Joint Statement on Antimicrobial Resistance

The UK Faculty of Public Health (FPH), the Royal College of Physicians (RCP), the Royal Pharmaceutical Society (RPS), the Royal College of Nursing (RCN) and the Royal College of General Practitioners (RCGP)
Acknowledgements

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## Summary of recommendations

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<td>2. Healthcare and public health professionals have a professional duty to help educate patients and the public in minimising the use of unnecessary antibiotics</td>
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Introduction

Antimicrobial resistance (AMR) is one of the greatest health and public health challenges of our time. If we do not take action now, rates of resistance will continue to increase; we then face the real possibility that infections will become more difficult to treat, and that large swathes of modern medicine will become untenable.

Our professional bodies endorse the recommendations in the Chief Medical Officer for England’s report\(^1\) on the ‘State of the Public Health’ calling for action in this area. We also support the three strategic aims outlined in the Department of Health’s UK Five Year Antimicrobial Resistance Strategy to:

- improve the knowledge and understanding of AMR across healthcare professions and the public
- conserve and steward the effectiveness of existing treatments
- stimulate the development of new antibiotics, diagnostics and novel therapies.\(^2\)

The analogy of antimicrobials, particularly antibiotics, as a natural resource is very appropriate. Antimicrobials (especially antibiotics, which are used to treat bacterial infections) should be considered a limited and precious resource. Even when used appropriately, nature will follow its evolutionary course leading to genetic variation in microbes and the development of resistance. Inappropriate use increases the potential for and rate that resistance develops, and will deplete the availability of antimicrobial drugs even faster. This is a truly global issue because use and inappropriate use in different counties will impact on all of us.

The actions necessary to address this problem require a response on multiple levels including on an individual, organisational, national and global level, and in all settings where antibiotic use occurs (including agricultural and veterinarian settings, but particularly in the primary care setting were as much as 80% of prescribing for humans occurs). There are clearly a number of research and surveillance needs that should be addressed, such as reinvigorating the antibiotic development pipeline and investing in more fit-for-purpose surveillance, including linking the monitoring of resistance and antimicrobial prescribing. However, our recommendations for action focus on those areas where there is the potential for immediate action.

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Our position

The professional bodies supporting this joint statement consider that action must be taken collegiately by the professions, commissioners, service providers, quality assurance bodies and regulators across the UK to reduce the threat of AMR. Leadership and action must be taken at local, regional, national and international level in support of the AMR strategy, and to tackle this issue in a concerted manner.

Actions

Local level

1) Personal responsibility: health and public health professionals need to take action to enable changes in culture around antibiotic prescribing and use across all settings. The attitude whereby use of antimicrobials is seen as a ‘better safe than sorry’ option needs to be challenged. Senior leaders, including medical directors, Clinical Commissioning Group (CCG) chairs and directors of public health, need to support and empower prescribers, and other health and public health professionals who advise on prescribing decisions, to make the decision not to prescribe where other appropriate strategies exist such as ‘watchful waiting’ or delayed prescribing.

2) All health and public health professionals have a duty to educate and engage with patients and the public about the steps they can take to reduce possible risks of infection, and how they can minimise unnecessary use of antibiotics.

Organisational level

3) Antimicrobial stewardship should become a measure of quality in local systems. The key aims of good antimicrobial stewardship are:

   a) To optimise therapy for individual patients

   b) To prevent overuse, misuse and abuse

   c) To minimise development of resistance at patient and community levels.³

Resources to help improve prescribing are now widely available and should be implemented fully to support effective antibiotic prescribing. Examples, which can be seen across England, Wales, Scotland and Northern Ireland, include:

   • the RCGP and Public Health England’s TARGET Antibiotics toolkit⁴
   • the RCP’s Top Ten Tips⁵

⁵ www.rcplondon.ac.uk/resources/top-ten-tips-series.
• Public Health England and the Expert Committee on Antimicrobial Resistance and Healthcare Associated Infection’s Antimicrobial Prescribing and Stewardship Competencies
• Department of Health’s (England) Start Smart then Focus
• NHS Wales and Public Health Wales Start Smart then Focus
• Scottish Antimicrobial Prescribing Group (SAPG) guidance
• Northern Ireland Strategy for Tackling Antimicrobial Resistance (STAR)
  o Northern Ireland Antimicrobial Guidelines for Primary Care 2013
  o Northern Ireland Antimicrobial Guidelines for Secondary Care 2013.

4) Across the UK, antimicrobial stewardship and optimal prescribing must be adopted as a priority for all commissioning systems and provider organisations.

Commissioning must be strengthened and informed through inter-organisational involvement and engagement. This includes ensuring roles and responsibilities are clear for organisations such as health and wellbeing boards, clinical senates, clinical networks, professional bodies and the National Institute for Health and Care Excellence as well as those involved with commissioning and assurance roles.

5) Equivalent bodies in the devolved administrations with responsibilities for ensuring quality of care should also take on this role.

National

6) Antimicrobial prescribing data should be monitored in healthcare and other relevant settings. Measures of good antimicrobial stewardship should be explicitly included as outcomes on which the providers of care are held to account. For example, in England it should be included in the NHS outcomes framework. Health regulator assessments should include assessment of antimicrobial stewardship programmes.

7) Licensing requirements should be changed for new antimicrobials to include data on the minimum dosage required for clinical effectiveness as prescribing guidance is often based on the licensing data.

8) Veterinary and agricultural use of antimicrobials is driving resistance in organisms affecting human health, but the extent to which they are creating problems remains hotly debated. The principle of overuse of a scarce resource applies to veterinary and agricultural use setting as much as to humans.

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7 www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus
9 www.scottishmedicines.org.uk/SAPG/Quality_Improvement/Hospital_Prescribing_Guidance
10 www.dhsspsni.gov.uk/health_protection-antimicrobial_resistance
The practice of using antibiotics as a growth promoter in animals is a particularly important cause of overuse that is banned in the UK and the EU but remains common practice elsewhere internationally. An immediate national policy requirement for labelling food produced using antibiotics as growth promoters would give consumers choice around this issue. Economic incentives to reduce the international misuse of antibiotics in animal production could potentially make local producers, who are currently penalised for their better practice, more commercially competitive. Similarly, tighter regulation needs consideration for the use of antimicrobials in crop production.11

International

9) Action needs to be taken to reinvigorate the development of new antibiotics and their alternatives. Public funding alone should not address the market failure. Co-public investment should include mechanisms that ensure that the use of new antibiotics is ‘reserved’ (i.e. only used in the most serious cases, where immunity is compromised, or as a last-resort antibiotic).

10) The spread of resistant organisms in both healthy and unhealthy individuals due to environmental factors (e.g. inadequate sewage systems) is becoming clearer. The inappropriate use of antibiotics (often due to poverty and lack of access to appropriate or alternative modes of treatment) in people affected by illnesses that can be protected against by immunisation is not just an ethical travesty but also of material harm, both to the country in which it occurs and to all other countries through the spread of avoidable disease. Renewed action is needed to improve prevention of infectious and tropical diseases in developing countries (e.g. through vaccination programmes).

Call to action

We invite individual professionals and organisations to take action. Action at the local and regional level will require that individuals seek to make a difference in their own professional practice and activities as well as engaging with local structures. However, as organisations we will look to promote this agenda at the national level including joint action in support of the relevant recommendations in the Chief Medical Officer’s report, and at an international level we propose to undertake a strong advocacy role for change in the global arena.

Also, we would ask individuals, professionals and organisations to express your support for this joint statement and endorse its recommendations. You may do this by contacting CIRC@rcgp.org.uk.