ANTIMICROBIAL RESISTANCE: A PATIENT SAFETY ISSUE

A Patients Association report to assess whether Clinical Commissioning Groups are fulfilling their stewardship responsibilities in the battle against antibiotic resistance

May 2016
Unless we take global action, antimicrobial resistance will become an even greater threat to mankind than cancer currently is.

Chancellor of the Exchequer, the Rt Hon George Osborne MP, April 2016
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I am delighted to be able to present this Patients Association report exploring the uptake of key antimicrobial stewardship policy measures by Clinical Commissioning Groups (CCGs) across England. Antimicrobial resistance represents arguably the greatest patient safety threat of our time, and was therefore the obvious choice when deciding upon the first area that the newly created All Party Parliamentary Group on Patient Safety should focus on.

It is now well-established that modern society is in danger of entering a ‘post-antibiotic era’, with ageing and increasingly ineffective antibiotics meaning that diseases currently considered as routine are becoming once again near-un treatable. Needless to say, the consequences of such a scenario would be disastrous, both in terms of the impact on health outcomes and our overall life expectancy, as well as the likely effect it would have on the global economy and indeed, our very way of life.

With all this in mind, it has been encouraging to see a greater recognition of the scale of the challenge facing us, and the need to take action to address it. The recently commissioned recommendation-based Review on Antimicrobial Resistance led by Lord Jim O’Neill has formed a key part of this response, helping to galvanise efforts towards the adoption of improved antimicrobial stewardship initiatives, both within the United Kingdom and beyond. It has also reinforced the notion that this is very much a global challenge, requiring global solutions.

Whilst we can and should take heart from this, it is also essential that we do not rest on our laurels. Alongside the ongoing drive to develop new and much needed antimicrobials, we must also ensure that our remaining treatment options are maintained as effectively as possible. The only way this can be achieved is by adhering fully to current guidance and examples of best practice. The findings to this report clearly illustrate that although progress is being made and a number of areas should be commended for their antimicrobial stewardship efforts, other areas lag worryingly behind and much more needs to be done to ensure that those with whom responsibility rests are doing all they can to help minimise the very real dangers that antimicrobial resistance presents.

Andrea Jenkyns MP
Chair of the All-Party Parliamentary Group for Patient Safety
Antimicrobial resistance is at heart a patient safety issue. Considering that speaking up for and on behalf of patients is what the Patients Association is all about, producing a report to better understand how those responsible for the implementation of antimicrobial stewardship guidance were faring across the country seemed like a natural step. The report focuses in particular on Clinical Commissioning Groups and the area of primary care, as this is where the overwhelming majority of antibiotics are currently prescribed, many of which inappropriately.

What we found is that ultimately, more needs to be done to better safeguard patients and minimise their risk of developing dangerous antimicrobial-resistant disease. More support needs to be provided to the areas that are not implementing enough of the key antimicrobial stewardship recommendations or making use of available resources, with particular attention required for those that do not even have antimicrobial stewardship programmes in place. There have been a number of recently introduced policy measures and financial incentives that encourage the delivery of improved antimicrobial stewardship at a CCG level, and this is something that should be welcomed.

However, and as this report illustrates, failing to provide this focus and support for improving the uptake of key guidance already in existence will severely undermine the aspirations for this country to be a global leader in the battle against antimicrobial resistance, and will jeopardise the safety of patients in this crucial area.

Katherine Murphy
Chief Executive Officer, Patients Association
Without doubt there is a greater appreciation now more than ever before of just how serious the threat of antimicrobial resistance (AMR) is, to our collective health and wellbeing and to modern society. There has also been a recognition of the need to put in place more coordinated and ambitious strategies to help avert this threat at a local, national and international level. In the United Kingdom, this has been illustrated by the high profile and Government-commissioned Review on Antimicrobial Resistance, led by Lord Jim O’Neill and focused on the development of global solutions to AMR across the agriculture and healthcare sectors, and recognising the role of the pharmaceutical and diagnostic industries.\(^2\)

Despite this improved awareness, concerns remain that progress ‘on the ground’, in terms of embedding recommended antimicrobial stewardship (AMS) practice across the country, remains patchy. Implementation of key and established policy initiatives has also been slower than it should have been, particularly in lieu of the scale of the threat we are all faced with. If the UK is truly to be recognised as a global leader in the battle against AMR and in protecting the safety of its patients, it is essential that we are embedding effective systems across our own healthcare system first.

With this in mind and working with a number of experts in the area, in April 2016 the Patients Association sent a Freedom of Information (FOI) request to every Clinical Commissioning Group (CCG) in England, asking how successfully they were implementing a number of key policy initiatives that promote the adoption of local AMS programmes and support patient safety.

Having received responses to these requests from 144 CCGs (out of the 209 in England), the results presented something of a mixed picture. Whilst there is clearly a considerable amount of good work being done to develop more effective AMS initiatives in a number of areas, this isn’t necessarily the case everywhere. Almost a third of respondents were not able to confirm whether they had a named individual in place responsible for the implementation of a local AMS programme, and worryingly, one in ten CCGs said they did not have an AMR stewardship programme in place at all, meaning that as many as 5.3 million patients in England are being put at an increased risk of developing potentially avoidable infections.

Even in the areas that are prioritising AMS, implementation of guidance is still not happening quickly enough; only 12 per cent of CCGs had fully implemented NICE Guideline 15 Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use \(^3\), whilst less than a quarter of CCGs had incorporated all elements of the Royal College of General Practitioners TARGET Antibiotics Toolkit \(^4\) into routine practice. The results also show that too many CCGs are continuing to overlook existing measures and tools that have a proven impact on promoting more effective antibiotic prescribing. With the latest data from Public Health England showing that 74 per cent of antibiotics are currently prescribed in primary care\(^5\), many inappropriately, there is clearly a major need to provide as much support as possible to healthcare practitioners in this part of the system, and help ensure that the right prescribing decisions are being made. Despite this, over half of CCGs said they still had not carried out an evaluation on the use of C-reactive Protein Point of Care Testing in primary care, even though it has been included as a key recommendation within NICE Clinical Guideline 19\(^6\) and the RCGP TARGET Antibiotics Toolkit\(^4\), whilst it has also been shown to represent a cost-effective and proven means of cutting levels of antibiotic prescribing and reducing patient re-attendance for respiratory tract infections.\(^7\)

It is essential that we do everything in our powers to respond to the threat presented by AMR. In light of the information received through our FOI requests, it seems apparent that our collective response should feature a renewed focus on encouraging the adoption and implementation of the key AMS policy levers already at our disposal, including those that can reduce inappropriate antibiotic prescribing and minimise the risk of AMR. In doing so, we can help ensure that the UK is rightly seen as the world leader in mobilising efforts to halt the spread of AMR, and ultimately, protect patient safety.
INTRODUCTION

A PATIENT SAFETY THREAT
The threat of antimicrobial resistance (AMR) represents arguably the greatest patient safety challenge of our time. It has been widely reported that the world is on the cusp of a ‘post-antibiotic era’, with the growth in treatment-resistant bacteria raising the prospect that modern medicine will be increasingly unable to treat what are currently considered to be routine infections. Without effective antibiotics, cancer treatments, childbirth and many other operations would also be far riskier. If we are unable to reverse this trend, it has been estimated that AMR could kill up to 10 million people a year by 2050, with a cumulative cost to the global economy of £70 trillion.1

Evidence suggests that we may also be nearing this cusp sooner than originally thought. In December 2015, a report in the Lancet Journal of Infectious Diseases demonstrated that certain strains of bacteria found in patients and livestock across China had started to become resistant to the ‘last resort’ antibiotic colistin.8 This development effectively means that bacteria causing a number of gut, urinary and blood infections in humans are at risk of developing pan-resistance, and could become untreatable by all currently-available antibiotics.

In April 2016, Public Health England announced a ‘national incident response’ following a new outbreak of high-level azithromycin resistant gonorrhoea in parts of England.9 There are already a dwindling number of antimicrobials that remain effective in the treatment of gonorrhoea, with ceftriaxone representing the last line of antibiotic treatment for the condition. Current practice recommends that ceftriaxone is prescribed in a dual-therapy approach alongside azithromycin, to maintain the drug’s effectiveness. The emergence however of azithromycin resistant gonorrhoea jeopardises this “second lock” that currently prevents or delays the emergence of resistance to ceftriaxone, meaning that we are one step closer to the development of entirely treatment-resistant gonorrhoea.

AMR has the potential to dramatically increase the morbidity, mortality and costs associated with bacterial infections across the world. Data already shows that infections accounted for 4 per cent of potential years of life lost in England in 2010, caused 7 per cent of deaths and were the primary reason for admission for 8 per cent of hospital bed days.10 Without effective action, these figures are only likely to deteriorate, especially in light of recent data showing that overall antibiotic resistant infections increased throughout 2014.11

These developments remind us that in the battle against AMR, the stakes could hardly be higher, both for individual patients and for society as a whole. In recognition, this report explores the extent to which Clinical Commissioning Groups (CCGs), key organisations in terms of delivering local antimicrobial stewardship (AMS) programmes, are taking the challenge on-board and enacting key recommendations helping to manage the threat of AMR. Ultimately, the Patients Association hope its findings can inform current policy and encourage greater support to be provided where it is needed.

THE ALL-PARTY PARLIAMENTARY GROUP ON PATIENT SAFETY
The All-Party Parliamentary Group on Patient Safety was established by the Patients Association in July 2015, with the aim of ensuring that patient safety remains at the heart of the Government’s agenda. Chaired by Andrea Jenkyns, Member of Parliament for Morley and Outwood, the group brings together interested Parliamentarians, members of the public and healthcare experts to address all issues affecting patients in the care sector. Areas of focus for the group include access to hospital information, avoidable adverse patient events, medication errors, safety alerts and unsafe hospital discharge.

The group’s first area of focus has been antimicrobial resistance and prevention of healthcare-associated infections, the subject of this report and an area that the Patients Association have campaigned tirelessly on for the past 15 years. The first meeting of the group took place on October 21st 2015 and featured a number of presentations from experts in the area, highlighting the importance of ensuring improved infection control compliance across a range of healthcare settings and adhering to existing AMS best practice.
THE POLICY RESPONSE

Measures designed to encourage a system-wide and proactive response to the challenge of AMR have been increasingly prominent within the NHS policy framework in recent years. Perhaps the most high-profile policy response to this challenge has been the Government-commissioned Review on Antimicrobial Resistance, which is being delivered collaboratively with the Wellcome Trust to analyse AMR from a global perspective and propose recommended actions to help avert its threat. The Review has now published a series of recommendation-based reports exploring the broader environment around antimicrobial resistance, covering the topics of agriculture, vaccines, infection prevention and the value of diagnostics.

Whilst much of the output of the Review has been globally-focused, there have also been a number of other recent policy developments, targeted at healthcare professionals, providers and commissioners in England. The National Institute for Health and Care Excellence (NICE) has published a series of guidance documents over the past few years designed to improve AMS practices at a national level and encourage more appropriate antibiotic prescribing locally. This can be illustrated by the accompanying table below.

One of the most prominent recommendations within this suite of guidance has been around encouraging commissioners to develop AMS programmes in their respective localities, providing mechanisms for regular feedback on patient safety incidents related to antimicrobial use, containing clearly defined roles and responsibilities and operating across all local care settings.

Commissioners have also been urged to help improve education and understanding of AMR amongst both healthcare practitioners through training programme materials and targeted events, as well as amongst patients and the wider public, by making available resources such as information leaflets. Commissioners can draw upon available NICE guidance in this area, as well as materials from the Public Health England (PHE) endorsed RCGP TARGET Antibiotics Toolkit (Toolkit).

In addition to recommended guidance, Clinical Commissioning Groups (CCGs) have also been incentivised financially to deliver a reduction in levels of antibiotic prescribing, particularly in primary care, through the introduction of the Antibiotic Quality Premium. Overseen by NHS England, Quality Premiums are intended to reward CCGs for improvements they deliver in the quality of services commissioned locally and for associated improvements in health outcomes and reducing inequalities. A three-part composite Quality Premium measure designed to reduce overuse and inappropriate use of antibiotics in primary and secondary care, and thereby reduce the spread of AMR, was first introduced in the 2015/16 Quality Premium framework, and was worth up to 10 per cent of the total Quality Premium payment available, or £80,000 for an average-sized CCG.

The headline component of the measure required CCGs to realise a reduction in the number of antibiotics prescribed in primary care by at least 1 per cent compared to the CCGs 2013/14 value. Following data showing that this measure was being broadly met, a more stringent antibiotic Quality Premium has been included for the 2016/17 Quality Premium framework, with CCGs now required to achieve a 4 per cent reduction in prescribing levels based on 2013/14 performance. CCGs are also required to reduce their prescribing of a number of listed broad-spectrum antibiotics, to be equal or lower than 10 per cent of total number of antibiotics prescribed in primary care (previously 11.3 per cent) or to reduce by 20 per cent from 2014/15 value (previously 10 per cent from 2013/14 value).

RECENT NICE GUIDANCE TO ENCOURAGE MORE APPROPRIATE ANTIBIOTIC PRESCRIBING

- **Quality Standard 61**: Infection prevention and control [April 2014]¹²
- **Clinical Guideline 191**: Pneumonia in adults: diagnosis and management [December 2014]⁹
- **NICE Guideline 15**: Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use [August 2015]³
- **Quality Standard 121**: Antimicrobial stewardship [April 2016]¹³

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THE ROLE OF PRIMARY CARE

The Quality Premium measure is now entirely focused on primary care, reflecting the significance of achieving improved prescribing behaviour in the sector. Primary care represents the first point of contact in the NHS for most patients, particularly those presenting with minor ailments such as common coughs and colds - conditions for which antibiotics are often expected but in reality are of no benefit. This is reflected by the proportion of antibiotics prescribed in primary care, with the latest data from PHE indicating that 74 per cent of all prescriptions are provided in the primary care setting.5

With this in mind, the introduction of the new Antibiotic Quality Premium measure should be welcomed, particularly as it demonstrates that improvements are being made in primary care prescribing practice. This is also an assessment supported by the latest available statistics from Antibiotics Research UK, showing that antibiotic prescribing by GPs has dropped to their lowest levels in five years, with 36.5m prescribed in 2015, compared to 36.75m in 2011 and from a peak in 2013, when 37.92m antibiotics were given out to patients.16

The publication of data depicting how well this new measure is being achieved is eagerly awaited by the Patients Association, however there is clearly much more that needs to be done across the primary care setting, especially considering that significant levels of deprivation-linked variation in prescribing remain. Antibiotic prescribing levels in Clacton-on-Sea for instance, the UK’s most deprived area, are almost twice the national average, whilst there are 21 per cent fewer antibiotics prescribed in London compared to northern England.16 This is something that has been acknowledged by the Royal College of General Practitioner’s Chair, Dr Maureen Baker.

It has also been recognised by PHE, who in April 2016 provided an update to their ‘fingertips portal’, which for the first time provides GPs with the ability to digitally compare the amount of antibiotics their surgery is prescribing with others, both within their individual CCG and across England as a whole. This will hopefully lead to GPs in high prescribing areas reducing the number of antibiotics handed out to patients and beginning to change their prescribing approach as well.17

Antimicrobial resistance remains a huge global concern and we, as GPs, still have a lot to do to try and curb this worrying trend.

Dr Maureen Baker, Chair of the Royal College of General Practitioners and a GP in Lincoln, November 201516

We’re giving GPs the power to see the latest data on how many antibiotics their peers are prescribing. I want to see antibiotics being prescribed only when necessary and hope this will be a new weapon to help GPs cut the numbers of antibiotics needlessly being given out.

Secretary of State for Health, Rt Hon Jeremy Hunt MP, commenting on the fingertips portal announcement, April 201617
C-REACTIVE PROTEIN POINT OF CARE TESTING: PART OF THE SOLUTION?

Consideration of the use of C-Reactive protein point of care testing (CRP POCT) in primary care settings is recommended within existing NICE guidance, as well as within the RCGP TARGET Toolkit. CRP POCT can help practitioners determine whether a patient needs antibiotics and involves the measurement of the level of C-reactive protein in the patient’s blood, which increases significantly as part of the body’s natural response to bacterial infection. Viruses cause most coughs, colds and other respiratory tract infections (RTIs), against which antibiotics have no effect and are unable to reduce symptoms.

Used alongside signs, symptoms and history taking however, CRP POCT can help practitioners prescribe antibiotics more effectively, reducing the risk of increased AMR. The test itself takes only a few minutes and can be performed during a consultation. Many other European countries already use CRP POCT on a much more frequent basis to decide whether antibiotics are needed when patients present with coughs, colds and chest infections, and a number of these countries also report lower occurrences of antibiotic resistance in comparison to the UK.

Whilst many policymakers have spoken about the importance of developing new antibiotics and diagnostic tools to help combat the threat of AMR, it is important that existing evidence-based interventions are also positioned as part of the solution, particularly those that have already demonstrated success in a UK-setting.

To achieve a long-term solution we also need better rapid diagnostics that will cut the vast amounts of unnecessary antibiotic use.

Rt Hon. George Osborne MP, April 2016

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The most interesting part for me was if I didn’t prescribe antibiotics last winter when patients came in with their chesty coughs, a quarter would come back and they would present to a GP, out-of-hours, or A&E.

And now, if I don’t prescribe and have done the CRP test, only half that number come back, so my re-attendance rates are really reduced.

The pilot is also cost-neutral, meaning the project is sustainable and patients get better quality care.

Liz Cross, NHS Innovation Prize award winner and advanced nurse practitioner, Attenborough Surgery, Hertfordshire, Herts Valley CCG
Considering the breadth of recently published commissioner-focused AMS guidance, and with CCGs increasingly assuming ‘co-commissioning’ arrangements in the area of primary care alongside NHS England, CCGs clearly represent an essential part of the healthcare system in terms of delivering the change that is needed to promote improved antibiotic prescribing behaviour, and helping to minimise the patient safety threat of AMR.

With this in mind, and to develop an improved understanding of the extent to which CCGs are implementing a number of key AMS patient safety levers, the Patients Association developed and sent a set of Freedom of Information (FOI) requests to all 209 CCGs across England. The questions that formed the basis of the requests were developed with insight from expert members of the Straight to the Point! consensus panel and sought to identify:

- Whether a local Antimicrobial Stewardship programme is in place and if so, for how long
- If there is a named individual responsible for the implementation of a local Antimicrobial Stewardship programme
- To what extent the recommendations included within NICE Antimicrobial Stewardship guidelines have been implemented
- If the Public Health England Antimicrobial Stewardship Patient Safety Alert had been actioned
- Which components of the RCGP TARGET Antibiotics toolkit have been implemented
- Whether a feasibility study has been carried out on the cost implications for implementing C-Reactive Protein Point of Care Testing

In total, the requests elicited responses from 144 CCGs within the statutory window of 20 working days, representing an overall response rate of 67 per cent.*

**THE STRAIGHT TO THE POINT! CONSENSUS PANEL**

In 2015, a multidisciplinary panel of leading healthcare professionals, researchers and experts met to discuss the danger posed by growing levels of antimicrobial resistance, with the aim of reaching a consensus around the opportunity for an increased use of C-Reactive Protein point of care testing (CRP POCT) within the NHS to act as a solution to this challenge. A consensus report, informed by the panel’s deliberations, was produced in June 2015 and recommended that an increased use of CRP POCT in primary care could reduce the number of antibiotic prescriptions by up to 10 million each year and could save £56 million a year in prescribing and dispensing costs alone.19

The Straight to the Point! consensus panel helped inform the development of the final set of FOI requests through a series of teleconferences and advice. These questions however should not be attributed to the consensus panel, and nor does the evaluation of the responses received necessarily represent the views of those individuals involved.

* This includes 2 responses from CCGs received 21 working days after the requests were sent out. After this period, no more responses were factored into the analysis.
RESULTS

The responses to the FOI requests sent to CCGs demonstrated that there is something of a mixed picture in terms of uptake of key AMS guidance across the country. Of the 144 CCGs who responded to the requests, it appears that a number of areas are clearly adopting a proactive approach in terms of putting in place effective responses to the threat of AMR, through the introduction of comprehensive and well-coordinated AMS programmes, implementation of key NICE guidance and use of diagnostic tools in primary care, such as CRP POCT. That said, there were also a number of CCGs for whom their AMS strategies seemed to be much less well developed, with some areas yet to action important NICE recommendations, tools such as the RCGP’s multi-component TARGET Antibiotics Toolkit, or even have an AMS programme in place at all.

This segment of the report sets out these results in further detail and draws on a number of comments that were provided as additional information by CCGs in their responses.

IMPLEMENTING NICE GUIDANCE

NICE Guideline 15 ‘Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use’ (NG 15) was published in August 2015 and encompasses a number of key recommendations that are designed to positively influence antibiotic prescribing practice and help slow the emergence of AMR.3 The guidance is targeted at those working across the healthcare system and implementation falls under the responsibility of commissioners and providers.

Results from the Patients Association’s FOI requests revealed that only 12 per cent of CCGs had implemented all the recommendations contained within the guidance, with the overwhelming majority (82 per cent) saying that they had partially implemented them. Of the CCGs who responded, 6 per cent said they had yet to begin implementing any of the recommendations contained within the guidance, despite it having been identified as a key means of improving antimicrobial stewardship.

The responses showed that a number of CCGs who had indicated they had partially implemented the recommendations from NG 15 were aiming to implement the remaining areas throughout the year.

Other responses suggested that the success they have had in delivering effective local stewardship plans were dependent on the efforts of an individual within the local CCG, rather than necessarily being a direct result of NICE guidelines themselves.

Whilst the broad narrative put forward by CCGs in their responses was generally positive, in terms of recognising the value of the guidelines and having aspirations to implement further aspects of them, most CCGs did not provide an indication of the anticipated timelines for this. Analysis of the results also showed that the CCGs who had not yet begun to implement NG 15 were also significantly less likely to have enacted other key AMS levers as well. 86 per cent of CCGs who reported not having implemented any aspects of the NG 15 guidelines also failed to have a local AMS programme in place, whilst half of this cohort hadn’t implemented any aspects of the RCGP TARGET toolkit. These respondents were similarly less likely to have completed the actions set out in Public Health England’s Patient Safety Alert.

"We have partially implemented these recommendations the anti-microbial stewardship group will support the development of a work plan in 2016 to fully implement all the recommendations.

CCG with ‘partial’ implementation of the guidance"
We have an antibiotic specialist pharmacist post which works across the primary/secondary care interface. We have done well with performance against local and Quality Premium targets but this success is due to the diligence of this post holder rather than just the presence of any of the aforementioned strategies.

### CCG with ‘partial’ implementation of the guidance

To what extent has your Clinical Commissioning Group implemented the recommendations contained within NICE Guideline 15 ‘Antimicrobial Stewardship’?

Answered: 136  Skipped: 8

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<tr>
<th>Percentage</th>
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<tr>
<td>100%</td>
<td>Clinical Commissioning Group has implemented all NG15 recommendations as standard</td>
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<tr>
<td>82.35%</td>
<td>Clinical Commissioning Group has partially implemented/is in the process of implementing NG15 recommendations</td>
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<tr>
<td>5.88%</td>
<td>Clinical Commissioning Group has not begun to implement NG15 recommendations</td>
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### AREAS OF CONCERN

Six Clinical Commissioning Groups responded saying they did not have a local antimicrobial stewardship programme in place, and nor had they begun to implement the recommendations from NICE Guideline 15.
LOCAL ANTIMICROBIAL STEWARDSHIP PROGRAMMES

Embedding coordinated and effective antimicrobial stewardship programmes across the healthcare system at both a national and local level has been identified by policymakers as a key way of ensuring more appropriate antibiotic prescribing.

Locally, CCGs are key organisations in the delivery of AMS programmes and this is reflected in NG 15, which recommends that commissioners and providers establish antimicrobial stewardship programmes in their respective locality.3 The guideline also recommends that commissioners ensure roles, responsibilities and accountabilities are clearly defined within antimicrobial stewardship programmes.

The responses received to the requests revealed that whilst the majority of CCGs do have an AMS programme in place, worryingly, one in ten CCGs said they did not have a programme in place at all. Failing to put in place an AMS programme indicates that patients are being put at an unnecessarily increased risk of being given poorer prescribing decision, and have a greater likelihood therefore of acquiring treatment-resistant infections.

One CCG indicated that whilst they did not necessarily have a ‘formal’ stewardship programme in place, the CCG commissions others to deliver core monitoring and review mechanisms.

How long has your local antimicrobial stewardship programme been in place for?

Answered: 136  Skipped: 8

For the CCGs who did have an AMS programme in place, the majority of these programmes (62 per cent) have been in place for over a year. The next most common timeframe of AMS programme implementation was 9-12 months (12 per cent). 3 per cent of CCGs reported that an AMS programme had been established as recently as 0-3 months.

We do not have a formal ‘stewardship programme’, however, the CCG commissions a Prescribing and Medicines Optimisation Service (PMOS) service which has monitored antibiotic usage at practice and locality level for a number of years. An annually updated “Guidelines for the treatment of commonly occurring infections in primary care” is issued to all practices. Monthly monitoring at practice level is shared and discussed with all practices.

CCG without a formal antimicrobial stewardship programme in place
CCGs were also asked whether a named individual was in place to oversee the implementation of their local antimicrobial stewardship programme. Guidance from PHE suggests that AMS leadership roles should be established across the local health pathway (PHE Safety Alert), however almost a third of CCGs (31 per cent) were unable to confirm that this was the case.

For the CCGs who did confirm that leadership roles were in place for the implementation of local AMS programmes, the responses revealed that in many cases responsibility for the role was split between several individuals, often involving a combination of the local head of medicines management, the pharmacy prescribing lead and the chief infection control nurse. Information provided suggested that such an approach helped facilitate better joint working across the local healthcare pathway.

However, the fact that almost a third of CCGs were not able to provide details of an individual with responsibility for their local AMS programme, or whether alternative arrangements are in place, raises concerns about how effectively some programmes are being implemented, and also whether this potentially jeopardises the ability for local areas to respond swiftly to emerging AMR challenges, or embed best practice from other areas.

**Does your Clinical Commissioning Group have a named individual responsible for the implementation of a local antimicrobial stewardship programme?**

Answered: 143  Skipped: 1

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This responsibility is shared between the Infection Prevention Lead and the Associate Director – Medicines Management

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In August 2015 PHE issued the Patient Safety Alert ‘Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme’. The Alert, comprised of three distinct actions for the attention of organisations involved in providing NHS funded care where antibiotics are prescribed, dispensed or administered, was issued in order to highlight the challenge of AMR and to signpost the resources that have been developed by PHE to support the NHS in improving antimicrobial stewardship in both primary and secondary care. The Alert was released on 18th August 2015, with an expected completion due date for 31st March 2016.

Broadly speaking, most CCGs appeared to have met the requirements of the Patient Safety Alert and actioned each of its components. Of those who responded, 93 per cent of CCGs had brought the Alert to the attention of those holding leadership roles for antimicrobial stewardship within the area; 93 per cent had reviewed the resources signposted in the Alert and through linking with organisational or cross-system antimicrobial stewardship teams/committees, or equivalent, had identified how the resources could be used to support local antimicrobial stewardship programme; and 95 per cent had either circulated the Alert or through local alternatives (such as newsletters, local awareness campaigns etc.) ensured that staff were aware of the key antimicrobial stewardship messages and resources relevant to their clinical practice.

The CCG monitors antimicrobial stewardship through partnership working (for example a CCG representative attends a local trusts antimicrobial stewardship committee meeting twice yearly) and acute trust contracts. In primary care the CCG promotes antimicrobial stewardship through educational bulletins, events and audit.

Has your Clinical Commissioning Group completed the following actions set out within the Public Health England Patient Safety Alert ‘Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme’?

Answered: 130  Skipped: 14

| Action 1: Bring this Alert to the attention of those holding leadership roles for antimicrobial stewardship in your organisation. | 93.08% |
| Action 2: Review the resources signposted in this Alert and through linking with organisational or cross-system antimicrobial stewardship teams/committees, or equivalent, identify how the resources can be used to support your local antimicrobial stewardship programme. | 92.31% |
| Action 3: By either circulating this Alert or through local alternatives (such as newsletters, local awareness campaigns etc.) ensure that staff are aware of the key antimicrobial stewardship messages and resources relevant to their clinical practice. | 95.38% |
IMPLEMENTING THE RCGP TARGET TOOLKIT

Launched by the Royal College of General Practitioners in 2012, the TARGET Antibiotics Toolkit (Treat Antibiotics Responsibly, Guidance and Education Tool), was developed by the Antimicrobial Stewardship in Primary Care (ASPIC) collaboration as a means of influencing the attitudes and behaviour of prescribers and ultimately helping to support the optimisation of antibiotic prescribing in primary care. 4 Designed to be used across the whole primary care team, the toolkit is comprised of seven distinct elements, including training resources for healthcare professionals, information leaflets for patients and audit materials designed to monitor the implementation. The Toolkit also recommends the use of CRP POCT as an effective means of improving antibiotic prescribing practice.

The value of using the Toolkit is articulated within NG 15 and the Toolkit aligns with the recommendations included within the guidance itself. The resource has also been endorsed by PHE and the Department of Health.

Despite a recommendation that all components of the Toolkit are implemented locally, the responses received to the FOI requests demonstrates that uptake amongst CCGs is variable, and there is still a considerable way to go before the Toolkit’s components are adopted as standard.

Less than a quarter of CCGs (23 per cent) have implemented all aspects of the Toolkit, and there are varied rates of uptake for the Toolkit’s individual components, with many of the aspects having been adopted in less than half of CCG localities. Only 40 per cent of CCGs said that training resources had been shared with staff, whilst over a third had not yet facilitated the sharing of leaflets with patients. These are designed to be shared at consultation stage and improve confidence in self-care and reasoning behind a prescribing decision and have been identified as a particularly useful resource by some CCGs.

“Leaflets for patients [are the] most helpful [component] and have been included into the GPs clinical system for easy access during consultations.”

CCG TARGET Toolkit response
The responses did show that there are clearly a number of CCGs who are doing well in terms of implementing the Toolkit, and almost a quarter of those who responded (24 per cent) said they had implemented all of its aspects within their local area. Encouragingly, many CCGs also appeared to be going above and beyond what the Toolkit recommends, as the following response indicates.

That said, there does appear to be a need for greater support to be provided to the areas who are not using the TARGET Toolkit optimally, and there is arguably an opportunity for learnings to be drawn from the CCGs who are making best use of it.

We have also made a pledge to be Antibiotic Guardians as an organisation and as individual HCPs have produced locally approved guidance for effective utilisation of AMS across primary care. [We] send out regular updates regarding our prescribing profile for total antibiotics prescribed including prescribing trends for our broad spectrum antibiotic prescribing. [We have] worked closely with secondary care to ensure effective implementation of NHS/PSA/Re/2015/007 [We] support secondary care with Commissioning for Quality and innovation (CQUIN) 2016/17.

CCG TARGET Toolkit response

Which of the following components of the RCGP TARGET Antibiotics toolkit have you implemented within your Clinical Commissioning Group area, as listed in the supporting RCGP document: ‘For Prescribers and Commissioning Organisations’?

Answered: 137  Skipped: 7
UTILISING C-REACTIVE PROTEIN POINT OF CARE TESTING

Considering the use of a C-Reactive protein point of care test (CRP POCT) for people presenting in primary care with symptoms of lower respiratory tract infection (LRTI) and evaluating its cost implications was included as a key recommendation within NICE Guidance CG 191 “Pneumonia in adults: diagnosis and management”, which was published in December 2014, and is also included within NICE Guideline 15. CRP POCT is a proven and cost-effective means of reducing inappropriate antibiotic prescribing in primary care and its use supports ambitions to improve patient safety and reduce the threat of increased AMR. 7,18

The results of the FOI requests revealed that less than a fifth of CCGs (19 per cent) had carried out a feasibility test on the potential introduction of CRP POCT locally. Almost a third of respondents (30 per cent) said that they had not carried out a feasibility study so far but planned to do so, whilst over half (51 per cent) said that they had not carried out a feasibility study and had no plans to do so.

A recurring theme from the responses provided by CCGs were concerns around securing funding to introduce CRP POCT, especially in light of the wider financial pressures that they are already under. Several of the areas, who were planning on introducing CRP testing in some capacity, were doing so because they had received funding from external sources, such as NHS England’s Primary Care Infrastructure Fund. Some CCGs undertaking the pilots also stated that they expected rolling out the use of CRP POCT would help support ambitions to achieve a reduction in the prescribing of antibiotics for LRTIs; reduce GP appointments and fulfilment of delayed prescriptions and achieve a decrease in costs as well. There was also an expectation that CRP POCT would help increase patient understanding and reassurance of their presenting condition, something that could be measured through the use of patient audits.

Whilst it is encouraging that almost half of CCGs (49 per cent) either had or were planning on carrying out a feasibility study on the cost implications for implementing CRP POCT within their commissioning area, it appears that even greater uptake could be achieved through the provision of additional financial support from NHS England.

In doing so, efforts to reduce inappropriate antibiotic prescribing in primary care, a key driver of AMR, would be strengthened significantly.
The CCG has secured some Primary Care Infrastructure Funding from NHS England to trial point of care testing of respiratory tract infections (RTI)... As part of the joint working between the two Medicines Management Teams, the outcomes will be shared with [the neighbouring] CCG. The trial will run in 10 GP practices for three months starting September 2016. The primary aim of the initiative is to reduce the prescribing of antibiotics for RTI which will lead to a reduction in costs.

CCG response on whether a feasibility study has been carried out for CRP POCT
CONCLUSIONS

Addressing the threat of AMR is a challenge for policymakers, the NHS and wider society in general. With that in mind, the Patients Association designed these FOI requests to better understand how successfully CCGs, key organisations in terms of implementing AMS programmes at a local level, were playing their part. As the results to these requests demonstrate, whilst there are encouraging signs that a number of areas are doing very well in delivering upon the expectations set out by NICE, and adopting available policy initiatives and existing solutions to improve prescribing behaviour, this is not the case everywhere.

More focus needs to be given not just to the development of new guidance and resources, but also on how to drive forward the uptake of already existing solutions, which provide a considerable wealth of best practice and expertise for CCGs to draw upon when considering how to improve their AMS efforts. These solutions take the form of the RCGP’s TARGET Antibiotics Toolkit for instance, which contains a broad range of helpful and outcome-focused components to support local stewardship efforts. Diagnostic testing has also been shown to support efforts to improve antibiotic prescribing behaviour, with CRP POCT in primary care representing a particularly effective example of this.

Putting this extra support in place will not only provide greater encouragement to mobilise other countries into action, but will also minimise the risk of increased resistance within the UK, reduce costs for the NHS and ultimately, help to safeguard the health of our patients.
3 NICE Guideline 15. Antimicrobial stewardship: systems and processes for effective antimicrobial medicines use. August 2015. Available online at: https://www.nice.org.uk/guidance/ng15
ANNEX 1:

FREEDOM OF INFORMATION REQUESTS

The following set of FOI requests were sent to all Clinical Commissioning Groups across England to inform the production of this report:

1. Does your Clinical Commissioning Group have a named individual responsible for the implementation of a local antimicrobial stewardship programme?
   - If yes, could you please provide the name and the job title of the individual here:

   - Action 1: Bring this Alert to the attention of those holding leadership roles for antimicrobial stewardship in your organisation.
   - Action 2: Review the resources signposted in this Alert and through linking with organisational or cross-system antimicrobial stewardship teams/committees, or equivalent, identify how the resources can be used to support your local antimicrobial stewardship programme.
   - Action 3: By either circulating this Alert or through local alternatives (such as newsletters, local awareness campaigns etc.) ensure that staff are aware of the key antimicrobial stewardship messages and resources relevant to their clinical practice.
   - Please provide information on how your Clinical Commissioning Group monitors the implementation and uptake of these actions here:

3. How long has your local antimicrobial stewardship programme been in place for?
   - A. 0-3 months
   - B. 3-6 months
   - C. 6-9 months
   - D. 9-12 months
   - E. Over a year
   - F. We do not have a local antimicrobial stewardship programme

4. Which of the following components of the RCGP TARGET Antibiotics toolkit have you implemented within your Clinical Commissioning Group area (as listed in the supporting RCGP document: For Prescribers and Commissioning Organisations, January 2015):
A. Interactive workshop presentation and clinical eModule (4.1)
B. Leaflets shared with patients (4.2)
C. Audit toolkits (4.3)
D. National antibiotic management guidance (4.4)
E. Training resources (4.5)
F. Resources for clinical and waiting areas (series of posters and videos that can be used to change patient expectations for antibiotics) (4.6)
G. Self-assessment checklist (4.7)
H. All of the above
I. None of the above

• Please include any further information you may wish to provide here:

5. To what extent has your Clinical Commissioning Group implemented the recommendations contained within NICE Guideline 15 ‘Antimicrobial Stewardship’ (August 2015: https://www.nice.org.uk/guidance/ng15):
   A. Clinical Commissioning Group has implemented all NG15 recommendations as standard
   B. Clinical Commissioning Group has partially implemented/is in the process of implementing NG15 recommendations
   C. Clinical Commissioning Group has not begun to implement NG15 recommendations

• If available, please provide the name and position of the individual within your Clinical Commissioning Group responsible for the implementation of these specific guidelines. Please also include any further information you may wish to provide here:

6. Please confirm whether a feasibility study has been carried out on the cost implications for implementing C-Reactive Protein Point of Care testing within your Clinical Commissioning Group area, as is set out as a recommendation within NICE Guidance CG191 (December 2014: https://www.nice.org.uk/guidance/cg191).
   A. Yes
   B. No
   C. No but planning to carry out feasibility study

• If a feasibility study has been carried out, when did this take place? Please include any further information you may wish to provide here:
DEAR SIR/MADAM,

Antimicrobial resistance has been identified by the Government as one of the most significant challenges facing our society and represents a growing threat to the foundations of modern medicine.

As part of the Patient Association’s ongoing commitment to address the challenge posed by antimicrobial resistance, and through the supporting work of the All Party Parliamentary Group on Patient Safety, we are carrying out an investigation into the uptake and implementation of a number of key antimicrobial stewardship policy initiatives by Clinical Commissioning Groups.

The specific questions are laid out below this letter and are also accessible via the following ‘SurveyMonkey’ link, if it is easier for you to provide the requested information in this way: https://www.surveymonkey.co.uk/r/KKYRDSZ

The Patients Association would like to obtain this information under a Freedom of Information Act 2000 Request. I expect your response within the statutory period of 20 working days.

Yours Faithfully,

Katherine Murphy,
Chief Executive
The Patients Association
www.patients-association.com
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