UNIVERSITY OF LEEDS

Lowering AntiMicrobial Prescribing (LAMP)

UK Health Security Agency

NHS

Dear Practice Manager and colleagues,

Antimicrobial resistance (AMR) is a growing global threat that undermines the effectiveness of life-saving treatments and increases risks from common infections and routine medical procedures. [(1)] The World Health Organization (WHO) identifies AMR as one of the top global public health and development threats, affecting countries at all income levels. **Antibiotics are fundamental to modern medicine — without them, procedures such as chemotherapy, caesarean section, joint replacement and organ transplantation become significantly more hazardous**. [(2)]

> Over recent years, GPs have taken significant steps to reduce unnecessary antibiotic prescribing, ensuring that these medicines are used only when they are clinically appropriate. But curbing antibiotic resistance is a shared responsibility – and it's important that all prescribing clinicians working within the NHS and outside of it, as well as patients, play their role.
>
> Professor Kamila Hawthorne
>
> Chair of the RCGP

In 2019, the Interagency Coordination Group on Antimicrobial Resistance estimated that **drug-resistant infections already cause at least 700,000 deaths globally each year**, with projections rising substantially by 2050 if no action is taken. The economic impact could be comparable to the 2008–2009 global financial crisis. [(3)]

AMR represents a substantial and escalating global health challenge. Understanding its principal drivers allows for targeted, evidence-based interventions. **Key drivers include injudicious or unnecessary antibiotic use; Inappropriate duration of treatment; and antibiotics prescribed without adequate source control** (e.g. unresolved infection focus, retained devices). [(4)]

In primary care, **prescribing decisions are one of the most important modifiable factors**. Antimicrobial stewardship programmes — including audit and feedback initiatives such as LAMP — improve antimicrobial use and may help extend the effective lifespan of existing agents while new antibiotics are in development. [(5)]

Primary care plays a central role in ensuring antibiotics remain effective for future generations. Through evidence-based prescribing, reflective review of data, and continued engagement with stewardship principles, your practice can make a measurable and lasting impact.

If you require further assistance please contact Michael Crookes, michael.crookes@nhs.net tel: 07920 581594

Yours sincerely,

Paul Carder, Head of West Yorkshire Research and Development

Partners:

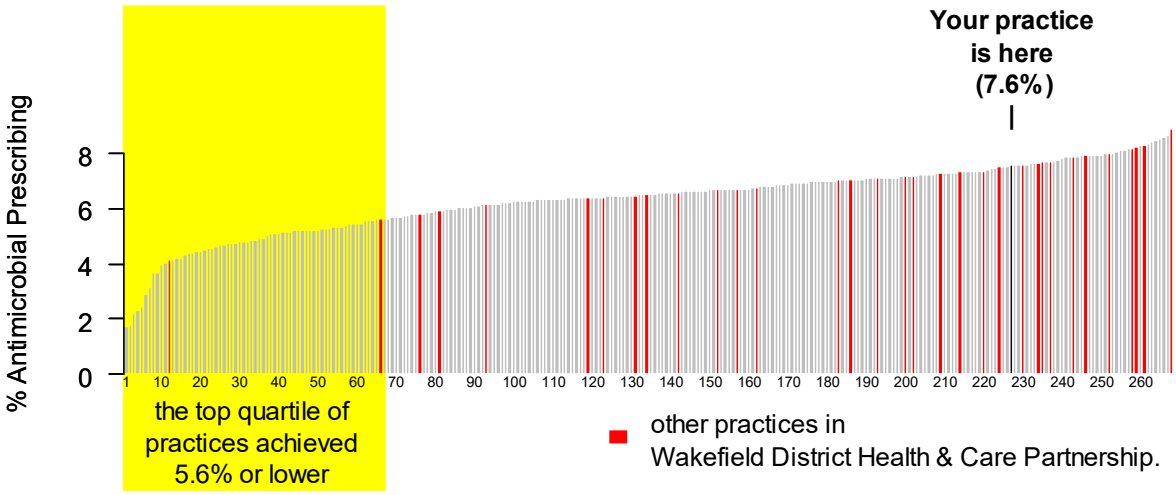
Bradford District and Craven Health and Care Partnership
Calderdale Cares Partnership
Kirklees Health and Care Partnership
Leeds Health and Care Partnership
Wakefield District Health & Care Partnership
UK Health Security Agency (UKHSA)
University of Leeds
West Yorkshire Health and Care Partnership
West Yorkshire Integrated Care Board
West Yorkshire Research & Development

Can you reduce how many of your patients are prescribed an antibiotic?

College Lane Surgery

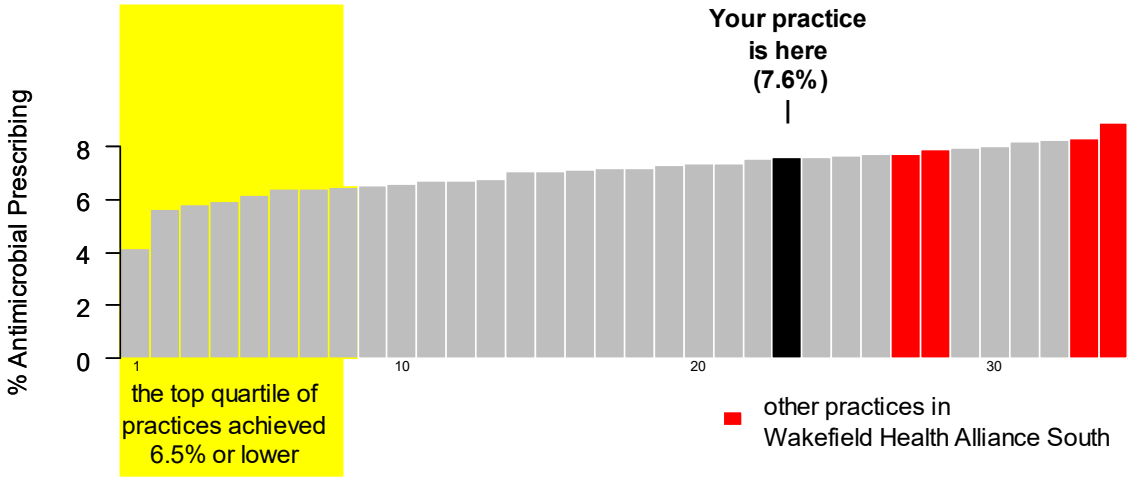
Achievement in participating practices across West Yorkshire Health and Care Partnership

The graph below demonstrates: Your practice (black bar) and percentage of the practice population prescribed an antibiotic (833) in the last 8 weeks; a lower value indicates better clinical practice.



- Achievement throughout West Yorkshire Health and Care Partnership (range 1.7% to 8.9%)
- The best achieving practices within West Yorkshire Health and Care Partnership (yellow box – achieving 5.6% or below)
- Other practices within your place (red bars, Wakefield District Health & Care Partnership.)

Achievement in participating practices across your PCN and Place



- Achievement within your place (range 4.1% to 8.9%)
- The best achieving practices within your place (yellow box – achieving 6.5% or below)
- Achievement within your PCN (range 7.6% to 8.9%)
- Other practices within your PCN (red bars, Wakefield Health Alliance South)

Your practice achievement on individual indicators:

Key indicators for the last 8 weeks	Number of patients	Percentage	Top quartile of practices in ICB achieved:
Prescribed an antibiotic — This measures total number of antibiotic prescriptions for all indications issued in the data collection period.	833	7.56%	5.6% or below
Any age repeat prescription antibiotic >6 months — We remind practices to review patients on antibiotics on repeat regularly – there have been examples of prophylactic antibiotics for UTI being prescribed for years with little or no benefit seen after 6 months.	20	0.18%	0.1% or below
Aged 16-64 with acute prescription of a UTI related antibiotic excluding pregnant women — Guidance for UTI prescribing has changed several times over recent years which can cause confusion. This measure looks at all acute prescriptions for UTI in practices for all patients aged 16-64 years.	20	0.30%	0.2% or below
Prescribed Co-amoxiclav — Co-amoxiclav is an antibiotic which should be reserved for a few specific indications, this measure will allow you to review appropriateness of all co-amoxiclav prescribing.	59	0.54%	0.1% or below
COPD - >2 rescue packs (antibiotic and steroid) issued in the last 12 months — Guidance recommends for people who have used 3 or more courses of oral corticosteroids and/or oral antibiotics in the last year, investigate the possible reasons for this.	26	0.24%	0.1% or below
0-9 Year olds prescribed antibiotic for RTI (upper & lower) — West Yorkshire is almost in the worst quartile for prescribing of antibiotics for children. Practices should be cautious about prescribing antibiotics for children, especially if there is doubt that the infection may be viral in origin.	8	0.74%	0.7% or below
Aged 65+ Prescribed an antibiotic for UTI - No Urine culture — Guidance recommends urine culture in UTI in older adults - ideally before antibiotics are started due to the risks of resistance increasing. Consider review of patients who did not have MSU when antibiotic prescribed.	13	0.50%	0.2% or below
Acute prescription of topical cream — Topical antimicrobials can also contribute to antibiotic resistance if used inappropriately. This measure is specifically focusing on the prescribing of fusidic acid containing products e.g. Fucidin to review whether use is appropriate.	29	0.26%	0.2% or below
Coded sinusitis and prescribed an antibiotic that's not penicillin with no allergy status — Guidance states only in cases lasting longer than 10 days (unless the patient is systemically very unwell or at high risk of complications) and if an antibiotic is necessary first line treatment is phenoxymethylpenicillin.	7	0.06%	0.1% or below
Overall number of respiratory tract infection with an antibiotic prescribed (upper & lower) — The majority of respiratory tract infections will be viral in origin – otitis media, sinusitis, cough and sore throat, in these circumstances antibiotics should not be first line in most cases.	87	0.79%	0.5% or below

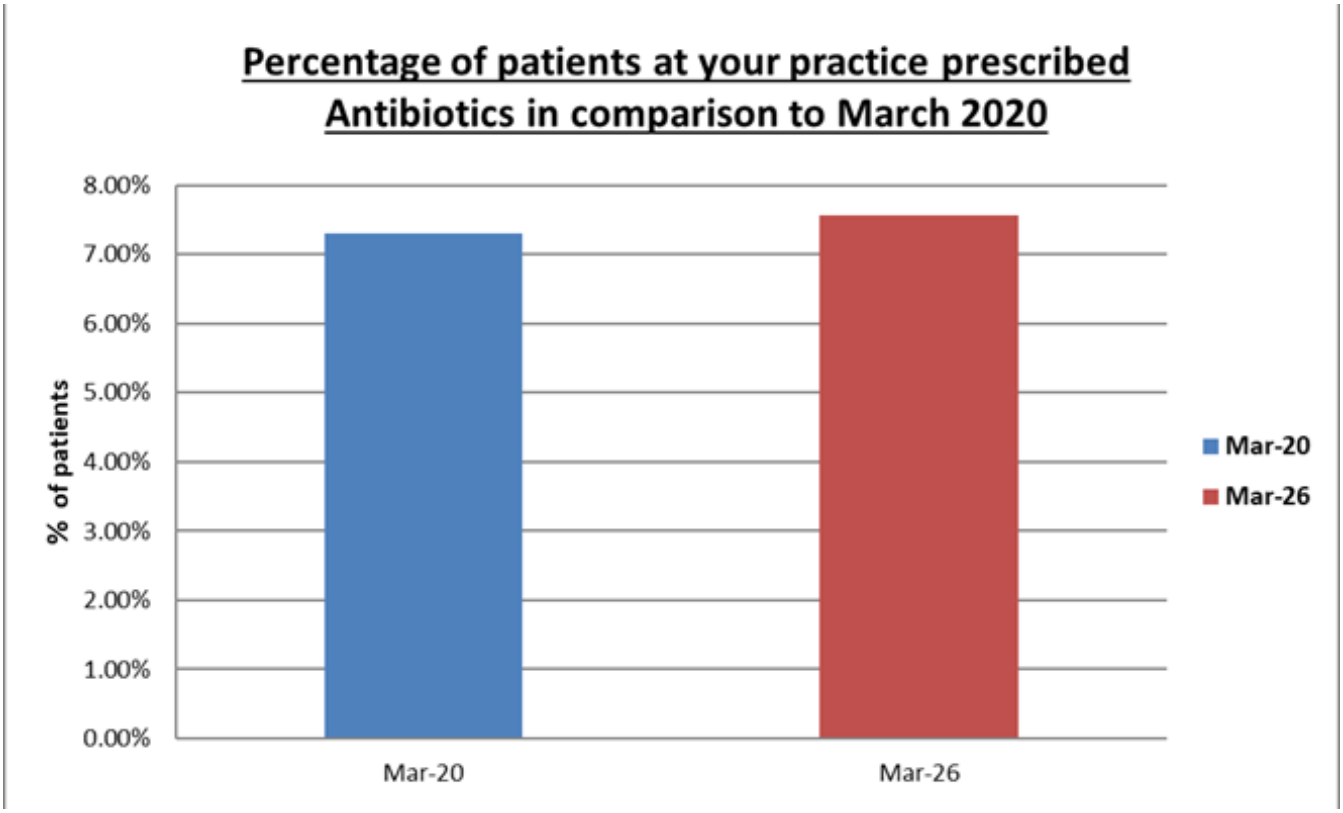
What has changed?

Since this time six years ago Antimicrobial prescribing in your practice has increased by

14%

Don't be disheartened, there may be many clinical reasons why there wasn't a reduction in your antibiotic prescribing. Childhood diseases are becoming prevalent once more and Covid-19 has not gone away, can you identify anything that may have influenced your prescribing over the last 2 months? Have there been any localised outbreaks of illness that required you to prescribe antibiotics? You can use the attached action plan to help with this.

Can you reduce prescribing in the sixth year of LAMP? This is your comparison to this stage at baseline March 2020



Public Health Susceptibility Data

In this issue of LAMP we are going to talk about something other than bacteria!

In 2022 The World Health Organisation developed a fungal priority pathogen list. *Candidozyma auris* (formely known as *Candida albicans*) appeared as a "critical priority" pathogen (along with *Cryptococcus neoformans*, *Aspergillus fumigatus* and *Candida albicans*).

It is estimated that around 6.55 million people are affected by fungal infections with fungal infections directly leading to 2.55 million deaths. *C.auris* first reported in Japan in 2009 (named after being found in the ear of the patient). It has now been reported from over 50 countries and six continents. *C.auris* is specifically adapted (unlike *C.albicans*) to survive on dry human skin and environmental surfaces. It is able to tolerate both higher temperatures and salt content making it ideal to survive on the skin and in particular within the hair follicles.

Why is *C.auris* such a threat? The answer to this is in its acquisition of antifungal resistance in particular over 90% of strains are resistant to the azoles (e.g. fluconazole), its ability to develop resistance to the echinocandins (e.g. caspofunfungin) during treatment and the emergence of strains that are resistant to amphotericin B (still very rare in the UK). Why does this matter? The number of agents available to treat fungal infections is limited and amphotericin B is the equivalent of the carbapenems (e.g. meropenem) in fungal therapy.

Currently *C.auris* in England is predominantly causing healthcare associated outbreaks in NHS Trusts in London and the South-East. We are fortunate in Yorkshire and Humber to have seen very limited numbers. Typically, it is imported into a unit by either a patient repatriated from overseas or a transfer from another hospital e.g. London in this it is very similar to the spread of Carbapenemase Producing Organisms (CPO's). In April 2025 *Cauris* became a notifiable organism under Schedule 2 of the Health Protection (Notification) Regulations 2010.

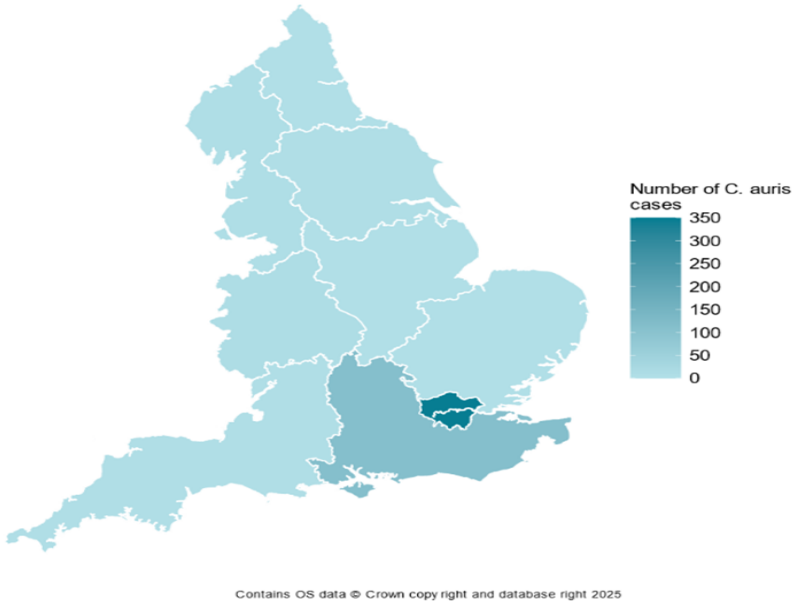
Does it have implications in the community?

In January 2026 UKHSA published guidance. **https://www.gov.uk/guidance/infection-prevention-and-control-for-multidrug-resistant-organisms-in-adult-social-care-settings**

This document sets out practical steps to prevent the spread of these organisms in community settings.

For *C.auris* treatment expert advice should be sought from your local NHS Trust Infection Doctors (Microbiology and/or Infectious Diseases).

Figure 3: Map of C. auris cases by region, England 2023 to 2025



https://www.gov.uk/government/publications/candidozyma-auris-in-england-biannual-epidemiological-commentaries/candidozyma-auris-in-england-data-up-to-september-2025

Have you reviewed and updated your team plan of action?

- What are we going to do (e.g. which indicators would you like to review if any)?

- When are we going to do it (opportunistic, systematic, a combination or another time)?

- Who will be involved (GPs, pharmacist, administrative staff)?

Frequently Asked Questions:

Where do these data sets come from? These West Yorkshire data sets were extracted from SystmOne and EMIS by the Place based teams on Wednesday 4th of March 2026.

How can we share this at practice level? Your latest report will be available online via your general practice stack. You can access this via the QR Code or web link for your GP practice stack **https://api.ltb.io/show/BHJGH**. You can also download a PDF version and print if necessary.

Where can I find the searches in the GP IT system? The searches can be found at:
Bradford District & Craven -Reporting > clinical reporting > data quality > meds mgmt. > LAMP year two
Calderdale, Kirklees and Wakefield
SystmOne:- Data Quality > CCGs Collaborative> LAMP Antibiotic data
EMIS Web:- CHKW CCGs Enterprise > CCGs Collaborative > Antibiotics
Leeds — SystmOne:- NHS Leeds CCG > Meds Opt Provider Team > LAMP searches FINAL
Leeds — EMIS Web:- Leeds Central Reporting Unit > Medicines Opt (Provider) > LAMP searches

Report 43 April 2025	Report 44 May 2025	Report 45 July 2025	Report 46 September 2025	Report 47 November 2025	Report 48 January 2026	Report 49 March 2026

References:

(1) World Health Organization. (2025) *Global antibiotic resistance surveillance report.* (Global Report Overview). https://www.who.int/publications/i/item/9789240116337

(2) World Health Organization. (2023) *Antimicrobial resistance* (Newsroom) https://www.who.int/news-room/fact-sheets/detail/antimicrobial-resistance

(3) Coordination Group on Antimicrobial Resistance. (2019) Report to the Secretary-General of the United Nations. https://cdn.who.int/media/docs/default-source/documents/no-time-to-wait-securing-the-future-from-drug-resistant-infections-en.pdf?sfvrsn=5b424d7_6&download=true

(4) Reza N, Dubey V, Sharland M, Hope W. Antimicrobial use and resistance *BMJ* (2025) 391:e082681 doi:10.1136/bmj-2024-082681.

(5) Araujo da Silva AR, Marques A, Di Biase C, et al. Effectiveness of antimicrobial stewardship programmes in neonatology: a systematic review *BMJ* (2020) 105:563–568.

(6) World Health Organization. (2023) *AWaRe classification of antibiotics for evaluation and monitoring of use.* https://www.who.int/publications/i/item/WHO-MHP-HPS-EML-2023.04.

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