



RCGP response to the Antimicrobial resistance national action plan: Call for evidence

Q1. From your experience, how has the scale of the threat of AMR changed since the national action plan was published in 2019?

The threat of AMR has increased since 2019.

Q2. In your opinion, what are the top 3 drivers of AMR? Please give 3 short answers.

First driver:

Cognitive biases from both doctors and patients. Doctors will often want to take precautions and prescribe antibiotics early with patients who are registering high NEWS scores and treating them with antibiotics without a specific diagnosis, especially in patients with a febrile illness. In addition to this, many patients who begin experiencing symptoms of an infection, regardless of cause, often expect to be given, and sometimes demand a prescription for antibiotics, even if the clinical advice is that they may be ineffective. For both doctors and patients, prescribing antibiotics can give a better sense of reassurance due to direct action, even if it is inappropriate.

Second driver:

The overuse of antibiotics when public health messaging increases. Though this may seem obvious, there is often loud public debate around infectious diseases such as sepsis and at the current time strep A. Following any increased public messaging, the prescribing of antibiotics is likely to increase, sometimes disproportionately to the increase in incidence of disease. This is driven by both patients (increased knowledge), who recognise the symptoms of specific infections where they may not have before, and doctors who want to ensure the best care for their patients.

Third driver:

Pressures within health and social care services, lack of investment in these services, and limited access to investigations e.g., point of care testing and rapid blood test results. In order to most accurately diagnose and treat an infection, it often requires blood work and /or testing to first identify the pathogen in order to enable clinicians to determine the most appropriate antibiotic to treat it. However, due to pressures in the services and lack of resources, there is often a lack of time to fully assess the patient, (noting GP appointments are often 5-10 minutes only due to capacity pressures) or a lack of access to rapid diagnostic services such as point of care testing which means that these infections may not always be correctly identified or treated.



Q3. Which of these areas would you most like to see prioritised over the next 5 years? (Rate in order of priority)

- A) Reducing the need for, and unintentional exposure to, antimicrobials.
- B) Investing in innovation, supply, and access.
- C) Optimising the use of antimicrobials.

Q4. Are there any actions you think are required to tackle AMR that do not fall within one of these categories?

Yes. There needs to be improved patient information and public health campaigns to increase information and awareness of when to seek help and when antibiotic prescribing is needed, improved information on self-care strategies, and nationally recognised safety netting for patients when at risk of serious infection and sepsis.

An increase in national access for clinicians to rapid point-of-care testing is required to enable a correct diagnosis to be made quickly at the bedside and to influence whether antibiotics are prescribed and antibiotic choices. This will require investment and training.

Q5. Within the UK, what are the key successes we should look to maintain or build on in responding to AMR? Please include up to 3 examples in no more than 250 words.

First example:

Prescribing data dashboards in England that clinicians and commissioners have access to.

Second example:

The successful review of prophylactic antibiotics prescribed for patients with recurrent UTI, as well as the advice and support available to deliver the most appropriate antibiotics for these patients. The implementation of the NICE guidance in these areas has also been very successful and effective.

Third example:

The continued support for GPs and first contact clinicians to identify sick people, and document those who are not particularly unwell at first presentation with additional safeguarding advice. This has had a huge impact on minimising the pressure to prescribe “just in case” of an infection, with safety netting instructions given to ensure recontact with health services if they are more unwell.

Q6. Within the UK, what are the areas that require more focus or development to address AMR? Please include up to 3 examples using no more than 250 words in total.

First example:

Explore how rapid point of care testing services can be developed to minimise the need for antibiotics. Any plan developed for this would need to recognise that it would need to fit in with GP availability and resourcing; not only to decide if it is cost effective but also



how it might be delivered when GPs are under pressure from high volumes of acute respiratory illness.

Second example:

A rapid update and support platform for clinicians including genuine peer discussion and protected time to discuss, learn and debate. This could improve prescribing confidence, and knowledge of the latest guidelines and methods to support AMR, such as back-up prescriptions. Resources were developed by multidisciplinary groups to provide key messages on common infections (e.g., NICE-endorsed or TARGET toolkit) but these do not reach many front-line prescribers.

Third example:

Increase resources for GP prescriber champions across the UK. Currently, the role of antimicrobial stewardship is largely pharmacist led, but only some of whom are prescribers and most of the AMR regional leads are pharmacists. Locality GP-prescribing leads are not well networked across the country or as involved as they should be in discussions & initiatives. As most patients will receive an antibiotic prescription from a GP, it is important that they are involved in these conversations.

Q7. Within your sector, do you think the UK has sufficient capacity and capability to tackle AMR?

Yes, in some areas. Primary care is under unprecedented pressure with the number of patient contacts increasing and the number of full-time equivalent GPs decreasing. Between September 2015 and November 2022, the number of full-time equivalent fully qualified GPs has fallen by 6.7%. While the number of other practice staff members are increasing, this is not sufficient to meet patient needs. If primary care were funded and staffed well, then primary care would have sufficient time to talk to patients, and potentially to help teach and educate their practice population. As part of this, practices or networks of practices could have a dedicated and funded antimicrobial steward, who could focus on improving care pathways and auditing antibiotic use. Some practices who have sufficient workforce do manage to support antimicrobial stewardship with consistent messages amongst prescribers and do exceptionally well at this.

The focus on access, rather than continuity of care and resulting reduced ability to follow-up people who are potentially septic within primary care (review 48 hours later, often undertaken by phone or as an “additional/ extra” patient by primary care), may in some circumstances encourage the use of antimicrobials compared to a “watch and wait”/ review approach to care.

Additionally, GPs don’t have the most modern resources to support diagnosis (rapid point of care testing), nor do they have the staff or time/resources to implement these types of working changes or audit their practice.

With appropriate resourcing, antimicrobial stewardship could be improved and become a core part of the primary care workload.



Q8. What additional capacity and capability is needed in your sector to effectively tackle AMR? Please give up to 3 examples using no more than 250 words in total.

First example:

The current time pressures within general practice, with increased numbers of patients at a time of reductions in the full-time GP workforce, means that clinicians may have to manage the risks presented to them more quickly than they would like. For example, there are many reasons that an older person may become more confused (PINCH ME – UKHSA), however, current time pressures do not allow for a full exploration of differential diagnoses and so the prescription of antibiotics is often the safest and quickest route. Additionally, prescribers may not feel supported by the locality, public, or GMC to reduce antimicrobial prescribing. Theoretically, prescribers are supported after undertaking a careful assessment e.g. NICE [Recommendations | Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use | Guidance | NICE](#) “Encourage and support prescribers only to prescribe antimicrobials when this is clinically appropriate” however there is not always the time or capacity to do this.

Second example:

There needs to be additional access to rapid point-of-care testing and additional staff to help deliver this with appropriate training in place to ensure it is safe and effective.

Q9. In your opinion, what are the key barriers to making progress on tackling AMR in your sector? Please give up to 3 examples using no more than 250 words in total.

First example:

There is a lack of resources and time for GPs to effectively tackle the issues around AMR. Whilst GPs are often at the forefront of antimicrobial stewardship when it comes to prescribing, they do not have the capacity or protected time to actively involve themselves in peer-to-peer learning or to undertake mini-audits, or to process and share learning within a practice. This means that practices get stuck in cycles within which they don't have the time and space to actively improve. By providing adequate resources and funding to primary care, specifically for AMR, improvements would provide benefits.

Second example:

There are issues around public and clinician concern regarding sepsis. Sepsis is poorly defined and often poorly understood which can lead, in some circumstances, to ignoring important warning signs by the public and of confusion regarding clinical symptoms and signs of sepsis and when care should be escalated. Clear public health messaging and improving clinical pathways would improve this.

Third example:

There is little or no financial support for alternate pathways at the current time, meaning primary care either has to prescribe antibiotics, offer “delayed prescriptions” or “wait and see” what happens, based upon the physical signs and the story that the patient tells. Watching and waiting uses up additional clinical time in many cases, necessitating follow up telephone calls or appointments. By adding into the pathway point of care testing for



primary care it would give an additional option for clinicians, who may then be clearer about the best effective option for care. However, this must, if implemented, be fully resourced and have education provided to ensure patient safety is maintained.

Q11. In your opinion, which of these tools should be prioritised for adapting to use in tackling AMR? (Rate in order of priority)

- A) diagnostics
- B) surveillance
- D) vaccines
- C) therapeutics

Q12. In your opinion, are there any other tools that should be adapted from use during the COVID-19 pandemic for tackling AMR?

Yes. The adaptations that people took towards their behaviour during the COVID-19 pandemic, including staying home from school, work, or social events when they were unwell, was an important health protection measure that could be promoted for all general respiratory infections. The increased personal responsibility for health also could be utilised with clearer public health, prevention, and self-care information for the public. During the pandemic, there was also improved access to rapid point-of-care testing for clinicians and patients, with patients offering to test themselves. Utilising personal/ self-care, community pharmacy support for minor infections, and ensuring every aspect of care aligns with national guidance, whichever service you attend is essential.

Q13. Do you believe the changes in ways of working within your organisation due to the COVID-19 pandemic have affected efforts to respond to AMR, such as delivery of the current national action plan (NAP)?

Yes. The Covid-19 pandemic had an impact on health services across the country, and that includes general practices. Note: although this response is from the RCGP as an organisation, the following refers to general practices as organisations we represent.

First example:

Remote consultations have been an established part of General Practice for some time. However, as a result of the COVID-19 pandemic, General Practice, following NHS England guidance, rapidly adopted a way of working which led to significantly more remote consultations taking place in order to reduce the spread of the virus. This move, however, was not updated in national guidance such as NICE guidance, e.g. [for acute cough](#). The acute cough guidance promotes face to face consultation before considering prescribing an antibiotic, however this was not always an option during the pandemic. The impact of this approach has not yet been fully evaluated but may have led to an increase in antimicrobial prescribing in some instances. While 69.1% of appointments were carried out face-to-face in [Nov 2022](#), additional guidance, and the updating of existing guidance,



would help in providing support to practices on how to manage antibiotic prescribing remotely, where required.

Second example:

The fragmentation of primary care and workforce crisis worsened by COVID-19 has further reduced opportunities for continuity of care within primary care and the opportunistic encounters that helped to develop trusting relationships between patients and clinicians, the benefits of which are clear from evidence. Continuity of care not only reduces mortality, but also supports risk/benefit discussions and personalised care, especially when it comes to antibiotic use.

Third example:

Training. Due to the crisis in the NHS, increased workload, demand and decreasing of the number of full-time equivalent GPs, many clinicians do not have as much time to attend training and updates which is key to improving AMR as guidance changes and pathways and prescribing choices alter. There is no protected learning time in general practice and with the need to keep up to date with every condition across the whole of health and care, it is not always possible to make antibiotic stewardship the top priority. It would be preferable to change mandatory training, moving away from non-clinical topics such as fire training and moving and handling, to then allow clinicians more dedicated time for critically important education and learning such as AMR.

Q14. Are there other ways in which the COVID-19 pandemic has altered the AMR risk landscape? Please give up to 3 examples in no more than 250 words in total.

Due to severe workforce and workload constraints in General Practice, and political prioritisation of speed of access, there has been a reduction in continuity of care and in some cases the strength of relationships between GP teams and patients. These pressures have been exacerbated by the COVID-19 pandemic and risk care becoming more transactional and mean patients are less likely to see a clinician they know. The relational elements of care are no less important than convenience and there is evidence to show that trusting relationships between GP teams and their patients lead to better adherence to medical advice^{1,2}. The trust that is built through strong relational care also means that patients may be more willing to accept a "wait and see" approach or the advice of their clinician that they do not need antibiotics. Similarly, the clinician can have confidence that they will be able to follow up with the patient and that the patient will return if they get worse. The impact of pressures to prioritise speed of access, the decline in continuity of care and the increase in transactional care prompted by the pressures facing general practice, have not yet been fully evaluated.

Q15. Are there other global events, such as supply chain disruption or the conflict in Ukraine, that have changed the UK's ability to respond to AMR?

No.



**Q16. In your opinion, what are the best measures of success in tackling AMR?
Please give up to 3 suggestions.**

- Reduced overall antibiotic volumes used, adjusted for demographics e.g., STAR-PU.
 - Reduced drug resistance, without an increase in hospital admissions (e.g. E. coli – trimethoprim resistance)
 - Number of hospital admissions with confirmed infection (not suspected)
- However, all of the above are likely to depend on the targets that are set.

Q17. Do you believe that there is sufficient public and professional awareness of AMR?

No. Public understanding of antimicrobial resistance has improved in recent years; however, this can be overshadowed by public and professional concerns about sepsis. There is a lack of clarity about sepsis; what it is, and how it should be treated. The Academy of Medical Royal Colleges Report 2022 aimed to balance the need to minimise mortality associated with sepsis, with the necessity to conduct appropriate antimicrobial stewardship (e.g., timely investigations). There is limited recognition that in general practice, patient presentations can be complex, and decisions are rarely black and white. A risk-benefit discussion, shared decision-making, and safety netting can be important.