PSL's 30 questions on LFPSE - August 2023

Design and impact assessment of LFPSE

1. **What workload assessment has been undertaken of the transition for users to the new dataset, to assess the reporting burden and impact on reporting rates etc?**

The wide range of systems, users and services in the NHS precludes such a mammoth exercise and any attempt to do this would not produce accurate data.

Part of the purpose of the Digital Service Standards that are being used to guide the development of LFPSE is to ensure that the experience of users directly informs the ongoing iteration of the service.

Instead of a static and ultimately inaccurate guess as to the overall impact on workload, ongoing iteration of the service based on use and feedback allows us to balance user needs from various perspectives, including workload burden, alongside the aims of the programme.

Therefore, the sooner organisations transition to LFPSE and begin using the service, the more able we are to make iterative changes based on user experience.

2. **What review and sign-off of the dataset was undertaken from a quality perspective including patient safety managers, incident reporting leads, human factors experts etc?**

The LFPSE dataset has been developed from the existing NRLS dataset, and the WHO Minimal Information Model, by patient safety experts, managers, human factors experts, taxonomy and ontology experts, data scientists, reporting leads, users and others.

As an agile and iterative service, there is no 'sign-off' point or a stage at which the dataset will be 'complete'. It must iterate as our understanding of healthcare safety grows.

We would like to update the dataset faster and more responsively but there are several constraints to this including user tolerance for changes, and LRMS vendor technical capabilities. We will continue to balance these competing needs as best we can.

3. **What are the success criteria that will be used to assess whether the LFPSE benefits have been realised?**

At the most basic, the success criteria for LFPSE include the creation of a national system that is reliable, uses up to date technology, reflects up to date understanding of patient safety science, and meets user needs.

We are using a series of Key Performance Indicators to monitor service performance. These include:

- Providers' information sharing burden reduction
- Improving data quality of national patient safety data: collection timeliness, standardised taxonomy, real-time data quality feedback
- Improving data processing activities
- Increase the overall user experience and user satisfaction of users of our online applications, data tools and outputs

4. **How have the questions in the dataset been assessed to ensure that they reinforce a systems approach to safety and not unintentionally focus on blaming staff?**

This question seems to derive from a belief that reference to 'people' in questions seeking to understand what parts of healthcare have not worked as expected, will lead to blame. We understand the problems with a blame approach and the NHS Patient Safety Strategy, which LFPSE is part of, is very clear that a blame approach is counter-productive. However, that does not preclude any discussion of how people were involved in incidents because people are part of the system.

Healthcare is a people business, so it is not possible to entirely exclude people from consideration when understanding the performance of the system. What is key is to understand the aspects of the system that did not support people to perform their roles as they wished to, and how the system can be changed to improve the safety of care. It is also important to be able to capture where, for example, the actions of a person such as a patient may have impacted on another patient. LFPSE does not capture any personal details of individuals involved, beyond this broad classifications of staff, patients, family members or others, in an optional field.

We have deliberately placed questions about people after questions about other aspects of the system such as task, environment, technology and tools in the question flow, and they only appear when none of the prior are indicated as relevant by the user. We have also removed a set of questions about people from the dataset following the private beta testing phase to further reduce any sense of 'blame' based on user feedback.

We are currently, and will continue to regularly analyse the completion of questions in this flow with a view to maximising the useful information that is collected, ensuring we have comprehensive alternative options for users to select before they need to default to "none of the above".

5. **How have the questions been developed and assessed by human factors experts to ensure a systems focused approach?**

The questions are developed and iterated by experts in the NHS National Patient Safety Team, including individuals with Human Factors qualifications and experience, with support from external experts as necessary throughout the life of the project. The importance of taking a systems-based approach is clear. All aspects of the NHS Patient Safety Strategy, including LFPSE, PSIRF and our improvement programmes, are based on systems thinking.

6. **What is the outcome of testing with early adopters e.g., the impact on staff time and the rate and quality of reported incidents following implementation?**

The service is continually iterated so there is not a single point at which the 'outcome' is tested. We are balancing the need to make recording as easy as possible with the importance of collecting useful data. There is not a fixed point in time that the 'outcome' can be assessed.

Feedback from the earliest adopters in secondary care has been:

- that there is some, but not a prohibitive impact upon time to report, once the questions are integrated into their local systems
- that they felt well supported by the LFPSE team

Feedback provided was considered and improvements were quickly implemented. Please refer to the below podcast on Provider Transition experience for more details: https://share.transistor.fm/s/9a449845

We are continuing to monitor data quality, and work with connected providers to improve where we find issues: this learning is then applied to the next providers to transition, so that the adoption process and materials are also finessed over time.

7. **How much has been spent on the development of the LFPSE, nationally and locally?**

Development costs including apps used by national Patient Safety staff for review and analysis, the PSIRF module and NRLS decommissioning total £4.2M from 2017 to 2022. For context, the NHS Patient Safety Strategy estimates that almost 1,000 extra lives and £100 million in care costs could be saved each year from 2023/24 by its full implementation, including the delivery of LFPSE. The potential exists to reduce claims provision by around £750 million per year by 2025.

We are not aware of any costs spent locally on development of LFPSE.

8. **How will the LPFSE improve learning through its national analysis and sharing of data?**

LFPSE aims to improve learning through a number of means:

- Supporting recording from a wider range of health settings, specifically via the online service for those without LRMS who have traditionally been very low-participation groups
- Updating the taxonomy to capture more mechanistic details of how things go wrong, rather than inflexible lists (which conflate incidents, outcomes, contributory factors, etc and so fail the basic purpose of a data collection taxonomy), to support targeted interventions upstream
- Providing new kinds of analysis, looking at common factors across safety events, to be supported by machine learning, and prioritisation based on more nuanced combinations of information than simply levels of harm.
- Making data more accessible and transparent, and providing a platform for users to meaningfully collaborate and share learning and improvement resources, to help good ideas spread.

These services will grow over time, and with input from users.

9. **Is there a LFPSE risk or issues log and does this include all the concerns being raised by users?**

Yes, there is a full RAID (risk, actions, issues, decisions) log for the LFPSE project, which is regularly iterated and updated. It contains operational items relating to user satisfaction and service adequacy, roll-out timelines, LRMS vendor readiness and responsiveness, dependencies on data analysis to inform changes, and change management.

The RAID log does not detail every single query raised by users on an individual basis as that would not serve the purpose of a RAID log. Individual concerns are collated into working files and addressed through service iteration, published FAQs, information sessions, and other mechanisms. Some ideas raised go on to form the basis of service design changes, and some are discussed and not prioritised for action.

Implementation

10. **What guidance is available and under development to support Trust implementation and staff training?**

The following information is available;

- There are user guides for the online services, available on-screen.
- A transition guide on the FutureNHS platform has been circulated to all 2,106 active NRLS users
- There are FAQs on the web page, and a further more detailed Q and A document on FutureNHS.
- LFPSE Taxonomy and questions flow documentation have been forwarded to all current NRLS users. We are also in the process of signing off a more user-friendly document that lays out the taxonomy information, when questions will be relevant, question rationale and when they are optional or mandatory.
- We are also finalising an updated version of the old NRLS guidance on levels of harm, with LFPSE information on the new harm definitions, as well as on event types and how they can be applied.
- Following requests from users, we will be releasing a refreshed suite of communications relating to implementation shortly.

11. **In user testing, how has it been assessed what knowledge and training users will need to complete the necessary mandatory fields?**

We follow the GDS requirements for Agile delivery, and the NHS England digital approvals process, which requires us to undertake User Acceptance Testing (UAT) for each change that goes live. Part of this is assessed by setting users a task and checking they can complete it without needing further assistance. All design components that are live in the service have been through this process.

12. **In user testing, how have the process flows been assessed to ensure that Trusts staff are able to update a report following quality review and that this doesn't lead to any double counting?**

The responsibility for acting on patient safety events, and as part of this collecting high quality data about them, lies with each provider.

Records created by users of the online service should be reviewed by those with enhanced permissions. This allows individuals with locally designated access to view and amend all fields submitted, which should take place as part of the ongoing response to events and quality assurance of data. The status of each record is visible in the dashboard, and records can be filtered by whether or not a review has been completed.

In LRMS, we expect the same review and quality assurance processes that have always existed to continue, with the only difference being that LFPSE will receive automatic updates with each change saved from the first data capture onwards. These come through as numbered versions of the same record, and not new submissions as in NRLS. This is to improve our ability nationally to identify and respond to urgent emerging issues.

There is work planned to add the ability to "link" multiple records to one single event, so that if staff (and in future, patients) create separate records about one occurrence, these can be looked at together to enhance learning and reduce the risk of double counting which has always existed in NRLS.

13. **What assurance have NHSE sought or received that vendors are prioritising the changes they need to make and will have completed these for all Trusts by end Jan 2023?**

All six LRMS vendors with LFPSE-compliant systems have assured us in person and in writing that they are able to onboard providers to LFPSE compliant systems now and that they have the capacity to support their customers to implement LFPSE by April 2023.

14. **Is there scope to pause the requirement for all Trusts to transition to LFPSE by end March 2023 if vendors are struggling to get all Trusts upgraded in time?**

Our work with the vendors started around 8 years ago, and we have worked with them regularly throughout this period to update them on our plans, ask what support they require, and prepare them for the coming changes.

We have been repeatedly assured that LRMS vendors are able to provide the necessary changes and support to transition their customers to the given timelines, and that there would be no financial implications for providers upgrading to LFPSE-compliant software. However, depending on individual support contracts, some organisations may choose to contract LRMS vendor support to apply the updates on their environment.

15. **What have the experiences been as to how staff will need to be briefed as to the changes and what guidance and briefing notes are available to assist Trusts in their implementation planning and staff communication?**

We have listened to users and a range of information is available based on this feedback. We continue to add to the following information:

- A podcast featuring one of the first adopters of LFPSE talking about their experiences can be found here: https://share.transistor.fm/s/9a449845
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16. **What assessment has been made on the impact of a standardised reporting on staff understanding or willingness to report? How can this inform Trusts' implementation planning and staff communication and training?**

All reporting processes, questions and forms are tested with users before implementation and are continually iterated based on feedback received. We do not have single static assessments in the agile development process.

NHS staff are the best incident reporters in the world and we are confident that this will continue as we improve the quality and consistency of the data that is collected.

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17. **What assessment has been made of the training requirement for staff, an overall capacity assessment given the hundreds of thousands of staff that will need to be trained and during the winter months?**

The intention with LFPSE has always been that it should be clear enough not to require training to use. This is in line with GDS principles, with design patterns and usability standards developed, tested and used for many digital services, such as applying for a passport, all based on the premise that users should be able to succeed first time without support or training.

Question and guidance development has focussed on this, and we have iteratively improved wording and clarity in response to feedback. If there are areas where users feel this could be strengthened, we are very interested to engage and hear further details of potential improvements.

How different organisations choose to implement the service, and how LRMS vendors represent changes in their front ends, is for local decision-making.

User engagement

18. **Are there proposed to be user forums that invite all interested parties from Trusts and primary care to collectively raise concerns and develop a shared agreement of ways forward for subsequent dissemination?**

We have undertaken wide engagement with users from across healthcare in the development and piloting of this service. Meeting with all potential users in one place (in person or digitally) would be challenging, so we have included information about the project in publicly-accessible places like the NHS England webpage, on social media, and through the FutureNHS platform where we can host documents, recorded presentations, discussion boards etc.

We have arranged 12 Q&A sessions between May and September this year, attended by 401 individuals from over 275 organisations.

Throughout the project, we have attended as many relevant group meetings as possible, including the Patient Safety Managers Forum, to share our plans and to listen and respond to questions.

19. What user testing was undertaken with patient safety managers/specialists and incident reporting leads and what were the sign off arrangements?

Throughout the project, relevant staff from provider organisations were invited to participate in user research activities and provide feedback. Patient safety managers, specialists and reporting leads have been engaged during each phase of the agile development cycle from the initial exploration of user needs to formal user acceptance testing and sign-off.

- **Example 1 Discovery Phase -** During the Discovery phase for the LFPSE Data Access Application, 37 users from all sectors, including acute trusts, mental health trusts, CCGs, independent healthcare providers, pharmacies, dentistry, GP practices and internal patient safety stakeholders, were interviewed to explore their user needs for a minimal viable product version of our aggregated reporting of patient safety data.

- **Example 2 User Acceptance Testing (UAT) -** As part of the development of the differing user type permissions, 17 organisations completed a round of user acceptance testing (UAT) on account set-up and enhanced user functionality of the system. In a summative exercise, such as UAT, we collect pass/fail statistics of the task set, as well as any other comments for future iterations.

We are required to provide evidence of UAT having passed to internal controls before we can make any changes live.

In addition, the project is overseen by the Government Digital Services team, who assess against their Service Standard at key checkpoints. The LFPSE project passed its Alpha (March 2018) and Private Beta (March 2020) assessments, an additional checkpoint with NHSX in October 2020, and will undergo a further assessment before it officially passes into a Live service once all providers have transitioned.

20. Some of the new terminology does not relate at [sic] to what most trusts use. What consultation has been undertaken?

All question sets undergo user research and testing, (as per our GDS standard development cycle), before release and are iterated according to feedback (e.g. 40 users involved in 2 rounds of UAT May-October 2021 and over 200 ad-hoc individual comments/feedback logged since its public beta launch 1 year ago). Some of the changes represent a deliberate shift in language – such as moving from “reporting” to “recording”, and the separation of incidents, outcomes and risks with new labels, which until now have all been correctly reported to NRLS, but incorrectly all labelled as “incidents”.

If trusts have specific items they wish to collect data on that are not included in the LFPSE dataset then they can continue to do so within customisations of their local systems; these fields will not be transmitted to the LFPSE service.

The National Patient Safety Team is developing a consistent national dataset to improve our ability to use national data to support NHS organisations, but that does not preclude local data collection where trusts wish to do that - this was also the case in the NRLS.

Currently, due to variations in data collections we are not always 'comparing apples with apples' nationally. While the LFPSE service is not designed to compare organisations safety performance, it is important that data collection is consistent so that if we are looking for themes and trends in the data across organisations, we know when we are looking at similar events in different places. Activities such as mapping of local fields introduce this kind of inconsistency, and inhibit our ability to iterate the service by causing brittle connections between local and national fields, which stop working when central changes are made, and then require dedicated work to amend at each new service improvement, in each organisation with mapping.

21. **The feedback about LFPSE has been overwhelmingly negative and people have raised many concerns. Does that give the LFPSE team any pause for thought at all that this is the right approach, being implemented in the right way? If not, why not?**

This is not our experience. The feedback we have received has not been overwhelmingly negative and we are concerned that some in the Patient Safety Managers Network have interpreted it as such. Many organisations are embracing the change and moving ahead with their transition plans. We do encounter important questions about implementation that we seek to answer in an open and transparent way, and to make those answers available to others (e.g., through the FAQ documents/pages). We are also committed to amending and developing the service to improve user experience.

Feedback about how to improve the service is encouraged and absolutely vital, we have been listening, learning and developing the service in response to feedback – given the changes we are making, we would find it concerning and not at all helpful if all the feedback we received was 'this is fine'. We therefore actively seek out and welcome constructive criticism and ideas about where the LFPSE service could be improved.

We think that there has been a marked increase in the levels of satisfaction and a reduction in people's anxiety regarding LFPSE demonstrated at the Q&A sessions we have held over the past few months. We also note that providers who have been onboarded have generally submitted positive feedback about the service and the benefits it offers, based on their experience of implementing it.

22. **Given the workforce and wellbeing crisis in the NHS, what assessment has been made of the impact of this change in terms of staff morale?**

We know that the NHS is under unprecedented pressure. The NHS National Patient Safety Team considered this carefully when deciding what aspects of the NHS Patient Safety Strategy to continue with after the brief pause at the beginning of the Covid pandemic.

It is our view that we cannot halt work on improving patient safety at this time – if anything, at times of pressure, when systems are even more challenged, it becomes even more vital to equip our staff with the skills and mechanisms to reduce risks wherever they can.

Delivering continued increases in our patient safety **insight**, the skills and breadth of people **involved** in patient safety, and our work to **improve** specific safety challenges are more important now than ever before.

We believe that improving safety impacts staff morale positively because staff tell us that unsafe care impacts their morale negatively. Improving and enhancing the utility of data that staff take the time to collect about patient safety makes this a worthwhile activity.

Guidance required

23. **How are staff to report 'near misses?' There is much debate about the definitions of near misses, what guidance is available and training of staff to ensure consistency in reporting and effective learning?**

Staff can report 'near misses' as they do now – as patient safety incidents. Near misses have been included in the definition of a 'no harm' patient safety incident since 2004 and remain within that definition.

However, this is an interesting question and we are keen to explore with users if they would find a separate "near miss" category useful, alongside/within other "no harm" events. This will add to the data set so needs to be considered alongside the question of reporting burden, but we will explore this as part of our ongoing work to iterate the data set.

Forthcoming guidance on applying levels of harm will provide further details and examples.

24. **What the definition of 'sex' is for the purposes of LFPSE. Have the options in the Patient's Sex field had any oversight from an EDI perspective e.g., inclusion of 'other?'**

As we have already posted on the NHS Futures platform in response to this same question about recording sex and gender, currently LFPSE only captures data on patient sex. This is because national clinical experts deemed this to be the most important data point for national surveillance, given some well-known sex-specific safety risks (e.g. wrong catheter, sodium valproate, etc), and we are trying continually to minimise the number of questions asked.

We have taken the codes for sex (and other protected characteristics) from the NHS Data Dictionary (male/female/not specified), with the additions of "withheld" and "I don't know" for instances where accessing this information is not possible. For our current purposes, we think this most closely matches "sex assigned at birth" or possibly "sex as per medical records", though we will seek to clarify this with the NHS Data Dictionary leads.

It is also worth noting that we have work scheduled to improve the way we capture data around some priority protected characteristics, and top of the list is adding a way to routinely capture sex AND gender (data collection burden permitting). We'll be undertaking user research to find the best ways of doing this, understanding what codes are commonly in use locally, and how to support staff to answer if they are unable to get confirmation from the patient about their self-identified gender.

25. **What resources have been developed and shared with Trusts and primary care to enable them to brief and engage their staff in this fundamental and large-scale change in how incidents, near misses, outcomes and good practice are to be reported?**

We have listened to users and a range of information is available based on this feedback. We continue to add to the following information:

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26. How will the dataset reflect the new PSIRF reporting requirements?

As PSIRF rolls out, a new module will be made available on LFPSE to support this. Those developing the LFPSE service and the PSIRF work within the same team and work closely on a daily basis. Those developing the PSIRF are leading on the design of the relevant reporting requirements in the LFPSE service. In this way, LFPSE and PSIRF are entirely aligned and both form part of the wider NHS Patient Safety Strategy.

27. How does this link into Use of Force Act, mortality learning and the MH minimum dataset?

Assuming 'this' refers to LFPSE, there are a few links;

- We are in discussion with NHS England Mental Health (MH) policy leads to clarify their expectations about what they consider to be a patient safety incident from a MH perspective. This includes consideration of the implications of the Use of Force Act and how this links across to the MH minimum dataset. We will take their expert lead, and if that indicates updates to LFPSE are appropriate then we will put those in place.
- For mortality governance and learning purposes, we are clear that policy-wise, when mortality review or other related activity indicates a patient safety incident, then this should be recorded on a trust local risk management system as a patient safety incident.
- Aligned to this we are in discussion with the NHS England Better Tomorrow team regarding a Discovery phase exploring if LFPSE could include a mortality module to further streamline information collection and recording. If that were to generate evidence for a business case to create such a module then we will include that in our work planning.

28. Will it be possible to hide questions that are totally irrelevant to Trusts' services?

Currently, no, this is not possible because we have not identified any questions which are irrelevant to Trusts' services, given that the system can and should be used to record events that have been picked up locally but occurred earlier in the pathway, to facilitate cross-organisational working within Integrated Care Systems (ICSs).

If your members can provide further detail on which fields they feel could be hidden, we will take this into consideration.

29. **How has the information governance risk been assessed e.g., staff unintentionally uploading personal identifiable info (PII) nationally (even if there is a warning response)? Trusts currently check incidents for PII before NRLS upload.**

Information Governance (IG) for the entire service has been a key consideration throughout and LFPSE is fully compliant with all NHS England and NHS Digital Information Governance requirements. In fact, LFPSE is a significant improvement over NRLS given it is a more secure and stable environment and includes a significant upgrade in terms of the new anonymisation app that removes PII prior to data being visible via LFPSE. PII compliance will be monitored, as with NRLS, and instant feedback given via the Application Programme Interface (API) where issues are identified, supporting more real-time data quality improvement in providers. Alongside this, the efficacy of the cleansing algorithm is also kept under review to ensure acceptable IG is maintained.

30. **Will the NRLS continue to exist for Wales after 31/03/2023? If so, could the implementation deadline for England not be longer?**

The NRLS must be decommissioned as soon as reasonably possible, because its now-outdated technology makes the operation of the NRLS inefficient and higher risk due to issues like support costs, performance, and the risk of data loss.

Wales stopped using the NRLS last year as they wished to implement a single reporting database for Wales only rather than allowing a range of local risk management systems to be used across healthcare organisations.

Should Wales wish to begin using LFPSE in the future we would of course welcome that and make necessary arrangements.