

Questions and Answers (Q&A) from the LFPSE Patient and Family Discovery Show and Tell 19/10/2023

Please note: some answers have been taken from the chat at the time, some have been adapted from the transcripts where verbal answers were given, and some have been generated since, where we were unable to publish/answer all questions at the time. Some questions mirrored ones previously asked, so we have removed duplicates to keep this document concise.

Shared in chat by organisers: Thank you for joining the Learn from patient safety events (LFPSE) service Patient and family Discovery phase show and tell. This session is being recorded for future sharing and collaboration. If you would like to read the full report, you can access this here: <https://www.england.nhs.uk/publication/the-learn-from-patient-safety-events-lfpse-service-patient-and-family-discovery-report/>

1. With the introduction of LFPSE, some of the definitions regarding harm have been refined. How can we ensure accurate capture of harm to patients, both physically and psychologically?

The current guidance states that where practical, patients views on levels of harm should be taken into account when staff record an incident: <https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm/>

In the old system, there was only ever one scale for capturing harm. In theory it was supposed to cover physical and psychological, but in reality, it was generally used just to represent physical harm. One big change that we've made in LFPSE is to separate those out into two separate scales, one for physical harm and one for psychological harm, which has been really well received by the majority of people including patients. And that idea actually came from patients and families in the first place.

We have just done a workshop with some staff and service users thinking about the psychological harm aspect in particular, because it's hard to get it right on both scales, and in the end, both of those are subjective assessments of how badly hurt someone has been - be that physically or emotionally. The summary is available here: [20231016 LFPSE - Psychological Harm Workshop Write-Up v1.0 - NHS Patient Safety - FutureNHS Collaboration Platform](#).

One of the ways that LFPSE handles the complexity of getting these responses right is that answers can be updated at a later date: if more information comes to light or the situation changes, then users can go back into LFPSE and update the level of harm. Any other actions that are then triggered by a record meeting a certain level of harm – such as Duty of Candour (which is the legal requirement to tell a patient about something that's gone wrong) – will then be enacted at that point, so the opportunity is not lost. Likewise, things that are

graded as having caused severe harm or death go to the top of the queue within the internal NHS England surveillance process, and that can happen at any time as well.

In the context of this Patient and Family Discovery we're going to have to look really carefully at the language that we use to describe levels of harm, and examples that we give, with a lot of patient and family input, so we can create a scale that works for people.

2. How do you encompass the system influences at the time of an incident, such as staff shortages?

Broadly speaking, users are asked to input any information they think was important into the free text field – this means we can capture any and all factors, without need to pre-determine what should be a categorical field. As our Machine Learning tools improve, we can use them to help automatically detect these and bring them to the fore, so we'll get data-driven insights into any emerging themes.

More specifically, LFPSE asks if staffing levels were a factor in the incident being recorded, so we'll have a finite measure of how often this is deemed to be a system issue.

3. During the presentation and user research sessions, a common theme was ensuring that the solution for patients, families, and carers to record their patient safety concerns needs to be accessible. Would you be able to explain how the project ensures it meets the requirements of people with accessibility needs please?

Developing a service that is for everyone is really important, and it's also really important that everybody can access it in a way that suits them, and so one of the things that we are going to consider very carefully when we design this will be the accessibility of the service. That comes in in various different ways; the first way of that is that if we're creating this as an online service that it meets certain standards. There are [Web Content Accessibility Guidelines](#) and they're a standard that all government services have to meet, which ensures people with various access needs can use the service. This takes into account people who've got visual or cognitive impairments who might need help with using the service. So whatever we design we will make sure that it meets those needs.

But it isn't just about meeting their standards, it's also about testing it with people. So what we'll do when we build a prototype in Alpha is we will take that out to various people with those needs to make sure it's working for them.

There's another side of this, which is also what is known as assisted digital. So that's people who perhaps can't or prefer not to use an online service at all and need another route they can go down. That's why we're already considering things such as speaking to a staff member, or perhaps going through a family member, and we will also make sure that there are options for people which don't involve them using the online service. These are all things that we'll consider during alpha and why it's so important for us to engage and work with such a wide range of users from the start.

4. Who is going to investigate the patient issues? Will it be the service providers (as is currently done with LFPSE events)?

In the vast majority of cases, the learning response to any patient safety incident is decided and conducted by the service provider.

The NHS' approach to responding to patient safety incidents is set out in the new Patient Safety Incident Response Framework, and you can read more about that here: [NHS England » Patient Safety Incident Response Framework](#)

One of the reasons the hybrid approach to patient/public reporting has been deemed the most appropriate is that it would allow local providers to respond to issues raised, as well as allowing the national team to use the records for learning. The provider will likely have more context and information in order to undertake follow-up, and local teams to liaise with the patient and family, while the national team (who receive over 2.5m safety event records per year) can focus on adding value by their unique perspective of seeing national data as a whole.

5. How many are here? Listening and not part of LFPSE etc?

Around 140 people joined the session. Unfortunately we cannot see who they all represented.

6. How would solicitors access the system?

The forthcoming LFPSE Recorded Data Dashboard app will be publicly available – this is an enhancement to the existing Data Access app (which requires a log in) and provides much more transparent and interactive quantitative data. We hope this will go live by the end of this calendar year.

As the data NHSE holds is all anonymised, access to records of patient safety incidents is primarily something for local providers to manage according to existing legislation (which may be Freedom of Information (FOI) legislation, Subject Access Request processes, or legal rights to access healthcare records, depending on the nature of the request). It is much easier to obtain these from the primary source of the record, i.e. the organisation that submitted the record, who will retain identifiers, so we would refer any such request there.

7. Everyone who has been through it were once a naive patient that there was a system-their experience through a long frustrating heavily promoted and perhaps mis represented process.

As we move further through the design process for this service, we'll need to look carefully at how we promote and signpost options to patients and families, and how we explain what they can expect if they do choose to report a safety concern.

8. How do patients make sure their view of harm is recorded accurately-please share summary of workshop-key is to record patient subjectivity accurately?

The [policy guidance](#) provided to staff for the existing service states that “where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient’s perspective on the harm definitions”. There will remain an element of judgement on what is considered “practical” by staff (considering issues like patient cognition, mental health and the relative risk of re-traumatisation).

As the service develops and the patient-recording options are designed, we will work closely with patients to ensure that any options they are given to select levels of harm are accessible, meaningful and easy to use.

9. Ombudsman and advocacy we should all must be offered by all trusts to organise a advocate not we have to fight to get one

As we develop the patient recording options we will look at what kind of support services users are likely to need. We can use this to develop guidance on how providers can support patients in this, to help get the best learning outcomes. The recording service itself will be a digital-first solution, and so any additional interpersonal support will need to be enabled by the healthcare provider.

10. As disabled you never get reasonable adjustments applied.

The LFPSE service is governed by the Government Digital Services [Service Standard](#), which includes the requirement that we [Make sure everyone can use the service - Service Manual - GOV.UK \(www.gov.uk\)](#). This means that we will need to demonstrate that we have thought about different accessibility needs, and provided alternatives where required.

11. Doesn't the LFPSE online system already meet a lot of these requirements (to allow patients to report incidents)? Feedback might be an issue though.

The NRLS e-Form has always existed as a route for patients to report incidents. However, it is not well used, for a number of reasons – including that not many people know about it, and it often does not give patients and families what they are seeking, especially in terms of feedback. The LFPSE Patient and Family Discovery phase has been looking therefore not just at how to allow patients to report, but how to do that in a way that will makes sense to people who have never heard of “patient safety” before, be easy to use, and meet their needs for feedback and response.

12. Are able to start with the basic dataset that we already collect in large NHS Trusts could we use mapping, within reason?

Some of the Discovery findings were that in many providers, safety issues raised by patients through various means, including complaints, were already being reported by staff as a routine exercise. What we have found is that we need to consolidate and standardise this, and to ensure that the patient’s authentic account can be retained and not reframed through the words of staff. This requires a new channel, with a consistent data capture, as well as the process of follow-up and feedback surrounding it that patients often want.

13. For this to work the clinicians have to be honest and transparent. They must have confidence that they can embrace (and be supported) in a "no blame" culture and acknowledge their mistakes. Often this diffuses the situation and a constructive lessons learned with the patient can commence. My family's experience was total acknowledgment by the matron of nursing failures - which was really helpful for both sides. Consultant mistakes - system stonewalled the patient and so the issue ended up being escalated (legally) over a period of 3 years. Such a waste of time and resources on both sides. Totally avoidable. We were never looking for compensation - wanted lessons to be learned however consultant felt he could not admit his mistakes.

This feeling was widespread in the people we spoke to during Discovery – often people do not want a combative experience, just openness and honesty, and to work together to make things right. This is why we feel the hybrid option is best suited to user needs: it allows for the patients and staff to have a conversation about what has gone wrong and for local learning to take place, whilst also feeding into the national improvement work.

14. How can we going measure the culture from management to block and cover up when things go wrong so it's not recorded?

There are a number of ways to measure safety culture – and one of them is by looking at the relative number of safety events recorded. We know that in an open and safe environment, people tend to record a lot of incidents, especially those of lower harms, and this is one of the measures that the national team looks at when supporting providers. This will be available to view publicly in the new Recorded Data Dashboard app (due towards the end of this calendar year). The incident records in LFPSE also have audit trails of changes made in the local risk management system.

You can read more about how to improve safety culture here: [NHS England » Improving patient safety culture – a practical guide](#)

15. We want all the info, but once received it needs to be categorised as if it is a complaint there are requirements / regulations around responding.

We support and encourage the triangulation of complaints and patient safety event records to generate a more rounded view of safety, but our research shows that a patient wanting to contribute to this record is not necessarily the same as a patient complaining, and so would not be subject to the same rules. If the patient does want to complain, however, this must be fed through the complaints route as well.

A user in the chat also provided this response: This question has already been answered; collecting the patients view of an event prevents complaint: [Getting the whole story: Integrating patient complaints and staff reports of unsafe care - PMC \(nih.gov\)](#)

16. Are we missing an opportunity to also learn from good care/near misses as well as unwanted events?

An important new feature of LFPSE over the NRLS is that it specifically allows staff to capture positive safety events: good care that we can learn from. As we design the patient recording service, we will look at how we can include a similar option.

LFPSE also allows users to submit “near misses” - which are a subset of patient safety incidents resulting in no harm.

17. How will the process integrate with the Trust, ICP Integrated Care System, Primary Care Networks systems?

As with the current staff LFPSE service, the patient-facing elements will be integrated into existing systems. Where Local Risk Management Systems (LRMS) are used, new forms/pathways will be added that can share data directly with LFPSE. Where users do not have LRMS, we will add new options to the [online service](#).

There is more information on how local software can be integrated with LFPSE here: [NHS England » LFPSE-compliant Local Risk Management System \(LRMS\) suppliers](#)

18. Seems like you are filtering out questions as some of mine have not appeared in "featured". Why?

Due to the number of questions received, we were not able to publish and respond to all of them during the session whilst also presenting. We are making them available afterwards, along with the recording.

19. Until patient safety investigations are run separate to the organisation provider and made a regulated requirement you will always struggle to get them done in a timely and impartial manner.

The way in which investigations take place is changing under the new Patient Safety Incident Response Framework (PSIRF), and you can read more about that here: [NHS England » Patient Safety Incident Response Framework](#)

We disagree that independent investigation is required to deliver timely and objective patient safety incident learning responses. PSIRF is clear that there are a range of effective responses to patient safety incidents including after action reviews, hot debriefs and huddles as well as provider-led and independent investigation. Independent investigation is one mechanism of response but is not proportionate in most circumstances, given it is a very lengthy and expensive process.

20. Hi, a quick point - the link to PDF version on the website only allows printing rather than download.

Selecting "Print to PDF" will allow you to download the report.

21. Will slides be shared please? I had trouble joining so I might have missed some items.

Yes, we will share the slides with all participants after the session. You can also read the full detail within the report here: <https://www.england.nhs.uk/publication/the-learn-from-patient-safety-events-lfpse-service-patient-and-family-discovery-report/>

22. What about users of LRMS like Ulysses and Datix?

Whatever we design will need to take local systems into account - we need something that works where people have local risk management systems, and also for places like primary care where these are less common.

23. Is it true another 80 patients wanted to speak to you and there was no resource to interview them? was the survey co-produced?

Yes, and we have circulated the survey to them. The survey was produced with input from the Patient Safety Partner working on LFPSE, and the NHSE Engagement team's Citizen Advisory Group.

24. Who do you get permission from for alpha stage? Are patients involved?

It is part of the NHS E budget and planning cycle.

25. Can you promote here the current patient public NRLS portal which this project is replacing, as until this project has a system that is all there is for patients, family public wanting to report harm events? And it is still open I gather?

Thank you. You can find the link here: <https://www.eforms.nrls.nhs.uk/eformPP/>

26. What about complaints that are not Patient Safety incidents?

These should be unaffected and still follow the existing processes.

27. Is the patient safety / LFPSE team interested in hearing from staff who have faced significant barriers in raising patient safety concerns within NHS organisations?

Yes - reducing barriers to learning from patient safety events is really important to our national work. We have information about Safety Culture here, which might be of interest:

<https://www.england.nhs.uk/patient-safety/patient-safety-culture/>

28. Have you spoken to the RMS providers (who are LFPSE validated) so they are aware that this development is coming?

We have intended to look at patient and family recording for some time, and it has been part of our public messaging (for example, in our [FAQs](#) - which now need updating!). Liaison with the LRMS vendors will be a part of the Alpha and Beta phases, as we start to design a service.

29. Given the number of NHS Trusts and local providers, I was surprised by the small number of respondents in this survey. Did you limit numbers? Could you give some idea of how representative this survey is in relation to culture, deprivation and IT literacy.

We circulated the survey to everyone who had initially volunteered to be interviewed, but who we were unable to schedule sessions with. The survey will now remain open until at least the end of the year, and be publicised more widely, to allow us to start the Alpha phase (subject to approvals) with more data, and validate our Discovery findings. The survey collects optional diversity information, so we can publish this in Alpha.

30. Are you looking at PSIRF?

The LFPSE and PSIRF teams work closely together. The next update to the LFPSE taxonomy (question set), rolling out from the end of this financial year, will include a PSIRF module.

31. What campaigns were considered from their patient focused experience e.g. Inquest, AVMA, Shaping our Lives?

We contacted NHS Resolution, AvMA, Patient Opinion, Healthwatch and the Patients Association, and the research was also promoted via various other channels such the NICE and CQC patient fora, as well as being circulated onward by those networks.

32. Will this change be properly funded at trust level?

The technical elements of the patient and family recording service will be rolled out as a continuous improvement to the LFPSE service. During Alpha and Beta we can explore if there are other changes required (for example, staff training, provision of leaflets or posters for patients, etc) and how these should be resourced.

33. Was minimising compounded harm to patient reporting one issue considered in the process?

The UR sessions covered many aspects of patient reporting, both the positive and the negative. We believe that by providing a service that meets user needs (an accessible process, clearly signposted, that engages with the patient, and makes it clear what will happen with the information shared – see the full [report](#) for more details), further harm and distress can be minimised, whilst learning and improvement are facilitated.

A related issue also came up recently in a workshop about recording of psychological harm – the risk of retraumatising patients by asking them about the impact of safety incidents. In that session, the group felt that the need to consider the patients' views was more important than the risk: you can read more about this on the NHS Futures platform: [20231016 LFPSE - Psychological Harm Workshop Write-Up v1.0 - NHS Patient Safety - FutureNHS Collaboration Platform](#)

34. You mention the overlap with Complaints - how has this been developed with those regulations and PHSO framework in mind?

The complaints process, which is enshrined in law, will be unaffected by the development of the LFPSE patient and family recording service – people can still make complaints as they wish, and escalate issues to the PHSO if they need to. We hope that this can be avoided in some cases, however, if the service allows providers to handle safety concerns in a better way, and give patients more of the outcomes they need.

35. Has the project team looked at solutions used in other industries/countries. NHS is not so different that it can't learn from others? Might avoid reinventing the wheel in places?

We have not looked specifically at how the public raise safety concerns in other industries, as we think the particular environment of the NHS, the services it already provides, UK legislation, and the IT infrastructure it uses make it sufficiently unique that we need to design a bespoke service. That said, if anyone is aware of any relevant processes used elsewhere with sufficient parallels that we might learn from, please get in touch!

36. Is it correct that the reporter can change the levels of harm?

The LFPSE service has been designed so that the person recording the event can update any fields at any time after initial submission, including adding more information, answering additional optional questions, or changing any answers previously submitted – this is how it works in the online service, if a user is logged in. This is because we know that sometimes not all information is known or available at the point of recording, especially soon after an event, and sometimes staff only have time to include key details immediately, and need to add more information later, or refine their answers once more is known about the situation.

Some providers have chosen to implement it this way in their local risk management systems, and others have set it so that only “reviewers” (people working in governance, safety, or risk management roles, etc) can amend the records once the initial submission is made.

LFPSE keeps a log of all changes made to the record.

Q Regarding the issue of duplication - patients may record events which have already been "noted" by clinicians - should this be classed as a duplication or is it just personal perspective of the event? if for example a clinician noted the event will the patient/su/carers be contacted for further information? what happens if the clinician isn't truthful regarding the event?

The “hybrid” option we are proposing should minimise duplication where possible – if patients are supported to record a concern or incident alongside staff, it can be linked to any other records created by staff. We believe that there is great learning value in seeing multiple perspectives on one event, especially when they may differ.

If a patient chooses to record directly to LFPSE and not via their provider, there may be a duplicate record.

We have plans to create a feature in LFPSE so that multiple records can be linked to one event – once this is available, it may be possible to then re-join any “duplicate” records that are identified.

Whether or not patients are contacted by the provider about a safety event will vary from issue to issue, including based on severity (for example, when [Duty of Candour](#) applies).

37. In regards to the winterbourne scandal specifically those su/patients/families and carers/ how have those individuals been considered when a safety event has occurred... some may not even understand what happened to them let alone have someone to speak too about it.

The current guidance states that where practical, patients views on levels of harm should be taken into account when staff record an incident: <https://www.england.nhs.uk/long-read/policy-guidance-on-recording-patient-safety-events-and-levels-of-harm/>

This will not always be possible of course – sometimes a patient has died, sometimes they lack capacity, and sometimes staff may deem in their professional judgement that speaking to the patient about the issue may do more harm than good. This will need to be assessed on a case by case basis.

Any service that we develop as part of LFPSE should be accessible to all, however, so that should a patient or service user with additional needs wish to record an incident, they should be supported to do so.

38. Are we only talking about patients - does this include service users of all types?

This will be for all patients, service users, family members, carers and members of the public. (We sometimes use “patients” as a shorthand for this, but the Discovery Phase report notes the involvement of “patients, service users or a member of their family who use the NHS, or care for family members who use the NHS”.)

39. So, is it to capture incidents or complaints? The distinction is not clear for patients on what the difference would be.

The question of “how do you distinguish between the two” is one that lots of the people we interviewed also could not answer, both staff and patients.

Working out how to solve that problem is part of this work. The key thing to remember is that we need to make sure we're picking up the information to support learning from wherever we can: it shouldn't matter if it's come in as a complaint - if we think there is safety learning in there, we still need to pull that out for local and national use, even if it's continuing to be handled through the complaints process. That's one of the reasons that this hybrid local-national model felt like the right one.

40. This work is critical and need to look at hiding complaints the culture staff and patients are scared of reporting.

The proposed option of the local-national hybrid model, with the option for patients to record directly if they choose to, should both ensure we are capturing as much learning as possible (including data on where the service is used more and less, which in itself will tell us a lot about culture), and protect a channel for patients to speak up about safety concerns without having to go through the provider.

41. These processes are for an "after the event" review and patient engagement. What happens if there is a safety issue that needs addressing in the moment - how does the patient / family get heard then? Thx

Patients and families should feel able to speak up about issues as soon as they become aware of them, and as soon as they feel able to. This LFPSE recording service is only one piece of the puzzle, and providers will still need to work on their local culture and processes to support patients in the moment.

42. Permission who from?? Aidan Fowler? DHSC?

(We believe this is a question about approvals to progress to Alpha and Beta phases of the work.) This will form part of the business-as-usual NHSE funding planning cycle.

43. If patients use the anon reporting function, the trust can't investigate robustly - therefore losing the learning.

We will need to make it clear within the service that by choosing to report anonymously, certain options are lost, and we do this currently with the anonymous staff recording form. But it is important to have that option available to people who need it.

44. Will this replace KO41?

No, this does not change the complaints process. The complaints process is enshrined in law, and that was one of the factors that we established early on in the desk research exercise. There are a lot of circumstances where patients need the complaints process, and the assurances that come with it, which we would not want to change, even if we could.

What we're looking at here is something that can sit alongside it in a complementary fashion; to be an option for people who don't want to complain but still want learning to occur. Maybe people will want to do both side by side. We need to make sure that as we're designing the service and the wrap-around process for both staff and patients to follow, that we're thinking about how they work together. We would want the LFPSE service to work alongside it in a really constructive way, giving patients more of what they want in terms of a process that is less combative than people sometimes find Complaints. We heard from our research that people fear things becoming "us versus them", so this is hopefully going to be a way to provide a less confrontational alternative.

45. Were participant's input sought from diverse background patients who might not be so informed when things go wrong & any arising healthcare incidents (from deprived areas etc) - it's important for improving apparent healthcare inequalities, that all voices are received from ALL patients and family.

We're collecting diversity information about survey participants, so we can monitor wider involvement and make extra efforts to speak with the seldom-heard-from groups if they need more representation.

In the interviews, we wanted to make sure that we had covered a really wide range of people. We know that there are lots of people who perhaps have never experienced what they might think to be a patient safety event, or even be aware of what one is. It's really important that we capture those views, as well as those of people who have been through it and raised an event before - so we made sure to cover a really wide range of bases. That's so that we can make sure that our service takes into account all the all the different people who might be using it. We recruited a mix of people - people who were very engaged and have been engaged with NHS and the various different routes there are for incident

recording previously, and also people who had never been involved in safety discussions before.

Full details of patient participation are available in the slides, or in the [Report](#)

46. Are the team considering co-production - i.e., involving empowered patients at the core of design processes of any of these stages-rather than just signing off a fait accompli service at the end -like this discovery process- we tell you, you analyse, you report-we feedback after the event and move on? I can say more on empowerment.

NHS England's policy on [involving people and communities](#) requires that we involve patients, service users and their families, which we are able to do in a variety of ways depending on the nature of the work. When it comes to designing services, we should work "in partnership with people so they meet their needs and preferences and reflect experience". This aligns with the GDS Service Standard, which governs how we should work with users of digital services (in this case LFPSE) to ensure we meet their needs. Full details of patient participation are available in the slides, or in the [Report](#).

Patients and their representatives are also involved in the wider work of the national Patient Safety team in a [wide range of ways](#), including as Patient Safety Partners – who were part of the team designing and running this Discovery Phase.

As we go through the Agile design process we'll start to move away from the exploratory interview style used in Discovery, and starting to move towards testing concepts and ideas, which we have a range of ways of doing. For example, we can use simple cartoons and storyboards for people to feed back on the experience they'd like to have, and from there we can start to make prototypes. These might start as simple sketches on a piece of paper for people to feed in to and they can say whether they like it or not, all the way through to actually building something which looks and feels like the real service, and get people to use it as if they were reporting an event. However, as it's not the real service, we can really quickly iterate that and make sure that our design works for everybody before we actually spend any time building the real thing. And that means that we can try things really quickly, throw things away, and involve users the whole way through the process.

47. LFPSE does not include PID, would this new system?

We'll need to look at the service design, and what is necessary. One benefit of the hybrid model we're proposing is that we should have the option for patient details to be held locally, to enable follow up and engagement, and then only have the learning information shared

nationally, to reduce the risk of identifiability and ensure we can keep the data transparent to support more learning.

48. How will this differ from the CQC reporting system?

LFPSE is primarily concerned with capturing a patient safety incidents for the purposes of learning. This proposed patient recording option would therefore be a way for patients to say “something happened, things went wrong during it, and I would like to make sure that that is both looked at by the provider, to respond to and improve from, and also that the learning can also be looked at nationally”.

CQC is the regulator of the system, so their role is in assessing the quality of services, of which patient safety is one part. We share the information we collect with the CQC for them to use as part of the safety component of their wider quality assessment remit.

49. If staff can filter patient's reports what is the criteria for doing so?

The intention with the local-hybrid model is that the authentic patient account can be retained, alongside the information from the provider or staff perspective, so we can look at them both together.

50. Please share the survey in wide social media campaign and link here.

We now have permission to circulate the survey widely – please share this amongst your networks: <https://x.com/LucieNHSSafety/status/1716820881018876165?s=20>