiency targets. Bibecfo® is included in the local adult asthma guidelines and MART guidelines for 12 years and over. Early switching is recommended to maximise cumulative savings.

Why does adherence to preferred formulary choice Bibecfo® matter?

The addition of Bibecfo® 100/6 and 200/6 mcg pMDIs to the local formulary was supported by local respiratory specialists and evaluated by the Area Prescribing Committee prior to approval. Prescribing preferred formulary options establishes safe, clinically effective and cost-efficient medicines use and reduces variation in medication provided to patients.

Bibecfo® pMDI contains the same active ingredients, is bioequivalent and has the same device type as Fostair® pMDI meaning it delivers equivalent clinical effect whilst supporting the NHS goal of financial sustainability and maximising medicines value.



Is it clinically appropriate to switch from Fostair® pMDI to Bibecfo® pMDI?

For most adult patients stable on treatment with Fostair® and where use of a pMDI device remains the most appropriate device type, Bibecfo® is considered therapeutically equivalent and suitable for direct switching in most cases. Changes in treatment should follow local guidance and clinical judgement should always be applied.

NICE Asthma Guidance 245 does not distinguish between different brands of inhalers with recommendations limited to drug class and combinations only e.g. ICS/LABA. In line with local and national guidance **all inhaler prescribing must be by brand** to prevent inappropriate and unplanned switching of inhalers.

Switches will be prompted by the prescribing support software on GP prescribing systems. Patients should be informed of any changes to their medication and be allowed an opportunity to discuss changes or book an asthma review.

Practices are encouraged to discuss how community pharmacy colleagues can support patients via the new medicines service.

Are there circumstances when it may not be appropriate to switch from Fostair® to Bibecfo®?

Yes, there are usually patients that would be excluded from switching for various reasons, the following should not be considered exhaustive and clinical judgement should be applied if other circumstances exist:

- Both Fostair® pMDI and Bibecfo ® pMDI are licensed only for use in 18 years and over.
- For unstable patients with poorly controlled asthma a review of their management plan may be required to ensure their treatment is appropriate and optimised in line with local guidance.
- Patients under the care of a specialist respiratory team.
- Patients who have trialled and failed on Bibecfo® pMDI previously.

Please note **previous treatment failure with Luforbec® pMDI does not exclude a patient from a switch from Fostair® pMDI to Bibecfo® pMDI**; unlike Bibecfo whose active ingredients and excipients are the same as Fostair®, Luforbec® contains a different excipient and therefore response or adverse effects experienced may be different.

What resources are available to support switching from Fostair® pMDI to Bibecfo® pMDI?

Updated asthma guidance and supporting resources for previous ECF quality indicators are available on the legacy Hertfordshire and West Essex PMOT website. These documents support prescribing in line with local and national guidance and provide information on preferred formulary choices, links are shared below:

Bibecfo® (ICS/LABA, Beclometasone/Formoterol) pMDI for treatment of asthma in adults GREEN First line pMDI option for patient in whom a dry powder inhaler is unsuitable

Anti-inflammatory reliever (AIR) therapy and Maintenance and Reliever Therapy (MART) Regimens with Symbicort®/DuoResp® spiromax/Bibecfo®

Guidelines for the management of Adults with Confirmed Asthma (18 years and over)

Quick Reference Guide: Optimising Prescribing in Respiratory

5. Generic prescribing as an area of opportunity

How does generic prescribing support the ECF 2026/27 requirements?

As part of the ECF 2026/27, practices are required to deliver medicines efficiencies through an agreed practice-level efficiency plan. Generic prescribing supports best use of NHS resources and financial sustainability across the NHS. Practices are expected to prescribe generically as standard, unless there is a clear clinical reason to prescribe by brand, in line with local and national guidance. Even small changes in prescribing behaviour can achieve significant efficiencies. Early identification and action on high-impact opportunities will support practices to maximise delivery against their efficiency targets.

Why does generic prescribing matter?

Generic prescribing supports achievement of the efficiency plan while supporting consistent and equitable patient care through use of bioequivalent and clinically effective generic medicines. Increasing generic prescribing is one of the most effective ways to deliver better value and should be the default position in most situations.

The Hertfordshire wide position on Generic prescribing supports the routine prescribing of medicines by their generic names, except in limited circumstances where prescribing by brand is clinically appropriate and necessary for patient safety. Where a branded product is prescribed for a patient by a Hertfordshire provider clinician, this is most often due to familiarity with the brand name rather than an intention for branded supply and Hertfordshire specialists agree it is appropriate for primary care prescribers to routinely switch to a generic product. For example, Hertfordshire Consultant Ophthalmologists support the use of generic eyedrops.

As a practice how can we support generic prescribing in the NHS?

Information on the local position regarding generic prescribing should be shared with all prescribers to maximise efficiencies and ensure safe prescribing. Prescribers should be familiar with medicines that are recommended for brand prescribing. Supply shortages may result in requests from community pharmacies to re-prescribe some generic medicines by brand however this should be a temporary situation, and prescriptions should be issued as acutes only. Unless there is a specific safety reason clearly noted on clinical documentation all prescribers across Hertfordshire should support generic prescribing. Prescribing of branded medicines outside of local guidance should be identified and switched to generic alternatives; switch offers by ScriptSwitch should be accepted unless there a clinical reason to reject the switch. In summary:

- Ensure all prescribers, including locums, adhere to generic prescribing guidance and local formulary recommendations
- When prescribing generically DO NOT select items where the manufacturers name is stated in brackets after the name of the medication. These items can be more expensive and restrict what can be dispensed to a single manufacturer's product
- Only prescribe by brand in line with clinical brand prescribing guidance e.g. where brand prescribing is required to ensure safety, efficacy, or consistent therapeutic effect

What data is available to support generic prescribing and review and switch branded prescribing?

Fig 2 Top 10 high-impact opportunities where prescribing could be switched from branded to generic medicines for Hertfordshire are highlighted below:

Top 10 proprietary brand prescribing (primary care)	Generic Equivalent	Estimated Annualised Saving (£)	Switch offered by ScriptSwitch®/additional resource(s)
Utrogestan® 100mg capsules	Progesterone micronized 100mg capsules	198,000	YES
Forxiga® 10mg tablets	Dapagliflozin tablets 10mg tablets	82,000	YES Dapagliflozin Switch Guidance
Vagifem® 10 microgram vaginal tablets	Estradiol 10 microgram vaginal pessaries	72,000	YES
Concerta® XL 54mg tablets	Methylphenidate 54mg modified-release tablets	53,000	YES Bioequivalent branded generic offered by ScriptSwitch (Xaggitin XL 54mg tablets) as per shared care protocol
Dymista® 137/50micrograms/dose nasal spray	Fluticasone propionate/Azelastine 137/50 microgram/dose nasal spray	52,000	YES Allergic Rhinitis pathway
Circadin® 2mg MR tablets	Melatonin 2mg MR tablets	49,000	YES Circadin® brand of MR melatonin no longer approved for use
Ganfort® 0.3mg/5mg/ml eye drops	Bimatoprost + timolol 300micrograms/Timolol 5mg/ml eye drops	49,000	YES Ophthalmology specialists support generic prescribing
Movicol® oral powder 13.7g sachets (Plain/lemon & lime)	Macrogol compound oral powder sachets NPF sugar free	44,000	YES, information message prompts for OTC. If prescribed, use generic equivalent (30 sachet more cost effective). Adjust quantity for as needed use.
Sinemet® Plus 25mg/100mg tablets	Co-careldopa 25mg/100mg tablets	36,000	YES
Lumigan® 100micrograms/ml eye drops	Bimatoprost 100micrograms/ml eye drops	33,000	YES Ophthalmology specialists support generic prescribing
Estimated savings from switching to generic equivalent		**668,000**	

Data Source: ePACT2 Comparator report: Potential Generic Savings Monthly data for Jan 26 for SWH and ENH sub-ICBs annualised to show 12m potential savings opportunity for Top 10 brand prescribing

Baseline practice level data for generic prescribing opportunities has been provided at efficiency planning meetings as potential opportunity will vary by practice depending on extent of brand prescribing. ScriptSwitch® reporting will continue to be included on the ECF dashboard and should be reviewed monthly to identify missed savings and prioritise high impact switching opportunities.

6. Opportunities in Diabetes

Optimising prescribing in diabetes offers a key opportunity for practices to deliver against their efficiency plans for the 2026/27 ECF.

As a practice how can we optimise prescribing in diabetes?

The Optimising Prescribing in Diabetes Quick Reference Guide provides guidance and links to supporting resources across key priority areas, including:

- **SGLT-2 Inhibitors** – **Dapagliflozin** generic 1st line choice
  - Prescribe dapagliflozin generic for new patients
  - Switch eligible patients from alternative SGLT-2 inhibitors

- **DPP-4 inhibitors** – **Sitagliptin** generic 1st line choice
  - Prescribe sitagliptin generic for new patients
  - Switch eligible patients from alternative DPP-4 inhibitors

- **Blood glucose meters, test strips and lancets** – preferred choices for T2DM
  - Initiate in new patients with T2DM who require blood glucose monitoring
  - Switch eligible patients to a recommended blood glucose meter
  - Deprescribe if blood glucose monitoring is not clinically required

These areas represent high-volume prescribing with significant variation, offering strong potential for efficiency savings at scale.

What data is available to support optimisation of prescribing in diabetes?

ECF dashboard data and Open Prescribing should be used to identify and prioritise areas with the greatest potential for optimisation. Practices should focus on identifying patients suitable for review and implementing clinically appropriate changes in line with local guidance.

7. Reducing antibiotic prescribing in paediatric patients

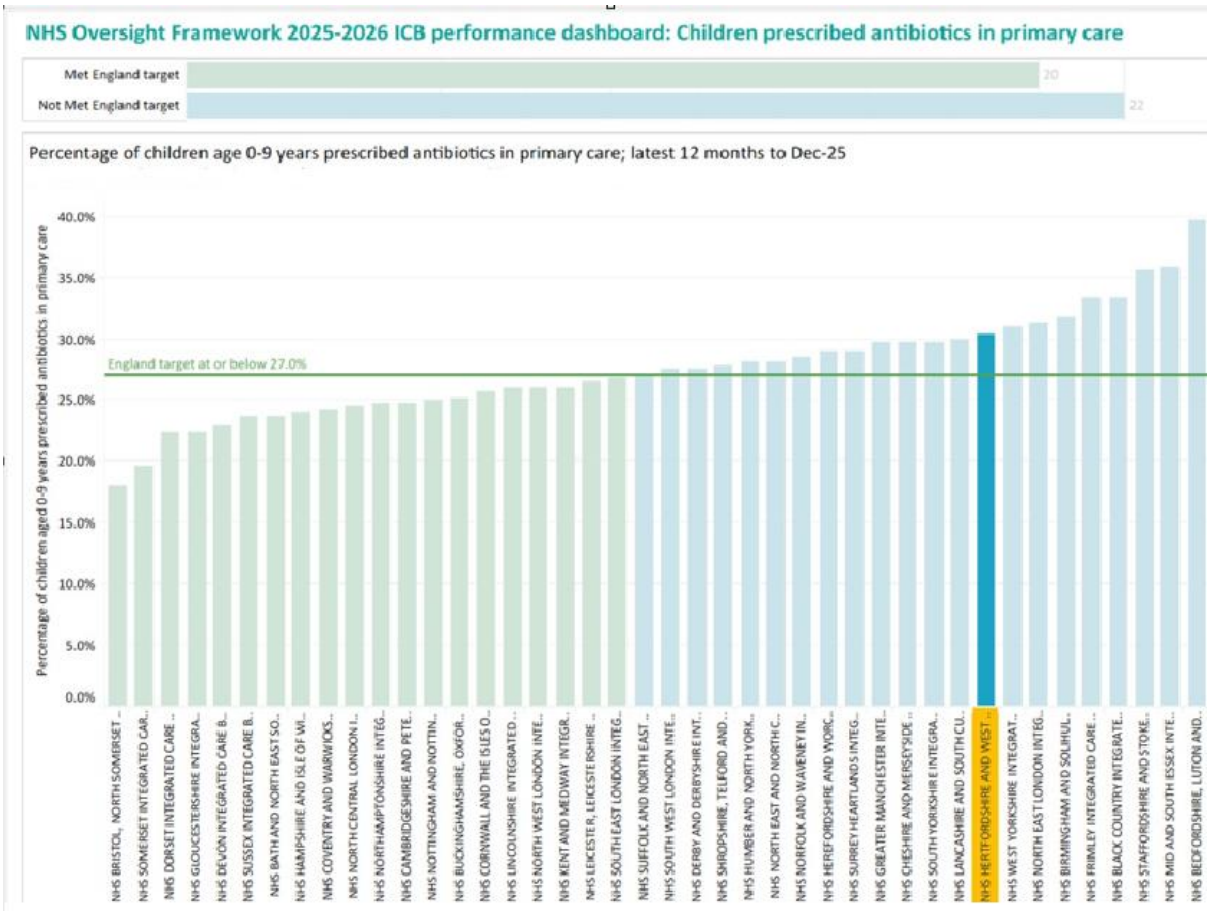
The NHS Performance and Assessment Framework for 2025/26 introduced a new metric that measures the percentage of children aged 0–9 years who have been prescribed at least one antibiotic in primary care over the previous 12-month period. The national target is 27.0% or below.

The ECF 2026/27 will include an element focused on reducing the prescribing of inappropriate antimicrobials in paediatric patients. Practices should aim to reduce the proportion of children aged 0-9 years who are prescribed antibiotics in the last 12 months to the nationally agreed target of ≤27%. Reporting of this metric will be taken from the ePACT2 paediatric antimicrobials dashboard (ASC02) rolling 12 months.

Why is this metric included in the ECF?

Hertfordshire has relatively high prescribing of antimicrobials in the paediatric population aged 0-9 years. Paediatric prescribing remains above threshold level (≤27%) for both the Hertfordshire area and East of England region.

Fig 3 Percentage of children age 0-9 years prescribed antibiotics in primary care, latest 12 months to Dec-25



Reducing antibiotic prescribing in children requires a whole-system approach. Community pharmacies are required under the NHS Pharmacy Quality Scheme 2025/26 to audit their management of patients presenting with sore throat who do not meet the criteria for antibiotic supply under Pharmacy First, reducing the likelihood of these patients presenting to general practice. Acute trusts are working to national UKHSA intravenous to oral switch (IVOS) standards that now include a specific paediatric framework. Both initiatives contribute to the UK Government's AMR National Action Plan 2024 to 2029, which targets a 5% reduction in total antibiotic use in human populations from the 2019

baseline by 2029. Primary care prescribers are central to delivering this system-wide ambition, and the paediatric metric described in this toolkit represents general practice's contribution to a set of national expectations that span all NHS settings.

Why is it important to reduce inappropriate antimicrobial prescribing in children?

Early antibiotic exposure (during the first 2 years of life) is associated with an increased risk of childhood-onset asthma, allergic rhinitis, atopic dermatitis, coeliac disease, being overweight, obesity, and attention deficit hyperactivity disorder. Antibiotics are implicated in nearly half of all emergency department visits for adverse drug events attributed to a systemic medication among children of all ages.

While prompt antibiotic treatment remains essential in suspected sepsis, stewardship principles are equally important. Prescriptions should be reviewed regularly, therapy de-escalated when appropriate, and source control prioritised. The UK Sepsis Trust provides useful resources to guide balanced management, please see following link to NICE aligned clinical tools and resources.

Why are antimicrobials prescribed in children and how to minimise inappropriate prescribing?

Respiratory tract infections and cough in children (due to upper respiratory tract infections, bronchitis, bronchiolitis, infective exacerbation of asthma, and pneumonia) are the most common respiratory tract infection syndromes managed by health services. Many clinicians report that they prescribe antibiotics just in case, to mitigate perceived risk of future hospital admission and complications and that failing to provide a prescription for a child who subsequently becomes seriously unwell is professionally unacceptable.

Prescribers view the onset of sepsis as the most concerning potential outcome of reduced antibiotic prescribing but for children aged 0-4 years the number needed to treat (NNT) with antibiotics to avoid one case of sepsis has been estimated at 27,000-29,000 children. Please see safety of reducing antibiotic prescribing in primary care: a mixed-methods study for further information.

NICE guidance – Cough (acute): antimicrobial prescribing recommends that clinicians do not offer an antibiotic to individuals with upper respiratory tract infection or acute bronchitis who are not systemically very unwell or at higher risk of complications.

What education and training tools are available for prescribers?

The Royal College of General Practitioners (RCGP) TARGET website has a webinar on antibiotics for children explaining how to identify the unwell child, whether they require antibiotics and how to provide clear safety netting materials and information for home care. There are a number of other training resources that can be used to ensure that all prescribers in practice are made aware of the most recent evidence for the appropriate management of children presenting with uncomplicated respiratory tract. The website also contains audit tools that can be used to evaluate the success of the implementation of education and training.

Each clinician should have access to a digital version of the Caring for Children with Coughs leaflet (sometimes referred to as the Polar Bear leaflet) either via a text message hyperlink or via a QR code linked to the Polar Bear leaflet website for parents to scan using their smartphones during a consultation.

There is a also a TARGET Self Assessment checklist available for GP pratices to measure current antimicrobial prescribing in practice (see appendix 1).

What is the STARWAVe clinical rule?

STARWAVe clinical rule is a tool to predict risk (low, normal, or elevated) of future hospitalisation among children who have presented to in-hours primary care with acute (≤28 days) cough and respiratory tract infection (RTI). It was developed in response to primary care clinicians saying they prescribe antibiotics "just in case" children's illnesses deteriorate.

This is a validated points-based clinical rule consisting of:

- Short duration of illness equal to or less than 3 days
- Temperature – patient reported fever in the previous 24 hours or temperature of 37.8°C or over
- Age – less than 2 years
- Recession – clinician reported inter- or subcostal recession
- Wheeze – clinician reported wheeze on auscultation
- Asthma – current diagnosis of asthma
- Vomiting – parent reported moderate or severe vomiting in the previous 24 hours

The mnemonic is STARWAVe. One point is scored for the presence of each sign or symptom. Risk of hospital admission is based on total score with:

- 1 point or less, very low risk (0·3%, 0·2–0·4%) of future admission and researchers believe a 'no' antibiotic strategy should be considered for this group
- 2 or 3 points, normal risk (1·5%, 1·0–1·9%) of future admission. In keeping with NICE guidelines, researchers believe a 'no' or 'delayed or back-up' antibiotic prescribing strategy should be considered
- 4 points or more, high or elevated risk (11·8%, 7·3–16·2%) future admission and should be closely monitored for signs of deterioration. As 11.7%, around 1:9 were admitted, consideration should be given to proactive arangement of same-day or next-day follow-up and prescribing an immediate antibiotic

IMPORTANT: The STARWAVe clinical rule is useful, but not perfect, meaning that it should supplement, not replace, usual clinical assessment and observations. As a result, clinicians should use safety netting, advising parents about the conditions under which they should reconsult.

What other resources are available to support reducing antibiotic prescribing in paediatric patients?

NICE Guideline NG51: Recognition, Diagnosis and Early Management of Suspected Sepsis

HWE ICB Guidance Q&A for Appropriate Antimicrobial Prescribing

ePACT2 Children's Antimicrobial Stewardship Dashboard for Prescribing Review and Benchmarking

RCGP TARGET Patient Information and Consultation Support Materials for Common Infections

RCGP TARGET Antibiotic Stewardship Toolkit for Primary Care

RCGP Respiratory Tract Infection Audit Templates and Action Planning Resources

KidzMed e-Learning Programme: Supporting Children and Young People to Swallow Tablets (e-learning for healthcare login required)

8. Specials Prescribing Resources

This resource document is to support primary care clinicians when reviewing and prescribing unlicensed ‘specials’ medication.

Is a ‘special’ really needed?

Before prescribing a special consider if a medicine is needed at all. If a medicine is required a stepped approach is suggested to choose an appropriate preparation, especially where an adult has difficulties swallowing:

1. Licensed medicines administered as intended.

2. Licensed medicines administered in an unlicensed manner.

3. Imported products.

4. Special-order products.

- A special should only be prescribed when there is no available licensed medicine which fully meets the patient’s clinical needs.
- Decisions about the prescribing of specials should be based on professional judgment and an understanding of individual patient need as accountability for prescribing a special rests with the prescriber.
- Review patient’s prescribed specials to ensure that a special is (and remains) the most appropriate option
- Consider deprescribing, ‘drug holidays’, alternative treatments, and licensed administration of oral formulations. ‘Specials’ should be reserved for those who truly cannot take tablets or capsules in their solid form.

Specials prescribing in paediatric patients:

Consideration should be given to encouraging children to swallow oral solid dose forms (tablets or capsules) where possible.

Are opening capsules and crushing tablets a sensible alternative to liquids?

Guidance from the Specialist Pharmacy Service and tertiary centres such as Great Ormond Street Hospital highlights that intact tablets and capsules are the preferred choice. Whenever children can safely take solid oral dosage forms, these should be prescribed. When this is not possible, and there is no liquid option available, crushing tablets or opening capsules may be considered. However, this is off-label, and so should only be done where there are no suitable alternatives. Prescribers should bear in mind that this alters pharmacokinetics and should not be considered for modified-release or enteric-coated products where it can cause therapeutic failure or toxicity.

What other resources are available when reviewing and prescribing unlicensed ‘specials’ medication?

Specialist Pharmacy Service Guidance on Medicines Use in Swallowing Difficulties

PrescQIPP Resources for Reviewing and Prescribing Specials

British Association of Dermatologists Guidance on Recommended Specials for Skin Disease

British Journal of General Practice Article: Tablets Before Liquids? Rethinking Paediatric Prescribing in Primary Care

9. Appendix 1: TARGET self-assessment checklist for GP practices



Self-Assessment Checklist
GP Practice Questions

SELF ASSESSMENT CHECKLIST

What would be good practice now?

1. Do you use national or local antibiotic guidance when considering how to treat common infections? Yes ☐ No ☐

You should be using local antibiotic guidance – this is based on national guidance produced by National Institute for Clinical Excellence (NICE) and UK Health Security Agency (UKHSA) and may have been modified locally by commissioners and microbiologists to localise the antibiotic guidance in accordance with local resistance and susceptibility patterns. This should be consistently used by all staff in your practice and out-of-hours services and can be found on the NICE website. The Summary of antimicrobial prescribing guidance for managing common infections summary tables https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/antimicrobial-prescribing-guidelinesare available on the BNF website.

2. Do you analyse and discuss antibiotic prescribing at your practice in comparison to local indicators at least once a year? Yes ☐ No ☐

Analysing antibiotic prescribing figures against set indicators during the audit process enables the surgery to benchmark itself and determine whether there is a need to review their antibiotic prescribing practices. It is good practice to keep these figures and re-audit annually. Tackling antimicrobial resistance 2019–2024 - the UK's five-year national action plan aims to halve healthcare associated gram-negative bloodstream infections by 2024 and reduce the number of specific drug-resistant infections in people by 10% by 2025. Use ECF dashboard and national prescribing data on Fingertips to compare antibiotic prescribing in your practice to local levels.

3. Do you use patient focused strategies to highlight the importance of responsible antibiotic use? For example, videos and posters in clinical and waiting areas. Yes ☐ No ☐

There are patient facing materials available in the TARGET toolkit that can be used in the surgery waiting areas or in the consultation to improve patient awareness and to facilitate communication around responsible antibiotic use, antibiotic resistance and patient self-care of infections. You can refer to posters and videos during your consultations to highlight that there is a national strategy to tackle resistance and inappropriate antibiotic use.

4. Reflective notes on current guidance, benchmarking and patient focused strategies in my practice

5. Have you been involved in a practice antibiotic audit in the last two years?
Yes in last year ☐ Yes in last 2 years ☐ No ☐

It is important to conduct regular antibiotic audits within your practice, with peer review of the results to further improve antibiotic prescribing. Audits have been shown to lead to improved prescribing and are now a requirement of your CPD and appraisal. Why not identify an area in your practice where prescribing rates are high – e.g. sore throat or UTI and take one forward using the audit templates available in the TARGET Toolkit.

6. Do you usually record clinical indications for antibiotic prescribed in patient notes using Read Codes or Snomed?

Yes ☐ No ☐

Using appropriate Read Codes during consultations will further improve the audit process and can be used to support the prescribing decisions made on any given occasion. Consider having agreed codes or a code formulary in your practice and discuss at a meeting. Not recording an indication for prescribing antibiotics may be perceived as a reason to hide inappropriate prescribing. Agreeing your coding means that audits will be more meaningful.

7. Reflective notes on audits and coding

What most practices should aim to do soon

8. Is the latest antibiotic guidance made available to all temporary prescribers working in your surgery? Yes ☐ No ☐ Don't Know ☐

To have a consistent approach within the surgery is very important, otherwise it gives patients mixed messages and they may just re-consult with another colleague.

9. Do you use back up/delayed antibiotic prescriptions at least:
Weekly ☐ Monthly ☐ Yearly ☐ No ☐ I don't agree with back-up prescriptions ☐

Back up/delayed prescribing is a very useful strategy to use when pressure to prescribe is greater, especially just before the weekend. Typically, about 4/10 patients given a back-up/delayed prescription will collect and use the antibiotic. Patients may feel reassured that they have a prescription available to use if their symptoms do not get better as expected, or worsen, and the TARGET 'Treating your infection' leaflets can be used to help communicate the benefits of this approach. Back-up/delayed prescribing is a specific technique which includes giving advice on the natural history of the illness, alarm symptoms, when to re-consult and why and when to take the antibiotics. For more information on this approach consider discussing antibiotics with patients. To encourage use of back pocket/delayed prescriptions in your practice, computer prompts could be used when someone enters a Read Code for an infection. Using the SNOMED Read Code 967191000000104 when you give advice on treating your infection with self-care patient leaflet with back-up/delayed prescription issue will also help you audit prescribing decisions.

10. Do you have infection leaflets easily available to share in the consultation?

No ☐ Yes – hard copies on my desk ☐ Yes – computer prompt ☐ Other ☐

We are all familiar with the patient centred consultation, and a recent UK survey showed that 88% of patients trust their GP to give them advice on when they need antibiotics. Improved communication with patients around antibiotics has been shown to reduce antibiotic prescribing. The TARGET 'Treating your infection' RTI and UTI leaflets have been produced to share with patients in consultations when you think they may benefit from a no or delayed prescription; these have been endorsed by NICE. These can be downloaded and used on many GP computer systems to form part of your patient consultation record. The leaflet allows you to close the consultation without a prescription, promote and increase patients' confidence to self-care and reduce re-consultations for the infection in the future. The 'When Should I Worry' booklet can be used for parents when you think their child will benefit from a no, or delayed antibiotic prescription. This should be endorsed in the consultation and related to the current illness. Record the use of a leaflet in consultations with Read Code 8CE

11. Reflective Notes

What all antibiotic aware practices should be doing

12. Do you keep a written record and surgery action plan resulting from antibiotic audits?

Yes ☐ No ☐ Don't know ☐

Audits are most effective when actions are set to improve prescribing, with subsequent audits then being completed to analyse whether the actions have been successfully implemented. See where you sit within the Quality Premium for antibiotic prescribing in total, broad spectrum and UTI's.

13. Do you have strategy to avoid patients re-consulting with other clinicians to obtain antibiotics? Yes ☐ No ☐

Patients with a high expectation for antibiotics may revisit their surgery or other providers to obtain a prescription for antibiotics if they were initially refused antibiotics. This may be countered by good communication skills, the use of leaflets and a back-up/delayed prescription strategy as part of a standardised approach supported by antibiotic guidance. We suggest you create an action plan at a practice meeting with all staff, and ask your local medicines manager to help.

14. Have you undertaken any antibiotic-related prescribing clinical courses, for example the TARGET Webinars, "Managing Acute Respiratory Tract Infections" and "Managing UTIs" eLearning courses on the RCGP Online Learning Environment within the past 2 years?

Yes ☐ No ☐

These courses count as Continued Professional Development (CPD) for your portfolio. Training resources are free for all to access from the RCGP website.

15. Is there a GP or nurse prescriber within your practice who takes a lead for antibiotic stewardship in the practice? Yes ☐ No ☐

Having an antibiotic champion within the surgery can lead to significant improvements in antibiotic prescribing as they can help to drive and maintain initiatives to affect the required changes. The champion should aim to discuss antibiotic issues in the practice at least twice a year.

16. Reflective notes
