NHS England

Clostridium difficile infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation.

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Clostridium difficile infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation.

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Prepared by Patient Safety Domain, NHS England

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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. 17% of patients who are diagnosed with CDI have died by day 30 after diagnosis. After controlling for risk of death in non-CDI patients (9%), the CDI attributable death rate is 8% i.e. one in 12 patients[1]

1.2 Very high infection rates at the beginning of this century led to concerted efforts by the NHS to reduce numbers, principally by use of mandatory targets for reductions in cases. These efforts have been hugely successful. The numbers of reported *C. difficile* cases have dropped by 74% since 2007/08, and the major strain of *C. difficile* which was responsible for the rise in numbers (ribotype O27) has been reduced to a prevalence of approximately 10%[2].

1.3 The current pattern of strains of *C. difficile* infection, where they are located and who they are affecting – i.e. the epidemiological landscape – is now much more complex. Unlike in 2007/08, there are no particularly predominant strains of *C. difficile* and new testing technologies that are now available are unable to show that significant numbers of cases are linked, suggesting that patient to patient transmission in hospital of particular strains of *C. difficile* is not currently a major feature of reported CDIs. Given the increased complexity of *C. difficile* epidemiology, further improving patient safety can best be achieved via event closer examination of individual CDI cases and the implementation of relevant learning. It is therefore important to further incentivise and support learning and improvement of patient safety.

1.4 Up to and including 2013/14, NHS organisations have continued to be required to demonstrate stretching year on year reductions in *C. difficile* cases based on the previous year's trend reduction in *C. difficile* cases. However, as published data shows, the rate of improvement for *C. difficile* has slowed over recent years. Infection prevention and control experts from within the NHS and from Public Health England advise that this is likely to be due to a combination of factors including the biology and epidemiology of the *C. difficile* organism. There are indications that, for some organisations at least, the level of CDIs may be approaching their irreducible minimum level at which these infections will occur regardless of the quality of care provided. This can occur due to the fact that some people carry *C. difficile* in their bowel and will develop symptoms due to their underlying clinical conditions or as a consequence of the antibiotics they have to take. Put simply, some infections are a consequence of factors outside the control of the NHS organisation that detected the infection.

1.5 The previous system of setting objectives for acute organisations in particular and the use of associated sanctions for breaches led to rapid reductions in infection rates and was very effective when the NHS was confronted with an epidemic strain that emerged around

[1] Planche et al. Lancet Infect Dis 2013
[2] See http://www.hpa.org.uk/webw/HPAweb&HPAwebStandard/HPAweb_C/1317140658987

2002-2003. But experts tell us we are now at a point where a more flexible approach is appropriate.

1.6 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. This means the system needs to encourage organisations to assess each CDI case individually and understand what, if anything, went wrong, and then to put it right. This is the most effective approach for delivering continuous improvement of patient safety.

2. Revised CDI objectives and sanction regime

2.1 It is important to make clear that regardless of the changes outlined below, guidance for testing and reporting of CDI cases remains unchanged and that the safety and care of patients must be the over-riding concern of everyone. The current protocols for testing and diagnosing CDI (published in March 2012) advise that organisations adhere to a two stage approach. This consists of a GDH EIA (or NAAT or PCR) test to screen samples, followed by a sensitive toxin EIA test (or a cytotoxin assay). This guidance 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

Acute providers

2.2 In response to advice from infection control experts, NHS England is making the following changes to the CDI objective setting and sanction process for acute providers to encourage greater assessment of CDI cases for 2014/15. These changes are primarily focussed on further encouraging organisations to look at each CDI case they identify to understand what lessons they are able to learn in order to improve the safety of patients. NHS England, Public Health England and the DH Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections (ARHAI) will be further reviewing the future infection control strategy for the NHS during 2014/15:

2.2.1 For 2014/15, organisations will be encouraged to assess each CDI case they identify to determine whether the case was linked with a lapse in the quality of care provided to patients. This will increase the organisation's understanding of the quality of the care they are providing and highlight areas where care could be improved. The Co-ordinating Commissioner under each commissioning contract will be able to consider the results of these assessments and exercise discretion in deciding whether any individual case of *C. difficile* affecting a patient under its contract should count towards the aggregate number of cases on the basis of which contractual sanctions are calculated. Where CDI cases are not linked with identifiable lapses in care, it is proposed that those cases are

not considered when contractual sanctions are being calculated. More detail is provided from paragraph 2.3 below.

2.2.2 For 2014/15, the contractual sanction that can be applied to each *C. difficile* case in excess of an acute organisation's objective will be reduced by 80% from £50,000 to £10,000 (see NHS Standard Contract 2014/15 at http://www.england.nhs.uk/wp-content/uploads/2013/12/sec-a-part-1415.pdf)

2.2.3 *C. difficile* objectives for acute organisations (and CCGs) in 2014/15 are provided in Annex E and are calculated as follows;

2.2.3.1 Three cohorts of acute trusts have been recognised for the purposes of calculating median CDI rates based on expert advice – acute teaching hospitals, specialist hospitals and small, medium, large and mixed service acute hospitals as defined by the Hospital Estates and Facilities ERIC return.

2.2.3.2 For 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 2013 by one case. This reflects the principle of continuous improvement.

2.2.3.3 For the two non-specialist trust cohorts, the median CDI rate for the most recent available 12 months (to November 2013) is calculated for each cohort separately. This is also done for each cohort for their previous 12 month median CDI rate (to November 2012). For each cohort, the rate of CDI rate improvement from the preceding 12 months (to November 2012) to the most recent 12 months (to November 2013) are then calculated to give a cohort rate of CDI improvement.

2.2.3.4 All organisations with a current CDI rate for the 12 months to November 2013 below (better than) their cohort median for the same period, have a CDI objective for 2014/15 set as their current number of CDI cases reported during the year to November 2013 minus one. This maintains the principle of the NHS delivering continuous improvement in patient safety but reflects that those performing better than average may be approaching the irreducible minimum of cases.

2.2.3.5 All organisations with a current CDI rate for the 12 months to November 2013 above (worse than) their cohort median for the same period have a CDI objective set as their CDI rate for the year to November 2013 minus the percentage reduction in median CDI rate seen for their cohort between the preceding year and the current year to November 13. This means their objective reflects the rate of improvement seen for their cohort of trusts over the previous year. For teaching hospitals this rate is about 13.5% and for non-teaching hospitals is just over 12%. 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.

2.2.3.6 Where this methodology requires 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 have an objective of their current number of cases reported during the year to Nov 2013 minus one. This avoids requiring organisations performing worse than average to leapfrog those performing better than average.

Application of contractual sanctions

2.3 Co-ordinating commissioners, in reaching their decision on whether an individual case of *C. difficile* should count towards the aggregate number of cases on the basis of which contractual sanctions are calculated, may 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. A lapse in care would be indicated by evidence that policies and procedures consistent with national guidance and standards[3] 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.

2.4 Confirmed CDI cases should in all instances be reported to PHE as normal. However, they should also 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. Suggested methodologies for this process of assessing cases are outlined in section 3 below.

2.5 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 *C. difficile* cases on which any sanction will be based (figure A in the formula in Schedule 4G of the NHS Standard Contract). This decision 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.

2.6 As an illustrative example, therefore, a single provider may have a target of 25 CDI cases for 2014/15. It may report 30 actual cases in total, but its subsequent assessment of the cases may indicate that only 20 of these were linked with lapses in care by that provider. In this situation, at its discretion, the Co-ordinating Commissioner may choose to use this second number (20 in this case) as the basis for determining whether any contractual sanction should be applied. If it does so, no sanction will apply.

[3] See relevant documents at http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/Guidelines/

2.7 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

2.8 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.

2.9 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.

2.10 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.

2.11 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 4G) will reflect the decisions reached separately on individual cases by each Co-ordinating Commissioner.

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

2.13 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

2.14 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 4 G.

Application to community providers

2.15 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 72 hours of admission to an acute setting or from a community setting or independent provider, providers and commissioners should assess the care provided using a relevant assessment tool 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.

2.16 There are currently, however, 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.

National reporting

2.17 All positive samples should still be reported as per current national reporting requirements regardless of whether they were associated with lapses in care or not. The results of any assessment do not alter the current rules for attribution of CDIs to either acute providers or CCGs.

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

3.1 A number of provider and commissioner organisations have recently developed and introduced various processes and tools to assist providers and commissioners in determining whether a particular CDI was associated with a lapse in care and therefore what lessons need to be learned in order to ensure the safety of patients is continuously improved. These tools can also be used to determine whether the application of sanctions is appropriate. NHS England supports the use of these tools where the process involved directly supports the improvement of the safety of patients and is focussed on clinical learning. It is not appropriate for these tools to be used simply to attempt to avoid contractual sanctions. Organisations are free to develop their own tools if they wish, in agreement with their commissioners, although we have provided two such tools in the annexes to this document as exemplar processes for those organisations who wish to use either of them. See Annex A for a simplified flowchart of the recommended process and Annex B and C for exemplar tools.

3.2 The exemplar tools provided allow a assessment of each identified CDI case 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 assessed 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.

3.3 The types of issues which would result in the infection being considered to be associated with a lapse in care could be any case where there was evidence of transmission of *C. difficile* in hospital such as via ribotyping of the infection indicating the same strain is involved, where there were breakdowns in cleaning or hand hygiene, or where there were problems identified with choice, duration, or documentation of antibiotic prescribing. It must be noted that none of these would indicate that the infection was definitely caused by the provider organisation, only that we cannot state that best practice was followed at all times. Where any of these issues, or indeed any others are 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.

3.4 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.

3.5 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 though, 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.

3.6 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[4],[5]. 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 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.

3.7 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 should still be

[4] Inclusion criteria for reporting C. difficile infection to the surveillance system http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317132954594

[5] Updated Guidance on the Diagnosis and Report of Clostridium Difficile https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215135/dh_133016.pdf

reported as per national reporting requirements[6] and given they are patient safety incidents should also be reported via local risk management systems to the National Reporting and Learning System[7]. Staff reporting CDIs as patient safety incidents are encouraged to update incident reports with any learning from their local assessment processes. All those CDIs that are deemed Serious Incidents according to existing national definitions[8] (typically those 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.

3.8 NHS England is working with Public Health England and the Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated infections (ARHAI) to further develop healthcare associated infection strategies that will support the NHS to continue its excellent achievements in infection prevention and control, while reflecting the changing nature of healthcare associated infections in the NHS. We will be considering whether to make changes to the mandatory reporting of CDIs to capture more data from the assessment of each *C. difficile* case as part of this work as well as considering more widely the best approach to future infection control strategies in the NHS.

3.9 In the interim, 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 *C. difficile* objectives have been calculated for CCGs according to the similar principles as for acute providers and are provided in Annex E:

4.1.1 All CCGs whose current performance (the most recent 12-month CDI rate to November 2013) is the same as or better than (lower than) the most recent 12-month England median should have their CDI objective for 2014/15 set as their most recent 12-month CDI rate, converted to actual CDI cases, minus 1 case. Therefore if a CCG is better than average their objective will be set as one case lower than their current CDI rate. This maintains the principle of the NHS delivering continuous improvement in patient safety.

4.1.2 All CCGs whose current performance (their most recent 12-month CDI rate to November 2013) is worse than (higher than) the most recent 12-month England median should have their CDI objective for 2014/15 set to require a continued reduction in their CDI rate equal to the reduction in CDI rates seen for England as a whole between the most recent 12-month period and the equivalent 12 month period before that. This equates to a roughly 8% reduction.

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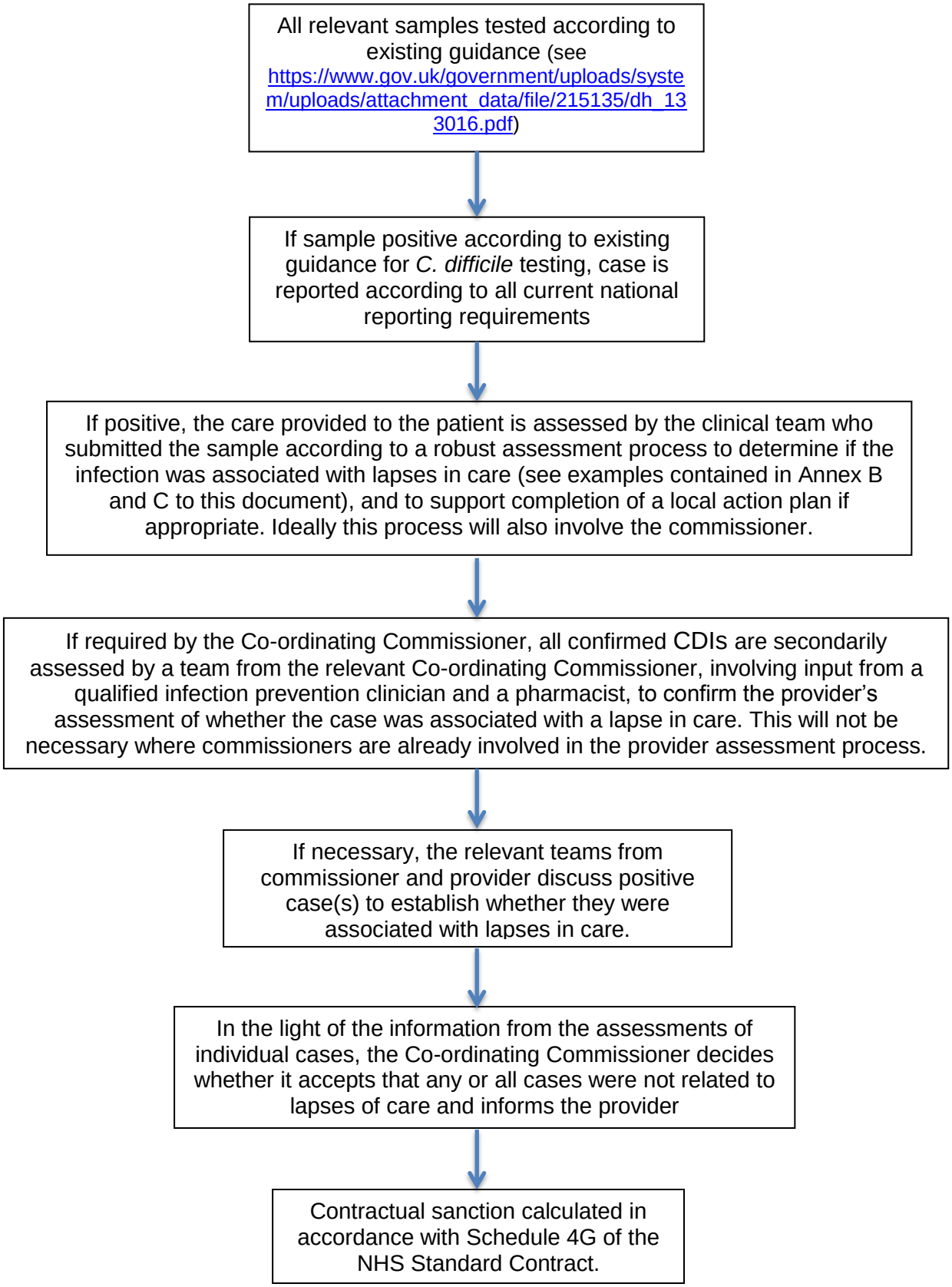
[6] See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215135/dh_133016.pdf
[7] See http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/
[8] See the *Serious Incident Framework* at http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf

4.2 As set out in the Planning Guidance for 2014/15[9] and specifically the Quality Premium Guidance for 2014/15[10], CDI rates no longer form part of the CCG Quality Premium calculations.

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

[9] See http://www.england.nhs.uk/ourwork/sop/
[10] See http://www.england.nhs.uk/ccg-ois/qual-prem/

Annex A – Exemplar assessment process for determining which C. difficile infections are relevant for the application of sanctions



Annex B – See separate excel file developed from University Hospitals Birmingham NHS Foundation Trust's assessment process for CDIs.

Annex C – See separate assessment toolkit developed from the NHS England East Anglia Area Team appeal process for non-trajectory cases of CDIs.

Annex D - Key baseline questions before assessing the effectiveness of *C. difficile* infection treatment and prevention practices from the Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infections

C. difficile infection (CDI) causes serious illness and outbreaks among hospital in-patients. Normally it affects the elderly, the debilitated and patients who have had antibiotic treatment.

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 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 of minimisation of risk of CDI in patients and/or transmission of *C. difficile* between patients.

There are three key elements to measuring the burden of *C. difficile* infection (CDI). A consistent approach to:

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

aims to ensure the prompt recognition and isolation of infected patients in the interests of patient safety, and to assure that recorded numbers of CDIs reflect the true rate of infection. Clear guidance on these three elements was issued to the NHS in 2012.

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.

Table 1: Questions to determine whether the recorded number of cases accurately reflects CDI burden Question		
Question	**How to assess compliance**	**Notes**
1. Are faecal samples sent for *C. difficile* 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? **Answer should be yes.**	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.	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.
2. What is the evidence that this is understood and practised consistently by all healthcare staff across the organisation?	Direct questioning of healthcare workers or via audit data as above.	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.
3. Are all diarrhoeal samples received in the laboratory from hospital patients aged >2 years, community patients aged >65 years, and community patients aged <65 years wherever clinically indicated tested for *C. difficile*? **Answer should be yes.**	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. 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	Guidance states: **Diarrhoeal samples should be tested for *C. difficile* from:** • **hospital patients aged >2 years, and,** • **community patients, aged >65 years, and** • **community patients aged <65 years wherever clinically indicated.**

	appropriate samples are tested for CDI and inappropriate samples are not tested for CDI (e.g. samples from infants, non-diarrhoeal samples)?	
4. Is all *C. difficile* testing consistent with the recommended two-stage algorithm? **Answer should be yes.**	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?	Guidance states: **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.
5. Are all toxin positive patients reported to PHE? **Answer should be yes.**	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)?	Guidance states: **All GDH EIA (or NAAT) positive, toxin positive patients/reports should be reporting to PHE.**
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? **Answer should be no.**	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).	**See 5. above.** **The results of other tests and/or clinical criteria should NOT be used to determine which positive patients are reported to PHE.**
7. Are toxin positive results obtained >28 days after a previous positive result on the same patient reported to PHE. **Answer should be yes.**	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).	**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.

Annex E - CDI Objectives for normal, teaching and specialist acute trusts and CCGs for 2014/15

Principles and methodology

Three cohorts of acute trusts have been recognised for the purposes of calculating median CDI rates based on expert advice – acute teaching hospitals, specialist hospitals and non-teaching (ie 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 2013 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 2013) 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 rate improvement from the preceding 12 months (to November 2012) to the most recent 12 months (to November 2013) are then calculated to give a cohort rate of CDI improvement. These values are set out in the table below;

Cohort	Current CDI rate (for year to November 2013)	Previous CDI rate (for year to November 2012)	Reduction in CDI rate from previous year to current year
Non-teaching acute trusts	**14.73** CDI cases per 100,000 bed days	**16.74** CDI cases per 100,000 bed days	**12.01%**
Teaching acute trusts	**16.89** CDI cases per 100,000 bed days	**19.53** CDI cases per 100,000 bed days	**13.47%**
CCGs	**25.78** CDI cases per 100,000 population	**28.02** CDI cases per 100,000 population	**8.00%**

All organisations with a current CDI rate for the year to November 2013 below (better than) their cohort median for the same period, have a CDI objective for 2014/15 set as their current number of CDI cases reported during the year to November 2013 minus one. This maintains the principle of the NHS delivering continuous improvement in patient safety but reflects that those performing better than average may be approaching the irreducible minimum of cases.

All organisations with a current CDI rate for the year to November 2013 above (worse than) their cohort median for the same period have a CDI objective set as their CDI rate for the year to November 2013 minus the percentage reduction in median CDI rate seen for their cohort between the preceding year and the current year. This means their objective reflects 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 requires 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 2013 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:

Normal Acute Trusts			
Org code	**Name**	**CDI case objective for 2014/15**	**CDI rate objective for 2014/15**
REM	Aintree University Hospitals	81	33.0
RCF	Airedale	9	7.5
RTK	Ashford & St Peter's Hospitals	9	5.1
RF4	Barking, Havering & Redbridge Hospitals	37	10.2
RVL	Barnet & Chase Farm Hospitals	20	8.2
RFF	Barnsley Hospital	20	12.7
R1H	Barts Health	71	11.2
RDD	Basildon & Thurrock University Hospitals	18	8.3
RC1	Bedford Hospital	18	14.3
RXL	Blackpool, Fylde & Wyre Hospitals	28	10.4
RXQ	Buckinghamshire Hospitals	33	13.2
RJF	Burton Hospitals	15	10.0
RWY	Calderdale & Huddersfield	18	7.5
RFS	Chesterfield Royal Hospital	40	21.5
RLN	City Hospitals Sunderland	51	20.6
RDE	Colchester Hospital University	20	10.3
RJR	Countess of Chester Hospital	30	15.5
RXP	County Durham & Darlington	37	11.4
RJ6	Croydon Health Services	17	9.9
RN7	Dartford & Gravesham	17	9.5
RTG	Derby Hospitals	69	22.6
RP5	Doncaster & Bassetlaw Hospitals	45	15.1
RBD	Dorset County Hospital	22	21.7
RC3	Ealing Hospital	8	5.0
RWH	East & North Hertfordshire	15	6.6
RJN	East Cheshire	14	11.2
RVV	East Kent Hospitals University	47	14.7
RXR	East Lancashire Hospitals	23	7.7
RXC	East Sussex Healthcare	44	17.4
RVR	Epsom & St Helier University Hospitals	40	16.6
RDU	Frimley Park Hospital	18	9.6
RR7	Gateshead Health	24	14.5
RLT	George Eliot Hospital	7	6.7
RTE	Gloucestershire Hospitals	55	16.9
RN3	Great Western Hospitals	28	14.0
RN5	Hampshire Hospitals	37	14.6
RCD	Harrogate & District	15	14.9

RR1	Heart of England	78	15.0
RD7	Heatherwood & Wexham Park Hospitals	34	18.0
RLQ	Hereford Hospitals	12	14.3
RAS	Hillingdon Hospital	16	12.5
RQQ	Hinchingbrooke Healthcare	7	8.6
RQX	Homerton University Hospital	2	1.6
RGQ	Ipswich Hospital	23	12.7
R1F	Isle of Wight Healthcare	6	6.1
RGP	James Paget University Hospitals	17	13.1
RNQ	Kettering General Hospital	28	14.9
RAX	Kingston Hospital	24	16.5
RC9	Luton & Dunstable Hospital	19	9.5
RWF	Maidstone & Tunbridge Wells	40	16.6
RPA	Medway	14	7.7
RBT	Mid Cheshire Hospitals	23	11.8
RQ8	Mid Essex Hospital Services	13	7.4
RJD	Mid Staffordshire	24	21.2
RXF	Mid Yorkshire Hospitals	42	12.7
RD8	Milton Keynes Hospital	19	13.0
RVJ	North Bristol	79	23.2
RNL	North Cumbria University Hospitals	37	20.2
RAP	North Middlesex University Hospital	17	14.5
RVW	North Tees & Hartlepool	40	20.2
RV8	North West London Hospitals	18	7.3
RNS	Northampton General Hospital	35	14.0
RBZ	Northern Devon Healthcare	16	14.2
RJL	Northern Lincolnshire & Goole Hospitals	33	14.9
RTF	Northumbria Healthcare	30	8.8
RW6	Pennine Acute Hospitals	62	14.1
RGN	Peterborough & Stamford Hospitals	31	15.8
RK9	Plymouth Hospitals	30	11.0
RD3	Poole Hospital	13	7.8
RHU	Portsmouth Hospitals	31	9.7
RQW	Princess Alexandra Hospital	16	10.8
RHW	Royal Berkshire	40	18.6
RMC	Royal Bolton Hospital	48	23.0
REF	Royal Cornwall Hospitals	35	16.4
RH8	Royal Devon & Exeter	30	12.8
RA2	Royal Surrey County Hospital	23	14.8
RD1	Royal United Hospital Bath	37	17.5
RL4	Royal Wolverhampton Hospitals	36	13.9
RNZ	Salisbury	18	12.6
RXK	Sandwell & West Birmingham Hospitals	37	14.8
RK5	Sherwood Forest Hospitals	37	14.7

RXW	Shrewsbury & Telford Hospital	38	14.6
RA9	South Devon Healthcare	11	8.8
RTR	South Tees Hospitals	49	14.4
RE9	South Tyneside	10	7.9
RJC	South Warwickshire	24	12.6
RAJ	Southend University Hospital	26	14.5
RVY	Southport & Ormskirk Hospital	27	18.3
RBN	St Helens & Knowsley Hospitals	19	8.2
RWJ	Stockport	39	17.8
RTP	Surrey & Sussex Healthcare	29	14.9
RMP	Tameside Hospital	41	25.3
RBA	Taunton & Somerset	11	6.0
RNA	The Dudley Group of Hospitals	48	20.5
RJ2	The Lewisham Hospital	39	13.1
RCX	The Queen Elizabeth Hospital King's Lynn	14	9.2
RFR	The Rotherham	24	14.2
RDZ	The Royal Bournemouth & Christchurch Hospitals	25	12.2
RKE	The Whittington Hospital	19	19.6
RWD	United Lincolnshire Hospitals	62	16.0
RJE	University Hospital of North Staffordshire	50	14.6
RKB	University Hospitals Coventry & Warwickshire	54	14.3
RTX	University Hospitals of Morecambe Bay	46	19.6
RBK	Walsall Hospitals	28	18.5
RWW	Warrington & Halton Hospitals	26	12.9
RWG	West Hertfordshire Hospitals	31	14.7
RFW	West Middlesex University Hospital	19	15.3
RGR	West Suffolk Hospitals	25	19.4
RYR	Western Sussex Hospitals	56	18.4
RA3	Weston Area Health	17	21.8
RWP	Worcestershire Acute Hospitals	41	14.8
RRF	Wrightington, Wigan & Leigh	32	21.4
RA4	Yeovil District Hospital	10	10.5
RCB	York Hospitals	59	16.6

Teaching Acute Trusts			
Org code	**Name**	**CDI case objective for 2014/15**	**CDI rate objective for 2014/15**
RAE	Bradford Teaching Hospitals	35	17.1
RXH	Brighton & Sussex University Hospitals	50	18.6
RGT	Cambridge University Hospitals	61	19.6
RW3	Central Manchester University Hospitals	66	16.8
RQM	Chelsea & Westminster Hospital	8	6.4
RJ1	Guy's & St. Thomas'	37	11.8
RWA	Hull & East Yorkshire Hospitals	57	15.7

RYJ	Imperial College Healthcare	65	16.8
RJZ	King's College Hospital	58	12.8
RXN	Lancashire Teaching Hospitals	51	17.0
RR8	Leeds Teaching Hospitals	127	21.5
RM1	Norfolk & Norwich University Hospitals	50	15.8
RX1	Nottingham University Hospitals	98	19.4
RTH	Oxford University Hospitals	67	16.9
RAL	Royal Free Hampstead	38	23.2
RQ6	Royal Liverpool & Broadgreen University Hospitals	48	18.7
RM3	Salford Royal	21	9.7
RHQ	Sheffield Teaching Hospitals	94	16.1
RHM	Southampton University Hospitals	29	8.2
RJ7	St. George's Healthcare	40	14.1
RTD	The Newcastle upon Tyne Hospitals	80	16.7
RRV	University College London Hospitals	57	21.6
RRK	University Hospital Birmingham	67	19.5
RM2	University Hospital of South Manchester	39	14.1
RA7	University Hospitals Bristol	40	15.3
RWE	University Hospitals of Leicester	81	15.6
RBL	Wirral University Teaching Hospital	24	9.6

Specialist Acute Trusts			
Org code	**Name**	**CDI case objective for 2014/15**	**CDI rate objective for 2014/15**
RBS	Alder Hey Children's	0	0.00
RQ3	Birmingham Children's Hospital	0	0.00
RLU	Birmingham Women's	0	0.00
RBV	Christie Hospital	4	7.92
REN	Clatterbridge Centre for Oncology	2	10.20
RP4	Great Ormond Street Hospital for Children	7	6.85
RBQ	Liverpool Heart & Chest Hospital	1	2.07
REP	Liverpool Women's	0	0.00
RP6	Moorfields Eye Hospital	0	0.00
RGM	Papworth Hospital	4	5.58
RPC	Queen Victoria Hospital	0	0.00
RL1	Robert Jones & Agnes Hunt Orthopaedic	0	0.00
RT3	Royal Brompton & Harefield	9	7.56
RBB	Royal National Hospital for Rheumatic Diseases	0	0.00
RAN	Royal National Orthopaedic Hospital	13	25.62
RCU	Sheffield Children's	4	9.90
RPY	The Royal Marsden	16	26.83
RRJ	The Royal Orthopaedic Hospital	0	0.00
RET	The Walton Centre for Neurology & Neurosurgery	9	20.02

CCGs			
Org code	**Name**	**CDI case objective for 2014/15**	**CDI rate objective for 2014/15**
02N	NHS Airedale, Wharfedale and Craven CCG	47	29.7
09C	NHS Ashford CCG	20	16.9
10Y	NHS Aylesbury Vale CCG	50	25.9
07L	NHS Barking & Dagenham CCG	39	20.9
07M	NHS Barnet CCG	66	18.5
02P	NHS Barnsley CCG	73	31.5
99E	NHS Basildon and Brentwood CCG	33	13.3
02Q	NHS Bassetlaw CCG	26	23.0
11E	NHS Bath and North East Somerset CCG	49	27.9
06F	NHS Bedfordshire CCG	69	16.7
07N	NHS Bexley CCG	63	27.1
13P	NHS Birmingham CrossCity CCG	163	22.8
04X	NHS Birmingham South and Central CCG	56	28.2
00Q	NHS Blackburn with Darwen CCG	25	16.9
00R	NHS Blackpool CCG	43	30.3
00T	NHS Bolton CCG	96	34.6
10G	NHS Bracknell and Ascot CCG	28	21.2
02W	NHS Bradford City CCG	21	25.7
02R	NHS Bradford Districts CCG	99	29.8
07P	NHS Brent CCG	35	11.2
09D	NHS Brighton & Hove CCG	70	25.6
11H	NHS Bristol CCG	131	30.6
07Q	NHS Bromley CCG	69	22.2
00V	NHS Bury CCG	63	34.0
02T	NHS Calderdale CCG	47	23.0
06H	NHS Cambridgeshire and Peterborough CCG	162	19.3
07R	NHS Camden CCG	87	39.5
04Y	NHS Cannock Chase CCG	35	26.5
09E	NHS Canterbury and Coastal CCG	50	25.3
99F	NHS Castle Point and Rochford CCG	37	21.6
09A	NHS Central London (Westminster) CCG	39	24.7
00W	NHS Central Manchester CCG	33	18.4
10H	NHS Chiltern CCG	57	18.0
00X	NHS Chorley and South Ribble CCG	47	28.2
07T	NHS City and Hackney CCG	27	10.6
09G	NHS Coastal West Sussex CCG	168	35.5
03V	NHS Corby CCG	20	32.5
05A	NHS Coventry and Rugby CCG	123	29.5
09H	NHS Crawley CCG	28	26.2
07V	NHS Croydon CCG	59	16.2

01H	NHS Cumbria CCG	196	38.7
00C	NHS Darlington CCG	20	18.9
09J	NHS Dartford, Gravesham and Swanley CCG	64	26.0
02X	NHS Doncaster CCG	91	30.1
11J	NHS Dorset CCG	192	25.8
05C	NHS Dudley CCG	108	34.5
00D	NHS Durham Dales, Easington and Sedgefield CCG	75	27.5
07W	NHS Ealing CCG	45	13.3
06K	NHS East and North Hertfordshire CCG	97	18.1
01A	NHS East Lancashire CCG	67	18.0
03W	NHS East Leicestershire and Rutland CCG	97	30.5
02Y	NHS East Riding of Yorkshire CCG	90	28.7
05D	NHS East Staffordshire CCG	30	24.3
09L	NHS East Surrey CCG	31	17.8
09F	NHS Eastbourne, Hailsham and Seaford CCG	62	34.4
01C	NHS Eastern Cheshire CCG	42	21.6
07X	NHS Enfield CCG	76	24.2
03X	NHS Erewash CCG	25	26.5
10K	NHS Fareham and Gosport CCG	48	24.7
02M	NHS Fylde & Wyre CCG	31	18.8
00F	NHS Gateshead CCG	62	30.9
11M	NHS Gloucestershire CCG	201	33.6
06M	NHS Great Yarmouth & Waveney CCG	55	25.8
03A	NHS Greater Huddersfield CCG	42	17.7
01E	NHS Greater Preston CCG	60	29.8
08A	NHS Greenwich CCG	63	24.7
09N	NHS Guildford and Waverley CCG	29	14.2
01F	NHS Halton CCG	20	15.9
03D	NHS Hambleton, Richmondshire and Whitby CCG	52	34.0
08C	NHS Hammersmith and Fulham CCG	33	18.1
03Y	NHS Hardwick CCG	29	26.8
08D	NHS Haringey CCG	37	14.5
03E	NHS Harrogate and Rural District CCG	38	23.9
08E	NHS Harrow CCG	40	16.6
00K	NHS Hartlepool and Stockton-on-Tees CCG	123	43.3
09P	NHS Hastings & Rother CCG	47	26.0
08F	NHS Havering CCG	59	24.8
05F	NHS Herefordshire CCG	46	25.1
06N	NHS Herts Valleys CCG	123	21.8
01D	NHS Heywood, Middleton & Rochdale CCG	49	23.1
99K	NHS High Weald Lewes Havens CCG	33	19.9
08G	NHS Hillingdon CCG	48	17.4
09X	NHS Horsham and Mid Sussex CCG	49	22.1
07Y	NHS Hounslow CCG	62	24.3

03F	NHS Hull CCG	68	26.5
06L	NHS Ipswich and East Suffolk CCG	99	25.1
10L	NHS Isle of Wight CCG	20	14.5
08H	NHS Islington CCG	52	25.2
11N	NHS Kernow CCG	138	25.7
08J	NHS Kingston CCG	35	21.8
01J	NHS Knowsley CCG	56	38.4
08K	NHS Lambeth CCG	51	16.7
01K	NHS Lancashire North CCG	56	35.8
02V	NHS Leeds North CCG	65	32.7
03G	NHS Leeds South and East CCG	106	45.0
03C	NHS Leeds West CCG	97	30.7
04C	NHS Leicester City CCG	80	24.3
08L	NHS Lewisham CCG	33	11.9
03T	NHS Lincolnshire East CCG	60	26.3
04D	NHS Lincolnshire West CCG	42	18.6
99A	NHS Liverpool CCG	158	33.9
06P	NHS Luton CCG	31	15.2
04E	NHS Mansfield & Ashfield CCG	85	44.3
09W	NHS Medway CCG	61	23.0
08R	NHS Merton CCG	25	12.5
06Q	NHS Mid Essex CCG	56	14.8
04F	NHS Milton Keynes CCG	63	24.7
04G	NHS Nene CCG	167	27.1
04H	NHS Newark & Sherwood CCG	40	34.8
10M	NHS Newbury and District CCG	16	15.3
00G	NHS Newcastle North and East CCG	43	30.9
00H	NHS Newcastle West CCG	25	17.9
08M	NHS Newham CCG	21	6.8
10N	NHS North & West Reading CCG	29	29.2
04J	NHS North Derbyshire CCG	138	50.8
00J	NHS North Durham CCG	62	25.8
06T	NHS North East Essex CCG	39	12.5
99M	NHS North East Hampshire and Farnham CCG	33	16.0
03H	NHS North East Lincolnshire CCG	22	13.8
10J	NHS North Hampshire CCG	55	25.7
03J	NHS North Kirklees CCG	50	27.0
03K	NHS North Lincolnshire CCG	37	22.1
01M	NHS North Manchester CCG	46	28.2
06V	NHS North Norfolk CCG	43	25.7
11T	NHS North Somerset CCG	73	35.9
05G	NHS North Staffordshire CCG	55	25.8
99C	NHS North Tyneside CCG	52	25.8
09Y	NHS North West Surrey CCG	62	18.4
99P	NHS North, East, West Devon CCG	204	23.6

00L	NHS Northumberland CCG	82	25.9
06W	NHS Norwich CCG	43	22.5
04K	NHS Nottingham City CCG	60	19.7
04L	NHS Nottingham North & East CCG	42	28.8
04M	NHS Nottingham West CCG	35	31.9
00Y	NHS Oldham CCG	68	30.2
10Q	NHS Oxfordshire CCG	172	26.8
10R	NHS Portsmouth CCG	39	19.0
08N	NHS Redbridge CCG	27	9.6
05J	NHS Redditch and Bromsgrove CCG	45	25.3
08P	NHS Richmond CCG	21	11.2
03L	NHS Rotherham CCG	66	25.6
04N	NHS Rushcliffe CCG	28	25.2
01G	NHS Salford CCG	60	25.6
05L	NHS Sandwell and West Birmingham CCG	112	23.8
03M	NHS Scarborough and Ryedale CCG	34	30.8
03N	NHS Sheffield CCG	193	35.0
05N	NHS Shropshire CCG	97	31.6
10T	NHS Slough CCG	24	17.1
05P	NHS Solihull CCG	70	33.8
11X	NHS Somerset CCG	107	20.1
01R	NHS South Cheshire CCG	42	23.9
99Q	NHS South Devon and Torbay CCG	81	29.8
05Q	NHS South East Staffs and Seisdon Peninsular CCG	42	18.9
10V	NHS South Eastern Hampshire CCG	42	20.1
12A	NHS South Gloucestershire CCG	68	25.8
10A	NHS South Kent Coast CCG	39	19.3
99D	NHS South Lincolnshire CCG	38	27.1
01N	NHS South Manchester CCG	43	26.9
06Y	NHS South Norfolk CCG	59	25.3
10W	NHS South Reading CCG	30	28.4
01T	NHS South Sefton CCG	60	37.6
00M	NHS South Tees CCG	51	18.6
00N	NHS South Tyneside CCG	31	20.9
05R	NHS South Warwickshire CCG	88	34.0
04Q	NHS South West Lincolnshire CCG	20	16.5
05T	NHS South Worcestershire CCG	70	24.1
10X	NHS Southampton CCG	57	24.2
99G	NHS Southend CCG	36	20.7
04R	NHS Southern Derbyshire CCG	134	26.2
01V	NHS Southport and Formby CCG	43	37.7
08Q	NHS Southwark CCG	42	14.5
01X	NHS St Helens CCG	57	32.5
05V	NHS Stafford and Surrounds CCG	65	43.2

01W	NHS Stockport CCG	88	31.1
05W	NHS Stoke on Trent CCG	76	29.6
00P	NHS Sunderland CCG	103	37.4
99H	NHS Surrey Downs CCG	76	27.1
10C	NHS Surrey Heath CCG	13	13.9
08T	NHS Sutton CCG	35	18.3
10D	NHS Swale CCG	29	27.1
12D	NHS Swindon CCG	55	25.6
01Y	NHS Tameside and Glossop CCG	101	39.9
05X	NHS Telford & Wrekin CCG	23	13.8
10E	NHS Thanet CCG	47	35.0
07G	NHS Thurrock CCG	22	13.9
08V	NHS Tower Hamlets CCG	38	14.8
02A	NHS Trafford CCG	59	26.0
03Q	NHS Vale of York CCG	90	26.2
02D	NHS Vale Royal CCG	17	16.6
03R	NHS Wakefield CCG	92	28.2
05Y	NHS Walsall CCG	62	23.0
08W	NHS Waltham Forest CCG	37	14.2
08X	NHS Wandsworth CCG	51	16.6
02E	NHS Warrington CCG	42	20.7
05H	NHS Warwickshire North CCG	48	25.6
02F	NHS West Cheshire CCG	61	26.8
07H	NHS West Essex CCG	54	18.8
11A	NHS West Hampshire CCG	109	20.1
99J	NHS West Kent CCG	98	21.3
02G	NHS West Lancashire CCG	33	29.8
04V	NHS West Leicestershire CCG	89	24.0
08Y	NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	69	31.3
07J	NHS West Norfolk CCG	42	24.6
07K	NHS West Suffolk CCG	58	26.4
02H	NHS Wigan Borough CCG	107	33.6
99N	NHS Wiltshire CCG	140	29.5
11C	NHS Windsor, Ascot and Maidenhead CCG	24	17.4
12F	NHS Wirral CCG	64	20.0
11D	NHS Wokingham CCG	40	25.8
06A	NHS Wolverhampton CCG	67	26.8
06D	NHS Wyre Forest CCG	22	22.4