

Clostridioides difficile infection, Escherichia coli bacteraemia, Staphylococcus aureus bacteraemia and Surgical Site Infection in Scotland

July to September 2025

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Scotland**

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Introduction

Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland provides a commentary on quarterly epidemiological data in Scotland for July to September (Q3) 2025 on the following:

- *Clostridioides difficile* infection
- *Escherichia coli* bacteraemia
- *Staphylococcus aureus* bacteraemia
- Surgical Site Infection

Data are provided for the 14 NHS boards and one NHS Special Health Board.

Main Points

Clostridioides difficile infection (CDI) during July to September 2025

- The total number of CDI cases in patients reported to ARHAI was 330.
- 246 (74.5%) CDI cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 16.1 cases per 100,000 total occupied bed days (TOBDs).
- 84 (25.5%) CDI cases were reported as community associated. This corresponds to an incidence rate of 6.0 cases per 100,000 population.
- No NHS boards were above the 95% confidence interval upper limit for healthcare associated CDI in the funnel plot analysis.
- NHS Highland were above the 95% confidence interval upper limit for community associated CDI in the funnel plot analysis.
- No NHS boards were above normal variation for healthcare associated or community associated CDI when analysing trends over the past three years.

Escherichia coli bacteraemia (ECB) during July to September 2025

- The total number of ECB cases in patients reported to ARHAI was 1,233.
- 658 (53.4%) ECB cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 43.2 cases per 100,000 TOBDs.
- 575 (46.6%) ECB cases were reported as community associated. This corresponds to an incidence rate of 41.1 cases per 100,000 population.
- NHS Lanarkshire were above the 95% confidence interval upper limit for healthcare associated ECB in the funnel plot analysis.
- NHS Ayrshire & Arran and NHS Dumfries & Galloway were above the 95% confidence interval upper limit for community associated ECB in the funnel plot analysis.

- NHS Scotland and NHS Lanarkshire were above normal variation for healthcare associated ECB when analysing trends over the past three years.
- No NHS boards were above normal variation for community associated ECB when analysing trends over the past three years.

Staphylococcus aureus bacteraemia (SAB) during July to September 2025

- The total number of SAB cases in patients reported to ARHAI was 422.
- 296 (70.1%) SAB cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 19.4 cases per 100,000 TOBDs.
- 126 (29.9%) SAB cases were reported as community associated. This corresponds to an incidence rate of 9.0 cases per 100,000 population.
- No NHS boards were above the 95% confidence interval upper limit for healthcare associated SAB in the funnel plot analysis.
- No NHS boards were above the 95% confidence interval upper limit for community associated SAB in the funnel plot analysis.
- No NHS boards were above normal variation for healthcare associated SAB when analysing trends over the past three years.
- No NHS board were above normal variation for community associated SAB when analysing trends over the past three years.

Surgical Site Infection (SSI) during July to September 2025

Epidemiological data for SSI are not included for this quarter. National mandatory SSI surveillance was paused in 2020 to support the COVID-19 response and has not yet resumed.

Results and Commentary

***Clostridioides difficile* infection (CDI)**

Total cases for quarter

- During Q3 2025, 330 *Clostridioides difficile* infection (CDI) cases in patients were reported to ARHAI. In the previous quarter there were 286 cases.
- In the clinical surveillance typing scheme (covering severe cases and/or outbreaks), out of a total of 55 isolates, ribotype 002 (18.2%) was the most common ribotype identified, followed by ribotype 015 (12.7%), 014, 020, and 023 (all 9.1%), 005, 078 and 277 (all 5.5%), and 012, 050 and 081 (all 3.6%). The remaining 14.5% of isolates comprised a mixture of ribotypes, each with a prevalence of less than 3%.
- In the snapshot surveillance (which aims to reflect the general distribution of ribotypes among CDI cases across Scotland), out of a total of 86 isolates, ribotype 002 (16.3%) was the most common ribotype identified, followed by ribotypes 014 (12.8%), 005 (11.6%), 015 (10.5%), 023 (8.1%), and 026, 076 and 137 (3.5%). The remaining 30.2% of isolates comprised a mixture of ribotypes, each with a prevalence of less than 3%.
- All isolates tested (clinical and snapshot) were susceptible to metronidazole and vancomycin.

Healthcare associated infection cases by NHS board where specimen taken

- During Q3 2025, 246 (74.5%) CDI cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 16.1 cases per 100,000 total occupied bed days (TOBDs) ([Table 1](#)).
- Yearly comparisons (comparing year-ending September 2024 with year-ending September 2025) show that there was an increase in NHS Fife ([Table 2](#)).
- No NHS boards were above the 95% confidence interval upper limit in the funnel plot analysis ([Figure 1](#)).
- No NHS boards were above normal variation when analysing trends over the past three years (see [supplementary data](#)).

Community associated infection cases by NHS board of residence

- During Q3 2025, 84 (25.5%) CDI cases were reported as community associated. This corresponds to an incidence rate of 6.0 cases per 100,000 population ([Table 3](#)).
- Yearly comparisons (comparing year-ending September 2024 with year-ending September 2025) show that there were decreases in NHS Lothian and NHS Scotland ([Table 4](#)).
- NHS Highland were above the 95% confidence interval upper limit in the funnel plot analysis ([Figure 2](#)).
- No NHS boards were above normal variation when analysing trends over the past three years (see [supplementary data](#)).

Table 1: CDI cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).^{1,2}

NHS board	Q2 Cases	Q2 Bed days	Q2 Rate	Q3 Cases	Q3 Bed days	Q3 Rate
AA	25	115,390	21.7	27	113,721	23.7
BR	4	27,963	14.3	2	27,979	7.1
DG	8	42,839	18.7	10	42,682	23.4
FF	11	85,393	12.9	11	86,778	12.7
FV	6	76,932	7.8	9	70,023	12.9
GJ	3	15,068	19.9	4	15,428	25.9
GR	15	142,007	10.6	14	140,963	9.9
GGC	46	440,445	10.4	71	443,010	16.0
HG	15	77,823	19.3	20	80,900	24.7
LN	28	149,520	18.7	16	149,640	10.7
LO	41	227,037	18.1	44	225,602	19.5
OR	0	3,101	0.0	0	3,585	0.0
SH	2	2,738	73.0	1	2,865	34.9
TY	9	112,791	8.0	16	113,347	14.1
WI	0	6,530	0.0	1	6,800	14.7
Scotland	213	1,525,577	14.0	246	1,523,323	16.1

1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.

Table 2: CDI cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).^{1,2}

NHS board	YE Q3 24 Cases	YE Q3 24 Bed days	YE Q3 24 Rate	YE Q3 25 Cases	YE Q3 25 Bed days	YE Q3 25 Rate
AA	80	459,839	17.4	93	459,531	20.2
BR	15	128,554	11.7	17	119,339	14.2
DG	37	185,838	19.9	38	177,934	21.4
FF	27	356,286	7.6	47	348,376	↑13.5
FV	53	314,428	16.9	39	296,520	13.2
GJ	2	55,462	3.6	7	58,925	11.9
GR	72	550,022	13.1	72	560,439	12.8
GGC	279	1,796,729	15.5	253	1,778,580	14.2
HG	82	319,116	25.7	69	319,912	21.6
LN	120	615,153	19.5	98	602,223	16.3
LO	148	963,828	15.4	159	928,139	17.1
OR	1	12,435	8.0	1	13,114	7.6
SH	9	10,074	89.3	5	11,150	44.8
TY	49	472,071	10.4	47	460,877	10.2
WI	2	27,700	7.2	4	26,326	15.2
Scotland	976	6,267,535	15.6	949	6,161,385	15.4

1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.

Table 3: CDI cases and incidence rates (per 100,000 population) for community associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).^{1, 2, 3}

NHS board	Q2 Cases	Q2 Population	Q2 Rate	Q3 Cases	Q3 Population	Q3 Rate
AA	9	367,750	9.8	7	367,750	7.6
BR	0	116,980	0.0	0	116,980	0.0
DG	3	145,860	8.2	1	145,860	2.7
FF	3	374,760	3.2	3	374,760	3.2
FV	1	306,340	1.3	1	306,340	1.3
GR	11	591,870	7.5	10	591,870	6.7
GGC	10	1,217,270	3.3	15	1,217,270	4.9
HG	8	324,980	9.9	12	324,980	14.6
LN	7	678,570	4.1	6	678,570	3.5
LO	15	932,180	6.5	22	932,180	9.4
OR	0	22,020	0.0	0	22,020	0.0
SH	0	23,190	0.0	1	23,190	17.1
TY	5	419,110	4.8	6	419,110	5.7
WI	1	26,020	15.4	0	26,020	0.0
Scotland	73	5,546,900	5.3	84	5,546,900	6.0

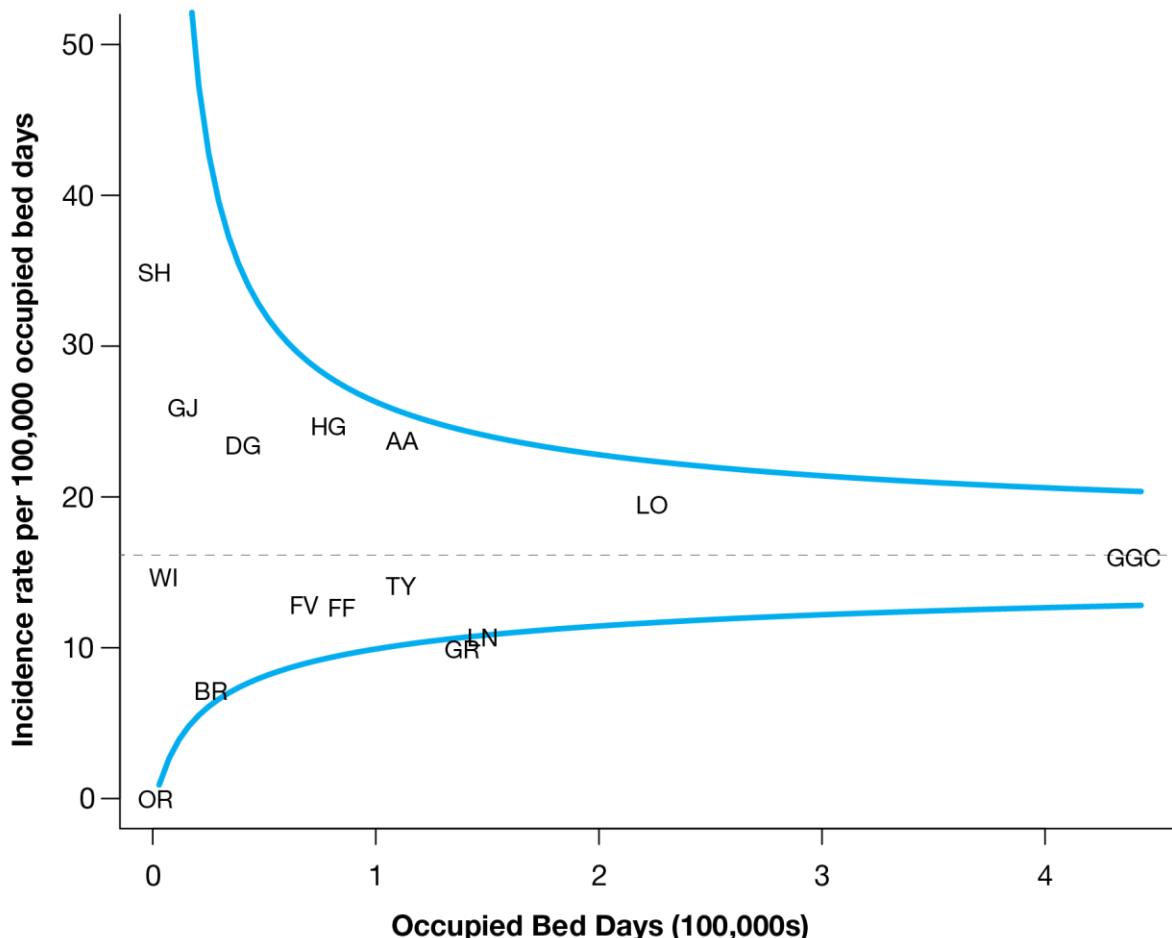
1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Quarterly population rates are based on an annualised population.
3. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Table 4: CDI cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).^{1, 2}

NHS board	YE Q3 24 Cases	YE Q3 24 Population	YE Q3 24 Rate	YE Q3 25 Cases	YE Q3 25 Population	YE Q3 25 Rate
AA	32	367,750	8.7	31	367,750	8.4
BR	6	116,980	5.1	3	116,980	2.6
DG	13	145,860	8.9	7	145,860	4.8
FF	22	374,760	5.9	13	374,760	3.5
FV	11	306,340	3.6	8	306,340	2.6
GR	36	591,870	6.1	47	591,870	7.9
GGC	56	1,217,270	4.6	44	1,217,270	3.6
HG	32	324,980	9.8	32	324,980	9.8
LN	36	678,570	5.3	26	678,570	3.8
LO	96	932,180	10.3	64	932,180	↓6.9
OR	3	22,020	13.6	1	22,020	4.5
SH	1	23,190	4.3	5	23,190	21.6
TY	22	419,110	5.2	24	419,110	5.7
WI	5	26,020	19.2	1	26,020	3.8
Scotland	371	5,546,900	6.7	306	5,546,900	↓5.5

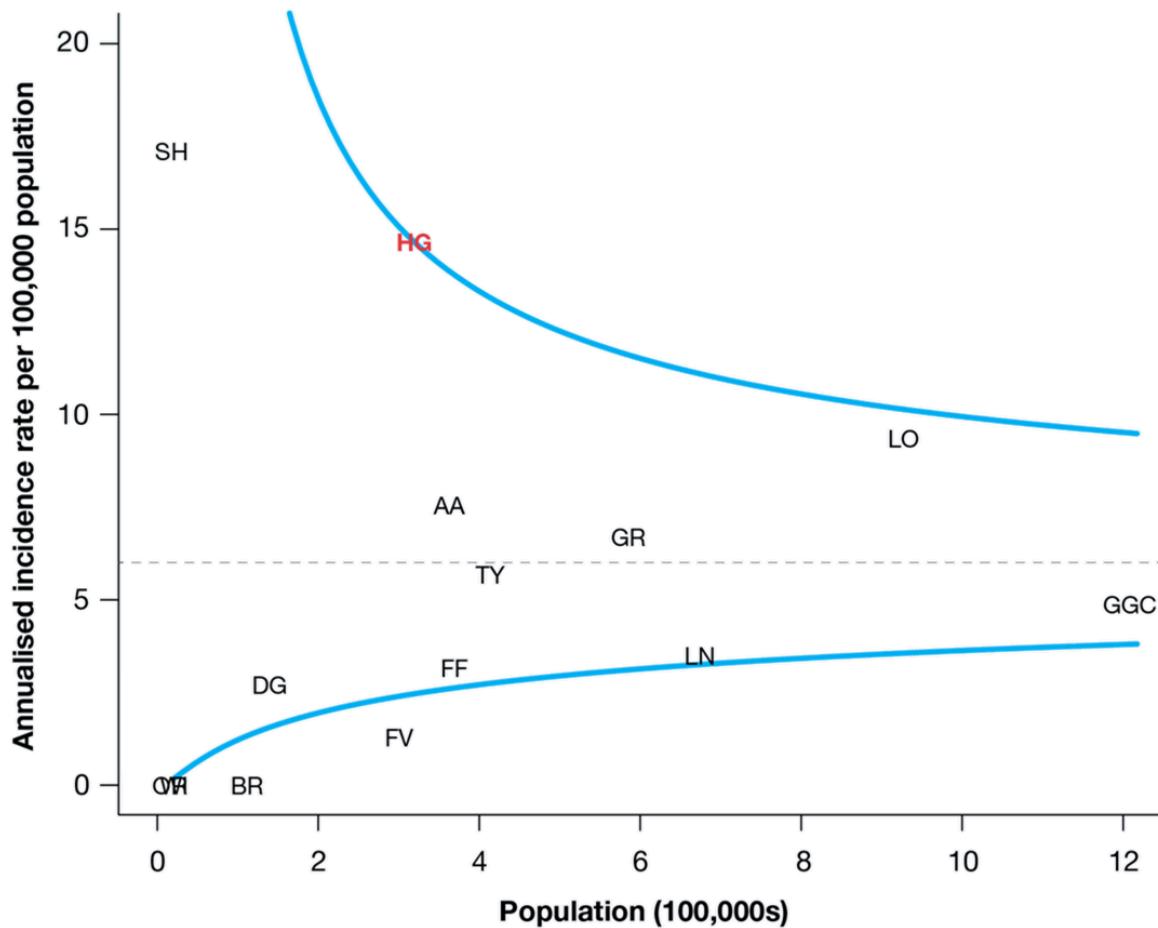
1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 1: Funnel plot of CDI incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q3 2025.^{1, 2}



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.
2. NHS Grampian and NHS Lanarkshire overlap.

Figure 2: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS boards in Scotland in Q3 2025.^{1, 2, 3}



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS boards above the 95% confidence interval upper limit are highlighted in red.
3. NHS Orkney and NHS Western Isles overlap.

***Escherichia coli* bacteraemia (ECB)**

Total Cases for Quarter

- During Q3 2025, 1,233 *Escherichia coli* bacteraemia (ECB) cases in patients were reported to ARHAI. In the previous quarter there were 1,237 cases.

Healthcare associated infection cases by NHS board where specimen taken

- During Q3 2025, 658 (53.4%) ECB cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 43.2 cases per 100,000 TOBDs ([Table 5](#)).
- Yearly comparisons (comparing year-ending September 2024 with year-ending September 2025) show that there was an increase in NHSScotland, NHS Greater Glasgow & Clyde, NHS Lanarkshire and NHS Lothian ([Table 6](#)).
- NHS Lanarkshire were above the 95% confidence interval upper limit in the funnel plot analysis ([Figure 3](#)).
- NHS Scotland and NHS Lanarkshire were above normal variation when analysing trends over the past three years (see [supplementary data](#)).

Community associated infection cases by NHS board of residence

- During Q3 2025, 575 (46.6%) ECB cases were reported as community associated. This corresponds to an incidence rate of 41.1 cases per 100,000 population ([Table 7](#)).
- Yearly comparisons (comparing year-ending September 2024 with year-ending September 2025) show there were increases in NHS Scotland, NHS Shetland and NHS Western Isles ([Table 8](#)).
- NHS Ayrshire & Arran and NHS Dumfries & Galloway were above the 95% confidence interval upper limit in the funnel plot analysis ([Figure 4](#)).
- No NHS boards were above normal variation when analysing trends over the past three years (see [supplementary data](#)).

Table 5: ECB cases and incidence rates (per 100,000 TOBD) for healthcare associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).^{1, 2}

NHS board	Q2 Cases	Q2 Bed days	Q2 Rate	Q3 Cases	Q3 Bed days	Q3 Rate
AA	47	115,390	40.7	56	113,721	49.2
BR	16	27,963	57.2	12	27,979	42.9
DG	22	42,839	51.4	23	42,682	53.9
FF	44	85,393	51.5	37	86,778	42.6
FV	38	76,932	49.4	25	70,023	35.7
GJ	3	15,068	19.9	3	15,428	19.4
GR	68	142,007	47.9	40	140,963	28.4
GGC	191	440,445	43.4	190	443,010	42.9
HG	19	77,823	24.4	18	80,900	22.2
LN	69	149,520	46.1	92	149,640	61.5
LO	92	227,037	40.5	88	225,602	39.0
OR	1	3,101	32.2	3	3,585	83.7
SH	6	2,738	219.1	4	2,865	139.6
TY	49	112,791	43.4	63	113,347	55.6
WI	7	6,530	107.2	4	6,800	58.8
Scotland	672	1,525,577	44.0	658	1,523,323	43.2

1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.

Table 6: ECB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).^{1,2}

NHS board	YE Q3 24 Cases	YE Q3 24 Bed days	YE Q3 24 Rate	YE Q3 25 Cases	YE Q3 25 Bed days	YE Q3 25 Rate
AA	210	459,839	45.7	201	459,531	43.7
BR	51	128,554	39.7	46	119,339	38.5
DG	86	185,838	46.3	77	177,934	43.3
FF	149	356,286	41.8	148	348,376	42.5
FV	149	314,428	47.4	126	296,520	42.5
GJ	10	55,462	18.0	7	58,925	11.9
GR	190	550,022	34.5	195	560,439	34.8
GGC	611	1,796,729	34.0	724	1,778,580	↑40.7
HG	79	319,116	24.8	81	319,912	25.3
LN	225	615,153	36.6	290	602,223	↑48.2
LO	308	963,828	32.0	359	928,139	↑38.7
OR	8	12,435	64.3	6	13,114	45.8
SH	12	10,074	119.1	14	11,150	125.6
TY	233	472,071	49.4	215	460,877	46.7
WI	20	27,700	72.2	21	26,326	79.8
Scotland	2,341	6,267,535	37.4	2,510	6,161,385	↑40.7

1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.

Table 7: ECB cases and incidence rates (per 100,000 population) for community associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).^{1, 2, 3}

NHS board	Q2 Cases	Q2 Population	Q2 Rate	Q3 Cases	Q3 Population	Q3 Rate
AA	56	367,750	61.1	65	367,750	70.1
BR	22	116,980	75.4	13	116,980	44.1
DG	31	145,860	85.2	26	145,860	70.7
FF	42	374,760	45.0	33	374,760	34.9
FV	33	306,340	43.2	44	306,340	57.0
GR	43	591,870	29.1	47	591,870	31.5
GGC	92	1,217,270	30.3	113	1,217,270	36.8
HG	30	324,980	37.0	28	324,980	34.2
LN	83	678,570	49.1	76	678,570	44.4
LO	67	932,180	28.8	74	932,180	31.5
OR	1	22,020	18.2	2	22,020	36.0
SH	3	23,190	51.9	1	23,190	17.1
TY	59	419,110	56.5	51	419,110	48.3
WI	3	26,020	46.2	2	26,020	30.5
Scotland	565	5,546,900	40.9	575	5,546,900	41.1

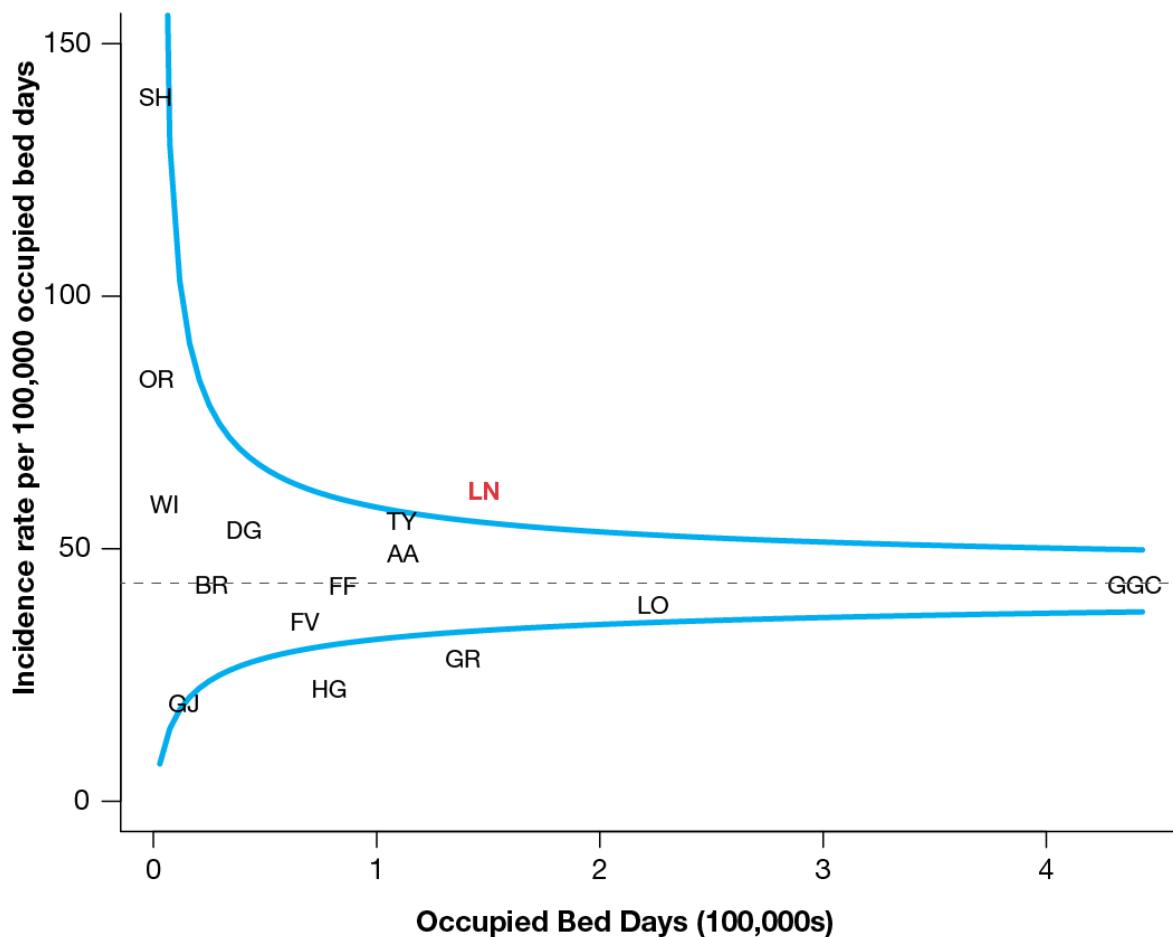
1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Quarterly population rates are based on an annualised population.
3. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Table 8: ECB cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).^{1, 2}

NHS board	YE Q3 24 Cases	YE Q3 24 Population	YE Q3 24 Rate	YE Q3 25 Cases	YE Q3 25 Population	YE Q3 25 Rate
AA	200	367,750	54.4	229	367,750	62.3
BR	60	116,980	51.3	60	116,980	51.3
DG	83	145,860	56.9	93	145,860	63.8
FF	134	374,760	35.8	139	374,760	37.1
FV	119	306,340	38.8	139	306,340	45.4
GR	154	591,870	26.0	148	591,870	25.0
GGC	365	1,217,270	30.0	382	1,217,270	31.4
HG	112	324,980	34.5	113	324,980	34.8
LN	270	678,570	39.8	303	678,570	44.7
LO	260	932,180	27.9	253	932,180	27.1
OR	10	22,020	45.4	5	22,020	22.7
SH	2	23,190	8.6	11	23,190	↑47.4
TY	179	419,110	42.7	195	419,110	46.5
WI	2	26,020	7.7	10	26,020	↑38.4
Scotland	1,950	5,546,900	35.2	2,080	5,546,900	↑37.5

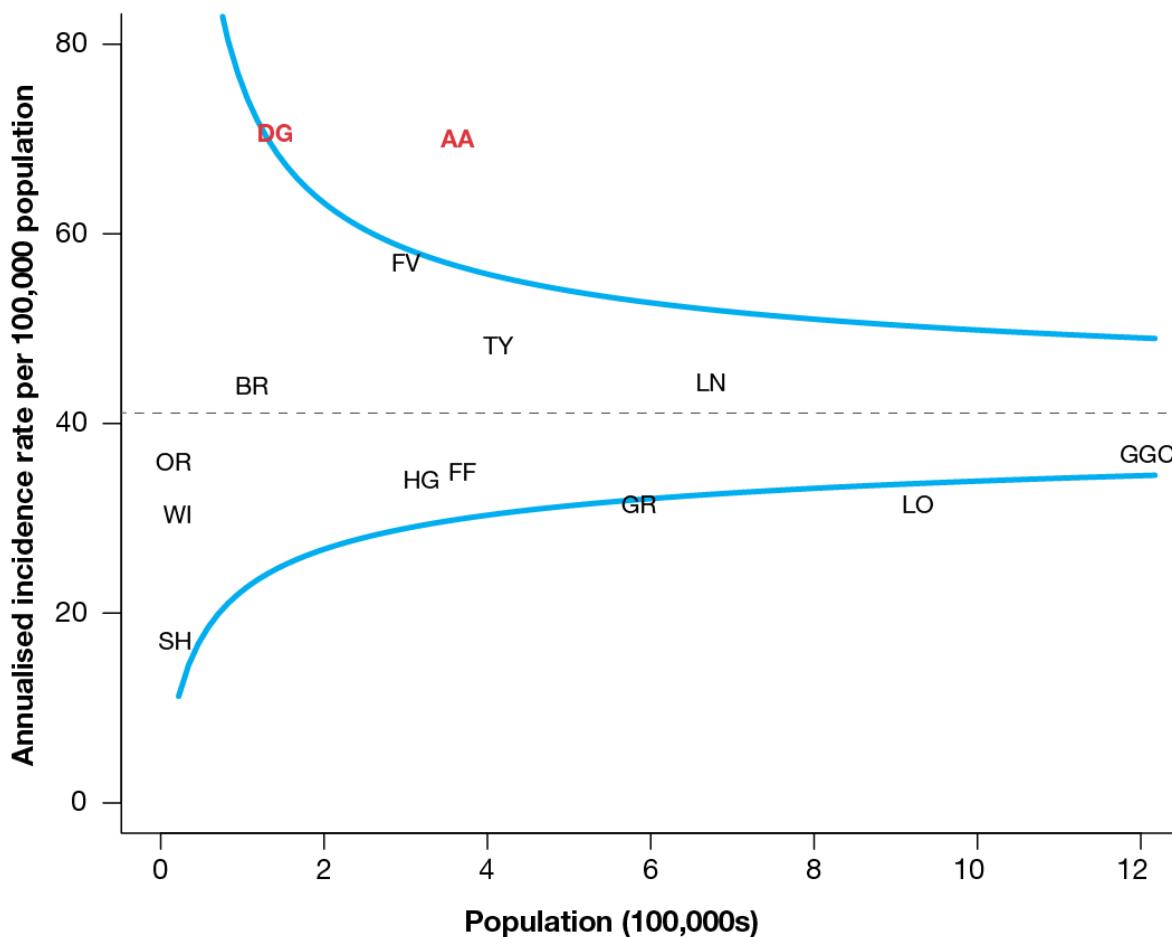
1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 3: Funnel plot of ECB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q3 2025.^{1, 2}



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.
2. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 4: Funnel plot of ECB incidence rates (per 100,000 population) in community associated infection cases for all NHS boards in Scotland in Q3 2025.^{1, 2}



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Staphylococcus aureus bacteraemia (SAB)

Total cases for quarter

- During Q3 2025, 422 *Staphylococcus aureus* bacteraemia (SAB) cases in patients were reported to ARHAI. In the previous quarter there were 459 SAB cases.

Healthcare associated infection cases by NHS board where specimen taken

- During Q3 2025, 296 (70.1%) SAB cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 19.4 cases per 100,000 TOBDs ([Table 9](#)).
- Yearly comparisons (comparing year-ending September 2024 with year-ending September 2025) show there was a decrease in NHS Tayside ([Table 10](#)).
- No NHS boards were above the 95% confidence interval upper limit in the funnel plot analysis ([Figure 5](#)).
- No NHS boards were above normal variation when analysing trends over the past three years (see [supplementary data](#)).

Community associated infection cases by NHS board of residence

- During Q3 2025, 126 (29.9%) SAB cases were reported as community associated. This corresponds to an incidence rate of 9.0 cases per 100,000 population ([Table 11](#)).
- Yearly comparisons (comparing year-ending September 2024 with year-ending September 2025) show no increases or decreases ([Table 12](#)).
- No NHS boards were above the 95% confidence interval upper limit in the funnel plot analysis ([Figure 6](#)).
- No NHS boards were above normal variation when analysing trends over the past three years (see [supplementary data](#)).

Table 9: SAB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).^{1, 2}

NHS board	Q2 Cases	Q2 Bed days	Q2 Rate	Q3 Cases	Q3 Bed days	Q3 Rate
AA	28	115,390	24.3	24	113,721	21.1
BR	8	27,963	28.6	1	27,979	3.6
DG	5	42,839	11.7	8	42,682	18.7
FF	10	85,393	11.7	7	86,778	8.1
FV	16	76,932	20.8	10	70,023	14.3
GJ	2	15,068	13.3	3	15,428	19.4
GR	27	142,007	19.0	28	140,963	19.9
GGC	97	440,445	22.0	97	443,010	21.9
HG	18	77,823	23.1	11	80,900	13.6
LN	37	149,520	24.7	38	149,640	25.4
LO	32	227,037	14.1	45	225,602	19.9
OR	2	3,101	64.5	1	3,585	27.9
SH	2	2,738	73.0	1	2,865	34.9
TY	17	112,791	15.1	21	113,347	18.5
WI	2	6,530	30.6	1	6,800	14.7
Scotland	303	1,525,577	19.9	296	1,523,323	19.4

1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.

Table 10: SAB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).^{1,2}

NHS board	YE Q3 24 Cases	YE Q3 24 Bed days	YE Q3 24 Rate	YE Q3 25 Cases	YE Q3 25 Bed days	YE Q3 25 Rate
AA	96	459,839	20.9	115	459,531	25.0
BR	16	128,554	12.4	24	119,339	20.1
DG	34	185,838	18.3	27	177,934	15.2
FF	45	356,286	12.6	44	348,376	12.6
FV	55	314,428	17.5	56	296,520	18.9
GJ	11	55,462	19.8	8	58,925	13.6
GR	104	550,022	18.9	116	560,439	20.7
GGC	328	1,796,729	18.3	355	1,778,580	20.0
HG	37	319,116	11.6	53	319,912	16.6
LN	127	615,153	20.6	128	602,223	21.3
LO	167	963,828	17.3	148	928,139	15.9
OR	0	12,435	0.0	3	13,114	22.9
SH	7	10,074	69.5	7	11,150	62.8
TY	120	472,071	25.4	79	460,877	↓17.1
WI	8	27,700	28.9	6	26,326	22.8
Scotland	1,155	6,267,535	18.4	1,169	6,161,385	19.0

1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.

Table 11: SAB cases and incidence rates (per 100,000 population) for community associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).^{1, 2, 3, 4, 5}

NHS board	Q2 Cases	Q2 Population	Q2 Rate	Q3 Cases	Q3 Population	Q3 Rate
AA	8	367,750	8.7	14	367,750	15.1
BR	1	116,980	3.4	3	116,980	10.2
DG	5	145,860	13.7	6	145,860	16.3
FF	26	374,760	27.8	12	374,760	12.7
FV	14	306,340	18.3	11	306,340	14.2
GR	8	591,870	5.4	16	591,870	10.7
GGC	23	1,217,270	7.6	18	1,217,270	5.9
HG	7	324,980	8.6	5	324,980	6.1
LN	16	678,570	9.5	7	678,570	4.1
LO	28	932,180	12.0	19	932,180	8.1
OR	2	22,020	36.4	1	22,020	18.0
SH	2	23,190	34.6	0	23,190	0.0
TY	16	419,110	15.3	14	419,110	13.3
WI	0	26,020	0.0	0	26,020	0.0
Scotland	156	5,546,900	11.3	126	5,546,900	9.0

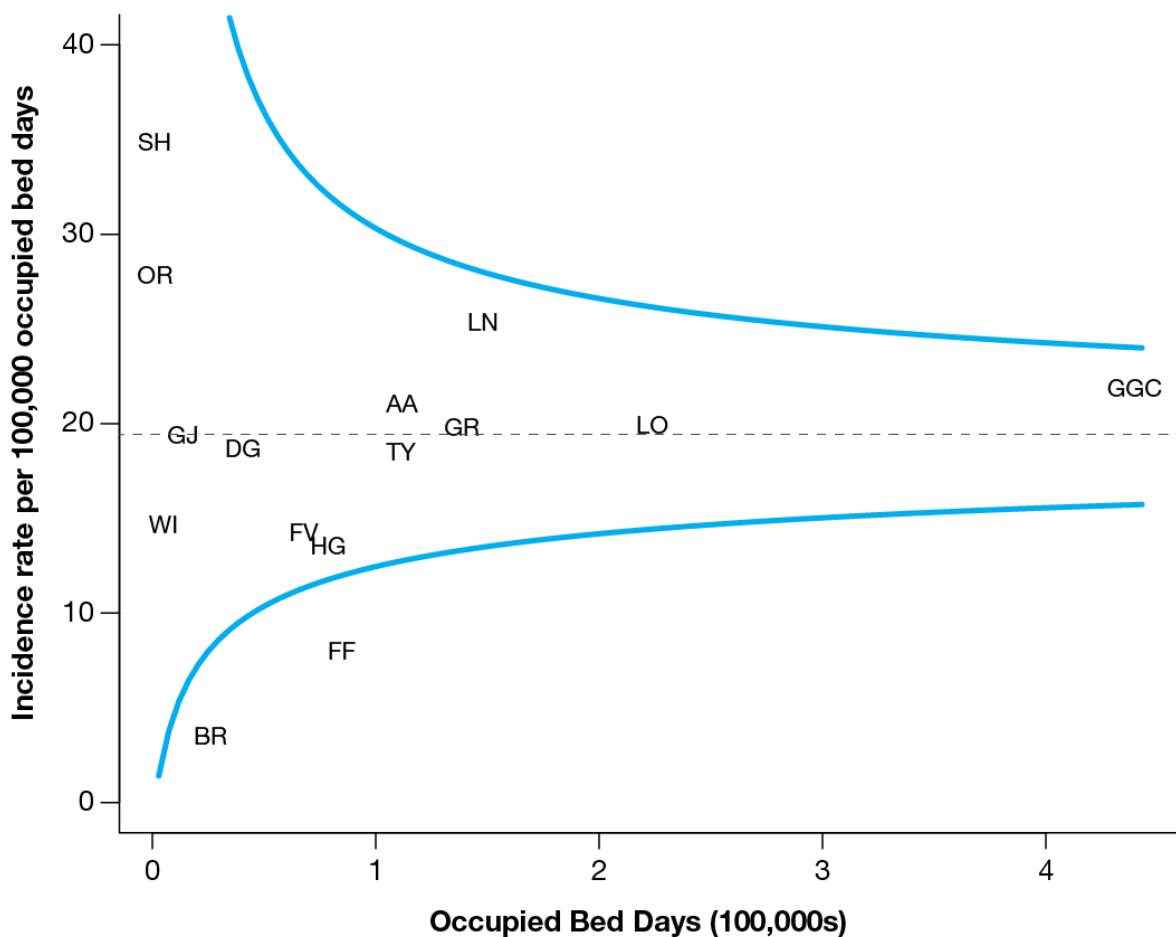
1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Quarterly population rates are based on an annualised population.
3. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Table 12: SAB cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).^{1, 2, 3}

NHS board	YE Q3 24 Cases	YE Q3 24 Population	YE Q3 24 Rate	YE Q3 25 Cases	YE Q3 25 Population	YE Q3 25 Rate
AA	51	367,750	13.9	41	367,750	11.1
BR	18	116,980	15.4	16	116,980	13.7
DG	17	145,860	11.7	21	145,860	14.4
FF	48	374,760	12.8	57	374,760	15.2
FV	34	306,340	11.1	46	306,340	15.0
GR	74	591,870	12.5	61	591,870	10.3
GGC	79	1,217,270	6.5	73	1,217,270	6.0
HG	23	324,980	7.1	24	324,980	7.4
LN	74	678,570	10.9	57	678,570	8.4
LO	97	932,180	10.4	91	932,180	9.8
OR	1	22,020	4.5	3	22,020	13.6
SH	5	23,190	21.6	6	23,190	25.9
TY	42	419,110	10.0	56	419,110	13.4
WI	1	26,020	3.8	0	26,020	0.0
Scotland	564	5,546,900	10.2	552	5,546,900	10.0

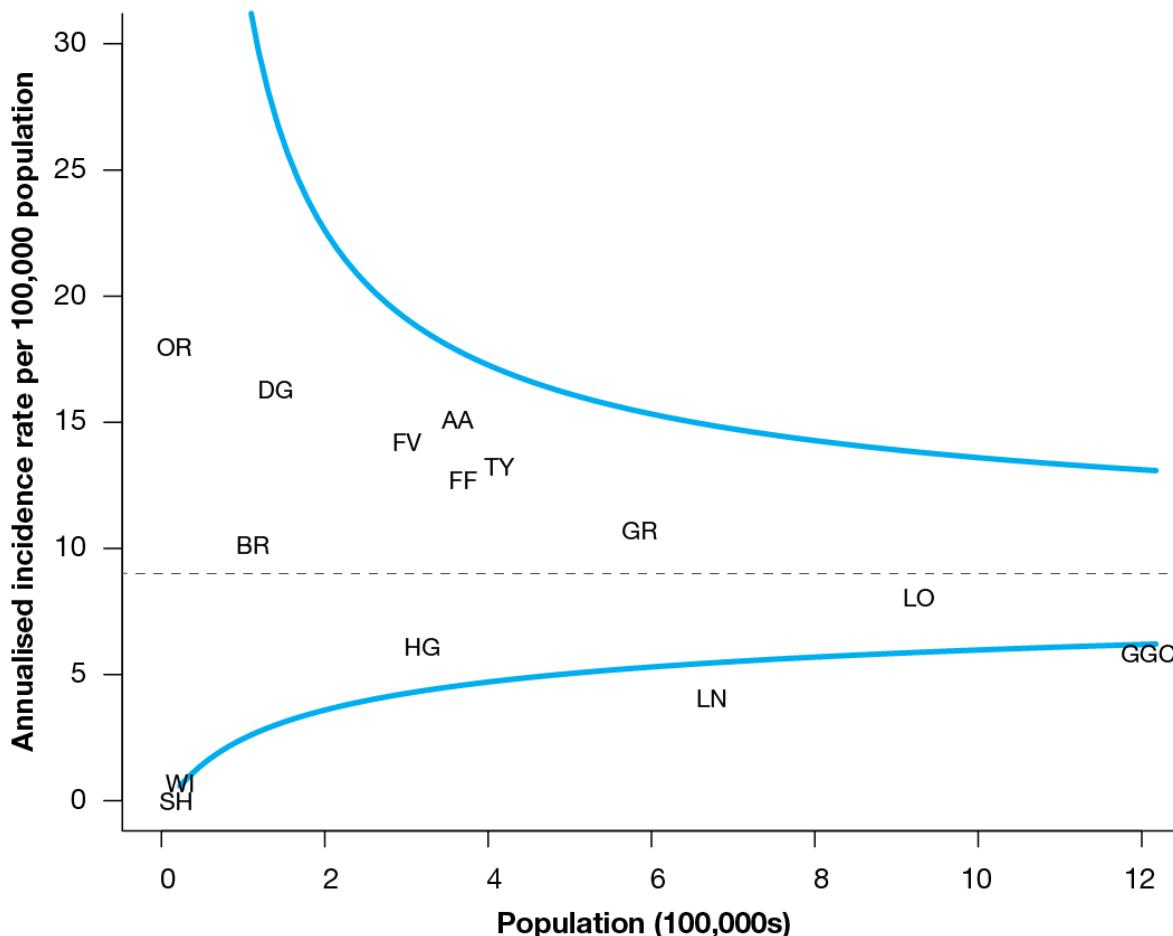
1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 5: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q3 2025.¹



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.

Figure 6: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS boards in Scotland in Q3 2025.¹



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Surgical Site Infection (SSI)

Epidemiological data for SSI are not included for this quarter. National mandatory SSI surveillance was paused in 2020 to support the COVID-19 response and has not yet resumed.

List of Tables

Name	File and size
Table 1: CDI cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).	supplementary data (534 Kb)
Table 2: CDI cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).	supplementary data (534 Kb)
Table 3: CDI cases and incidence rates (per 100,000 population) for community associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).	supplementary data (534 Kb)
Table 4: CDI cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).	supplementary data (534 Kb)
Table 5: ECB cases and incidence rates (per 100,000 TOBD) for healthcare associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).	supplementary data (534 Kb)
Table 6: ECB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).	supplementary data (534 Kb)
Table 7: ECB cases and incidence rates (per 100,000 population) for community associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).	supplementary data (534 Kb)
Table 8: ECB cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).	supplementary data (534 Kb)
Table 9: SAB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: Q2 2025 (April to July 2025) compared to Q3 2025 (July to September 2025).	supplementary data (534 Kb)
Table 10: SAB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).	supplementary data (534 Kb)

Table 11: SAB cases and incidence rates (per 100,000 population) for community associated infection cases: Q2 2025 (April to June 2025) compared to Q3 2025 (July to September 2025).	<u>supplementary data (534 Kb)</u>
Table 12: SAB cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending September 2024 (YE Q3 24) compared to year-ending September 2025 (YE Q3 25).	<u>supplementary data (534 Kb)</u>

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Further Information

Further information can be found on the [ARHAI Scotland website](#).

The data from this publication is available to download [from our web page](#) along with background information and metadata.

For more information on types of infections included in this report, please see the [CDI](#), [ECB](#), [SAB](#) and [SSI](#) pages.

The next release of this publication will be April 2026.

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Appendices

Appendix 1 – Background information

Revisions to the surveillance

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
Addition of healthcare/ community case assignment.	October 2017	CDI/SAB	An increasing awareness of those infections occurring in community settings has warranted measurement of incidence rates by healthcare setting (healthcare settings vs. community settings) to enable interventions to be targeted to the relevant settings.
Use of standardised denominator data for CDI/ECB/SAB.	October 2017	CDI/SAB	The 'total occupied bed days' data will be extracted from the ISD(S)1 data collection which contains aggregated information on acute and non-acute bed days including geriatric medicine and long-term stays in real-time. The standardisation of denominator data across the three surveillance programmes could result in slightly less accurate denominators due to inclusion of persons in the denominator who are at slightly lower risk of infection. However, in surveillance programmes developed for the purpose of preventing infection and driving quality improvement in care, consistency of the denominators over time tends to be more important than getting a very precise estimate of the population at risk, as the primary aim is to reduce infection to a lower incidence relative to what it was at the initial time of benchmarking.
Reporting of CDI cases aged 15 years and above only.	October 2017	CDI	Current Scottish Government Local Delivery Plan (LDP) Standards are based on the incidence rate in cases aged 15 years and above, therefore the report has been aligned to reflect this. ARHAI will

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
			continue to monitor CDI incidence rates in the separate age groups (15-64 years and 65 years and above) internally.
Reporting of total SAB cases only (i.e. Removal of MRSA sub-analysis).	October 2017	SAB	The count of MRSA bacteraemia cases are now too small to carry out statistical analysis. ARHAI Scotland will continue to monitor internally.
Name change for <i>Clostridium difficile</i> to <i>Clostridioides difficile</i> .	October 2018	CDI	A novel genus <i>Clostridioides</i> has been proposed for <i>Clostridium difficile</i> which will now be known as <i>Clostridioides difficile</i> . There are no implications with regards to the natural history of infection, infection prevention and control, or clinical treatment.
Addition of year end comparisons to ECB.	October 2018	ECB	This analysis (already included for other reported organisms) is now possible for ECB due the amount of data that has now been collected.
Change in production of quarterly SPC charts.	April 2020	All sections	Updated method used for calculating exceptions within the statistical process control (SPC) charts. The mean, Trigger/warning lines (+2 standard deviations) and upper control limits (+3 standard deviations) presented, are now calculated using the 12 quarters prior to the most recent quarter, as to compare the new rate against an existing baseline.
Changes to data collection in response to COVID-19.	July 2020	All sections	<p>A CNO letter sent 25th March 2020 asked NHS boards to continue to report case numbers and origin of infection data but they would not be required to report risk factor data as would normally be expected under enhanced/extended surveillance for <i>Staphylococcus aureus</i> bacteraemia (SAB), <i>Escherichia coli</i> bacteraemia (ECB) and <i>Clostridioides difficile</i> infection (CDI).</p> <p>All mandatory and voluntary Surgical Site Infection (SSI) surveillance was paused until further notice.</p>

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
Change from Health Protection Scotland to ARHAI Scotland.	October 2020	All sections	<p>In April 2020, as part of launch of Public Health Scotland, the ARHAI Group within Health Protection Scotland (HPS) became ARHAI Scotland.</p> <p>ARHAI Scotland will continue to support NHS boards in the prevention and control of healthcare associated infections. The report was updated to reflect this branding change.</p>
Change from National Waiting Times Centre (NWTC) to NHS Golden Jubilee (GJ).	January 2021	All sections	Labelling updated.
Change to reporting of ribotypes.	October 2022	CDI	A description of <i>C. difficile</i> PCR ribotypes (RTs) had not been included in the reports published between October 2022 and July 2023, while the CDI typing service provided by the Scottish Microbiology Reference Laboratory (SMiRL) was being reviewed.
Recommencement of mandatory surveillance following COVID-19 response.	April 2023	All sections	<p>As part of a return to pre-pandemic surveillance, for data collected from October 2022 onwards enhanced/extended surveillance for <i>Escherichia coli</i> bacteraemia (ECB) and <i>Staphylococcus aureus</i> bacteraemia (SAB) has been reinstated. Mandatory surveillance of enhanced fields including source of infection/entry point and risk factors as appropriate has resumed in line with the bacteraemia surveillance protocol.</p> <p>Previously, for data collected from 25 March 2020 onwards, only origin of infection was mandatory for ECB and SAB surveillance.</p> <p>Meanwhile all mandatory and voluntary Surgical Site Infection (SSI) surveillance will remain paused until further notice.</p>

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
Update to CDI surveillance protocol	September 2024	CDI	This protocol update should not have any impact on current CDI surveillance activities but has been updated to better reflect the current data handling methodologies as well as updating links to relevant documents.
Update to CDI snapshot surveillance protocol	September 2024	CDI	This protocol update reflected changes in laboratory reporting criteria and links to relevant documents were updated throughout.

Report methods and caveats

Full details of the report methods and caveats can be found [here](#).

UK comparisons

Improved collaboration with the other UK nations has made comparisons and standardisation across the UK a high priority for all four nations' governments/health departments. The changes introduced in the Scottish HAI surveillance described here facilitate benchmarking of the Scottish data against those of the rest of the UK.

Key to NHS boards

AA = NHS Ayrshire & Arran

BR = NHS Borders

DG = NHS Dumfries & Galloway

FV = NHS Forth Valley

FF = NHS Fife

GJ = NHS Golden Jubilee

GR = NHS Grampian

GGC = NHS Greater Glasgow & Clyde

HG = NHS Highland

LN = NHS Lanarkshire

LO = NHS Lothian

OR = NHS Orkney

SH = NHS Shetland

TY = NHS Tayside

WI = NHS Western Isles

Appendix 2 – Publication Metadata

Publication title

Quarterly epidemiological data on *Clostridioides difficile* infection, *Escherichia coli* bacteraemia, *Staphylococcus aureus* bacteraemia and Surgical Site Infection in Scotland.

Description

This release provides information on *Clostridioides difficile* infection, *Escherichia coli* bacteraemia, *Staphylococcus aureus* bacteraemia and Surgical Site Infection in Scotland for the period July to September 2025.

Theme

Infections in Scotland.

Topic

Clostridioides difficile infection, *Escherichia coli* bacteraemia, *Staphylococcus aureus* bacteraemia and Surgical Site Infection.

Format

MS Word reports and MS Excel workbooks.

Data source(s)

Clostridioides difficile infection:

Case data source: Electronic Communication of Surveillance in Scotland (ECOSS).

Data linkage source: General / Acute Inpatient and Day Case Scottish Morbidity Records (SMR01).

Healthcare associated denominator: Total occupied bed days: Public Health Scotland ISD(S)1.

Community associated denominator: National Records of Scotland (NRS) mid-year population estimates. Note: mid-year population estimates are not yet available for 2025, therefore mid-year population data for 2024 are used for rates of community associated infections for 2024 and 2025.

***Escherichia coli* bacteraemia:**

Case data source: Electronic Communication of Surveillance in Scotland (ECOSS) Enhanced Surveillance Web Tool.

Healthcare associated denominator: Total occupied bed days: Public Health Scotland ISD(S)1.

Community associated denominator: NRS mid-year population estimates. Note: mid-year population estimates are not yet available for 2025, therefore mid-year population data for 2024 are used for rates of community associated infections for 2024 and 2025.

***Staphylococcus aureus* bacteraemia:**

Case data source: Electronic Communication of Surveillance in Scotland (ECOSS) Enhanced Surveillance Web Tool.

Healthcare associated denominator: Total occupied bed days: Public Health Scotland ISD(S)1.

Community associated denominator: NRS mid-year population estimates. Note: mid-year population estimates are not yet available for 2025, therefore mid-year population data for 2024 are used for rates of community associated infections for 2024 and 2025.

Surgical Site Infection:

Epidemiological data for SSI are not included for this quarter. National mandatory SSI surveillance was paused in 2020 to support the COVID-19 response and has not yet resumed.

Date that data are acquired

The date the data were extracted for analysis.

Clostridioides difficile infection: 16 October 2025.

Escherichia coli bacteraemia: 20 November 2025.

Staphylococcus aureus bacteraemia: 20 November 2025.

Surgical Site Infection: Epidemiological data for SSI are not included for this quarter.

National Mandatory SSI surveillance was paused in 2020 to support the COVID-19 response and has not yet resumed.

Release date

13 January 2025.

Frequency

Quarterly.

Timeframe of data and timeliness

The latest iteration of data is 30 September 2025, therefore the data are three months in arrears.

Continuity of data

Quarterly as at March, June, September, and December.

Revisions statement

These data are not subject to planned major revisions. However, ARHAI aims to continually improve the interpretation of the data and therefore analysis methods are regularly reviewed and may be updated in the future.

Revisions relevant to this publication

Updates to previously published figures.

National Records for Scotland (NRS) mid-year population estimates

There were no retrospective amendments to the data.

Total Occupied Bed Days (TOBDs)

Quarter	NHS board	Previous TOBDs	Updated TOBDs	Reason
2025 Q2	FF	85,401	85,393	Retrospective data amendment.
2025 Q2	GGC	443,813	440,445	Retrospective data amendment.
2025 Q2	LN	149,047	149,520	Retrospective data amendment.
2025 Q2	OR	3,141	3,101	Retrospective data amendment.
2025 Q2	Scotland	1,528,520	1,525,577	Retrospective data amendment.

Clostridioides difficile infection (CDI)

There were no retrospective amendments to the data.

Escherichia coli bacteraemia (ECB)

There were no retrospective amendments to the data.

Staphylococcus aureus bacteraemia (SAB)

There were no retrospective amendments to the data.

Surgical Site Infection (SSI)

Epidemiological data for SSI are not included for this quarter. National mandatory SSI surveillance was paused in 2020 to support the COVID-19 response and has not yet resumed.

Concepts and definitions

Further information on the methods and caveats can be found [here](#).

When a board is highlighted as an exception this will be looked at further as per the exception reporting process.

Further information on the production of quarterly exception reports (SOP) can be found [here](#).

***Clostridioides difficile* infection (CDI)**

Clostridioides difficile infection (CDI) is the most common cause of intestinal infections (and diarrhoea) associated with antimicrobial therapy. Clinical disease comprises a range of toxin mediated symptoms from mild diarrhoea, which can resolve without treatment, to severe cases such as pseudomembranous colitis (PMC), toxic megacolon and peritonitis that can lead to death.

For mild disease, diarrhoea is usually the only symptom. Other clinical features consistent with more severe forms of CDI include fever, leukocytosis, pseudomembranous colitis and ileus.

Symptoms of CDI, and associated immune reactions in children, differ from those in adults, but the pathology is not well described. Routine testing in children aged less than 3 years old is not recommended, see [C. difficile testing algorithm](#) published by the Scottish Microbiology and Virology Network in 2024.

There remains scope for a reduction of incidence rates through continued local monitoring, appropriate prescribing, and compliance with infection prevention and control measures. The Scottish Health Protection Network published community based guidance in November 2024 [here](#). The [National Infection Prevention and Control Manual](#) provides IPC guidance to all those involved in care provision and is considered best practice across all health and care settings in Scotland. Full details of the surveillance methods may be found in the [Protocol for the Scottish Surveillance Programme for Clostridioides difficile infection: user manual | National Services Scotland](#).

***Escherichia coli* bacteraemia (ECB)**

Escherichia coli (*E. coli*) is a bacterium commonly found in the gut of animals and people where it forms part of the normal gut flora that helps human digestion. Although most types of *E. coli* live harmlessly in your gut, some types can make you unwell. Some types of *E. coli* can cause urinary tract infections (UTI) and illnesses such as pneumonia.

E. coli continues to be the most frequent cause of Gram-negative bacteraemia in Scotland and is a frequent cause of infection worldwide.

New cases of ECB are identified by laboratory testing (via positive blood cultures) and submitted to the national system ECOSS. Only cases of ECB that have been reviewed and confirmed by the NHS boards in the enhanced surveillance system are included in the quarterly commentaries. Full details of the surveillance methods may be found in the [protocol](#).

***Staphylococcus aureus* bacteraemia (SAB)**

Staphylococcus aureus (*S. aureus*) is a Gram-positive bacterium that colonises the nasal cavity of about a quarter of the healthy population. This colonisation is usually harmless. However, infection can occur if *S. aureus* breaches the body's defence systems and can cause a range of illnesses from minor skin infections to serious systemic infections such as bacteraemia. Some strains of *S. aureus* produce toxins or show resistance to first line treatments, therefore, can be more complicated to treat.

Scotland has had a mandatory meticillin resistant *S. aureus* (MRSA) bacteraemia surveillance programme since 2001. The programme was extended to include meticillin sensitive *S. aureus* (MSSA) bacteraemia in 2006 and in 2014 to include enhanced *S. aureus* bacteraemia (SAB) surveillance. Full details of the surveillance methods may be found in the [protocol](#).

Surgical Site Infection (SSI)

A surgical site infection (SSI) is an infection that occurs after surgery in the part of the body where the surgery took place. SSI may be superficial infections involving the skin only, while other SSI is more serious and can involve tissues under the skin, organs, or implanted material.

SSI is one of the most common types of healthcare associated infection in Scotland, estimated to account for 16.5% of inpatient healthcare associated infection within NHSScotland, according to Scottish Point Prevalence Survey 2016. Prior to the COVID-19 pandemic, NHS boards participated in SSI surveillance for procedures including caesarean section, hip arthroplasty, large bowel, and vascular procedures. National mandatory SSI surveillance was paused in 2020 to support the COVID-19 response and has not yet resumed.

Relevance and key uses of the statistics

***Clostridioides difficile* infection (CDI)**

Surveillance data is essential for monitoring trends and assisting in outbreak investigations. Certain strains of *C. difficile* have been associated with more severe disease (e.g. PCR ribotypes 027 and 078) and antibiotic resistance has been suggested to be a factor in the emergence and spread of *C. difficile* epidemic types. In addition, the identification of ribotypes and whole genome sequencing can assist in the investigation of outbreaks.

The surveillance data should inform and support NHS boards in implementing antimicrobial prescribing policies, infection control and prevention interventions. Further information on typing schemes may be found in the [Protocol for the *Clostridioides difficile* snapshot programme | National Services Scotland.](#)

***Escherichia coli* bacteraemia (ECB)**

The outputs of the surveillance programme are intended to support the NHS boards in controlling and reducing the burden of ECB. Benchmarking against other NHS boards (and other countries) is an important function of the surveillance. In

conjunction with other sources of intelligence (including enhanced surveillance data) the outputs of the quarterly surveillance can also help the NHS boards with planning and targeting activities to reduce risk to patient of becoming infected and improve the care of patients (i.e. strategic planning, targeted intervention, care quality improvement).

As urinary tract infections are commonly associated with *E. coli* bacteraemia cases, ARHAI Scotland coordinates the sharing of urinary tract infection (UTI) reduction resources. These include the National Hydration Campaign which aims to convey the public health benefits of good hydration in terms of UTI prevention, and the National Catheter Passport which gives information on how to care for urinary catheters at home as well as a clinical section for a nurse, doctor, or carer. Work is also being done on improving antimicrobial treatment of people with infections – co-ordinated by the Scottish Antimicrobial Prescribing Group (SAPG) through a network of antimicrobial management teams.

***Staphylococcus aureus* bacteraemia (SAB)**

ARHAI continues to offer support to NHS boards across Scotland to aid their local SAB reduction strategies. A programme of enhanced SAB surveillance commenced in all NHS boards in Scotland on 1 October 2014. This is providing further intelligence to focus future reduction interventions.

Surgical Site Infection (SSI)

SSIs are estimated to double the length of post-operative stay in hospital and significantly increase the cost of care. The national SSI programme is intended to enhance the quality of patient care with use of data obtained from surveillance to compare incidence of SSI over time and against a benchmark rate and to use this information locally to review and guide clinical practice. National mandatory SSI surveillance was paused in 2020 to support the COVID-19 response and has not yet resumed.

Accuracy

CDI, ECB and SAB data are the product of the Electronic Communication of Surveillance in Scotland (ECOSS). Participating laboratories routinely report all identifications of organisms, infection, or microbiological intoxication unless they are known to be of no clinical or public health importance. The collected data are used for: the identification of single cases of severe disease, outbreaks, longer term trends in the incidence of laboratory reported infections, enhanced surveillance, health protection, and analytical and statistical use.

Delays in SMR01 data availability at the time of report production means that the origin of infection for some CDI cases may be reassigned at a later date. Therefore, healthcare-associated and community-associated CDI cases in this report are provisional and may change as more data becomes available.

The enhanced ECB and SAB ECOSS web tool has built-in validation rules that must be met before the data are submitted. Further checks of the data are made by ARHAI before the data are analysed. CDI validation of collected data entails sending a list of CDI cases extracted from ECOSS to all NHS boards and asking for confirmation that the cases represent true CDI cases, i.e., meet the case definition which is defined in the [Protocol for the Scottish Surveillance Programme for Clostridioides difficile infection: user manual | National Services Scotland, prior to sending for linkage with national hospital activity registers](#). The final list of CDI cases is then agreed before publishing.

SSI data is reported via the Surgical Site Infection Reporting System (SSIRS). Complying with a national minimum dataset and definitions for Surgical Site Infections, enables the data submitted to ARHAI Scotland to be mapped into the national dataset following a rigorous quality assurance process.

SSIRS has built-in validation rules and data cannot be submitted until rules are met. SSIRS primary validation checks for incomplete or conflicting information entered in core data fields. Secondary validation includes data checks that can be accepted without completion and/or values that are outside the stated requirements.

Completeness

TOBD:

The total occupied bed days for September 2025 in NHS Fife were not available at the time of publication, therefore the TOBDs for September 2024 were used as a proxy.

ECB/SAB:

Surveillance data are collected using an ECOSS Surveillance Web Tool that allows data collectors in NHS boards to validate ECOSS records as well as additional cases that may not be included in the ECOSS system. This therefore means that completeness is near to 100%. Only cases validated through enhanced surveillance are included in this publication.

CDI:

Diagnosis of CDI is confirmed in a patient who is both symptomatic with diarrhoea and whose stool has tested positive for *C. difficile* toxin using the diagnostic algorithm outlined in the [*C. difficile* testing algorithm](#) published by the Scottish Microbiology and Virology Network in 2024. Origin of infections are assigned using a combination of NHS board validation and data linkage with national hospital activity registers ([Protocol for the Scottish Surveillance Programme for *Clostridioides difficile* infection: user manual | National Services Scotland](#)). As with most surveillance programmes, completeness will not be 100% but mandatory surveillance methodology ensures this is as near to 100% as practically possible.

CDI Ribotyping: The snapshot programme ([Protocol for the *Clostridioides difficile* snapshot programme | National Services Scotland](#)) aims to obtain a representative sample of isolates from CDI cases across all NHS boards in Scotland, but this cannot always be achieved, therefore the data should be interpreted with caution.

The clinical typing scheme aims to provide data from severe CDI cases and/or suspected outbreaks. These data are based on the specimens and information received by the reference laboratory and are not validated by individual NHS boards for completeness, therefore, the data should be interpreted with caution.

SSI:

National mandatory SSI surveillance was paused in 2020 to support the COVID-19 response and has not yet resumed.

Comparability

UK Health Security Agency (UKHSA) report rates per quarter for CDI, ECB and SAB, and annually for SSI (methods and definitions may differ).

[*Clostridioides difficile*: guidance, data and analysis](#)

[*Escherichia coli \(E. coli\)*: guidance, data and analysis](#)

[*Staphylococcus aureus*: guidance, data and analysis](#)

[Surgical site infection \(SSI\): guidance, data and analysis](#)

Accessibility

It is the policy of ARHAI to make its web sites and products accessible according to [published guidelines](#).

Coherence and clarity

Tables and charts are accessible via the [supplementary data](#) file on the ARHAI Scotland website.

Value type and unit of measurement

Healthcare associated cases and incidence rates (per 100,000 Total occupied bed days (TOBDs)) for *Clostridioides difficile* infection, *Escherichia coli* bacteraemia & *Staphylococcus aureus* bacteraemia.

Community associated cases and incidence rates (per 100,000 population) for *Clostridioides difficile* infection, *Escherichia coli* bacteraemia & *Staphylococcus aureus* bacteraemia. Quarterly rates of community associated infections are calculated pro-rata for the number of days in the quarter, so that quarterly and yearly incidence rates are comparable.

Number of procedures and Surgical Site Infections and incidence per categories (per 100 procedures) for inpatients and post discharge surveillance.

Further information on the methods and caveats for can be found [here](#).

Disclosure

The PHS protocol on [Statistical Disclosure Protocol](#) is followed.

Official Statistics accreditation

Official Statistics.

UK Statistics Authority Assessment

Not Assessed.

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Date of first publication

07 April 2015. Prior to this *Clostridioides difficile* infection (first publication - 2 Apr 2008) and *Staphylococcus aureus* bacteraemia (first publication - 3 Apr 2002) were separate reports.

Help email

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Date form completed

13 January 2026.

Appendix 3 – Early access details

Pre-Release Access

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ARHAI is obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access.

Standard Pre-Release Access:

- Scottish Government Health Department
- NHS board Chief Executives
- NHS board Communication leads

Appendix 4 – ARHAI Scotland and Official Statistics

About ARHAI Scotland

ARHAI Scotland works at the very heart of the health service across Scotland, delivering services critical to frontline patient care and supporting the efficient and effective operation of NHSScotland.

Official Statistics

Our statistics comply with the [Code of Practice for Statistics](#) in terms of trustworthiness, high quality and public value. This also means that we keep data secure at all stages, through collection, processing, analysis and output production, and adhere to the [‘five safes’](#).

This document has been prepared by Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) team of NHS Scotland Assure, part of NHS National Services Scotland (NSS).

This publication can be made available in large print, braille (English only), audio tape and different languages. Please contact nss.equalitydiversity@nhs.scot for further information.

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