Quarterly epidemiological commentary

Mandatory MRSA, MSSA, Gram-negative bacteraemia and *C. difficile* infections data (up to October to December 2018)

March 2019
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Data included in this quarterly epidemiological commentary

This document contains quarterly, national-level epidemiological commentaries for MRSA, MSSA, *E. coli*, *Klebsiella* spp. and *P. aeruginosa* bacteraemia and *C. difficile* infections. This includes analyses on counts and incidence rates of all cases and hospital-onset (previously referred to as trust-apportioned) cases of MRSA, MSSA, *E. coli*, *Klebsiella* spp. and *P. aeruginosa* bacteraemia and *C. difficile* infection.

The terminologies; ‘trust-apportioned’ and ‘not trust-apportioned’ have been updated to ‘hospital-onset’ and ‘community-onset’ respectively. Please note that this is only a change in the description and not a change in the methodology for apportionment.

All data tables associated with this report are included in an accompanying OpenDocument spreadsheet.

Revisions to data included are covered by a data-specific revisions and correction policy.

Citation

Further information

This publication forms part of the range of National Statistics outputs routinely published by Public Health England (PHE) which include monthly and annual reports on the mandatory surveillance of MRSA, MSSA and *E. coli*, *Klebsiella* spp. and *P. aeruginosa* bacteraemia and *C. difficile* infections (CDI).

**Annual report output**

Further epidemiological analyses by financial year can be found in PHE’s annual epidemiological commentary.

**Monthly report outputs**

The following reports are produced by PHE on a monthly basis.

**MRSA bacteraemia:**
- counts of all reported, hospital and community-onset cases of MRSA bacteraemia by NHS acute trust
- counts of all attributed, hospital and community-onset cases of MRSA bacteraemia by CCG
- monthly MRSA counts by CCG

**MSSA bacteraemia:**
- counts of all reported, hospital and community-onset cases of MSSA bacteraemia by NHS acute trust
- counts of all attributed, hospital and community-onset cases of MSSA bacteraemia by CCG
- monthly MSSA counts by acute trust; hospital-onset (trust-apportioned) cases only
- monthly MSSA counts by CCG

**E. coli** bacteraemia:
- monthly counts of *E. coli* bacteraemia by trust; all reported cases only
- monthly counts of *E. coli* bacteraemia by CCG
- counts of all reported, hospital and community-onset cases of *E. coli* bacteraemia by NHS acute trust
- counts of all attributed, hospital and community-onset cases of *E. coli* bacteraemia by CCG
Klebsiella spp. bacteraemia:

- counts of all reported, hospital and community-onset cases of Klebsiella spp. bacteraemia by NHS acute trust
- counts of all attributed, hospital and community-onset cases of Klebsiella spp. bacteraemia by CCG

P. aeruginosa bacteraemia:

- counts of all reported, hospital and community-onset cases of P. aeruginosa bacteraemia by NHS acute trust
- counts of all attributed, hospital and community-onset cases of P. aeruginosa bacteraemia by CCG

CDI:

- monthly CDI counts by acute trust in patients aged 2 years and over; hospital-onset (trust-apportioned) cases only
- monthly CDI counts by acute trust by prior healthcare exposure
- monthly CDI counts by CCG in patients aged 2 years and over
- monthly CDI counts by CCG in patients aged 2 years and over, by prior healthcare exposure

Data for this report was extracted from PHE’s healthcare associated infections data capture system (HCAI DCS) on 18 January 2019.
Epidemiological analyses of *Staphylococcus aureus* bacteraemia data

**MRSA bacteraemia**

There has been a considerable decrease in the incidence rate of all reported MRSA bacteraemia since the enhanced mandatory surveillance of MRSA bacteraemia began in April 2007 (figures 1a, table S1a). There was a steep decline of 85% in the incidence rate of all reported cases between April to June 2007 and January to March 2014 from 10.2 cases per 100,000 population to 1.5. The rate has remained broadly stable at around 1.5 cases per 100,000 population between January to March 2014 and October to December 2018.

A similar trend was observed with the incidence rate of hospital-onset cases (figures 1b, table S1a). There was a steep decrease of 79% from 4.9 cases per 100,000 bed-days to 1.0 between April to June 2008 and January to March 2014. Subsequently, between January to March 2014 and October to December 2018, the rate of MRSA bacteraemia has remained broadly stable.

The incidence rate of hospital-onset MRSA bacteraemia in the most recent quarter (October to December 2018) was similar to that in the same period in the previous year (October to December 2017) at 0.8 cases per 100,000 bed-days (table S1a). The incidence rate of community-onset MRSA bacteraemia increased 29% in the most recent quarter compared to the same quarter from the previous year from 0.8 cases per 100,000 population compared to 1.0 cases per 100,000 population.
Figure 1a: Quarterly rates of all reported MRSA bacteraemia: April to June 2007 to October to December 2018

Rate per 100,000 population

Financial quarter
Figure 1b: Quarterly rates of hospital-onset MRSA bacteraemia: April to June 2008 to October to December 2018
Source of MRSA bacteraemia by onset: January 2018 to December 2018

Between January and December 2018, 35% (308/896) of cases were reported with a source of bacteraemia. Among hospital-onset infections skin & soft tissue (SSTI) infections (29%, 32/112) and catheters & lines (25%, 28/112) were the most common sources reported. Among community-onset the most common source recorded was SSTI (38%, 75/196), although of note, the combined category of others was higher (42%, 82/196) (figure 1c and table S1b).

Figure 1c: Source of MRSA bacteraemia: January to December 2018
MSSA bacteraemia

Since the mandatory reporting of MSSA bacteraemia began in January 2011 there has been a general trend of increasing counts and incidence rates. All reported cases of MSSA bacteraemia increased by 39% from 2,191 to 3,057 between January to March 2011 and October to December 2018. This was accompanied by a 30% increase in incidence rate (per 100,000 population) from 16.8 to 21.8 (figure 2a, table S2).

These increases are primarily driven by the increase in community-onset cases. Between January 2011 to September 2018, the count and the incidence rate of community-onset cases increased by 51% and 41% respectively from 1,464 to 2,217 cases and from 11.2 to 15.8 cases per 100,000 population. Over the same period, the count of hospital-onset case increased by 14% (735 to 840 cases) and the incidence rate increased 15% (8.4 to 9.6 cases per 100,000 bed-days figure 2a and 2b, table S2a).

When comparing the most recent quarter with the same period last year (October to December 2017 and October to December 2018), the incidence rate of hospital-onset MSSA bacteraemia increased by 4% from 9.3 to 9.6 cases per 100,000 bed-days while the incidence rate of community-onset cases increased 3% from 15.3 to 15.8 cases per 100,000 population.
Figure 2a: Quarterly rates of all reported MSSA bacteraemia: January to April 2011 to October to December 2018

Rate per 100,000 population

Financial quarter

Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4
Figure 2b: Quarterly rates of hospital-onset MSSA bacteraemia: January to April 2011 to October to December 2018
Source of MSSA bacteraemia by onset: January 2018 to December 2018

Between January and December 2018 30%, (3,619/12,078) of MSSA cases had a reported source of bacteraemia. Among hospital-onset infections catheters & lines (27%, 261/971) and SSTI (23%, 227/971) were the most common sources reported. Among community-onset the most common source reported was SSTI (31%, 818/2,648) (figure 2c and table S2b).

Figure 2c: Source of MSSA bacteraemia: January 2018 to December 2018
Epidemiological analyses of Gram-negative bacteraemia data

*E. coli* bacteraemia

The incidence rate of all reported *E. coli* bacteraemia has continued to increase each year since the initiation of mandatory surveillance of *E. coli* bacteraemia in July 2011 (figure 3a). This is primarily driven by the increase in the rate of community-onset cases (table S3a). Conversely, the incidence rate of hospital-onset cases has been relatively stable within the same period (figure 3b).

Between July to September 2011 and October to December 2018, incidence rate of all reported cases of *E. coli* bacteraemia increased by 28% from 8,725 to 10,612 cases and from 61.8 to 75.7 cases per 100,000 population. Similarly, over the same period, incidence rate of community-onset cases increased by 39% from 6,279 to 8,741 and from 46.9 to 62.4 cases per 100,000 population.

The incidence rate of hospital-onset cases decreased 9% from 23.7 (n=1,996) to 21.4 (n=1,871) per 100,000 bed-days from July to September 2011 to October to December 2018.

Comparing the most recent quarter (October to December 2018) to the same period in the previous year (October to December 2017) shows a 3% increase in both the count and the incidence rate of all reported cases from 10,303 to 10,612 cases and from 73.5 to 75.7 cases per 100,000 population respectively. While this increase may seem small, it is the sixth consecutive year where October to December has increased comparatively to the previous year.

During the same period the count and the incidence rate of community-onset cases increased by 4% from 8,398 to 8,741 cases and from 59.9 to 62.4 cases per 100,000 population respectively. In contrast, there was little change (2%) in the incidence rate of hospital-onset cases between October to December 2017 and October to December 2018 with a rate of 21.8 (n=1,905) and 21.4 (n=1,871) cases per 100,000 bed-days respectively (figure 3a and 3b, table S3).
Figure 3a: Quarterly rates of all reported *E. coli* bacteraemia: July to September 2011 to October to December 2018
Figure 3b: Quarterly rates of hospital-onset *E. coli* bacteraemia: July to September 2011 to October to December 2018

Rate per 100,000 bed-days

Financial quarter

- Q1 2011/12
- Q2 2011/12
- Q3 2011/12
- Q4 2011/12
- Q1 2012/13
- Q2 2012/13
- Q3 2012/13
- Q4 2012/13
- Q1 2013/14
- Q2 2013/14
- Q3 2013/14
- Q4 2013/14
- Q1 2014/15
- Q2 2014/15
- Q3 2014/15
- Q4 2014/15
- Q1 2015/16
- Q2 2015/16
- Q3 2015/16
- Q4 2015/16
- Q1 2016/17
- Q2 2016/17
- Q3 2016/17
- Q4 2016/17
- Q1 2017/18
- Q2 2017/18
- Q3 2017/18
- Q4 2017/18
- Q1 2018/19
- Q2 2018/19
- Q3 2018/19
Primary focus of *E. coli* bacteraemia by onset: January 2018 to December 2018

Between January and December 2018 63%, (26,703/42,462) of cases had reported a primary focus of bacteraemia. Among hospital-onset infections, urinary tract infection (UTI) was the most common primary focus reported (37%, 1,942/5,224). Likewise, among community-onset the most common primary focus reported was also UTI (52%, 11,166/21,479) (figure 3c and table S3b).

**Figure 3c: Primary focus of *E. coli* bacteraemia: January 2018 to December 2018**

![Graph showing primary focus of bacteraemia](image)

*Klebsiella* spp. bacteraemia

Between April to June 2017 and October to December 2018, there was a 15% increase in the count and a 13% increase in the incidence rate of all reported *Klebsiella* spp. bacteraemia cases from 2,339 to 2,680 and from 16.9 to 19.1 cases per 100,000 population respectively (figure 4a). The count and the incidence rate of community-onset cases also increased by 12% from 1,674 to 1,882 cases and by 11% from 12.1 to 13.4 cases per 100,000 population respectively. Over the same period, the count and the incidence rate of hospital-onset cases increased by 20% from 665 to 798 cases and by 18% from 7.7 to 9.1 cases per 100,000 bed-days respectively (figure 4b).
Comparing the most recent quarter (October to December 2018) to the same period in the previous year (October to December 2017) shows a 7% increase in both the count and the incidence rate of all reported cases from 2,498 to 2,680 cases and from 17.8 to 19.1 cases per 100,000 population respectively. During the same period the count and the incidence rate of community-onset cases increased by 8% from 1,749 to 1,882 cases and from 12.5 to 13.4 cases per 100,000 population respectively. Similarly, the count and incidence rate of hospital-onset cases increased 7% between October to December 2017 and October to December 2018 from 749 to 798 and from 8.6 to 9.1 cases per 100,000 bed-days respectively (table S4).

During October to December 2018, 74% (1,987/2,680) of all reported *Klebsiella* spp. bacteraemia were caused by *K. pneumoniae*, an increase from 70% in the same quarter in the previous year (October to December 2017), compared to 15% (401/2,680) caused by *K. oxytoca* in October to December 2018, a decrease from 17% in the same quarter in the previous year (October to December 2017).

**Figure 4a: Quarterly rates of all reported *Klebsiella* spp. bacteraemia by species: April to June 2017 to October to December 2018**
Primary focus of *Klebsiella* spp. bacteraemia by onset: January 2018 to December 2018

Between January and December 2018, 53% (5,397/10,278) of cases reported a primary focus of bacteraemia. Among hospital-onset infections UTI was the most common primary focus recorded (23%, 393/1,700). Likewise, among community-onset the most common primary focus recorded was also UTI (39%, 1,434/3,697) (figure 4c and table S4b).
Figure 4c: Primary focus of *Klebsiella* spp. bacteraemia: January 2018 to December 2018

**Pseudomonas aeruginosa** bacteraemia

Between April to June 2017 and October to December 2018, there was a 5% increase in the count of *P. aeruginosa* infections from 1,011 to 1,066 cases; accordingly, incidence rate also increased during this period by 4% from 7.3 to 7.6 cases per 100,000 population (figure 5a). Over the same period both the count and incidence rate of community-onset cases increased 7% and 6% respectively from 637 to 680 cases and from 4.6 to 4.9 cases per 100,000 population respectively. Over the same period, the count and incidence rate of hospital-onset cases remained broadly similar at 374 to 386 cases and 4.3 to 4.4 cases per 100,000 population respectively (figure 5b).

Comparing the most recent quarter (October to December 2018) to the same period in the previous year (October to December 2017) shows a 7% decrease in both the count and the incidence rate of all reported cases from 1,144 to 1,066 cases and from 8.2 to 7.6 cases per 100,000 population respectively. During the same period the count and the incidence rate of community-onset cases both decreased by 4%, from 710 to 680 cases and from 5.1 to 4.9 cases per 100,000 population respectively. Similarly, the count and the incidence rate of hospital-onset cases decreased 11% between October to December 2017 and October to December 2018 from 434 to 386 and from 5.0 to 4.4 cases per 100,000 bed-days respectively (table S5).
Figure 5a: Quarterly rates of all reported *P. aeruginosa* bacteraemia: April to June 2017 to October to December 2018

Figure 5b: Quarterly rates of hospital-onset *P. aeruginosa* bacteraemia: April to June 2017 to October to December 2018
Primary focus of *P. aeruginosa* bacteraemia by onset: January 2018 to December 2018

Between January and December 2018, 50% (2,091/4,184) of cases reported the primary focus of infection. Among hospital-onset infections UTI (22%, 183/818) was the most common primary focus reported, although it should be noted that the “Others” category accounted for a greater proportion when accumulated together (29%, 237/818). Among community-onset, the most common primary focus recorded was UTI (31%, 445/1,273) (figure 5c and table S5b).

**Figure 5c: Primary focus of *P. aeruginosa* bacteraemia: January 2018 to December 2018**
Epidemiological analyses of *Clostridium difficile* infection data

Since the initiation of CDI surveillance in April 2007, there has been an overall decrease in the count and associated incidence rate of both all-reported and hospital-onset cases of *C. difficile* infection (CDI) (figure 6a, 6b and table S6).

Most of the decrease in the incidence rate occurred between April to June 2007 and January to March 2012 with a 78% decrease in all-reported cases of CDI from 16,864 to 3,711 cases and an associated 79% reduction in incidence rate (per 100,000 population) from 131.6 to 27.9. Subsequently, between January to March 2012 and October to December 2018, the count of all-reported cases fell by 24% from 3,711 to 2,827 cases and the incidence rate reduced by 28% from 27.9 and 20.2.

There were similar, but greater, reductions among hospital-onset CDI cases with an 85% reduction in count of cases from 10,436 to 1,613 cases and 84% reduction in the incidence rate from 112.5 to 18.2 per 100,000 bed-days between April to June 2007 and January to March 2012. This was followed by a further 42% decrease in the count of cases from 1,613 to 938 cases and a decrease of 41% in the incidence rate from 18.2 to 10.8 cases per 100,000 bed-days between January to March 2012 and October to December 2018.

When the most recent quarter is compared with the same quarter in the previous year (October to December 2017 and October to December 2018) both the count and incidence rate (per 100,000 population) of all reported CDI decreased by 13% from 3,248 to 2,827 cases and from 23.2 to 20.2 respectively, while both the count and incidence rate (per 100,000 bed-days) of hospital-onset CDI cases both decreased by 18% from 1,149 to 938 cases and 13.2 to 10.8 respectively.
Figure 6a: Quarterly rates of all reported CDI: April to June 2007 to October to December 2018
Figure 6b: Quarterly rates of hospital-onset CDI: April to June 2007 to October to December 2018
Appendix

Bed-day data

For *S. aureus* (MRSA and MSSA) bacteraemia and CDI, the average bed-day activity reported by acute trusts via KH03 returns is used to derive the bed-day denominator for acute trust incidence rate rates (assigned and apportioned). As of Q1 2011/12, bed-day data has been available on a quarterly basis and has been used as such for Q2 2011/12 to Q2 2018/19. This data is available at: [www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/](http://www.england.nhs.uk/statistics/statistical-work-areas/bed-availability-and-occupancy/bed-data-overnight/)

Amendments to the published figures on KH03 included the following.

Q3 2018/19 bed-day data was not available at the time of writing this report; therefore, bed-day data for the same quarter of the previous year (Q3 2017/18) was used as a proxy for this quarter.

In Quarterly Epidemiological Commentaries published prior to 1 December 2015, April to June 2014 to October to December 2014 quarterly KH03 figures for one acute trust (RWD) had a percentage change of more than 20% compared with the previous quarter and the same quarter in the previous year. As a result it was replaced with the KH03 data of the same quarter in the previous year (April to June 2013 to October to December 2013).

However, PHE has reviewed its policy for processing KH03 data. Data irregularities identified have been flagged with colleagues at NHS England (data owners of the KH03 dataset). Until we receive confirmation that any identified change in the occupied overnight bed-days for an acute trust is anomalous, PHE now uses the data as published in the KH03 dataset. This affects all reports published since 1 December 2015 and incidence rate rates published prior that time will differ slightly as a result. In order for the KH03 data used to calculate rates included in this report to be consistent over the full time period, previously amended KH03 data for trust United Lincolnshire Hospitals (RWD) for FY 2014/2015 has been altered to reflect that published in the KH03 dataset. Please note that this could lead to slight differences in hospital-onset/assigned rates when compared with publications prior to 1 December 2015.

Missing data for acute trusts in the KH03 returns will continue to be processed as before, where the KH03 return for the same quarter from the previous year will be used as a proxy.
The following acute trusts were thus affected:

- Moorfields Eye Hospital NHS Foundation Trust (RP6) 2007/08 and 2008/09 KH03 figures: replaced with 2006/07 KH03 figure
- Rotherham NHS Foundation Trust (RFR): 2009/10 and April-June 2010 to April-June 2011 KH03 figures: replaced with 2008/09 KH03 figure
- Sheffield Teaching Hospitals NHS Foundation Trust (RHQ) April-June 2010 to April-June 2011 KH03 figures: replaced with 2009/10 KH03 data
- The Princess Alexandra Hospital NHS Trust (RQW) April-June 2014 and October-December 2014 KH03 figures: replaced with April-June 2013 to October-December 2013 KH03 figures, respectively
- Ipswich Hospital NHS Trust (RGQ) January-March 2016 KH03 figure: replaced with January-March 2015 figures
- West Suffolk NHS Foundation Trust (RGR) April-June 2016 to October-December 2016 and April-June 2017 KH03 figures: replaced with April-June 2015 to October-December 2015 KH03 figures
- Gloucestershire Hospitals NHS Foundation Trust (RTE) October-December 2016 to January-March 2017 KH03 figures: replaced with October-December 2015 to January-March 2016 KH03 figures

The KH03 data used for this report was published on 22 November 2018. This includes revisions of previously published KH03 data and so these data may differ from those used in earlier reports.

Population data

National incidence rates are calculated using 2007 to 2017 mid-year resident population estimates which are based on the 2011 census for England (2018 estimates are based on 2017 mid-year estimates).

Definitions

**MSSA, E. coli, Klebsiella spp. and P. aeruginosa bacteremia hospital-onset (trust-apportioned) cases:**
Include patients who are (i) in-patients, day-patients, emergency assessment patients or not known; AND (ii) have had their specimen taken at an acute trust or not known; AND (iii) specimen was taken on or after day 3 of the admission (admission date is considered day ‘one’). Cases that do not meet these criteria are categorised as community-onset (not-trust apportioned).

**CDI hospital-onset (trust-apportioned) cases:**
Include patients who are (i) in-patients, day-patients, emergency assessment patients or not known; AND (ii) have had their specimen taken at an acute trust or not known; AND (iii) specimen was taken on or after day 4 of the admission
(admission date is considered day ‘one’). Cases that do not meet these criteria are
categorised as community-onset (not-trust apportioned).

Historically, report published before September 2017 have used the term ‘trust-
apportioned’ to describe cases meeting the above conditions for apportionment
and ‘not trust-apportioned’ for those that do not. Moving forward, these
terminologies have been updated to ‘hospital-onset’ and ‘community-onset’
respectively. Please note that this is simply a change in terminology and does not
constitute a change in the methodology for apportionment.

**Total reported cases:**
This is the total count of infections for each organism as of the date of extraction.
Please note that for *C. difficile*, this count excludes those from patients less than 2
years old.

**Episode duration:**
The length of an infection episode is defined as 14 days for MRSA, MSSA and *E.
coli* bacteraemia and 28 days for CDI, with the date of specimen being considered
day ‘one’.

**Incidence rate calculations:**

**MRSA, MSSA and *E. coli*, Klebsiella spp., *P. aeruginosa* bacteraemia, and CDI population incidence rate (episodes per 100,000):**
This incidence rate is calculated using the mid-year England population and is

\[
= \frac{n \text{ episodes}}{\left( \frac{\text{mid-year population for England}}{\text{days in quarter}} \right) \times 100,000}
\]

**MRSA, MSSA and *E. coli*, Klebsiella spp., *P. aeruginosa* and CDI hospital-onset incidence:**
This incidence rate is calculated using KH03 average bed-day activity (see bed-
day data above) and is calculated as follows:

\[
= \frac{n \text{ episodes}}{\text{average KH03 beds per day} \times \text{days in quarter}} \times 100,000
\]

**Graphs and percentage change calculation:**
Please note that percentage changes in rate have been calculated using raw rate
figures while those presented in the tables and commentary have been rounded to
one decimal place. Similarly, graphs included in this report were plotted using raw
rates figures. The raw rate figures are included in the accompanying Quarterly Epidemiological Commentary’s accompanying data.

**Quarters:**
In publications prior to March 2016, all references to quarterly data are based on calendar year definitions and NOT financial year definitions, that is:

- Q1 2014: January to March 2014
- Q2 2014: April to June 2014
- Q3 2014: July to September 2014
- Q4 2014: October to December 2014

However, for all subsequent publications, including this one, all references to quarterly data are based on financial year definitions and NOT calendar year definitions, that is:

- Q1 2014/15: April to June 2014
- Q2 2014/15: July to September 2014
- Q3 2014/15: October to December 2014
- Q4 2014/15: January to March 2015