Clostridium difficile infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation
### Publications Gateway Reference: 04949

**Document Purpose:** Resources

**Document Name:** Clostridium difficile infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation

**Author:** NHS England Patient Safety Domain

**Publication Date:** 15 March 2016

**Target Audience:** Medical Directors, Directors of Nursing, GPs

**Additional Circulation List:** CCG Clinical Leaders, CCG Accountable Officers, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, NHS England Regional Directors, Directors of Finance, NHS Trust CEs

**Description:** CDI objectives for 2016/17 for acute trusts and CCGs and guidance on assessing CDI cases to determine whether using sanctions for breach of CDI objectives is appropriate.

**Cross Reference:** N/A

**Superseded Docs (if applicable):** Clostridium difficile infection objectives for NHS organisations in 2015/16 and guidance on sanction implementation

**Action Required:** For consideration by acute trusts and commissioners

**Timing / Deadlines (if applicable):** N/A

**Contact Details for further information:** Patient Safety Domain

NHS England

Skipton House

80 London Road

London

SE1 6LH

---

**Document Status**

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet. **NB:** The NHS Commissioning Board (NHS CB) was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the NHS Commissioning Board has used the name NHS England for operational purposes."
**Clostridium difficile** infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation.

First published: February 2016

**Prepared by Patient Safety Domain, NHS England**

Classification: Official

**Equality and health inequalities statement**

Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

• Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

• Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.
Contents

1. Introduction ........................................................................................................... 5

2. CDI objectives and sanction regime ..................................................................... 5
   - Acute providers .................................................................................................. 5
   - Application of contractual sanctions .................................................................. 6
   - Where a provider has multiple contracts ......................................................... 7
   - Application to community providers .................................................................. 8

3. Assessing whether a CDI was associated with a lapse in care ............................. 8

4. Setting objectives for CCGs .................................................................................. 10

Annex A – Example assessment process for determining which Clostridium difficile infections are relevant for the application of sanctions ......................................................... 11

Annex B – Clostridium difficile case checklist ................................................................ 12

Annex C – See separate example Clostridium difficile infection assessment tool and action plan .......................................................................................................................... 17

Annex D - Key baseline questions before assessing the effectiveness of C. difficile infection treatment and prevention practices ........................................................................................................ 18

Developed by Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections. .................................................................................. 18

Annex E – Clostridium difficile Infection Objectives for non-teaching, teaching and specialist acute trusts, and CCGs for 2016/17 .................................................................................. 22
1. Introduction

1.1 *Clostridium difficile* infection (CDI) remains an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups especially those who have been exposed to antibiotic treatment.

1.2 The NHS has made great strides in reducing the numbers of CDIs, however, the rate of improvement for CDI has slowed over recent years and some infections are a consequence of factors outside the control of the NHS organisation that detected the infection. Further improvement on the current position is likely to require a greater understanding of the individual causes of CDI cases, in order to understand if there were any lapses in the quality of care provided in each case, and if so, to take appropriate steps to address any problems identified. To support this, in 2014/15 NHS England introduced a change in the methodology for calculating organisational CDI objectives and encouraged commissioners to consider sanctions for breach of CDI objectives only where those CDIs were associated with lapses in care.

1.3 This approach remains unchanged for 2016/17, however, due to an overall small rise in the median rate of CDIs, NHS England is carrying over the CDI objectives for 2015/16 into 2016/17.

1.4 Guidance for testing and reporting of CDI cases remains unchanged and the safety and care of patients must be the over-riding concern of everyone. The current protocol for testing and diagnosing CDI (published in March 2012) is based on peer reviewed, published research. It is recognised that no test, or combination of tests, is infallible and the clinical condition of the patient should always be taken into consideration when making management and clinical choices. The guidance can be accessed at [https://www.gov.uk/government/publications/updated-guidance-on-the-diagnosis-and-reporting-of-clostridium-difficile](https://www.gov.uk/government/publications/updated-guidance-on-the-diagnosis-and-reporting-of-clostridium-difficile)

2. CDI objectives and sanction regime

*Acute providers*

2.1 For 2016/17, organisations will continue to be encouraged to assess each CDI case to determine whether the case was linked with a lapse in the quality of care provided to patients. The Co-ordinating Commissioner under each commissioning contract will continue to be able to consider the results of these assessments and exercise discretion in deciding whether any individual case of CDI affecting a patient under its contract should count towards the aggregate number of cases on the basis of which contractual sanctions are calculated.

2.2 For 2016/17, the contractual sanction that can be applied to each *CDI* case in excess of an acute organisation’s objective will remain £10,000.

2.3 CDI objectives for acute organisations (and CCGs) in 2016/17 are the same as those for 2015/16.
2.4 The decision to carry over the 2015/16 objectives has been prompted by the fact that there has been a slight increase in the median CDI rate from the year to November 2014 to the year to November 2015. The current methodology for calculating new CDI objectives relies on requiring organisations that are worse than the median in terms of their rate of CDI to improve by the same amount that the wider median CDI rate has improved from one year to the next. If there is no improvement in this wider rate, it cannot be used to calculate revised objectives. It has therefore been decided to carry over the 2015/16 CDI objectives into 2016/17.

2.5 This should not be interpreted as suggesting that an ‘irreducible minimum’ of CDI cases has been reached for all organisations. Efforts must continue to reduce CDI across the NHS.

2.6 Annex E lists the CDI objectives for Trusts and CCGs for 2016/17

Application of contractual sanctions

2.7 Co-ordinating commissioners, in reaching their decision on whether an individual case of CDI should count towards the aggregate number of cases on the basis of which contractual sanctions are calculated, should take into account information about the extent to which individual CDIs are linked, or not, with lapses in care by the relevant organisation reporting the infection.

2.8 Confirmed CDI cases should be assessed by the reporting provider and the relevant Co-ordinating Commissioner, to determine whether the case was linked with lapses in care by the provider reporting the infection. The provider should involve the relevant Co-ordinating Commissioner in this process in the first instance if possible and, regardless, submit information on each case to their relevant Co-ordinating Commissioner. The Co-ordinating Commissioner may also wish to undertake further assessment of the data on individual cases submitted by the provider.

2.9 For each case where the provider assessment indicates that the case was not linked to a provider lapse of care, the Co-ordinating Commissioner will then determine whether it accepts this argument – and inform the provider accordingly. If it accepts that there has been no lapse of care, then that case should not count towards the total number of actual CDI cases on which any sanction will be based (figure A in the formula in Schedule 4F of the NHS Standard Contract). The decision as to whether a case involves a lapse in care is for the Co-ordinating Commissioner to make at its entire discretion and is not subject to challenge through contract dispute resolution procedures. The flowchart in Annex A summarises this process.

2.10 For example, a single provider may have a target of 25 CDI cases for 2016/17. It may report 30 actual cases in total, but its subsequent assessment of the cases may indicate that only 20 out of the 30 cases were linked with lapses in care by that provider. In this situation, the Co-ordinating Commissioner should use this second number (20 in this
case) as the basis for determining whether any contractual sanction should be applied. If it does so, as this number falls below target, no sanction will apply.

2.11 The provider and Co-ordinating Commissioner should ensure that the process of case assessment is undertaken on an ongoing basis throughout the year as this process will ensure relevant lessons are learned promptly and provide a basis upon which organisations can target further improvement activity to increase patient safety. This will also mean that a clear position on the application of any financial sanctions can be determined promptly at the year-end.

**Where a provider has multiple contracts**

2.12 Most acute providers will have a number of separate contracts and therefore a number of separate Co-ordinating Commissioners. The CDI objective continues to apply at the level of the provider as a whole, however, and this will require a slightly more complex process, which should be considered amongst co-commissioners at the beginning of the financial year.

2.13 For any specific CDI case, the provider should submit the case assessment information to the Co-ordinating Commissioner for the contract under which the patient was treated for the relevant episode of care.

2.14 That Co-ordinating Commissioner should decide, at its own discretion as outlined above, whether it accepts that there has been no lapse of care and whether, therefore, the individual case should not count towards the provider’s actual number of CDI cases for the purposes of calculation of sanctions.

2.15 The level of any overall sanction for the provider as a whole will then be calculated on the basis of the aggregate position against target for the provider as a whole. The figure used for actual cases in the contractual formula (figure A in Schedule 4F) will reflect the decisions reached separately on individual cases by each Co-ordinating Commissioner.

2.16 The split of any overall sanction between separate contracts will then be determined through application of the formula in Schedule 4F of the contract (based on the bed day split between contracts).

2.17 The parties to the provider’s various contracts will need to work closely together to make this process work efficiently and to avoid any duplication in the reporting requirements placed on the provider.

**Application to independent sector providers**

2.18 The process outlined above applies to NHS Trust and FT providers. Where the provider is an independent sector provider, the same principles will apply, in that the Co-ordinating Commissioner will have discretion to determine whether or not an individual case is to count towards the figure A in Schedule 4F.
**Application to community providers**

2.19 Commissioners are advised to apply exactly the same principles as outlined for infections identified as acute related infections to those identified from within the community in order to encourage learning and improvement. This should include cases associated with community providers, relevant independent contractors and other health or social care providers. Following identification of a sample positive for *C. difficile* obtained within four days (where day one is day of admission) of admission to an acute setting or from a community setting or independent provider, providers and commissioners should assess the care provided to determine if there were lapses in care. Any learning should support the development of an action plan and subsequent improvement in care as well as forming part of the relevant contract management processes.

2.20 There are currently no national CDI objectives for community services providers, and no financial sanctions related to CDI are mandated in the NHS Standard Contract for community services providers.

### 3. Assessing whether a CDI was associated with a lapse in care

3.1 Organisations should be encouraged to examine their infection cases to learn any lessons necessary to continuously improve the safety of patients, be focussed on clinical learning and not an attempt to avoid contractual sanctions.

3.2 Each identified CDI case should be assessed with the relevant clinical teams to see if there were any aspects of care that could have been done differently and therefore might have led to a different outcome. The assessment documentation should then be reviewed again by a team from or acting on behalf of the relevant commissioner. This assessment should involve input from a qualified infection prevention clinician and a pharmacist, and should also seek advice and input from local Public Health England experts. If commissioners do not have the relevant expertise in-house, they should seek input from elsewhere. The flowchart in Annex A summarises this process.

3.3 A lapse in care would be indicated by evidence that policies and procedures consistent with local guidance, written in line with national guidance\(^1\) and standards, were not followed by the relevant provider. First and foremost, organisations should be encouraged to examine their infection cases to learn any lessons necessary to continuously improve patient safety.

3.4 The elements of care provision that should be assessed to judge whether an infection was associated with a lapse in care are set out in Annex B. It must be noted that lack of

---

\(^1\) Updated Guidance on the Diagnosis and Reporting of Clostridium Difficile  
compliance with any one of these elements would not in itself indicate that the infection was definitely caused by the provider organisation, only that best practice was not followed at all times. Where a lack of compliance with any of these elements or indeed any others considered relevant is identified, it is the primary responsibility of the provider organisation to take immediate action to reduce any risks to patients. Failure to do so would be unacceptable to commissioners and regulators and most importantly, patients.

3.5 Please refer to Annex B for CDI case checklist, intended to provide a standard way of assessing whether cases do, or do not, represent a lapse in care.

3.6 Please refer to Annex C for an example assessment tool that organisations and commissioners can adapt according to local policy.

3.7 A process of assessing each infection allows infection prevention teams to focus their efforts on areas where problems have been identified and ensure that lessons are learned to support future prevention of infections. This approach supports continual learning and improvement of patient safety and it is critical that appropriate action planning and implementation follows identification of cases involving lapses in care.

3.8 It is important that the objective/sanction regime for CDIs is applied through an intelligent commissioning process that is sensitive to and understands the local context while being resolutely focussed on delivering continual improvement in the quality of care for patients. To this end we recommend that the relevant commissioner is involved in the assessment process in order to generate a common understanding of how findings are reached and what informs the decision making. Ultimately, it is the relevant commissioner who decides whether or not to include any particular CDI case when considering which CDI cases count for the purposes of the contractual sanctions. There is no arbitration process.

3.9 It is also important to emphasise that commissioners should have effective systems for monitoring trust compliance in the application of the recommended, evidence-based *C. difficile* case definition and testing algorithm\(^1\), \(^2\). A consistent approach across trusts is essential in terms of supporting the process of learning to enhance patient safety, and to ensure fair and effective application of the objective/sanction process. We recommend that reviewing compliance with the guidance is part of the commissioners’ quality assessment process. A series of questions to aid this process has been agreed by the DH Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) and can be found at Annex D.

3.10 There is currently no requirement for national reporting of the results of the assessment of whether a CDI case was linked to a lapse in care. However, all CDIs, whether deemed to be associated with a lapse in care or not, should still be reported as per national reporting requirements\(^2\). Where they are associated with lapses in care they are patient safety incidents and should also be reported via local risk management systems to the

\(^2\) Inclusion criteria for reporting *C. difficile* infection to the surveillance system

National Reporting and Learning System\textsuperscript{3}. Staff reporting CDIs as patient safety incidents are encouraged to update incident reports with any learning from their local assessment processes. All CDIs that are deemed Serious Incidents according to existing national definitions\textsuperscript{4} (typically CDIs with identified lapses in care and that led to death or serious harm) should be reported to the Strategic Executive Information System (STEIS), and the ‘lessons learned’ field in STEIS completed.

3.11 Providers and commissioner should publish the results of CDI assessments on their own websites regardless as this will provide patients and others with a richer understanding of the CDI cases reported by organisations.

4. Setting objectives for CCGs

4.1 \textit{C. difficile} objectives have been carried over for CCGs in the same way as for acute providers and are provided in Annex E:

4.2 CCGs should use the objectives provided as thresholds of levels of ambition for planning purposes and NHS England regions, Health and Wellbeing Boards and others should use the objectives as benchmarks for assessing CCGs in tackling CDIs in their areas.

\begin{footnotesize}
\begin{enumerate}
\item Report a patient safety incident \url{http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/}
\item See the \textit{Serious Incident Framework} at \url{https://www.england.nhs.uk/patientsafety/serious-incident/}
\end{enumerate}
\end{footnotesize}
Annex A – Example assessment process for determining which *Clostridium difficile* infections are relevant for the application of sanctions

All relevant samples tested according to existing guidance

If sample positive according to existing guidance for *C. difficile* testing, case is reported according to all current national reporting requirements

If positive, the care provided to the patient is assessed by the clinical team who submitted the sample according to a robust assessment process to determine if the infection was associated with a lapse in care (see checklist contained in Annex B and example assessment tool in Annex C), and to support completion of a local action plan if appropriate. Ideally this process will also involve the commissioner.

If required by the Co-ordinating Commissioner, all confirmed CDIs are secondarily assessed by a team from the relevant Co-ordinating Commissioner, involving input from a qualified infection prevention clinician and a pharmacist, to confirm the provider’s assessment of whether the case was associated with a lapse in care. This will not be necessary where commissioners are already involved in the provider assessment process.

If necessary, the relevant teams from commissioner and provider discuss positive case(s) to establish whether they were associated with a lapse in care.

In the light of the information from the assessments of individual cases, the Co-ordinating Commissioner decides whether it accepts that any or all cases were not related to a lapse in care and informs the provider.

Contractual sanction calculated in accordance with the NHS Standard Contract.
Annex B – Clostridium difficile case checklist

The purpose of this checklist is to guide your local assessment of Clostridium difficile cases so that the minimum information needed to determine the learning required to prevent Clostridium difficile cases can be captured. It should ensure a consistent approach to information contained in Clostridium difficile case assessments across the whole health economy to identify recurring themes and reduce HCAI. It will also help you to understand what your local co-ordinating commissioners will be looking for should you wish to discuss cases you consider to have occurred despite no lapses in care, as outlined in this guidance.

This checklist was developed by the Public Health England CDI 'Lapse in Care' sub-group

1.0 Local C. difficile infection assessment – what to include

1.1 HDCS Case Number.

1.2 Date of Birth.

1.3 Male/Female.

1.4 Date of current admission during which C. difficile infection (CDI) was diagnosed.

1.5 Initial reason for this admission, underlying conditions, and whether diarrhoea was present when admitted.

1.6 The patient pathway should be clearly stated.

1.7 Were any of the following risk factors for developing diarrhoea identified on admission or at the time when the specimen was taken, including:

- Recent laxatives / enemas / anti-emetics / protein pump inhibitors
- Enteral nutrition
- Inflammatory bowel disease
- Previous gastrointestinal surgery
- Gastrointestinal malignancy
- Ileostomy / colostomy
- Other gastrointestinal infection e.g. norovirus
- Chemotherapy / graft versus host disease
- Other immnosuppressive illness or therapies e.g. steroids

1.8 Was bowel habit recorded on admission? Was the Bristol Stool Chart (BSC) used? Was it used immediately when symptoms began? Summarise the BSC results. Were other measures used to monitor for the presence of diarrhoea in this patient?

1.9 On what date were diarrhoeal symptoms first documented in relation to the current episode of CDI? Was the patient source isolated at the time? If no, how soon after onset of diarrhoeal symptoms was the patient source isolated? What was/were the
reasons for delay in source-isolation? \textit{If there is insufficient information available to determine the timeliness of interventions then this is a potentially important short-coming.}

1.10 On what date and in which location was sample taken? Was there a delay in sampling according to your local guidance? \textit{As a minimum, national guidance should have been followed.}

1.11 On what date and at what time was the sample received in the laboratory? On what date and at what time was the result was reported to the sender?

1.12 Were the sampling, testing and reporting arrangements in this case clearly compliant with the 2012 Department of Health guidance ‘Updated guidance on the diagnosis and reporting of \textit{Clostridium difficile}?’

1.13 How long did the patient remain under appropriate source-isolation after the CDI diagnosis? If the patient was removed from source isolation what was the rationale? Was this consistent with your local guidance?

1.14 If there was any non-compliance above – explain why.

2.0 \textbf{Chronology of patient pathway}

2.1 \textit{Provide an outline} timeline where the patient was in the three months prior to the latest CDI diagnosis e.g. Home, hospital, care home, etc. Ideally, identify if they had any contact with known CDI cases or carriers of \textit{C. difficile} (e.g. GDH-positive, toxin-negative cases) in these locations and, if so, any relevant ribotyping/MLVA results that are available.

2.2 Had the patient had any previous confirmed episodes of CDI? If yes, when did they occur? If performed, what are/were the ribotyping/MLVA typing results of the current and any past episodes of CDI? Had the patient been told of the CDI diagnosis and understood the condition?

2.3 If you suspect that the latest case is a ‘recurrence’, outline if the previous episode(s) were correctly treated as per your local CDI treatment guideline. Was the patient treated with any other antimicrobials between this and the previous episode(s)? Was this treatment in line with local guidelines?

2.4 Has the patient received other treatment (e.g. enteral feeding) and/or medication (e.g. PPIs) possibly relevant to the development of this episode of CDI? Were these in line with local guidelines?

2.5 If there was any non-compliance above – explain why.
3.0 Antimicrobial Therapy

3.1 List all antimicrobial therapy (antibiotic, dose, duration) in the previous 3 months.

3.2 Concerning the current episode/admission, were the indication(s) for antimicrobial treatment duration and the review date written in the patient’s notes or drug chart? Was the indication(s) for this treatment appropriate at the point it was prescribed?

3.3 Was initial empiric therapy appropriately modified in response to microbiological results?

3.4 Were all antimicrobials prescribed compliant with local guidelines? If not, were they still clinically justified (please provide an explanation)?

3.5 If there was any non-compliance above, explain why.

4.0 Treatment of CDI and outcome

4.1 Was the patient treated for CDI on this occasion? If not, what were the clinical factors that were used to determine treatment was not required?

4.2 Was the patient told of the CDI diagnosis and did he/she demonstrate an understanding of the condition?

4.3 Does your local CDI treatment guideline contain a measure of severity? If so, how was this case categorised?

4.4 If this case was treated, what treatment (drug, dose, duration) was used? Was this treatment compliant with your local guidance?

4.5 What was the clinical outcome? Did the patient die within 30 days of CDI diagnosis? If so, was this death linked to CDI? Did CDI appear on the Death Certificate (which part); please provide details of all conditions listed?

4.6 If there was any non-compliance above – explain why.

5.0 Environmental Factors

5.1 Were there any cleanliness/environmental issues reported in relation to the area(s) in which the patient was cared for prior to the development of CDI (including the results of recent audits)? Please provide details of any issues.

5.2 Outline details of any additional cleaning measures that have been deployed in this/these area(s) over the previous three months (e.g. hydrogen peroxide vaporization) either as a pre-emptive measure (e.g. whole ward decant/deep clean) or as terminal side room cleaning in relation to previous episodes of CDI

5.3 What audit/monitoring measures were in place to assess the efficacy of cleaning? How robust (quantitative/qualitative) are these?

5.4 What monitoring of hand hygiene compliance was in place at the time including how robust this monitoring was e.g. who did this? What were the results?

5.5 If there was any non-compliance above, explain why.
6.0 Organisation issues

6.1 Were there any organisational factors that might have influenced this case? This could include whether staffing levels/skill mix were in line with local agreements where this patient was managed.

6.2 Is there evidence that mandatory training and IPC training have been undertaken by staff relevant to this case?

6.3 Is there evidence that communication and documentation related to this patient was adequate?

6.4 If there was any non-compliance above, explain why and how this could / could not be related to the development of C. difficile infection.

7.0 Optimisation of diarrhoea control in the organisation

7.1 Does the organisation have a protocol for the management of patients with diarrhoea? Was this being followed in the clinical area relevant to this case?

   More specifically:

   7.1.1 Was the documentation of patients with diarrhoea adequate/complete?

   7.1.2 Was the rate of diarrhoea increased in the clinical area relevant to the index case (during the 1 month beforehand)? Was a reason for this found and what measures were put in place to address this? Were these patients managed in accordance with local guidance in relation to sampling and source isolation of suspected infectious causes of diarrhoea?

7.2 If there was any non-compliance above, explain why.

8.0 Lessons Learned

8.1 Outline the lessons learned from this episode of CDI. Are there any recurring themes seen across this and other assessments? How have these been addressed?

8.2 Provide a commentary on any recurring themes from previous CDI case assessments. What is the hypothesis for why these cases are still happening? What action(s) has the organisation put in place to prevent further cases of CDI? What factors appear to be responsible for their lack of success?
9.0 Preventability

9.1 State whether you have identified any ‘lapses in care’ that could have contributed to the development of this CDI case.

9.2 In order to facilitate learning and optimisation of patient care, please identify any other lapses in care i.e. that did not contribute to the development of this CDI case.

9.3 If you consider this CDI case occurred despite no lapses in care (and so was deemed not to be ‘preventable’), outline your reason(s) why.
Annex C – See separate example *Clostridium difficile* infection assessment tool and action plan

Organisations may wish to use this example assessment tool to collect the minimum information needed to determine the learning required to prevent CDI cases. Use of this example assessment tool will support a consistent approach to gathering information generated by CDI assessments across the whole health economy and is encouraged in order to support the identification of recurring themes and therefore the reduction of HCAIs.

Organisations and commissioners are encouraged to use this tool but are free to adapt it according to local guidance.
Annex D - Key baseline questions before assessing the effectiveness of *C. difficile* infection treatment and prevention practices.

Developed by Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections.

These questions have been developed to support organisations to understand whether patients presenting with diarrhoea are appropriately assessed and their illness investigated. It is important that when a patient presents with diarrhoea, the possibility that there may be an infectious cause is considered. Patients with suspected potentially infectious diarrhoea should be isolated, and have appropriate investigation(s) to determine the aetiology.

If patients with suspected *C. difficile* infection (CDI) are not investigated appropriately then there is a risk of sub-optimal treatment and risk of transmission of *C. difficile* to other patients. The timely submission of a faecal sample for microbiological testing is a fundamental part of the investigation of potentially infectious diarrhoea.

Furthermore, reported numbers of cases may provide false assurance that there is minimal risk of CDI in patients and/or transmission of *C. difficile* between patients.

There are three key elements to measuring the burden of CDI. A consistent approach to;

- which patients are sampled;
- how laboratory testing is carried out; and
- which results are reported;

will ensure the prompt recognition and isolation of infected patients in the interests of patient safety, and will ensure that recorded numbers of CDIs reflect the true rate of infection.

Clear guidance on these three elements was issued to the NHS in 2012⁵.

Failure to diagnose CDI carries increased potential risk for patients because treatment and prevention practices may be compromised.

Failure to detect all possible cases of CDI increases the chance of transmission of *C. difficile*, including the spread of epidemic/virulent strains.

The 7 questions below (Table 1) are designed to determine whether the recorded number of cases accurately reflects CDI burden.

---

⁵ Updated Guidance on the Diagnosis and Reporting of Clostridium Difficile
<table>
<thead>
<tr>
<th>Question</th>
<th>How to assess compliance</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are faecal samples sent for <em>C. difficile</em> testing from all patients who develop diarrhoea, regardless of when this occurs, who do not have a clear, non-infection, alternative explanation for its cause?</td>
<td>Ideally via audit data that show how many patients have new onset diarrhoea (as defined in guidance: Bristol Stool Chart types 5-7), and what proportion of these are sampled appropriately. This assessment should include whether necessary samples are sent to Microbiology and when are they sent – should be on the same day as new symptoms commence.</td>
<td>Guidance states: If a patient has diarrhoea (Bristol Stool Chart types 5-7) that is not clearly attributable to an underlying condition (e.g. inflammatory colitis, overflow) or therapy (e.g. laxatives, enteral feeding) then it is necessary to determine if this is due to CDI. If in doubt please seek advice. Assumptions that CDI is not the cause of new diarrhoeal episodes need to be robust and documented in the patient’s notes. There should be a medical assessment of cases to assure that diarrhoea is not of infective origin; reasonable alternative explanations are quoted in the above excerpt from guidance.</td>
</tr>
<tr>
<td>2. What is the evidence that this is understood and practised consistently by all healthcare staff across the organisation?</td>
<td>Direct questioning of healthcare workers or via audit data as above.</td>
<td>As this is starting point for the entire testing pathway, it is important that healthcare workers understand which patients require samples to be sent to Microbiology.</td>
</tr>
<tr>
<td>3. Are all diarrhoeal samples received in the laboratory from hospital patients aged &gt;2 years, community patients aged &gt;65 years, and community patients aged &lt;65 years wherever</td>
<td>There should be laboratory standard operating procedure (sometimes referred to an Examination procedure) that clearly states which samples received in the laboratory are tested for evidence of CDI.</td>
<td>Guidance states: diarrhoeal samples should be tested for <em>C. difficile</em> from: hospital patients aged &gt;2 years, and, community patients, aged &gt;65 years, and community patients aged...</td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
<td>Guidance</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>clinically indicated tested for <em>C. difficile</em>?</td>
<td>There will likely be different rules in place for how hospital inpatient vs community patient samples are processed as set out in DH CDI testing guidance (see right). Have laboratories audited their practice to show that appropriate samples are tested for CDI and inappropriate samples are not tested for CDI (e.g. samples from infants, non-diarrhoeal samples)?</td>
<td>&lt;65 years wherever clinically indicated.</td>
</tr>
<tr>
<td>4. Is all <em>C. difficile</em> testing consistent with the recommended two-stage algorithm?</td>
<td>There should be laboratory standard operating procedure that clearly states how samples received in the laboratory are tested for evidence of CDI. Have laboratories audited their practice to show that samples are tested appropriately?</td>
<td>Guidance states:</td>
</tr>
<tr>
<td></td>
<td>The first test should be either a GDH or toxin gene (PCR) test; if this is positive, the second test should be a toxin (EIA or cytotoxin) test. If the first test is negative a second test is not needed. Additional tests may be used, but not instead of the recommended approach. If samples from patients with diarrhoea are not tested appropriately for evidence of CDI then there is a risk of false-negative and/or false-positive results.</td>
<td></td>
</tr>
<tr>
<td>5. Are all toxin positive patients reported to PHE?</td>
<td>The number of laboratory reported CDI positive samples should match the number of cases reported to PHE (after applying de-duplication according to 28 day rule). What is the organisation’s rationale for not reporting toxin positive cases (see 6. below)?</td>
<td>Guidance states:</td>
</tr>
<tr>
<td></td>
<td>All GDH EIA (or NAAT) positive, toxin positive patients/reports should be reporting to PHE.</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Response</td>
<td>Reference</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>6. Are clinical criteria or other tests outside of the algorithm referred to in question 4 above used to determine which toxin positive results are reported to PHE?</td>
<td>The number of laboratory reported CDI positive cases should match the number of cases reported to PHE (after applying de-duplication according to 28 day rule).</td>
<td>See 5. above. passengers do not use tests and/or clinical criteria to determine which positive patients are reported to PHE.</td>
</tr>
<tr>
<td>7. Are toxin positive results obtained &gt;28 days after a previous positive result on the same patient reported to PHE?</td>
<td>The number of laboratory reported CDI positive cases should match the number of cases reported to PHE (after applying de-duplication according to 28 day rule).</td>
<td>See 5. above. Patients with repeat positive results more than 28 days apart should also be reported. Such results likely indicate recurrence of CDI. Such recurrences are due to relapse or re-infection, and some may be preventable.</td>
</tr>
</tbody>
</table>
Annex E – *Clostridium difficile* Infection Objectives for non-teaching, teaching and specialist acute trusts, and CCGs for 2016/17

**Principles and methodology**

The objectives for all organisations in 2016/17 are the same as for 2015/16 although updated for trust and CCG mergers. The methodology used to calculate the objectives for 2015/16 is set out below for information.

Three cohorts of acute trusts have been recognised for the purposes of calculating median CDI rates—acute teaching hospitals, specialist hospitals and non-teaching (such as, small, medium, large and mixed service) acute hospitals as defined by the Hospital Estates and Facilities ERIC return. CCGs form their own separate cohort.

For one of these cohorts, specialist trusts, due to the heterogeneity of these organisations meaning a single median for this group is arbitrary, CDI objectives have been set by requiring all specialist trusts to reduce their current CDI case total for the 12 months to November 2014 by one case. This reflects the principle of continuous improvement. The calculations below are therefore not relevant to specialist trusts.

For the two non-specialist trust cohorts (teaching and non-teaching acute trusts) and CCGs, the median CDI rate for the most recent available 12 months (to November 2014) is calculated for each cohort separately. The median CDI rate is also calculated for each cohort for their previous 12 month median CDI rate. For each cohort, the rate of CDI improvement from the preceding 12 months (to November 2013) to the most recent 12 months (to November 2014) are then calculated to give a cohort rate of CDI improvement. These values are set out in the table below;

<table>
<thead>
<tr>
<th>Cohort</th>
<th>CDI rate for year to November 2014</th>
<th>CDI rate for year to November 2013</th>
<th>Reduction in CDI rate from 2013 year to 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-teaching acute trusts</td>
<td>13.1 CDI cases per 100,000 bed days</td>
<td>14.9 CDI cases per 100,000 bed days</td>
<td>12.5%</td>
</tr>
<tr>
<td>Teaching acute trusts</td>
<td>16.3 CDI cases per 100,000 bed days</td>
<td>16.9 CDI cases per 100,000 bed days</td>
<td>3.6%</td>
</tr>
<tr>
<td>CCGs</td>
<td>24.3 CDI cases per 100,000 population</td>
<td>25.8 CDI cases per 100,000 population</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

All organisations with a CDI rate for the year to November 2014 below (better than) their cohort median for the same period, had a CDI objective for 2015/16 set as their number of CDI cases reported during the year to November 2014 minus one.
All organisations with a CDI rate for the year to November 2014 above (worse than) their cohort median for the same period had a CDI objective set as their CDI rate for the year to November 2014 minus the percentage reduction in median CDI rate seen for their cohort between the preceding year and the current year. This means their objective reflected the rate of improvement seen for their cohort of trusts over the previous year. This reflects the need for those organisations with CDI rates worse than average to improve at a faster rate than those that are better than average, but that this rate of improvement should reflect the most recent available information about what is achievable.

Where this methodology required an organisation to improve from above their cohort median to below it, their objective becomes their cohort median unless the reduction required to move below the median is less than one CDI case. If so, the organisation has an objective of their current number of cases reported during the year to November 2014 minus one case. This avoids requiring organisations performing worse than average to leapfrog those performing better than average.

The tables below set out the objectives for all organisation cohorts:

<table>
<thead>
<tr>
<th>Org code</th>
<th>Name</th>
<th>CDI case objective for 2016/17</th>
<th>CDI rate objective for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>REM</td>
<td>Aintree University</td>
<td>46</td>
<td>19.5</td>
</tr>
<tr>
<td>RCF</td>
<td>Airedale</td>
<td>6</td>
<td>5.3</td>
</tr>
<tr>
<td>RTK</td>
<td>Ashford and St. Peter’s Hospitals</td>
<td>17</td>
<td>9.9</td>
</tr>
<tr>
<td>RF4</td>
<td>Barking, Havering and Redbridge University Hospitals</td>
<td>30</td>
<td>8.6</td>
</tr>
<tr>
<td>RFF</td>
<td>Barnsley Hospital</td>
<td>13</td>
<td>8.8</td>
</tr>
<tr>
<td>R1H</td>
<td>Barts Health</td>
<td>82</td>
<td>13.0</td>
</tr>
<tr>
<td>RDD</td>
<td>Basildon and Thurrock University Hospitals</td>
<td>31</td>
<td>13.6</td>
</tr>
<tr>
<td>RC1</td>
<td>Bedford Hospital</td>
<td>10</td>
<td>8.3</td>
</tr>
<tr>
<td>RMC</td>
<td>Bolton</td>
<td>19</td>
<td>9.5</td>
</tr>
<tr>
<td>RXQ</td>
<td>Buckinghamshire Healthcare</td>
<td>32</td>
<td>13.1</td>
</tr>
<tr>
<td>RJF</td>
<td>Burton Hospitals</td>
<td>20</td>
<td>13.4</td>
</tr>
<tr>
<td>RWY</td>
<td>Calderdale and Huddersfield</td>
<td>21</td>
<td>8.6</td>
</tr>
<tr>
<td>RFS</td>
<td>Chesterfield Royal Hospital</td>
<td>31</td>
<td>16.4</td>
</tr>
<tr>
<td>RLN</td>
<td>City Hospitals Sunderland</td>
<td>34</td>
<td>15.4</td>
</tr>
<tr>
<td>RDE</td>
<td>Colchester Hospital University</td>
<td>18</td>
<td>9.1</td>
</tr>
<tr>
<td>RJR</td>
<td>Countess Of Chester Hospital</td>
<td>24</td>
<td>12.8</td>
</tr>
<tr>
<td>RXP</td>
<td>County Durham and Darlington</td>
<td>19</td>
<td>5.9</td>
</tr>
<tr>
<td>Code</td>
<td>Trust Name</td>
<td>Score</td>
<td>Rank</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>RJ6</td>
<td>Croydon Health Services</td>
<td>16</td>
<td>9.6</td>
</tr>
<tr>
<td>RN7</td>
<td>Dartford and Gravesham</td>
<td>24</td>
<td>12.5</td>
</tr>
<tr>
<td>RP5</td>
<td>Doncaster and Bassetlaw Hospitals</td>
<td>40</td>
<td>13.8</td>
</tr>
<tr>
<td>RBD</td>
<td>Dorset County Hospital</td>
<td>14</td>
<td>13.6</td>
</tr>
<tr>
<td>RWH</td>
<td>East and North Hertfordshire</td>
<td>11</td>
<td>4.9</td>
</tr>
<tr>
<td>RN</td>
<td>East Cheshire</td>
<td>14</td>
<td>12.0</td>
</tr>
<tr>
<td>RVV</td>
<td>East Kent Hospitals University</td>
<td>46</td>
<td>13.9</td>
</tr>
<tr>
<td>RXR</td>
<td>East Lancashire Hospitals</td>
<td>28</td>
<td>9.3</td>
</tr>
<tr>
<td>RXC</td>
<td>East Sussex Healthcare</td>
<td>41</td>
<td>16.8</td>
</tr>
<tr>
<td>RVR</td>
<td>Epsom and St. Helier University Hospitals</td>
<td>39</td>
<td>15.9</td>
</tr>
<tr>
<td>RDU</td>
<td>Frimley Health</td>
<td>31</td>
<td>7.6</td>
</tr>
<tr>
<td>RR7</td>
<td>Gateshead Health</td>
<td>19</td>
<td>11.6</td>
</tr>
<tr>
<td>RLT</td>
<td>George Eliot Hospital</td>
<td>13</td>
<td>12.5</td>
</tr>
<tr>
<td>RTE</td>
<td>Gloucestershire Hospitals</td>
<td>37</td>
<td>11.5</td>
</tr>
<tr>
<td>RN3</td>
<td>Great Western Hospitals</td>
<td>20</td>
<td>9.4</td>
</tr>
<tr>
<td>RN5</td>
<td>Hampshire Hospitals</td>
<td>34</td>
<td>13.2</td>
</tr>
<tr>
<td>RCD</td>
<td>Harrogate and District</td>
<td>12</td>
<td>11.7</td>
</tr>
<tr>
<td>RR1</td>
<td>Heart Of England</td>
<td>64</td>
<td>13.0</td>
</tr>
<tr>
<td>RQQ</td>
<td>Hinchingbrooke Health Care</td>
<td>11</td>
<td>15.6</td>
</tr>
<tr>
<td>RQX</td>
<td>Homerton University Hospital</td>
<td>7</td>
<td>5.6</td>
</tr>
<tr>
<td>RGQ</td>
<td>Ipswich Hospital</td>
<td>18</td>
<td>9.4</td>
</tr>
<tr>
<td>R1F</td>
<td>Isle of Wight</td>
<td>7</td>
<td>7.3</td>
</tr>
<tr>
<td>RGP</td>
<td>James Paget University Hospitals</td>
<td>17</td>
<td>13.1</td>
</tr>
<tr>
<td>RNQ</td>
<td>Kettering General Hospital</td>
<td>26</td>
<td>13.4</td>
</tr>
<tr>
<td>RAX</td>
<td>Kingston Hospital</td>
<td>9</td>
<td>6.5</td>
</tr>
<tr>
<td>RJ2</td>
<td>Lewisham and Greenwich</td>
<td>39</td>
<td>13.0</td>
</tr>
<tr>
<td>R1K</td>
<td>London North West Healthcare</td>
<td>37</td>
<td>9.4</td>
</tr>
<tr>
<td>RC9</td>
<td>Luton and Dunstable University Hospital</td>
<td>6</td>
<td>3.1</td>
</tr>
<tr>
<td>RWF</td>
<td>Maidstone and Tunbridge Wells</td>
<td>27</td>
<td>11.5</td>
</tr>
<tr>
<td>RPA</td>
<td>Medway</td>
<td>20</td>
<td>10.9</td>
</tr>
<tr>
<td>RBT</td>
<td>Mid Cheshire Hospitals</td>
<td>24</td>
<td>13.1</td>
</tr>
<tr>
<td>RQ8</td>
<td>Mid Essex Hospital Services</td>
<td>13</td>
<td>7.3</td>
</tr>
<tr>
<td>RXF</td>
<td>Mid Yorkshire Hospitals</td>
<td>27</td>
<td>8.3</td>
</tr>
<tr>
<td>Code</td>
<td>Hospital Name</td>
<td>Code</td>
<td>Hospital Name</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------------</td>
<td>------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>RD8</td>
<td>Milton Keynes University Hospital</td>
<td>39</td>
<td>25.8</td>
</tr>
<tr>
<td>RVJ</td>
<td>North Bristol</td>
<td>43</td>
<td>13.0</td>
</tr>
<tr>
<td>RNL</td>
<td>North Cumbria University Hospitals</td>
<td>25</td>
<td>13.2</td>
</tr>
<tr>
<td>RAP</td>
<td>North Middlesex University Hospital</td>
<td>34</td>
<td>25.8</td>
</tr>
<tr>
<td>RVW</td>
<td>North Tees and Hartlepool</td>
<td>13</td>
<td>6.8</td>
</tr>
<tr>
<td>RNS</td>
<td>Northampton General Hospital</td>
<td>21</td>
<td>8.2</td>
</tr>
<tr>
<td>RBZ</td>
<td>Northern Devon Healthcare</td>
<td>7</td>
<td>6.9</td>
</tr>
<tr>
<td>RJL</td>
<td>Northern Lincolnshire and Goole</td>
<td>21</td>
<td>8.5</td>
</tr>
<tr>
<td>RTF</td>
<td>Northumbria Healthcare</td>
<td>30</td>
<td>9.4</td>
</tr>
<tr>
<td>RW6</td>
<td>Pennine Acute Hospitals</td>
<td>55</td>
<td>13.3</td>
</tr>
<tr>
<td>RGN</td>
<td>Peterborough &amp; Stamford Hospitals</td>
<td>29</td>
<td>14.4</td>
</tr>
<tr>
<td>RK9</td>
<td>Plymouth Hospitals</td>
<td>35</td>
<td>13.2</td>
</tr>
<tr>
<td>RD3</td>
<td>Poole Hospital</td>
<td>15</td>
<td>9.2</td>
</tr>
<tr>
<td>RHU</td>
<td>Portsmouth Hospitals</td>
<td>40</td>
<td>12.2</td>
</tr>
<tr>
<td>RHW</td>
<td>Royal Berkshire</td>
<td>27</td>
<td>12.2</td>
</tr>
<tr>
<td>REF</td>
<td>Royal Cornwall Hospitals</td>
<td>23</td>
<td>10.6</td>
</tr>
<tr>
<td>RH8</td>
<td>Royal Devon and Exeter</td>
<td>31</td>
<td>12.7</td>
</tr>
<tr>
<td>RA2</td>
<td>Royal Surrey County Hospital</td>
<td>21</td>
<td>13.6</td>
</tr>
<tr>
<td>RD1</td>
<td>Royal United Hospitals Bath</td>
<td>22</td>
<td>10.9</td>
</tr>
<tr>
<td>RNZ</td>
<td>Salisbury</td>
<td>19</td>
<td>13.0</td>
</tr>
<tr>
<td>RXK</td>
<td>Sandwell and West Birmingham Hospitals</td>
<td>30</td>
<td>12.3</td>
</tr>
<tr>
<td>RK5</td>
<td>Sherwood Forest Hospitals</td>
<td>48</td>
<td>19.4</td>
</tr>
<tr>
<td>RXW</td>
<td>Shrewsbury and Telford Hospital</td>
<td>25</td>
<td>9.9</td>
</tr>
<tr>
<td>RE9</td>
<td>South Tyneside</td>
<td>8</td>
<td>6.5</td>
</tr>
<tr>
<td>RJC</td>
<td>South Warwickshire</td>
<td>6</td>
<td>3.6</td>
</tr>
<tr>
<td>RAJ</td>
<td>Southend University Hospital</td>
<td>30</td>
<td>17.3</td>
</tr>
<tr>
<td>RVY</td>
<td>Southport and Ormskirk Hospital</td>
<td>36</td>
<td>24.0</td>
</tr>
<tr>
<td>RBN</td>
<td>St. Helens and Knowsley Hospitals</td>
<td>41</td>
<td>17.5</td>
</tr>
<tr>
<td>RWJ</td>
<td>Stockport</td>
<td>17</td>
<td>7.8</td>
</tr>
<tr>
<td>RTP</td>
<td>Surrey and Sussex Healthcare</td>
<td>15</td>
<td>7.6</td>
</tr>
<tr>
<td>RMP</td>
<td>Tameside Hospital</td>
<td>46</td>
<td>29.9</td>
</tr>
<tr>
<td>RBA</td>
<td>Taunton and Somerset</td>
<td>12</td>
<td>7.0</td>
</tr>
<tr>
<td>RNA</td>
<td>The Dudley Group</td>
<td>29</td>
<td>13.0</td>
</tr>
<tr>
<td>Code</td>
<td>Hospital Name</td>
<td>Value</td>
<td>Percentage</td>
</tr>
<tr>
<td>------</td>
<td>---------------------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>RAS</td>
<td>The Hillingdon Hospitals</td>
<td>8</td>
<td>6.3</td>
</tr>
<tr>
<td>RQW</td>
<td>The Princess Alexandra Hospital</td>
<td>10</td>
<td>6.5</td>
</tr>
<tr>
<td>RCX</td>
<td>The Queen Elizabeth Hospital, King’s Lynn</td>
<td>53</td>
<td>38.0</td>
</tr>
<tr>
<td>RFR</td>
<td>The Rotherham</td>
<td>26</td>
<td>13.0</td>
</tr>
<tr>
<td>RDZ</td>
<td>The Royal Bournemouth and Christchurch Hospitals</td>
<td>14</td>
<td>6.9</td>
</tr>
<tr>
<td>RL4</td>
<td>The Royal Wolverhampton</td>
<td>35</td>
<td>13.1</td>
</tr>
<tr>
<td>RKE</td>
<td>The Whittington Hospital</td>
<td>17</td>
<td>17.3</td>
</tr>
<tr>
<td>RA9</td>
<td>Torbay and South Devon</td>
<td>18</td>
<td>14.2</td>
</tr>
<tr>
<td>RWD</td>
<td>United Lincolnshire Hospitals</td>
<td>59</td>
<td>16.9</td>
</tr>
<tr>
<td>RKB</td>
<td>University Hospitals Coventry and Warwickshire</td>
<td>42</td>
<td>11.3</td>
</tr>
<tr>
<td>RTX</td>
<td>University Hospitals Of Morecambe Bay</td>
<td>44</td>
<td>20.1</td>
</tr>
<tr>
<td>RBK</td>
<td>Walsall Healthcare</td>
<td>18</td>
<td>11.1</td>
</tr>
<tr>
<td>RWW</td>
<td>Warrington and Halton Hospitals</td>
<td>27</td>
<td>14.2</td>
</tr>
<tr>
<td>RWG</td>
<td>West Hertfordshire Hospitals</td>
<td>23</td>
<td>10.9</td>
</tr>
<tr>
<td>RGR</td>
<td>West Suffolk</td>
<td>16</td>
<td>12.5</td>
</tr>
<tr>
<td>RYR</td>
<td>Western Sussex Hospitals</td>
<td>39</td>
<td>13.0</td>
</tr>
<tr>
<td>RA3</td>
<td>Weston Area Health</td>
<td>18</td>
<td>21.4</td>
</tr>
<tr>
<td>RWP</td>
<td>Worcestershire Acute Hospitals</td>
<td>32</td>
<td>11.8</td>
</tr>
<tr>
<td>RRF</td>
<td>Wrightington, Wigan and Leigh</td>
<td>19</td>
<td>12.7</td>
</tr>
<tr>
<td>RLQ</td>
<td>Wye Valley</td>
<td>18</td>
<td>21.7</td>
</tr>
<tr>
<td>RA4</td>
<td>Yeovil District Hospital</td>
<td>8</td>
<td>7.9</td>
</tr>
</tbody>
</table>
### Teaching Acute Trusts

<table>
<thead>
<tr>
<th>Org code</th>
<th>Name</th>
<th>CDI case objective for 2016/17</th>
<th>CDI rate objective for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>RXL</td>
<td>Blackpool Teaching Hospitals&lt;sup&gt;6&lt;/sup&gt;</td>
<td>40</td>
<td>15.0</td>
</tr>
<tr>
<td>RAE</td>
<td>Bradford Teaching Hospitals</td>
<td>51</td>
<td>26.8</td>
</tr>
<tr>
<td>RXH</td>
<td>Brighton &amp; Sussex University Hospitals</td>
<td>46</td>
<td>17.2</td>
</tr>
<tr>
<td>RGT</td>
<td>Cambridge University Hospitals</td>
<td>49</td>
<td>15.6</td>
</tr>
<tr>
<td>RW3</td>
<td>Central Manchester University Hospitals</td>
<td>66</td>
<td>16.4</td>
</tr>
<tr>
<td>RQM</td>
<td>Chelsea and Westminster Hospital&lt;sup&gt;7&lt;/sup&gt;</td>
<td>16</td>
<td>5.0</td>
</tr>
<tr>
<td>RTG</td>
<td>Derby Teaching Hospitals&lt;sup&gt;8&lt;/sup&gt;</td>
<td>53</td>
<td>16.6</td>
</tr>
<tr>
<td>RJ1</td>
<td>Guy’s and St. Thomas’</td>
<td>51</td>
<td>16.0</td>
</tr>
<tr>
<td>RWA</td>
<td>Hull and East Yorkshire Hospitals</td>
<td>53</td>
<td>15.0</td>
</tr>
<tr>
<td>RYJ</td>
<td>Imperial College Healthcare</td>
<td>69</td>
<td>23.1</td>
</tr>
<tr>
<td>RJZ</td>
<td>King’s College Hospital</td>
<td>72</td>
<td>15.2</td>
</tr>
<tr>
<td>RXN</td>
<td>Lancashire Teaching Hospitals</td>
<td>66</td>
<td>22.5</td>
</tr>
<tr>
<td>RR8</td>
<td>Leeds Teaching Hospitals</td>
<td>119</td>
<td>21.1</td>
</tr>
<tr>
<td>RM1</td>
<td>Norfolk and Norwich University Hospitals</td>
<td>49</td>
<td>15.1</td>
</tr>
<tr>
<td>RX1</td>
<td>Nottingham University Hospitals</td>
<td>91</td>
<td>17.7</td>
</tr>
<tr>
<td>RTH</td>
<td>Oxford University Hospitals</td>
<td>69</td>
<td>15.0</td>
</tr>
<tr>
<td>RAL</td>
<td>Royal Free London</td>
<td>66</td>
<td>41.9</td>
</tr>
<tr>
<td>RQ6</td>
<td>Royal Liverpool and Broadgreen University Hospitals</td>
<td>44</td>
<td>17.1</td>
</tr>
<tr>
<td>RM3</td>
<td>Salford Royal</td>
<td>21</td>
<td>9.4</td>
</tr>
<tr>
<td>RHQ</td>
<td>Sheffield Teaching Hospitals</td>
<td>87</td>
<td>14.9</td>
</tr>
<tr>
<td>RJ7</td>
<td>St. George’s Healthcare</td>
<td>31</td>
<td>10.2</td>
</tr>
<tr>
<td>RTD</td>
<td>The Newcastle Upon Tyne Hospitals</td>
<td>77</td>
<td>16.3</td>
</tr>
<tr>
<td>RRV</td>
<td>University College London Hospitals</td>
<td>97</td>
<td>36.4</td>
</tr>
<tr>
<td>RJE</td>
<td>University Hospitals Of North Midlands&lt;sup&gt;9&lt;/sup&gt;</td>
<td>82</td>
<td>17.8</td>
</tr>
</tbody>
</table>

<sup>6</sup> Previously incorrectly included within ‘non-teaching acute Trust’ objective table (corrected 28/04/2016)

<sup>7</sup> Note: the total CDI cases for Chelsea and Westminster reflect the merger between this trust and West Middlesex on 01/09/2015

<sup>8</sup> Objective amended as previously incorrectly categorised as a non-teaching acute Trust (corrected 28/4/2016)

<sup>9</sup> Objective amended as previously incorrectly categorised as a non-teaching acute Trust (corrected 28/4/2016)
<table>
<thead>
<tr>
<th>Org code</th>
<th>Name</th>
<th>CDI case objective for 2016/17</th>
<th>CDI rate objective for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBS</td>
<td>Alder Hey Children's</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>RQ3</td>
<td>Birmingham Children's Hospital</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>RLU</td>
<td>Birmingham Women's</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>RP4</td>
<td>Great Ormond Street Hospital for Children</td>
<td>15</td>
<td>13.8</td>
</tr>
<tr>
<td>RBQ</td>
<td>Liverpool Heart and Chest Hospital</td>
<td>4</td>
<td>8.6</td>
</tr>
<tr>
<td>REP</td>
<td>Liverpool Women's</td>
<td>1</td>
<td>2.7</td>
</tr>
<tr>
<td>RP6</td>
<td>Moorfields Eye Hospital</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>RGM</td>
<td>Papworth Hospital</td>
<td>5</td>
<td>7.0</td>
</tr>
<tr>
<td>RPC</td>
<td>Queen Victoria Hospital</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>RT3</td>
<td>Royal Brompton and Harefield</td>
<td>23</td>
<td>19.4</td>
</tr>
<tr>
<td>RAN</td>
<td>Royal National Orthopaedic Hospital</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td>RCU</td>
<td>Sheffield Children's</td>
<td>3</td>
<td>7.4</td>
</tr>
<tr>
<td>RBV</td>
<td>The Christie</td>
<td>19</td>
<td>38.9</td>
</tr>
<tr>
<td>REN</td>
<td>The Clatterbridge Cancer Centre</td>
<td>1</td>
<td>5.8</td>
</tr>
<tr>
<td>RL1</td>
<td>The Robert Jones and Agnes Hunt Orthopaedic Hospital</td>
<td>2</td>
<td>3.8</td>
</tr>
<tr>
<td>RPY</td>
<td>The Royal Marsden</td>
<td>31</td>
<td>51.4</td>
</tr>
<tr>
<td>RRJ</td>
<td>The Royal Orthopaedic Hospital</td>
<td>2</td>
<td>6.3</td>
</tr>
<tr>
<td>RET</td>
<td>The Walton Centre</td>
<td>10</td>
<td>19.9</td>
</tr>
</tbody>
</table>

10 Objective amended as previously incorrectly categorised as a non-teaching acute Trust (corrected 28/4/2016)
11 Amended following agreement between provider and commissioner
<table>
<thead>
<tr>
<th>CCG code</th>
<th>Name</th>
<th>CDI case objective for 2016/17</th>
<th>CDI rate objective for 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>02N</td>
<td>Airedale, Wharfdale and Craven</td>
<td>36</td>
<td>22.7</td>
</tr>
<tr>
<td>09C</td>
<td>Ashford</td>
<td>31</td>
<td>25.5</td>
</tr>
<tr>
<td>10Y</td>
<td>Aylesbury Vale</td>
<td>49</td>
<td>24.6</td>
</tr>
<tr>
<td>07L</td>
<td>Barking and Dagenham</td>
<td>37</td>
<td>19.0</td>
</tr>
<tr>
<td>07M</td>
<td>Barnet</td>
<td>79</td>
<td>21.4</td>
</tr>
<tr>
<td>02P</td>
<td>Barnsley</td>
<td>63</td>
<td>26.7</td>
</tr>
<tr>
<td>99E</td>
<td>Basildon and Brentwood</td>
<td>45</td>
<td>17.8</td>
</tr>
<tr>
<td>02Q</td>
<td>Bassetlaw</td>
<td>22</td>
<td>19.4</td>
</tr>
<tr>
<td>11E</td>
<td>Bath and North East Somerset</td>
<td>47</td>
<td>26.1</td>
</tr>
<tr>
<td>06F</td>
<td>Bedfordshire</td>
<td>73</td>
<td>17.1</td>
</tr>
<tr>
<td>07N</td>
<td>Bexley</td>
<td>56</td>
<td>23.7</td>
</tr>
<tr>
<td>13P</td>
<td>Birmingham Crosscity</td>
<td>183</td>
<td>25.2</td>
</tr>
<tr>
<td>04X</td>
<td>Birmingham South and Central</td>
<td>46</td>
<td>22.9</td>
</tr>
<tr>
<td>00Q</td>
<td>Blackburn with Darwen</td>
<td>40</td>
<td>27.1</td>
</tr>
<tr>
<td>00R</td>
<td>Blackpool</td>
<td>58</td>
<td>41.0</td>
</tr>
<tr>
<td>00T</td>
<td>Bolton</td>
<td>80</td>
<td>28.6</td>
</tr>
<tr>
<td>10G</td>
<td>Bracknell and Ascot</td>
<td>18</td>
<td>13.4</td>
</tr>
<tr>
<td>02W</td>
<td>Bradford City</td>
<td>23</td>
<td>27.8</td>
</tr>
<tr>
<td>02R</td>
<td>Bradford Districts</td>
<td>116</td>
<td>34.7</td>
</tr>
<tr>
<td>07P</td>
<td>Brent</td>
<td>56</td>
<td>17.7</td>
</tr>
<tr>
<td>09D</td>
<td>Brighton and Hove</td>
<td>52</td>
<td>18.7</td>
</tr>
<tr>
<td>11H</td>
<td>Bristol</td>
<td>131</td>
<td>29.9</td>
</tr>
<tr>
<td>07Q</td>
<td>Bromley</td>
<td>76</td>
<td>23.9</td>
</tr>
<tr>
<td>00V</td>
<td>Bury</td>
<td>45</td>
<td>24.1</td>
</tr>
<tr>
<td>02T</td>
<td>Calderdale</td>
<td>39</td>
<td>18.9</td>
</tr>
<tr>
<td>06H</td>
<td>Cambridgeshire and Peterborough</td>
<td>188</td>
<td>22.0</td>
</tr>
<tr>
<td>07R</td>
<td>Camden</td>
<td>90</td>
<td>39.2</td>
</tr>
<tr>
<td>04Y</td>
<td>Cannock Chase</td>
<td>48</td>
<td>35.9</td>
</tr>
<tr>
<td>09E</td>
<td>Canterbury and Coastal</td>
<td>35</td>
<td>17.3</td>
</tr>
<tr>
<td>Code</td>
<td>Location</td>
<td>Value</td>
<td>Rating</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------</td>
<td>-------</td>
<td>--------</td>
</tr>
<tr>
<td>99F</td>
<td>Castle Point and Rochford</td>
<td>44</td>
<td>25.5</td>
</tr>
<tr>
<td>09A</td>
<td>Central London (Westminster)</td>
<td>40</td>
<td>24.6</td>
</tr>
<tr>
<td>00W</td>
<td>Central Manchester</td>
<td>41</td>
<td>22.5</td>
</tr>
<tr>
<td>10H</td>
<td>Chiltern</td>
<td>61</td>
<td>19.1</td>
</tr>
<tr>
<td>00X</td>
<td>Chorley and South Ribble</td>
<td>59</td>
<td>34.8</td>
</tr>
<tr>
<td>07T</td>
<td>City and Hackney</td>
<td>31</td>
<td>11.7</td>
</tr>
<tr>
<td>09G</td>
<td>Coastal West Sussex</td>
<td>155</td>
<td>32.3</td>
</tr>
<tr>
<td>03V</td>
<td>Corby</td>
<td>18</td>
<td>28.0</td>
</tr>
<tr>
<td>05A</td>
<td>Coventry and Rugby</td>
<td>107</td>
<td>24.8</td>
</tr>
<tr>
<td>09H</td>
<td>Crawley</td>
<td>17</td>
<td>15.6</td>
</tr>
<tr>
<td>07V</td>
<td>Croydon</td>
<td>55</td>
<td>14.8</td>
</tr>
<tr>
<td>01H</td>
<td>Cumbria</td>
<td>201</td>
<td>39.9</td>
</tr>
<tr>
<td>00C</td>
<td>Darlington</td>
<td>17</td>
<td>16.1</td>
</tr>
<tr>
<td>09J</td>
<td>Dartford, Gravesham and Swanley</td>
<td>61</td>
<td>24.2</td>
</tr>
<tr>
<td>02X</td>
<td>Doncaster</td>
<td>81</td>
<td>26.7</td>
</tr>
<tr>
<td>11J</td>
<td>Dorset</td>
<td>204</td>
<td>27.0</td>
</tr>
<tr>
<td>05C</td>
<td>Dudley</td>
<td>76</td>
<td>24.2</td>
</tr>
<tr>
<td>00D</td>
<td>Durham Dales, Easington and Sedgefield</td>
<td>74</td>
<td>27.1</td>
</tr>
<tr>
<td>07W</td>
<td>Ealing</td>
<td>67</td>
<td>19.6</td>
</tr>
<tr>
<td>06K</td>
<td>East and North Hertfordshire</td>
<td>112</td>
<td>20.5</td>
</tr>
<tr>
<td>01A</td>
<td>East Lancashire</td>
<td>58</td>
<td>15.6</td>
</tr>
<tr>
<td>03W</td>
<td>East Leicestershire and Rutland</td>
<td>78</td>
<td>24.2</td>
</tr>
<tr>
<td>02Y</td>
<td>East Riding of Yorkshire</td>
<td>85</td>
<td>27.0</td>
</tr>
<tr>
<td>05D</td>
<td>East Staffordshire</td>
<td>31</td>
<td>24.9</td>
</tr>
<tr>
<td>09L</td>
<td>East Surrey</td>
<td>43</td>
<td>24.2</td>
</tr>
<tr>
<td>09F</td>
<td>Eastbourne, Hailsham and Seaford</td>
<td>59</td>
<td>32.2</td>
</tr>
<tr>
<td>01C</td>
<td>Eastern Cheshire</td>
<td>50</td>
<td>25.6</td>
</tr>
<tr>
<td>07X</td>
<td>Enfield</td>
<td>76</td>
<td>23.7</td>
</tr>
<tr>
<td>03X</td>
<td>Erewash</td>
<td>19</td>
<td>20.0</td>
</tr>
<tr>
<td>10K</td>
<td>Fareham and Gosport</td>
<td>30</td>
<td>15.2</td>
</tr>
<tr>
<td>02M</td>
<td>Fylde &amp; Wyre</td>
<td>44</td>
<td>26.5</td>
</tr>
<tr>
<td>11M</td>
<td>Gloucestershire</td>
<td>157</td>
<td>25.9</td>
</tr>
<tr>
<td>06M</td>
<td>Great Yarmouth and Waveney</td>
<td>70</td>
<td>32.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>----</td>
<td>---</td>
</tr>
<tr>
<td>03A</td>
<td>Greater Huddersfield</td>
<td>40</td>
<td>16.6</td>
</tr>
<tr>
<td>01E</td>
<td>Greater Preston</td>
<td>49</td>
<td>24.3</td>
</tr>
<tr>
<td>08A</td>
<td>Greenwich</td>
<td>62</td>
<td>23.5</td>
</tr>
<tr>
<td>09N</td>
<td>Guildford and Waverley</td>
<td>20</td>
<td>9.6</td>
</tr>
<tr>
<td>01F</td>
<td>Halton</td>
<td>36</td>
<td>28.6</td>
</tr>
<tr>
<td>03D</td>
<td>Hambleton, Richmondshire and Whitby</td>
<td>45</td>
<td>29.3</td>
</tr>
<tr>
<td>08C</td>
<td>Hammersmith and Fulham</td>
<td>35</td>
<td>19.6</td>
</tr>
<tr>
<td>03Y</td>
<td>Hardwick</td>
<td>43</td>
<td>39.4</td>
</tr>
<tr>
<td>08D</td>
<td>Haringey</td>
<td>50</td>
<td>19.0</td>
</tr>
<tr>
<td>03E</td>
<td>Harrogate and Rural District</td>
<td>34</td>
<td>21.5</td>
</tr>
<tr>
<td>08E</td>
<td>Harrow</td>
<td>32</td>
<td>13.1</td>
</tr>
<tr>
<td>00K</td>
<td>Hartlepool and Stockton-on-Tees</td>
<td>72</td>
<td>25.2</td>
</tr>
<tr>
<td>09P</td>
<td>Hastings and Rother</td>
<td>44</td>
<td>24.2</td>
</tr>
<tr>
<td>08F</td>
<td>Havering</td>
<td>51</td>
<td>21.1</td>
</tr>
<tr>
<td>05F</td>
<td>Herefordshire</td>
<td>46</td>
<td>24.7</td>
</tr>
<tr>
<td>06N</td>
<td>Herts Valleys</td>
<td>131</td>
<td>22.8</td>
</tr>
<tr>
<td>01D</td>
<td>Heywood, Middleton and Rochdale</td>
<td>49</td>
<td>23.1</td>
</tr>
<tr>
<td>99K</td>
<td>High Weald Lewes Havens</td>
<td>35</td>
<td>20.7</td>
</tr>
<tr>
<td>08G</td>
<td>Hillingdon</td>
<td>37</td>
<td>12.9</td>
</tr>
<tr>
<td>09X</td>
<td>Horsham and Mid Sussex</td>
<td>46</td>
<td>20.4</td>
</tr>
<tr>
<td>07Y</td>
<td>Hounslow</td>
<td>37</td>
<td>14.1</td>
</tr>
<tr>
<td>03F</td>
<td>Hull</td>
<td>82</td>
<td>31.8</td>
</tr>
<tr>
<td>06L</td>
<td>Ipswich and East Suffolk</td>
<td>107</td>
<td>27.0</td>
</tr>
<tr>
<td>10L</td>
<td>Isle of Wight</td>
<td>28</td>
<td>20.2</td>
</tr>
<tr>
<td>08H</td>
<td>Islington</td>
<td>60</td>
<td>27.8</td>
</tr>
<tr>
<td>11N</td>
<td>Kernow</td>
<td>136</td>
<td>25.0</td>
</tr>
<tr>
<td>08J</td>
<td>Kingston</td>
<td>30</td>
<td>18.0</td>
</tr>
<tr>
<td>01J</td>
<td>Knowsley</td>
<td>56</td>
<td>38.3</td>
</tr>
<tr>
<td>08K</td>
<td>Lambeth</td>
<td>75</td>
<td>23.9</td>
</tr>
<tr>
<td>01K</td>
<td>Lancashire North</td>
<td>72</td>
<td>45.2</td>
</tr>
<tr>
<td>02V</td>
<td>Leeds North</td>
<td>58</td>
<td>29.0</td>
</tr>
<tr>
<td>03G</td>
<td>Leeds South and East</td>
<td>104</td>
<td>43.1</td>
</tr>
<tr>
<td>03C</td>
<td>Leeds West</td>
<td>90</td>
<td>28.1</td>
</tr>
<tr>
<td>Code</td>
<td>Area</td>
<td>Value</td>
<td>Percentage</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>04C</td>
<td>Leicester City</td>
<td>74</td>
<td>22.2</td>
</tr>
<tr>
<td>08L</td>
<td>Lewisham</td>
<td>53</td>
<td>18.5</td>
</tr>
<tr>
<td>03T</td>
<td>Lincolnshire East</td>
<td>65</td>
<td>28.3</td>
</tr>
<tr>
<td>04D</td>
<td>Lincolnshire West</td>
<td>45</td>
<td>19.6</td>
</tr>
<tr>
<td>99A</td>
<td>Liverpool</td>
<td>138</td>
<td>29.3</td>
</tr>
<tr>
<td>06P</td>
<td>Luton</td>
<td>28</td>
<td>13.5</td>
</tr>
<tr>
<td>04E</td>
<td>Mansfield and Ashfield</td>
<td>94</td>
<td>48.5</td>
</tr>
<tr>
<td>09W</td>
<td>Medway</td>
<td>55</td>
<td>20.3</td>
</tr>
<tr>
<td>08R</td>
<td>Merton</td>
<td>28</td>
<td>13.8</td>
</tr>
<tr>
<td>06Q</td>
<td>Mid Essex</td>
<td>71</td>
<td>18.6</td>
</tr>
<tr>
<td>04F</td>
<td>Milton Keynes</td>
<td>81</td>
<td>31.0</td>
</tr>
<tr>
<td>04G</td>
<td>Nene</td>
<td>164</td>
<td>26.2</td>
</tr>
<tr>
<td>04H</td>
<td>Newark &amp; Sherwood</td>
<td>39</td>
<td>33.3</td>
</tr>
<tr>
<td>10M</td>
<td>Newbury and District</td>
<td>25</td>
<td>23.6</td>
</tr>
<tr>
<td>13T</td>
<td>Newcastle Gateshead¹²</td>
<td>142</td>
<td>29.0</td>
</tr>
<tr>
<td>08M</td>
<td>Newham</td>
<td>35</td>
<td>11.0</td>
</tr>
<tr>
<td>10N</td>
<td>North &amp; West Reading</td>
<td>23</td>
<td>23.0</td>
</tr>
<tr>
<td>04J</td>
<td>North Derbyshire</td>
<td>107</td>
<td>39.3</td>
</tr>
<tr>
<td>00J</td>
<td>North Durham</td>
<td>42</td>
<td>17.3</td>
</tr>
<tr>
<td>06T</td>
<td>North East Essex</td>
<td>45</td>
<td>14.2</td>
</tr>
<tr>
<td>99M</td>
<td>North East Hampshire and Farnham</td>
<td>33</td>
<td>15.9</td>
</tr>
<tr>
<td>03H</td>
<td>North East Lincolnshire</td>
<td>35</td>
<td>21.9</td>
</tr>
<tr>
<td>10J</td>
<td>North Hampshire</td>
<td>60</td>
<td>27.5</td>
</tr>
<tr>
<td>03J</td>
<td>North Kirklees</td>
<td>38</td>
<td>20.2</td>
</tr>
<tr>
<td>03K</td>
<td>North Lincolnshire</td>
<td>31</td>
<td>18.4</td>
</tr>
<tr>
<td>01M</td>
<td>North Manchester</td>
<td>39</td>
<td>22.9</td>
</tr>
<tr>
<td>06V</td>
<td>North Norfolk</td>
<td>58</td>
<td>34.4</td>
</tr>
<tr>
<td>11T</td>
<td>North Somerset</td>
<td>87</td>
<td>42.2</td>
</tr>
<tr>
<td>05G</td>
<td>North Staffordshire</td>
<td>61</td>
<td>28.4</td>
</tr>
<tr>
<td>99C</td>
<td>North Tyneside</td>
<td>74</td>
<td>36.6</td>
</tr>
</tbody>
</table>

¹² Newcastle Gateshead CCG was formed from the combination of Newcastle West, Newcastle North & East and Gateshead CCGs on 1st April 2015. Therefore the current counts etc for Newcastle Gateshead CCG are the sum of the counts for each of these three CCGs.
<table>
<thead>
<tr>
<th>Code</th>
<th>Area</th>
<th>Value</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>99P</td>
<td>North, East, West Devon</td>
<td>219</td>
<td>25.0</td>
</tr>
<tr>
<td>00L</td>
<td>Northumberland</td>
<td>77</td>
<td>24.4</td>
</tr>
<tr>
<td>06W</td>
<td>Norwich</td>
<td>52</td>
<td>26.7</td>
</tr>
<tr>
<td>04K</td>
<td>Nottingham City</td>
<td>51</td>
<td>16.4</td>
</tr>
<tr>
<td>04L</td>
<td>Nottingham North and East</td>
<td>47</td>
<td>31.8</td>
</tr>
<tr>
<td>04M</td>
<td>Nottingham West</td>
<td>21</td>
<td>18.9</td>
</tr>
<tr>
<td>00Y</td>
<td>Oldham</td>
<td>91</td>
<td>40.0</td>
</tr>
<tr>
<td>10Q</td>
<td>Oxfordshire</td>
<td>145</td>
<td>22.2</td>
</tr>
<tr>
<td>10R</td>
<td>Portsmouth</td>
<td>50</td>
<td>24.1</td>
</tr>
<tr>
<td>08N</td>
<td>Redbridge</td>
<td>26</td>
<td>9.0</td>
</tr>
<tr>
<td>05J</td>
<td>Redditch and Bromsgrove</td>
<td>36</td>
<td>20.1</td>
</tr>
<tr>
<td>08P</td>
<td>Richmond</td>
<td>31</td>
<td>16.2</td>
</tr>
<tr>
<td>03L</td>
<td>Rotherham</td>
<td>63</td>
<td>24.4</td>
</tr>
<tr>
<td>04N</td>
<td>Rushcliffe</td>
<td>24</td>
<td>21.3</td>
</tr>
<tr>
<td>01G</td>
<td>Salford</td>
<td>62</td>
<td>25.9</td>
</tr>
<tr>
<td>05L</td>
<td>Sandwell and West Birmingham</td>
<td>109</td>
<td>22.7</td>
</tr>
<tr>
<td>03M</td>
<td>Scarborough and Ryedale</td>
<td>31</td>
<td>28.1</td>
</tr>
<tr>
<td>03N</td>
<td>Sheffield</td>
<td>194</td>
<td>34.6</td>
</tr>
<tr>
<td>05N</td>
<td>Shropshire</td>
<td>73</td>
<td>23.7</td>
</tr>
<tr>
<td>10T</td>
<td>Slough</td>
<td>22</td>
<td>15.4</td>
</tr>
<tr>
<td>05P</td>
<td>Solihull</td>
<td>58</td>
<td>27.8</td>
</tr>
<tr>
<td>11X</td>
<td>Somerset</td>
<td>131</td>
<td>24.3</td>
</tr>
<tr>
<td>01R</td>
<td>South Cheshire</td>
<td>52</td>
<td>29.3</td>
</tr>
<tr>
<td>99Q</td>
<td>South Devon and Torbay</td>
<td>97</td>
<td>35.3</td>
</tr>
<tr>
<td>05Q</td>
<td>South East Staffs and Seisdon Peninsula</td>
<td>47</td>
<td>20.9</td>
</tr>
<tr>
<td>10V</td>
<td>South Eastern Hampshire</td>
<td>50</td>
<td>23.8</td>
</tr>
<tr>
<td>12A</td>
<td>South Gloucestershire</td>
<td>94</td>
<td>34.9</td>
</tr>
<tr>
<td>10A</td>
<td>South Kent Coast</td>
<td>44</td>
<td>21.6</td>
</tr>
<tr>
<td>99D</td>
<td>South Lincolnshire</td>
<td>34</td>
<td>23.8</td>
</tr>
<tr>
<td>01N</td>
<td>South Manchester</td>
<td>47</td>
<td>29.1</td>
</tr>
<tr>
<td>06Y</td>
<td>South Norfolk</td>
<td>65</td>
<td>27.4</td>
</tr>
<tr>
<td>10W</td>
<td>South Reading</td>
<td>20</td>
<td>18.3</td>
</tr>
<tr>
<td>Code</td>
<td>Area Name</td>
<td>Code</td>
<td>Area Name</td>
</tr>
<tr>
<td>------</td>
<td>------------------------------</td>
<td>------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>01T</td>
<td>South Sefton</td>
<td>54</td>
<td>34.0</td>
</tr>
<tr>
<td>00M</td>
<td>South Tees</td>
<td>91</td>
<td>33.2</td>
</tr>
<tr>
<td>00N</td>
<td>South Tyneside</td>
<td>53</td>
<td>35.7</td>
</tr>
<tr>
<td>05R</td>
<td>South Warwickshire</td>
<td>60</td>
<td>23.1</td>
</tr>
<tr>
<td>04Q</td>
<td>South West Lincolnshire</td>
<td>25</td>
<td>20.4</td>
</tr>
<tr>
<td>05T</td>
<td>South Worcestershire</td>
<td>63</td>
<td>21.4</td>
</tr>
<tr>
<td>10X</td>
<td>Southampton</td>
<td>46</td>
<td>19.0</td>
</tr>
<tr>
<td>99G</td>
<td>Southend</td>
<td>36</td>
<td>20.5</td>
</tr>
<tr>
<td>04R</td>
<td>Southern Derbyshire</td>
<td>114</td>
<td>22.0</td>
</tr>
<tr>
<td>01V</td>
<td>Southport and Formby</td>
<td>38</td>
<td>33.2</td>
</tr>
<tr>
<td>08Q</td>
<td>Southwark</td>
<td>45</td>
<td>15.1</td>
</tr>
<tr>
<td>01X</td>
<td>St Helens</td>
<td>75</td>
<td>42.6</td>
</tr>
<tr>
<td>05V</td>
<td>Stafford and Surrounds</td>
<td>59</td>
<td>38.9</td>
</tr>
<tr>
<td>01W</td>
<td>Stockport</td>
<td>69</td>
<td>24.2</td>
</tr>
<tr>
<td>05W</td>
<td>Stoke on Trent</td>
<td>87</td>
<td>33.7</td>
</tr>
<tr>
<td>00P</td>
<td>Sunderland</td>
<td>82</td>
<td>29.7</td>
</tr>
<tr>
<td>99H</td>
<td>Surrey Downs</td>
<td>76</td>
<td>26.7</td>
</tr>
<tr>
<td>10C</td>
<td>Surrey Heath</td>
<td>19</td>
<td>20.1</td>
</tr>
<tr>
<td>08T</td>
<td>Sutton</td>
<td>41</td>
<td>20.9</td>
</tr>
<tr>
<td>10D</td>
<td>Swale</td>
<td>14</td>
<td>12.8</td>
</tr>
<tr>
<td>12D</td>
<td>Swindon</td>
<td>44</td>
<td>20.1</td>
</tr>
<tr>
<td>01Y</td>
<td>Tameside and Glossop</td>
<td>97</td>
<td>38.2</td>
</tr>
<tr>
<td>05X</td>
<td>Telford and Wrekin</td>
<td>20</td>
<td>11.9</td>
</tr>
<tr>
<td>10E</td>
<td>Thanet</td>
<td>41</td>
<td>30.0</td>
</tr>
<tr>
<td>07G</td>
<td>Thurrock</td>
<td>29</td>
<td>18.0</td>
</tr>
<tr>
<td>08V</td>
<td>Tower Hamlets</td>
<td>36</td>
<td>13.2</td>
</tr>
<tr>
<td>02A</td>
<td>Trafford</td>
<td>64</td>
<td>27.8</td>
</tr>
<tr>
<td>03Q</td>
<td>Vale of York</td>
<td>78</td>
<td>22.3</td>
</tr>
<tr>
<td>02D</td>
<td>Vale Royal</td>
<td>20</td>
<td>19.6</td>
</tr>
<tr>
<td>03R</td>
<td>Wakefield</td>
<td>72</td>
<td>21.8</td>
</tr>
<tr>
<td>05Y</td>
<td>Walsall</td>
<td>56</td>
<td>20.6</td>
</tr>
<tr>
<td>08W</td>
<td>Waltham Forest</td>
<td>46</td>
<td>17.3</td>
</tr>
<tr>
<td>08X</td>
<td>Wandsworth</td>
<td>50</td>
<td>16.1</td>
</tr>
<tr>
<td>Code</td>
<td>Area</td>
<td>Value</td>
<td>%Change</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------</td>
<td>-------</td>
<td>---------</td>
</tr>
<tr>
<td>02E</td>
<td>Warrington</td>
<td>46</td>
<td>22.4</td>
</tr>
<tr>
<td>05H</td>
<td>Warwickshire North</td>
<td>70</td>
<td>37.2</td>
</tr>
<tr>
<td>02F</td>
<td>West Cheshire</td>
<td>78</td>
<td>34.1</td>
</tr>
<tr>
<td>07H</td>
<td>West Essex</td>
<td>49</td>
<td>16.7</td>
</tr>
<tr>
<td>11A</td>
<td>West Hampshire</td>
<td>133</td>
<td>24.3</td>
</tr>
<tr>
<td>99J</td>
<td>West Kent</td>
<td>94</td>
<td>20.1</td>
</tr>
<tr>
<td>02G</td>
<td>West Lancashire</td>
<td>46</td>
<td>41.3</td>
</tr>
<tr>
<td>04V</td>
<td>West Leicestershire</td>
<td>77</td>
<td>20.4</td>
</tr>
<tr>
<td>08Y</td>
<td>West London (K&amp;C &amp; Qpp)</td>
<td>51</td>
<td>23.2</td>
</tr>
<tr>
<td>07J</td>
<td>West Norfolk</td>
<td>100</td>
<td>58.3</td>
</tr>
<tr>
<td>07K</td>
<td>West Suffolk</td>
<td>45</td>
<td>20.1</td>
</tr>
<tr>
<td>02H</td>
<td>Wigan Borough</td>
<td>81</td>
<td>25.3</td>
</tr>
<tr>
<td>99N</td>
<td>Wiltshire</td>
<td>103</td>
<td>21.5</td>
</tr>
<tr>
<td>11C</td>
<td>Windsor, Ascot and Maidenhead</td>
<td>33</td>
<td>23.6</td>
</tr>
<tr>
<td>12F</td>
<td>Wirral</td>
<td>75</td>
<td>23.4</td>
</tr>
<tr>
<td>11D</td>
<td>Wokingham</td>
<td>28</td>
<td>17.7</td>
</tr>
<tr>
<td>06A</td>
<td>Wolverhampton</td>
<td>71</td>
<td>28.2</td>
</tr>
<tr>
<td>06D</td>
<td>Wyre Forest</td>
<td>15</td>
<td>15.2</td>
</tr>
</tbody>
</table>