Roles For NatSSIPs Deliverys, Implementation and Sustainment

In summary: Every Trust/Healthcare Board must have an adequately resourced leadership team to deliver the NatSSIPs.

- Trusts / Healthcare Boards[b] should have a named Board-member[c] with NatSSIPs within their portfolio.
- There should be a named, substantive senior clinician[d], **practising clinically within the invasive procedures domain**, who is responsible for strategic direction and oversight of the implementation, development and improvements related to NatSSIPs.
  - This individual should have sufficient, transparently allocated time within their job-plan for this role, commensurate with the size of the organisation
  - This individual should have sufficient, transparently allocated administrative support for the role, commensurate with the size of the organisation
  - This individual should have the ability, and authority, to be able to obtain strategic and operational support from across the organisation including, but not limited to: Information Technology (IT); education; quality improvement support; and procurement
- Each Trust should have a formally constituted multidisciplinary steering group (to include all relevant professions and sites), chaired by the NatSSIPs lead, with responsibility for:
  - Strategic oversight
  - Review of relevant data / intelligence/ insight
  - Provision of assurance to the Board
  - Providing updates as a standing agenda item to Governance and Quality Boards
  - Organisational sign-off of NatSSIPs-related policies and procedures
  - Reinforcing that NatSSIPs are more than 'checklists' and that they require a strategy for organisational as well as Sequential Standards improvement
  - Embedding systems and human factors knowledge and understanding[49]
  - Ensuring alignment of NatSSIPs with Trust Safety Strategy and Quality Objectives
- Every relevant specialty group within a Trust should have a named senior clinician[e], again practising clinically within invasive procedures with responsibility for specialty level governance of NatSSIPs and with representation on the Trust NatSSIPs group.
- In large Trusts, each site should have a NatSSIPs lead with allocated time to support the trust-wide remit.
- MDT members in training should be a formal part of these groups.
- The Trust NatSSIPs lead(s) should provide assurance to the Site and the Board on all aspects of NatSSIPs.
  - This assurance should include at a minimum an annual, publicly available account of progress and measurable outcomes related to NatSSIPs
- Boards should aim to include NatSSIPs within the strategic remit of patient safety specialists
  - Trust Boards should consider how NatSSIPs related activities will integrate with other key patient safety specialist roles (e.g. for maternity)

[b] For brevity within the document, Trust will be used as shorthand for the variety of names across the four nations. Similarly, Board should be understood as the level of the organisation with statutory responsibility for the organisation.
[c] There will be different structures. It is the concept of leadership and ownership at the top of the organisation that is key.
[d] Clinician deliberately includes medical, nursing, midwifery, pharmacy and Allied Health Professionals.
[e] This individual may well have other governance roles within the specialty. The intention is to be clear who is responsible for NatSSIPs, not to create more jobs.

Invasive Area Staffing and Resources

In summary: Every Trust and service must have sufficiently skilled and knowledgeable teams to deliver invasive care safely.

Safety in invasive procedures relies upon:

i. Having sufficient numbers of permanent staff vs agency staff.
ii. Appropriately trained and competent staff (trained in specialty safety aspects).
iii. Appropriate skill mix, and ratios of staff with relevant primary or postgraduate qualification (qualified in specialty).
iv. Sufficiently rested staff who can take planned breaks during their shifts.
v. Appropriate resources to plan for and perform the planned procedure.
vi. List planning and scheduling that includes adequate preparation time.
vii. Flow in and out of the invasive procedures (e.g. ward beds, critical care facilities).
viii. A supportive culture and civil behaviour. Staff able to report safety concerns or exception reporting without fear of reprisal.
ix. An understanding of how to support staff with building resilience, wellness and avoiding burnout.[50 51]
x. An understanding of the safety differences and risks between elective vs emergency patients.
xi. Mechanisms, such as Team Briefs that can be used to share concerns with staff and build trust.

It is outside the scope of the NatSSIPs to directly quantify these needs, and they are intimately related with the processes, resources, and culture of the rest of the organisation and the wider healthcare system.

- The Trust NatSSIPs lead(s) should give an account of the state of these factors when describing the services within their organisation.
- Data relating to these aspects should inform the intelligence used by the NatSSIPs steering group. These may usefully include:
  - Performance measures such as agency staffing rates, staff leaving rates/retention/turnover
  - Cultural surveys (ability/opportunity to speak up, being listened to)
  - Specialty-based staffing algorithms for staffing
- There should be a clear procedure, risk assessment and escalation for when invasive procedures do not take place or are delayed due to safety concerns.