

Written evidence submitted by NHS England (PSN0028)


1. Documentation about the NHSE Investigations Unit and the framework it has published, and how this has been used.

The National Patient Safety Independent Investigations team (NPSIIT) is part of the NHS England National Patient Safety Team and was introduced in October 2022. The NPSIIT's role is to;

- Establish and maintain a standardised organisational approach to the overall governance, process and insight gained from NHS England commissioned patient safety independent investigations and reviews;
- Support the work of both national commissioning teams and NHS England regional teams, to commission investigations and escalate issues as appropriate; and
- To support the coordination of responses to insight generated where appropriate.

The National Independent Patient Safety Investigations Framework (NIPSIF) was developed by the NPSIIT, working with teams across NHS England, as an internal policy to support NHS England teams when they are commissioning and managing a patient safety independent investigation. Due to the complexities of such investigations, the guidance has 3 parts: the framework document itself, a series of supporting guidance documents and a toolkit. It includes step by step guidance around planning and implementation, flagging key issues to consider and giving key contacts. The framework standardises the internal independent investigation processes within NHS England to ensure good use of public money, generation of effective insight from NHS England-commissioned investigations and use of that insight to generate recommendations from such investigations that provide the best opportunity for patient safety improvement.

The Framework was developed and tested over the course of 2023 through the commissioning, monitoring, and completion of a significant independent patient safety investigation. It incorporates principles of the widely tested and evaluated Patient Safety Incident Response Framework (<https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/>), including in relation to the paramount importance of the compassionate engagement of those affected by patient safety incidents. The Framework was considered and agreed for internal use by NHS England's Quality and



Performance Committee in November 2023. Work is now underway to embed the detail of the Framework in NHS England's operations. It will be adapted and updated as appropriate and as more is learned about its operation.

2. List of actions for the NHS to take forward over three to five years to improve culture, taken from a synthesis of recommendations on culture and leadership management.

The NHS Management and Leadership Development Programme (MALD) delivers the response to the Messenger (2022) and Kark (2019) reviews and supports the delivery of the retain chapter in the LTWP. The programme objectives include the development of management and leadership talent and capability the NHS needs to provide high-quality and safe patient care and deliver benefits in service of inclusion, productivity, improvement and system working. The programme has developed a high level roadmap and delivery plans up to 2024/25 with the following vision:


1. Leaders and managers at all levels meet the standards and competencies we should expect of them
2. All leaders and managers have access to professional development and support to meet the expected standards and competencies
3. The NHS attracts, develops and retains the best talent
4. The public has increased confidence in NHS leaders and managers, who feel a continued sense of pride in their profession.

With the input of the Management and Leadership Advisory Group and other stakeholders, NHS England are now creating a three year roadmap for delivery from 2024/25 to 2026/27 and 1 year implementation plans.

This work links with the Long Term Workforce Plan (retention), the EDI Improvement plan, regional work around leadership and talent and NHS Impact and Retention.

The roadmap describes NHS England's vision for management and leadership in the NHS and sets out the route to achieving it through clearly identified deliverables and outcomes grouped by three themes.

These are:

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- Management and leadership frameworks
 - Management and leadership development
 - Talent and career management

The roadmap will also be underpinned by a communications and engagement strategy.

3. Numbers on take up of PSIRF by trust type as of 13 February 2024. Expectations on take-up of PSIRF given the feedback from the pilot evaluation.

The latest data from 20 February (unpublished, unverified) indicates that 132 trusts have implemented PSIRF and 75 are yet to implement (63% to 36%). In the acute sector 64% (86/134 trusts) have implemented. 80% (8/10) ambulance trusts have implemented, 79% of community trusts (11/14) have implemented and 53% (26/48) of MH trusts have implemented. One combined care sector organisation has also implemented.

No funding has been provided to trusts to implement PSIRF.

Implementation is being supported through the Patient Safety Collaboratives hosted by the 15 Health Innovation Networks (HINs) and through direct support from the national patient safety team.

PSIRF implementation is subject to independent evaluation via the Response Study (<https://responsestudy.leeds.ac.uk/>) based at the University of Leeds.


Work is underway to consider the content of PSIR Plans although this will not be subject to comprehensive national review.

Roll-out of PSIRF into primary care has focused initially on developing guidance for GPs and is now being incorporated into wider Primary Care Patient Safety Strategy workstream (due for publication later in 2024)

4. Numbers of trusts transferred to reporting on LFPSE and date at which it is expected that all organisations will have transferred over to the new system so the old one can be retired.

As at 20/2/24, 70% of NHS Trusts have transitioned (145), it is anticipated that 90% will have transitioned by the end of the financial year.

The new Recorded Data Dashboard is launching shortly, giving public access to interactive and filterable data, for prioritisation and improvement. It allows users to view aggregate data



nationally, by provider type, region, ICB, speciality or individual provider, and by levels of harm and date.

The Recorded Data Dashboard also contains some early insights from the Machine Learning workstream around sentiment analysis, classifying the emotion presented in the free text, and topic analysis, identifying key themes.

As an agile digital service, LFPSE is subject to continuous user engagement and iteration to improve the functionality.

5. Most recent data on uptake of patient safety training by level (e.g. 850,000 level 1; 425,000 level 2; 40,000 essentials for patient safety on Boards) with denominators to enable the calculation of percentage uptake.

Unpublished data, based on December 2023 figures:

- ~855,000 staff have completed Level 1 Essentials of patient safety for all staff
- ~42,000 have completed Essentials of patient safety for boards and senior leaders
- ~430,000 have completed Level 2 Access to Practice
- ~900 are signed up for Level 3 and 4 blended learning training modules

Note: it's not possible to breakdown the data by organisation or region as most training is completed by organisations own learning platforms/ ESR and data pulled through to e- Learning for Health is only high level.

The denominator for Level 1 training is 1.4 million NHS colleagues

We do not have a denominator for Board Level training although we do know that in the NHS we have:

- 42 integrated care boards which each have an integrated care partnerships
- 229 total number of trusts, including 154 foundation trusts
- 50 mental health trusts
- 10 ambulance trusts