Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Sheffield Clostridium Difficile Action Plan Assurance

Governing Body meeting

J

6 March 2014

Author(s)/Presenter and title	Jane Harriman, Deputy Chief Nurse
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Key messages

Sheffield CCG has had an action plan in place for a number of years to ensure a reduction in Clostridium Difficile cases in primary care and care homes. Due to the significant reduction target this year, the CCG arranged for a peer review of the 2013/14 plan (updated in October 2014).

The peer review was undertaken by Professor Mark Wilcox - Consultant / Head of Microbiology, Leeds Teaching Hospitals NHS Trust, who suggested our plan to be very reasonable and provided some advice regarding a number of issues. The review opinion is enclosed in a letter format, followed by a response from the CCG.

Assurance Framework (AF)

How does this paper provide assurance to the Governing Body that the risk is being addressed?
The paper provides information regarding the requirement to meet Clostridium Difficile national targets.

Is this an existing or additional control:
Existing AF 2.1.

Equality/Diversity Impact

Has an equality impact assessment been undertaken? No

Which of the 9 Protected Characteristics does it have an impact on?
Potentially impact on all characteristics

Public and Patient Engagement

Please list actions for PPE: None

Recommendations

The Governing Body is asked to note the outcomes of the Peer Review.

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Jane Harriman
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Dear Jane

Re: Review of *Clostridium difficile* Annual Report and Action Plan

2012 – 13 Annual Report
There is a remarkably consistent finding from studies of CDI in different community settings (UK, Netherlands, US) that about one third of cases have not had recently prescribed antibiotics or recent hospital admission.

The Sheffield data show that 19/70 (27%) of the community associated cases (that have had no recent hospital admissions) have no record of recent antibiotics. It is almost impossible at present to recommend rational interventions to reduce the incidence of such CDI cases as we do not understand the aetiology.

I suggest that the term CDAD (or CADA!) is not used. CDI is the preferred term.

The 2012-13 annual report states in section 5.0 that

> 'However, not all cases in the cohort had such an exposure, suggesting these patients could well have been one of the 3-5% of normal carriers.'

This is unlikely to be true. True *C. difficile* carriers are likely to have humoral immunity to *C. difficile* (toxins). It is more likely that the community cases without a history of prescribed antibiotic exposure had other unidentified factor(s) that initiated CDI at a time when they became temporarily colonised by *C. difficile*. Currently, we do not understand what these factors are, but the non-exhaustive list of possibilities includes: a course of (not recently prescribed) antibiotics, antimicrobial substances in food, other CDI promoters (e.g. PPIs).

In the great majority of those community associated cases (n=51) where antibiotics have been prescribed review has shown that the agents/courses are appropriate.

The use of cephalexin in general practice has been highlighted and further work is planned. I am not clear what has been done (the same topic is mentioned in the April to September 2013 report for ('A more in depth audit of UTI prophylaxis is currently being planned for this autumn').

April to September 2013 report:

You have carried out the analysis of possible risk factors for a combined data set on cases presenting in the community (i.e. those with no recent hospitalization and recent hospitalization). Ideally, the data should be provided separately for these two groups, as you should not assume that the aetiologies/conclusions will be the same. Data were provided for the no recent hospitalization group in the 2012-13 annual report. If you can show difference between the two groups this could be useful in planning strategies and/or in discussions with commissioners.

In the recommendations it states:

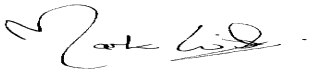
> 'Work with Public Health England to establish a strategy to address Difficile carriage in the population, for example vaccination.'

There is no vaccine – unlikely to be available for 3-5 years.

Other that the points noted above, the reports/plans are very reasonable.

Kind regards

Yours sincerely



Professor Mark H. Wilcox
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Date February 13 2014

Professor Mark Wilcox
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Dear Professor Wilcox,

Re: Peer Review of Sheffield CCG C Difficile Annual report and Action Plan.

Thank you for your comments on the above provided to us on 13th December 2013 and your expert advice – it has been extremely helpful and reassuring that you generally consider our plans to be very reasonable. We have noted specific points that you have raised below.

Regarding the 2012-13 annual report:

It is reassuring that the profile of our Sheffield community associated cases (27% had no recent hospital admissions or record of recent antibiotics) corresponds to consistent findings from studies of CDI in different community settings including the UK, Netherlands, USA. Equally it is reassuring, although frustrating, that there are currently no rational interventions to reduce the incidence of such cases and in Sheffield we have undertaken in-depth analysis of risk factors for the last three years.

You stated that patients with no risk factors or exposure to C Difficile are unlikely to be normal carriers. This is helpful we will take this into account in future analysis of cases.

Regarding the use of Cephalexin in General Practice - we undertook an audit of Quinolone and Cephalexin prescribing in the summer of 2012. A random selection of 10 prescriptions for each antibiotic group were audited for antibiotic used, dose, course length, indication for use and reason for initiating treatment with a cephalosporin or quinolone. Results indicated that while Quinolone prescribing was in line with recommendations, Cephalexin prescribing was undertaken for a number of indications most notably “prophylaxis of UTI”. We are therefore auditing the long term prophylactic use of all antibiotics for UTIs in every GP practice starting this month.

Regarding the April to September Community C Difficile Cases 2013 report:

Again, thank you for your advice with regard to separating the combined data set on cases presenting in the community - those with no recent hospitalization and recent hospitalization. We agree that reviewing these cases separately will enable us to better understand the aetiology of these cases in the future.

In respect of a C Difficile vaccination we await with anticipation that one may be available within 3-5 years.

Thank you again for your time to review our plans.

Yours sincerely,

Jane Harriman
Deputy Chief Nurse
Sheffield Clinical Commissioning Group

Cc:
Dr Rob Townsend – Consultant Microbiologist
Kevin Clifford -Chief Nurse