



# Patient Safety Alert

## Stage Two: Resources

### Supporting the introduction of the National Safety Standards for Invasive Procedures

14 September 2015

Alert reference number: NHS/PSA/RE/2015/008

Alert stage: Two - Resources

Never Events related to invasive procedures comprise 85% of all reported Never Events in the NHS in England. Provisional Never Events data from 1 April 2014 to 31 March 2015 show there were 126 wrong site surgery, 102 retained foreign object post procedure and 38 wrong implant/prosthesis incidents reported to STEIS<sup>1</sup>. Reported data show that these Never Events occur in a wide range of invasive procedures in varying specialties, for instance retained guide wires after central venous line insertion or retained vaginal swabs after perineal suturing.

In 2013, NHS England commissioned a 'Surgical Never Events Taskforce' to examine the reasons for the persistence of these Never Events and to produce a report making recommendations on how their occurrence could be minimised. The report, published in 2014<sup>2</sup>, recommended the development of high-level national standards that would support all providers of NHS-funded care to develop and maintain their own, more detailed, local standards.

As it is recognised that 'surgical' Never Events are relevant to all clinical settings where invasive procedures are undertaken, the decision was taken to broaden the scope of the standards to include all invasive procedures in which a Never Event could potentially occur. Evidence-based standards that build on the WHO Surgical Safety Checklist approach have now been developed and tested by clinical experts. The standards, named National Safety Standards for Invasive Procedures (NatSSIPs)<sup>3</sup> <http://www.england.nhs.uk/ourwork/patientsafety/never-events/natssips/> have been formally endorsed by a number of organisations. NatSSIPs address many of the underlying causes of Never Events, and compliance with them will also help ensure that evidence-based best practice is implemented, and that the number of patient safety incidents occurring in association with invasive procedures is reduced.

This Stage 2 Alert launches an NHS-wide programme of work in which relevant NHS organisations will develop their own Local Safety Standards for Invasive Procedures (LocSSIPs) based upon the high-level national standards. It will also ensure that those organisations are compliant with the LocSSIPs they develop. Work is now underway to ensure that both NatSSIPs and LocSSIPs are supported at a national level through inclusion in relevant education programmes and curricula.

Organisations will be supported by the sharing of resources on the NHS England website, including examples of LocSSIPs as they are developed. Support will also be provided through the professional organisations endorsing the NatSSIPs.

As we learn about the creation of LocSSIPs, the implementation of new ways of working in response, and include learning from reported safety incidents, we will amend and adapt the NatSSIPs and the wider programme of work as appropriate. This includes the consideration of any specific requirements for general practice.

Further Alerts, including Stage 3 (Directive) Alerts may follow in due course.

## Actions

**Who:** All organisations providing NHS-funded care

**When:** To be completed by no later than 14 September 2016

- 1 Agree director (or equivalent) with lead responsibility for ensuring all relevant staff are aware of the NatSSIPs and are supported in developing LocSSIPs.
- 2 Identify all procedures undertaken across clinical settings in your organisation that the NatSSIPs are applicable to.
- 3 For these identified clinical procedures, develop and test LocSSIPs based on the relevant NatSSIPs using local insight, including from patients and the public, together with the resources, networks and collaborative opportunities highlighted in this Alert.
- 4 Commence implementation of procedures and practice compliant with LocSSIPs within cycles of continuous improvement including consideration of teamwork and training, human factors and cultural aspects of compliance.
- 5 Please share local good practice and LocSSIPs by emailing: [patientsafety.enquiries@nhs.net](mailto:patientsafety.enquiries@nhs.net).

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### Technical information

The provisional total number of Never Events reported between 1 April 2014 and 31 March 2015 is 308. Of these, surgical Never Events total 266 incidents:

- Total number of wrong site surgery = 126
- Total number of retained foreign object post procedure = 102
- Total number of wrong implant/prosthesis = 38

These 266 incidents comprise 86.36% of the total 308 incidents.

### References

1. Provisional publication of Never Events reported as occurring between 1 April 2014 and 31 March 2015. NHS England, April 2015. Available at: <http://www.england.nhs.uk/wp-content/uploads/2015/07/provsnl-ne-data-04-14-to-03-15.pdf>
2. Surgical never events taskforce report. NHS England, February 2014. Available at: <http://www.england.nhs.uk/ourwork/patientsafety/never-events/surgical/>
3. The National Safety Standards for Invasive Procedures (NatSSIPs). NHS England, September 2015. Available at: <http://www.england.nhs.uk/ourwork/patientsafety/never-events/natssips/>

### Stakeholder engagement

This alert has been developed with advice from the following, who fully support its publication:

- NHS England National Safety Standards for Invasive Procedures Reference Group
- NHS England Surgical Services Patient Safety Expert Group
- NHS England Medical Specialties Patient Safety Expert Group
- NHS England Women's Health Patient Safety Expert Group
- NHS England Children and Young People Patient Safety Expert Group
- NHS England Patient Safety Steering Group
- Confidential Reporting System for Surgery (CORESS) <http://www.coress.org.uk/>

For details of the membership of the NHS England Patient Safety Expert Groups see <http://www.england.nhs.uk/ourwork/patientsafety/patient-safety-groups/>

The NatSSIPs have been fully endorsed by the following organisations:

- Association for Perioperative Practice
- Association of Anaesthetists of Great Britain and Ireland
- Care Quality Commission
- College of Operating Department Practitioners
- General Dental Council
- General Medical Council
- Health and Care Professions Council
- Health Education England
- Monitor
- NHS Employers
- NHS Litigation Authority
- NHS Providers
- Nursing & Midwifery Council
- Royal College of Anaesthetists
- Royal College of Emergency Medicine
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Obstetricians & Gynaecologists
- Royal College of Ophthalmologists
- Royal College of Physicians
- Royal College of Radiologists
- Royal College of Surgeons
- Trust Development Authority