NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

27 September 2022

Dear Helen,

Thanks for your letter. As you will know, we have continued our work on the LFPSE service over the last few weeks, including some actions which we hope will be welcomed by your group. Continuous improvement is a core part of our project, and we continue to strive to develop both the technical service and the policies it supports to best meet the needs of users within providers, and within national teams and organisations.

We have collated some key information on the main topics you raise below.

1. Implementation timescale
    - It is necessary to replace the NRLS as soon as possible – its current fragility represents a data security risk, and requires significant resource to keep it going, which at the moment involves several potential single points of failure which are increasingly challenging to mitigate.
    - This is the reason for the urgent necessity of the transition to LFPSE – it is impossible to safely close down the NRLS until all current users have transitioned.
    - We are working on a comms pack for providers to use with their staff, which will minimise the need for additional training.
    - The experience of transitioned trusts to date has shown the varied need for training, from none required, to a three-month programme when incorporated into a wider LRMS change. As local LRMS implementation varies so much, this is hard to quantify, but our Team has been offering support to organisations that have started the transition, and has found that the closer to "LFPSE as designed" the local solution is, the less training required.
    - It is also important that LFPSE is able to support the transition to the new Patient Safety Incident Response Framework (PSIRF). A key benefit of LFPSE is the removal of the duplication of reporting that currently occurs with NRLS and StEIS reporting. Ensuring LFPSE is able to support reporting under PSIRF is an important driver for transition.
    - Much of the work currently underway will help to make the transition as simple as possible.
    - Despite the concerns that we are hearing very clearly from your members, we would like to assure you that we are also hearing very positive feedback from

providers who have transitioned, and we will be asking for their permission to share this in more detail to provide reassurance to those looking at the hill from the bottom of the climb, in addition to the podcast highlighted in our previous letter.

2. Vendors and LRMS issues
    - Inconsistency with vendors is contrary to our instructions, and they have been reminded of this when we became aware of the issue a few days prior to receipt of this letter, and again since.
    - Some of the inconsistency relates to a specific field "Which specialty does the incident relate to?" – this is currently being reviewed by the LFPSE team and further guidance will be provided shortly. Further variation seems to be around the instant upload of records to LFPSE: the current guidance to LRMS vendors is that this should be enforced, with no "holding period"; but we are also exploring options to provide more comfort to providers on this topic. We await written confirmation from CQC but verbal discussions have confirmed they are aware of the difference between raw and reviewed/updated data (which is clear to them via the use of version numbers), and take this into account when formulating any responses.
    - We do encourage providers to speak to different vendors as the significant opening-up of the market can confer benefits, and differences in transition requirements and timescales.
    - Different vendors also present different cost profiles including for upgrades – LFPSE has been designed as a cloud service (in line with the NHS Data Strategy) so that taxonomy updates etc are not disruptive, but handled automatically by the APIs (as one of your members notes in annex 9).
    - Irrespective, changes will be required, as we do not want a repeat of the NRLS for which version 2 was *never* successfully rolled out, actively hindering safety improvement. Ideally, changes would be small and frequent, but vendors have indicated a maximum capacity for a 6-monthly frequency.
    - We will be polling providers on their preferences when it comes to the frequency of updates: whether little and often (i.e. seeing the changes they ask for sooner) vs bundling changes into less frequent update packages (living with issues for longer but doing fewer updates in total) is preferable.
    - We are also working on an updated pack of comms about what NHSE requires vendors to implement in order to be compliant, and where providers have the opportunity to customise their systems.

3. LFPSE development, engagement and communication
    - We are glad that our actions to date have been well-received, and we'll continue to try to improve this.
    - It is important to note that all changes take time: collating feedback, which is often contradictory (even from within the PSMN feedback – see a few examples in section 6 below), deciding when it has reached a critical mass as

opposed to incidental opinion, assessing policy impacts, looking at design options, liaising with different impacted user groups, understanding what is and is not possible for LRMS vendors, before any of the technical work begins…and then all changes have to be reflected appropriately in the full suite of apps (online forms, APIs, internal review tools, data access app, user guides, vendor documentation, etc), with our own QA and internal controls processes to be navigated too. We are working as fast as we can on these, whilst also trying to maintain clear communication about what is underway.

4. LFPSE in use, implementation process and reporting timescale
    - It is important to note that LFPSE is doing what NRLS did: asking for a core of fields that are required for national use, and continuing to allow local activity around it – this approach is aligned with innovation diffusion theory of "hard core" and "soft periphery", as the most effective way of supporting change in complex systems. Our work with users is around navigating the boundaries of the fixed versus adaptable components, and will require some adjustment to get right.
    - The "unique selling point" of the LFPSE service is enabling national surveillance, learning and support, as it was in the NRLS before it, but more effectively, and in line with the NHS Patient Safety Strategy, the NHS Data Strategy, and other key policies.
    - Sharing events in real time has been a core part of the plan for LFPSE, for this reason. However, as stated above, we are looking at a number of options to provide reassurance to providers on this topic, including written confirmation from CQC that they will not react immediately to data that has not yet been QA'd; and options for delaying availability of the data to various parties, though not its transmission.
    - As stated above, we have reminded vendors and providers that at present, "holding" records is not permitted, and will be publishing details on what LRMS vendors have been advised, so providers can see what is and what is not within their remit to adapt. We'd also restate that vendor system capabilities for some issues will vary, so it is worth exploring other options if some features are not best serving LFPSE's and providers' needs.

5. Reporting issues
    - We understand these concerns, and have been working to reduce form length (NB: this is an example of something that won't be visible until an upgrade – see previous comment on whether little and often or later and more significant changes are likely to be preferred).
    - We are also exploring other approaches, including the possibility of hiding some options, provided that the full set are available to click into *where necessary* (e.g. in the case of recording an event that took place in a different organisation which has different services available); of moving most

frequently-selected answers to the top; or of deploying synonym lists to aid searching where terms are unfamiliar.

- Providers should also speak to their vendor about form design: for example, having all mandatory questions first (with the ability to save at that point) and the optional questions/sections following, for completion later or by other designated staff – this is for local adaptation, based on what local fields are required in addition. This is another area where we would urge providers to look at different LRMS solutions, which have different ways of optimising forms.
- We must reiterate that, at present, all mandatory fields are considered essential for the execution of national requirements, and many of the lists in use (e.g. Specialty) come from the NHS Data Dictionary which we have been advised to use, to support consistency and comparability of data between organisations. For a more detailed explanation of this, please see the comment by Dr Matt Fogarty on the Futures platform discussion, dated Friday 23rd September.
- Alongside time taken to report, a lack of feedback has been raised by front line staff over the life of the project as one of the main barriers to reporting: this is something that LFPSE can support in a way that NRLS could not. We are trying to promote the use of new functionalities, such as pre-population of fields based on previous responses, and user profile and history, to optimise reporting, without losing out on data collection integrity, data reusability and analysis validity. As user experience is intrinsically different between LRMS products, our Team has been offering to review individual organisations local implementations and making suggestions for them to consider discussing with the relevant vendor.

6. Taxonomy issues and questions
    - We are receiving positive feedback from some transitioned providers who have welcomed the additional event types, and are electing to implement them as they are finding them really useful.
    - To the point about LFPSE being too acute-focussed: interestingly, we've received feedback that some Acutes feel the service is geared for everyone *but* them, so while this means we obviously have not yet got this right, there is not yet a consensus on which direction any movement would be helpful.
    - To this end, and as mentioned in our previous letter, we welcome your members' suggestions for specifics of where question wording could be improved, and in what way. If members would like to submit proposed examples with current text and suggested changes, these would be very helpful. By way of illustration of the complexity of finding the right balance on this, some examples from your correspondence include:
        - Previous feedback from PSMN indicated a concern that too many questions have an "I don't know" option, while 7c of the annex to your

most recent letter recognises that many things *are* unknown at the time of reporting.
    - Similarly, previous feedback criticised the lack of clinical language used, but another respondent cites the need for more accessible language for lower levels of reading comprehension.
- Since your first letter, there have been a number of useful discussions on the Futures platform about some specifics of taxonomy, including Strength of Association, Level of Concern, and Patient Sex - we'll continue these and update in due course.

7. Mental health and other specific reporting
    - Two mental health trusts are going live with LFPSE this month.
    - We are involved in ongoing conversations (which have been delayed by summer leave) with other policy areas, including Mental Health, to seek clarity on what should be reported as a PSI and what should form routine audit-style data collection.
    - At high level, however, LFPSE is interested in patient safety incidents. Incident reporting should not be treated as analogous to routine data collection, hence incidences of practices which are in line with therapeutic best practice do not meet the criteria of a patient safety event. Instances where they are inappropriate, not clinically indicated, result in harm or otherwise go wrong, would qualify, and be reportable to LFPSE.
    - Currently, LFPSE is only configured to collect data on incidents affecting patients. Incidents resulting in harm to, or other impacts upon staff are out of scope (annex 10f). LRMS vendors may be able to configure forms to support this data collection where helpful, but this does not form part of the LFPSE collection and so will not be transmitted via the API.
    - Likewise, the dataset represents the national safety team's requirement for information on falls. Providers are free to collect any other additional details they need within their LRMS configuration (annex 10e).

8. Other
    - Presentation in the front end (whether non-mandatory questions are presented together or separately) are up to vendor implementation, and different products will vary. The primary requirement is that all mandatory fields are completed on first creation, from the prescribed questions and answers, wherever they appear, irrespective of the placement/sequence of optional LFPSE, or locally required fields.
    - Updated guidance on handling open incidents during transition (page 14) is now available on Futures.
    - Mapping remains a significant issue: it was a large part of the reason that NRLS v2 was not rolled out. Cloud products using the taxonomy API will

support instant, cost-free updates, hence the importance of choosing the right LRMS software.

- We must reiterate the importance of comparable national data: the fact that specialties vary so much between organisations is an example of why this needs to be addressed. We need to be able to answer questions like “how many surgical PSIs occur nationally?” which becomes impossible with inconsistently mapped categories; and mapping means we can’t roll out changes quickly or smoothly when needed.
- As we continue our work on incorporating meaningful machine learning into LFPSE’s suite of tools, the reliance on categorical data capture will reduce: the software will be able to categorise and theme records in more consistent and wide-reaching ways, and the need for the user to have “flagged” a record as relating to falls, or self-harm, or medication, will be removed. This will allow us to reduce form length and burden on reporters, and offer new insights that the taxonomy alone cannot provide. In the meantime, however, we have a specific user need for each of the fields requested, be that to identify which records relate to other organisation’s remit for safety (e.g. the “things involved” question not only triggers more detail questions about how things went wrong, but allows MHRA to focus on those relating to medications and medical devices); or to “filter off” well-investigated areas such as falls via the “safety challenges” question, to ensure our clinical reviewers are routinely seeing the subset of data most likely to contain new or under-recognised risks where we can have the most impact upon harm prevention at a national level.

One initial area where the PSMN input would be especially valuable would be to provide suggestions as to what specific kinds of materials or formats would be of particular use in an LFPSE comms support pack for providers to deploy within their organisations, to ensure we are filling the right gaps.

We thank the PSMN for their continued engagement with and passion for this work. The experience of frontline recording staff is of very high importance to us, and we recognise that barriers to recording need to be reduced wherever possible. We are working with some of the largest trusts in England (including Manchester, Birmingham and Guys’) on an early adopter evaluation, to support and evaluate adoption of LFPSE, and roll any learning out to other providers as they come online.

Kind regards,

Aidan Fowler

National Director for Patient Safety