



National Standards of Healthcare Cleanliness 2021

April 2021

Contents

Summary	5
Commitment to Cleanliness Charter	7
1. Introduction.....	8
2. General principles and definitions of cleaning and disinfection.....	10
2.1. Definitions	10
2.2. Choice of cleaning/disinfecting agent.....	10
2.3. Contact time	11
2.4. Direction of cleaning.....	11
2.4. Manual cleaning action	11
2.5. Frequent touch points	11
2.6. Transference.....	11
3. Cleaning responsibilities	12
4. Safe cleaning frequencies	13
5. Risk categories and standards for functional areas	14
5.1. Purpose.....	14
5.2. Cleaning specifications – elements, cleaning frequencies and performance parameters	14
5.3. Cleaning frequency definitions	15
5.4. Enhanced cleaning	16
5.5. High frequency touch points.....	16
5.6 Blended area approach.....	17
5.6. Cleaning operations through a pandemic.....	17
6. Importance of effective cleaning: infection prevention and control	19
6.1. Classification of infection risk and cleaning frequencies	19
6.2. National colour-coding scheme.....	19
6.3. Employer responsibilities	20
6.4. Disposable plastic aprons	21
6.5. Protective gloves.....	21
6.6. Hand Hygiene	21
6.7. Training.....	23
6.8. Accidental exposure to blood or substances.....	24
6.9. Spillages of bodily substances	24

6.10. Uniforms and jewellery	24
6.11. Waste management	25
7. Governance	26
7.1. Committee and board reporting	26
8. Auditing and monitoring information	28
8.1. Purpose.....	28
8.2. Principles	28
8.4. Audit scores	29
8.5. Percentage score	29
8.6. Other options	30
Not adopting all functional risk categories.....	30
Blended area option	30
Governance for functional risk areas	32
8.7. Star rating score.....	32
8.8. Star rating implementation timescales	36
9. Audit process.....	37
9.1. Technical audits	37
Timing	37
Multidisciplinary teams	38
Audit personnel.....	38
Process	38
Frequency.....	39
Sample size	39
Scoring.....	39
Overall target score	40
Demand-led cleaning technology	41
Trend analysis.....	41
Reporting.....	41
9.2. Efficacy audits.....	42
Frequency and scoring.....	42
9.3. External assurance audits.....	43
Frequency.....	43
9.4 Timeframe for rectifying technical problems.....	44
10. Digital and technological audit solutions	46
10.1 Audit Technology	46

10.2 Audit Reporting	46
11. PLACE and the National standards of healthcare cleanliness	48
12. Glossary	49
13. References	51
14. Acknowledgements	53

Since the first publication of national cleaning standards in 2001, NHS managers have welcomed the opportunity to measure performance in a uniform way, and to benchmark it against similar healthcare environments. A collaborative approach is essential to continuously improve cleanliness: organisations can benefit from involving a board nominee, clinical colleagues, partner organisations and patients in setting and monitoring cleaning standards for consistently high levels of service.

The collaboration of this expert multidisciplinary team facilitated the enhancement, elaboration, and modernisation of the standards to ensure that they can be applied to all healthcare settings.

Note: It is the user's responsibility before implementing this guidance to first check on the NHS Collaboration Hub as to whether any enhancements to cleaning regimes are required as a result of a national pandemic/circumstance/incident (also see [Section 5.6](#) – cleaning through a pandemic.)

Executive Summary

Healthcare establishments must be able to demonstrate how and to what standard they are being cleaned. The NHS has rightly earned a high reputation for the cleanliness of its environments.

The *National standards of healthcare cleanliness 2021* apply to all healthcare environments and replace the *National specifications for cleanliness in the NHS 2007* (and amendments) published by the National Patient Safety Agency.¹ To encourage continuous improvement they combine mandates, guidance, recommendations and good practice.

They seek to drive improvements while being flexible enough to meet the different and complex requirements of all healthcare organisations.² Healthcare establishments can decide how their cleaning resources are best organised for their local environment and services, but meeting aspects of these standards is mandatory. The [compliance grid](#) details what is mandatory. Compliance with the standards, and the auditing processes, should be written into contracts with cleaning service providers. Cleaning service managers and providers should ensure all staff are familiar with this document.

The 2021 standards reflect modern methods of cleaning, infection prevention and control (IPC) and other changes since the last review,³ and important considerations for cleaning services during a pandemic; and emphasise transparency to assure patients, the public and staff that safe standards of cleanliness have been met.

To continue to drive improvement in cleanliness, the 2021 standards:

- Focus on the need for a collaborative approach. Different staff groups, both clinical and non-clinical, will be responsible for cleaning different elements within an area; they need to work together to meet the cleanliness standard for the whole area. Published ratings will reflect the cleanliness score for whole areas, not the performance of individual parties responsible for cleaning certain elements. Taking this approach makes it clearer to patients, staff, and visitors how clean an area is and encourages collective responsibility which ultimately inspires people to work together to achieve high standards

¹ The *National standards of healthcare cleanliness 2021* reintroduces the term 'standard' to reinforce that all NHS healthcare establishments in England must adhere to this document. It had been replaced with 'specification' in December 2004 to avoid confusion with the Healthcare Commission's Standards for Better Health (now the Care Quality Commission).

² These standards were developed by healthcare professionals and subject experts from:
Association of Healthcare Cleaning Professionals
Contractor-provider partners
NHS estates and facilities professionals
Healthcare Estates and Facilities Management Association
Health and Safety Executive

³ Particularly, but not restricted to: Publicly Available Specification: PAS 5748:2011 and PAS 5748:2014; *National specifications for cleanliness in the NHS 2012: guidance on setting and measuring performance outcomes in primary care medical and dental premises*; *The revised healthcare cleaning manual* (AHCP 2013).

- With some exemptions (detailed in the audit section) replace the cleaning audit percentage scores for functional areas with a new star rating for patient-facing areas. This star rating should be displayed to give patients, staff, and public an easily understood visual score of the standard of cleanliness being met. It reflects the cleanliness of a functional area regardless of which staff group is responsible for cleaning each element
- Increased flexibility, so they apply to all healthcare settings. Two risk rating score categories have been added to the original four. Organisations can remain within their existing scoring regime if they choose to do so, but the expanded scoring approach enables them to increase or decrease the risk rating in individual functional areas as appropriate, either to facilitate the better use of resources or to recognise that the cleaning of an area needs to improve
- Revise and update the elements list. Organisations will need to determine which elements are applicable to their setting and add to it as appropriate.
- Introduce efficacy audits, widening the audit function to include the cleaning process, as well as measuring the technical cleaning outcome
- There is also an option to blend functional risk areas, **if organisations wish to do so**, to provide greater flexibility and to maximise resource allocation. If used, this methodology can be applied to whole risk categories or to individual areas based on a hybrid approach
- The safe cleaning frequencies linked to each element include the ability to determine the requisite cleaning frequencies for each functional risk (FR) area
- The Standards introduce a [Commitment to Cleanliness Charter](#) to promote the ethos of the 2021 standards, particularly by highlighting the importance of a collaborative approach. Signing up to this charter publicises an organisation's commitment to achieving a consistently safe and high standard of cleanliness

All healthcare organisations need to implement the standards within the set timelines stated in the implementation guidance – as mentioned, the compliance grid identifies what is best practice and what is mandatory. If organisations apply to nhsi.estatesandfacilities@nhs.net for an extension to the planned implementation date, and this is sanctioned, monthly progress updates will be required. Any requests for extra support will be considered.

Introduction of the new standards should not generate additional costs providing organisations are fully compliant with the 2007 standards.

Organisations that do not already operate to these standards will need to evaluate the cost of change and provide a business case for extra support. Where the standards were not previously applicable, organisations will need to assess the implications and agree an implementation plan on an individual basis. Organisations can operate above the baseline if they choose to do so. Should organisations choose to enhance the standards, and this creates an additional cost, they will need to provide a business case outlining the cause of change.

Commitment to Cleanliness Charter

The Commitment to Cleanliness Charter sets out an organisation's commitment to achieve a consistently high standard of cleanliness in all its healthcare facilities using the functional risk category, cleaning frequencies and cleaning responsibilities for each functional area.

The charter demonstrates an organisation is serious about providing a safe clean environment by referencing the new star rating system which reflects the cleanliness of the whole area regardless of who is responsible for cleaning it.

All organisations are required to display the charter where it will be seen – for example, in or near ward and department entrances, outside lifts used by the public, and in circulation areas and waiting rooms. Templates have been provided so that charters throughout the NHS are of the same standard and format, so easily recognised by patients, the public, and staff. We recommend the charter is printed on A3 paper as a minimum, so it is easy to read.

It may not be practical to display the charter in some areas, such as an ambulance. An organisation must always seek a derogation to confirm that it is acceptable not to display the charter by submitting their completed charter to nhsi.estatesandfacilities@nhs.net, together with details of how they propose to make it easily accessible.

Organisations can edit the charter template, e.g. to insert logos and contact details, but some fields and headings are fixed and cannot be changed, such as cleaning task, cleaning frequency and responsibility, as this information must be retained to appropriately inform patients, the public and staff about cleanliness. For this reason, [Appendix 5](#) (separate document) gives more information on how to complete the charter, as well as editable templates for all functional risk areas and for blended areas, as well as worked examples.

Simon Corben

Director and Head of Profession NHS
Estates at NHS England and NHS
Improvement

1. Introduction

All those involved in providing healthcare cleaning services should work towards high quality, safe cleaning services that meet the needs and expectations of patients, the staff and public, to contribute to the overall patient experience and to high quality patient-centred care.

Delivering a high-quality healthcare cleaning service is complex, demanding and not to be underestimated. The aim is to ensure all cleaning-related risks are identified, minimised, and managed on a consistent, long-term basis, irrespective of where the responsibility for providing cleaning services lies.

Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires that healthcare premises are clean, secure, suitable and used properly and that a provider maintains standards of hygiene appropriate to the purposes for which they are being used.⁴ Further, the code of practice for preventing and controlling infections, and related guidance, states NHS bodies and independent providers of healthcare and adult social care in England must adequately resource local provision of cleaning services. They should also have a strategic cleaning plan and clear cleaning schedules and frequencies so that patients, staff, and the public know what they can expect.

An effective healthcare cleaning service should:

- be patient and customer-focused
- provide clarity for all personnel responsible for ensuring the healthcare environment is clean and safe
- enhance quality assurance systems
- address governance and risk assessment
- be consistent with IPC standards and requirements
- meet the requirements of CQC outcome standard Regulation 15 key criteria (1 and 2) in the Health and Social Care Act Code of Practice 2015 in terms of legal responsibilities for a cleaning lead, personal responsibilities, the need for audit, governance and reporting
- set clear outcome statements that can be used as benchmarks and output indicators
- have clear objectives that provide a foundation for service improvements
- be flexible to meet the needs of specific healthcare environments circumstances, and priorities
- have well documented cleanliness policies and procedures
- provide for a culture of continuous improvement
- be flexible, to meet the ongoing needs of operational service delivery

⁴ See regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (SI 2014 No.2396)

- consider the health, safety, and wellbeing of patients, staff, and the public
- be efficiently delivered

The *National standards of healthcare cleanliness 2021* (the national standards) apply to all healthcare settings – acute hospitals, mental health, community, primary care, dental care, ambulance trusts, GP surgeries and clinics, and care homes, regardless of the way cleaning services are provided. They provide a common understanding of what it means to be a clean healthcare setting and give healthcare organisations in England a framework for detailing the required cleaning services and how ‘technical’ cleanliness and the efficacy of the cleaning process should be assessed. They replace the *National specifications for cleanliness in the NHS 2007* (and amendments) published by the National Patient Safety Agency, and the *Healthcare cleaning manual*, revised by the Association of Healthcare Cleaning Professionals (AHCP) in 2013. Together with the Health and Social Care Act 2008 and associated regulations, these provide an assurance framework to support compliance with the core cleanliness standard and the code of practice. The cleaning methodologies referred to are provided for guidance only.

The standards do not state precisely how cleaning services should be provided, e.g. by direct employment or contracting out. Such matters are for local determination. Ultimately, local management teams are accountable for the effectiveness of cleaning services.

The standards provide clear advice and guidance on:

- what cleaning is required
- how organisations can demonstrate cleaning services meet these standards

Recommendations are based on sound evidence and accepted good practice relating to using equipment and avoiding the transfer of healthcare-associated infections in the UK.⁵

The standards will support:

- the basis for developing specifications for service-level agreements or local procedures
- a benchmark against which to compare services
- establishing the optimum levels of resource to deliver safe cleaning standards
- part of an ongoing performance management process
- a framework for auditing and monitoring
- as a tool for improving patient and visitor satisfaction

⁵ <https://www.gov.uk/government/collections/healthcare-associated-infections-hcai-guidance-data-and-analysis>
<https://www.england.nhs.uk/wp-content/uploads/2015/04/10-amr-lon-reducing-hcai.pdf>
<https://improvement.nhs.uk/resources/healthcare-associated-infections/>

2. General principles and definitions of cleaning and disinfection

The principles behind effective cleaning and disinfection must be understood and applied to all cleaning tasks or equipment.

2.1. Definitions

The terms cleaning, disinfection, decontamination, and sterilisation are not interchangeable, and their differences need to be understood.

Cleaning: Involves 'fluid' – usually detergent and water, and 'friction' – the mechanical or physical removal of organic matter including dirt, debris, blood, and bodily fluids. Micro-organisms are removed rather than killed. Effective cleaning leaves a surface or equipment visibly clean. This alone may be enough in foyers, offices, corridors and other 'low risk' environments, the disinfection is also needed in many healthcare environments. Cleaning is a pre-requisite to effective disinfection. Some disinfectants are readily deactivated by organic matter.

Disinfection: Process of eliminating or reducing harmful micro-organisms from inanimate objects and surfaces.

Sterilisation: The process of killing all micro-organisms through physical or chemical means. Sterilisation is used only for critical items, i.e. objects or instruments that enter or penetrate sterile tissues, cavities, or the bloodstream.

Decontamination: Cleaning, disinfection and sterilisation are all decontamination processes. In the context of the environment or non-critical equipment (i.e. equipment or devices that are in contact with intact skin only), the term is usually refers to cleaning and disinfection, either using separate cleaning and disinfecting agent in a two-step process, or a '2 in 1' product that cleans and disinfects in one step.

2.2. Choice of cleaning/disinfecting agent

Local policy should outline where and when detergent and water are enough and where a detergent and disinfectant (or combined cleaning and disinfecting agent) are required.

Staff should be:

- familiar with the local policy and how to make up any cleaning/disinfecting solutions in line with manufacturers' instructions
- trained in how to prepare any disinfectants safely in a well-ventilated area and wearing the appropriate PPE
- know how to store unused product and how to dispose of it safely

2.3. Contact time

A disinfectant must be in contact with a surface for a specified time and the surface needs to remain wet for that time. Staff should know the contact times for the disinfectants in use locally. Products with realistic contact times for use in a busy healthcare environment should be selected.

2.4. Direction of cleaning

To minimise recontamination of an area and transfer of micro-organisms, clean from:

- top to bottom
- clean to dirty

Dusting technique should not disperse the dust (i.e. use damp cloths/dusting devices). High horizontal surfaces should be cleaned first.

Floors should be cleaned last, with adequate signage placed while floors are cleaned and dry to prevent slips, trips and falls on wet floors. Once floors are completely dry, they must be removed as they present a trip hazard.

2.4. Manual cleaning action

Large and flat surfaces should be cleaned using an 'S' shape motion, starting at the point furthest away, then overlapping slightly but without going back over the area to avoid recontamination.

2.5. Frequent touch points

Frequent touch points in patient care and procedural areas, such as door handles, call bells, light switches, cot sides and bedtables, should be cleaned more frequently than other surfaces.

2.6. Transference

During use cleaning solutions can become contaminated during use and need to be regularly replaced in accordance with manufacturers' instructions to prevent transfer of micro-organisms from one surface to the next. Their replacement may need to be more frequent when cleaning heavily soiled areas, when solutions appear visibly dirty, and immediately after cleaning blood and body fluid spills, e.g. when using a socket mop.

Micro-organisms can be transferred between surfaces on cleaning cloths and wipes as well as hands. Care should be taken to avoid cross contamination.

3. Cleaning responsibilities

Those responsible for cleaning will vary (cleaning services providers, nursing, and other clinical and non-clinical staff (including housekeepers) and estates staff), depending on the size of healthcare establishments and the clinical and non-clinical equipment they house.

Assigning responsibility for specific cleaning functions is a significant and essential task. Cleaning professionals' experience suggests items such as patient-related equipment can easily 'fall through the gaps'. To capture all items that require cleaning, clinical and non-clinical teams must be consulted when agreeing local cleaning responsibility frameworks.

Healthcare establishments must produce a local schedule of cleaning responsibilities detailing all items to be cleaned and who is responsible for cleaning each one. This must allow enough time to complete specific training tasks, and training to do this, regardless of the team member assigned to the task.

To help you with this:

- [Appendix 1](#) (separate document) gives an example cleaning responsibility framework with suggested cleaning frequencies and responsibilities to meet safe standards. Clear assignment of responsibilities and cleaning whole items in one process by one individual and/or staff group help with compliance. The cleaning responsibilities framework in Appendix 1 is an example only and can be adapted to meet local needs and must be reviewed regularly by each organisation
- [Appendix 2](#) (separate document) lists the 50 broad elements of clinical and non-clinical 'items' that require cleaning in healthcare environments. A national list of all items that may require cleaning is impractical

4. Safe cleaning frequencies

Discussions with NHS cleaning service providers indicates that one nationally set of safe cleaning frequencies cannot meet every healthcare organisation's needs and is therefore inappropriate. It would also stifle healthcare organisations' ability to allocate cleaning resources where they are most needed, and potentially compromise the requirement to give clinical teams more control in terms of agreeing where available cleaning services are best deployed. However, the safe cleaning frequencies in [Appendix 2](#) (separate document) are a required baseline for healthcare organisations.

If healthcare organisations choose to enhance frequencies or take a blended approach ([8.6](#)), they must have a clear written rationale and risk assessment for this, as well as a supporting local safe cleaning schedule.

Organisations are also expected during times of pandemic such as the current COVID-19 outbreak to respond accordingly by re-evaluating their cleaning frequencies and keep up to date with any national advice or guidance.

5. Risk categories and standards for functional areas

5.1. Purpose

All healthcare environments should pose minimal risk to patients, staff, and visitors, but because different functional areas do not carry the same degree of risk, they will require different cleaning frequencies and levels of monitoring and auditing. For example, a records storeroom will not require as frequent cleaning as an intensive care unit.

All functional areas must be assessed and assigned to one of six functional risk (FR1–6) categories (see [Table 1 in Section 8.5](#)).

Identifying the FR category for functional areas is the crucial first step in applying the standards: the cleaning, monitoring and audit frequency and audit target scores are all directly linked to this.

Adoption of all six FR categories where practicable is considered good practice but is not mandatory, for example, an organisation may choose to use FR1 98%, FR2 95%, FR4 85% and FR6 75%, or any other combination. Healthcare organisations must have a sound written rationale for deciding not to adopt all six FR categories (see governance for FR areas [section 8](#).) as this must not jeopardise achieving safe standards in individual or collective functional areas.

To help you:

- [Appendix 3](#) (separate document) is a guide to which functional areas might be allocated to each FR category, but ultimately risk identification must be locally decided as no two organisations are the same.
- Use the relevant FR audit score and cleaning frequency to help determine which areas qualify for which category.

5.2. Cleaning specifications – elements, cleaning frequencies and performance parameters

Once an organisation has identified its functional area risk categories, it must produce a ‘cleaning specification’ with more detailed information on how cleaning will be carried out. This specification should include:

- cleaning elements – a list of individual items/categories of items that require cleaning
- performance parameters – the expected standard of each item (element) after cleaning
- cleaning frequencies – how often each item (element) should be cleaned, broken down by FR category.

Organisations may also include information on who is responsible for cleaning each item (element), but this should be in addition to, not instead of, developing a cleaning responsibilities framework (see [Appendix 1](#) (separate document)).

The frequency of cleaning must be broken down by FR category. In the same way that functional areas need to be categorised according to risk, the frequency with which individual elements need to be cleaned will depend on the risk category they fall in. For instance, a toilet in an A&E department will need to be cleaned more often than one in a low traffic admin area.

To help you:

- [Appendix 2](#) (separate document) is an example cleaning specification template that can be adapted for local use. Organisations do not have to follow the same format if what they use covers the key information detailed in this section. Frequencies outlined in the appendix are designed to help organisations achieve the required outcomes

The example specification is a guide only because a single national approach is unlikely to meet the needs of every healthcare organisation and location. But in adapting it for local use, cleaning frequencies must not be reduced below the levels suggested; these are based on what are regarded to be the safe standards for meeting the performance parameters and achieving cleaning audit target scores. Meeting the required cleaning frequencies may be achieved via several different groups of staff including clinical colleagues e.g. theatres. Organisations should base their decisions on frequency on IPC risks but also consider patient/public confidence and aesthetics. A floor in a public corridor will not generally be considered a high IPC risk, but its cleanliness significantly impacts on confidence.

The example cleaning specification uses the 50 cleaning elements most found in healthcare settings (see [Appendix 2](#) – separate document), a list that is not intended to be exhaustive. Healthcare organisations may add or delete elements to the specification where they do not exist in the organisation or to meet the individual needs. For example, an organisation may create a separate element on the specification for picture frames but for auditing purposes will need to consider it under ‘high surfaces’. Any added elements should be reflected in an organisation’s cleaning responsibility framework.

The example cleaning specification details the performance parameter i.e. the expected standard of cleanliness of each element after cleaning.

5.3. Cleaning frequency definitions

To make best use of resource and meet all requirements, organisations are strongly recommended to differentiate between types of cleaning in their cleaning specifications. For instance, many items may not always need to be cleaned daily, but it may be important to validate this – the intention of a ‘check clean’. Five routine cleaning frequency definitions should be used:

- **Full clean** – cleaning all elements using an appropriate method to remove all visible dust, dirt, marks, and contamination, leaving the item in accordance with the required performance parameters
- **Spot clean** – cleaning specific elements using an appropriate method to remove all visible dust, dirt, marks, and contamination, leaving the item in accordance with the required performance parameters

- **Check clean** – a check to assess if an element meets the performance parameters. If it does not, a full or a spot clean should be undertaken (in line with the above) to bring the element up to the performance parameter level
- **Periodic clean** – full clean of an item at a set interval as part of routine environmental maintenance where daily or weekly activity is not required. This becomes periodic; fortnightly, monthly (four weeks), quarterly (12 weeks), six-monthly or annually. Periodic cleaning of items less frequently than fortnightly or monthly (e.g. carpet washing, floor stripping/polish/sealing and external window cleaning) is not considered routine and should form part of a planned and documented annual programme
- **Touch point clean** – a full clean of items that are frequently touched (identified in [Section 5.5](#); see also [Appendix 4](#) (separate document)) using an appropriate method to remove contamination

5.4. Enhanced cleaning

The above frequency definitions are based on routine service provision. Organisations should recognise as part of their planning process that events may increase the resources their cleaning service requires, e.g. to manage IPC cleaning and during outbreaks.

Cleaning planning should clearly identify and document the specific extra steps required before, during and after a full clean in such circumstances. Organisations should base their identification of the extra steps required on local IPC policy and advice, in line with national guidance and good practice.

5.5. High frequency touch points

Hand-mediated transmission is a major contributor to the spread of infection in healthcare environments. Cleaning plans must recognise the importance of keeping frequently touched surfaces clean in minimising organism transfer between individuals and surfaces.

Organisations should give elements that are high frequency touch points⁶ consideration when developing their cleaning specifications. [Appendix 4](#) (separate document) provides a non-exhaustive list of high frequency touch points, but each organisation should make its own assessment depending on the area and service delivered.

Their cleaning frequencies should be adjusted accordingly: this can be done by focusing on the specific high-risk parts of an element, e.g. cleaning the door handle more frequently than the door. The example cleaning specification in [Appendix 2](#) (separate document) includes weighting towards high frequency touch points.

⁶ Touch points were previously referred to as contact points.

5.6 Blended area approach

The blended area approach for functional risk areas is an option for healthcare organisations wanting more flexibility and to maximise resource allocation. It does add a layer of complexity as it requires in-depth profiling of an establishment and an electronic audit system. Calculating the blended percentage scores without an electronic audit system is very complicated and across a large organisation would require significant administrative resource.

The methodology for categorising whole FR areas is based on applying the same risk rating to each room within an area. However, individual rooms within a functional area may require a different cleaning frequency and clinical outcome and hence a different risk rating. Categorising the whole of a functional area under one FR rating, i.e. FR1, FR2, FR3, FR4, FR5 or FR6, could result in certain parts of it being cleaned either too much or too little.

For this reason, within each FR area, based on risk assessment according to activity, a different risk category can be allocated to individual rooms – the blended approach, e.g. FR5 for an office or a meeting room, FR3 for a staff room and FR2 for an inpatient room. These rooms will then be cleaned according to their risk category, not that of the functional area within which they are located.

This approach may also facilitate better use of resources by focusing on the risk of individual rooms rather than that of an entire area.

If this approach is adopted, it must be based on activity, not type of room: for example, if clinical staff use an office in a clinical area, it is likely to need the same frequency of cleaning as the rest of the functional area. It is important to determine the risk each individual room or area poses and make a pragmatic decision based on this.

The proportion of areas in each risk category within a functional area will determine the overall functional area risk assessment, and a new overall target score can be calculated: see [examples 1 and 2 in Section 8.6](#). If most rooms fall into one FR category, that will be the overall rating for the functional area; for example, if ten rooms are in FR2, five in FR3, and one in FR4, the rating for the would be **FR2 blended**. If there is an even split across the rooms in a functional area then the highest FR rating must be adopted; for example, if ten rooms are in FR3 and ten in FR4, the rating for this area must be **FR3 blended**.

While the cleaning frequency for FR blended areas is controlled by the FR rating of individual rooms, to facilitate the set up and maintenance of an electronic audit system, the auditing frequency for FR blended areas and FR areas will be the same.

5.6. Cleaning operations through a pandemic

The cleaning service is always key but never more so than during a pandemic.

Many local protocols cease and guidance from governing bodies such as Public Health England, NHS England and NHS Improvement are issued nationally. The director of IPC will be the conduit for risk-based assessments of the care environment and assist in the interpretation of the national guidance to maximise cleaning services locally.

The specific advice will depend on the organism causing the pandemic but generally organisations should:

1. Follow all issued operational guidance such as standard operating procedures (SOPs), methodologies, etc.
2. Ensure staff are trained in all new procedures and guidance and that all staff have appropriate risk assessments to monitor personal risk factors.
3. Personal protective equipment (PPE) must be available and suitable for the guidance issued.
4. Where possible dedicate staff to the areas of the building that are affected by the pandemic.
5. Review with the director of IPC and the IPC team whether the frequency of cleaning for all FR categories, and especially that for touchpoints, is appropriate to the organism.
6. Review the auditing frequency and consider minimising activity within affected areas. An agreed monitoring protocol for use during the episode should be drawn up and documented for future reference.
7. Ensure consistency across all facilities management services.

6. Importance of effective cleaning: infection prevention and control

These standards support the development of local risk management plans by providing a framework for assessing the effectiveness of cleaning programmes. The director of IPC – or nominated lead for non-NHS providers – and IPC teams must be involved in their development and implementation as well as being regularly told the results of assessment, monitoring and audit.

Personal responsibility and accountability are crucial to maintaining a clean and safe environment. Objectives should reflect the deliverable outcomes for cleanliness, to incorporate them in the healthcare organisation's performance frameworks and ensure staff are accountable for meeting them.

6.1. Classification of infection risk and cleaning frequencies

The type and frequency of cleaning spaces require, depends on what activities are carried out in them, and the level of infection risk.

Staff should fully understand the cleaning frequencies their work areas require and follow these closely. When room use or priorities change, the cleaning frequencies for the area should be reviewed.

6.2. National colour-coding scheme

A national colour-coding scheme for all cleaning materials and equipment is widely applied throughout healthcare organisations to reduce cross-contamination risk between different types of area, e.g. bathrooms and kitchens (see Figure 1). For example, cloths (reusable and disposable), mops, buckets and non-disposable gloves that are colour-coded red are only used in bathroom facilities. The colour coding is clear and permanent. Any deviation/derogation from this requires approval from NHS England and Improvement via nhsi.estatesandfacilities@nhs.net.

Figure 1: National colour-coding scheme



Source: Association of Healthcare Cleaning Professionals

The simplicity of this scheme means staff can easily observe this safe working practice.

Cleaning products (chemicals and detergents) do not need to be colour coded and the coding does not extend to catering equipment (e.g. chopping boards and knives) which already has well-recognised and established procedures for food hygiene and food separation.

6.3. Employer responsibilities

Under the [Health and Safety at Work Act 1974](#), an employer has a legal duty to protect employees and others (agency workers, contractors) from workplace injuries and ill-health, including work-related dermatitis.

Organisations are required to ensure all their staff are appropriately trained in using gloves and other PPE.

6.4. Disposable plastic aprons

Disposable plastic aprons should be worn for all cleaning tasks where clothing is likely to be splashed. An organisation can procure colour-coded aprons if it wants to limit the likelihood the same apron will be worn in different risk areas. Cleaning methodologies should clearly indicate if aprons should be worn when cleaning rooms occupied by patients being cared for in isolation because they have specified infections.

For certain specialised cleaning tasks involving large amounts of fluid (e.g. flood response), risk assessment may indicate overalls and waterproof footwear need to be worn.

6.5. Protective gloves

Protective domestic gloves should be worn for all cleaning tasks. These should be sturdy, suitable for purpose and comply with the national colour-coding system. Gloves should be inspected before use to ensure that they are intact. Where the task involves the use of chemicals, the gloves should be certified as suitable for chemical resistance and comply with the PPE Directive (89/686/EEC).

Local infection prevention and control teams may advise on the use of single-use gloves in certain circumstances such as outbreaks or patients being nursed in isolation for specified infections.

Gloves should be cleaned regularly between cleaning tasks. Use of gloves does not reduce the requirement for hand washing.

Latex free gloves should be available to the above specification where a latex allergy has been identified.

6.6. Hand Hygiene

Hand washing is one of the most important steps in reducing the risk of transferring infections in a healthcare environment. The correct hand washing technique should form part of all mandatory training with a programme of ongoing monitoring for all staff.

Good hand hygiene helps stop organisms being transferred from one patient to another, known as cross contamination. It is important to stop the transfer of organisms moving in this way as this can cause infections.

When working in a healthcare environment there are three important questions about hand hygiene:

When? With what? How?

When should I clean my hands during work?

The Five Moments approach for hand hygiene defines the key moments when healthcare workers should perform hand hygiene. The approach was developed by the World Health Organisation and is used by the national cleanyourhands campaign to help everyone working in healthcare to decide when to clean their hands. The Five Moments are: before touching a patient, before clean/aseptic procedures, after body fluid exposure/risk, after touching a patient and after touching patients surroundings.

What should I use to clean my hands and how should I use it?

There are two things you can use to clean your hands: washing with soap and water, or you can use alcohol hand rub. Both are acceptable ways to clean your hands. It is important to make sure your hands are cleaned thoroughly to ensure acceptable decontamination is achieved.

See the technique diagram below for how to do this:



Although alcohol hand rub is a quick and easy way to clean your hands, especially when a sink is not easily accessible, there are times when you must wash your hands with soap and water:

- Always wash your hands with soap and water when hands are visibly soiled. This is because alcohol hand rub kills germs on clean hands, but because it's not soap it can't dissolve grease or oil, so if hands are soiled, they need to be washed. Usually this is after so many uses of alcohol hand rub and will be advised as part of your training.
- Hands that have come into contact with body fluids. This is because the mechanical action of washing is important in removing any body fluid material that may be on the hands.
- Cleaning in an area where a patient has diarrhoea and/or vomiting. This is because alcohol hand rub does not kill some of the germs that cause diarrhoea and vomiting.

Some important points

Cleaning staff are important members of the healthcare team; in fact, cleaning is one of the most important tasks in keeping patients safe from infection. It is therefore important that cleaning staff are kept informed of patients requiring isolation cleaning both barrier and protective.

Remember that gloves can move organisms around just as well as hands. Wearing gloves does not replace the need for hand hygiene.

Training and support

All healthcare establishments in England and Wales have access to the national clean~~your~~hands campaign. If your organisation is already part of the campaign you will have a coordinator, usually in your infection prevention and control team, who can supply you with more information on the Five Moments as well as training material. It is the responsibility of the organisation to ensure staff have the appropriate training for their job. Hand hygiene training must be part of Healthcare training for all staff and reviewed regularly.

6.7. Training

Cleaning is a vital part of the overall infection prevention and control (IPAC) process, which aims to provide a clinically clean and safe environment for delivering patient care. Areas that are not cleaned properly could aid the transfer of harmful organisms in a healthcare environment, potentially causing infection. For this reason, the importance of robust training is paramount. All levels of the cleaning team, as well as anybody else undertaking cleaning tasks, should be clear about their roles and responsibilities.

Cleaning regimes should be underpinned by Standard Operating Procedures and any other national guidance, as well as the current cleaning manual (2009)⁷, which will be updated and relaunched in Spring 2021.

6.8. Accidental exposure to blood or substances

Inoculation injuries, such as needlestick, other sharps injuries, bites, scratches and splash contamination of broken skin, require immediate action and organisations should ensure that staff know what their local policies are.

The staff member should contact either the occupational health department or A&E department for further advice, whichever is specified by the healthcare provider's policy. The incident should be reported to a manager who should ensure it is recorded.

Splashed intact skin should be washed immediately with warm soapy water. If the mouth is splashed it should be rinsed out with large quantities of water and reported. Splashed eyes should be irrigated immediately with water – or, if available, sterile saline from an eye station – and reported.

6.9. Spillages of bodily substances

'Bodily substances' refers to fluid or tissue issuing from a patient either directly or indirectly in the form of, for example, a specimen. Staff with cleaning responsibilities are most likely to encounter wound exudate, blood, vomit, sputum, urine and faeces.

Spillages may be cleaned up by nursing/departmental staff or cleaning staff. A healthcare provider's local policy on cleanliness will have clear instructions on whose responsibility this is. Staff members performing this duty must have been trained in spillage cleaning and follow the method statement for this.

6.10. Uniforms and jewellery

The guidance in this section is consistent with the [Department of Health's uniform and workwear guidance 2007](#).

Hand and wrist jewellery can harbour micro-organisms and reduce compliance with hand hygiene. Wristwatches and jewellery should be removed at the beginning of a shift. Organisation policy for jewellery should be followed.

Line manager should ensure that all staff follow local uniform policy and follow up issues of non-compliance. Uniform sleeves should either end above the elbow or be kept rolled up above the elbow when undertaking cleaning duties.

Staff should change into a clean uniform before each shift, and if the uniform becomes visibly contaminated or soiled during a shift, they should change into another one as soon as they can.

⁷ <https://www.ahcp.co.uk/wp-content/uploads/NRLS-0949-Healthcare-clea-ng-manual-2009-06-v1.pdf>

Uniforms should be worn only while on duty, except where a local healthcare provider policy specifies otherwise.

Wearing numerous badges should be avoided. All staff should follow their organisation's policy for name badges and/or ID.

6.11. Waste management

Waste management is the generic term for a range of waste-associated activities –its generation, handling, storage, and transportation from point of source (e.g. treatment or consultation room) to final place of disposal (recycling, alternative treatments and composting or incinerator). Improper waste management risks staff safety and could affect a wider network of people including patients, visitors, and waste contractors.

Organisations are responsible for ensuring compliance with legislation around the segregation of waste. **They have a duty of care for waste from cradle to grave (including incineration)** and therefore need to understand the different disposal routes for all the waste they produce.

The segregation, collection, storage, handling, transportation, and disposal of waste must be undertaken with care and in line with local policy and procedure.

Cleaning and waste management are intrinsically linked. The safe and effective management of each one relies on the successful application of the other. Organisations should ensure that cleaning processes and systems, including the adoption of these standards, reflect local policy relating to waste. All waste management activities should also comply with national guidance and good practice ([Health Technical Memorandum – Management and disposal of healthcare waste 078433](#)). As a starting point, consider:

- roles and responsibilities relating to waste
- waste training
- waste classification, categories (streams) and colour coding
- waste storage and transport arrangements
- PPE and standard precautions
- application and use of waste disposal equipment
- risk management and incident reporting
- spillage management procedures, including accidental exposure

7. Governance

The national standards require all healthcare organisations to meet safe standards of cleanliness to minimise risk to patient safety from inadequate cleaning.

Healthcare organisations should therefore have a strategic plan detailing how they will ensure a clean and safe environment for everyone using or working in their healthcare facilities and develop cleaning policies that are ratified by a relevant committee with board membership, e.g. the IPC committee.

The policies should cover all cleaning activity within the organisation – that is, undertaken by cleaning teams as well as estates technical services staff, clinical staff and other staff groups such as housekeepers, catering, laboratory and portering staff – and, where relevant, underlying specifications and procedures.

They need to identify the strategic aims and how, through liaison between the director of IPC, facilities management and the IPC team, the requirements of the national standards will be met.

The responsible board members should ensure that who are staff responsible for cleaning understand their personal responsibilities; develop systems and procedures that support good practice and delivery of the national standards; implement and follow guidance and procedures; follow reasonable instructions and procedures; and are trained in these procedures.

Local managers will update the organisations cleaning policy to ensure the national standards are met.

Responsible departmental managers will be required to investigate substandard performance and report the remedial actions to improve, e.g. changing cleaning frequencies, to the appropriate committee, and provide assurance that these actions have been. The committee will review any resource implications required to deliver improvements identified in the improvement plan ([See section 8.7](#)).

7.1. Committee and board reporting

Committee/board papers may include a report on each functional area's cleaning performance including audit scores and the frequency of audit. Reports should detail:

- cleanliness audit scores and any areas where remedial action is required
- details of any areas that have failed to achieve a 5, or 4, star rating and the actions taken to improve in the areas
- efficacy audit plan and scores against the plan, with any areas for concern identified
- any recommended strategic changes for agreement by the committee/board, including the resource implications of changes
- assurance that star ratings are correctly displayed and updated
- assurance that cleaning frequencies are displayed using the commitment to cleanliness charter

- assurance that efficacy audits are carried out and that they meet agreed standards and remedial action is taken to rectify any non-conformance
- confirmation that an annual external audit is undertaken to assure the quality and methodology adopted by the healthcare organisation

8. Auditing and monitoring information

8.1. Purpose

Healthcare organisations need to provide assurance at all levels that their establishments are meeting and maintaining safe standards of cleanliness, and be able to demonstrate to patients, staff and the public that cleanliness meets the required standards. This supports IPC good practice by ensuring patients, staff and the public are confident that the use of both visual and efficacy audits provides the assurance that safe standards of cleaning are met.

Auditing in all types of healthcare setting should provide clear evidence that cleanliness standards are being met safely and responsibly, and where they are not, detail any service deficiencies and areas for improvement.

8.2. Principles

The audit principles for the national standards provide a national approach to auditing healthcare cleanliness in all types of healthcare settings. The overarching aim is to encourage safe standards of cleanliness in all healthcare environments. The audit process is designed to be easy to use and adaptable to local requirements.

Cleaning and infection prevention are intrinsically linked. It is therefore essential to demonstrate cleaning efficacy by auditing both the outcome of cleaning and the process by which the cleaning standards are achieved. To meet safe standards, the efficacy of the cleaning process is as important as the technical outcomes of cleaning, which is why it is now an area of focus.

Providing assurance that cleanliness has been delivered is critical; therefore, displaying the overall cleanliness result is now an important part of the audit process.

8.3. Audit risk categories

As described in [Section 5.1](#), the audit standard operates according to six functional risk (FR) categories and six target audit scores. Each cleanable clinical and non-clinical functional area in a healthcare facility is allocated to a FR category, the crucial first step in applying the standards since the level of monitoring and audit directly links to the allocated FR.

[Section 9](#) provides full guidance on the recommended audit frequencies for each of the six FR categories.

8.4. Audit scores

The audit scores for each functional area are represented in two ways: **a percentage score** and **a star rating score**. The percentage score is for internal verification and scrutiny that a safe standard has been achieved, whereas the star rating score is for external verification of this.

Percentage scores are still split by responsible staff group, i.e. cleaning, nursing, estates, etc, to understand if there are any gaps in performance. However, the star rating score is determined from the average percentage for all responsible staff groups.

Star ratings are widely used in many other industries such as hotels, restaurants and the media, as well as professional organisations such as the food safety ratings provided by local authority Environmental Health Departments for food premises; such a system for healthcare cleanliness will be instantly recognisable and easy-to-understand for patients, the public and staff.

8.5. Percentage score

The target percentage scores for the six FR categories are shown in Table 1.

Table 1: Functional risk categories and associated audit target scores

Functional risk category	Audit target score	Audit frequency*
FR1	98% and above	Weekly*
FR2	95% and above	Monthly*
FR3	90% and above	Every 2 months*
FR4	85% and above	Every 3 months*
FR5	80% and above	Every 6 months*
FR6	75% and above	Every 12 months*

* See [Section 9](#) for recommended audit frequencies.

8.6. Other options

Not adopting all functional risk categories

Adoption of all six FR categories is considered good practice but is not mandatory, for example, an organisation may choose to use FR1 98%, FR2 95%, FR4 85% and FR6 75%, or any other combination. Healthcare organisations must have a sound written rationale for deciding not to adopt all six FR categories (see [governance for FR areas](#)) as this must not jeopardise achieving safe standards in individual or collective functional areas. Adopting all six FR categories allows for the smooth transition from the National Specifications for Cleanliness in the NHS 2007 and gives the flexibility often sought by different healthcare environments.

Blended area option

The target for a blended area is based on the combined targets for rooms in each functional area. The final star rating is capped; the functional area is assigned the **highest rating** from:

- the combined calculated score for the entire blended area **or**
- the score for the highest risk category audited.

Blended example 1: Outpatient area

Targets

This outpatient area has twelve rooms, two of which are minor operations suites that are higher risk.

Risk category	FR target % score	No of rooms	Target calculation	Audit frequency
FR2	95%	2	$2 \times 95 = 190$	Every 3 months
FR4	85%	10	$10 \times 85 = 850$	Every 3 months
FR4 Blended	87%	12	$(190 + 850)/12 = 86.66\%$	Every 3 months

The overall functional risk category is **FR4 blended** with an overall target score of 86.66% (rounded to 87%) and an audit frequency of every three months.

While the overall target is 87%, the star rating is capped to the average score of the rooms audited at the highest risk category. If the highest risk category target is **not** achieved for the room(s) to which it is assigned, then the combined score of the lower

risk categories cannot result in a 5 star rating. **The FR2 room(s) must achieve 95% to achieve a 5 star rating (refer to star rating percentages see [Appendix 6](#) (opens in a separate document)).**

Calculations and rating

Risk category	FR target % score	No of rooms	Rooms audited	Example score	Star rating
FR2	95%	2*	2*	$37/40 = 92.5\%$	4 stars
FR4	85%	10*	8*	$120/120 = 100\%$	5 stars
FR4 blended	87%	12	10*	$153/155 = 98.1\%$	4 stars

The overall score is 98.1%. This surpasses the blended target of 87% for the functional area, however a 5-star rating is not achieved because the FR2 rooms have not achieved their 95% target. The rating for the functional area is capped at the 4-star rating achieved for the FR2 rooms.

* As stated in [Section 9.1](#), in small areas with ten or fewer rooms it is good practice for all of these to be audited at the same time. Please note classifying one room as an FR area will not give an accurate reflection of the quality of cleanliness across the healthcare organisation. However, where a room attracts a higher risk score compared to the overall blended category, then it must be audited according to its risk audit frequency.

Blended example 2: General inpatient ward

Targets

This is a general inpatient ward with rooms in a mix of FR categories.

Risk category	FR target score	No of rooms	Target calculation	Audit frequency
FR2	95%	15	$15 \times 95 = 1425$	Monthly
FR3	90%	3	$3 \times 90 = 270$	Monthly
FR4	85%	2	$2 \times 85 = 170$	Monthly
FR2	93%	20	$(1425 + 270 + 170)/20 = 93.25\%$	Monthly

blended				
---------	--	--	--	--

The overall category is **FR2 blended** with a target score of 93.25% (rounded to 93%) and an audit frequency of monthly.

Calculations and rating

Risk category	FR target % score	No of rooms	Rooms audited	Example score	Star rating
FR2	95%	15	8	310/320 = 96.9%	5 stars
FR3	90%	3	1	13/15 = 86.7%	3 stars
FR4	85%	2	1	23/30 = 76.6%	2 stars
FR2 blended	93%	20	10	346/365 = 94.8%	5 stars

The overall score is 94.8% (rounded to 95%). This surpasses the blended target of 93% for the functional area. A 5-star rating is achieved because the FR2 rooms have achieved/surpassed their 95% target (96.6%).

Governance for functional risk areas

Whether a healthcare organisation decides to adopt the six functional risk categories or the blended approach, it must ensure documentation clearly outlines the allocation process it is using. This should cover:

1. A written rationale for how the risk category has been derived for each functional area, or room/group of rooms if blended.
2. Regular review of the functional area (at least annually, or when there is a significant change in clinical activity), to ensure that the rationale and risk ratings are still appropriate.
3. A written record of the functional area review.

8.7. Star rating score

[Star ratings](#) are a simple and effective means of providing meaningful information about quality to patients, the public and staff (see [Figure 2](#)). When used in the correct way, they will reassure patients, the public, departmental and clinical leads, and staff about cleanliness, and enhance the profile of cleaning. They patients, staff and public, are based on the cleanliness not the condition of the building and reflect the cleanliness of a functional area regardless of who is responsible for cleaning each element of it, e.g. cleaning, nursing, estates and other staff (physio, ward housekeepers, porters, catering, laboratory, etc).

Figure 2: Star rating displays



When agreeing where to display the star ratings, organisations should consider disparate sites, type of healthcare setting and the logistics of administering this process. Organisations may deem it impractical to display star ratings in some areas, e.g. in ambulances or community settings with numerous outbuildings.

We recommend that star ratings are only displayed in areas accessed by patients and where they will be visible, e.g. in or near ward and department entrances, outside lifts, and in circulation areas and waiting rooms, and close to the Commitment to Cleanliness Charter.

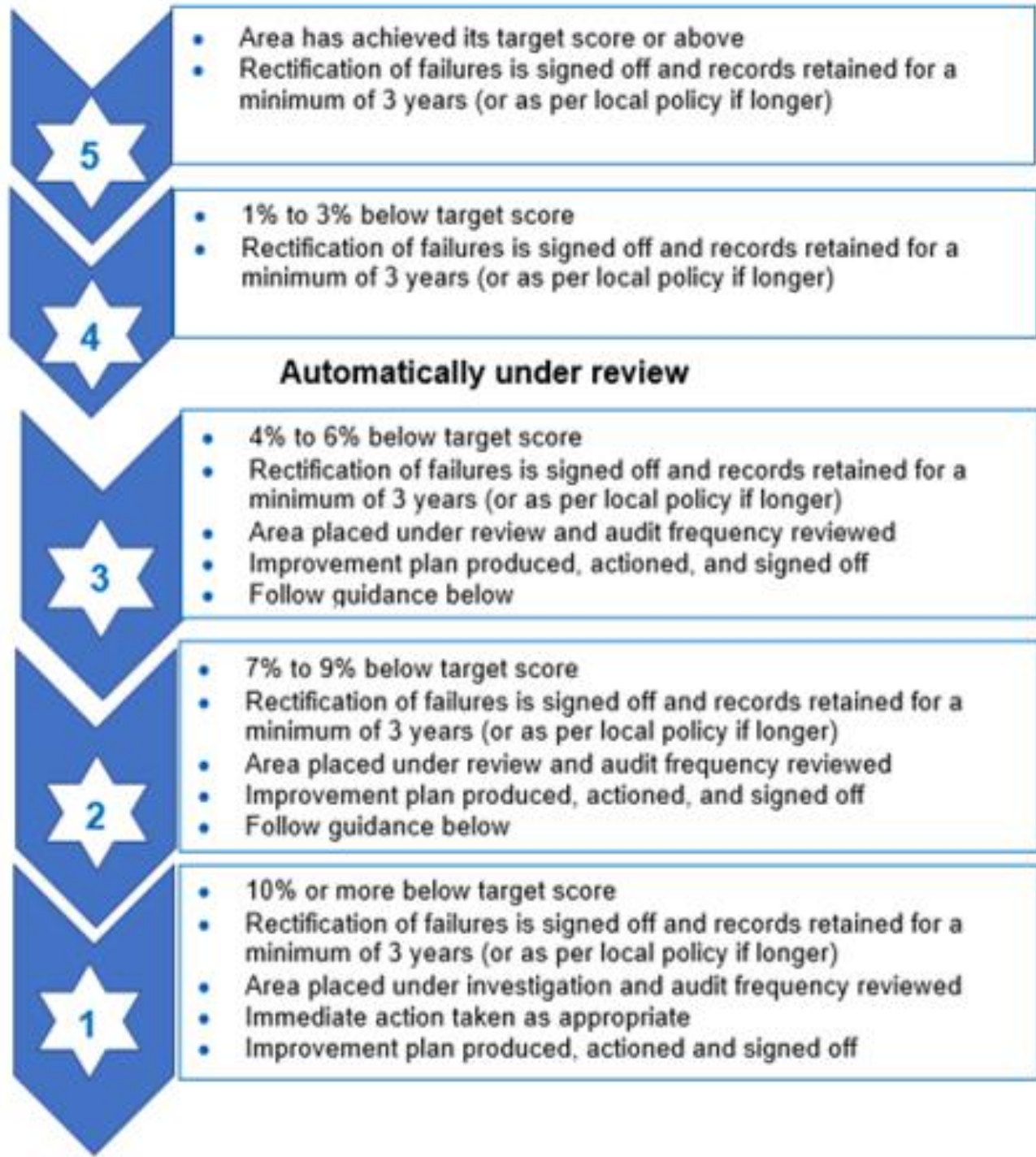
The star rating must be derived from the original audit score at the time of audit and cannot be updated as part of any subsequent rectification process. The star rating score can only be updated following the next full re-audit.

The star rating displays allow organisations to set the expiry date, to make the system easier to administer – for example, a longer expiry date can be set for an area that consistently achieves 5 stars at every audit, possibly up to 12 months. Of course, if an area's star rating changes before the expiry date for the display, it will need to be changed.

Functional areas rated at 3 stars or fewer must be subject to an improvement plan with agreed timescales appropriate to the functional area and the score achieved. **Please note that multiple rectifications may need to be co-ordinated by multiple responsible groups, e.g. failings could be attributable to both the cleaning and nursing teams, and successfully remedied before the star rating can be revised.** Even 5 star or 4-star ratings are likely to generate remedial actions to improve unless the functional area scores 100%.

The star rating rectification escalation flowchart in Figure 3 details the actions that must be taken following each audit of a functional area.

Figure 3: Star rating rectification escalation flowchart



All areas under automatic review are subject to an extensive improvement plan within a timescale appropriate to the issues identified. The cause of the poor result must be understood and those responsible involved in the rectification. All areas scoring 3 stars or below must be reported to the board representative(s).

An improvement plan should consider the following:

- an understanding as to how star ratings below 3 stars will affect patient, staff, and public perception
- an analysis of the failed elements and which staff group is responsible for cleaning each one i.e.
- whether audits have been at the right frequency and whether they indicated an issue
- a review of the cleaning input hours to determine if the resources are adequate or if there have been staff shortages
- a review of cleaning times to determine if the service is being delivered at the right time
- a review of the cleaning frequencies to determine if they are appropriate
- a review of the area to understand if there has been a significant change in its use
- whether the cleaning equipment, materials and consumables are suitable their supply adequate
- whether staff have been appropriately trained
- whether there is a staff competency issue
- whether there is an access issue
- whether an efficacy audit has been done in the last 12 months
- whether the area's risk rating has been reviewed and checked
- whether a temporary increase in monitoring has been considered until standards are consistently met and maintained.

8.8. Star rating implementation timescales

During the first six-month implementation phase for the national standards each organisation will continue to display only the cleaning scores as a percentage for each functional risk category, not the star rating. All other operational considerations in the star rating guidance should be implemented fully in this first phase, e.g. remedial actions

At six months the star rating will be displayed. This will be calculated from the percentage calculation scores displayed in the previous six months, so based on cleaning performance for elements that are the primary responsibility of the cleaning team.

After a further six months the star ratings calculations will include scoring for other responsible staff groups, i.e. nursing teams and estates teams.

9. Audit process

The integrity of the audit process is fundamental to providing assurance that an organisation is delivering safe standards of cleanliness. Accurate, honest and open audit reporting underpins the ethos of the standards – to drive safe standards and continuous improvement, whether a cleaning service is insourced or outsourced.

We expect organisations to have a robust process and transparent approach to auditing, to ensure the new standards are met. The audit process will ultimately encourage quality improvements and must not be punitive.

There are three audits:

1. **technical audit:** checks and scores cleanliness outcomes against the safe standard
2. **efficacy audit:** checks the efficacy of the cleaning process at the point of service delivery, i.e. the correct use of colour coding, equipment, materials, methodology, as well as supporting policies and procedures
3. **external audit:** provides quality assurance and checks both the technical audit and the efficacy audit

9.1. Technical audits

These regular audits, undertaken by appropriately experienced staff, are a continuous and integral part of the day-to-day management and supervision of cleaning services.

Timing

Technical audits should be randomly undertaken at different times and on different days, but with consideration for the frequency of cleaning and the cleaning schedule.

The time or frequency of cleaning and associated risk category need to be regularly reviewed and adjusted if indicated to continuously improve safe cleaning standards.

Auditors need to exercise discretion in judging the acceptability of any element (see [Appendix 7](#) for the technical audit process – opens in a separate document), for example, one or two scuff marks on a floor, an isolated smudge on a window or a hand towel/tissue dropped on a floor in an otherwise clean area should not be scored as unacceptable.

The audit score must accurately reflect the standard of cleanliness at the time. The need for transparency and openness is paramount to drive continuous improvement, for example, if some areas fall below the standard it is important for Organisations must be able to identify any areas falling below the standard so they can act to resolve the underlying cause.

Multidisciplinary teams

Good practice is to adopt a multidisciplinary approach to technical auditing periodically, to assess the cleaning from different perspectives. We recognise it may not be possible to routinely deploy a multidisciplinary team (MDT) and the frequency of such audits is for each healthcare organisation to decide. These teams should include both those responsible for delivering the service and those receiving the services, e.g. IPC teams and nursing staff, as well as non-clinical staff and service users.

It is also good practice on an ongoing basis for technical audits undertaken by the cleaning services department to be signed off at ward or department level by a member of the clinical/non-clinical team with responsibility for the functional area. The designated member of the clinical/non-clinical team should be agreed locally and will vary according to the needs of each organisation. This sign-off provides an opportunity to discuss the cleanliness of the functional area and validates the audit score.

Audit personnel

Audits, particularly technical audits, should not be the sole responsibility of the cleaning services department. They should be supported by all relevant stakeholders in the healthcare facility. It is important that results are available to all those responsible for cleaning each element in the functional area audited.

Managers and staff involved with audits should:

- have a detailed knowledge of healthcare establishments and procedures and the service-level agreements in place
- be professionally competent to judge what is 'acceptable' in terms of cleanliness and IPC (local protocols and agreements should support this)
- be able to make discriminating judgements on risk relating to the areas being cleaned and any associated risks relating to individual elements or items
- be able to make informed judgements on the extent to which existing cleaning frequencies may be insufficient

Those undertaking audits should receive regular training to ensure that they are proficient in making technical assessments of each functional area from considering risk, frequency, environment, and footfall. We recommend that managers and staff who audit on a regular basis receive annual training and that this is documented; to ensure professional competence, sound judgement of risk and understanding of the frequencies required to meet cleaning standards in different environments. The technical audit process detailed in [Appendix 7](#) (separate document) could be used as the basis for audit training delivered by the cleaning team.

Process

It is important that organisations agree the principles against which they audit and how to score each element in terms of what constitutes a pass and what constitutes a fail. [Appendix 7](#) (separate document) identifies questions organisations should ask about their technical audit process, with suggested model responses. It is good practice to work through these questions and agree the standards that technical auditors adopt. This exercise will ensure the audit process is consistent, regardless of who undertakes it.

Frequency

Healthcare organisations can decide what audit frequency best monitors safe standards for each functional area. The frequency of audit should be reviewed regularly to meet the changing needs of the service, patients, and the environment, and to continuously improve safe cleaning standards.

As a guide Table 1 lists suggested audit frequencies.

Table 1: Suggested audit frequencies

Functional risk	Audit frequency
FR1	Weekly
FR2	Monthly
FR3	Bi-monthly
FR4	Quarterly
FR5	Six-monthly
FR6	Annually

Sample size

Good practice is for a minimum of 50% of each functional area to be audited in one session, making the audit representative of the whole area. For example, if an area has twenty rooms, a minimum of ten rooms must be audited, including all fifty elements within those ten rooms. In small areas with ten or fewer rooms, good practice is for all of them to be audited at the same time.

If 50% of a functional area is audited in one session, the other 50% must be audited in the next session, not the same 50%.

Scoring

The auditor will score elements as either 1 (pass) or 0 (fail) room by room. Together these will give the score for each functional area. Where an element fails and is scored as 0, the reason for failure needs to be recorded. The appropriate time for remedial action has been determined using the [rectification table](#).

The scoring will reflect the assigned general responsibility for elements as determined by each healthcare facility as advised in the cleaning responsibilities section (see [Section 3](#)).

The [electronic version](#) of the score sheet will calculate the percentage score achieved for each functional area. The score sheet can make horizontal (outcome per room) and vertical (outcome per element) calculations, along with the totals.

A room's number of pass scores will be expressed as a percentage of the possible number of 'pass' scores in that room. For example, if ten of the twelve elements in the sanitary area pass, the overall percentage would be 83.33% (10/12).

The functional area score is the number of pass scores in the functional area expressed as a percentage of the possible number of pass scores in the functional area. For example, in Table 2 it is 177/180 = 98.33%.

Table 2: Example scoring

Functional area	Target audit score	Room	Total questions	Audit questions passed	Actual audit score
FR1	98%	1	35	34	97.14%
FR1	98%	2	40	39	97.5%
FR1	98%	3	44	44	100%
FR1	98%	4	25	25	100%
FR1	98%	5	21	20	95.24%
FR1	98%	6	15	15	100%
Total	98%		180	177	98.33%

Overall target score

Once healthcare organisations have determined their target scores in each risk category, an overall target score can be calculated by determining the percentage of the hospital or other type of premises that falls into each risk category.

The overall healthcare facility score is then calculated by taking the number of pass scores expressed as a percentage of the possible number of pass scores in the healthcare facility. For example, in Table 3 it is 7,700/8,930 = 86.23%. Please note this example does not include any blended areas.

Table 3: Example overall organisation scoring

Functional risk category and corresponding target audit score	Number of areas	Calculation	Overall possible target score	Overall actual score
FR1 98%	10	10 x 98%	980	900
FR2 95%	40	40 x 95%	3,800	3,500
FR3 90%	15	15 x 90%	1,275	1,025
FR4 85%	20	20 x 85%	1,700	1,400
FR5 80%	10	10 x 80%	800	600
FR6 75%	5	5 x 75%	375	275
Total	100	8,930	8,930	7,700
Target audit score for the whole facility			89.30%	86.23%

Where an overall score is required, or facilities need to be grouped, an aggregated score can be used to calculate the overall score for cleanliness. However, the relative size of each of the healthcare facilities being aggregated must be considered. Healthcare providers need to determine the configuration of their sites and how they want the reports to be generated.

Demand-led cleaning technology

Under certain circumstances – high usage, depleted consumables, spillages, or incidents – reactive cleaning technology using sensors, feedback, or call buttons can quickly alert and/or direct the responsible staff group to attend the area that needs to be cleaned. Use of such technology is encouraged as it ensures that areas are cleaned based on need and level of use, rather than according to routine cleaning schedules, reducing the need for rectification.

Trend analysis

We recommend trend analysis of quality data as part of continuous service improvement. This will identify specific areas that require review and where resources are best deployed.

Reporting

Cleanliness audit scores can be determined for the same type of equipment or the same element across a healthcare facility or parts of buildings. Scores can also be broken down further, e.g. across all wards or departments, or groupings of wards and departments. This enables identification of variations in quality across similar areas and the causes of failure that need to be addressed to meet safe standards.

9.2. Efficacy audits

The efficacy audit is a management tool to provide assurance that the correct cleaning procedures are consistently delivered to satisfy IPC and safety standards. These audits inform the healthcare organisation that correct training, IPC, health and safety, and safe systems of work are being used.

An integral part of the efficacy audit is observing the cleaning to check that staff use the colour coding correctly, follow cleaning methodologies, wear the correct uniform and PPE, use chemicals appropriately and adhere to safe ways of working.

These audits are intended to provide assurance that cleaning standards are met using good practice. We recommend efficacy audits are only carried out in areas where patients and visitors are present, not in staff-only areas. Each patient-facing area should be audited at least once each year. If an area falls below 80%, it should be re-audited within a reasonable timeframe to check that following remedial action it is achieving an audit score of over 80%.

Functional risk areas that have not achieved safe standards consistently or areas that have high rates of infection should be prioritised for efficacy audits. The findings should be used to develop an improvement plan, which may include further training, investment in new equipment and materials, increased supervision, increased resources, changing the times of cleaning, performance management, etc.

Wherever possible, efficacy audits should be conducted by multidisciplinary teams that include staff responsible for cleanliness, nursing staff, IPC and other estates and facilities colleagues to give a rounded view of the cleaning process. It is also good practice to invite patient representatives to be involved from time to time.

To help you:

- An example [efficacy audit template](#) is provided. This can be changed to meet individual healthcare cleaning requirements and the organisation's priorities. To facilitate comparison and enable benchmarking, the template is split into 38 'clean only' questions which must be answered and five non-cleaning questions which should be answered where appropriate. The template allows the efficacy audit calculation formula to be adjusted so data remains comparable.

Frequency and scoring

We recommend that efficacy audits are conducted annually. Each organisation can decide how to schedule the audits, e.g. monthly as a rolling programme with a sample of patient-facing areas audited at a time of day when cleaning is being undertaken.

Except for areas that are being targeted for performance review, other areas should be randomly selected for efficacy audits. The actual number should be determined locally but it needs to be enough to validate that safe standards are being achieved.

The efficacy audit scores do not form part of, or contribute to, the technical audit percentage scores or the star rating scores.

Good practice is to report the findings from efficacy audits at executive level, to acknowledge good service, address poor service and drive continuous improvement.

9.3. External assurance audits

External assurance audits are good practice as they provide an independent view of cleanliness and validate the healthcare facility's own internally awarded technical and efficacy scores.

Collaborating with neighbouring facilities or NHS healthcare organisations is often the easiest way to get appropriately qualified staff or managers to take part in an external audit process. There may also be value in reciprocal arrangements between healthcare organisations, providing managers that do not know each other are involved and geographical distance separates them. Such arrangements may also provide opportunities to share good practice.

Professional associations may also provide qualified external auditors as well as personnel involved in the patient-led assessments of the care environment (PLACE).

Frequency

We recommend that an external audit is carried out annually and that it considers whether:

- a board member with responsibility for cleaning has been appointed
- a cleaning policy is in place that reflects the national cleaning standards and any specific local requirements
- functional areas have been categorised according to the cleaning policy
- completed commitment to cleanliness charter posters are displayed in all required areas
- the cleaning frequencies meet or exceed the safe standards
- there is evidence that cleaning frequencies are being adhered to (commitment to cleanliness charters, checklists, etc)
- in-date star ratings are displayed in all required areas
- the cleaning standard seen on inspection is consistent with the star ratings displayed
- efficacy checks are being carried out
- the efficacy check results are consistent with the standard seen in the audit
- trend analysis is being undertaken to support continuous improvement
- there is evidence that failings have been rectified for all responsible staff groups
- rectifications are being made in a timely manner for all responsible staff groups
- there is evidence that the introduction of the standards has improved the cleanliness delivered by all responsible staff groups in the facility
- any actions will be recommended as a result of the external audit

Please note that this list of considerations is not exhaustive.

9.4 Timeframe for rectifying technical problems

Regular audits should form part of the cleaning services and quality assurance programme. Lead times for remedial action that are dependent on magnitude and location should be identified, e.g. within an hour of the audit for a problem in an operating theatre but within a week or during the next schedule audit for one in a stationery storeroom. Please see Table 4 for guidance.

Any urgent issues found during the audit need to be flagged and rectified immediately either by the auditor or by escalation through operational teams. All routine failures picked up during the audit should be rectified according to documented local agreement or as per Table 4.

A multidisciplinary approach to dealing with rectifications needs to be taken to ensure that all failures, regardless of the staff group responsible for cleaning the element, are rectified to the correct standard within the agreed timeframes detailed below.

Table 4: Maximum timeframe for rectifying cleaning problems

Priority of rectification	Maximum timeframe for rectifying cleaning problems
Rapid response items – this includes all areas regardless of functional risk rating where there is a health and safety, patient safety or IPC issue	Assessment of task should be within 20 minutes with task completed in no longer than 1 hour Cleaning these items should be recognised as a team responsibility. Where necessary and cleaning staff are unavailable, e.g. at night, the task should be the responsibility of other ward or department staff. It is important that all tasks are clearly outlined and that all staff understand their responsibilities and methods of cleaning, including what the appropriate equipment and materials to use are
FR1	Assessment within 20 minutes and task completed at the next scheduled clean or within 2 hours (if the area is accessible), whichever is soonest
FR2	Assessment within 20 minutes and task completed at the next scheduled clean or within 4 hours (if the area is accessible), whichever is soonest
FR3	Assessment within 1 hour and task completed at the next scheduled clean or within 12 hours (if the area is accessible), whichever is soonest
FR4	Assessment within 1 hour and task completed at the next scheduled clean or within 72 hours, whichever is soonest
FR5	Assessment within 24 hours and task completed at the next scheduled clean or within 96 hours, whichever is soonest
FR6	Assessment within 24 hours and task completed at the next scheduled clean or within 120 hours, whichever is soonest

Priority of rectification	Maximum timeframe for rectifying cleaning problems
FRB (blended functional area)	The above rectification times should be used depending on the FR for the room concerned

10. Digital and technological audit solutions

10.1 Audit Technology

The process for technical auditing of cleaning described above focuses on subjective methods, i.e. visual checks of the standard of cleanliness. As it relies on the expertise of auditor(s), good practice to minimise auditor bias is a multidisciplinary approach and annual training of audit personnel.

Consideration should also be given to audit technologies that use objective evidence-based methodology to support the subjective measurement and efficacy of the cleaning process.

A wide variety of technical tools are available. Those that identify what has not been cleaned effectively, e.g. ultraviolet gels, adenosine triphosphate and ultraviolet black light, can be used to highlight training needs.

Electronic audit systems are useful for highlighting trends and hot spots, as well as greater transparency and more effective sharing of data.

The efficacy of the cleaning process is becoming increasingly important for IPC, particularly for FR1 and FR2 functional risk areas. More advanced technology is being developed to support the objective measurement of environmental cleanliness.

Each organisation should determine its level of investment in technology and electronic audit systems to support the audit process.

10.2 Audit Reporting

Information technology plays an important part in the audit process, documenting findings and analysing failures, trends, and results.

Factors to consider when developing or procuring an electronic audit tool include:

- ease of use
- ability to meet the needs of the facility; one size does not fit all
- ability to produce metrics from elements, frequency, and room data to show compliance with the standard
- ability to 'build as you go' to easily capture room function changes, new rooms, etc
- ability to easily build from plans

- ability to transfer data from one service provider to another (ownership of base data)
- ability easily to export data
- compatibility with NHS building regulation data
- simplified reporting functionality
- functionality to work in healthcare facilities with data device capability

Healthcare organisations that choose not to use information technology as part of the audit process should be able to use Excel spreadsheets that provide the same reporting format as an electronic system.

11. PLACE and the National standards of healthcare cleanliness

Patient-led assessments of the care environment (PLACE) is an annual national inspection self-assessment programme, which is managed by NHS Digital on NHS England and NHS Improvement's behalf. The assessments mainly apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors, but other providers are encouraged and helped to participate in the programme. PLACE replaced the longstanding PEAT (patient environment action team) programme in 2013.

Under PLACE, organisations make an in-depth assessment of the non-clinical, patient-related aspects of the care environment for all qualifying inpatient settings. Responses contribute to scores across six domains, including one specifically for 'cleanliness'. Questions within some of the other domains also relate to cleaning and associated services.

PLACE scores are released as an official statistic, and the results are published to help drive improvements in the care environment. The results show how healthcare organisations are performing both nationally and in relation to similar service providers.

Teams taking part comprise staff and patient assessors, who view settings from a non-technical (i.e. visual) and non-system focused perspective, giving a good indication of how patients and the public view standards.

In terms of cleaning, it is important that organisations reflect and react to PLACE scores and underlying action/improvement plans to make and maintain required and realistic improvements.

12. Glossary

Various terms in this guide have a specific meaning when used in relation to cleanliness in healthcare premises. The below definitions are not exhaustive.

Dust includes lint, powder, fluff, cobweb.

Dirt includes mud, smudges, soil, graffiti, mould, fingerprints, ingrained dirt, scum.

Debris includes litter and rubbish, such as crisp packets, drinks cans and bottles, chewing gum, cigarette butts, adhesive tape; grit; limescale.

Element is an item within a functional area, or any part of the fabric or fittings of a functional area, which requires cleaning.

Functional area is a room or physically contiguous group of rooms deemed by a healthcare organisation to constitute an area of operation.

Spillage includes any liquid, stains, and sticky substances.

Rooms are a subset of functional areas, e.g. on a ward these can be bedded bays and sanitary areas. Their identification allows cleaning managers to more closely audit and manage standards in specific parts of functional areas.

Inputs are the resources used to produce and deliver outputs, e.g. staff, equipment, or materials.

Low surfaces include items such as skirting boards, floor edges, low-level pipe work and trunking, low cupboard exteriors.

Middle surfaces include items such as grab rails, tables, trunking, desks, shelves, ledges, work surfaces, cupboard exteriors, windowsills.

High surfaces include items such as filing cabinets, curtain rails, locker and cupboard tops, picture frames.

Outcomes are the effect or consequences of the output, e.g. cleaning (output) produces a clean and safe environment for patient care (outcome).

Outputs are the actual product or service, e.g. cleaning.

Performance parameter is the expected standard when cleaning is completed.

Processes are the procedures, methods and activities that turn the inputs into outputs, e.g. mopping a floor.

Quality systems refer to integration of organisational structure, integrated procedures, resources, and responsibilities required to implement quality management. Taken together, these provide for the development of a comprehensive and consistent service.

13. References

Standards for better health

https://webarchive.nationalarchives.gov.uk/20121206105212/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4132991.pdf

Cleanliness matters – a regional strategy for improving the standard

<http://www.dhsspsni.gov.uk/cleanliness-matters-strategy-2005.pdf>

Cleanliness matters toolkit – practical guidance for assessment of standards of environmental cleanliness in HSS trusts

<https://www.health-ni.gov.uk/publications/environmental-cleanliness-documents>

<http://www.dhsspsni.gov.uk/index/hss/governance/governance-controls.htm>

The revised healthcare cleaning manual

<https://www.ahcp.co.uk/wp-content/uploads/NRLS-0949-Healthcare-cleaning-manual-2009-06-v1.pdf>

Code of practice for the prevention and control of healthcare associated infections (Health Act 2006); Department of Health 2006

<https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance>

AN INTEGRATED APPROACH TO HOSPITAL CLEANING: MICROFIBRE CLOTH AND STEAM CLEANING TECHNOLOGY

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/143264/Microfibre_report_revised_Mar_08.pdf

NHS Wales health circulars

These provide a streamlined, transparent and traceable method of communication between the department and the NHS. The circulars are divided into categories for different areas of health.

<https://gov.wales/health-circulars>

Health and care standards

<http://www.wales.nhs.uk/governance-emanual/health-and-care-standards>

Free to lead, free to care

<http://www.wales.nhs.uk/documents/cleanliness-report.pdf>

Code of practice for the prevention and control of healthcare associated infections

<https://gov.wales/sites/default/files/publications/2019-06/code-of-practice-for-the-prevention-and-control-of-healthcare-associated-infections.pdf>

Commitment to purpose: eliminating preventable healthcare associated infections (HCAIs)

<http://www.wales.nhs.uk/document/243853/info/>

The communicable disease outbreak plan for Wales ('The Wales outbreak plan')

<http://www.wales.nhs.uk/sites3/docmetadata.cfm?orgid=457&id=255613>

Antimicrobial resistance – a delivery plan for NHS Wales and its partners

<http://www.wales.nhs.uk/sitesplus/documents/888/Antimicrobial%20Resistance%20Delivery%20Plan.pdf>

CQC cleaning outcome standard 15

<https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-15-premises-equipment>

National Services Scotland – standard infection control precautions literature review: routine cleaning of the care environment

<http://www.nipcm.scot.nhs.uk/documents/sicp-routine-cleaning-of-the-environment-in-the-hospital-setting/>

National Services Scotland – transmission-based precautions literature review: management of care equipment and environmental decontamination <http://www.nipcm.scot.nhs.uk/documents/tbp-management-of-care-equipment-and-environmental-decontamination/>

Health Protection Scotland – literature reviews on emerging decontamination technologies

<https://www.hps.scot.nhs.uk/a-to-z-of-topics/decontamination/#publications>

14. Acknowledgements

Special thanks to David Griffiths, who has advised in the making of these standards as technical author of PAS:5748 and editor of the *Revised healthcare cleaning manual*.

Special acknowledgement to Yvonne Fortt and Lynne Evans for their tireless efforts in compiling this document.

Thank you to Royal Derby Hospital for the commitment to cleanliness charter.

We also thank all the people who dedicated their time and energy to producing this document.

Emma Brookes	Head of Soft FM, Strategy and Operations	NHS Improvement and NHS England (Project Lead)
Richard Ashton	Performance and Compliance Manager	Gloucester Health and Care NHS Foundation Trust
Carol Birch	Associate Director of Facilities	Synchronicity Care Ltd
Pauline Bradshaw	Clinical Lead – North West	NHS England & Improvement
Donna Brown	Divisional Director	ISS Facility Services Healthcare
Charlie Buck	Principal Services Assurance Manager	NHS Property Services
Linda Dempster	Head of Infection Prevention & Control	NHS England & Improvement
Jenni Doman	Deputy Director, Estates & Facilities	St Georges University NHS Foundation Trust
Stuart Douglas	Head of Estate Development	NHS Wales Shared Partnership Services
Gary Ethridge	Director of Nursing & Safeguarding Director	Barking, Havering and Redbridge University Foundation Trust
Caroline Fennessy	FM Specialist (cleaning)	Serco UK & Europe
Denise Foster	National Chair	Association of Healthcare Cleaning Professionals
Dr Amy Gyte	Capability Team Leader Exposures and Health Consequences Portfolio Health Capability Group	Health & Safety Executive (HSE)
Anna Hallas	National Domestic Manager	Compass Group
Ashley Harrison	Services Assurance Manager	NHS Property Services
Martyn Hearn	Operations Director	MITIE Plc
Jenifer Holmyard	Head of Facilities (London)	West London NHS Trust
Ian Jackson	Domestic Services Manager	Salford Royal Hospital
Rob Jepson	Deputy Director of Estates, Facilities and Capital	Northern Care Alliance
Debbie Jones	Chief Executive	Butterwick Hospice Care
Catherine Leak	General Manager	St Georges University NHS Foundation Trust

Christopher Lewis	Senior Environment & Facilities Management Advisor	NHS Wales Shared Services Partnership - Specialist Estates Services
Penny Lewis	Soft FM Solutions Lead	Serco Group PLC
TJ Litherland	National President	Health Estates & facilities Management Association
Florence Looi	Estates & Facilities Site Manager	Basildon University Hospital, Mid & South Essex University Hospitals Group
Gail Lusardi	Consultant Nurse, HARP Team	Public Health Wales
William McNeill	Deputy Patient Facing Services Manager	West London NHS Trust (Broadmoor)
Kathryn Mitchell	Director of Estates and Facilities	Manchester University NHS Foundation Trust
Liz Pass	Patient Facing Services Manager	Broadmoor Hospital
Lee Peddle	Head of Facilities Management – Soft FM & Transport	Quality Trusted Solutions
Ed Robinson		Health & Safety Executive (HSE)
Delia Rodrigues	Head of Facilities	Royal Brompton & Harefield NHS Foundation Trust
Michael Rollins	Healthcare Specialist IPC Consultant	Independent
Dr Chris Settle	Consultant Microbiologist	City Hospitals Sunderland
Amilcar Simoes	Facilities Manager	West London NHS Trust
Louise Simpson	Group Senior Nurse E&F	Northern Care Alliance
Katie Sparrow	Account Manager	G4S Facilities Management
Yvonne Spencer	Clinical Lead, IFM	Sodexo Healthcare
Collette Sweeney	Head of Healthcare Cleaning	ISS Facility Services Healthcare
Yvonne Taylor	Global Head of Cleaning	OCS Group Ltd UK
Maciel Vinagre	Assistant Hotel Services Manager	Ashford & St Peter's NHS Foundation Trust
Jane Ward	Deputy Director of Facilities	Epsom & St Helier University Hospital Trust

Contact us: nshi.estatesandfacilities@nhs.net

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publication approval reference: PAR271