Healthier Communities, Outstanding Care

INVASIVE PROCEDURES POLICY – Minor Procedures

POLICY

Reference	CPG-TW-NatSSIP/LocSSIP		
Approving Body	Surgery Divisional Governance Anaesthetic Governance		
Date Approved	January 2026		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	X		
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Sponsor (Position)	Medical Director		
Author (Position & Name)	Trust NatSSIPS lead – Mr Desai		
Co-Author)Position and Name)	Patient Safety and Clinical Governance Theatres– A. Robinson		
Lead Division/ Directorate	Surgery, Critical Care and Anaesthesia		
Lead Specialty/ Service/ Department	Surgery Divisional Management Team		
Position of Person able to provide Further Guidance/Information	Trust NatSSIP's Lead – Mr Desia		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
Not Applicable	Not Applicable
Template control	June 2020

CONTENTS

1.0 INTRODUCTION

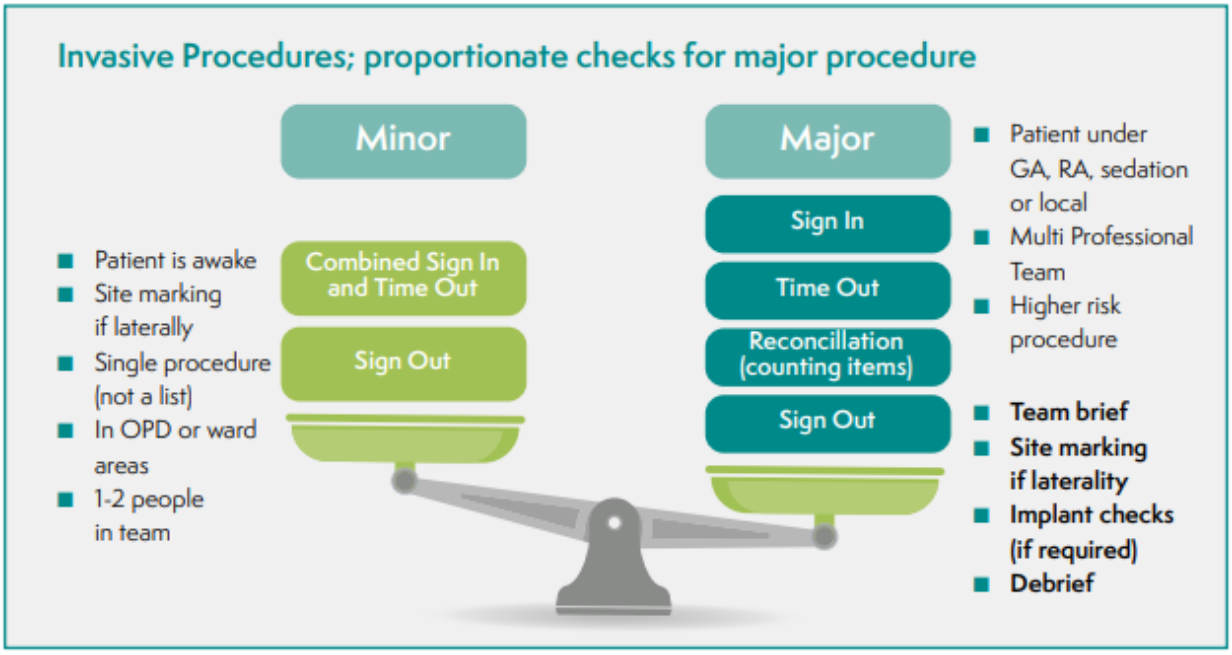
The concept of ‘Never Events’ was introduced in the NHS in 2009 with a list of 8 serious and largely preventable adverse patient safety events which “should not occur if the available preventative measures have been implemented” (NPSA, 2009). Amongst these original eight Never Events were two surgical Never Events: wrong site surgery and retained instrument post-operation, subsequently extended to include retained swabs and throat packs. A third surgical Never Event, wrong implant / prosthesis, was added in 2012.

In January 2023, the Centre for Perioperative Care published revised National Safety Standards for Invasive Procedures (NatSSIPs 2), designed to reduce misunderstandings or errors and to improve team cohesion. NatSSIPs 2 also newly includes 'proportionate counts' for more 'minor' procedures. 'Standardisation, Harmonisation and Education' are recommended.

(LocSSIPs) In the original NatSSIPs, organisations were required to write LocSSIPs for each procedure. There is a risk of over-complicating checklists and introducing bureaucracy. NatSSIPs now recommends that Standard Operating Procedures or LocSSIPs may be developed, based on this long version of NatSSIPs 2. These should be based on the local system and align where appropriate through standardisation, harmonisation and education. LocSSIPs should include sequential and organisational review to be effective. For many procedures and contexts there will be no need to create completely new or bespoke standards or processes.

Individual organisations and departments are required to develop Local Safety Standards for Invasive Procedures (LocSSIPs) that include the key steps outlined in the NatSSIPs 2 and to harmonise practice across the organisation so that there is a consistent approach to the care of patients undergoing invasive procedures in any location.

1.1 Diagram referencing Minor and Major checks – Centre for Perioperative Care



2.0 POLICY STATEMENT

The purpose of this policy is to define and standardise the approach taken by Sherwood Forest Hospitals NHS Foundation Trust to the implementation of LocSSIPs that are consistent with the principles and framework set out in the NatSSIPs.

This policy should be applied to all Minor invasive procedures, wherever they are carried out.

An invasive procedure is defined in the NatSSIPs as a procedure that has the potential to be associated with a Never Event if safety standards are not set and followed. The following is an indicative not a comprehensive list which includes:

- All surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms, and other procedural areas within the organisation.
- Surgical repair of episiotomy or genital tract trauma associated with vaginal delivery.
- Invasive cardiological procedures such as cardiac catheterisation, angioplasty and stent insertion.
- Endoscopic procedures such as gastroscopy and colonoscopy.
- Interventional radiological procedures.
- Thoracic interventions such as bronchoscopy and the insertion of chest drains.
- Biopsies and other invasive tissue sampling.

The process of safe care begins on the ward and this policy should be applied in conjunction with other policies and guidelines specific to the procedure being undertaken.

NatSSIPs 2 include all 8 stages of the 8 Steps to Safer Surgery and are to be applied in clinical areas where ‘lists’ of invasive procedures are undertaken (ie where several patients attend pre-planned/ scheduled appointments) eg:

- Theatres
- Endoscopy Suite
- Cardiac Catheter Suite

- Wards
- Out Patient Clinics

LocSSIPs require a 3 stage WHO checklist to be applied in clinical areas where invasive procedures are undertaken on an individual/ ad-hoc/ case by case basis. Either a generic Invasive Procedure Safety Checklist (Appendix A) must be used or a local variation (which has been through the process described later in this policy) can be used.

This clinical document applies to:

Staff group(s)
- All staff involved in either developing or approving a local variation checklist
- All staff caring for and treating patients requiring invasive procedures

Clinical area(s)
- Trustwide application across all relevant sites
- All clinical areas where invasive procedures are undertaken

3.0 DEFINITIONS/ ABBREVIATIONS

Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employees of the Trust including those managed by a third party on behalf of the Trust
Invasive procedure	A procedure that has the potential to be associated with a Never Event if safety standards are not set and followed
NatSSIPs	National Safety Standards for Invasive Procedures: • A procedure that has the potential to be associated with a Never Event if safety standards are not set and followed, which includes all surgical and interventional procedures performed in operating theatres, outpatient treatment areas, labour ward delivery rooms, and other procedural areas within the organisation.
LocSSIPs	Local Safety Standards for Invasive Procedures • An invasive procedure which has the potential for a 'Never Event' performed in a clinical area not designated as a NatSSIPs location.
WHO	World Health Organisation
NPSA	National Patient Safety Agency

4.0 ROLES AND RESPONSIBILITIES

4.1 Divisional Clinical Chairs

Divisional Clinical Chairs will be responsible for ensuring that those within their specialties who are involved in delivering minor procedures carry out the instructions within this policy.

4.2 Operator

The most appropriate operator present during the invasive procedure will be responsible for ensuring that sign in on the Surgical Safety Checklist (or approved variation) is read aloud and completed. The operator must ensure the sign in section of the checklist has been signed before administration of Local Anaesthesia and or sedation

4.3 Senior Nurse

The most appropriate member of the nursing team should ensure that a briefing and debriefing take place at the start and finish of the procedure

4.4 All Operating Theatre/Procedure Room Staff

- The Eight Steps to Safer Surgery process is a team function and all team members should contribute and feel empowered to speak out if they have a concern.
- Where it has been identified that a patient has been put at risk by failure to follow the Eight Steps (a near miss has occurred) staff should raise/ submit an incident on Datix.
- Where an incident has occurred due to failure to follow the policy staff must alert the theatre manager/ senior manager of production area and relevant Head of Service, in addition to raising/ submitting an incident on Datix.
- Any concerns regarding the practice of individuals in relation to implementation of this policy should be escalated appropriately to an individual's line manager and/or professional lead.

5.0 APPROVAL

Following appropriate consultation, this policy (v3.0) has been approved by Clinical Governance Lead of the respective divisions involved

6.0 DOCUMENT REQUIREMENTS

Use diagram on page 4 to reference which invasive procedure document needed.

6.1 The Process

6.1.1 The Eight Steps to Safer Surgery

The key elements to the "Eight Steps to Safer Surgery" are the Consent and Procedure Verification, Brief, Sign-in, Time-out, Implant checking, Equipment reconciliation Sign-out and Debrief. The original WHO Checklist did not mandate Brief and Debrief, but the evidence base supports the importance of these steps from a safety point of view and the time spent ensuring everyone is briefed at the start of a list will often save time later.

6.1.1 Consent Verification

This is the first of the 8 steps in NatSSIPs 2 and should be done where the patient has been admitted / brought for the intervention.

6.1.2 Safety briefing

A ***safety briefing*** must be performed at the start of all elective procedure sessions wherever the procedures are taking place. A briefing should also be performed before all 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. Staff will need to introduce themselves if they come part way through the list / procedure.

The safety briefing should take place in a discreet location in which patient confidentially can be maintained, while enabling inclusivity and contribution from all team members. As many members of the procedural team as possible should attend the briefing, but as a minimum it must include the operator ~~and anaesthetist~~ who has seen and consented the patient(s) shortly before the procedural session and the theatre nursing staff/ procedural area support staff.

The safety briefing should consider each patient on the procedural list from an operator, anaesthetic and practitioner perspective and the list order should be confirmed.

For each patient, the discussion should include:

- Diagnosis and planned procedure.
- Availability of prosthesis when relevant.
- 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’.
- Post-procedure destination for the patient, e.g. ward or critical care unit.

6.1.3 Sign in

All patients undergoing invasive procedures under local anaesthesia, and or under mild sedation, must undergo safety checks on arrival at the procedure area: ***the sign in***. Participation of the patient (and/or parent, guardian, carer or birth partner) in the sign in should be encouraged when possible.

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 except in extreme emergencies. The necessary checks as part of the sign in process are detailed in the relevant procedural checklist.

The sign in must be performed by at least two people involved in the procedure. The operator and an assistant should perform the sign in. The sign in section of the procedural checklist must be signed and dated.

6.1.4 Time out

A time out must be conducted immediately before the start of the procedure and the relevant checks are listed in the procedural checklist. This can be combined with the sign in.

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 and, except in extreme emergencies, all team members must stop what they are doing and participate.

Any omissions, discrepancies or uncertainties identified during the time out should be resolved before the procedure starts. Consideration should also be given to other safety guidelines that may apply to the specific procedure being carried out.

6.1.5 Implant stop if Appropriate

The procedure for checking of prostheses/ implants is detailed in a separate SOP. A summary is included below.

Implant / Prosthesis SOP (awaiting ratification)

The Operating Surgeon will inform the circulating staff of the prosthesis/ implant required stating Component TYPE, SIZE, LATERALITY, and MANUFACTURER.

When the components have been collected from the store the circulating practitioner will highlight the size information on the implant box.

Before the boxes are opened a 'Prosthesis/ Implant Stop Check Moment' will be performed with reference to the operating list and consent form so the Operating Surgeon, Scrub Practitioner and Circulating Practitioner can verify the prosthesis/ implant is correct in terms of

Type, design, style or material
Size
Laterality
Manufacturer
Expiry date
Sterility
Compatibility of multi-component prosthesis
Any other required characteristics

Any prosthesis/ implant not required will be removed from the area to minimise the risk of confusion between prosthesis at time of implantation.

If there are any changes to the prosthesis/ implant i.e. change of size, a time out is taken to verify the changes with the Operating Surgeon Scrub Practitioner and Circulating Practitioner.

The prosthesis/ implant can then be opened.

6.1.6 Reconciliation of Equipment

This is a proportionate count if site is accessed via a needle or surface incision. If guidewires are used, they should be counted for reconciliation of items. The purpose of this count is to ensure no unintentional items have been retained in the patient.

6.1.7Sign out

All patients undergoing invasive procedures under local anaesthesia and / or minor sedation, must undergo safety checks at the end of the procedure before handover to the post-procedure care team: ***the sign out***. The necessary checks are detailed in the relevant checklist.

Any member of the procedure team may lead the sign out.

An operator must sign the sign out section of the checklist.

6.1.8 Debriefing – This is stated as If required on pg 25 of Natssips 2.

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 should occur in a manner and location that ensures patient confidentially, while enabling inclusivity and contribution from all team members.

Every member of the procedural team should take part in the debriefing. Any team member may lead the debriefing, but the operator must be present.

If any team member has to leave before the debriefing is conducted, they should record any positive feedback and raise any issues they would like discussed during the debriefing.

The content of the team debriefing can 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.

Any problems identified or issues that need to be corrected should be communicated to theatre managers / managers of procedural area.

6.2 Process and Printing for Local Variations/ Adaptations

Adapted specialty/ procedure specific checklists which have been approved for use are listed in Appendix B ***(or can be found in the appendices of the individual divisional implementation SOPs)***

There should be no other checklists in use other than those listed in Appendix B ***(or appendix of the divisional SOPs),*** and as a default; the generic Invasive Procedure Safety Checklist should be used (Appendix A).

If a member of staff feels that none of the approved checklists relate to their area of practice yet invasive procedures are taking place, they should seek clarification from their line manager. If he/she feels that there is a good reason why a particular clinical area should adopt a different checklist, this would require appropriate agreement, development and consultation at specialty level (or wider as applicable eg multi-specialty/ divisional/ cross-divisional) with subsequent/ final approval by the Consent Group, which has been delegated authority for this purpose by the Quality Assurance Safety Cabinet (QASC).

Adapted specialty/ procedure specific checklists must be developed in the approved standard template (Appendix A). An editable WORD file can be requested for the purpose from the Governance Support Unit (GSU).

Approved checklists will be published by the Governance Support Unit (GSU) in the relevant section of the Policies, Procedures and Guidelines intranet. Once published, GSU will update and list/ link the checklist in Appendix B ***(or in the appendix of the relevant divisional implementation SOP)*** as having been approved for use in practice.

Checklists are subject to periodic reviews in-line with other centrally maintained clinical documents.

- Minor wording amendments can be approved at specialty level (with escalation to Division level if deemed necessary)
- Moderate/ Significant amendments need to be agreed/ consulted at specialty level with escalation to Division level if deemed necessary followed by subsequent/ final approval by the Consent Group.

Printing: For smaller volumes, checklists should be printed for use on a case by case basis from the intranet as needed. For larger quantities, either contact Clinical Illustration to support the requirement or raise an order in the usual manner via the e-Series process for procurement.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Use of NatSSIPs and LocSSIPs must be monitored by specialties/ clinical areas to ensure safe practice. Any issues/ good practice should be shared accordingly for learning and where necessary action plans should be devised to support improvements.

	Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
1	Patient safety incidents associated with invasive procedures	Heads of Service	Review of patient safety incident reports raised/ submitted on Datix.	As they occur	Specialty Clinical Governance Group with escalation as required through governance structure.
2	Use and completion of invasive procedure checklists (NatSSIPs and LocSSIPs) – generic and specialty/ procedure specific.	Heads of Service/ Department Lead	Data Collection/ observational audit/ completed checklists. *(eg audit via BlueSpier in Theatres or using audit tool on AMaT in Medicine Division)* Information from the above to be included in Divisional Highlight Report to Consent Group	Minimum 20 patients/ sets of notes every 6 months Every 6 months	Specialty Clinical Governance Group with escalation as required through governance structure. Consent Group via Divisional Representative on the Group

8.0 TRAINING AND IMPLEMENTATION

Staff will be appropriately trained in the various procedures requiring the use of a checklist (5 steps/ 3 steps). This will be undertaken at specialty level, usually at induction.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix C
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- De Vries EN, PrinsHA, Crolla RMPH, et al. (2010) "Effect of a comprehensive surgical safety system on patient outcomes". N Engl J Med; 363:1928-37.
- NHS England (2015) Revised Never Events Policy & Framework
- NHS England (2015) National Safety Standards for Invasive Procedures (NatSSIPs).

Related SFHFT Documents:

- Health Records Management Policy (regarding standards for documentation to be retained in medical notes)

11.0 KEYWORDS

WHO checklist; Never events; NatSSIPs; LocSSIPs; Surgical safety checklist; natsip; locsip; natsipp; locsipp;

12.0 APPENDICES

Appendix A – Invasive Procedure Safety Checklist (hyperlinked to intranet)
Appendix B – List of approved variations of Invasive Procedure Safety Checklists
Appendix C – Equality Impact Assessment Form

Appendix B – List of approved variations of Invasive Procedure Safety Checklists
(last updated:Last Updated October 2025

Please also see the following divisional SOPs which also indicate “Procedures requiring use of procedure specific safety checklist” as well as those requiring use of generic safety checklist accessed/ printed from the intranet

- CSTO: SOP for the implementation of the SFH Invasive Procedures Policy within the division of Clinical Support, Therapies and Outpatients
- Medicine: SOP for the implementation of the SFH Invasive Procedures Policy in the Division of Medicine
- Surgery: SOP for the implementation of the Invasive Procedures Policy in the Division of Surgery, Critical Care and Anaesthesia
- U&EC: SOP for the implementation of the SFH Invasive Procedures Policy in the Division of Urgent & Emergency Care

Title of checklist	Date initially approved	Owning Specialty	Intranet Location:
Maternity - Invasive Procedure Safety Checklist	July 2017 Consent Steering Group	Maternity	➢ Policies, Procedures & Guidelines ➢ CLINICAL (Specialty/ Department) ➢ Maternity ➢ Theatres (maternity)
Gynaecology Outpatient Procedures – Invasive Procedure Safety Checklist	Sept 2019 Consent Group	Gynaecology	➢ Policies, Procedures & Guidelines ➢ CLINICAL (Specialty/ Department) ➢ Gynaecology

APPENDIX C – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Vikram Desai	**Date of EIA completion: 10/11/2025**
Department: Surgery	**Division: Surgery**
Name of service/policy/procedure being reviewed or created:	
Name of person responsible for service/policy/procedure:	
Brief summary of policy, procedure or service being assessed: The purpose of this policy is to define and standardise the approach taken by Sherwood Forest Hospitals NHS Foundation Trust to the implementation of LocSSIPs that are consistent with the principles and framework set out in the NatSSIPs.	
Please state who this policy will affect: • All staff caring for and treating patients requiring invasive procedures Patients or Service Users, Carers or families, Commissioned Services, Communities in placed based settings, Staff, Stakeholder organisations, Others (give details) **(Please delete as appropriate)**	

Protected Characteristic	**Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)**	**Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening.** **Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.**
Race and Ethnicity	NO	This policy is a Patient and Procedural safety policy and applies equally to all users
Sex	NO	
Age	NO	
Religion and Belief	NO	
Disability	NO	
Sexuality	NO	
Pregnancy and Maternity	NO	

Gender Reassignment	NO	

Marriage and Civil Partnership	NO	
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)	NO	

If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

What consultation with protected characteristic groups including patient groups have you carried out?
NIL

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?
NO

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

Positive			Negative			
~~**High**~~	~~**Medium**~~	~~**Low**~~	**Nil**	~~**Low**~~	~~**Medium**~~	~~**High**~~

If you identified positive impact, please outline the details here:

Signature: Vikram Desai *I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form*
Date: 10th November 2025