NHS
Blood and Transplant

Board Meeting in Public
Tuesday, 03 February 2026

Title of Paper	Infection Prevention and Control (IPC) Board Assurance Framework	**Agenda No.**	3.5
Nature of Paper	☒ Official	☐ Official Sensitive	
Author(s)	Sarah Humberstone, Lead Nurse, Infection Prevention and Control		
Lead Executive	Professor Dee Thiruchelvam, Chief Nursing Officer, Director IPC		
Non-Executive Director Sponsor	Professor Lorna Marson, CGC Chair		
Presenter(s) at Meeting	Sally Bleeks, Senior Nurse, Infection Prevention and Control Ellen Bull, Chief Nurse Strategy Workforce Practice Standards		
Presented for	☒ Approval ☒ Information ☒ Assurance ☐ Update		
Is there a plan to communicate this to the organisation?	☐ Yes ☐ No ☒ Yet to be determined		

Executive Summary

The Infection Prevention and Control (IPC) Board Assurance Framework (BAF)[1] is being submitted to the Board for information and to confirm assurance of the robust systems in place to safeguard donors, patients, staff, and visitors, and that continuous improvement is embedded in practice. By systematically mapping IPC activities to statutory obligations, the framework enables the Clinical Governance Committee and NHSBT Board to have clear assurance of areas achieved and areas in progress.

The IPC BAF is a structured tool that sets out the systems, processes, and evidence that NHSBT has in place to meet national IPC standards. It provides the Board with clear oversight, highlighting areas of full compliance, partial compliance, and will formulate action plans, thereby offering assurance that risks are effectively managed and continuous improvement is embedded.

For 2024–25, the BAF has one point of non-compliance, relating to PLACE-Lite[2] which the organisation is considering implementing, and a small number of partial compliances were also noted, including incomplete Occupational Health, health surveillance records, the need to strengthen hand hygiene compliance within Tissue and Eye Services (TES), the establishment of a new Ventilation Safety Group, and the NHSBT IPC Policy is out of date and is being revised for completion in 2025–26. All areas have clear improvement plans in place and are actively being addressed.

Previously Considered by

The BAF has been previously considered by the IPC Committee and with Group Clinical Director Infection Prevention and Control, St George's, Epsom and St Helier University Hospitals and Health Group (GESH) Strategic Lead IPC Subject Matter Expert for NHSBT. Clinical Quality and Safety Governance Group 26th September 2025. BAF previous version at IPCC. This version circulated to IPCC. Signed off by DIPC.

Recommendation

The Board is asked to confirm assurance and approve the evidence, framework and the ongoing actions required for the areas of partial compliance.

Risk(s) identified (Link to Board Assurance Framework Risks)

IPC – 01 Occupational Health Service

Strategic Objective(s) this paper relates to:

☐ Collaborate with partners ☐ Invest in people and culture ☒ Drive innovation
☒ Modernise our operations ☐ Grow and diversify our donor base

Appendices:

[1] NHS England » National infection prevention and control
[2] Patient Led Assessments of the Care Environment (PLACE)-Lite guidance - NHS England Digital

NHS Blood and Transplant Infection Prevention and Control Board Assurance Framework

The Infection Prevention and Control (IPC) Board Assurance Framework (BAF) was developed to strengthen organisational oversight and alignment with national requirements. The framework provides a structured mechanism through which NHSBT can demonstrate compliance with the Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Infections. It sets out the key lines of enquiry, evidence sources, and governance processes that enable risks to be identified, monitored, and effectively managed. By systematically mapping IPC activities to statutory obligations, the framework enables the Clinical Governance Committee and NHSBT Board to obtain assurance that robust systems are in place to safeguard donors, patients, staff, and visitors, and that continuous improvement is embedded in practice.

Completed by: Sarah Humberstone, Lead Nurse Infection Prevention and Control. Date……19th September 2025

Oversight by: Prodine Kubalalika, Group Clinical Director Infection Prevention and Control, St George's, Epsom and St Helier University Hospitals and Health Group (GESH) Strategic Lead IPC Subject Matter Expert for NHSBT Date…26th September 2025

Approved by: Dee Thiruchelvum, Director Infection Prevention and Control and Chief Nursing Officer

Date…26th September 2025

Approved by: NHSBT Infection Prevention and Control Committee Date…3rd November 2025

Approved by: NHSBT Clinical Governance Committee Date.. 20th October 2025

- ✅ **Green – Fully Compliant Areas – 9**
- 🟠 **Amber – Partial Compliance – 8**
- 🔴 **Red – Non-Compliance – 0**
- ⚪ **Not Applicable - 3**

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them						
Organisational or board systems and process should be in place to ensure that:						
1.1	There is a governance structure, which as a minimum should include an IPC committee or equivalent, including a Director of Infection Prevention and Control (DIPC) and an IPC lead, ensuring roles and responsibilities are clearly defined with clear lines of accountability to the IPC team.	Governance structure:  Roles and responsibilities: • **Director of Infection Prevention and Control (DIPC)**: Provides executive leadership and strategic oversight of all IPC activities. The DIPC is accountable to the Board for ensuring compliance with statutory requirements, driving continuous improvement, and embedding IPC principles across the organisation. • **IPC Lead Nurse:** Oversees the operational delivery of the IPC programme, ensuring that policies, procedures, and audits are implemented effectively. The Lead Nurse provides professional leadership, supports assurance reporting, and acts as a key link	NHSBT does not employ an IPC Doctor	In the absence of a designated IPC doctor, clinical advice and specialist guidance is provided by NHSBT's Consultant in Epidemiology and Health Protection, Consultant Virologist, and Consultant Bacteriologist, ensuring that expert input is available to support safe and evidence-based decision-making. This arrangement is aligned with the IPC Board Assurance Framework, providing assurance that appropriate clinical oversight and expertise are embedded within organisational governance structures.	IPC role has been added to the job plan for a new medical consultant. The role is out to advert.	Partial Compliance

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		between the DIPC, senior management, and frontline teams. • **IPC Senior Nurse:** Supports the Lead Nurse in delivering the IPC agenda, with responsibility for coordinating audits, monitoring compliance, and providing specialist advice to services. The Senior Nurse plays a central role in training, incident review, and escalation of risks through governance structures. • **Strategic Lead IPC Subject Matter Expert:** Offers expert guidance on complex or specialist areas of IPC, including water safety, ventilation, and built environment projects. This role ensures that national standards and emerging evidence are reflected in NHSBT's policies and strategic planning. • **IPC Link Nurses and Practitioners:** Act as local champions within their clinical areas, promoting best practice and supporting the dissemination of IPC guidance. Link staff play a vital role in peer-to-peer education, embedding compliance at service level, and providing feedback to inform organisational learning.				
1.2	There is monitoring and reporting of infections with appropriate governance structures to mitigate the risk of infection transmission.	NHSBT provides assurance that infection risks are effectively monitored and governed across all services by screening all platelet products for bacterial contamination, with any positive results investigated and	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		discarded to protect patient safety. Transfusion transmitted infections reported by hospitals are formally investigated through the PSI process, strengthening governance and organisational learning. Routine environmental monitoring in clean rooms, structured staff illness reporting, and infection-related donor deferrals provide further safeguards. Within Therapeutic Apheresis Services (TAS), infection risk is assessed at every patient contact and supported by regular IPC audits. Deceased donors are comprehensively screened for infection risk, with results shared directly with recipient teams. Together, these measures demonstrate consistent surveillance, clear escalation routes, and robust governance arrangements that provide strong assurance of the organisation's ability to monitor and mitigate the risk of infection transmission. All clinical departments report into directorate and national Clinical Governance Committees, ensuring oversight and accountability at the highest organisational level.				
1.3	That there is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices, that is, that any workplace risk(s) are mitigated maximally for everyone.	NHSBT provides assurance that a strong reporting culture is in place to support infection prevention and control. Patient Safety Incident Response Framework (PSIRF) processes are embedded for the investigation of all patient and donor safety incidents relating to infections, ensuring a structured approach to review and learning. Near misses and inoculation incidents are reported and logged through the Datix system, allowing	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		timely investigation, identification of contributory factors, and implementation of improvement actions. The Patient and Donor Safety Incident Review Group (PDSIRG) provides oversight of all incidents, ensuring themes are identified and addressed, while shared learning is cascaded through Directorate Clinical Audit Risk Effectiveness (CARE) Committees to strengthen local practice. NHSBT also supports open communication and psychological safety through the Just Culture policy and access to Freedom to Speak Up Guardians, which further encourage staff to report concerns without fear of blame. Together, these measures provide assurance that incidents and near misses are not only captured and investigated but also used to drive learning and improvement, thereby reducing risk and supporting a safe working environment across all services.				
1.4	They implement, monitor, and report adherence to the National infection prevention and control manual (NIPCM.)	Mandatory training; national standards audits; IPC and CARE Committees; PPE and equipment decontamination processes • All staff undertake mandatory IPC training (Levels 1 or 2), current compliance 95%. • National Standards of Healthcare Cleanliness technical audits embedded March 2023; efficacy audits commenced June 2024.	NHSBT IPC team does not have oversight of OTDT SN-OD's where their IPC practices are monitored in their embedded trust. OTDT Tissue and Eye Services (TES) do not currently carry out hand hygiene auditing.	OTDT have oversight of the clinical practice of their nurses. TES staff who work directly with donors undergo level II IPC training, they now have IPC link practitioners and are working with the IPC team to implement hand hygiene auditing.	NHSBT has a nominated authorising engineer for ventilation safety and a national ventilation safety group has its inaugural meeting September 2025 and will report into the IPC Committee.	Partial Compliance

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		• Hand hygiene audits undertaken in Blood Donation (BD) and Therapeutic Apheresis (TAS), reviewed monthly and reported to IPC Committee and CARE Committees. • TAS hand hygiene compliance monitored via Tendable platform. • Respiratory hygiene etiquette communicated at induction and within training. • PPE provided in all settings with clinical guidance. • Equipment cleaning and decontamination processes in place.	NHSBT has not had a ventilation authorising engineer or ventilation safety group.	NHSBT uses contractors for the maintenance of its centre ventilation systems.		
1.5	They undertake surveillance (mandatory infectious agents as a minimum) to ensure identification, monitoring, and reporting of incidents/outbreaks with an associated action plan agreed at or with oversight at board level.	NHSBT undertakes routine surveillance to identify, monitor, and report infections and infection risks. When donors provide important health information after donation, this is reviewed and managed by the Clinical Support Team in line with agreed procedures. Any infections identified during screening are managed by NHSBT's microbiology specialists under established protocols. Routine environmental monitoring is carried out in cleanrooms and have oversight from the Clean Room Advisory Group to ensure safe working conditions. Patients and donors in the Therapeutic Apheresis Service (TAS) and organ/tissue donors (OTDT) are managed in line with departmental	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		procedures, with advice from the IPC team or consultant virologist where required. Incidents and outbreaks are investigated individually, with action plans developed where needed. Oversight is provided through the CARE committees and IPC Committee, which reports outcomes and learning to the Board, ensuring that governance and accountability are maintained.				
1.6	Systems and resources are available to implement and monitor compliance with infection prevention and control as outlined in the responsibilities section of the NIPCM.	The IPC Committee reports to CQSGG and bi-annually to the Clinical Governance Committee, ensuring strong oversight of infection prevention and control activities. The IPC team works collaboratively with Health, Safety & Wellbeing and Estates and Facilities colleagues to maintain safe systems of work, which are audited by the Estates and Facilities Cleaning Group in line with the National Standards of Healthcare Cleanliness (2021) and through the Health & Safety Scorecard. The IPC team is in place to monitor compliance with the NIPCM and NSHC'21. In addition, the Occupational Health service provides a 24-hour sharps line for blood exposures and maintains immunisation records to support staff safety, with clinical oversight by the IPC team. Together, with the expansion of the use of Tendable audit platform for IPC audits these systems provide assurance that NHSBT has the governance, resources, and processes required to implement and monitor infection prevention and	Further assurance is required for confirmation OH hold a full set of immunisation records for NHSBT staff, work is ongoing jointly with OH and NHSBT Health and Wellbeing team to get this full assurance.	Managers have been trained for MPD 359 - Vaccination Programmes and Pre Placement Immunisation Clearance, this ensures a conversation with new starter on immunisation clearances where required and organising of hep B immunisation where recommended.	A sample audit of staff surveillance records showed some gaps, action plan in place to re-populate the records where required and plan for longer term complete records held for our staff.	Partial Compliance

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		control in accordance with the responsibilities outlined in the NIPCM. The IPC Link nurse/practitioner network with provide locally based IPC oversight and will monitor and feedback any concerns from their clinical areas.				
1.7	All staff receive the required training commensurate with their duties to minimise the risks of infection transmission.	All staff complete level 1 IPC mandatory training and those working with donors and patients also complete level 2. Compliance data for this is reviewed by the IPC committee. The IPC Link nurses and link practitioners also attend an onboarding day, with the course content being based on the IPC educational framework. Nurses working with highest risk patients (TAS) have an IPC policy and list of documents that ensures they are trained in procedures that includes IPC requirements.	None	None	IPC team subscribed to updates from UKHSA, Infection Prevention Society, NHS England, Specialist Pharmacy Service, healthcare leader's updates, NICE updates, CNO bulletins and NHS collaboration hub to keep up to date.	Compliant
1.8	There is support in clinical areas to undertake a local dynamic risk assessment based on the hierarchy of controls to prevent/reduce or control infection transmission and provide mitigations. (primary care, community care and outpatient settings, acute inpatient	Clinical teams are supported to carry out local risk assessments to identify and control infection risks, using the recognised hierarchy of controls (from environmental measures through to PPE). IPC Link Nurses, managers, and staff have access to templates, checklists, and specialist advice from the IPC team when needed, ensuring risks are assessed and mitigated at the point of	None	None	None	Complaint

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	areas, and primary and community care dental settings)	care. Outcomes from these assessments are recorded, escalated where necessary, and reported through governance structures, providing assurance to the Board that infection risks are actively managed across all services.				
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
System and process are in place to ensure that:						
2.1	There is evidence of compliance with National cleanliness standards including monitoring and mitigations (**excludes some settings e.g. ambulance, primary care/dental unless part of the NHS standard contract** these setting will have locally agreed processes in place).	The National Standards of Healthcare Cleanliness are now fully embedded, with both technical and efficacy audits undertaken collaboratively by department managers, Estates and Facilities, and the IPC team. Audits are recorded within the TABS computer aided facilities management (CAFM) system, which automatically generates jobs for any non-compliance, ensuring timely action. Where audit failures are identified, reaudits are conducted within one month to confirm improvements. Audit outcomes are reviewed by both the IPC Committee and the Estates and Facilities Cleaning Group, providing assurance that	Patient Led Audit of the Care Environment Lite assessments are not currently undertaken for internal benchmarking. NHSBT should Consider piloting PLACE Lite to provide additional assurance on patient/donor-facing environments.	Technical and Efficacy audits are undertaken across NHSBT properties in collaboration with department managers, estates and facilities and IPC, outcomes of which are reported up to the IPC Committee	Need to ensure sufficient resource of team members to conduct efficacy audits at 90 sites. Recruitment to IPC Link roles in progress	Partial Compliance

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		standards are monitored, maintained, and escalated through governance structures where required.				
2.2	There is an annual programme of Patient-Led Assessments of the Care Environment (PLACE) visits and completion of action plans monitored by the board.	PLACE audits will not be undertaken within NHSBT, as previously advised by NHS England, since the organisation is not a secondary care provider and participation could distort national reporting. However, the organisation is considering the use of PLACE Lite as an internal benchmarking tool, which would allow targeted assessments of donor- and patient-facing areas without impacting national results.	PLACE Lite assessments are not currently undertaken for internal benchmarking.	Service users are provided with multiple opportunities and channels to share concerns, feedback, or compliments regarding both the care they receive and the environment in which it is delivered, ensuring issues are identified and acted upon promptly.	The Clinical Governance Committee supports the use of PLACE lite assessments. The implementation of these are added to the action plan.	Not applicable
2.3	There are clear guidelines to identify roles and responsibilities for maintaining a clean environment (including patient care equipment) in line with the national cleanliness standards.	MPD119 – Management of Cleaning Services sets out the organisation's cleaning requirements, including frequencies, parameters, and responsibilities. These standards form the basis of the technical audit, which assesses departmental cleanliness. Departments maintain cleaning records that are reviewed as part of these audits, with departmental managers accountable for ensuring compliance. Oversight is provided through Estates and Facilities, who audit adherence to MPD119 to provide assurance of consistent standards.	None	None	None	3. Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
2.4	There is monitoring and reporting of water and ventilation safety, this must include a water and ventilation safety group and plan. **2.4.1** Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. **2.4.2** Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	National and regional Water Safety Groups are established, supported by Hydrop, NHSBT's appointed water safety specialists. Routine water safety maintenance is undertaken by Mitie in line with the Water Safety Plan (MPD1459) and recorded on the Compass database. NHSBT has a new contract with a Ventilation Safety Authorising Engineer to provide expert guidance. The inaugural Ventilation Safety Group will meet in September 2025, reporting into the IPC Committee and leading the development of a ventilation safety plan for NHSBT. These arrangements provide assurance that risks associated with water and ventilation systems are actively monitored, managed, and escalated through appropriate governance structures.	No current ventilation safety plan.	Capital projects are led by building and architectural contractors and comply with HTM 03-01 parts A&B Specialised ventilation for healthcare premises the Building Regulations. General building ventilation is maintained under the Planned Preventative Maintenance (PPM) contract, with tasks aligned to SFG20 standards for both scheduled and reactive work, and managed through the TABS CAFM system. Maintenance of air handling systems is undertaken by contractors, with all tasks recorded and tracked within TABS to ensure oversight and timely completion.	None	Partial Compliance
2.5	There is evidence of a programme of planned preventative maintenance for buildings and care environments and IPC involvement in the	Planned Preventative Maintenance (PPM) is undertaken by national estates and facilities contractors across all NHSBT sites, with all activity recorded and tracked through TABS, the organisation's CAFM system.	None	None	none	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	development new builds or refurbishments to ensure the estate is fit for purpose in compliance with the recommendations set out in HBN:00-09	The IPC team is engaged as a key stakeholder, following the guidance in HBN 09, in the development of new and refurbished clinical areas, providing input from the design stage through to CQC sign-off, ensuring infection prevention standards are embedded from the outset. In addition, IPC works collaboratively with estates and facilities teams to monitor and maintain compliance with the National Standards of Healthcare Cleanliness, providing assurance that environments are safe and fit for purpose.				
2.6	The storage, supply and provision of linen and laundry are appropriate for the level and type of care delivered and compliant with the recommendations set out in HTM:01-04 and the NIPCM.	Laboratory coats are laundered through NHSBT's contracted provider, MicronClean, with weekly collection and delivery ensuring sufficient stock rotation to maintain compliance. No other reusable linen is used within NHSBT centres. At blood donation sessions, single-use dignity blankets are provided and discarded after use, ensuring both infection prevention and patient comfort.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		No linen is used by TAS unit patients, if patients come for treatment in their beds they are hospital inpatients and this is where their linen is laundered.				
2.7	The classification, segregation, storage etc of healthcare waste is consistent with HTM:07:01 which contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment, and disposal.	Waste is classified, segregated, and stored in accordance with regulatory waste management requirements, underpinned by MPD699 – Waste Management and SOP1544 – Clinical Waste Management Procedures. Compliance is monitored through regular audits, with oversight provided by the Estates and Facilities Cleaning Group (EFCG) and the IPC Committee to ensure safe and consistent practice across all sites.	None	None	None	Compliant
2.8	There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM:01-01, HTM:01-05, and HTM:01-06.	All cleaning of equipment is directed on DAT4240 - NHSBT cleaning responsibility framework and captured on FRM7159 - NHSBT Elements, performance parameters and cleaning frequencies. All departments have cleaning records for equipment cleaning and decontamination; these are audited as part of the technical audit schedule with oversight by the EFCG and IPC Committee	None	None	None	Compliant
2.9	Food hygiene training is commensurate with the duties of staff **as per food hygiene regulations**. If food is brought into the care setting by a	No food production for patients/donors. Food prepared for staff is via a third-party caterer.	N/A	N/A	N/A	Not applicable

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	patient/service user, family/carer or staff this must be stored in line with food hygiene regulations.					
3. Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance						
Systems and process are in place to ensure that:						
3.1	If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	No antimicrobials are prescribed by NHSBT staff. Some organs and tissues are stored in an antibiotic cocktail.	N/A	N/A	N/A	Not applicable
3.2	The board receives a formal report on antimicrobial stewardship activities annually which includes the organisation's progress with achieving the UK AMR National Action Plan goals.	N/A	N/A	N/A	N/A	Not applicable
3.3	There is an executive on the board with responsibility for antimicrobial stewardship (AMS), as set out in the UK AMR National Action Plan.	N/A	N/A	N/A	N/A	Not applicable
3.4	NICE Guideline NG15 'Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use' or Treat	N/A	N/A	N/A	N/A	Not applicable

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	Antibiotics Responsibly, Guidance, Education, Tools (TARGET) are implemented and adherence to the use of antimicrobials is managed and monitored: • to optimise patient outcomes. • to minimise inappropriate prescribing. • to ensure the principles of Start Smart, Then Focus are followed.					
3.5	Contractual reporting requirements are adhered to, progress with incentive and performance improvement schemes relating to AMR are reported to the board where relevant, and boards continue to maintain oversight of key performance indicators for prescribing, including: • total antimicrobial prescribing. • broad-spectrum prescribing. • intravenous route prescribing. • treatment course length.	N/A	N/A	N/A	N/A	Not applicable
3.6	Resources are in place to support and measure adherence to good practice and quality improvement in AMS. This must include all care	N/A	N/A	N/A	N/A	Not applicable

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	areas and staff (permanent, flexible, agency, and external contractors)					
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment nursing/medical in a timely fashion						
Systems and processes are in place to ensure that:						
4.1	Information is developed with local service-user representative organisations, which should recognise and reflect local population demographics, diversity, inclusion, and health and care needs.	NHSBT develops information for service users in collaboration with local representative organisations to ensure it is accessible, inclusive, and reflective of the populations we serve. This includes engagement with donor representative groups, equality and inclusion networks, and patient/public involvement forums, to test that materials are understandable and culturally appropriate. Information is reviewed to reflect local demographics, language needs, and health inequalities, and adapted where required to ensure that all donors and patients can make informed choices. Oversight is provided through governance committees, ensuring alignment with NHSBT's equality, diversity, and inclusion objectives.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
4.2	Information is appropriate to the target audience, remains accurate and up to date, is provided in a timely manner and is easily accessible in a range of formats (e.g. digital and paper) and platforms, taking account of the communication needs of the patient/service user/care giver/visitor/advocate.	• Policy & Governance Oversight Patient and donor information leaflets reviewed through governance structures (e.g., Clinical Governance Committee, CARE Committees) to ensure accuracy and compliance with national standards. Regular updates triggered by changes in national guidance (e.g., NIPCM, NHS England, UKHSA). • Accessibility & Inclusion Donor and patient-facing materials available in digital formats (NHSBT website, email, online portals) and printed leaflets at donation/clinical sites. Translations provided for core leaflets where required to meet local population needs. Inclusive review of materials by NHSBT Equality, Diversity and Inclusion (EDI) networks and donor/patient representative groups. • Timeliness & Accuracy Rapid updates to information following emerging risks (e.g.,	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		infectious disease donor deferrals, changes to PPE or hygiene guidance). Version control maintained through SOPs and MPDs. Information is checked against national guidance to ensure consistency and accuracy. • Communication Channels Multi-platform distribution: NHSBT intranet (for staff), public website, donor apps, leaflets, posters, and direct communications. IPC newsletters and team briefings cascade information internally. • Service-User Engagement Feedback mechanisms in place (e.g., donor experience surveys, feedback forms, local engagement with representative groups). Evidence of changes made in response to service-user feedback (e.g., adapting wording, improving clarity, using inclusive imagery).				

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
4.3	The provision of information includes and supports general principles on the prevention and control of infection and antimicrobial resistance, setting out expectations and key aspects of the registered provider's policies on IPC and AMR.	• Policies and Guidance NHSBT policies (e.g., IPC Policy, Waste Management, Decontamination, and Uniform Policy) all incorporate principles of infection prevention and control (IPC). Antimicrobial stewardship principles considered within clinical practice guidance (e.g., donor deferral criteria for infections, management of suspected or confirmed infections, advice to referring clinicians). Policies approved and reviewed through Clinical Governance structures, ensuring alignment with the Health and Social Care Act Code of Practice. • Staff Training & Education Mandatory IPC training (Levels 1 and 2) covers general IPC principles, hand hygiene, respiratory etiquette, PPE, and environmental controls. Specialist training for clinical staff includes AMR awareness, safe prescribing, and escalation pathways. Cascade of learning via IPC newsletters, bulletins, and Link Nurse/Practitioner network. • Service User / Donor Information Donor-facing materials include infection-related information (e.g., eligibility criteria, post-donation illness reporting, infection deferrals).	Current NHSBT IPC Policy (POL173) was last updated in 2012	Clinical teams have policies and procedures for their activities that incorporate IPC best practices.	IPC team are working with Strategic Lead IPC Subject Matter Expert for NHSBT to develop updated NHSBT IPC Policy.	Partial Compliance

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		Clear expectations communicated at donation and treatment sites (e.g., signage on hand hygiene, respiratory etiquette). Public-facing NHSBT website includes up-to-date infection-related information and FAQs. • Governance & Oversight IPC Committee reviews training compliance, policy updates, and AMR-related issues. Clinical Governance Committee receives assurance on compliance with IPC and AMR policies. Incident reviews under PSIRF include learning related to infection prevention or AMR risks.				
4.4	Roles and responsibilities of specific individuals, carers, visitors, and advocates when attending with or visiting patients/service users in care settings, are clearly outlined to support good standards	• Clear Expectations Communicated: Hand hygiene, respiratory hygiene, and PPE use are reinforced through signage at clinical sites, donor information leaflets, and staff instruction. Donor and patients are asked to follow IPC measures as part of routine entry checks or during	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	of IPC and AMR and include: • hand hygiene, respiratory hygiene, PPE (mask use if applicable) • Supporting patients/service users' awareness and involvement in the safe provision of care in relation to IPC (e.g. cleanliness) • Explanations of infections such as incident/outbreak management and action taken to prevent recurrence. • Provide published materials from national/local public health campaigns (e.g. AMR awareness/vaccination programmes/seasonal and respiratory infections) should be utilised to inform and improve the knowledge of patients/service users, care givers, visitors and advocates to minimise the risk of transmission of infections.	specific incidents (e.g. outbreak management, mask-wearing guidance). • Donor and Patient Involvement: Donors and patients receive clear information about infection risks (e.g. donor deferral information, post-donation illness reporting, TAS admission guidance). Donors and patients are encouraged to give feedback on their experiences at our donor sessions and in our centres, supporting co-production of safe care. • Incident/Outbreak Communication: During incidents or outbreaks, affected donors and patients are informed of the infection, actions taken, and measures to prevent recurrence, with advice sought from IPC and local Public Health teams. Lessons learned are fed back into governance structures (CARE Committees, IPC Committee). • National & Local Campaigns: Published materials from any relevant, national and local public health campaigns are promoted and shared with staff, donors, and patients. • Governance Oversight IPC Committee and Clinical Governance Committee oversee compliance with national standards and ensure that communications remain accurate, accessible, and inclusive.				

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
4.5	Relevant information, including infectious status, invasive device passports/care plans, is provided across organisation boundaries to support safe and appropriate management of patients/service users.	Information relating to infection risk is captured on the TAS referral form or provided during clinical/nursing handover, ensuring key details are communicated at the point of transfer. For organ donors, this information is obtained at referral stage. Established processes are in place for the management of indwelling lines, delivered jointly with the referring trust to ensure safe and consistent practice.	None	None	None	Compliant
5.1	All patients/individuals are promptly assessed for infection and/or colonisation risk on arrival/transfer at the care area. Those who have, or are at risk of developing, an infection receives timely and appropriate treatment to reduce the risk of infection transmission.	Information on current or potential infection risks is included in TAS and OTDT patient/donor referrals to ensure they are placed in the most appropriate care setting. Patients with known infections are usually treated at the hospital bedside; if treatment in a TAS unit is unavoidable, they are scheduled at the end of the day, and the unit is deep cleaned afterwards. Teams seek advice from the IPC service where additional guidance is required. For blood donors, infection risk is managed through pre-attendance screening, including health questions, self-deferral via website links, and telephone calls. Donors identified as having an infection are deferred. Any confirmed positive bacterial screening results are managed by the Microbiology Services clinical team, who also provide follow-up advice and communication to the donor.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
5.2	Patients' infectious status should be continuously reviewed throughout their **stay/period of care**. This assessment should influence placement decisions in accordance with clinical/care need(s). If required, the patient is placed /isolated or cohorted accordingly whilst awaiting test results and documented in the patient's notes.	Infection risks are managed on a case-by-case basis by TAS teams, with patients who have known infections cared for in hospital wards rather than brought into TAS units, reducing the risk of transmission. These measures provide assurance that infection transmission risks are minimised across both patient and donor pathways.	None	None	None	Compliant
5.3	The infection status of the patient is communicated prior to transfer to the receiving organisation, department, or transferring services ensuring correct management/placement.	Patient referral forms for OTDT and TAS patients and donors capture relevant infection risk information, enabling appropriate care planning. Identified risks are managed on a case-by-case basis in collaboration between NHSBT teams and trust clinicians, who retain overall responsibility for the patient's care. This collaborative approach provides assurance that infection risks are identified and addressed consistently across organisational boundaries, supporting safe and effective patient care.	None	None	None	Compliant
5.4	Signage is displayed prior to and on entry to all health and care	Blood donors receive pre-session information advising them not to attend if they are unwell or experiencing	None	None	Additional signage is used during pandemic scenarios as part of triage	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	respiratory illness, with enhanced guidance on signage provided during pandemic situations. All donors also complete a thorough pre-donation health screen to identify any risks. TAS patients and donors are pre-screened by telephone, including questions about current health status, to ensure safety prior to attendance.			for getting into donor sessions and collection centres.	
5.5	Two or more infection cases (or a single case of serious infection) linked by time, place, and person triggers an incident/outbreak investigation and this must be reported via governance reporting structures.	• Clear Triggers Defined: Two or more infection cases (or a single case of serious infection) linked by time, place, and person automatically triggers an incident/outbreak investigation. Standard processes (PSIRF, Datix reporting, SITREP) ensure immediate capture and escalation. • Investigation & Management: IPC team leads or supports outbreak investigations with clinical teams, in collaboration with local	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		public health teams where appropriate. Action plans are developed to mitigate risks and prevent recurrence. • Governance Oversight: All incidents and outbreaks are formally reported via CARE Committees, the IPC Committee, and escalated to the Clinical Governance Committee. Outcomes and lessons learned are shared organisation-wide through newsletters, team briefs, shared learning forums and learning bulletins.				
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection						
Systems and processes are in place to ensure:						
6.1	Induction and mandatory training on IPC include the key criteria (SICPs/TBPs) for preventing and controlling infection within the context of the care setting.	• Content of Training: IPC mandatory training (Levels 1 and 2) explicitly includes the principles of Standard Infection Control Precautions (SICPs) and Transmission-Based Precautions (TBPs). Training covers hand hygiene, respiratory hygiene, PPE use, environmental cleanliness, equipment decontamination, and safe waste handling. Induction programmes reinforce these core principles for all new staff, contextualised to their role and care setting. • Accessibility & Delivery	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		Training is delivered via e-learning modules, classroom sessions (where appropriate), and supported by role-specific induction. Refresher training ensures knowledge remains current and aligned with the National Infection Prevention and Control Manual (NIPCM). • Monitoring & Compliance Training compliance is monitored bi-monthly by the IPC team and reported to the IPC Committee. Compliance rates are benchmarked corporately, with directorates held to account through Clinical Governance structures. • Governance Oversight: The IPC Committee provides assurance to the Clinical Governance Committee and Board that training is delivered, monitored, and effective.				
6.2	The workforce is competent in IPC commensurate with roles and responsibilities.	• Role-Specific Training: Mandatory IPC training delivered at the appropriate level (Level 1 for all staff; Level 2 for donor/patient-facing staff). Training content aligned to national standards (NIPCM) and tailored to NHSBT service delivery. • Competency Assessment: Competence assessed through supervised practice, local induction checklists.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		Audit processes (e.g., hand hygiene audits, cleaning efficacy audits, equipment decontamination checks) provide evidence of competence in practice. Peer-to-peer support and local IPC Link Nurses/Practitioners reinforce standards and provide coaching where inconsistencies are identified. • Continuous Development: Refresher training and updates issued when national guidance changes. IPC newsletters, team briefs, and targeted training briefs support ongoing learning. IPC link nurses/practitioners undertake a days IPC training, based on the IPC educational framework, they also attend bi-monthly workshops for additional education and sharing of best practices. • Governance Oversight: Compliance and outcomes are reviewed by the IPC Committee, with assurance provided through Clinical Governance reporting.				
6.3	Monitoring compliance and update IPC training programs as required.	Compliance with IPC training is monitored nationally through audits, practice observations, revalidation procedures, and oversight by local managers, nursing staff and IPC link nurses/practitioners. Training programmes are updated in line with the IPC education framework to reflect current best practice. The IPC team are active stakeholders on the Mandatory Training Subcommittee and	Hand hygiene auditing is not currently undertaken by TES staff, and some operating procedures do not consistently include hand hygiene	IPC link practitioners are now in place in TES and mangers have undergone hand hygiene refresher training.	A hand hygiene auditing programme is being introduced within TES, supported by the IPC Link Practitioner network. In parallel, TES operating procedures are under review to ensure hand hygiene requirements are explicitly incorporated,	Partially Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		review the content of IPC mandatory training annually to ensure alignment with national standards and organisational requirements.	instructions where required.		strengthening compliance and assurance.	
6.4	All identified staff are trained in the selection and use of personal protective equipment / respiratory protective equipment (PPE/RPE) appropriate for their place of work including how to safely put on and remove (donning and doffing) PPE and RPE.	All identified staff are trained in the correct selection, use, and disposal of PPE and RPE appropriate to their workplace. This includes competency in donning and doffing, with practical training provided for Type IIR masks and internal fit testing available for staff who may require FFP3 respirators. Training is supported by advice from the IPC team and regularly reviewed with the Health, Safety & Wellbeing team to ensure alignment with national guidance. Compliance is monitored through audit, observation, and incident review, providing assurance that staff are equipped to use PPE/RPE safely and effectively.	None	None	None	Compliant
6.5	That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Staff working with patients and donors who may be at risk of respiratory infection are fit-tested by trained Health, Safety & Wellbeing (HSW) team fit-testers. NHSBT has the equipment and capacity to undertake fit-testing as required, with the ability to scale up provision should the risk from patients or donors increase. Fit-testing records are maintained by the HSW team to provide assurance of compliance and readiness.	None	None	None	Compliant
6.6	If clinical staff undertake procedures that require additional clinical skills, for example, medical	TAS and OTDT nurses follow a dedicated suite of competencies, which are completed and recorded as required to evidence role-specific proficiency.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	device insertion, there is evidence staff are trained to an agreed standard, and the staff member has completed a competency assessment which is recorded in their records before being allowed to undertake the procedures independently.	Within TAS, ultrasound-guided cannulation is recognised as an extended role; colleagues undertaking this practice receive appropriate training and assessment, with all procedures documented in the patient record to ensure accountability and traceability.				
7. Provide or secure adequate isolation precautions and facilities						
Systems and processes are in place in line with the NIPCM to ensure that:						
7.1	Patients that are known or suspected to be infectious as per criterion 5 are individually clinically risk assessed for infectious status when entering a care facility. The result of individual clinical assessments should determine patient placement decisions and the required IPC precautions. Clinical care should not be delayed based on infectious status.	• Referral and Admission Processes Infection risk information is captured at referral for TAS and OTDT patients and updated at point of admission or handover from hospital clinical teams. Blood donors are pre-screened through health questionnaires, pre-attendance communications, and on-site health checks to identify infection risks. • Individual Clinical Risk Assessment All TAS and OTDT patients are clinically risk assessed for infection	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		on arrival, with assessments documented in patient records. Suspected or confirmed infectious patients are normally cared for at the hospital bedside; if unavoidable in a TAS unit, they are treated at the end of the day with full decontamination procedures afterwards. IPC advice is sought in complex cases to ensure consistent and proportionate precautions. • Placement Decisions & Precautions Placement decisions are based on the outcome of the risk assessment, with appropriate Transmission-Based Precautions (TBPs) applied where required. Clinical care is not delayed; patients are managed safely while IPC precautions are implemented. • Governance Oversight Compliance monitored through IPC audits, CARE Committees, and IPC Committee reporting. Any incidents relating to placement or infectious patients are reviewed under PSIRF/Datix, with learning cascaded.				
7.2	Isolation facilities are prioritised, depending on the known or suspected infectious agent and all decisions made are clearly documented in the patient's notes. Patients can be cohorted together if: • single rooms are in short supply and if there	TAS Patients with infections are cared for in hospital side rooms wherever possible to minimise the risk of transmission. Where this is not feasible, isolation within TAS may be required; in such cases, measures are implemented to reduce risk, including scheduling the patient as the last case of the day when no other vulnerable patients are present. Following treatment, the room undergoes deep cleaning, with Standard	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	are two or more patients with the same confirmed infection. • there are situations of service pressure, for example, winter, and patients may have different or multiple infections. In these situations, a preparedness plan must be in place ensuring that organisation/board level assurance on IPC systems and processes are in place to mitigate risk.	Infection Control Precautions (SICPs) and Transmission-Based Precautions (TBPs) applied throughout.				
7.3	Transmission based precautions (TBPs) in conjunction with SICPs are applied and monitored and there is clear signage where isolation is in progress, outlining the precautions required.	For TAS patients known to be infectious, Transmission-Based Precautions (TBPs) and Standard Infection Control Precautions (SICPs) are applied during treatment. Patients are treated within their hospital ward bed space rather than being transferred into a TAS unit, reducing the risk of cross-transmission.	None	None	None	Compliant
7.4	Infectious patients should only be transferred if clinically necessary. The receiving area (ward, hospital, care home etc.) must be made aware of the required precautions.	TAS patients requiring isolation are treated within their designated isolation units or hospital wards. Apheresis machines used in these settings are fully decontaminated after each use before being returned to the TAS unit, ensuring safe reintroduction of equipment into the clinical environment.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate						
Systems and processes to ensure that pathogen-specific guidance and testing in line with UKHSA are in place:						
8.1	Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	• Competence of Staff: Testing is undertaken only by staff who are appropriately trained and competent in sampling and laboratory procedures. Competencies are signed off locally and refreshed through revalidation and audit. • National Standards & Accreditation: All microbiology and virology testing is carried out in UKAS-accredited laboratories, meeting nationally recognised quality standards Policies (e.g., MPDs/SOPs) set out clear processes for testing, handling, and reporting of results, aligned with national guidance. • Quality Control & Oversight: Internal quality control and external quality assurance schemes are in place to ensure accuracy and reliability of results. Clinical oversight provided by NHSBT's Consultant Virologist, Consultant Bacteriologist, and Consultant in Epidemiology and Health Protection. • Governance & Reporting: Results of infectious disease testing feed into donor deferrals, patient management, and surveillance reporting. Assurance is provided through the IPC Committee and Clinical Governance Committee, ensuring	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		risks are monitored and escalated appropriately.				
8.2	Early identification and reporting of the infectious agent using the relevant test is required with reporting structures in place to escalate the result if necessary.	• Timely Testing: Donor and patient samples are tested promptly using validated methods within UKAS-accredited laboratories. Systems in place ensure rapid turnaround for critical results (e.g., bacterial screening of platelets, NAT testing for viral markers). • Clear Reporting Structures Positive or significant results are escalated immediately to the Microbiology Services clinical team, who confirm actions and communicate outcomes. Donors are directly informed of any positive results with appropriate referral or follow-up. Patient results are reported to the clinical care team and, where relevant, escalated to Infection Prevention and Control (IPC) teams and/or local public health authorities. • Governance & Oversight Results and follow-up actions are documented in line with SOPs/MPDs. Outbreaks or significant incidents trigger formal review under PSIRF and reporting to CARE Committees, IPC Committee, and Clinical Governance Committee. Trends and learning are shared through governance to ensure organisational awareness and system improvement.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
8.3	Protocols/service contracts for testing and reporting laboratory/pathology results, including turnaround times, should be in place. These should be agreed and monitored with relevant service users as part of contract monitoring and laboratory accreditation systems.	Protocols are in place to ensure safe testing, reporting, and turnaround of results to protect donor and patient safety. This includes MPD326 – Carriage and Packaging of Dangerous Goods, SPN201 (Bacteriology User Guide), INF1060 (Virology User Guide), and compliance with UN3373 standards for the movement of dangerous substances, using SOP1154 – Dispatch of Samples to External Laboratories by Micro Services Laboratories. Testing is carried out in UKAS-accredited laboratories (ISO 15189), with service contracts in place that set out reporting responsibilities and turnaround times. Contract monitoring and laboratory accreditation processes provide assurance that these standards are routinely achieved, with performance and compliance reviewed through governance structures.	None	None	None	Compliant
8.4	Patient/service user testing on admission, transfer, and discharge should be in line with national guidance, local protocols and results should be communicated to the relevant organisation.	Patient infection risk is identified through testing and screening processes in line with national guidance and local protocols. For TAS and OTDT referrals, infection risk information is captured on the referral form or via clinical/nursing handover. Patients with known infections are not routinely treated within TAS units; the referring Trust provides an alternative bed space. In exceptional circumstances, patients may be scheduled as the final case of the day, with full IPC precautions and a deep clean afterwards.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
		Testing results and infection risk information are communicated to the relevant clinical teams and organisations, ensuring safe placement, continuity of care, and compliance with national standards.				
8.5	Patients/service users who develops symptom of infection are tested / retested at the point symptoms arise and in line with national guidance and local protocols.	If a TAS patient develops symptoms of infection during or after a procedure, they are clinically reviewed and tested/retested in line with national guidance and local protocols. Results are communicated promptly to the relevant clinical teams and used to inform ongoing care and placement decisions. In parallel, the TAS unit undertakes an immediate deep clean of the environment, with consideration of exposure risks to other patients in the unit at the same time.	None	None	None	Compliant
8.6	There should be protocols agreed between laboratory services and the service user organisations for laboratory support during outbreak investigation and management of	NHSBT's Micro Services Laboratory has formal agreements with UKHSA laboratories to provide additional testing and specialist support where required, including outbreak investigations and management of known, emerging, novel, or high-risk pathogens. While such scenarios are extremely rare within NHSBT, the agreement provides	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
	known/ emerging/novel and high-risk pathogens.	assurance of rapid access to accredited national laboratory services should the need arise. Results and advice from UKHSA are shared with NHSBT clinical and IPC teams and reported through governance structures to ensure timely action and oversight.				
8.7	There should be protocols agreed between laboratory services and service user organisations for the transportation of specimens including routine/ novel/ emerging/high risk pathogens. This protocol should be regularly tested to ensure compliance.	Specimens are transported in line with agreed protocols and regulatory standards. NHSBT uses its internal transport network and documentation for routine specimen transfer, while samples requiring external testing (including novel, emerging, or high-risk pathogens) are sent to UKHSA reference laboratories using agreed safe procedures. MPD326 outlines organisational transport requirements for microorganisms, with responsibilities for users documented in SPN201 (Bacteriology User Guide) and INF1060 (Virology User Guide). External dispatches follow UN3373 transport requirements, as set out in SOP1154 – Dispatch of Samples to External Laboratories by Micro Services Laboratories. Compliance with transport protocols is assured through audit and monitoring processes, with corrective actions implemented where necessary, providing assurance that safe and compliant transport arrangements are maintained.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections						
9.1	Systems and processes are in place to ensure that guidance for the management of specific infectious agents is followed (as per UKHSA and the NIPCM) (UKHSA and NHSE A to Z pathogens list to be added once published). Policies and procedures are in place for the identification of and management of outbreaks/incidence of infection. This includes monitoring, recording, escalation and reporting of an outbreak/incident by the registered provider.	NHSBT works in close partnership with UKHSA and follows guidance from the NIPCM and national infectious agent management frameworks. Multiple department-specific documents are in place to support the management of a pandemic or outbreak scenario. Transfusion transmitted infection investigations are carried out by the Micro Services MDT, with any confirmed cases reported to SHOT in line with national reporting requirements. For donors, infection risk is managed through pre-attendance information and telephone screening, donor safety check questionnaire and appropriate deferral, with unwell donors advised to seek care from their GP. TAS patients and donors are outpatients; where they are inpatients, responsibility for their infection management lies with the hospital trust. Policies and procedures set out the process for monitoring, recording, escalation, and reporting outbreaks and incidents. Oversight is provided through the IPC Committee and Clinical Governance Committee, ensuring compliance with national standards and organisational learning.	None	None	None	Compliant
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection						
Systems and processes are in place to ensure that any workplace risk(s) are mitigated maximally for everyone. This includes access to an occupational health or an equivalent service to ensure:						

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
10.1	Staff who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment.	• Risk Assessment Processes Staff identified as being at higher risk of complications from infection (e.g. pregnancy, immunocompromise, long-term health conditions) undergo an individual risk assessment in line with organisational health and safety procedures. Risk assessments are documented and regularly reviewed, particularly if clinical duties, health status, or infection risk levels change (e.g. during outbreaks or pandemics). • Support & Adjustments Reasonable adjustments are made where required, such as modified duties, redeployment, or enhanced PPE. Occupational Health (OH) provides guidance and maintains oversight, including vaccination status and immunisation records. • Collaboration with IPC & HSW IPC team and Health, Safety & Wellbeing (HSW) colleagues advise managers to ensure assessments are proportionate and consistent with national guidance. Escalation routes are available for complex cases. • Governance Oversight Assurance is provided through the IPC Committee, HSW governance structures, and Clinical Governance Committee, ensuring risks are identified, documented, and mitigated.	None	None	None	Compliant

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
10.2	Staff who have had an occupational exposure are referred promptly to the relevant agency, for example, GP, occupational health, or accident and emergency, and understand immediate actions, for example, first aid, following an occupational exposure including process for reporting.	Staff have access to a 24-hour sharps line for immediate guidance and follow-up. Where required, they are referred by OH to their GP, Accident & Emergency, or Occupational Health for further care. Trained first aiders and nurses are available on site to provide immediate support. All occupational exposures are recorded through the DATIX system, with both electronic and paper options available to ensure accessibility across all sites. The IPC team provides specialist support for more complex blood exposures.	None	None	None	Compliant
10.3	Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	NHSBT's Occupational Health provider, People Asset Management (PAM), undertakes all recruitment health checks and immunisation clearances. Any outstanding immunisations are arranged through either OH or the Health, Safety & Wellbeing team, depending on the department, to ensure compliance. NHSBT does not have staff performing Exposure Prone Procedures (EPPs), removing the associated risk.	An audit of health surveillance records (August 2024) identified instances of incomplete staff records, indicating that not all records were transferred from the previous provider.	In the highest risk environments, TAS and OTDT who may work with clinically vulnerable patients, most staff are registered nurses who have previously undergone immunisation clearance in earlier roles, though this may not always be documented within OH records. To mitigate this, OH are arranging catch-up vaccinations or serology as required. Staff who work in roles where hepatitis B immunisation is recommended will also be asked to provide evidence of immunity	The NHSBT Health & Wellbeing team and IPC are working in partnership with PAM (Occupational Health provider) to ensure health surveillance records are fully maintained, accurate, and visible, providing continuous assurance.	Partial compliance

	Key Lines of Enquiry	Evidence	Gaps in Assurance	Mitigating Actions	Comments	Compliance rating
				where this is not recorded.		