Review of Clostridium Difficile Infection

Personal and Health Services Scrutiny Panel

July 2012

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Introduction by the Chair

I am pleased to present this report of a review undertaken by the Personal and Health Services Scrutiny Panel into Clostridium Difficile Infection and prescribing practices in acute and primary care settings within Tameside.

The North West has the highest rate of C.difficile infection at 15% of the UK total.

Tameside had the second highest rate of C.difficile infection incidences recorded amongst neighbouring authorities between January - March 2011.

The causative factor behind C.difficile infection is the over prescribing of antibiotics. Tameside's incidence of antibiotic prescribing is consistently higher than comparable Local, Regional and National figures.

Much work has been undertaken within Tameside to help reduce the cases of C.difficile infection and through continued education, monitoring and understanding we can ensure targets such as the Health Care Associated Infection (HCAI) reduction plans can be achieved.

Over prescribing of antibiotics is being targeted by prescribing teams within Tameside and Glossop. There needs to be a change towards more focussed prescribing using the right antibiotics in the right situations. The Panel is pleased to hear of the many interventions, educational material, processes and policies that are being implemented within Tameside and Glossop in order to tackle the incidents of C.difficile infection.

As part of its overview function, the Personal and Health Services Scrutiny Panel will continue to monitor the effectiveness of services to reduce C.difficile infection within Tameside.

On behalf of the Panel I would like to thank contributors to the review for their insight, expertise and assistance.

Councillor Brenda Warrington
Chair of the Personal and Health Services Scrutiny Panel

2. Summary

C.Difficile is a bacterium that lives in the gut and can be found in 3% of healthy adults and 66% of infants. C.Difficile rarely causes problems in healthy adults and children as it is controlled by normal bacteria within the intestines. The use of antibiotics can upset the balance of bacteria and cause C.difficile to multiply producing toxins. The toxin can cause diarrhoea and inflammation of the bowel which can be serious and in some cases lead to fatalities. The infection is also capable of forming spores, which can lead to spreading in poor hygiene controlled environments.

CDI is a Health Care Associated Infection (HCAI) and can be acquired in hospital or similar health care settings such as nursing/care homes or at home as a consequence of health care intervention. The reduction of CDI is a national target for HCAI's for Primary Care organisations and acute hospitals.

Historically Tameside has had a high level of overall antibiotic prescribing but measures identified within this review have reduced the level of prescribing to average. Tameside is identified as being average in relation to Greater Manchester prescribing frequency of all antibiotics between 2007 and 2011 compared to other Greater Manchester Authorities, the North West, the North of England and England as a whole. The prescribing of antibiotics in relation to CDI has dropped significantly within Tameside and Glossop between 2007 and 2011.

Those individuals more likely to contract the infection are older (65+) individuals, with possible long term illnesses such as chest and heart conditions and those approaching the end of their life.

There is a vast knowledge and understanding around the issues surrounding CDI; however, it is the issues around over prescribing that need to be addressed. Root Cause Analysis (RCA) is used to record the cases of avoidable and unavoidable cases. This enables analyses to establish whether there is a higher ratio of unavoidable cases being identified rather than avoidable cases.

3. Membership of the Scrutiny Panel

(2011-2012)
Councillor B Warrington (Chair), Councillor D Cartwright (Deputy Chair) Councillors R Ambler, M Bailey, J Bowerman, W Bray, J Brazil, D Buckley, M Downs, J Middleton, E Shorrock.

4. Terms of Reference

Aim of the Review:

To assess the root causes of Tameside's high incidence of C.difficile infection and recommend measures to reduce the rate of infection within Tameside.

Objectives:

- To examine the causes of Tameside's (and the North West's) high rate of C.difficile
- To assess mechanisms and measures that can be undertaken to reduce the rate.
- To ensure that reducing C.difficile remains a focus for the local health economy.

Value for Money/use of Resources:

The review will support appropriate prescribing practices in acute and primary care settings, which should reduce expenditure incurred from over-prescribing. Through reducing the rate of CDI, cost savings should be made from fewer people being treated for the infection, with a reduction in hospital admissions and length of stay.

Equalities issues:

C.difficile can affect residents from all sections of Tameside's communities, but the risk may be heightened amongst elderly patients and those taking antibiotics on a regular basis.

Tameside Area Agreements:

Healthy Tameside	
Key Quality of Life Measures	Life Expectancy
	All-age-all-cause-mortality

5. Methodology

5.1 The Panel met with Dr Anna Moloney, Consultant in Public Health Medicine for NHS Tameside and Glossop who provided an overview of CDI and cases identified within Tameside and Glossop compared to regional and national figures.

5.2 Dr John Doldon, Lead for HCAI (Health Care Associated Infections) and the Chair of the Primary Care Medicine Management Committee, provided an update on CDI in a non acute setting.

5.3 Peter Howarth, Head of Medicines Management for NHS Tameside and Glossop attended the Panel providing an insight into prescribing practices within Tameside and Glossop amongst antibiotic pharmacists and the message they are passing to prescribers.

5.4 Philip Dylak, Director of Nursing/Director of Infection Prevention and Control, also presented to the Panel regarding CDI in an acute setting, namely Tameside Hospital and the Hospital's actions to reduce the cases of CDI.

6. Background of the Review

6.1 C.difficile infection is a Health Care Associated Infection (HCAI) and can be acquired in any Hospital, health care environment or at home as a result of health care intervention or procedure.

6.2 C.Difficile is a bacterium that lives in the gut of 3% of healthy adults. The use of antibiotics can upset the balance of good and bad bacteria and C.Difficile can multiply and produce a toxin. The toxin causes diarrhoea and inflammation of the bowel which can be serious and in some cases fatal. CDI is capable of forming spores which can be easily ingested by others. This allows the infection to spread in an environment where hygiene control standards are poor.

6.3 The risk of CDI in a health care setting is higher due to a number of varying contributors, including a high proportion of elderly patients, antibiotic use and the high risk of cross infection within the environment.

- CDI is reducing nationally according to figures available
- The North West has the highest levels of CDI nationally at 15% of the national total
- The Department of Health, sets annual targets for local health organisations based on what they think can be achieved.
- It is normal for the isolation of patients with CDI and release from care does not generally take place until the infection has cleared and they have been seen by an Infection Control Nurse.

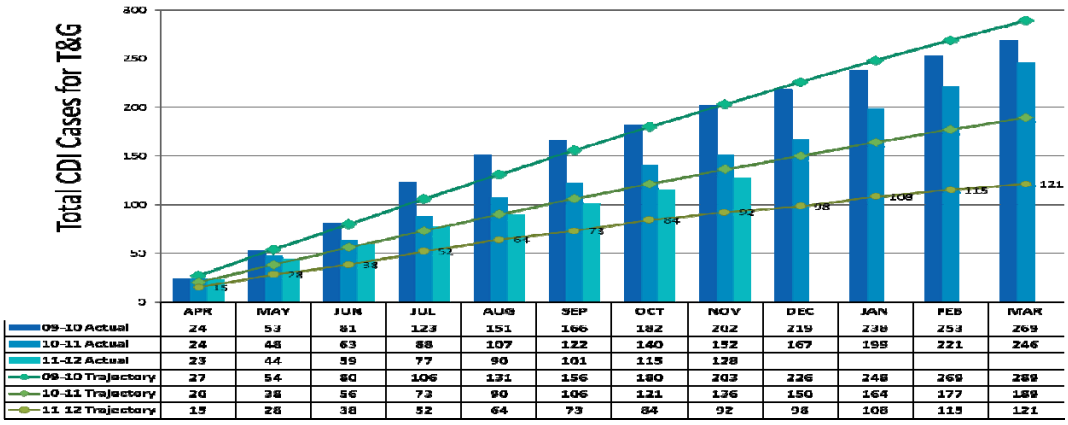
6.4 All NHS Trusts have to report cases of CDI for patients over the age of two, to the Health Protection Agency (HPA). This procedure has been in place since 2007 enabling the HPA to produce monthly and annual counts of rates of CDI. The HPA uses the information submitted to conduct surveillance of the infection and collect information in relation to the rates of CDI, including NHS number, Hospital number, date of birth, and sex, as well as information concerning the patient's location, date of admission, and care details at the time the faecal sample was taken.

7. Review Findings

7.1 **C.Difficile Infection in Tameside**

7.1.1 The reduction of CDI is a national target for HCAI's for Primary Care organisations and Hospitals. These targets are set by the Department of Health. All infections are validated and recorded on a national level. There are instances where cases can appear outside of the PCT but they are still recorded against the PCT to which that patient belongs.

7.1.2 In 2010/11 the number of CDI infections recorded for Tameside and Glossop compared to the trajectory was high, however the number of infections recorded had improved from the previous year (see chart One). The total number of infections for 11/12 is expected to exceed the trajectory set by the Department of Health, however there has been a reduction from the previous two years. Tameside and Glossop's CDI targets are expected to be the same for 2012/13 as they were for 2011/12.



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
09-10 Actual	24	53	81	123	151	166	182	202	219	238	253	269
10-11 Actual	24	48	63	88	107	122	140	152	167	198	221	246
11-12 Actual	23	44	59	77	90	101	115	128				
09-10 Trajectory	27	54	80	106	131	156	180	203	226	248	269	289
10-11 Trajectory	20	36	56	73	90	106	121	136	150	164	177	189
11-12 Trajectory	15	28	38	52	64	73	84	92	98	108	115	121

Chart 1 showing Total number of CDI infections against target 09/10 and 11/12 for Tameside and Glossop

7.1.3 Chart one shows the total number of recorded CDI cases for Tameside and Glossop for the periods 09/10, 10/11, 11/12 in comparison to the trajectory throughout the year. Although the number of CDI has exceeded the trajectory the total number of infections has been continuously decreasing over the last three years.

7.1.4 The accumulative target for Tameside and Glossop for Jan 2012 was 108, this was not achieved as the actual figure for Tameside and Glossop was 156. However, the positive aspect to this is that the figures earlier in the year were high and this has now decreased over the course of the year.

7.1.5 Those individuals more likely to contract the infection are older individuals (65+), with possible long term illnesses such as chest and heart conditions and those approaching the end of their life. Females are also more likely to contract the infection compared to males as identified in chart two (this could however be due to women living longer than men).

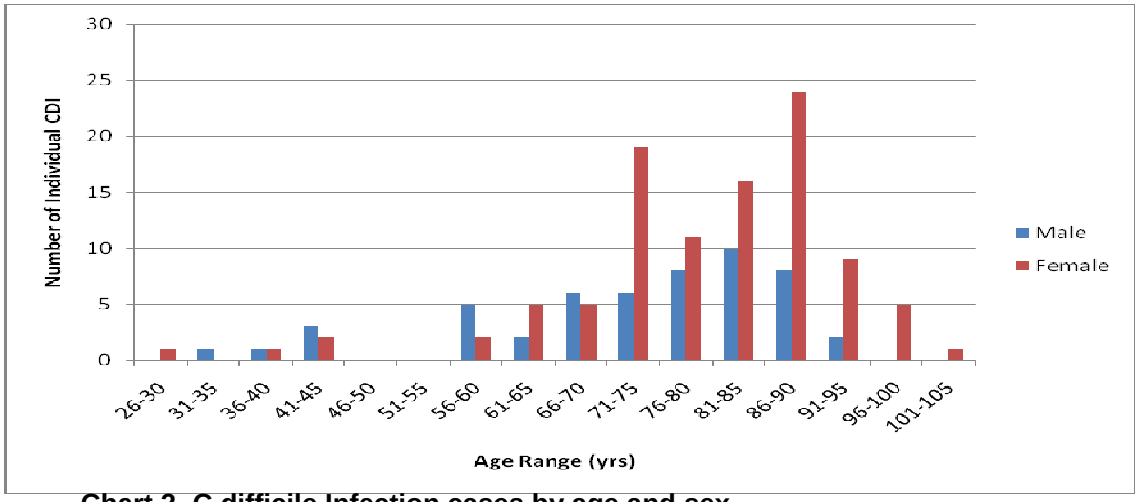


Chart 2- C.difficile Infection cases by age and sex

7.1.6 There are few cases of person to person spread where root cause analysis has identified the infection being picked up due to poor controlled hygiene in the hospital. The main cause of CDI is the over prescribing of antibiotics.

7.1.7 Chart two identifies the number of individual CDI instances recorded between Males and Females and by age comparison. The Chart highlights that females are more likely than males to contract CDI compared to males and there is a marked increase in the number of individuals being recorded as having CDI from 71-90 years of age.

7.1.8 A single patient can be recorded as having CDI twice due to cases of relapse and these are also recorded against the targets. There is a 20-30% chance that symptoms can return up to three months after treatment has been received for the infection. The Tameside and Glossop Infection Control Teams both within Tameside Hospital and in the community are working to reduce the number of unnecessary tests which would affect the figures provided to the Department of Health. The Infection Control Team is continuously working to educate practitioners to ensure testing is not undertaken where they already know an individual has the infection.

7.1.9 Although improvements are being made to tackle CDI, some instances are unavoidable due to issues such as the patient's age and health. The Department of Health produces a six monthly report regarding CDI.

7.1.10 If an individual dies and has had CDI within the last thirty days this is recorded on their death certificate. Although it may not be the cause of death it could be a contributing factor towards their death.

7.1.11 The prescribing of antibiotics in relation to CDI has dropped noticeably within Tameside and Glossop between 2007 and 2011. There have been a number of factors in Tameside contributing to this, including work being undertaken by the Antibiotic Prescribing Teams in Tameside and Glossop, both within the Hospital and in the community. There is still the need to look at each case of CDI individually and undertake root cause analysis in order to establish where the infection originated from.

7.1.12 General screening for CDI is not undertaken as this would not be cost effective and only a small proportion of people have C.Difficile. The increase in antibiotic prescribing has not been historic and this is contributing to the infection becoming more noticeable. There are

presently variations across the country as to when to test for CDI, this also has an effect on the figures seen within the North West and Tameside and Glossop.

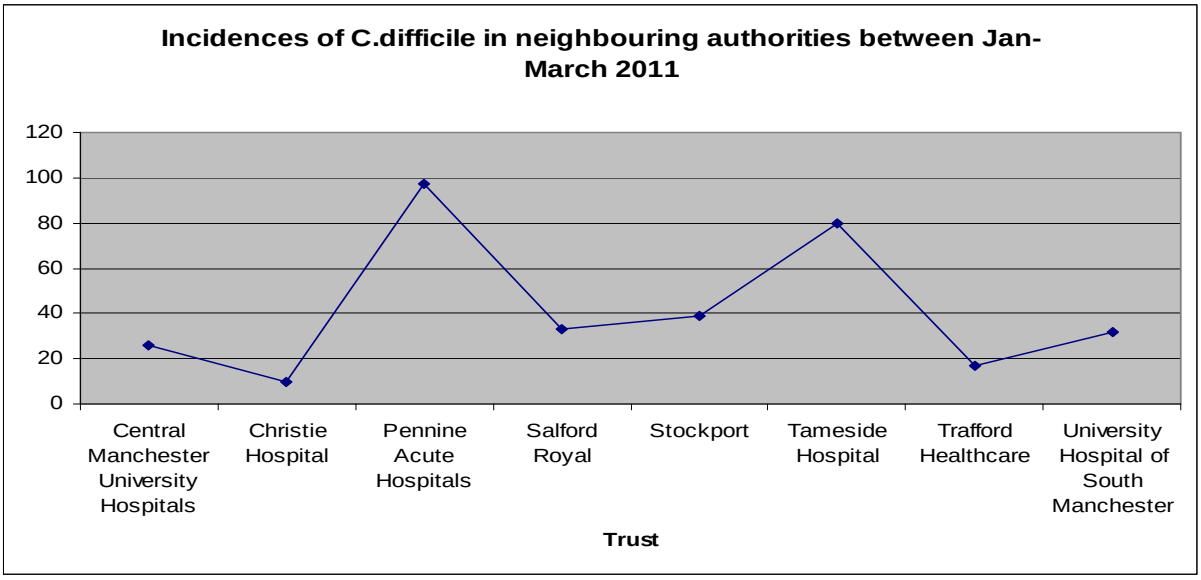
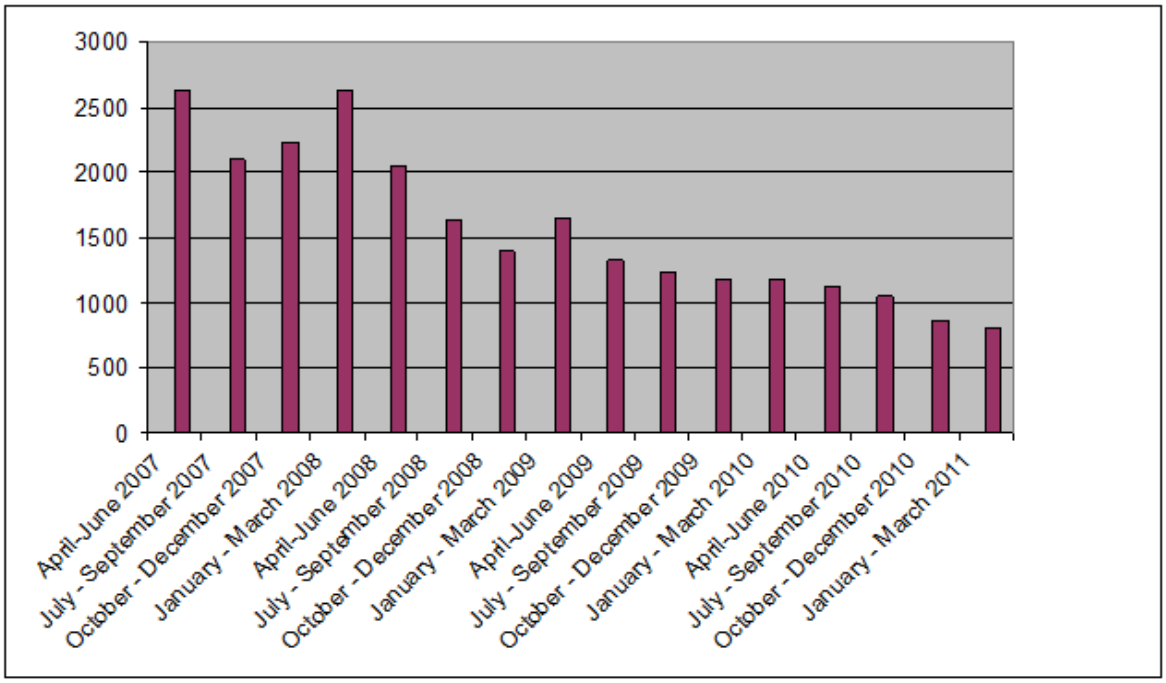


Chart 3 showing the number of incidence of C.difficile across neighbouring authorities recorded between January-March 2011 [1]

7.1.13 Chart three highlights the number of incidence of C.diff amongst Tameside's neighbouring authorities between January and March 2011. This identifies Tameside Hospital as recording the second highest amount of recorded incidences of CDI amongst neighbouring trusts. Pennine Acute Hospitals recorded the highest amount at just below 100 whilst the lowest recorded amount was Christie's Hospital with 10 recorded incidences of CDI between January and March 2011.



[1] (http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1278944233852)

Chart 4 identifies incidents of C.difficile recorded across all North West authorities April 2007- March 2011

7.1.14 Chart Four identifies the number of incidences of CDI recorded across the whole of the North West between April 2007 and March 2011. The chart identifies a clear reduction in the number of recorded incidents of CDI as reducing from over 2500 in 2007 to below 800 for January to March 2011.

7.1.14 There is a vast knowledge and understanding around the issues surrounding CDI however it is the issues around over prescribing that need to be addressed.

7.1.16 Tameside is identified as being average in relation to Greater Manchester prescribing frequency for all antibiotics between 2007 and 2011 compared to other Greater Manchester Authorities, the North West, the North of England and England as a whole.

Conclusions

1) The North West has the highest levels of CDI nationally at 15% of the national total.

2) Those individuals more likely to contract the infection are older individuals (65+), with possible long term illnesses such as chest and heart conditions.

3) A higher proportion of Females than Males contract the infection.

4) Some cases of CDI are unavoidable due to issues such as the patient's age and health.

5) The Infection Control Team are working to educate practitioners to ensure testing is not undertaken where they already know the patient has the infection.

6) There is a vast knowledge and understanding around the issues surrounding CDI however it is the issues around over prescribing that need to be addressed.

Recommendations

1) Health practitioners should ensure the right antibiotics, if necessary are used to treat infections to reduce the over prescribing of antibiotics.

2) Further education is needed for prescribers to ensure the correct antibiotics are used to treat CDI.

7.2 Hospital interventions around C.Difficile infection

7.2.1 CDI in the Hospital is measured against cases which occur within 72 hours of a patient's admission.

7.2.2 Only those patients over the age of two are recorded as having CDI. If an individual is recorded as having the infection twice within 28 days, this is only recorded once as it is considered to be the same episode of infection. The target for Tameside Hospital is 60 cases of CDI for the 2011/12 and 2012/13 periods.

7.2.3 Cases of CDI occur through antibiotic prescribing; however, antibiotic prescribing becomes problematic, as patients are faced with a choice which has advantages and disadvantages. Someone with a severe infection needs to be treated with antibiotics as the infection is a

priority for the Hospital and could be life threatening. The problems associated with CDI are considered as a secondary thought as the threat from the infection would be more profound.

7.2.4 General antibiotic intake for conditions such as Urinary Tract Infections (UTI) can be stopped after 72 hours if the infection has cleared. One dose of a strong antibiotic can clear certain infections; if this is ineffective then it may be necessary for the type of antibiotic to be changed.

7.2.5 Antibiotic use can kill both good and bad bacteria within the gut, when this occurs CDI can become dominant. There is still an expectation that if patients go to the doctor they expect to receive antibiotics and this will cure the problem, the right clinical balance needs to be struck.

7.2.6 On Tameside Hospital wards the Pharmacist or Doctor reviews all the drugs the patient is receiving. They also decide whether the prescriptions are necessary for the patient and if required stops the application of some medication.

7.2.7 Tameside Hospital has been considerably proactive in reducing the incidences of CDI within the Hospital and the target for the Hospital is 5 cases of CDI per month. Hopefully, this target can be reached in the forthcoming year. Chart one identifies the recorded and projected rates of CDI within Tameside showing a marked decrease from 2009. Tameside Hospital has higher incidences of CDI than other Hospitals. Tameside Hospital has reviewed their antibiotic policy and now benchmark against Health Protection Agency guidelines and other health economies.

7.2.8 The levels of antibiotic prescribing within Tameside and Glossop, has been high; however, this is changing. New antibiotic prescribing guidelines have been provided for the biggest conditions of admittance to the Hospital, for conditions such as Urinary Tract Infection (UTI), Chronic Obstructive Pulmonary Disease (COPD), Cellulitis, diabetic foot ulcer, pneumonia.

7.2.9 Root Cause Analysis has identified that the incidents of CDI can occur across all wards of the Hospital and are not only focussed on a few specific wards as originally thought. The whole health economy contributes to root cause analysis and further staff training and development is provided in areas where it is considered necessary. Root cause analysis for the whole health economy has a ten day turn around for investigations to take place.

7.2.10 There is no single method of resolving the problem of CDI, a consistent application of good practice standards is needed. “Making a C.difference” is a campaign which has been implemented to encourage patients not to pressurise GP’s for antibiotic treatment, if it is not required. The campaign identified the critical role played by antibiotics in the development of HCAI’s, and highlights why patients can expect to receive less antibiotics

7.2.11 There is a need to look into the labelling and information provided on prescriptions and the required change in prescribing patterns to reflect more up to date practices of reduced periods of antibiotic intake and much stronger, more focussed antibiotic prescribing.

Conclusions

7) There is no single method of resolving the problem of CDI, a consistent application of good practice standards is needed.

8) Antibiotic use can kill both good and bad bacteria within the gut, when this occurs CDI can become dominant.

9) Tameside Hospital has been considerably proactive in reducing the incidences of CDI within the Hospital and the target for the Hospital is 5 cases of CDI per month.

10) The incidents of CDI can potentially occur on any ward within a hospital and are not found to be ward specific.

Recommendations

3) Prescribing guidelines should be updated to reflect the understanding that once the infection has been treated the course of antibiotics can be stopped.

7.3 Responses to C.difficile Infection- Prevention and Management

7.3.1 Over prescribing of antibiotics is being targeted by prescribing teams within Tameside and Glossop. The Antibiotic Pharmacists have been visiting GP surgeries within Tameside and Glossop and through education, guidance and support the government aims to reduce instances of infection further.

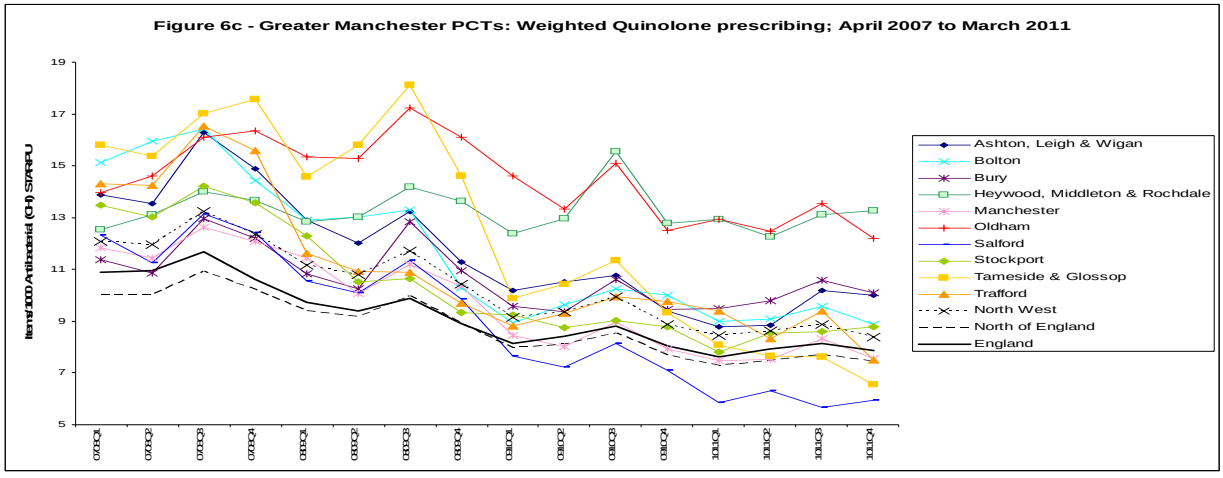


Chart 5 showing GP prescribing of antibiotics associated with CDI

7.3.2 Chart five, shows Tameside's rate of antibiotic prescribing compared to neighbouring authorities regionally and nationally between April 2007 and March 2011. Tameside shows considerably high numbers of prescribing within 2007 with the highest peak recorded in 2008/09 which was then followed by a dramatic drop in the following year to be the second lowest prescribing PCT in the fourth quarter of 2010/11 within Greater Manchester after Salford Primary Care Trust.

7.3.3 There should not be a distinction between acute and non acute environments regarding CDI, there should only be a whole health economy approach to the problems associated

with CDI. NHS Tameside and Glossop is obliged to report all cases of CDI recorded across the whole of the Trust regardless of whether it is identified as being recorded in an acute or non acute setting. In order to be able to tackle the issues around CDI a working collaboration is needed across the whole health community.

7.3.4 Issues of CDI arise around the vulnerability of patients, the archetypal patient to have CDI is from a vulnerable spectrum and are generally elderly, frail and likely to need antibiotic treatment, often over long periods of time which subsequently makes them prone to CDI. Certain types of antibiotics can also increase the chances of contracting CDI along with going from one course of antibiotics to another.

7.3.5 The Head of Medicines Management has liaised with neighbouring authorities where the incidence of CDI is identified as being low. Through discussions with the authorities it has been noted that CDI figures were low due to different testing practices within that particular PCT. This has subsequently been changed in March 2012 to reflect the testing practices of other PCT's in the region and will give a fairer reflection of CDI within that area.

7.3.6 There is an increase in antibiotic peer accountability at meeting groups within Tameside and Glossop where statistics and figures from each individual practice are compared. Practice specific letters have been sent to practices where incidents of prescribing are high. This also involves root cause analysis at practice level. Every case of CDI identified within Tameside and Glossop is subject to root cause analysis, which is then broken down, to identify the origin of the infection.

7.3.7 There are peaks and troughs in the levels of antibiotic prescribing within Tameside and Glossop the peaks are due to winter months, which historically has higher levels of antibiotic prescribing. Through reducing the prescribing of high risk antibiotics, Tameside and Glossop has fallen below the National average for prescribing.

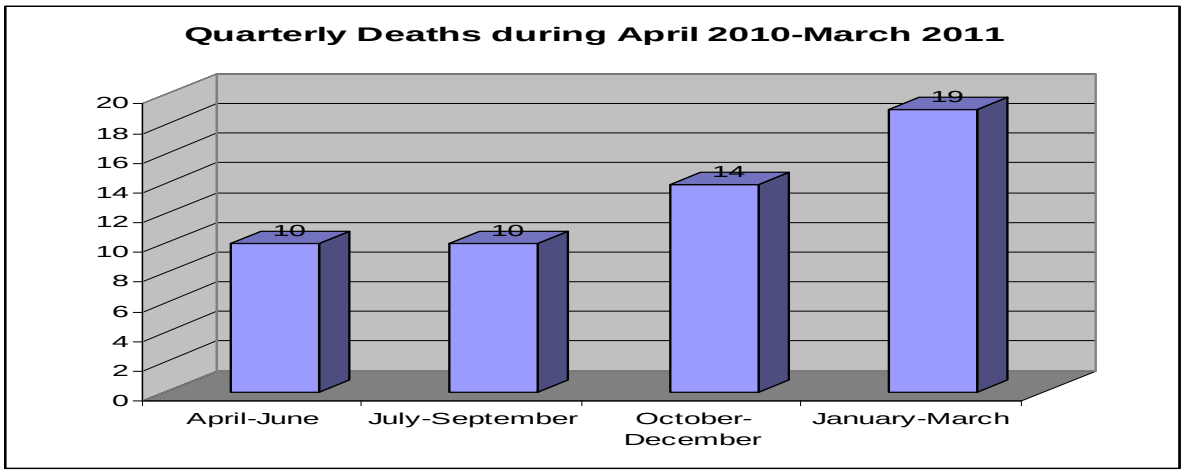


Chart 6 identifying the number of Quarterly deaths from CDI April 2010-March 2011 within Tameside

7.3.8 Chart six highlights the increase in the number of deaths from C.difficile infection between April 2010 and March 2011. The chart plots an incline of the number of deaths from 10 in April - June 2010 to 19 in January - March 2011. The incidents of C.Difficile are higher around the winter months, which may partly be due to the volume of antibiotic prescribing around this time of year.

7.3.9 There is no class of antibiotic that would not cause CDI. The antibiotics that are specific should be used more than those that are used widely to treat varying infections. There are in the region of 13,000 antibiotic items prescribed in Tameside and Glossop per month, of these 4600 that were prescribed to were 65+ years of age. Of the 13,000 antibiotic items there were 13/14 cases identified of CDI this accounts for 0.3% of the total prescribed within the month.

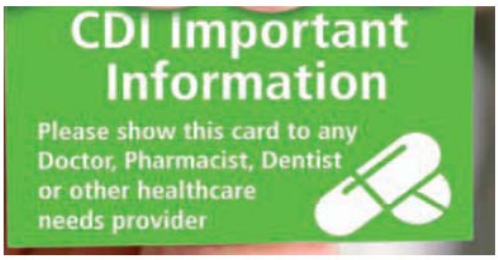
7.3.10 Further improvements have to be made for targeting the GP at the point of prescribing antibiotics. Although prescribers believe antibiotics are low risk it actually carries a very high risk for patients. GPs have for the last three months been provided with a risk/benefit assessment information check list in relation to the prescribing of antibiotics. This is to ensure that there is a management of the risk factors associated with the prescribing of antibiotics and that the right antibiotics are prescribed for the right condition for the right period of time. CDI can be treated by two specific antibiotics which are Metronidazole[2] or Vancomycin[3] and it is the education and understanding of prescribers that needs to be improved.

7.3.11 Root Cause Analysis is undertaken on all cases of recorded CDI and this analysis is helping to educate practitioners and push educational material in the right direction. Tameside and Glossop and the Prescribing Leads are aiming to change the way in which antibiotics are used.

7.3.12 The British National Formula which lists medicines available to prescribers, indicates that courses of antibiotics must be completed. This is not necessarily the case and it has been requested by the prescribing team within Tameside and Glossop, that the wording within the guidance is changed to indicate that in some circumstances a course of antibiotics can be finished early.

7.3.13 Letters are being sent to GPs and prescribers as an educational tool and advising in some cases antibiotics may not be needed. Negotiation is sometimes needed between prescribers and patients and it may be necessary for the patient to say no to their GP in the right way.

LOOK OUT FOR THIS CARD



[2] Metronidazole is an antibiotic, and the drug of choice for first episodes of mild-to-moderate *Clostridium difficile* infection

[3] Vancomycin is a glycopeptide antibiotic used in the treatment of infections caused by Gram-positive bacteria. It has traditionally been reserved as a drug of "last resort", used only after treatment with other antibiotics had failed

7.3.14 The CDI Green Card shown above is being used as an informational tool for prescribers and is being issued to patients with a CDI diagnosis. Patients are being encouraged to show these green cards to health care professionals to make them aware of CDI and that the patient is a high risk.

7.3.15 The prescribing leads for NHS Tameside and Glossop have developed an educational document titled “Management of Infections in Primary Care” which is being made available to all practitioners. This provides a handy reference and flexible booklet cross referenced to root cause analysis. When dispensing antibiotics the computers systems GPs use forces them to consult the antibiotic guidelines to reference the specific reason the antibiotics are being prescribed.

7.3.16 There is a requirement that where a patient has had CDI, this is flagged on the patient’s medical records electronically and where the patient is referred to hospital this flag is identifiable on their records. The CDI flag is held on their medical records indefinitely.

7.3.17 Antibiotic Pharmacists specialise in the prescribing of antibiotics and are based in the PCT. They provide workshops, education and feedback elements of poor prescribing practices. They are based within the Hospital and carry out ward rounds within the Hospital to ensure guidelines are being followed. The District Infection Prevention Committee looks at overarching concerns surrounding the issues and areas where improvement and development can be made.

7.3.18 Where prescribers or practices are not co-operating there are options available, the PCT can report the practice to the General Medical Council. This would occur in instances where there is non compliance from the practice or if the practices are not responding to requests to meet with Antibiotic Pharmacists and the Prescribing Team. In addition to this, prescribing guidelines are sent out to all practices and an individual letter is also sent to those practices which are underperforming. A response is required from them with regards to their performance and an action plan, for reducing the prescribing of antibiotics.

7.3.19 The PCT is able to compare those practices that are underperforming with their neighbours and against the PCT average. Through using this method there have been some marked improvements in the way in which antibiotics are prescribed.

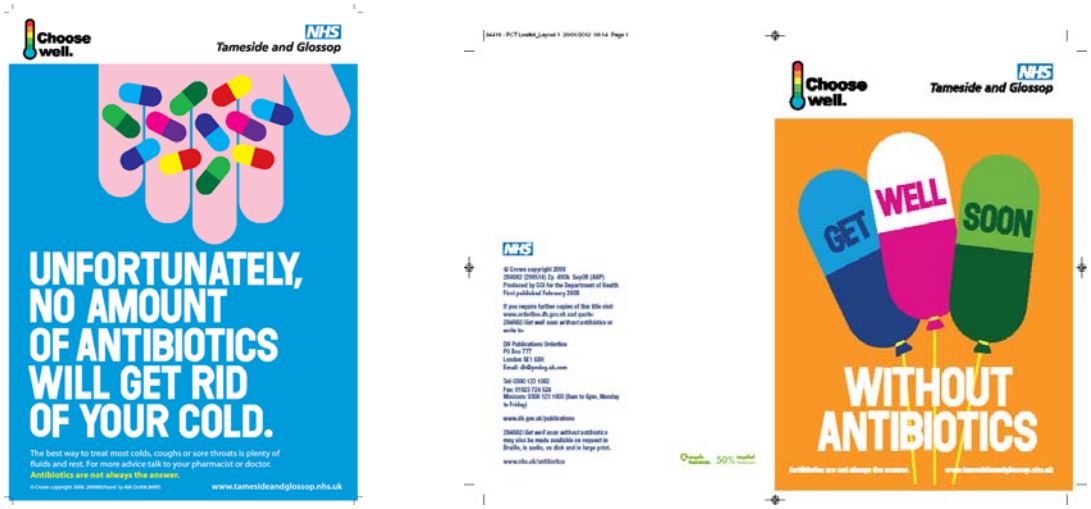
7.3.20 There needs to be a change to more focussed prescribing using the right antibiotics in the right situation. The extensive use of antibiotics could create resistance to the drugs. The issuing of antibiotics should be for short periods of time at high dosages. CDI is not likely to be eradicated; as it can be carried by an individual but show no symptoms of having the infection.

7.3.21 There is no indication that CDI would suffer as a result of the forthcoming Health Care Bill. Performance targets would be set as they are now and it is envisaged that CDI would be one of those performance targets and as such it is understood that the rates of CDI would not suffer as a consequence.

7.3.22 There is an emphasis at present on trying to get the standards of the best performing practices into all the other practices within the Trust along with looking at methods of measuring performance of antibiotic prescribing.

7.3.23 It is felt that Tameside is advanced in relation to intervention; however, this was required because of the poor previous levels of CDI. There is an appointed team at Greater

Manchester level who have confirmed that Tameside and Glossop are undertaking every possible method, to tackle the rates of CDI and poor prescribing practices.



Images 1 and 2 showing NHS Tameside and Glossop educational posters

7.3.24 Images one and two show examples of posters used for educational purposes, to raise the profile of antibiotic prescribing amongst practitioners and patients. The images highlight that antibiotics are not always needed to treat symptoms and illnesses.

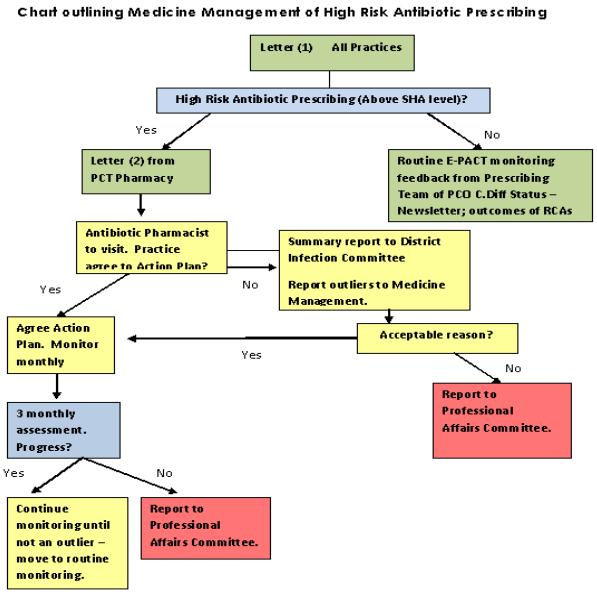


Chart 7 detailing the management of high risk antibiotic prescribing within the authority

7.3.25 Chart seven outlines the process for the management of high risk antibiotic prescribing practices. Letters are initially sent to the practices and further letters are issued if they are identified as being a high risk practice. The Antibiotic Pharmacist visits the practices of concern and devises an action plan which is monitored monthly. If the Antibiotic Pharmacist does not visit the practice a report is required to be sent to the District Infection Committee. If the reasons provided by the practice are acceptable the practice is monitored monthly, with a three month assessment of progress. The practice is continually monitored if information provided to Medicines Management is acceptable. If the reasons provided by the practice are not acceptable, or no improvement is made during the monitoring process, the practice is then referred to the Professional Affairs Committee.

7.3.26 Overall there are many steps being taken to improve the issues around CDI including:

- Implementation of Health Care Associated Infection Reduction Plans put into place to monitor and address the issues associated with CDI.
- Ensuring good infection control standards are maintained and audits are undertaken to ensure compliance with the appropriate standards.
- Reducing unnecessary or inappropriate antibiotic usage by targeting and educating the prescribers of antibiotics providing guidelines, auditing and clinical governance
- The introduction of the CDI green card scheme, has enabled patients to become pro-active in informing practitioners.
- Within the Hospital the Antibiotic prescribing specialist undertakes rounds accompanied by Junior Doctors to monitor the use of antibiotics and this is increasing awareness around the issues of prescribing antibiotics within the Hospital.
- Disciplinary processes for doctors that do not comply with reducing antibiotic prescribing and a governance process is in place to refer individuals who do not comply with the committee.

Conclusions

11) The majority of infections are antibiotic related and a small amount is through poor hygiene practices.

12) Practice specific letters have been sent to practices where incidents of prescribing are high.

13) Through reducing the prescribing of high risk antibiotics, Tameside and Glossop has fallen below the National average for prescribing.

14) There is a requirement where a patient has had CDI that this is flagged on the patient's medical records.

15) There is an emphasis at present on trying to get the standards of the best performing practices into all the other practices within the Trust.

Recommendations

4) Consideration should be taken to changing antibiotic labelling to reflect that antibiotics do not need to be taken for the full term of the course if the infection has cleared.

5) Prescribing guidelines and advice provided by the antibiotic pharmacist needs to be implemented across the PCT and the Foundation Trust.

6) All GP surgeries should strive to reduce the levels of CDI by working hard to achieve the targets set for reducing CDI.

7) Health practitioners should promote further, the use of the risk list for antibiotic prescribing and where risks are identified consult the antibiotic pharmacist for advice where necessary.

8) The antibiotic leaflet should be promoted widely across Tameside.

9) Patients should be encouraged to stop taking antibiotics if appropriate.

10) Support for antibiotic policy should be provided throughout the whole of Tameside's health community.

11) Greater Partnership working between practices is promoted to encourage sharing best practice regarding antibiotic prescribing and to promote GP dialogue around CDI performance.

8. Conclusions

1) The North West has the highest levels of CDI nationally at 15% of the national total.

2) Those individuals more likely to contract the infection are older individuals (65+), with possible long term illnesses such as chest and heart conditions.

3) A higher proportion of Females than Males contract the infection.

4) Some cases of CDI are unavoidable due to issues such as the patient's age and health.

5) The Infection Control Team are working to educate practitioners to ensure testing is not undertaken where they already know the patient has the infection.

6) There is a vast knowledge and understanding around the issues surrounding CDI however it is the issues around over prescribing that need to be addressed.

7) There is no single method of resolving the problem of CDI, a consistent application of good practice standards is needed.

8) Antibiotic use can kill both good and bad bacteria within the gut, when this occurs CDI can become dominant.

9) Tameside Hospital has been considerably proactive in reducing the incidences of CDI within the Hospital and the target for the Hospital is 5 cases of CDI per month.

10) The incidents of CDI can potentially occur on any ward within a hospital and are not found to be ward specific.

11) The majority of infections are antibiotic related and a small amount is through poor hygiene practices.

12) Practice specific letters have been sent to practices where incidents of prescribing are high.

13) Through reducing the prescribing of high risk antibiotics, Tameside and Glossop has fallen below the National average for prescribing.

14) There is a requirement where a patient has had CDI that this is flagged on the patient's medical records.

15) There is an emphasis at present on trying to get the standards of the best performing practices into all the other practices within the Trust.

9. Recommendations

1) Health practitioners should ensure the right antibiotics, if necessary are used to treat infections to reduce the over prescribing of antibiotics.

2) Further education is needed for prescribers to ensure the correct antibiotics are used to treat CDI.

3) Prescribing guidelines should be updated to reflect the understanding that once the infection has been treated the course of antibiotics can be stopped.

4) Consideration should be taken to changing antibiotic labelling to reflect that antibiotics do not need to be taken for the full term of the course if the infection has cleared.

5) Prescribing guidelines and advice provided by the antibiotic pharmacist needs to be implemented across the PCT and the Foundation Trust.

6) All GP surgeries should strive to reduce the levels of CDI by working hard to achieve the targets set for reducing CDI.

7) Health practitioners should promote further, the use of the risk list for antibiotic prescribing and where risks are identified consult the antibiotic pharmacist for advice where necessary.

8) The antibiotic leaflet should be promoted widely across Tameside.

9) Patients should be encouraged to stop taking antibiotics if appropriate.

10) Support for antibiotic policy should be provided throughout the whole of Tameside's health community.

11) Greater partnership working between practices is promoted to encourage sharing best practice regarding antibiotic prescribing and to promote GP dialogue around CDI performance.

10. Borough Treasurer's Comments

There are no direct financial implications to Tameside as a result of this report.

11. Borough Solicitor's Comments

The legislation places a duty on the council to scrutinise the core activities of NHS provision within the borough to ensure it is effective. This report looks at all areas of health where Tameside is performing worse than comparative neighbours and provides actions that should be implemented for positive outcomes. It is important that when the Chief Executive and Chair of the Trust attend the meeting, that appropriate responses are sought to ensure that the recommendations are being implemented and monitored to ensure progress and action taken if this is not having meaning and desired effect.