**Co-amoxiclav prescribing in NHSGGC GP Practices 2018**

**Executive Summary**

Primary Care has made significant progress in both reducing unnecessary antibiotic prescribing, and increasing the use of guideline recommended narrower spectrum antibiotics. In NHSGGC antibiotic prescribing volume is 12% less than 10 years ago, and is at the lowest level nationally since recording began in 1993.

Broad spectrum antibiotics such as quinolones, cephalosporins, co-amoxiclav, and clindamycin in particular have seen a dramatic reduction with prescribing volumes being a third of what they were 10 years ago. Within this co-amoxiclav prescription levels have about halved.

Despite this progress, recent data indicated that rates of co-amoxiclav were increasing. This along with concern around the proportion of c. *difficile* that was community acquired, resulted in a recommendation from NHSGGC Antimicrobial Utilisation Committee to review prescribing practice.

Whilst recognising the complexity of some cases GP practices are faced with, and that empirical guidelines do not cover all eventualities, audit data from 43 GP practices from the highest 20% by volume did allow us to identify recommendations for improvement.

**A key recommendation is to ensure that all viable guideline options are considered before using co-amoxiclav. This was not demonstrable in around half of all cases audited.** **Two thirds of patients had ≤ 1 antibiotic course for the same indication within the preceding few months, suggesting co-amoxiclav was often used first line.** Persistent symptoms (e.g. urinary or respiratory symptoms) are often not an indication for further antibiotics and alternative causes should be considered and investigated**.**

The main indication for acute prescribing was UTI (36%) followed by RTI (26**%). In 18% of cases the indication was a self-limiting respiratory tract infection, suggesting this proportion may represent unnecessary prescribing.**  [TARGET](https://www.rcgp.org.uk/TARGETantibiotics) resources remain useful to increase understanding of natural durations, self-care and safety netting advice.

**More than half the patients audited were given a 7 day course of co-amoxiclav. Most indications recommend that shorter course lengths are equally as effective e.g. 3 days for lower UTI, 5 days for lower RTI.**

Although likely to represent an underestimate due to data labelling, repeat co-amoxiclav for prophylaxis/ long-term use made up 7% of items audited. **Prophylactic/ long-term** **co-amoxiclav should be avoided where possible. Where used it should be prescribed as a fixed term course to allow appropriate review and avoid unnecessarily prolonged use.**

**Summary - Prescribing Recommendations**

* Co-amoxiclav should be avoided for prophylaxis or long term treatment where possible
* On the rare occasions where patients are initiated on repeat/longer term antibiotics, they should be classed as being on fixed term with a review period defined at initiation (including out-patient/ discharge recommendations)
* All guideline (non 4C) options should be tried first where appropriate
* Guideline durations should be adhered to in the majority of cases
* Persistent symptoms (e.g. urinary or respiratory symptoms) are often not an indication for further antibiotics and alternative causes should be considered and investigated
* Prescribing for self-limiting infection should be avoided, and patients should continue to be educated on the natural duration of self-limiting illness (in particular cough). RCGP [TARGET](https://www.rcgp.org.uk/TARGETantibiotics) resources can be used to support this.

These key findings were made possible by the support of the participating Practices, who have taken this opportunity to reflect on their own prescribing. Many of the findings, however, will be applicable to all Practices.