NHS England

Clostridium difficile infection objectives for NHS organisations in 2015/16 and guidance on sanction implementation

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Clostridium difficile infection objectives for NHS organisations in 2015/16 and guidance on sanction implementation.

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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

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, for 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. This approach remains unchanged for 2015/16; however NHS England, working with Public Health England, are providing further guidance on assessing lapses in care.

1.3 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

2. CDI objectives and sanction regime

Acute providers

2.1 Last year NHS England focussed on encouraging organisations to look at each CDI case to understand what lessons they are able to learn in order to improve the safety of patients.

2.2 For 2015/16, 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.

2.3 For 2015/16, the contractual sanction that can be applied to each *CDI* case in excess of an acute organisation's objective will remain £10,000 (see NHS Standard Contract 2015/16 at http://www.england.nhs.uk/nhs-standard-contract/15-16/

2.4 CDI objectives for acute organisations (and CCGs) in 2015/16 have been calculated using the same methodology as for 2014/15 and delivers realistic improvement objectives for organisations with high CDI rates. This methodology;

- Recognises some organisations are performing better than the England average and that further drives to significantly reduce CDI rates may be counter-productive;
- Emphasises the need for all organisations to continue to deliver good infection prevention and control practices;
- Does not penalise organisations for having done well in the past;
- Is based on an assessment of what 'good' looks like;
- Does not require organisations to improve beyond the performance of organisations who are already performing below the England median rate.

2.5 This methodology requires acute organisations and CCGs to improve from where they are now, rather than from their previous CDI objective. As a consequence of this, a number of acute organisations and CCGs who exceeded their CDI objective for 2014/15 will have a higher CDI objective for 2015/16.

- CCGs should work with those trusts with an increased CDI objective to understand the possible reasons for the increase and particularly how many CDI cases are associated (or not) with a lapse in care.
- CCGs with an increased CDI objective should review CDI cases to understand reasons for the increase and provide assurance to NHS England sub regions, Health and Wellbeing Boards and others that they are assessing and tackling CDIs in their areas.

2.6 Annex E lists the CDI objectives for Trusts and CCGs and includes a full description of the method used, which is unchanged from the method used for 2014/15.

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, 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.

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 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.

2.10 For example, a single provider may have a target of 25 CDI cases for 2015/16. 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, 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, as this number falls below target, no sanction would 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 4G) 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 4G 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 4 G.

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 should be noted that lack of 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 the new CDI case checklist, intended to provide a standard way of assessing whether cases do, or do not, represent a lapse in care. While its use is not compulsory at this point, this standard assessment is intended to reduce variability in the assessment and interpretation of what constitutes a lapse in care and may become compulsory in future years.

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.

[1] 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

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 National Reporting and Learning System[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[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 NHS England is working with Public Health England and the Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated infections (ARHAI) to capture more data from the assessment of each CDI case.

3.12 In the interim, providers and commissioners should publish the results of CDI assessments on their own websites 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:

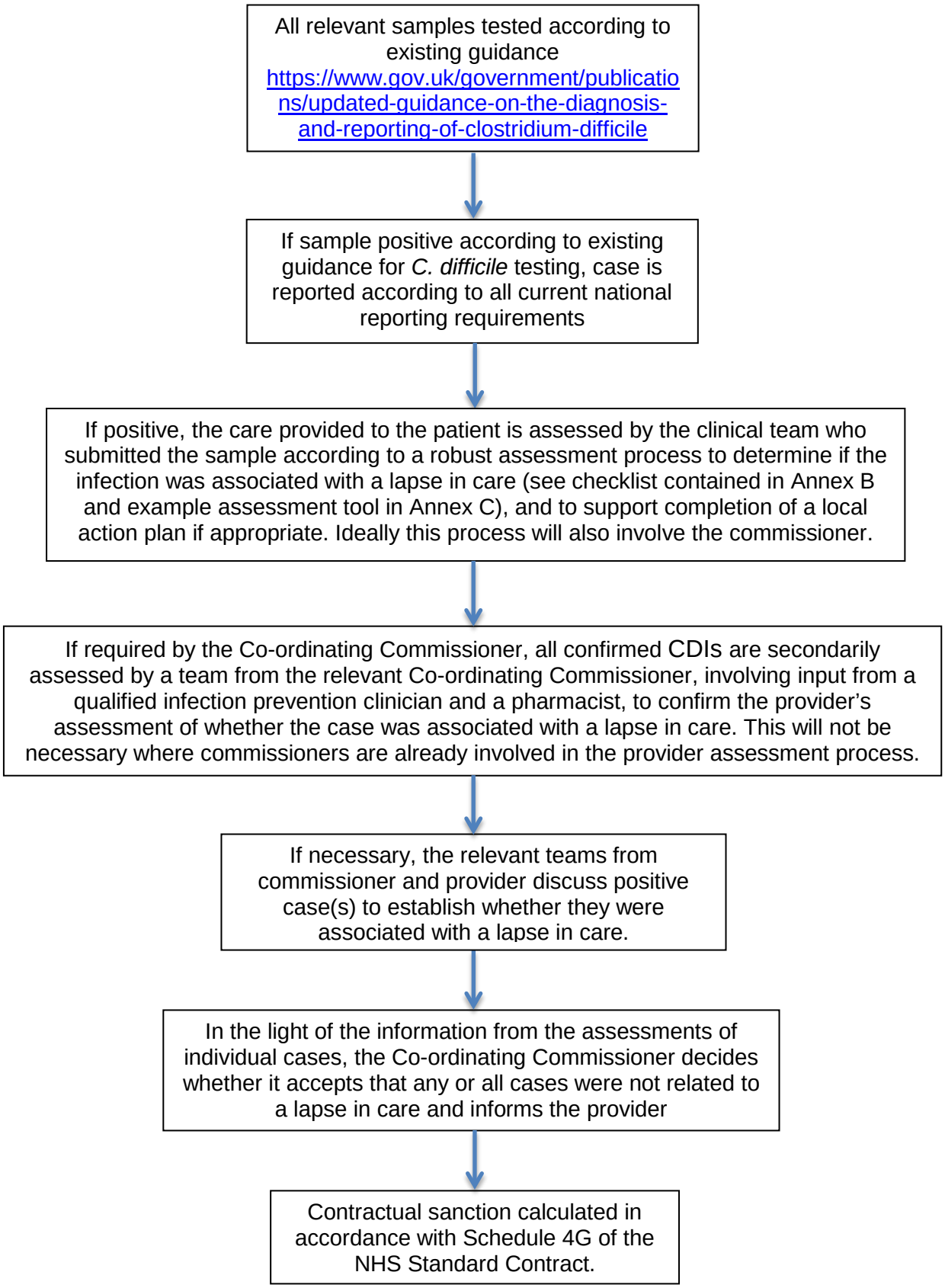
4.2 CCGs should use the objectives provided as thresholds of levels of ambition for planning purposes. NHS England sub regions, Health and Wellbeing Boards and others should use the objectives as benchmarks for assessing CCGs in tackling CDIs in their areas.

[2] Inclusion criteria for reporting C. difficile infection to the surveillance system https://www.gov.uk/government/publications/clostridium-difficile-infection-criteria-for-reporting

[3] Report a patient safety incident http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/

[4] See the *Serious Incident Framework* at https://www.england.nhs.uk/ourwork/patientsafety/

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



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 lapse 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 immunosuppressive 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? *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? *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 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 *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 Chronology of patient pathway

2.1 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 *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 undertook the monitoring? 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 Had 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 *Clostridium 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 2012[1].

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.

[1] 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

Table 1: Questions to determine whether the recorded number of cases accurately reflects CDI burden		
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?	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 they are 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.
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*?	There should be a laboratory standard operating procedure (sometimes referred to as an Examination procedure) that clearly states which samples received in the laboratory are tested for evidence of CDI. There will likely be	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**

	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)?	**clinically indicated.**
4. Is all *C. difficile* testing consistent with the recommended two-stage algorithm?	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?	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	The number of laboratory reported CDI positive cases should match the	**See 5. above** **The results of other tests**

referred to in question 4 above used to determine which toxin positive results are reported to PHE?	number of cases reported to PHE (after applying de-duplication according to 28 day rule).	**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.	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 - *Clostridium difficile* Infection Objectives for non-teaching, teaching and specialist acute trusts, and CCGs for 2015/16

Principles and methodology

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;

Cohort	**Current CDI rate (for year to November 2014)**	**Previous CDI rate (for year to November 2013)**	**Reduction in CDI rate from previous year to current year**
Non-teaching acute trusts	**13.1** CDI cases per 100,000 bed days	**14.9** CDI cases per 100,000 bed days	**12.5%**
Teaching acute trusts	**16.3** CDI cases per 100,000 bed days	**16.9** CDI cases per 100,000 bed days	**3.6%**
CCGs	**24.3** CDI cases per 100,000 population	**25.8** CDI cases per 100,000 population	**5.7%**

All organisations with a current CDI rate for the year to November 2014 below (better than) their cohort median for the same period, have a CDI objective for 2015/16 set as their current number of CDI cases reported during the year to November 2014 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 2014 above (worse than) their cohort median for the same period have 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 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 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:

Non-Teaching Acute Trusts			
Org code	**Name**	**CDI case objective for 2015/16**	**CDI rate objective for 2015/16**
REM	Aintree University Hospitals	46	19.3
RCF	Airedale	6	5.3
RTK	Ashford & St Peter's Hospitals	17	9.9
RF4	Barking, Havering & Redbridge Hospitals	30	8.6
RFF	Barnsley Hospital	13	8.8
R1H	Barts Health	82	13.1
RDD	Basildon & Thurrock University Hospitals	31	13.4
RC1	Bedford Hospital	10	8.3
RXL	Blackpool, Fylde & Wyre Hospitals **	40	15
RXQ	Buckinghamshire Hospitals	32	13.1
RJF	Burton Hospitals	20	13.1
RWY	Calderdale & Huddersfield	21	8.6
RFS	Chesterfield Royal Hospital	31	16.2
RLN	City Hospitals Sunderland	34	15.4
RDE	Colchester Hospital University	18	9.1
RJR	Countess of Chester Hospital	24	12.8
RXP	County Durham & Darlington	19	5.9
RJ6	Croydon Health Services	16	9.6

RN7	Dartford & Gravesham	24	12.5
RTG	Derby Hospitals***	53	16.6
RP5	Doncaster & Bassetlaw Hospitals	40	13.9
RBD	Dorset County Hospital	14	13.6
RWH	East & North Hertfordshire	11	4.9
RJN	East Cheshire *	14	12
RVV	East Kent Hospitals University *	46	13.9
RXR	East Lancashire Hospitals	28	9.3
RXC	East Sussex Healthcare	41	16.9
RVR	Epsom & St Helier University Hospitals	39	15.7
RDU	Frimley Health	31	7.6
RR7	Gateshead Health	19	11.6
RLT	George Eliot Hospital	13	12.5
RTE	Gloucestershire Hospitals	37	11.5
RN3	Great Western Hospitals	20	9.4
RN5	Hampshire Hospitals	34	13.1
RCD	Harrogate & District	12	11.7
RR1	Heart of England	64	13.1
RLQ	Hereford Hospitals	18	21.1
RAS	Hillingdon Hospital	8	6.3
RQQ	Hinchingbrooke Healthcare *	11	15.6
RQX	Homerton University Hospital	7	5.6
RGQ	Ipswich Hospital	18	9.4
R1F	Isle of Wight Healthcare	7	7.3
RGP	James Paget University Hospitals	17	13.1
RNQ	Kettering General Hospital	26	13.6
RAX	Kingston Hospital	9	6.5
R1K	London North West Healthcare	37	9.4
RC9	Luton & Dunstable Hospital	6	3.1
RWF	Maidstone & Tunbridge Wells	27	11.5
RPA	Medway	20	10.9
RBT	Mid Cheshire Hospitals	24	13.1
RQ8	Mid Essex Hospital Services	13	7.3
RXF	Mid Yorkshire Hospitals	27	8.3
RD8	Milton Keynes Hospital	39	26.0

RVJ	North Bristol	43	13.1
RNL	North Cumbria University Hospitals	25	13.1
RAP	North Middlesex University Hospital	34	25.9
RVW	North Tees & Hartlepool	13	6.8
RNS	Northampton General Hospital	21	8.2
RBZ	Northern Devon Healthcare	7	6.9
RJL	Northern Lincolnshire & Goole Hospitals	21	8.5
RTF	Northumbria Healthcare	30	9.4
RW6	Pennine Acute Hospitals	55	13.3
RGN	Peterborough & Stamford Hospitals	29	14.4
RK9	Plymouth Hospitals	35	13.2
RD3	Poole Hospital	15	9.2
RHU	Portsmouth Hospitals	40	12.2
RQW	Princess Alexandra Hospital	10	6.5
RHW	Royal Berkshire	27	12.2
RMC	Royal Bolton Hospital	19	9.5
REF	Royal Cornwall Hospitals	23	10.6
RH8	Royal Devon & Exeter	31	12.7
RA2	Royal Surrey County Hospital	21	13.6
RD1	Royal United Hospital Bath	22	10.9
RL4	Royal Wolverhampton Hospitals	35	13.1
RNZ	Salisbury	19	13.1
RXK	Sandwell & West Birmingham Hospitals	30	12.3
RK5	Sherwood Forest Hospitals	48	19.4
RXW	Shrewsbury & Telford Hospital	25	9.9
RA9	South Devon Healthcare	18	14.5
RTR	South Tees Hospitals	50	14.9
RE9	South Tyneside	8	6.5
RJC	South Warwickshire	6	3.6
RAJ	Southend University Hospital *	30	17.3
RVY	Southport & Ormskirk Hospital	36	23.9
RBN	St Helens & Knowsley Hospitals	41	17.6
RWJ	Stockport	17	7.8
RTP	Surrey & Sussex Healthcare	15	7.6
RMP	Tameside Hospital	46	29.6

RBA	Taunton & Somerset	12	7.0
RNA	The Dudley Group of Hospitals	29	13.0
RJ2	The Lewisham Hospital	39	13.1
RCX	The Queen Elizabeth Hospital King's Lynn	53	38.3
RFR	The Rotherham	26	13.0
RDZ	The Royal Bournemouth & Christchurch Hospitals	14	6.9
RKE	The Whittington Hospital	17	17.0
RWD	United Lincolnshire Hospitals	59	16.8
RJE	University Hospitals of North Midlands	74	16.1
RKB	University Hospitals Coventry & Warwickshire	42	11.3
RTX	University Hospitals of Morecambe Bay	44	20.0
RBK	Walsall Hospitals	18	11.1
RWW	Warrington & Halton Hospitals	27	14.3
RWG	West Hertfordshire Hospitals	23	10.9
RFW	West Middlesex University Hospital	9	6.8
RGR	West Suffolk Hospitals	16	12.5
RYR	Western Sussex Hospitals	39	13.1
RA3	Weston Area Health	18	20.8
RWP	Worcestershire Acute Hospitals *	32	11.8
RRF	Wrightington, Wigan & Leigh	19	12.7
RA4	Yeovil District Hospital	8	7.9

* The objective for this Trust was amended 20/02/15 to reflect a correction to the baseline data

** The objective for this Trust was revised 13/03/15 as it has now been classified as a teaching trust

*** The objective for this Trust was revised 17/07/15 as it has now been classified as a teaching trust

Teaching Acute Trusts			
Org code	**Name**	**CDI case objective for 2015/16**	**CDI rate objective for 2015/16**
RAE	Bradford Teaching Hospitals	51	26.8
RXH	Brighton & Sussex University Hospitals	46	17.3
RGT	Cambridge University Hospitals	49	15.6
RW3	Central Manchester University Hospitals	66	16.3
RQM	Chelsea & Westminster Hospital	7	5.4
RJ1	Guy's & St. Thomas'	51	16.0
RWA	Hull & East Yorkshire Hospitals	53	15.0
RYJ	Imperial College Healthcare	69	23.2
RJZ	King's College Hospital	72	15.2
RXN	Lancashire Teaching Hospitals	66	22.4
RR8	Leeds Teaching Hospitals	119	21.2
RM1	Norfolk & Norwich University Hospitals	49	15.1
RX1	Nottingham University Hospitals	91	17.6
RTH	Oxford University Hospitals	69	15.0
RAL	Royal Free Hampstead	66	41.6
RQ6	Royal Liverpool & Broadgreen University Hospitals	44	17.2
RM3	Salford Royal	21	9.4
RHQ	Sheffield Teaching Hospitals	87	14.9
RHM	Southampton University Hospitals	43	11.8
RJ7	St. George's Healthcare	31	10.2
RTD	The Newcastle upon Tyne Hospitals	77	16.3
RRV	University College London Hospitals	97	36.5
RRK	University Hospital Birmingham	63	17.2
RM2	University Hospital of South Manchester *	39	15.2
RA7	University Hospitals Bristol	45	17.4
RWE	University Hospitals of Leicester	61	11.7
RBL	Wirral University Teaching Hospital	29	11.7
RCB	York Hospitals	48	14.5

* The objective for this Trust was amended 20/02/15 to reflect a correction to the baseline data

** The objective for this Trust was revised 19/06/15 as it had previously been incorrectly classified as a non-teaching acute trust.

Specialist Acute Trusts			
Org code	**Name**	**CDI case objective for 2015/16**	**CDI rate objective for 2015/16**
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	14	28.7
REN	Clatterbridge Centre for Oncology	1	5.8
RP4	Great Ormond Street Hospital for Children	15	13.8
RBQ	Liverpool Heart & Chest Hospital	4	8.6
REP	Liverpool Women's	1	2.7
RP6	Moorfields Eye Hospital	0	0.00
RGM	Papworth Hospital	5	7.0
RPC	Queen Victoria Hospital	0	0.00
RL1	Robert Jones & Agnes Hunt Orthopaedic	2	3.8
RT3	Royal Brompton & Harefield	23	19.4
RBB	Royal National Hospital for Rheumatic Diseases	0	0.00
RAN	Royal National Orthopaedic Hospital	2	3.8
RCU	Sheffield Children's	3	7.4
RPY	The Royal Marsden	31	51.4
RRJ	The Royal Orthopaedic Hospital	2	6.3
RET	The Walton Centre for Neurology & Neurosurgery	10	19.9

CCGs			
Org code	**Name**	**CDI case objective for 2015/16**	**CDI rate objective for 2015/16**
02N	NHS Airedale, Wharfedale and Craven CCG *	36	22.7
09C	NHS Ashford CCG	31	25.5
10Y	NHS Aylesbury Vale CCG	49	24.6
07L	NHS Barking & Dagenham CCG *	37	19.0
07M	NHS Barnet CCG	79	21.4
02P	NHS Barnsley CCG	63	26.7
99E	NHS Basildon and Brentwood CCG	45	17.8
02Q	NHS Bassetlaw CCG	22	19.4
11E	NHS Bath and North East Somerset CCG	47	26.1
06F	NHS Bedfordshire CCG	73	17.1
07N	NHS Bexley CCG	56	23.7
13P	NHS Birmingham CrossCity CCG	183	25.2
04X	NHS Birmingham South and Central CCG	46	22.9
00Q	NHS Blackburn with Darwen CCG	40	27.1
00R	NHS Blackpool CCG	58	41.0
00T	NHS Bolton CCG *	80	28.6
10G	NHS Bracknell and Ascot CCG *	18	13.4
02W	NHS Bradford City CCG	23	27.8
02R	NHS Bradford Districts CCG *	116	34.7
07P	NHS Brent CCG	56	17.7
09D	NHS Brighton & Hove CCG	52	18.7
11H	NHS Bristol CCG	131	29.9
07Q	NHS Bromley CCG	76	23.9
00V	NHS Bury CCG	45	24.1
02T	NHS Calderdale CCG	39	18.9
06H	NHS Cambridgeshire and Peterborough CCG	188	22.0
07R	NHS Camden CCG	90	39.2
04Y	NHS Cannock Chase CCG	48	35.9
09E	NHS Canterbury and Coastal CCG	35	17.3
99F	NHS Castle Point and Rochford CCG	44	25.5
09A	NHS Central London (Westminster) CCG	40	24.6
00W	NHS Central Manchester CCG *	41	22.5
10H	NHS Chiltern CCG *	61	19.1
00X	NHS Chorley and South Ribble CCG	59	34.8

07T	NHS City and Hackney CCG	31	11.7
09G	NHS Coastal West Sussex CCG	155	32.3
03V	NHS Corby CCG	18	28.0
05A	NHS Coventry and Rugby CCG *	107	24.8
09H	NHS Crawley CCG	17	15.6
07V	NHS Croydon CCG	55	14.8
01H	NHS Cumbria CCG	201	39.9
00C	NHS Darlington CCG *	17	16.1
09J	NHS Dartford, Gravesham and Swanley CCG	61	24.2
02X	NHS Doncaster CCG	81	26.7
11J	NHS Dorset CCG *	204	27.0
05C	NHS Dudley CCG	76	24.2
00D	NHS Durham Dales, Easington and Sedgefield CCG *	74	27.1
07W	NHS Ealing CCG	67	19.6
06K	NHS East and North Hertfordshire CCG	112	20.5
01A	NHS East Lancashire CCG *	58	15.6
03W	NHS East Leicestershire and Rutland CCG	78	24.2
02Y	NHS East Riding of Yorkshire CCG	85	27.0
05D	NHS East Staffordshire CCG	31	24.9
09L	NHS East Surrey CCG	43	24.2
09F	NHS Eastbourne, Hailsham and Seaford CCG	59	32.2
01C	NHS Eastern Cheshire CCG	50	25.6
07X	NHS Enfield CCG *	76	23.7
03X	NHS Erewash CCG	19	20.0
10K	NHS Fareham and Gosport CCG	30	15.2
02M	NHS Fylde & Wyre CCG	44	26.5
00F	NHS Gateshead CCG	61	30.5
11M	NHS Gloucestershire CCG	157	25.9
06M	NHS Great Yarmouth & Waveney CCG	70	32.7
03A	NHS Greater Huddersfield CCG	40	16.6
01E	NHS Greater Preston CCG	49	24.3
08A	NHS Greenwich CCG	62	23.5
09N	NHS Guildford and Waverley CCG	20	9.6
01F	NHS Halton CCG	36	28.6
03D	NHS Hambleton, Richmondshire and Whitby CCG	45	29.3
08C	NHS Hammersmith and Fulham CCG	35	19.6
03Y	NHS Hardwick CCG	43	39.4

08D	NHS Haringey CCG *	50	19.0
03E	NHS Harrogate and Rural District CCG	34	21.5
08E	NHS Harrow CCG	32	13.1
00K	NHS Hartlepool and Stockton-on-Tees CCG	72	25.2
09P	NHS Hastings & Rother CCG	44	24.2
08F	NHS Havering CCG *	51	21.1
05F	NHS Herefordshire CCG	46	24.7
06N	NHS Herts Valleys CCG	131	22.8
01D	NHS Heywood, Middleton & Rochdale CCG	49	23.1
99K	NHS High Weald Lewes Havens CCG	35	20.7
08G	NHS Hillingdon CCG	37	12.9
09X	NHS Horsham and Mid Sussex CCG	46	20.4
07Y	NHS Hounslow CCG	37	14.1
03F	NHS Hull CCG	82	31.8
06L	NHS Ipswich and East Suffolk CCG *	107	27.0
10L	NHS Isle of Wight CCG	28	20.2
08H	NHS Islington CCG	60	27.8
11N	NHS Kernow CCG	136	25.0
08J	NHS Kingston CCG	30	18.0
01J	NHS Knowsley CCG	56	38.3
08K	NHS Lambeth CCG	75	23.9
01K	NHS Lancashire North CCG	72	45.2
02V	NHS Leeds North CCG *	58	29.0
03G	NHS Leeds South and East CCG *	104	43.1
03C	NHS Leeds West CCG	90	28.1
04C	NHS Leicester City CCG	74	22.2
08L	NHS Lewisham CCG	53	18.5
03T	NHS Lincolnshire East CCG	65	28.3
04D	NHS Lincolnshire West CCG	45	19.6
99A	NHS Liverpool CCG	138	29.3
06P	NHS Luton CCG	28	13.5
04E	NHS Mansfield & Ashfield CCG	94	48.5
09W	NHS Medway CCG	55	20.3
08R	NHS Merton CCG	28	13.8
06Q	NHS Mid Essex CCG	71	18.6
04F	NHS Milton Keynes CCG	81	31.0
04G	NHS Nene CCG	164	26.2

04H	NHS Newark & Sherwood CCG	39	33.3
10M	NHS Newbury and District CCG	25	23.6
00G	NHS Newcastle North and East CCG	36	25.0
00H	NHS Newcastle West CCG	45	31.5
08M	NHS Newham CCG	35	11.0
10N	NHS North & West Reading CCG	23	23.0
04J	NHS North Derbyshire CCG *	107	39.3
00J	NHS North Durham CCG *	42	17.3
06T	NHS North East Essex CCG	45	14.2
99M	NHS North East Hampshire and Farnham CCG	33	15.9
03H	NHS North East Lincolnshire CCG	35	21.9
10J	NHS North Hampshire CCG	60	27.5
03J	NHS North Kirklees CCG	38	20.2
03K	NHS North Lincolnshire CCG	31	18.4
01M	NHS North Manchester CCG	39	22.9
06V	NHS North Norfolk CCG	58	34.4
11T	NHS North Somerset CCG	87	42.2
05G	NHS North Staffordshire CCG	61	28.4
99C	NHS North Tyneside CCG *	74	36.6
09Y	NHS North West Surrey CCG	54	15.9
99P	NHS North, East, West Devon CCG	219	25.0
00L	NHS Northumberland CCG	77	24.4
06W	NHS Norwich CCG	52	26.7
04K	NHS Nottingham City CCG	51	16.4
04L	NHS Nottingham North & East CCG	47	31.8
04M	NHS Nottingham West CCG	21	18.9
00Y	NHS Oldham CCG	91	40.0
10Q	NHS Oxfordshire CCG	145	22.2
10R	NHS Portsmouth CCG	50	24.1
08N	NHS Redbridge CCG	26	9.0
05J	NHS Redditch and Bromsgrove CCG	36	20.1
08P	NHS Richmond CCG	31	16.2
03L	NHS Rotherham CCG	63	24.4
04N	NHS Rushcliffe CCG	24	21.3
01G	NHS Salford CCG	62	25.9
05L	NHS Sandwell and West Birmingham CCG	109	22.7
03M	NHS Scarborough and Ryedale CCG	31	28.1

03N	NHS Sheffield CCG	194	34.6
05N	NHS Shropshire CCG	73	23.7
10T	NHS Slough CCG *	22	15.4
05P	NHS Solihull CCG *	58	27.8
11X	NHS Somerset CCG	131	24.3
01R	NHS South Cheshire CCG	52	29.3
99Q	NHS South Devon and Torbay CCG	97	35.3
05Q	NHS South East Staffs and Seisdon Peninsular CCG	47	20.9
10V	NHS South Eastern Hampshire CCG	50	23.8
12A	NHS South Gloucestershire CCG	94	34.9
10A	NHS South Kent Coast CCG	44	21.6
99D	NHS South Lincolnshire CCG	34	23.8
01N	NHS South Manchester CCG *	47	29.1
06Y	NHS South Norfolk CCG	65	27.4
10W	NHS South Reading CCG	20	18.3
01T	NHS South Sefton CCG	54	34.0
00M	NHS South Tees CCG *	91	33.2
00N	NHS South Tyneside CCG	53	35.7
05R	NHS South Warwickshire CCG	60	23.1
04Q	NHS South West Lincolnshire CCG	25	20.4
05T	NHS South Worcestershire CCG *	63	21.4
10X	NHS Southampton CCG	46	19.0
99G	NHS Southend CCG	36	20.5
04R	NHS Southern Derbyshire CCG	114	22.0
01V	NHS Southport and Formby CCG	38	33.2
08Q	NHS Southwark CCG	45	15.1
01X	NHS St Helens CCG *	75	42.6
05V	NHS Stafford and Surrounds CCG *	59	38.9
01W	NHS Stockport CCG	69	24.2
05W	NHS Stoke on Trent CCG *	87	33.7
00P	NHS Sunderland CCG	82	29.7
99H	NHS Surrey Downs CCG	76	26.7
10C	NHS Surrey Heath CCG	19	20.1
08T	NHS Sutton CCG	41	20.9
10D	NHS Swale CCG	14	12.8
12D	NHS Swindon CCG	44	20.1
01Y	NHS Tameside and Glossop CCG *	97	38.2

05X	NHS Telford & Wrekin CCG	20	11.9
10E	NHS Thanet CCG *	41	30.0
07G	NHS Thurrock CCG	29	18.0
08V	NHS Tower Hamlets CCG *	36	13.2
02A	NHS Trafford CCG *	64	27.8
03Q	NHS Vale of York CCG	78	22.3
02D	NHS Vale Royal CCG	20	19.6
03R	NHS Wakefield CCG	72	21.8
05Y	NHS Walsall CCG	56	20.6
08W	NHS Waltham Forest CCG *	46	17.3
08X	NHS Wandsworth CCG	50	16.1
02E	NHS Warrington CCG *	46	22.4
05H	NHS Warwickshire North CCG	70	37.2
02F	NHS West Cheshire CCG	78	34.1
07H	NHS West Essex CCG *	49	16.7
11A	NHS West Hampshire CCG	133	24.3
99J	NHS West Kent CCG	94	20.1
02G	NHS West Lancashire CCG	46	41.3
04V	NHS West Leicestershire CCG	77	20.4
08Y	NHS West London (Kensington and Chelsea, Queen's Park and Paddington) CCG	51	23.2
07J	NHS West Norfolk CCG	100	58.3
07K	NHS West Suffolk CCG	45	20.1
02H	NHS Wigan Borough CCG	81	25.3
99N	NHS Wiltshire CCG	103	21.5
11C	NHS Windsor, Ascot and Maidenhead CCG *	33	23.6
12F	NHS Wirral CCG	75	23.4
11D	NHS Wokingham CCG	28	17.7
06A	NHS Wolverhampton CCG	71	28.2
06D	NHS Wyre Forest CCG	15	15.2

* The objective for this CCG was amended 20/02/15 to reflect a correction to the baseline data