

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

April to June (Q2) 2026

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This is an Official Statistics Publication

[The Official Statistics \(Scotland\) Order 2008](#) authorises Public Services Delivery Scotland (the legal name being the Common Services Agency for the Scottish Health Service) to produce official statistics.

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Introduction

Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland provides a commentary on quarterly epidemiological data in Scotland for April to June (Q2) 2026 on the following:

- *Clostridioides difficile* infection
- *Escherichia coli* bacteraemia
- *Staphylococcus aureus* bacteraemia

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

This report was previously titled “Quarterly epidemiological data on *Clostridioides difficile* infection, *Escherichia coli* bacteraemia, *Staphylococcus aureus* bacteraemia and Surgical Site Infection in Scotland”. In 2020, national surveillance of surgical site infection (SSI) was paused to support the COVID-19 pandemic response and is yet to recommence. The last iteration of the report including SSI data can be found [here](#).

Main Points

***Clostridioides difficile* infection (CDI) during April to June 2026**

- The total number of CDI cases in patients reported to ARHAI was 323.
- 234 (72.4%) CDI cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 15.4 cases per 100,000 total occupied bed days (TOBDs).
- 89 (27.6%) CDI cases were reported as community associated. This corresponds to an incidence rate of 6.4 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 Ayrshire & Arran was 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 April to June 2026**

- The total number of ECB cases in patients reported to ARHAI was 1,175.
- 673 (57.3%) ECB cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 44.4 cases per 100,000 TOBDs.
- 502 (42.7%) ECB cases were reported as community associated. This corresponds to an incidence rate of 36.3 cases per 100,000 population.
- NHS Ayrshire & Arran and Tayside were above the 95% confidence interval upper limit for healthcare associated ECB in the funnel plot analysis.
- NHS Ayrshire & Arran and Borders were above the 95% confidence interval upper limit for community associated ECB in the funnel plot analysis.
- NHS Scotland was above normal variation for healthcare associated ECB when analysing trends over the past three years

***Staphylococcus aureus* bacteraemia (SAB) during April to June 2026**

- The total number of SAB cases in patients reported to ARHAI was 424.
- 293 (69.1%) SAB cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 19.3 cases per 100,000 TOBDs.
- 131 (30.9%) SAB cases were reported as community associated. This corresponds to an incidence rate of 9.5 cases per 100,000 population.
- NHS Tayside was 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 or community associated SAB when analysing trends over the past three years.

Results and Commentary

Clostridioides difficile infection (CDI)

Total cases for quarter

- During Q2 2026, 323 *Clostridioides difficile* infection (CDI) cases in patients were reported to ARHAI. In the previous quarter there were 287 cases.
- In the clinical surveillance typing scheme (covering severe cases and/or outbreaks), out of a total of 21 isolates, ribotype 002 (23.8%) was the most common ribotype identified, followed by ribotypes 014 (19.0%), 106 (14.3%), 005 and (014/020/220) (both 9.5%), 015, 023, 045, 559 and 709 (all 4.8%).
- In the snapshot surveillance (which aims to reflect the general distribution of ribotypes among CDI cases across Scotland), out of a total of 71 isolates, ribotypes 002 and 005 (both 19.7%) were the most common ribotypes identified, followed by ribotypes 014/020/220 and 015 (both 7.0%), 020 (5.6%), 070, 081 and 106 (all 4.2%). The remaining 28.2% 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 Q2 2026, 234 (72.4%) CDI cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 15.4 cases per 100,000 total occupied bed days (TOBDs) ([Table 1](#)).
- Yearly comparisons (comparing year-ending June 2025 with year-ending June 2026) show that there was a decrease in NHS Grampian ([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 Q2 2026, 89 (27.6%) CDI cases were reported as community associated. This corresponds to an incidence rate of 6.4 cases per 100,000 population ([Table 3](#)).
- Yearly comparisons (comparing year-ending June 2025 with year-ending June 2026) show that there were no increases or decreases for NHS Boards ([Table 4](#)).
- NHS Ayrshire & Arran was 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: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).^{1,2}

NHS board	Q1 Cases	Q1 Bed days	Q1 Rate	Q2 Cases	Q2 Bed days	Q2 Rate
AA	9	115,764	7.8	20	112,488	17.8
BR	4	27,575	14.5	2	27,799	7.2
DG	6	46,060	13	6	44,730	13.4
FF	13	89,068	14.6	12	83,842	14.3
FV	7	75,254	9.3	15	70,659	21.2
GJ	1	14,660	6.8	0.0	14,333	0.0
GR	12	138,666	8.7	11	135,241	8.1
GGC	64	440,504	14.5	71	437,574	16.2
HG	16	82,700	19.3	20	82,146	24.3
LN	40	152,359	26.3	27	150,499	17.9
LO	38	225,358	16.9	32	227,037	14.1
OR	0.0	3,779	0.0	1	3,219	31.1
SH	0.0	2,654	0.0	3	2,976	100.8
TY	7	118,768	5.9	14	115,903	12.1
WI	0.0	6,944	0.0	0.0	7,438	0.0
Scotland	217	1540113	14.1	234	1515884	15.4

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 2: CDI cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).^{1,2}

NHS board	YE Q2 25 Cases	YE Q2 25 Bed days	YE Q2 25 Rate	YE Q2 26 Cases	YE Q2 26 Bed days	YE Q2 26 Rate
AA	89	460,881	19.3	74	455,491	16.2
BR	19	122,880	15.5	12	111,868	10.7
DG	44	180,828	24.3	32	178,593	17.9
FF	49	348,852	14	50	346,958	14.4
FV	47	303,158	15.5	42	287,598	14.6
GJ	3	57,429	5.2	8	59,719	13.4
GR	85	555,627	15.3	51	555,642	↓ 9.2
GGC	266	1,780,875	14.9	270	1,763,314	15.3
HG	73	318,735	22.9	64	326,947	19.6
LN	108	604,403	17.9	116	604,643	19.2
LO	150	943,208	15.9	142	905,624	15.7
OR	1	12,544	8	2	14,191	14.1
SH	6	10,917	55	5	11,270	44.4
TY	44	463,437	9.5	48	463,579	10.4
WI	4	26,746	15	2	28,215	7.1
Scotland	988	6,190,520	16	918	6,113,652	15.0

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 3: CDI cases and incidence rates (per 100,000 population) for community associated infection cases: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).^{1, 2, 3}

NHS board	Q1 Cases	Q1 Population	Q1 Rate	Q2 Cases	Q2 Population	Q2 Rate
AA	9	367,290	9.9	14	367,290	15.3
BR	2	116,800	6.9	0	116,800	0.0
DG	2	145,490	5.6	2	145,490	5.5
FF	1	373,990	1.1	6	373,990	6.4
FV	7	305,880	9.3	5	305,880	6.6
GR	9	589,550	6.2	5	589,550	3.4
GGC	8	1219,880	2.7	14	1,219,880	4.6
HG	4	324,570	5.0	12	324,570	14.8
LN	9	678,260	5.4	8	678,260	4.7
LO	12	935,460	5.2	12	935,460	5.1
OR	0	21,920	0.0	0	21,920	0.0
SH	1	22,710	17.9	1	22,710	17.7
TY	5	417,930	4.9	10	417,930	9.6
WI	1	25,770	15.7	0	25,770	0.0
Scotland	70	5,545,500	5.1	89	5,545,500	6.4

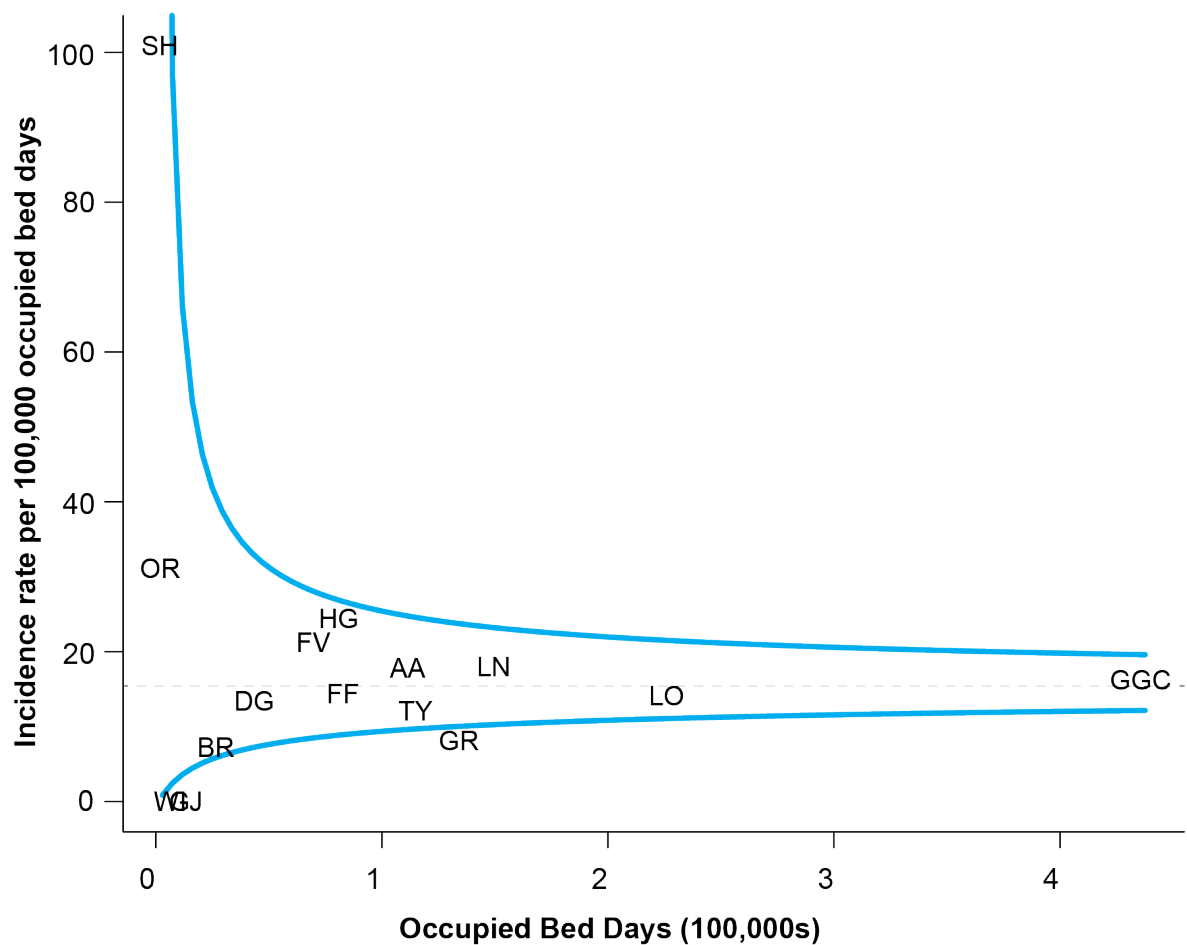
1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Quarterly population rates are based on an annualised population.
3. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS)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

Table 4: CDI cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).^{1, 2}

NHS board	YE Q2 25 Cases	YE Q2 25 Population	YE Q2 25 Rate	YE Q2 26 Cases	YE Q2 26 Population	YE Q2 26 Rate
AA	34	367,290	9.3	35	367,290	9.5
BR	7	116,800	6.0	5	116,800	4.3
DG	7	145,490	4.8	8	145,490	5.5
FF	16	373,990	4.3	12	373,990	3.2
FV	12	305,880	3.9	17	305,880	5.6
GR	49	589,550	8.3	32	589,550	5.4
GGC	39	1,219,880	3.2	48	1,219,880	3.9
HG	28	324,570	8.6	33	324,570	10.2
LN	28	678,260	4.1	26	678,260	3.8
LO	74	935,460	7.9	62	935,460	6.6
OR	3	21,920	13.7	0	21,920	0.0
SH	4	22,710	17.6	4	22,710	17.6
TY	24	417,930	5.7	30	417,930	7.2
WI	2	25,770	7.8	1	25,770	3.9
Scotland	327	5,545,500	5.9	313	5,545,500	5.6

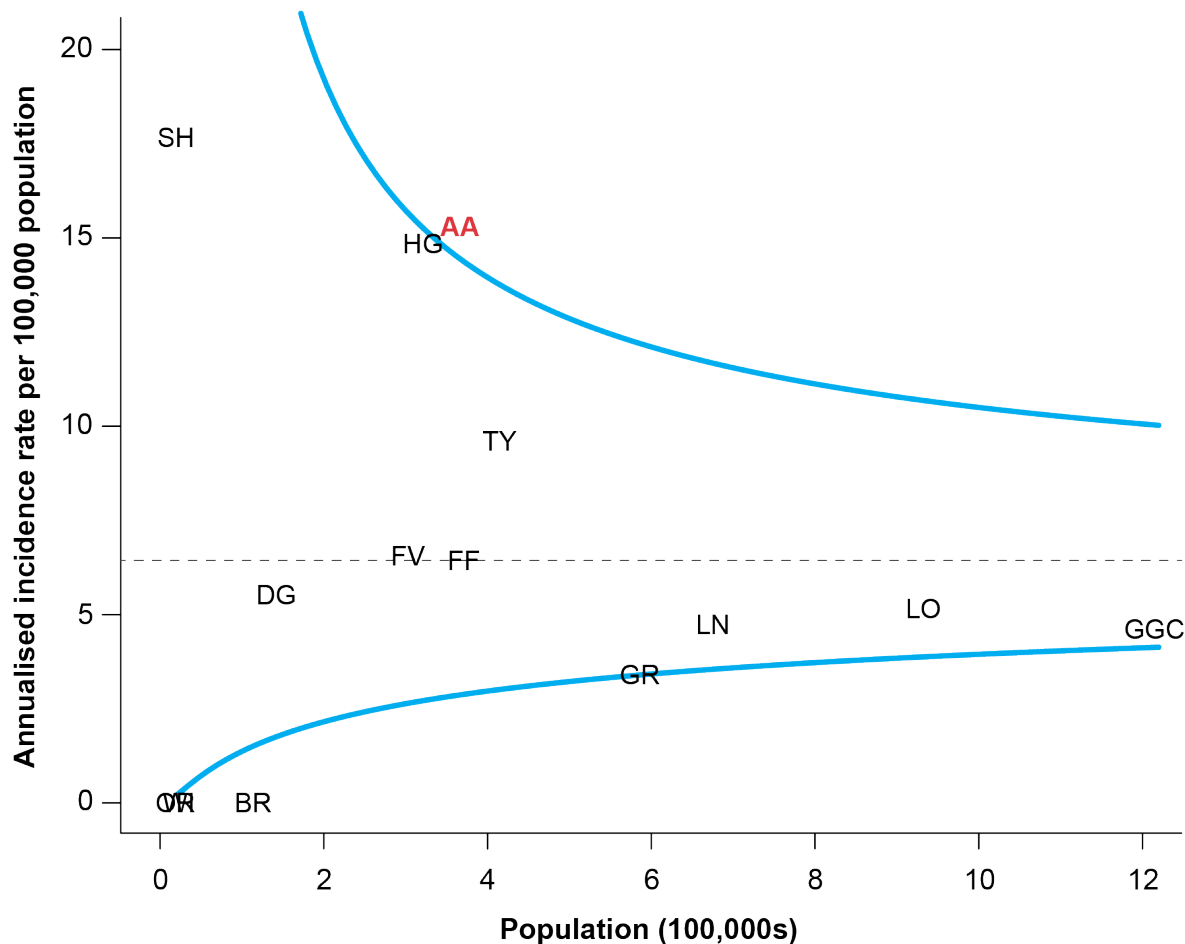
1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 1: Funnel plot of CDI incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q2 2026.^{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 Golden Jubilee and NHS Western Isles 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 Q2 2026.^{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 Q2 2026, 1,175 *Escherichia coli* bacteraemia (ECB) cases in patients were reported to ARHAI. In the previous quarter there were 1,074 cases.

Healthcare associated infection cases by NHS board where specimen taken

- During Q2 2026, 673 (57.3%) ECB cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 44.4 cases per 100,000 TOBDs ([Table 5](#)).
- Yearly comparisons (comparing year-ending June 2025 with year-ending June 2026) show that there was an increase in NHS Ayrshire & Arran, NHS Lanarkshire and NHS Tayside ([Table 6](#)).
- NHS Ayrshire & Arran and NHS Tayside were above the 95% confidence interval upper limit in the funnel plot analysis ([Figure 3](#)).
- NHS Scotland was above normal variation for healthcare associated ECB when analysing trends over the past three years (see [supplementary data](#)).

Community associated infection cases by NHS board of residence

- During Q2 2026, 502 (42.7%) ECB cases were reported as community associated. This corresponds to an incidence rate of 36.3 cases per 100,000 population ([Table 7](#)).
- Yearly comparisons (comparing year-ending June 2025 with year-ending June 2026) show there was an increase in NHS Lothian and a decrease in NHS Lanarkshire ([Table 8](#)).
- NHS Ayrshire & Arran and NHS Borders 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: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).^{1, 2}

NHS board	Q1 Cases	Q1 Bed days	Q1 Rate	Q2 Cases	Q2 Bed days	Q2 Rate
AA	54	115,764	46.6	68	112,488	60.5
BR	8	27,575	29.0	10	27,799	36.0
DG	30	46,060	65.1	12	44,730	26.8
FF	36	89,068	40.4	26	83,842	31.0
FV	28	75,254	37.2	29	70,659	41.0
GJ	1	14,660	6.8	4	14,333	27.9
GR	43	138,666	31.0	58	135,241	42.9
GGC	167	440,504	37.9	198	437,574	45.2
HG	18	82,700	21.8	19	82,146	23.1
LN	62	152,359	40.7	74	150,499	49.2
LO	85	225,358	37.7	94	227,037	41.4
OR	0	3,779	0.0	1	3,219	31.1
SH	5	2,654	188.4	4	2,976	134.4
TY	70	118,768	58.9	69	115,903	59.5
WI	6	6,944	86.4	7	7,438	94.1
Scotland	613	1,540,113	39.8	673	1,515,884	44.4

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 6: ECB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).^{1,2}

NHS board	YE Q2 25 Cases	YE Q2 25 Bed days	YE Q2 25 Rate	YE Q2 26 Cases	YE Q2 26 Bed days	YE Q2 26 Rate
AA	190	460,881	41.2	228	455,491	↑ 50.1
BR	45	122,880	36.6	45	111,868	40.2
DG	85	180,828	47.0	85	178,593	47.6
FF	143	348,852	41.0	129	346,958	37.2
FV	147	303,158	48.5	110	287,598	38.2
GJ	5	57,429	8.7	11	59,719	18.4
GR	201	555,627	36.2	195	555,642	35.1
GGC	704	1,780,875	39.5	717	1,763,314	40.7
HG	85	318,735	26.7	82	326,947	25.1
LN	261	604,403	43.2	308	604,643	↑ 50.9
LO	356	943,208	37.7	360	905,624	39.8
OR	5	12,544	39.9	4	14,191	28.2
SH	14	10,917	128.2	14	11,270	124.2
TY	208	463,437	44.9	262	463,579	↑ 56.5
WI	21	26,746	78.5	19	28,215	67.3
Scotland	2,470	6,190,520	39.9	2,569	6,113,652	42.0

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 7: ECB cases and incidence rates (per 100,000 population) for community associated infection cases: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).^{1, 2, 3}

NHS board	Q1 Cases	Q1 Population	Q1 Rate	Q2 Cases	Q2 Population	Q2 Rate
AA	35	367,290	38.6	55	367,290	60.1
BR	13	116,800	45.1	20	116,800	68.7
DG	21	145,490	58.5	22	145,490	60.7
FF	29	373,990	31.4	25	373,990	26.8
FV	36	305,880	47.7	39	305,880	51.1
GR	43	589,550	29.6	40	589,550	27.2
GGC	77	1,219,880	25.6	74	1,219,880	24.3
HG	23	324,570	28.7	33	324,570	40.8
LN	60	678,260	35.9	62	678,260	36.7
LO	70	935,460	30.3	90	935,460	38.6
OR	3	21,920	55.5	1	21,920	18.3
SH	3	22,710	53.6	4	22,710	70.6
TY	48	417,930	46.6	37	417,930	35.5
WI	0	25,770	0.0	0	25,770	0.0
Scotland	461	5,545,500	33.7	502	5,545,500	36.3

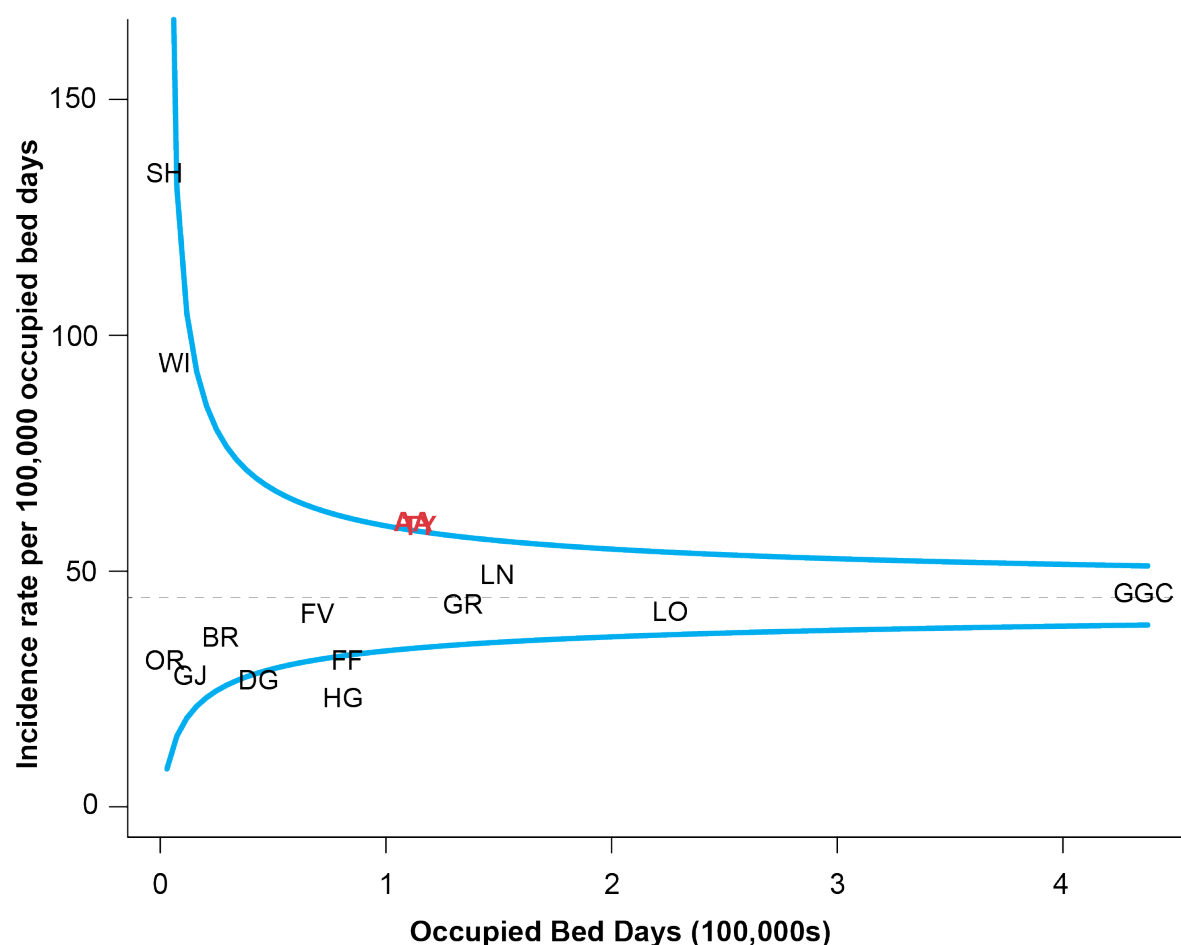
1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Quarterly population rates are based on an annualised population.
3. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS)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

Table 8: ECB cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).^{1, 2}

NHS board	YE Q2 25 Cases	YE Q2 25 Population	YE Q2 25 Rate	YE Q2 26 Cases	YE Q2 26 Population	YE Q2 26 Rate
AA	217	367,290	59.1	210	367,290	57.2
BR	72	116,800	61.6	63	116,800	53.9
DG	90	145,490	61.9	83	145,490	57.0
FF	144	373,990	38.5	122	373,990	32.6
FV	127	305,880	41.5	150	305,880	49.0
GR	132	589,550	22.4	157	589,550	26.6
GGC	364	1,219,880	29.8	345	1,219,880	28.3
HG	111	324,570	34.2	101	324,570	31.1
LN	297	678,260	43.8	251	678,260	↓ 37.0
LO	249	935,460	26.6	302	935,460	↑ 32.3
OR	7	21,920	31.9	8	21,920	36.5
SH	11	22,710	48.4	10	22,710	44.0
TY	190	417,930	45.5	179	417,930	42.8
WI	8	25,770	31.0	3	25,770	11.6
Scotland	2,019	5,545,500	36.4	1,984	5,545,500	35.8

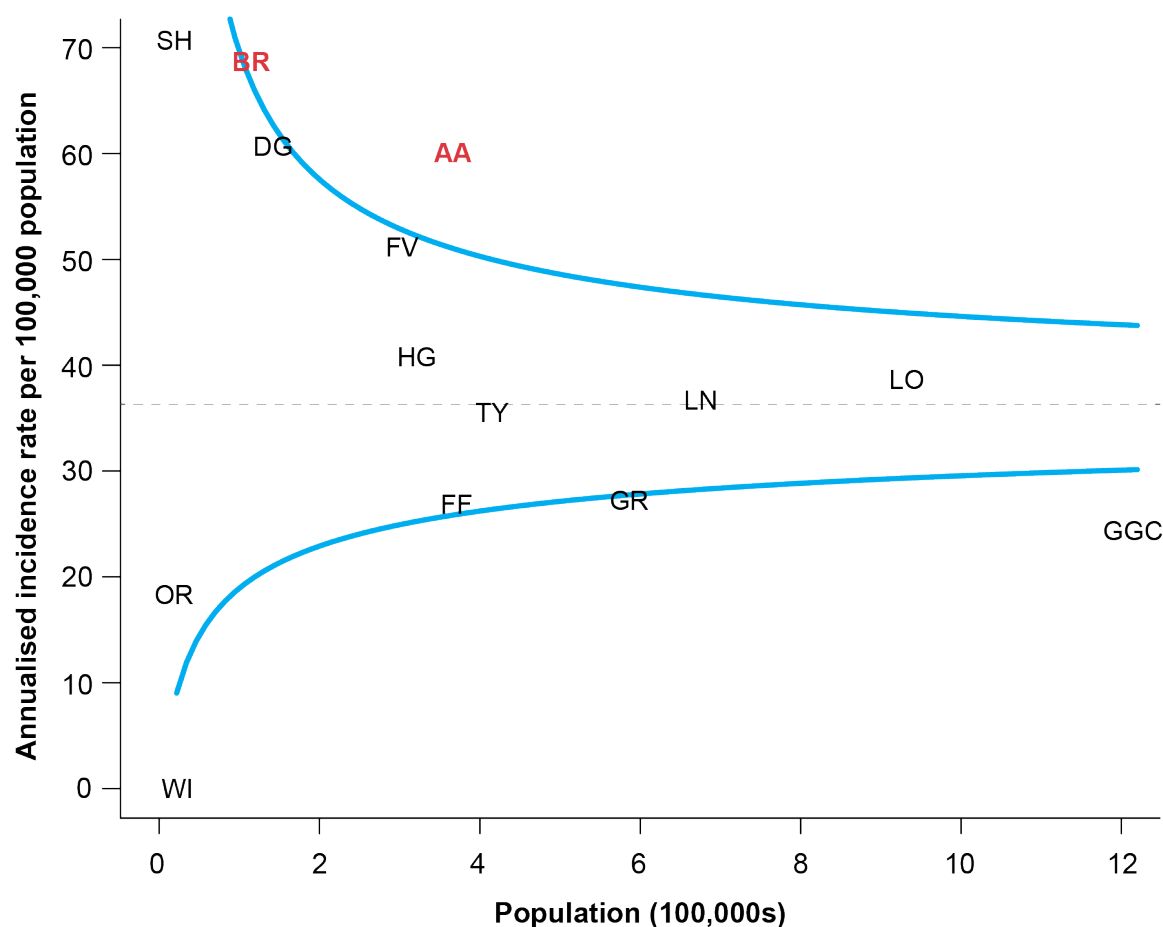
1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 3: Funnel plot of ECB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q2 2026.^{1, 2, 3}



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.
3. NHS Ayrshire & Arran and NHS Tayside overlap.

Figure 4: Funnel plot of ECB incidence rates (per 100,000 population) in community associated infection cases for all NHS boards in Scotland in Q2 2026.^{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 Q2 2026, 424 *Staphylococcus aureus* bacteraemia (SAB) cases in patients were reported to ARHAI. In the previous quarter there were 430 SAB cases.

Healthcare associated infection cases by NHS board where specimen taken

- During Q2 2026, 293 (69.1%) SAB cases were reported to ARHAI as healthcare associated. This corresponds to an incidence rate of 19.3 cases per 100,000 TOBDs ([Table 9](#)).
- Yearly comparisons (comparing year-ending June 2025 with year-ending June 2026) show there was an increase in NHS Tayside ([Table 10](#)).
- NHS Tayside was 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 Q2 2026, 131 (30.9%) SAB cases were reported as community associated. This corresponds to an incidence rate of 9.5 cases per 100,000 population ([Table 11](#)).
- Yearly comparisons (comparing year-ending June 2025 with year-ending June 2026) show there was a decrease in NHS Lanarkshire ([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: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).^{1, 2}

NHS board	Q1 Cases	Q1 Bed days	Q1 Rate	Q2 Cases	Q2 Bed days	Q2 Rate
AA	31	115,764	26.8	25	112,488	22.2
BR	6	27,575	21.8	10	27,799	36.0
DG	9	46,060	19.5	4	44,730	8.9
FF	13	89,068	14.6	13	83,842	15.5
FV	15	75,254	19.9	11	70,659	15.6
GJ	2	14,660	13.6	0	14,333	0.0
GR	29	138,666	20.9	21	135,241	15.5
GGC	82	440,504	18.6	82	437,574	18.7
HG	11	82,700	13.3	13	82,146	15.8
LN	20	152,359	13.1	22	150,499	14.6
LO	40	225,358	17.7	51	227,037	22.5
OR	1	3,779	26.5	1	3,219	31.1
SH	1	2,654	37.7	1	2,976	33.6
TY	31	118,768	26.1	38	115,903	32.8
WI	1	6,944	14.4	1	7,438	13.4
Scotland	292	1,540,113	19.0	293	1,515,884	19.3

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 June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).^{1,2}

NHS board	YE Q2 25 Cases	YE Q2 25 Bed days	YE Q2 25 Rate	YE Q2 26 Cases	YE Q2 26 Bed days	YE Q2 26 Rate
AA	129	460,881	28.0	106	455,491	23.3
BR	27	122,880	22.0	23	111,868	20.6
DG	29	180,828	16.0	33	178,593	18.5
FF	42	348,852	12.0	49	346,958	14.1
FV	62	303,158	20.5	47	287,598	16.3
GJ	8	57,429	13.9	7	59,719	11.7
GR	113	555,627	20.3	102	555,642	18.4
GGC	345	1,780,875	19.4	340	1,763,314	19.3
HG	49	318,735	15.4	49	326,947	15.0
LN	118	604,403	19.5	97	604,643	16.0
LO	154	943,208	16.3	177	905,624	19.5
OR	2	12,544	15.9	3	14,191	21.1
SH	8	10,917	73.3	4	11,270	35.5
TY	91	463,437	19.6	123	463,579	↑ 26.5
WI	9	26,746	33.6	3	28,215	10.6
Scotland	1,186	6,190,520	19.2	1,163	6,113,652	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: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).^{1, 2, 3}

NHS board	Q1 Cases	Q1 Population	Q1 Rate	Q2 Cases	Q2 Population	Q2 Rate
AA	9	367,290	9.9	7	367,290	7.6
BR	6	116,800	20.8	3	116,800	10.3
DG	5	145,490	13.9	3	145,490	8.3
FF	10	373,990	10.8	16	373,990	17.2
FV	6	305,880	8.0	9	305,880	11.8
GR	17	589,550	11.7	15	589,550	10.2
GGC	10	1,219,880	3.3	20	1,219,880	6.6
HG	10	324,570	12.5	5	324,570	6.2
LN	15	678,260	9.0	14	678,260	8.3
LO	26	935,460	11.3	24	935,460	10.3
OR	1	21,920	18.5	1	21,920	18.3
SH	1	22,710	17.9	1	22,710	17.7
TY	21	417,930	20.4	11	417,930	10.6
WI	1	25,770	15.7	2	25,770	31.1
Scotland	138	5,545,500	10.1	131	5,545,500	9.5

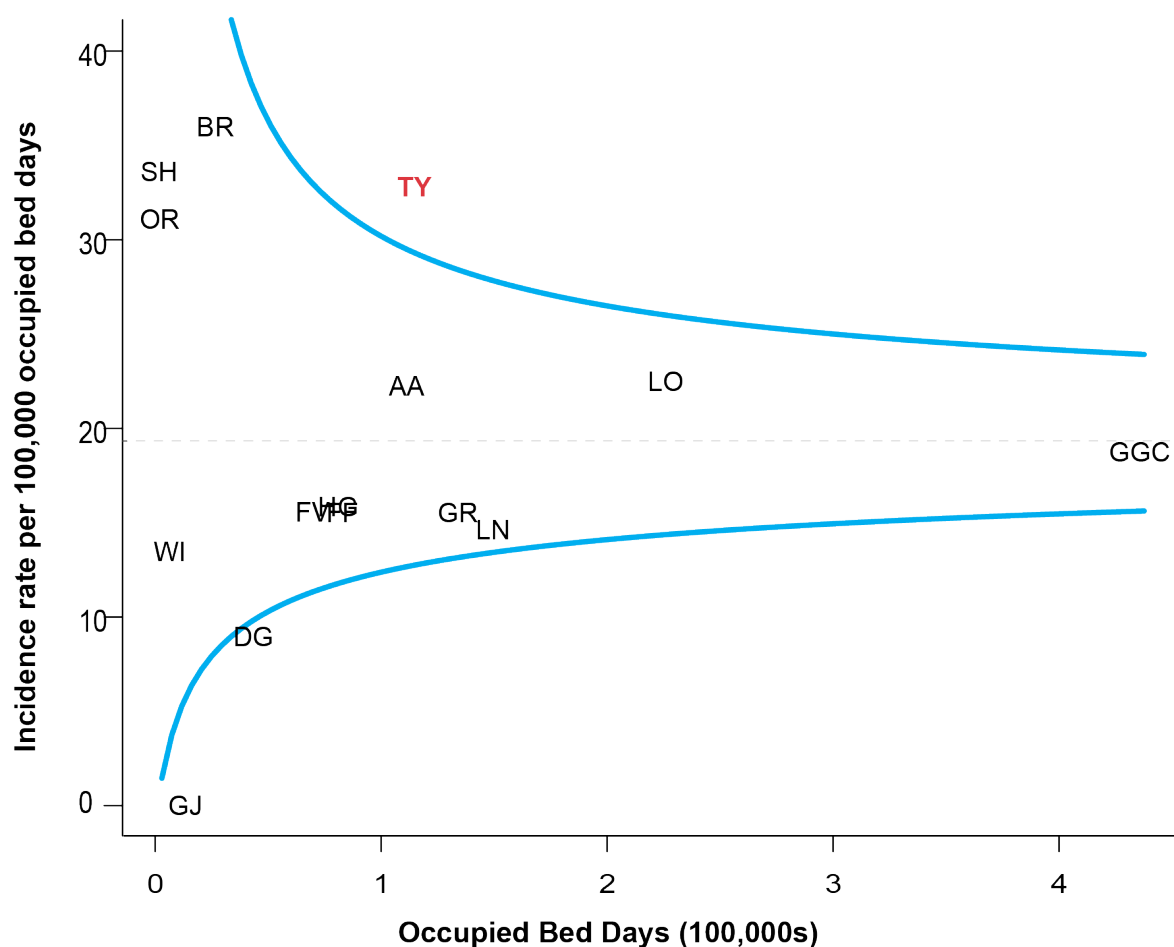
1. An arrow denotes a statistically significant change; quarterly comparisons are only made at a national level.
2. Quarterly population rates are based on an annualised population.
3. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS)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

Table 12: SAB cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).^{1, 2}

NHS board	YE Q2 25 Cases	YE Q2 25 Population	YE Q2 25 Rate	YE Q2 26 Cases	YE Q2 26 Population	YE Q2 26 Rate
AA	36	367,290	9.8	45	367,290	12.3
BR	17	116,800	14.6	20	116,800	17.1
DG	21	145,490	14.4	19	145,490	13.1
FF	61	373,990	16.3	52	373,990	13.9
FV	47	305,880	15.4	35	305,880	11.4
GR	65	589,550	11.0	60	589,550	10.2
GGC	72	1,219,880	5.9	69	1,219,880	5.7
HG	25	324,570	7.7	24	324,570	7.4
LN	67	678,260	9.9	45	678,260	↓ 6.6
LO	96	935,460	10.3	93	935,460	9.9
OR	2	21,920	9.1	3	21,920	13.7
SH	6	22,710	26.4	2	22,710	8.8
TY	53	417,930	12.7	57	417,930	13.6
WI	1	25,770	3.9	3	25,770	11.6
Scotland	569	5,545,500	10.3	527	5,545,500	9.5

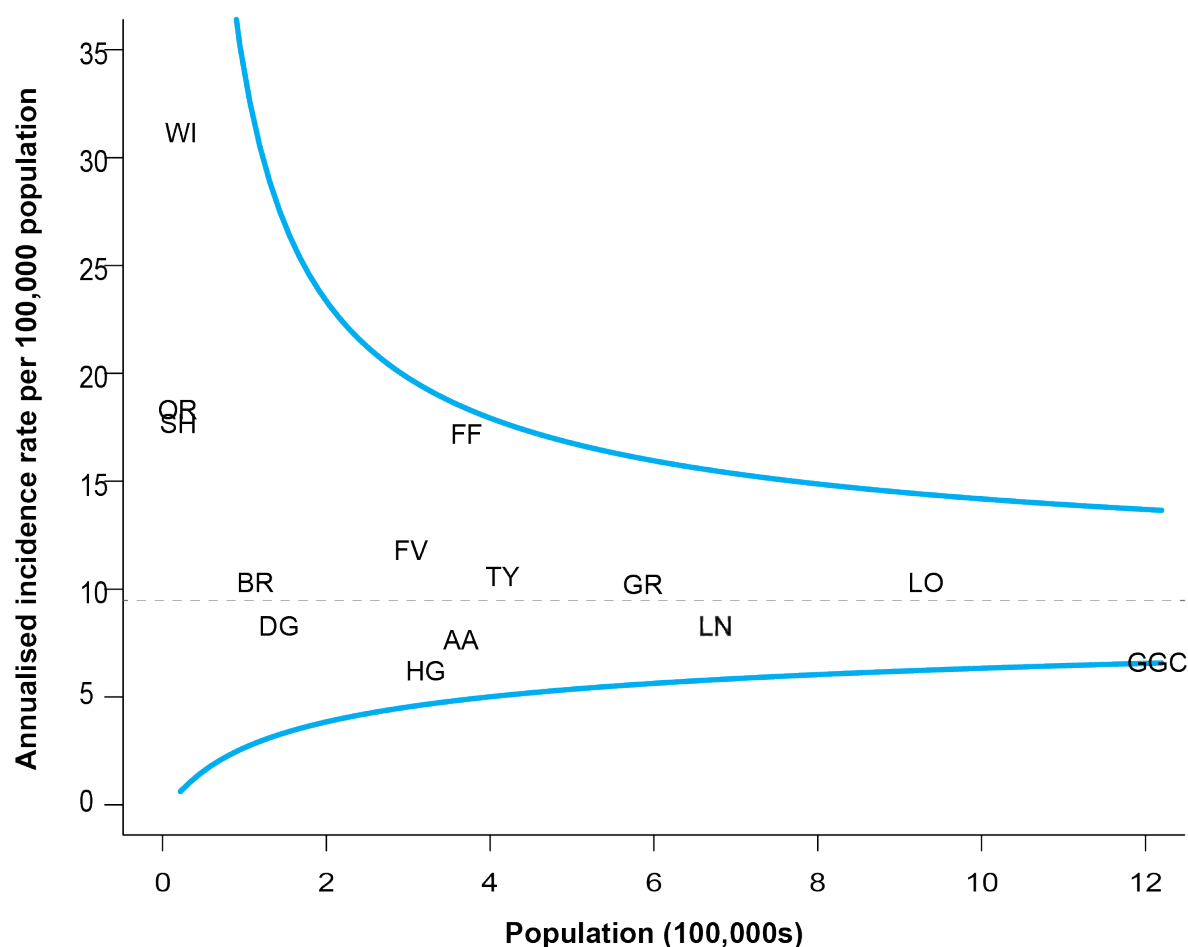
1. An arrow denotes a statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 5: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS boards in Scotland in Q2 2026.^{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 Fife, NHS Forth Valley and NHS Highland overlap.

Figure 6: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS boards in Scotland in Q2 2026.^{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 Orkney and NHS Shetland overlap.

List of Tables

Table Name	File and size
Table 1: CDI cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).	<u>supplementary data (546 Kb)</u>
Table 2: CDI cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).	<u>supplementary data (546 Kb)</u>
Table 3: CDI cases and incidence rates (per 100,000 population) for community associated infection cases: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).	<u>supplementary data (546 Kb)</u>
Table 4: CDI cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).	<u>supplementary data (546 Kb)</u>
Table 5: ECB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).	<u>supplementary data (546 Kb)</u>
Table 6: ECB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).	<u>supplementary data (546 Kb)</u>
Table 7: ECB cases and incidence rates (per 100,000 population) for community associated infection cases: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).	<u>supplementary data (546 Kb)</u>
Table 8: ECB cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).	<u>supplementary data (546 Kb)</u>
Table 9: SAB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).	<u>supplementary data (546 Kb)</u>
Table 10: SAB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).	<u>supplementary data (546 Kb)</u>
Table 11: SAB cases and incidence rates (per 100,000 population) for community associated infection cases: Q1 2026 (January to March 2026) compared to Q2 2026 (April to June 2026).	<u>supplementary data (546 Kb)</u>
Table 12: SAB cases and incidence rates (per 100,000 population) for community associated infection cases: year-ending June 2025 (YE Q2 25) compared to year-ending June 2026 (YE Q2 26).	<u>supplementary data (546 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](#), and [SAB](#) pages.

The next release of this publication will be January 2027.

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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.

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
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 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.

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
Changes to data collection in response to COVID-19.	July 2020	All sections	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). All mandatory and voluntary Surgical Site Infection (SSI) surveillance was paused until further notice.
Change from Health Protection Scotland to ARHAI Scotland.	October 2020	All sections	In April 2020, as part of launch of Public Health Scotland, the ARHAI Group within Health Protection Scotland (HPS) became ARHAI Scotland. 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.
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

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
			Laboratory (SMiRL) was being reviewed.
Recommencement of mandatory surveillance following COVID-19 response.	April 2023	All sections	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. Previously, for data collected from 25 March 2020 onwards, only origin of infection was mandatory for ECB and SAB surveillance. Meanwhile all mandatory and voluntary Surgical Site Infection (SSI) surveillance will remain paused until further notice.
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.
Update to branding	January 2026	All Sections	The branding in this report has been updated in line with the current

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
			organisational arrangements of ARHAI Scotland as an NHS Scotland Assure service.
Change from NHS National Services	July 2026	All Sections	In April 2026, National Services Scotland and NHS Education for Scotland formed a single national organisation, Public Services Delivery Scotland. ARHAI Scotland continues as an NHS Scotland Assure service, which now sits within Public Services Delivery Scotland. ARHAI Scotland will continue to support NHS boards in the prevention and control of healthcare associated infections. Report branding has been updated in line with the current organisation arrangements.
Removal of surgical site infections (SSI) from report	October 2026	SSI	This report was previously titled “Quarterly epidemiological data on Clostridioides difficile infection, Escherichia coli bacteraemia, Staphylococcus aureus bacteraemia and Surgical Site Infection in Scotland”. In 2020, national surveillance of surgical site infection (SSI) was paused to support the COVID-19 pandemic response and is yet to recommence.
Change to reporting of <i>C. difficile</i> ribotypes.	October 2026	CDI	In May 2025, the Scottish Microbiology Reference Laboratory, moved from ribotyping to whole genome sequence (WGS) typing of <i>C. difficile</i> specimens sent to the snapshot or clinical typing schemes. Ribotypes have been inferred from sequence types obtained during WGS derived multi-locus

Description of Revision	First report revision applied	Report section(s) revision applies to	Rational for revision
			sequence typing (MLST). Reported ribotypes have been grouped according to corresponding sequence types.

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 and *Staphylococcus aureus* bacteraemia in Scotland.

Description

This release provides information on *Clostridioides difficile* infection, *Escherichia coli* bacteraemia and *Staphylococcus aureus* bacteraemia in Scotland for the period April to June 2026.

Theme

Infections in Scotland

Topic

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

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 2026, therefore mid-year population data for 2025 are used for rates of community associated infections for 2025 to 2026.

***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 2026, therefore mid-year

population data for 2025 are used for rates of community associated infections for 2025 to 2026.

***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 2026, therefore mid-year population data for 2025 are used for rates of community associated infections for 2025 to 2026.

Date that data are acquired

The date the data were extracted for analysis.

Clostridioides difficile infection: 16 July 2026

Escherichia coli bacteraemia: 31 August 2026

Staphylococcus aureus bacteraemia: 31 August 2026

Release date

06 October 2026

Frequency

Quarterly

Timeframe of data and timeliness

The latest iteration of data is 30 June 2026; 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

All NHS board mid-year population estimates from 2025 Q1 to 2026 Q1 were updated following the release of [2025 NRS mid-year population estimates](#) on 14th July 2026.

Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland

An NHS Scotland Assure Service

Total Occupied Bed Days (TOBDs)

There were no retrospective amendments to the data.

Clostridioides difficile infection (CDI)

Quarter	NHS board	Previous healthcare associated CDI cases	Updated healthcare associated CDI cases	Previous community associated CDI cases	Updated community associated CDI cases	Reason
2026 Q1	GGC	63	64	9	8	Data amendment
2026 Q1	GR	11	12	10	9	Data amendment
2026 Q1	LN	39	40	10	9	Data amendment

Escherichia coli bacteraemia (ECB)

Quarter	NHS board	Previous healthcare associated ECB cases	Updated healthcare associated ECB cases	Previous community associated ECB cases	Updated community associated ECB cases	Reason
2026 Q1	GGC	166	167	-	-	Data amendment ¹
2026 Q1	HG	17	18	24	23	Data amendment ¹
2026 Q1	SH	4	5	-	-	Data amendment ¹
2026 Q1	TY	69	70	-	-	Data amendment ¹
2025 Q4	FV	-	-	32	31	Data amendment ¹
2024 Q4	DG	17	16	-	-	Data amendment ¹
2024 Q3	DG	31	32	-	-	Data amendment ¹

¹ Retrospective data amendment following database audit.

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

Quarter	NHS board	Previous healthcare associated SAB cases	Updated healthcare associated SAB cases	Previous community associated SAB cases	Updated community associated SAB cases	Reason
2026 Q1	DG	-	-	4	5	Data amendment ²
2026 Q1	SH	0	1	-	-	Data amendment ²
2021 Q4	GGC	-	-	20	19	Data amendment ²

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

² Retrospective data amendment following database audit.

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](#).

***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](#).

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](#).

***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.

Accuracy

CDI, ECB and SAB data are extracted from 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](#), prior to sending for linkage with national hospital activity registers. The final list of CDI cases is then agreed before publishing.

Completeness

TOBD: The total occupied bed days for January 2026 in NHS Forth Valley were not available at the time of publication, therefore the TOBDs for January 2025 were used as a proxy.

The total occupied bed days for April to June 2026 in NHS Lothian were not available at the time of publication, therefore the TOBDs for April to June 2025 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](#)). 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](#)) 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.

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](#)

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. 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

06 October 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 – Public Services Delivery Scotland and Official Statistics

About Public Services Delivery Scotland

ARHAI Scotland were formerly part of NHS National Services for Scotland and are now part of Public Services Delivery Scotland. From 1 April 2026, NHS Education for Scotland and NHS National Services for Scotland combined to form Public Services Delivery Scotland. Public Services Delivery Scotland works at the very heart of the health service across Scotland, delivering services critical to frontline patient care, supporting efficient and effective operation, and delivering training across NHS Scotland.

Official Statistics

Public Services Delivery Scotland has been created under the [Common Services Agency](#) which is already a [producer of Official Statistics](#), so there will be no change to the designation of 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 Public Services Delivery Scotland.

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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