Scheduling

In summary: Scheduling should include time for planning and supports safe and efficient practice.

- Scheduling should provide adequate preparation time and provide maximum list information to support safe and efficient care.
- Scheduling should take into account realistic anticipated workload and the need to follow 'The NatSSIPs Eight'.
- The scheduling process should strive for continuous improvement through information, feedback, improvement and training.
- The information that accompanies the scheduling of a procedure should include as a minimum: name, identification number, date of birth, gender, planned procedure, site (and side) of procedure, source of patient e.g. ward or admissions lounge.
- Laterality must always be written in full on schedules, i.e. 'left' or 'right'.
- Further relevant information should be included such as urgency of the procedure (e.g. NCEPOD codes,[58] timeframe etc.), significant comorbidities, allergies, infection risk, any non-standard equipment requirements or type-specific implants, BMI, planned postprocedural care etc.
- The use of abbreviations should generally be avoided but, when common abbreviations are used, a list of locally approved abbreviations should be readily available to all staff. Senior or well-established staff should appreciate that an abbreviation well known to them may be not understood, or perhaps worse, misunderstood, by colleagues.
- Any list and / or order changes made after the deadline for the publication of a final version of the list must be agreed with the procedure team and should be discussed by all members at the Team Brief.
- A clear, effective mechanism must exist for removing old lists when a newer version has been published.
- 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.

Induction Processes

In summary: Staff should receive an appropriate induction covering local NatSSIPs processes before working in these clinical areas.

The induction process marks the start of a staff members safety journey within that organisation and is critical to delivery of NatSSIPs.

- Induction of staff and students in both local and Organisational Standards should ensure NatSSIPs safety behaviour and processes/expectations are covered prior to work in a clinical or specialty area.
- Induction requires dedicated time, staffing, and space to enable delivery without any adverse effect on patient care.
- Agency staff should receive a shortened, documented, role / site specific induction.

Governance Processes

In summary: Insight regarding NatSSIPs performance and risk should be tracked, acted upon and fed back to teams in invasive areas.

Governance processes should support:

- NatSSIPs Insight (multiple sources of data), learning and involvement.
- The insight sources of data should link UK-wide standards and benchmarking, reports with local insight based on both qualitative and quantitative data and reported incidents. National level data include: Healthcare Safety Investigation Branch (HSIB) national investigations,[13] reports from safety bodies (Confidential Reporting System in Surgery (CORESS),[14] Safe Anaesthesia Liaison Group (SALG),[15] Learn from patient safety events (LFPSE) service,[16] National Reporting and Learning System (NRLS),[17] the former National Patient Safety Agency (NPSA),[18]), Coroners' Preventing Future Deaths (PFD) reports,[18] learning from excellence reports,[59] litigation, and patient complaints.
- Learning and action should be integrated into improvement, team induction and education opportunities.[60]
- A restorative safety culture ('Just Culture') where staff and patients 'trust' organisations to investigate safety events for learning rather than blame.[42 61 62 63]
- Proportionate responses and investigations to incidents with patient involvement[64] thematic analysis and a focus on learning in line with Patient Safety Incident Reporting Framework (PSIRF) recommendations[40]
- An approach of analysing work system design, with human factors expertise and using models such as the SEIPs model (Systems Engineering Initiative for Patient Safety)[30] , Accimaps[65] and hierarchy of hazard control.[66]
- Quality improvement methodology and implementation science to deliver meaningful and sustained change.
- Appropriate organisational roles and resource for the implementation of NatSSIPs.
- Risk assessment related to specific procedural harms in invasive areas. These include, but are not limited to:
    - Swab management (See Sequential Step 6) requires an organisational risk assessment and procurement alternatives/solutions to ensure swabs used for padding do not become an unknown risk to an accurate count
    - Fire Safety. Local policies should be in place to minimise risks, ensure safe laser management and ensure investigation of all fires:
        - Fires in airway surgery where laser is used are a known risk. A laser safety checklist is advised
        - Fires with surgical prep fluids, drapes and diathermy
- Procurement and tenders from contractors should also fall within this risk assessment and governance process to ensure quality and safety are matched to NatSSIPs requirements.
- Independent sector hospitals are encouraged to follow the same standards as NHS hospitals.

Performance

Measurement for improvement and assurance[f] should go beyond measurement of the NatSSIPs for compliance and create a suite of measures which reflects qualitative and quantitative aspects.[40 41 67 68]

Trusts

- Trusts should ensure regular collection, review and action upon data covering all aspects of implementation of NatSSIPs:
  - Metrics related to the Organisational and Sequential Standards performance
  - Data should include assessment of implementation and practice
  - Data should include behaviours (e.g. safety culture/climate and psychological safety[69 70]) and aspects of quality not quantity alone
  - Measurement for improvement concepts should be applied [67 68 71 72]
  - Data from incidents including near misses, serious incidents
  - Soft intelligence from teams via Team Brief and Debrief
  - Insight and action related to required actions from national and local reports[59] and from Organisational Standards
- The processes for collection of data should be standardised across the organisation as far as possible.
- The minimum standard for audit of NatSSIPs related practices and behaviours is intra-departmental peer-review accompanied by associated plans for improvement / innovation.
  - Peer review necessitates direct observation and assessment of quality of practice
  - Documentation audits are of little value on their own
  - Self-assessment may be a useful tool for teams to identify areas for improvement but does not constitute robust assurance

Wider NHS

- Regional structures (e.g. ICS, place-based partnerships, provider collaboratives etc.) should consider use of standardised tools to collect information about NatSSIPs implementation.
- The NHS (and equivalents) should consider provision of standardised tools to collect information about safety climate/culture and NatSSIPs implementation.
- Trusts may consider how to develop mutual relationships with neighbouring organisations to provide external review, and honest critique of practices.

Regulatory, legal and national body expectations

- The national regulators such as the CQC (England), HIW (Wales) and HIS (Scotland) and regional / local structures should use NatSSIPs as a framework for inspection and assurance. This should include both Organisational and Sequential Standards review.
- HSSIB (Healthcare Services Safety Investigations body) should use NatSSIPs as the reference for current expected standards for invasive procedure. This should include both Organisational and Sequential Standards.
- Central NHS bodies in the four nations including affiliated bodies related to commissioning, improvement, resolution and digitalisation should continue to promote the role of NatSSIPs in policy and strategy planning and documents.
- The GMC, GDC, NMC, HCPC and other standards bodies should include reference to Trusts' engagement and attainment of Organisational Standards if they are dealing with registrants who have been involved with incidents related to NatSSIPs.
- Royal Colleges, education and accreditation[22 23 73 74] bodies should include NatSSIPs 2 in their policies and in their assessments (see Staff training and Education for inclusion into curricula) when they are reviewing services, including both Organisational and Sequential Standards.

[f] There is no intent or desire to create yet another auditing / incident review framework. These processes should be seamless and integrated with the rest of the organisation.