

# Part 2c and 2d CQUIN 2018/19 webinar, 22 February 2018

## Answers to questions asked

### **1. What is the weighting in the CQUIN between the consultant review of antibiotics and the infection pharmacist?**

This section of the 2018/19 CQUIN retains the 2017/18 CQUIN indicator. A consultant or infection pharmacist does not need to achieve a specific number of reviews, as long as the prescription is reviewed by a member of staff listed in the CQUIN specification document (infection pharmacist, infection doctor ST3 or above, ward doctor ST3 or above).

### **2. What is the definition of an ‘infection pharmacist’? Is it any pharmacist with suitable training?**

Training or education for infection pharmacists has not been specified for the CQUIN. Band 7 pharmacists and above who work in the field of antimicrobials/infection, have the job title infection pharmacist (or similar) or infection in their job description, and who are deemed to be competent to review antibiotic prescriptions for the purposes of the CQUIN can be classed as infection pharmacists for the purposes of the CQUIN. General ward pharmacists are not classed as infection pharmacists; however, if band 7 pharmacists or above are rotating through antimicrobials/infection for a suitable period of time to gain an understanding of how to review antibiotic prescriptions, then they could also be included in the definition.

### **3. What evaluation has been done on the negative impacts and opportunity cost associated with the CQUINs?**

The Health Protection Research Unit (HPRU) at Imperial is undertaking research into the unintended consequences of the CQUIN indicators on patient outcomes. Findings will be published and used to influence future antimicrobial resistance (AMR) work.

### **4. Continue with a new review date or duration: If the existing duration stated on the prescription is still appropriate, why does a new review date or duration need to be documented?**

The initial review date or duration prescribed at day 0 must be reviewed to ensure that it is still appropriate for the patient and the condition being treated.

**5. Clarification on 2c of the CQUIN: Specialist sepsis nurses/AMS nurses cannot complete the data?**

Nurses are not included as an option in the CQUIN indicator. The antibiotic review should be undertaken by a member of staff listed in the CQUIN specification document (infection pharmacist, infection doctor ST3 or above, ward doctor ST3 or above).

**6. What happens if disruption to supply in 2018/19 causes us to use more meropenem?**

Advice given to trusts during the numerous antibiotic shortages over the past year has been to use alternative narrow-spectrum agents and not to automatically switch to meropenem as this is not considered good antimicrobial stewardship. Trusts' performance against the CQUIN is continuously monitored and it is unlikely the CQUIN will be adapted part way through the year.

**7. How will the impact of shortages of antibiotics across the board on use be monitored?**

The impact of antibiotic shortages on trusts CQUIN performance will be monitored as the shortages occur. The piperacillin/tazobactam shortage had the greatest impact on trusts, and national guidance was published to direct trusts to use alternative antibiotics. As such, trusts were able to manage their guideline choices appropriately and most continued to reduce both their total antibiotic and meropenem consumption during this challenging period. The CQUIN was not amended to take antibiotic shortages into account.

**8. What about carbapenem-sparing antibiotics like temocillin which are not in the Access group?**

Temocillin was not chosen to be placed in the Access group as it was felt that this antibiotic should be reserved for resistance infections. Trusts are still encouraged to use carbapenem-sparing agents in appropriate patients for whom microbiology susceptibility results are available. First-line empirical treatment should be based on those antibiotics in the Access group wherever possible.

**9. If the 2% reduction is not met this year, will it be 2% again next year?**

For the total antibiotic CQUIN indicator: if a 2% reduction is not met in 2017/18, a 2% reduction will be set for 2018/19. If the target is met in 2017/18, a 1% reduction will apply for 2018/19.

For the carbapenem CQUIN indicator: if a 2% reduction is not met in 2017/18, then a 3% reduction will be set for 2018/19. If the target is met in 2017/18, a 2% reduction will apply for 2018/19.

**10. What happens if a trust did not sign up to the 2016/17 AMR CQUIN and did not submit data?**

Trusts can still submit data to Public Health England (PHE). Data for all quarters in 2016/17 and Q1 to Q3 in 2017/18 can be submitted to [CQUIN@phe.gov.uk](mailto:CQUIN@phe.gov.uk)

**11. Can you clarify which year the baseline data will be from?**

The baseline data will be from calendar year 2016 (minus 2017/18 targets).

**12. We have advanced nurse practitioners (ANPs) on ward rounds who prescribe, stop and review antibiotics. Are they classed as senior staff?**

Nurses are not included as an option in the CQUIN indicator. The antibiotic review should be undertaken by a member of staff listed in the CQUIN specification document (infection pharmacist, infection doctor ST3 or above, ward doctor ST3 or above).

**13. If we meet this year's consumption targets do we still need to decrease usage by 1–2% from 2016?**

If targets are met for 2017/18, those for 2018/19 will be a further 1% reduction for total antibiotics and 2% reduction for carbapenems.

**14. How is antibiotic usage adjusted for activity? Like many trusts, we have open escalation areas which inevitably means more patients and more antibiotics.**

Antibiotic consumption is adjusted for activity by using defined daily doses (DDDs) per 1,000 admissions. This way of calculating consumption adjusts usage against the number of admissions for trusts and enables antibiotic usage to be compared year on year.

**15. NEWS2: In paediatrics we use PEWS. Is this acceptable?**

For sepsis-related questions for 2a and 2b of the CQUIN, please contact NHS England as it manages the Reducing the Impact of Serious Infections section of the CQUIN.

**16. NEWS2: How are paediatric specialist centres expected to report?**

For sepsis-related questions for 2a and 2b of the CQUIN, please contact NHS England as it manages the Reducing the Impact of Serious Infections section of the CQUIN.

**17. How can we keep clinicians up to date with how we are doing if our targets will not be finalised to Q3?**

Trusts need to assume the higher targets until actual targets are available. Trusts are encouraged to work towards these higher targets to improve antimicrobial stewardship and to reduce antibiotic consumption.

**18. Will Q4 be reported as an average consumption over the year or as the result at the end of the year?**

Antibiotic consumption for Q4 will be reported as the data for Q4, not an average for the year. Average antibiotic consumption over the year (Q1 to Q4) will be used to assess whether trusts have met the overall CQUIN indicator for 2d.

**19. We have reduced our piperacillin/tazobactam and carbapenem usage by 30–50% so far this year compared with baseline. If we cannot achieve a 2–3% reduction for 2018/19 are we being penalised for performing too well in earlier years?**

It is great to hear trusts are reducing their consumption of broad-spectrum antibiotics this year.

Previous achievements in terms of reducing antibiotic consumption will not be taken into account for the 2018/19 CQUIN. There are huge variations between trusts and compared to the best-performing countries, and we still use vast amounts of broad-spectrum antibiotics.

**20. Some antibiotics are included in the Access group for specific clinical indications only. How will these (including azithromycin, clarithromycin, ciprofloxacin, vancomycin) be counted from a CQUIN perspective?**

The AWaRe list being used in England is an adapted version of the WHO AWaRe list. Antibiotics will only be placed in one group. They can be used for any suitable indication as decided by the trust. Azithromycin, clarithromycin, ciprofloxacin and vancomycin are included in the Watch group of antibiotics and therefore will not be included in the version adapted for England of the WHO Access group proportion.

**21. We are due to take part in Antibiotic Review Kit (ARK) Hospital. How will the 2c antibiotic review categories map to the ARK decision aid?**

The ARK Hospital is an NIHR trial which some hospitals are participating in. The ARK audit tools options for prescribing decisions at 24 to 72 hours does not fit into the current 2c guidance. The CQUIN data collection tool provided by PHE will need to be used to collect antibiotic review data for the CQUIN and will need to be uploaded onto the submission survey for all four quarters submitted.

**22. We use an alternative early warning system (EWS) that is also electronic and have high assurance around its efficacy. We have some reservations about NEWS2 as its impact on resources has not been determined. We are undertaking a review to analyse this. Will we be penalised if we do not adopt NEWS2 until this work is completed?**

For sepsis-related questions for 2a and 2b of the CQUIN, please contact NHS England as it manages the Reducing the Impact of Serious Infections section of the CQUIN.

**23. I am surprised to see that vancomycin is not on the Access list but gentamicin is. Isn't vancomycin a good choice to drive down the consumption of broad-spectrum antibiotics?**

Vancomycin has been placed in the Watch category because rates of vancomycin-resistant enterococci (VRE) are increasing and antibiotic allergies should be addressed to improve antimicrobial stewardship. Philip Howard gave a presentation about the rationale behind the grouping of antibiotics for the AWaRe categories at the Knowlex IPC Conference on 21 February 2018. A recording of this will be available shortly.

**24. Regarding the response earlier on new review date, does it mean we audit the same patient twice?**

No, prescriptions will not need to be re-audited. The initial review date or duration will need to be reviewed if the decision is to continue the same antibiotic. This data will be captured once during the data collection period post the 72-hour review.

**25. Temocillin is in the Watch group. As we use a lot of this can we choose to increase our Access group by 3% if we do not expect to achieve 55% of use from the Access group?**

Yes, this is why we opted for two targets for this part of the CQUIN. If trusts cannot achieve a proportion of antibiotics used in the Access group of  $\geq 55\%$ , then there is an option to increase consumption in this group by 3% to also meet this CQUIN indicator.

**26. Is the percentage reduction per trust type again?**

Performance against median consumption per trust type was used for the 2017/18 CQUIN but is **not** used for the 2018/19 CQUIN because the targets have changed.

**27. How are paediatric specialist centres expected to report?**

Similar to the 2017/18 CQUIN, all hospitals are expected to participate in the CQUIN and consumption data will be converted to DDDs per 1,000 admissions for comparison against other trusts.

**28. Is Q4 consumption based on average usage over the quarter?**

No, Q4 consumption will be antibiotic usage for January, February and March 2019.

**29. For certain indications we can only recommend combinations of Access agents to replace the activity of a broad-spectrum antibiotic. This then increases the total consumption. How do you tackle this problem?**

The CQUIN will be a juggling act between using narrow-spectrum agents when appropriate and other agents for resistant infections. Using combination treatment may increase DDDs

compared to using single agents but as this can be predicted, guideline changes can ensure this impacts minimally on overall DDD consumption. In addition, improved day 3 review should de-escalate or stop use of many antibiotics and thus decrease consumption of antibiotics not in the Access list.