NHS
Oxford University Hospitals
NHS Foundation Trust

National Safety Standards for Invasive Procedures (NatSSIPs) Policy on a Page

This applies to all areas of the Trust where patients undergoes surgery or invasive Procedures and all employees of the Trust involved in these procedures.

Key points of the policy

NatSSIPs2 sets out key steps to deliver safer care for patients undergoing invasive procedures in a standardised way.

The Policy details key principles for Local Safety Standards for Invasive Procedures to:

- Harmonise practice and reduce the number of errors resulting from invasive procedures.

All LocSSIPs MUST include the following:

- Organisational Standards
- Governance and Audit requirements
- Documentation of Invasive Procedures
- Workforce Requirements
- Scheduling Management
- Handover and Transfer of Information

LocSSIPs not covered by the Generic WHO checklist may require a supporting bespoke WHO checklist.

The NatSSIPs 8

NatSSIPs2 has added three additional steps to the five steps to safer surgery making the NatSSIPs8:

- Consent, Procedural Verification and Site Marking
- Prosthesis Verification
- Prevention of Retained Foreign objects

National Safety Standards for Invasive Procedures (NatSSIPs) Policy on a Page. OMI 96667

Policy for the Adoption of the National Safety Standards for Invasive Procedures (NatSSIPs2)

Category:	Policy
Summary:	This policy adopts in full the principles laid out in the NHS England document 'National Safety Standards for Invasive Procedures (NatSSIPs2)'. This policy details the key principles for Local Safety Standards for Invasive Procedures (LocSSIP) development and conduct, and content of 'STOP' points for invasive procedures.
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Distribution:	Trustwide
Related Documents:	National Safety Standards for Invasive Procedures2 (NatSSIPs), NHS England Never Events Policy and Framework (2018) Being Open (Duty of Candour) Policy Procedural Verification of Site Marking OUH LocSSIP Template WHO Surgical Safety Checklist Policy Swab, Needle, Instrument and Accountable Items Count Policy PPID Policy Prothesis Verification Policy Consent to examination Policy
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This Document replaces:	Policy for the Adoption of the National Safety Standards for Invasive Procedures (NatSSIPs), Version 2.0 November 2021

Lead Director: Chief Medical Officer

Issue Date: April 2023

This document is uncontrolled once printed.

It is the responsibility of all users to this document to ensure that the correct and most current version is being used.
This document contains many hyperlinks to other related documents.
All users must check these documents are in date and have been ratified appropriately prior to use.

Document History

Date of revision	Version number	Author	Reason for review or update
September 2018	1.0	SSPIG Chair(s) Clinical Policies and Safety Standards Practitioner	New document.
July 2019	1.1	Clinical Policies and Safety Standards Practitioner	Amended to state Human Factors training is desirable, not essential.
September 2019	1.2		Two separate LocSSIP templates consolidated into one template.
October 2019	1.3		Statement added that approved LocSSIPs should be printed off reference in clinical areas.
January 2020	1.4		Clarification of monitoring compliance of LocSSIPs. Change from 'Datix' to 'incident management system'.
November 2021	2.0	Clinical Policies and Safety Standards Practitioner Head of Clinical Governance	3 yearly review, inclusion of recommendations from Safer Surgery audit
March 2023	3.0	Clinical Policies and Safety Standards Practitioner Head of Clinical Governance	Review following publication of NATSSIPS2 document
February 2024	3.1		Addition of Policy on a Page to Front page

Consultation Schedule

Who? Individuals or Committees	Rationale and/or Method of Involvement
Safe Surgery and Procedures Implementation Group (SSPIG) Chairs	Review and approval.
Clinical Policy Group (CPG)	Review and final approval.

Endorsement

Endorsee Job Title
SSPIG Chair(s)
CPG Chair
Chief Medical Officer

Contents

Who should read this document?

1. This document applies to all areas of the Trust where patients undergo surgery or invasive procedures, and all employees of the Trust who are involved in these procedures, including individuals employed by a third party, by external contractors, as voluntary workers, as students, as locums or as agency staff.

Key Standards/Messages

2. NatSSIPs2 set out the key steps necessary to deliver safe care for patients undergoing invasive procedures and allow organisations that deliver NHS funded care to **standardise** the processes that underpin patient safety.

3. The Policy details the Key principles for Local Safety Standards for Invasive procedures (LocSSIPs) development to:

   3.1. **harmonise** practice across the Trust so that there is a consistent approach to the care of patients undergoing invasive procedures in any location and

   3.2. to reduce the number of errors and complications resulting from invasive procedures considering human factors with systems thinking, culture, psychological safety and team work.

4. All LocSSIPS must include the following Safety Standards:

   4.1. **Organisational (standards that underpin safe delivery of procedural care):**

      4.1.1. Governance and audit

      4.1.2. Documentation of invasive Procedures

      4.1.3. Workforce

      4.1.4. Scheduling and List Management

      4.1.5. Handovers and Information Transfer

   4.2. Sequential Standards: (The NatSSIPs 8) (a logical sequence of steps that should be performed for every procedure session or operating list, and every patient):

      4.2.1. Consent, Procedural Verification and site marking

      4.2.2. Safety briefing

      4.2.3. Sign in

      4.2.4. Time out

      4.2.5. Prosthesis Verification (Implants) where relevant

      4.2.6. Prevention of retained foreign objects

      4.2.7. Sign out

      4.2.8. Debrief/Handover

Background/Scope

5. The concept of 'Never Events' was introduced into the UK in 2009, defined by NHS England as " *Patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers." (*NHS Improvement (2018) *Never Events Policy and Framework*.)

6. NHS England states that "*the aims of the creation of LocSSIPs are the standardisation and harmonisation of clinical practice throughout the NHS and the development of consistency in education, commissioning and regulation*" (NHS England (2015) *National Safety Standards for Invasive Procedures (NatSSIPs)*)

7. Patient safety is an essential element of effective, quality patient care and all healthcare staff have a duty of care to prevent harm to the patient. Oxford University Hospitals NHS Foundation Trust has adopted the NatSSIPs2 to improve patient safety for all invasive procedures. This document sets out the Trust's Policy for compliance with these standard operating procedures.

8. The NatSSIPs2 framework is intended to cover the part of the patient pathway that pertains specifically to the performance of an invasive procedure, whilst recognising that safe care of the patient starts well before and finishes well after the performance of the procedure.

9. The correct use of safety checklists (such as the WHO safe surgery checklist) can mitigate the risks and harm associated with invasive procedures and should accompany LocSSIPs where appropriate.

10. All patients having an invasive procedure within Oxford University Hospitals NHS Foundation Trust (OUH), including those under local anaesthetic, general anaesthetic or sedation, will have care in line with the principles laid out on this policy during their procedure.

11. The term 'invasive procedure' is inclusive of:

    11.1. All surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward, delivery rooms, and other procedural areas within an organisation.

    11.2. Surgical repair of episiotomy or genital tract trauma associated with vaginal birth. Invasive cardiological procedures such as cardiac catheterisation, angioplasty and stent insertion.

    11.3. Endoscopic procedures such as gastroscopy and colonoscopy.

    11.4. Interventional radiological procedures.

    11.5. Thoracic interventions such as bronchoscopy and the insertion of chest drains.

    11.6. Biopsies and other invasive tissue sampling.

Key Updates

12. Updating of links

13. Update due to release of NatSSIPs2:

14. Update of the WHO five steps to Safer Surgery to the NatSSIPS 8 Sequential Steps Standards: Team Brief, Time Out, sign Out and Handover/Debrief to include three more steps to make the sequential standards: Consent, Procedural Verification and site marking; Safe use of implants; and reconciliation of items.

Aim

15. The purpose of this policy is to:

    15.1. Improve patient safety during invasive procedures.

    15.2. Provide a skeleton framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs).

    15.3. Standardise key elements of procedural care, ensuring that care is harmonised across the Trust.

Content of the Policy

Never Events and Duty of Candour

16. Never Events are a particular type of serious incident that meet **all** the following criteria:

- They are **wholly preventable**, where guidance or safety recommendations that provide strong systemic protective barriers **are available at a national level, and should** have been implemented by all healthcare providers.
- Each Never Event type **has the potential to cause serious patient harm or death**. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- There is evidence that the category of Never Event **has occurred in the past**, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.
- **Occurrence of the Never Event is easily recognised and clearly defined** – this requirement helps minimise disputes around classification and ensures focus on learning and improving patient safety.

17. Never Events that have occurred at the OUH are detailed on our intranet site and can be found here.

18. The list of incidents considered to classify as Never Events can be found here.

19. Statutory Duty of Candour, in the form of Regulation 20 of the 2014 Regulations of the Health and Social Care Act 2008, places a statutory duty on healthcare providers in England to ensure that they are open and honest with patients when things go wrong with their care.

20. Please refer to the Trust Being Open (Duty of Candour) Policy for further information on Duty of Candour.

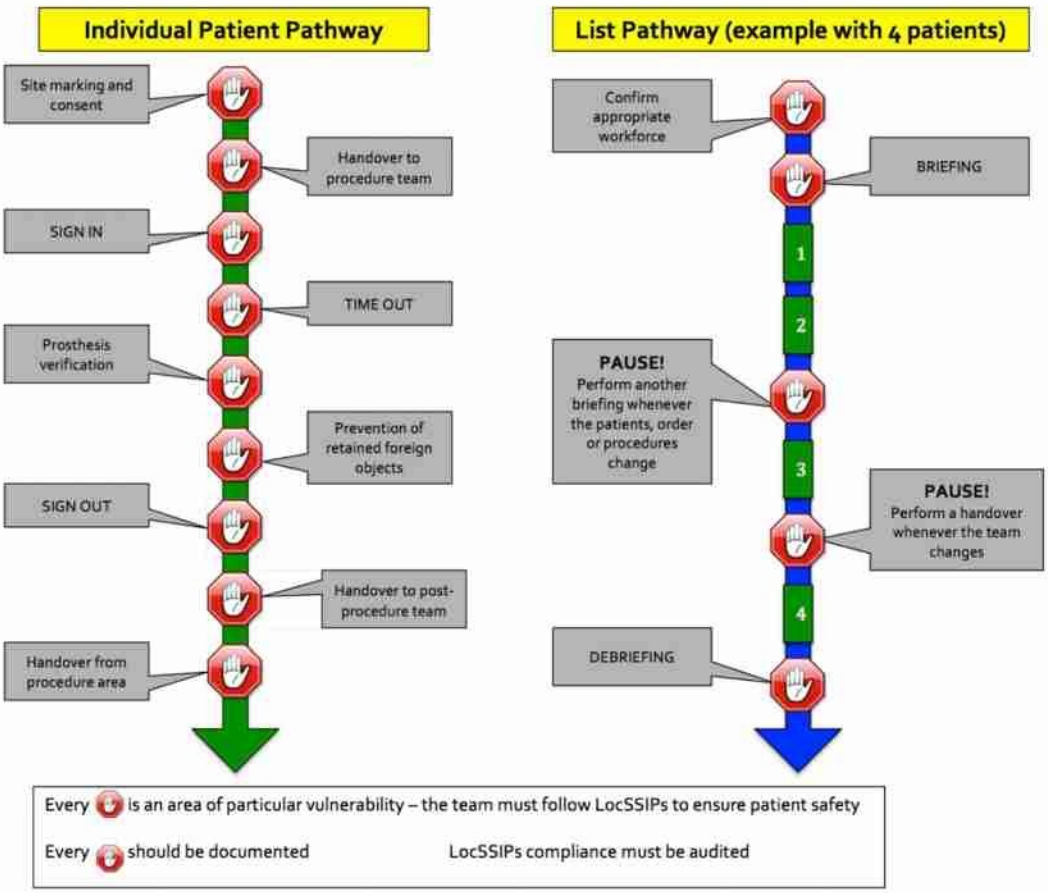
21. All incidents in the Trust will be investigated following the incident and investigation policy and this includes adhering to the Just Culture Guide. The

Just Culture Guide encourages managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way.

22. The NHS England NatSSIPs2 document divides the safety standards into two separate categories:

- **Organisational (standards that underpin safe delivery of procedural care):**
  - Governance and audit
  - Documentation of invasive procedures
  - Workforce
  - Scheduling and list management
  - Handovers and information transfer
- The NatSSIPs 8 sequential Steps standards (a logical sequence of steps that should be performed for every procedure session or operating list, and every patient):
  - Consent Procedural verification and site marking
  - Safety/team briefing
  - Sign in
  - Time out
  - Implant use/Prosthesis verification
  - Reconciliation of items/Prevention of retained foreign objects
  - Sign out
  - Debriefing

23. The diagram below, taken from the NatSSIPs document shows how these checks and 'STOP' points fit into an individual patient pathway and into a list with 4 patients.



Terminology

24. Throughout this document the words '**should'** and '**must**' are used. These words are taken directly from the NatSSIPs2 document and have specific meanings.

25. **'Must'** is used for an overriding duty or principle. The term 'must' is used for standards that are integral to modern invasive procedure practice and are markers of basic safety. A lack of embedded practice related to 'musts' should be seen as a red flag and should prompt processes to improve. Simply not wishing to follow a 'must' standard, either at individual or organisational level, is unlikely to be viewed as an acceptable justification by patients, inspectors, accreditation bodies or those investigating practice. The term 'not recommended' is an explicit 'do not' in the same vein as 'must'

26. **'Should'** is used when we are providing an explanation of how you / the team / the organisation will meet the overriding duty. 'Should' is also used where the duty or principle will not apply in all situations or circumstances, or where there are factors outside your / the team's / the organisation's control that affect whether or how the guidance can be followed. There will be entirely legitimate occasions when a 'should' statement cannot, and / or should not, be followed to the letter. These may be due to individual patient circumstances, or because there is some common aspect of a process that makes application of that statement a less safe option. Individual clinicians and organisations should be able to justify these decisions with risk assessment

27. The terms **'could'** and **'may** consider' are suggestions from the NatSSIPs working party of actions that have theoretical or anecdotal evidence of usefulness but may not be appropriate in all situations or may have insufficient evidence / consensus to mandate their global adoption.

Local Safety Standards for Invasive Procedures (LocSSIPs)

28. LocSSIPs are intended to be locally developed standards that incorporate the overriding principles of NatSSIPs. Where they are developed they **must** be developed in accordance with the principles laid out in the NatSSIPs2 document and this policy.

29. LocSSIPs **must** make reference, where relevant, to each of the domains outlined below. A LocSSIP can be a safety standard for a group of procedures where the overall process is sufficiently similar so as not to merit entirely separate documents. It will be for each Division to decide what procedure or group of procedures would be suitable for a single LocSSIP.

30. In the event of any conflicting guidance, NatSSIPs2 will take precedence and the locally developed LocSSIP **must** be adjusted accordingly.

31. Once a LocSSIP is approved at the Safe Surgery and Procedures Implementation Group (SSPIG), these must be adopted within 3 months. If electronic versions are not feasible hard copies should be printed off and made available in the relevant area(s) or clinic/procedure room(s) as a point of reference for staff. Availability of hard copies for staff will be queried in the event of an assurance visit.

Organisation and Governance

32. All LocSSIPs must be submitted to SSPIG for review and approval before implementation. The group will assess the LocSSIP against the NatSSIPs2 framework and provide support for further development and/or approve it for use.

33. Any LocSSIP involving a medicine must be reviewed by a pharmacist before approval, and they must be listed as an author to evidence this.

34. All new or updated LocSSIPs submitted to SSPIG for approval **must** include an audit tool to ensure monitoring compliance is completed regularly and consistently.

35. Implementation of new or updated LocSSIPs will take place in the initial 3 months following approval at SSPIG, to allow for dissemination and training of staff.

36. Compliance monitoring should be initiated 3 months after approval and completed on a regular basis, and once quarterly minimum. All audit results will be reported to Patient Safety and Effectiveness committee (PSEC) via divisional quality reports.

37. SSPIG will, at each meeting, request updates from Divisional representatives regarding:

- Incidents reported related to any area of practice that falls within the remit of NatSSIPs2.
- Progress on LocSSIP implementation.

- Monitoring of compliance with approved LocSSIPs. It is expected that each LocSSIP will describe within it the key indicators of successful implementation.

38. SSPIG will distribute, after every meeting, a list of key themes that have emerged from the above inputs with reference to relevant National and Local Standards to help prevent future occurrences. It is expected that this will be cascaded to all practitioners by the Divisional representative.

Workforce

39. LocSSIPs **must**:

- Be explicit about the staffing requirements for the Invasive Procedure(s) they relate to. This **must** include reference to specific competency, training requirements or induction information for the procedure. Where the procedure involves a non-medical procedural assistant, there **must** be an agreed process for training and competency review.
- Make reference to the supervision of staff, including but not limited to non-registered practitioners, doctors in training, student Operating Department Practitioners (ODPs), undergraduate and post-graduate training of nursing staff.
- Make reference to procedures for staff handover where procedure length exceeds the amount of time a single team can reasonably be expected to work.
- Where staff numbers or specific skill mix is below the minimum outlined in the LocSSIP, this must be reported to the theatre manager through the Trust Reporting Scheme.

40. Any member of the team who is concerned about the skill mix or staffing levels for a procedure should bring this to the attention of the team during the team brief. If the concern is still unresolved, they should bring this to the attention of the theatre manager or nominated deputy. An assessment should then be made of whether it is appropriate to continue.

Education, Training and Human Factors

41. Team members participating in any stage of any LocSSIPs must receive appropriate training to allow them to be able to fulfil their roles safely, effectively and consistently.

42. The competence of individuals and teams in the performance of LocSSIPs must be regularly assessed. Appraisal, revalidation, performance development and review processes will include active participation in LocSSIPs.

43. Training must be not only on an individual basis but must also include training as multidisciplinary and multiprofessional procedural teams – team members should train together in the delivery and development of LocSSIPs and their associated checklists. Procedural teams should also receive regular training in human factors and non-technical skills.

44. Particular care should be taken to ensure new members of surgical or procedural teams receive appropriate induction training to support them in using LocSSIPs.

Scheduling and List Management

45. Patient safety during the performance of invasive procedures is dependent upon adequate preparation, the accurate scheduling of procedures and the management of procedure lists.

46. LocSSIPs related to scheduling and list management **must:**

- Include the unambiguous use of language in all communications relating to the scheduling and listing of procedures. Laterality must always be written in full, i.e. 'left' or 'right'. The use of abbreviations should be avoided.
- When appropriate, involve supporting clinical services such as radiology and anaesthesia to ensure the availability of all required healthcare professionals.
- Take into account the expected workload, including time for anaesthesia, patient positioning, preparation of equipment and the familiarity and skill mix of the team. For common procedures reviews of existing data may be useful.

47. The principles of list management as laid out in NatSSIPs2 are adopted and include the following:

- List changes should be avoided if possible. Any list changes made after the deadline for the publication of a final version of the list must be agreed with identified key members of the procedure team, and should be discussed by all members of the procedure team at the safety briefing.
- All relevant personnel **must** be made aware of any late changes to a list. In the absence of electronic list scheduling, the organisation must have clear processes for managing lists and an effective mechanism for version control that ensures that different versions of lists are not available.
- The procedure list should be clearly displayed in the room in which the procedures are performed, and any other areas that are deemed important for the safe care of the patient. The final version of the list should be available at the safety briefing.

Principles common to all 'STOP' points

48. The following principles are common to all of the '**STOP'** points that follow.

- There **must** not be any non-pertinent conversation; only one person should speak at a time.
- Noise and interruptions should be minimised

1. Distracting activities must be stopped, or the '**STOP'** point delayed until such time as they have been safely completed. Such activities include but are not limited to:
    - Skin cleaning or preparation and draping of the patient
    - Scrubbing

- Transfer of monitoring and/or patient onto the operating theatre anaesthetic machine
- Application of wound dressings
- General theatre activity

- All staff members should be given the opportunity to ask questions and clarify information.
- Participation of the patient (and/or parent, guardian, carer or birth partner) should be encouraged where possible and appropriate.

Safety Briefing

49. A safety briefing **must** be performed at the start of all elective, unscheduled or emergency procedure sessions. The briefing may need to be conducted on a case-by-case basis if there is a change in key team members during a procedure session. Every team member is encouraged to ask questions, seek clarification or raise concerns about any aspect of the procedure.

50. The safety briefing should take place in a discreet location in which patient confidentiality can be maintained, while enabling inclusivity and contribution from all team members, and should usually be conducted before the first patient arrives in the procedure area.

51. Each member of the procedural team expected to be involved in the scheduled session **must** be named and this list made easily visible throughout the session. The operator, scrub practitioner and anaesthetist if relevant must be identified for each case listed. Any changes to the team members during the day should also be recorded in this document or notice and should be the subject of an appropriate briefing if anticipated.

52. Team members **should** introduce themselves to ensure that their roles and names are known and to encourage people to speak up.

53. The expected duration of each procedure, to include anaesthetic procedures should be identified. This should promote a discussion about agreed plans if it appears that the duration of the planned procedures will exceed the time allocated.

54. Any additional concerns from an operator, anaesthetic or practitioner perspective **must** be discussed and contingency plans made.

55. The briefing **must**:

- Include the lead surgeon and anaesthetist for the scheduled procedure list and any other operator(s) or anaesthetist(s) that have seen and consented the patient shortly before the procedure session. Where an individual other than the lead for the scheduled list is intended to be the lead anaesthetist surgeon or practitioner for the first case, this must be clearly documented on the published list.
- Discuss each patient on the list and address any concerns from any team member related to any aspect of the procedure, discussing surgical, anaesthetic and practitioner perspective

56. For each patient, the discussion **should** include when relevant, but is not limited to:

- Diagnosis and planned procedure.
- Availability of prosthesis.
- Site and side of procedure.
- Infection risk, e.g. MRSA status.
- Allergies.
- Relevant comorbidities or complications.
- Need for antibiotic prophylaxis.
- Likely need for blood or blood products.
- Patient positioning.
- Equipment requirements and availability, including special equipment or 'extras'.
- Postoperative destination for the patient, e.g. ward or critical care unit.

57. A record should be made of the team briefing and should be displayed in the procedural area for reference during the procedure list. If a significant issue about the care of a patient arises during the briefing, a clear and contemporaneous note of this should be made on the patient's record. Any issues raised in the briefing that may have relevance for the care given to other patients by the Trust should be reported to local governance systems by an identified team member and if necessary, an incident raised.

Sign in

58. All patients undergoing invasive procedures under general, regional or local anaesthesia, or under sedation, **must** undergo safety checks on arrival at the procedure area. This **'STOP'** point is referred to as the 'sign in'.

59. The sign in should not be performed until any omissions, discrepancies or uncertainties identified in the handover from the ward or admission area to the receiving practitioner in the procedure area or anaesthetic room have been fully resolved. On rare occasions, the immediate urgency of a procedure may mean that it may have to be performed without full resolution. Such occurrences should be reported as safety incidents via the Trust's incident reporting system, as per the Incident Reporting and Investigation Policy.

60. A sign in **must** be completed and documented on arrival at the procedure area or anaesthetic room. The checks performed during the sign in should include when relevant, but are not limited to:

- Patient name checked against identity band as detailed in the Positive Patient Identification Policy (PPID policy)
- Consent form
- Surgical site marking if applicable
- Operating list

- Anaesthetic safety checks: machine, monitoring, medications
- Allergies
- Aspiration risk
- Potential airway problems
- Arrangements in case of blood loss.

61. The sign in **must** be performed by at least two people involved in the procedure. For procedures performed under general or regional anaesthesia, these should include the anaesthetist and anaesthetic assistant. For procedures not involving an anaesthetist, the operator and an assistant should perform the sign in.

62. Any omissions or discrepancies identified during the sign in should be resolved before the time out is performed or any procedure starts. On rare occasions, the immediate urgency of a procedure may mean that it may have to be performed without full resolution of any omissions, discrepancies or uncertainties. Such occurrences should be reported as safety incidents via the Trust's incident reporting system, as per the Incident Reporting and Investigation Policy.

63. Immediately before the insertion of a regional anaesthetic, the anaesthetists and anaesthetic assistance must simultaneously check the surgical site marking and site of the block (Stop Before You Block). Further details on Stop Before You Block can be located in the Trust Stop Before You Block procedure.

Time out

64. All patients must undergo safety checks on arrival at the procedure area and before the start of the procedure. This '**STOP**' point is known as the 'time out'.

65. Where the following conditions are met, the sign in and time out may be merged into a single check:

- No sedation or general anaesthesia is being given
- The arrival room and the procedure room are the same
- All members of the team are present for the combined check

66. The time out **should** not be performed until any omissions, discrepancies or uncertainties identified in the 'sign in' have been fully resolved.

67. Any member of the procedure team may lead the time out. All team members involved in the procedure should be present at the time out. The team member leading the time out **should** verify that all team members are participating. This will usually require that they stop all other tasks and face the time out lead.

68. A time out **must** be conducted immediately before skin incision or the start of the procedure. It should include when relevant, but is not limited to, checks of:

- Patient's name and identity band against the consent form.
- The results of any relevant tests that **must** be present and available in theatre, e.g. imaging, hearing tests and eye tests.
- The procedure to be performed.

- Verification of surgical site marking.
- Operator:
  - The anticipated blood loss.
  - Any specific equipment requirements or special investigations.
  - Any critical or unexpected steps.
- Anaesthetist:
  - Any patient specific concerns.
  - Patient's ASA Physical Status.
  - Monitoring equipment and other specific support, e.g. blood availability.
- Scrub practitioner or operator's assistant:
  - Confirmation of sterility of instruments and equipment.
  - Any equipment issues or concerns.
- Surgical site infection:
  - Antibiotic prophylaxis.
  - Patient warming.
  - Glycaemic control.
  - Hair removal.
- VTE prophylaxis.
- Patient allergies.

69. Any omissions, discrepancies or uncertainties identified during the time out should be resolved before the procedure starts.

70. If the patient is not sedated, it is helpful for them to confirm their identity at this point using positive patient identification.

Prosthesis verification

71. There is a separate prosthesis verification policy.

72. Please refer to 'Sequential Standards page 29 of NatSSIPS2 (January 2023) for further information on standards for prosthesis and implant verification.

Prevention of retained foreign objects

73. The Trust has developed a separate policy 'Swabs, Sharps, Instruments and Accountable Items Policy'. This policy **must** be followed for all swabs, sharps, instruments and accountable items.

Sign out

74. All patients undergoing invasive procedures under general, regional or local anaesthesia, or under sedation, **must** undergo safety checks at the end of the procedure but before the handover to the post-procedure care team. This '**STOP'** point is known as the 'sign out'.

75. Any member of the procedure team may lead the sign out. All team members involved in the procedure should be present at the sign out. The team member leading the sign out should verify that all team members are participating in line with the general principles for all 'STOP' points laid out above.

76. Sign out checks should be conducted at the end of the procedure and before the patient is awoken from general anaesthesia or, when general anaesthesia is not used, before the patient leaves the procedure room. These checks should include when relevant, but are not limited to:

- Confirmation of the procedure performed, to include site and side if appropriate.
- Confirmation that instruments, sharps and swab counts are complete (or not applicable).
- Confirmation that any specimens have been labelled correctly, to include the patient's name and site or side when relevant.
- Discussion of post-procedural care, to include any patient-specific concerns.
- Equipment problems for inclusion in the debriefing.

Debrief

77. Procedural team debriefing is a key element of practice in the delivery of safe patient care during invasive procedures, and forms part of both the WHO Surgical Safety Checklist and the Five Steps to Safer Surgery. The debriefing should be seen as being as important a part of the safe performance of an invasive procedure as any of the other steps outlined in this document. Organisations should ensure that the job plans and working patterns of those involved in invasive procedures should allow and oblige them to attend debriefings in all but exceptional circumstances. Noise and interruptions should be minimised during the debriefing in keeping with the principles laid out for all sequential **'STOP'** points above.

78. A debriefing should be performed at the end of all elective procedure sessions. A debriefing should also be performed after all unscheduled or emergency procedure sessions. The debriefing may need to be conducted on a case-by-case basis if there is a change in key team members during a procedure session.

79. The total time set aside for the procedure or list of procedures should include the time taken to conduct the debriefing.

80. The debriefing should occur in a manner and location that ensures patient confidentiality, while enabling inclusivity and contribution from all team members. This should be agreed at the team briefing.

81. Every member of the procedural team should take part in the debriefing. Any team member may lead the debriefing, but the operator and anaesthetist (if an anaesthetist has been involved) **must** be present. If any team member, and especially the senior operator, scrub practitioner or anaesthetist, has to leave before the debriefing is conducted, they should have the opportunity to comment and document any positive feedback or issues for improvement they wish to see addressed during the debriefing. In this circumstance, their absence

from the debriefing should be recorded and included in routine audit of compliance with LocSSIPs.

82. Members of the procedural team **must** note any key points for consideration at the debriefing as the procedure list progresses. This can be on a personal record or annotated in the team briefing record

83. The content of the team debriefing should be modified locally and **must** be relevant to the patient and procedure. For each patient, the discussion should include, but is not limited to:

- Things that went well.
- Any problems with equipment or other issues that occurred.
- Any areas for improvement.

84. Records of debriefings should include an action log that can be used to communicate examples of good practice and any problems or errors that occurred. Each procedural team should have an identified member who is responsible for feeding this information into local governance processes.

85. If a significant issue about the care of a patient arises during the debriefing, a clear and contemporaneous note of this should be made in the patient's records. Local governance processes **must** ensure that issues identified in debriefing action logs are communicated at an appropriate level within the organisation, and that there is a mechanism to capture and promote learning.

Review

86. This policy will be reviewed every 3 years, as set out in the *Policy for the Development and Implementation of Procedural Documents*.

References

87. NHS Improvement (2018) *Never Events Policy and Framework revised January 2018* Available at https://www.england.nhs.uk/wp-content/uploads/2020/11/Revised-Never-Events-policy-and-framework-FINAL.pdf (Accessed December 2021)

88. NHS England (2015) *National Safety Standards for Invasive Procedures (NatSSIPs)*. Available at https://www.england.nhs.uk/wp-content/uploads/2015/09/natssips-safety-standards.pdf (Accessed December 2021)

89. Centre for Perioperative Care (2023) National Safety Standards for invasive Procedures 2: Available at 1. CPOC_NatSSIPs_FullVersion_2023_0.pdf (accessed March 2023)

Appendix 1: Responsibilities

1. The **Chief Executive Officer** has overall responsibility and accountability for the safety and care of patients in the Trust.

2. The **Chief Medical Officer** is responsible for ensuring:

   2.1. Dissemination of this policy in areas where invasive procedures are performed.

   2.2. Processes and programme of audit of compliance is established and conducted regularly with results reported to the **Trust Board** via the **Safe Surgery and Procedures Implementation Group**.

   2.3. Inclusion of the learning and participation from NatSSIPs and LocSSIPs as part of the process for medical revalidation.

3. **Divisional Directors and Clinical Directors** are responsible for:

   3.1. Dissemination and implementation of this policy across their areas of responsibility.

   3.2. Ensuring that LocSSIPs developed in their areas of responsibility are compliant with this policy and the standards detailed in the NHS England NatSSIPs document.

   3.3. Ensuring and promoting the collaborative working of relevant healthcare professionals to enable the development of LocSSIPs in their areas of responsibility.

   3.4. Addressing any shortfalls in compliance identified with this policy or the NHS England NatSSIPs document in their areas of responsibility.

4. **Divisional Nurses** or equivalent **Professional Leads** are responsible for:

   4.1. Dissemination and implementation of this policy across their areas of responsibility.

   4.2. Ensuring administrative and documentation processes are in place to enable compliance with the requirements of this policy.

   4.3. Collating evidence to demonstrate compliance with this policy.

   4.4. Overseeing any actions to address shortfalls in compliance with this policy.

5. **All Clinical Managers** are responsible for:

   5.1. Implementation of this policy in their areas of responsibility.

   5.2. Identification of staff training requirements, and provision of support and opportunity, in order for them to participate in training in relation to NatSSIPs and LocSSIPs. This training should be for all team members and should be in place to allow roles to be fulfilled safely, effectively and consistently.

   5.3. Ensuring records of training and competencies are maintained and that are readily accessible for assurance purposes.

6. **Multidisciplinary procedural teams**, e.g. operating theatre teams, to include medically qualified, registered and non-registered practitioners, are all equally responsible for:

   6.1. The development, implementation and continuous appraisal of the safety and efficacy of LocSSIPs, working with patient groups where appropriate.

   6.2. Ensuring that LocSSIPs are followed accurately for every patient.

6.3. Registered members of the team are accountable both to their registering bodies and to their employers.

6.4. Non-registered members of the team are accountable to their employers.

7. **All Trust staff** are responsible for:

7.1. Working within their scope of professional practice.

7.2. Adhering to the principles as detailed in this policy and being aware of their specific responsibilities and duties.

7.3. Undertaking required training and maintaining skills and competence according to role.

7.4. Reporting patient safety incidents and near misses via the Trust's incident reporting system, as per the Incident Reporting and Investigation Policy, irrespective of the level of harm.

7.5. Actively contributing to the development and review of LocSSIPs in terms of creation, implementation and audit of compliance.

8. The **Safe Surgery and Procedures Implementation Group** is responsible for:

8.1. Co-ordinating and monitoring the process for the identification, development, audit, approval and review of the overarching policies for the implementation of the NatSSIPs and LocSSIPs.

8.2. Developing and reviewing LocSSIPs relevant to the Never Events that have occurred in the Trust as a matter of priority and, as part of this, develop a plan for high impact actions for delivery.

8.3. To scope, develop and review other LocSSIPs in all other surgical and interventional areas within the Trust.

8.4. Ensure there are systems in place in clinical services to identify appropriate author(s) to develop and/or review the relevant LocSSIPs.

8.5. Ensure that all Trust-wide, Divisional-based and/or service-based LocSSIP development has an effective consultation and approval process in place.

Appendix 2: Definitions

1. The terms used in this policy are defined throughout the document.

Appendix 3: Education and Training

1. Training required to fulfil this policy will be provided in accordance with the Trust's Training Needs Analysis. Management and monitoring of training will be in accordance with the Trust's Learning and Development Policy. This information can be accessed via My Learning Hub on the Trust intranet.

Appendix 4: Monitoring Compliance

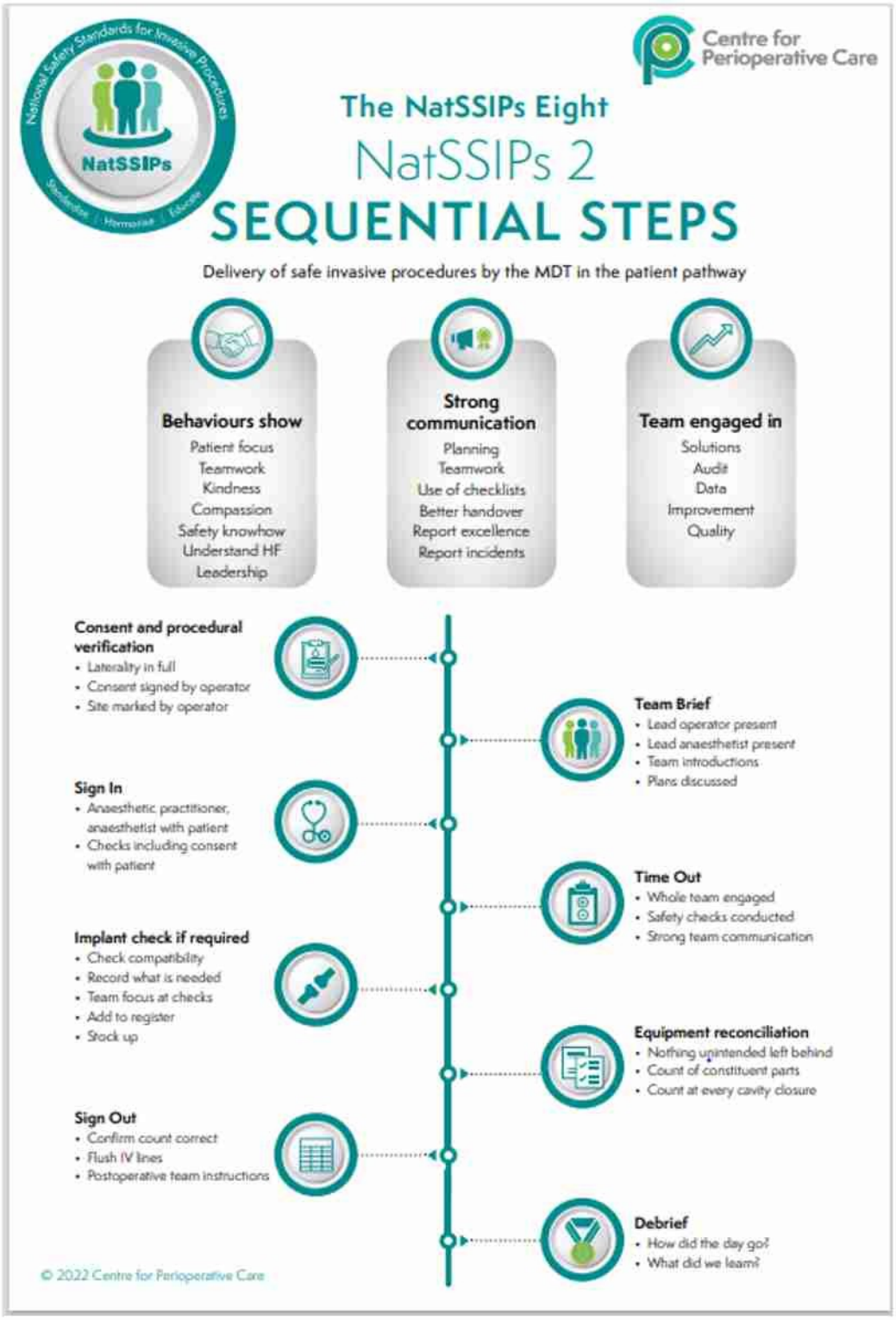
2. Use the following statement and mandatory table to list specifically what will be monitored to ensure that the policy is effective, including the minimum standards for compliance or non-compliance.

3. Compliance with the document will be monitored in the following ways.

What is being monitored:	How is it monitored:	By who, and when:	Minimum standard	Reporting to:
Compliance of all LocSSIPs with the NatSSIPs,	Review and approval process for LocSSIPs	SSPIG, monthly	100%	PSEC
Compliance of local practice with LocSSIPs	Audit	Local Governance Committees	Annual	CGC (via Divisional Quality Reports)
Evidence of action plans incorporating timescales for addressing any non-compliance identified	Audit	Local Governance Committees	Annual	CGC (via Divisional Quality Reports)
Evidence of regular review of LocSSIPs and their adjustment as required.	Review and approval process and document repository.	SSPIG, monthly	100%	CGC
	Monitoring compliance audit result report	SSPIG, annually	100%	CGC

Appendix 5: NatSSIPs2 Summary

Appendix 6: The NatSSIPS 8 Sequential Standards :



Appendix 7: Equality Impact Assessment

1. Information about the policy, service or function

What is being assessed	Existing Policy / Procedure
Job title of staff member completing assessment	Clinical Policies and Safety Standards Practitioner
Name of policy / service / function:	Policy for the Adoption of the National Safety Standards for Invasive Procedures (NatSSIPs)
Details about the policy / service / function	This policy adopts in full the principles laid out in the NHS England document 'National Safety Standards for Invasive Procedures (NatSSIPs)'. This policy details the key principles for Local Safety Standards for Invasive Procedures (LocSSIP) development and conduct, and content of 'STOP' points for invasive procedures.
Is this document compliant with the Web Content Accessibility Guidelines?	*Delete as appropriate* Yes
Review Date	March 2026
Date assessment completed	March 2023
Signature of staff member completing assessment	[redacted]
Signature of staff member approving assessment	

1. Screening Stage

Who benefits from this policy, service or function? Who is the target audience?

- Patients
- Staff

Does the policy, service or function involve direct engagement with the target audience?

Yes - *continue with full equality impact assessment*

2. Research Stage

Notes:

- If there is a neutral impact for a particular group or characteristic, mention this in the 'Reasoning' column and refer to evidence where applicable.
- Where there may be more than one impact for a characteristic (e.g. both positive and negative impact), identify this in the relevant columns and explain why in the 'Reasoning' column.
- The Characteristics include a wide range of groupings and the breakdown within characteristics is not exhaustive, but is used to give an indication of groups that should be considered. Where applicable please detail in the 'Reasoning' column where specific groups within categories are affected, for example, under Race the impact may only be upon certain ethnic groups.

Impact Assessment

Characteristic	Positive Impact	Negative Impact	Neutral Impact	Not enough information	Reasoning
Sex and Gender Re-assignment – men (including trans men), women (including trans women) and non-binary people.			X		
Race - Asian or Asian British; Black or Black British; Mixed Race; White British; White Other; and Other			X		
Disability - disabled people and carers			X		
Age			X		
Sexual Orientation			X		
Religion or Belief			X		
Pregnancy and Maternity			X		
Marriage or Civil Partnership			X		
Other Groups / Characteristics - for example, homeless people, sex workers, rural isolation.			X		

Sources of information

- *List any sources of information used*

Consultation with protected groups

List any protected groups you will target during the consultation process, and give a summary of those consultations

Group	Summary of consultation

Consultation with others

List any other individuals / groups that have been or will be consulted on this policy, service or function.

3. Summary stage

Outcome Measures

List the key benefits that are intended to be achieved through implementation of this policy, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.

Enter details here

Positive Impact

List any positive impacts that this policy, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.

Enter details here

Unjustifiable Adverse Effects

List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.

Enter details here

Justifiable Adverse Effects

List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.

Enter details here

Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

Identified risk	Recommended actions	Lead	Resource implications	Review date	Completion date

3. Research Stage

Notes:

If there is no impact for a particular group or characteristic, mention this in the Reasoning column and refer to evidence where applicable.

[1]Race categories follow those used in the National Census by the Office for National Statistics. Consideration should be given to the specific communities within broad categories such as Bangladeshi people.

[2]Please select age groups which may be impacted by the policy, service or function and complete as appropriate.

[3]Religion or Belief covers a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus; it also covers people who do not have a faith. Consider these individually and collectively when determining impacts.

Characteristic		Positive Impact	Negative Impact	Neutral Impact	Not Enough Information	Reasoning
Sex and Gender Reassignment	Men (incl. trans men)			X		
	Women (incl. trans women)			X		
	Non-binary people			X		
Race[1]	Asian or Asian British			X		
	Black or Black British			X		
	Mixed Race			X		
	White British			X		
	White Other			X		
	Other:			X		
Disability	Disabled people			X		
	Carers			X		
Age[2]				X		
Sexual Orientation				X		
Religion or Belief[3]				X		
Pregnancy and Maternity				X		
Marriage or Civil Partnership				X		
Other Groups /Characteristics	For example: homeless people, sex workers, rural isolation.			X		