

Oversight

from  InPhase.

Learn From Patient Safety Events (LFPSE) Questions

Taxonomy v5

Assistance Guide for Migration to Incident Oversight from InPhase

1 May 2022

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Support for Migration to Incident Oversight for LFPSE Questions

This LFPSE Questions document provides a support guide for organisations migrating from the National Reporting and Learning System (NRLS) to the Learn from Patient Safety Event (LFPSE) and Incident Oversight.

NHS England and Improvement have issued a requirement for all organisations to have at least a test mode version of a LFPSE system in place by 31 March 2023 and be fully live on the national LFPSE system by 30 September 2023.

Knowledge of the LFPSE questions supports migration for the whole organisation to the new taxonomy.

Activities this helps support include:

- training in new terminology
- preparation of what additional questions you will want to add to the LFPSE questions in your Oversight system
- Identification of where in the flow of questions you will want to insert the local questions to be easiest for the reporter to speed data capture and ensure staff time used is minimised.

The questions 'common reference numbers' in this document is a number consistent between adverse event types.

The guidance is the main Guidance text. We have not included response or response guidance text in this document, which is available in the Incident Oversight migration configuration tool.

You may re-order the questions in Incident Oversight into any order and include any local questions in any position by dragging them from one position to another at any time. Only LFPSE questions will be synchronised with the national NHSE LFPSE system.

Within Incident Oversight's Question Manager, you will always be able to see which questions are LFPSE (both mandatory and which are optional) and which are your local questions, along with the look-up for responses.

LFPSE Incident

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
1	Which things were involved in what went wrong?	Your answer should be based on the information you have at this point, and can be changed if further information becomes available.
2	Which medicines were involved in what went wrong?	Include details of generic name, brand, strength, formulation, batch number, administration route, and other details that may be relevant.
3	What kind of medical device was involved in what went wrong?	Start typing and select the relevant device from the list.
4	Or specify other	
5	Who manufactured the device?	
6	What was the model or serial number of the device?	
7	Was a device used to give medication in this instance?	
8	Which people's actions differed from what was expected or intended?	Select all that apply.
9	Please specify	
10	Which of the following were involved?	Select all that apply
11	Please specify	
12	Which of the following were involved?	Select all that apply
13	Please specify	
14	SABRE report number	Under the Blood Safety and Quality Regulations (2005 as amended) blood and blood component Serious Adverse Events (SAE) and Serious Adverse Reactions (SAR) are legally required to be reported to the Medicines and Healthcare products Regulatory Authority (MHRA). The Serious Hazards of Transfusion (SHOT) is the UK's independent, professionally led haemovigilance scheme, collecting and analysing anonymised information on adverse events and reactions in blood transfusions from all healthcare organisations in the United Kingdom. The MHRA and SHOT have collaborated to improve haemovigilance reporting by producing an integrated incident reporting process through the Serious Adverse Blood Reactions and Events (SABRE) platform. All
15	SHOT report number	

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
		<p>SAR and SAE incidents related to the safety and quality of blood must be reported through your local hospital blood bank or blood establishment SABRE representatives.</p> <p>If you know that this patient safety event has been reported to the MHRA and SHOT but you still wish to continue with the LFPSE submission, please include the SABRE/SHOT report number(s) for linkage.</p>
16	NHS Blood and Transplant report number	<p>Everyone involved in organ donation and transplantation wants to ensure that transplanted organs are as safe as possible for all transplant recipients.</p> <p>Under the Quality and Safety of Organs Intended for Transplantation Regulations, any incident that has any undesired, unintended and/or unexpected occurrence associated with any stage of the donation to transplantation pathway that might lead to the transmission of a communicable disease, to death or life-threatening, disabling or incapacitating conditions for patients or which results in, or prolongs, hospitalisation or morbidity must be reported to NHS Blood and Transplant.</p> <p>If you know that this event has been reported to NHSBT but you still wish to continue with the LFPSE submission, please provide the NHSBT report number to enable linkage.</p>
17	Which blood products were involved?	
18	What was the brand of the blood product involved?	
19	What was the batch number of the blood product involved?	
20	If you have already reported this event to the Yellow Card scheme, please include your reference number here	
21	What was done immediately to reduce harm caused by the incident?	Write what happened but do not include any details that could identify the patient or other people.

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
22	What kind of event do you want to record?	<p>Incident - Something has happened, or failed to happen, that could have or did lead to patient harm What does this mean?</p> <p>Outcome - A poor outcome routinely reported locally where it is not yet known whether or not the outcome was caused by a patient safety incident What does this mean?</p> <p>Risk - A risk to patient safety in the future, though no patients have yet been affected What does this mean?</p> <p>Good Care - An example of good care that can be learned from What does this mean?</p>
23	How concerned are you about this incident and its implications?	<p>Indicate the impact on the safety of healthcare overall, and/or to what extent others may not be aware that this issue exists. Your answer should be based on your own judgement, given the information you have at this point, and can be changed if further information becomes available. Select one.</p>
24	Does this qualify as a notifiable safety incident under the Duty of Candour regulations?	

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
29	To opt out of record sharing, check the box below	<p>We will share this record with other organisations.</p> <p>If your record relates to the delivery of primary care, we will also share this record with the relevant CCG.</p> <p>We will not share your personal data outside of your organisation. We will process your personal data only for the purpose set out in the Terms of Use.</p> <p>To opt out of record sharing, check the box below:</p> <p>* I do not want to share this record with the provider</p> <p>NHS England & Improvement may share this record with other relevant organisations under specific data sharing agreements (as set out in our Terms of Use). We make every effort to remove any unwanted personal identifiable data provided by you as part of this record before the data is shared with any other organisation.</p>
30	Does this event require statutory notification to CQC?	
31	Which of the following criteria does it meet?	Select all that apply.
32	Has this been referred to the Local Authority Safeguarding team?	
33	Describe what happened	Include details of anything you think was important, or might help us learn from what happened. Avoid including any identifiable information such as names of staff or patients here.

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
34	Did the incident occur whilst the patient was under your organisation's care?	
35	Under which organisation's care did the incident occur?	Start typing and select the organisation from the list. If you are unsure of your organisation's ODS code, you can use the ODS portal here to find it.
36	Or specify other	
37	Which service areas were involved?	Select all that apply.
38	Where did the incident happen?	
39	Which specialty does the incident relate to?	Start typing and select your speciality from the list. Click here for the full list of specialties.
40	Or specify other	
45	Does this event meet the national definition of a Never Event?	Only relevant designated individuals within an organisation should declare a Never Event, based on the definition in the Never Events Framework . Declaring a Never Event initiates the need for a systems-based patient safety investigation, focused on learning for improvement, with formal governance and oversight arrangements. All Never Events should also be declared as Serious Incidents, as stated in the Serious Incident and Never Events Frameworks
46	Does this event meet the national definition of a Serious Incident?	Only relevant designated individuals within an organisation should declare a Serious Incident, based on the definition in the Serious Incident Framework . Declaring a Serious Incident initiates the need for a systems-based patient safety investigation, focused on learning for improvement, with formal governance and oversight arrangements.

Incident Oversight from InPhase migration guidance

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
47	Does this incident relate to a baby and/or mother and require notification to HSIB under the defined criteria for maternity investigations?	
48	Which Never Event type are you declaring?	
49	To what extent was the patient physically harmed (including pain) in this incident?	<p>Your answer should be based on the information you have at this point, and can be changed if further information becomes available.</p> <p>If a death has occurred and you are not aware of any patient safety incident that preceded the death (including stillbirth or pregnancy loss) but want to notify others so that Learning from Deaths or other standard reviews can be conducted, please return to the start and record a 'Something routinely reported locally that at this time does not appear to be a patient safety incident but may have been preceded by one' rather than a patient safety incident.</p>

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
50	To what extent was the patient psychologically harmed in this incident?	<p>Distress is inherent in being involved in any patient safety incident, but please select 'no harm' if you are not aware of any specific psychological harm over and above this. Pain should be recorded under physical harm rather than psychological harm.</p> <p>Your answer should be based on the information you have at this point, and can be changed if further information becomes available.</p>
51	What was the clinical outcome for the patient?	<p>Describe any physical or psychological impact on the patient as a result of the incident, or how their care was subsequently changed as a result. Your answer should be based on the information you have at this point, and can be changed if further information becomes available.</p>
53	What was the patient's age at the time of the incident?	<p>You will be able to input the age on the next page after selecting the appropriate unit of time.</p>
54	Estimate the patient's age	
55	What is the patient's sex?	
56	Was the service user detained under the Mental Health Act at the time of the event?	

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
57	Was the service user subject to Deprivation of Liberty Safeguards at the time of the event?	
58	How many patients were involved in this incident?	If the event you are recording affects 10 or more patients, please record only the single most severe actual or anticipated harm here, and provide fuller details of the event's impact within the free text field labelled "Describe what happened"
59	What is the patient's self-identified ethnicity?	This may be in their record, or you can ask them or a family member. If this information has not been provided by the patient or their family, please select 'I don't know'.
60	Do you think this incident involved any of these problems with medicines or medical devices?	Select all that apply.
61	Please specify	
62	What was the problem with people's involvement or availability?	
63	At what point was the incident detected?	
64	Please specify	
66	How was people's availability involved in what went wrong?	Select all that apply
67	How did people's actions differ from what was expected or intended?	Select all that apply.
68	How was the device involved in what went wrong?	Select all that apply.
69	How was medication involved in what went wrong?	Select all that apply.
70	How were tissues or organs for transplant involved in what went wrong?	Select all that apply.
71	How were IT systems or software involved in what went wrong?	Select all that apply.
72	How did people do something too much?	Select all that apply.
73	How was the device used when it should not have been?	Select all that apply.
74	How was too much medication prescribed/dispensed/administered?	Select all that apply.

Incident Oversight from InPhase migration guidance

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
75	How were too much/many tissues or organs for transplant used?	Select all that apply.
76	Why were required people absent?	Select all that apply
77	How did people do something too little?	Select all that apply.
78	How was the device not used when it should have been?	Select all that apply.
79	How was too little medication prescribed/dispensed/administered?	Select all that apply.
80	How were too few/little tissues or organs for transplant used?	Select all that apply.
81	How did the wrong action get taken?	Select all that apply.
82	How was the device used incorrectly?	Select all that apply.
83	How were the wrong tissues or organs for transplant used?	Select all that apply.
84	Why wasn't the right action taken?	Select all that apply.
85	What was wrong with the device?	Select all that apply.
86	How were tissues or organs for transplant available but damaged or unfit for use?	Select all that apply.
87	How were actions or behaviours involved in what went wrong?	
88	What was the problem with the devices?	
89	What was the problem with the medication?	
90	What was the problem with tissues or organs for transplant?	
91	What was the problem with IT systems or software?	
92	Why were tissues or organs for transplant not used when they should have been?	Select all that apply.
93	Which of the following processes were involved in what went wrong?	Select all that apply.
94	What process was involved in what went wrong?	
95	How was the medication prescribed/dispensed/administered incorrectly?	Select all that apply.
96	What was wrong with the medication and/or its packaging?	Select all that apply.
97	How were buildings or infrastructure involved in what went wrong?	Select all that apply
98	Why were the correct buildings or infrastructure not used?	Select all that apply

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
99	How were the wrong buildings or infrastructure involved?	Select all that apply
100	What was the problem with buildings or infrastructure?	
101	How were estates services involved in what went wrong?	Select all that apply
102	Why were the correct estates services not used?	Select all that apply
103	How were the wrong estates services involved?	Select all that apply
104	What was the problem with estate services?	
105	How was blood involved in what went wrong?	Select all that apply.
106	How was too much blood used?	Select all that apply.
107	How was too little blood used?	Select all that apply.
108	How was the wrong blood used?	Select all that apply.
109	Why was blood not used when it should have been?	Select all that apply.
110	How was blood damaged or not fit for use?	Select all that apply
111	How were blood products involved in what went wrong?	Select all that apply.
112	How were too great an amount of blood products used?	Select all that apply.
113	How were too small an amount of blood products used?	Select all that apply.
114	How were the wrong blood products used?	Select all that apply.
115	Why were blood products not used when they should have been?	Select all that apply.
116	How were blood products damaged or not fit for use?	Select all that apply
117	What was the problem with the blood?	
118	What was the problem with the blood products?	
122	Which of these best describes your role?	
123	Please specify	
124	What was your relationship to the incident?	
125	Please specify	

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
126	Provide your email address so that the MHRA can follow up with you about this incident if they need to.	Incidents involving medications, blood products or medical devices should be reported to the MHRA using the Yellow Card scheme. As part of their role in regulating these products, they need to be able to contact you to get extra details.
127	Which organisation are you reporting from?	Start typing and select the organisation from the list. If you are unsure of your organisation's ODS code, you can use the ODS portal here to find it.
128	Or specify other	
129	Why are you recording this anonymously today?	Select all that apply.
130	Please specify	
134	Is there imminent risk of severe harm or death?	An imminent risk is one that is likely to be a problem within weeks. Severe harm is something that is likely to make someone need life-saving care, require hospital treatment for more than 2 weeks or reduce a person's independence for more than 6 months.
136	Which groups of patients are at risk?	For example, people of a certain age, gender, location or with a certain condition or treatment.
139	Does the incident appear to relate to any of these known safety challenges?	Your answer should be based on the information you have at this point, and can be changed if further information becomes available.
140	What is the radiotherapy error code?	For example, Level 2 / 13ff / 13cc / 13dd / MD13hh / CF3a / CF2c / CF1c TSRT9 - Guidance on the radiotherapy taxonomy and its application

Common Ref	LFPSE Incident Event Question	LFPSE Guidance Text
141	What is the Marvin reference number?	<p>Safety incidents and serious incidents that occur in the delivery of an NHS screening programme should be notified to the regional Public Health England Screening Quality Assurance Service (SQAS) and to the regional NHSE commissioner. Please refer to national guidance for information. Further advice can also be obtained from PHE's national screening helpdesk who can be contacted on 020 3682 0890 or via the online form.</p> <p>If you know that this event has been reported to SQAS and the NHSE commissioners but you still wish to continue with the LFPSE submission, please include the Marvin reference number in the field below to enable linkage.</p>
142	How much did the incident contribute to the outcome for the patient?	Your answer should be based on your own judgement, given the information you have at this point, and can be changed if further information becomes available.
143	Did the incident happen today?	
144	When do you think the incident happened?	Give the approximate month and year it happened.
145	What was the date of the incident?	For example, 16 3 1985
146	Do you think any of the below were relevant to the incident occurring?	This information is used to identify time-related trends in incidents. Your answer should be based on the information you have at this point, and can be changed if further information becomes available.
147	Approximately what time did the incident happen?	Your answer should be based on the information you have at this point, and can be changed if further information becomes available.
149	Do you have any ideas for what could be done to reduce the risk or impact of this happening again?	Suggestions provided here help us understand your perspective on how incidents occur and how they might be prevented.

LFPSE Risk

Common Ref	LFPSE Risk event question	LFPSE Guidance Text
22	What kind of event do you want to record?	<p>Incident - Something has happened, or failed to happen, that could have or did lead to patient harm What does this mean?</p> <p>Outcome - A poor outcome routinely reported locally where it is not yet known whether or not the outcome was caused by a patient safety incident What does this mean?</p> <p>Risk - A risk to patient safety in the future, though no patients have yet been affected What does this mean?</p> <p>Good Care - An example of good care that can be learned from What does this mean?</p>
23	How concerned are you about this risk and its implications?	<p>Indicate the impact on the safety of healthcare overall, and/or to what extent others may not be aware that this issue exists. Your answer should be based on your own judgement, given the information you have at this point, and can be changed if further information becomes available. Select one.</p>
24	Does this qualify as a notifiable safety incident under the Duty of Candour regulations?	

Common Ref	LFPSE Risk event question	LFPSE Guidance Text
29	To opt out of record sharing, check the box below	<p>We will share this record with other organisations.</p> <p>If your record relates to the delivery of primary care, we will also share this record with the relevant CCG.</p> <p>We will not share your personal data outside of your organisation. We will process your personal data only for the purpose set out in the Terms of Use.</p> <p>To opt out of record sharing, check the box below:</p> <p>* I do not want to share this record with the provider</p> <p>NHS England & Improvement may share this record with other relevant organisations under specific data sharing agreements (as set out in our Terms of Use). We make every effort to remove any unwanted personal identifiable data provided by you as part of this record before the data is shared with any other organisation.</p>
30	Does this event require statutory notification to CQC?	
31	Which of the following criteria does it meet?	Select all that apply.
32	Has this been referred to the Local Authority Safeguarding team?	
35	Which organisation does the risk relate to?	Start typing and select the organisation from the list. If you are unsure of your organisation's ODS code, you can use the ODS portal here to find it.

Common Ref	LFPSE Risk event question	LFPSE Guidance Text
36	Or specify other	
39	Which specialty does the risk relate to?	Start typing and select your speciality from the list. Click here for the full list of specialties.
40	Or specify other	
41	Which organisation was the risk identified in?	Start typing and select the organisation from the list. If you are unsure of your organisation's ODS code, you can use the ODS portal here to find it.
42	Or specify other	
43	Where does the risk exist?	
44	Where was the risk identified?	
45	Does this event meet the national definition of a Never Event?	Only relevant designated individuals within an organisation should declare a Never Event, based on the definition in the Never Events Framework . Declaring a Never Event initiates the need for a systems-based patient safety investigation, focused on learning for improvement, with formal governance and oversight arrangements. All Never Events should also be declared as Serious Incidents, as stated in the Serious Incident and Never Events Frameworks
46	Does this event meet the national definition of a Serious Incident?	Only relevant designated individuals within an organisation should declare a Serious Incident, based on the definition in the Serious Incident Framework . Declaring a Serious Incident initiates the need for a systems-based patient safety investigation, focused on learning for improvement, with formal governance and oversight arrangements.
47	Does this incident relate to a baby and/or mother and require notification to HSIB under the defined criteria for maternity investigations?	
48	Which Never Event type are you declaring?	

Common Ref	LFPSE Risk event question	LFPSE Guidance Text
49		<p>Your answer should be based on the information you have at this point, and can be changed if further information becomes available.</p> <p>If a death has occurred and you are not aware of any patient safety incident that preceded the death (including stillbirth or pregnancy loss) but want to notify others so that Learning from Deaths or other standard reviews can be conducted, please return to the start and record a 'Something routinely reported locally that at this time does not appear to be a patient safety incident but may have been preceded by one' rather than a patient safety incident.</p>
56	Was the service user detained under the Mental Health Act at the time of the event?	
57	Was the service user subject to Deprivation of Liberty Safeguards at the time of the event?	
122	Which of these best describes your role?	
123	Please specify	
127	Which organisation are you reporting from?	<p>Start typing and select the organisation from the list. If you are unsure of your organisation's ODS code, you can use the ODS portal here to find it.</p>
128	Or specify other	
129	Why are you recording this anonymously today?	Select all that apply.
130	Please specify	
131	Describe the risk	<p>Include any details you think might be important for trying to prevent this risk causing a problem in the future.</p>

Common Ref	LFPSE Risk event question	LFPSE Guidance Text
132	What type of risk to patient safety are you recording?	Select all that apply.
133	Please specify	
134	Is there imminent risk of severe harm or death?	An imminent risk is one that is likely to be a problem within weeks. Severe harm is something that is likely to make someone need life-saving care, require hospital treatment for more than 2 weeks or reduce a person's independence for more than 6 months.
135	Which service areas are at risk?	
136	Which groups of patients are at risk?	For example, people of a certain age, gender, location or with a certain condition or treatment.
137	When do you think this risk will cause harm?	
138	Please specify	
143	Was the risk identified today?	
144	When do you think the risk was identified?	Give the approximate month and year it happened.
145	What date was the risk identified on?	For example, 16 3 1985
149	Do you have any ideas for what could be done to reduce the risk or impact of this happening again?	Suggestions provided here help us understand your perspective on how incidents occur and how they might be prevented.

LFPSE Good Care

Common Ref	LFPSE Good Care event questions	LFPSE Guidance Text
22	What kind of event do you want to record?	<p>Incident - Something has happened, or failed to happen, that could have or did lead to patient harm What does this mean?</p> <p>Outcome - A poor outcome routinely reported locally where it is not yet known whether or not the outcome was caused by a patient safety incident What does this mean?</p> <p>Risk - A risk to patient safety in the future, though no patients have yet been affected What does this mean?</p> <p>Good Care - An example of good care that can be learned from What does this mean?</p>
24	Does this qualify as a notifiable safety incident under the Duty of Candour regulations?	

Common Ref	LFPSE Good Care event questions	LFPSE Guidance Text
29	To opt out of record sharing, check the box below	<p>We will share this record with other organisations.</p> <p>If your record relates to the delivery of primary care, we will also share this record with the relevant CCG.</p> <p>We will not share your personal data outside of your organisation. We will process your personal data only for the purpose set out in the Terms of Use.</p> <p>To opt out of record sharing, check the box below:</p> <p>* I do not want to share this record with the provider</p> <p>NHS England & Improvement may share this record with other relevant organisations under specific data sharing agreements (as set out in our Terms of Use). We make every effort to remove any unwanted personal identifiable data provided by you as part of this record before the data is shared with any other organisation.</p>
30	Does this event require statutory notification to CQC?	
31	Which of the following criteria does it meet?	Select all that apply.
32	Has this been referred to the Local Authority Safeguarding team?	
33	Describe what happened	Include details of anything you think was important, or might help us learn from what happened. Avoid including any identifiable information such as names of staff or patients here.

Common Ref	LFPSE Good Care event questions	LFPSE Guidance Text
34	Did the good care event occur whilst the patient was under your organisation's care?	
35	Under which organisation's care did the good care occur?	Start typing and select the organisation from the list. If you are unsure of your organisation's ODS code, you can use the ODS portal here to find it.
36	Or specify other	
45	Does this event meet the national definition of a Never Event?	Only relevant designated individuals within an organisation should declare a Never Event, based on the definition in the Never Events Framework . Declaring a Never Event initiates the need for a systems-based patient safety investigation, focused on learning for improvement, with formal governance and oversight arrangements. All Never Events should also be declared as Serious Incidents, as stated in the Serious Incident and Never Events Frameworks
46	Does this event meet the national definition of a Serious Incident?	Only relevant designated individuals within an organisation should declare a Serious Incident, based on the definition in the Serious Incident Framework . Declaring a Serious Incident initiates the need for a systems-based patient safety investigation, focused on learning for improvement, with formal governance and oversight arrangements.
47	Does this incident relate to a baby and/or mother and require notification to HSIB under the defined criteria for maternity investigations?	
48	Which Never Event type are you declaring?	
56	Was the service user detained under the Mental Health Act at the time of the event?	

Incident Oversight from InPhase migration guidance

Common Ref	LFPSE Good Care event questions	LFPSE Guidance Text
57	Was the service user subject to Deprivation of Liberty Safeguards at the time of the event?	
122	Which of these best describes your role?	
123	Please specify	
150	How could this excellence be amplified or recreated in the future?	
151	How did this example of good practice come to your attention?	
152	Please specify	

LFPSE Outcome

Common Ref	LFPSE Outcome event Questions	LFPSE Guidance Text
22	What kind of event do you want to record?	<p>Incident - Something has happened, or failed to happen, that could have or did lead to patient harm What does this mean?</p> <p>Outcome - A poor outcome routinely reported locally where it is not yet known whether or not the outcome was caused by a patient safety incident What does this mean?</p> <p>Risk - A risk to patient safety in the future, though no patients have yet been affected What does this mean?</p> <p>Good Care - An example of good care that can be learned from What does this mean?</p>
23	How concerned are you about this outcome and its implications?	<p>Indicate the impact on the safety of healthcare overall, and/or to what extent others may not be aware that this issue exists. Your answer should be based on your own judgement, given the information you have at this point, and can be changed if further information becomes available. Select one.</p>
24	Does this qualify as a notifiable safety incident under the Duty of Candour regulations?	
28	Is there anything in what you know at this point that makes you worry or suspect that a patient safety incident has occurred?	
29	To opt out of record sharing, check the box below	<p>We will share this record with other organisations.</p> <p>If your record relates to the delivery of primary care, we will also share this record with the relevant CCG.</p> <p>We will not share your personal data outside of your organisation. We will process your personal data only for the purpose set out in the Terms of Use.</p> <p>To opt out of record sharing, check the box below:</p>

Common Ref	LFPSE Outcome event Questions	LFPSE Guidance Text
		<p>* I do not want to share this record with the provider</p> <p>NHS England & Improvement may share this record with other relevant organisations under specific data sharing agreements (as set out in our Terms of Use). We make every effort to remove any unwanted personal identifiable data provided by you as part of this record before the data is shared with any other organisation.</p>
30	Does this event require statutory notification to CQC?	
31	Which of the following criteria does it meet?	Select all that apply.
32	Has this been referred to the Local Authority Safeguarding team?	
33	Describe what happened	Include details of anything you think was important, or might help us learn from what happened. Avoid including any identifiable information such as names of staff or patients here.
34	Did the outcome occur whilst the patient was under your organisation's care?	
35	Under which organisation's care did the outcome occur?	Start typing and select the organisation from the list. If you are unsure of your organisation's ODS code, you can use the ODS portal here to find it.
36	Or specify other	
37	Which service areas were involved?	Select all that apply.
39	Which specialty does the outcome relate to?	Start typing and select your speciality from the list. Click here for the full list of specialties.
40	Or specify other	
45	Does this event meet the national definition of a Never Event?	Only relevant designated individuals within an organisation should declare a Never Event, based on the definition in the Never Events Framework . Declaring a Never Event initiates the need for a systems-based patient safety investigation, focused on learning for improvement, with formal governance and oversight arrangements. All Never Events should also be declared as

Common Ref	LFPSE Outcome event Questions	LFPSE Guidance Text
		Serious Incidents, as stated in the Serious Incident and Never Events Frameworks
46	Does this event meet the national definition of a Serious Incident?	Only relevant designated individuals within an organisation should declare a Serious Incident, based on the definition in the Serious Incident Framework . Declaring a Serious Incident initiates the need for a systems-based patient safety investigation, focused on learning for improvement, with formal governance and oversight arrangements.
47	Does this incident relate to a baby and/or mother and require notification to HSIB under the defined criteria for maternity investigations?	
48	Which Never Event type are you declaring?	
52	Which of the following are you recording?	If the event you want to record is not listed below, and you are concerned that it could have or did affect patient safety, then please record this as an incident.
53	What was the patient's age at the time of the outcome?	You will be able to input the age on the next page after selecting the appropriate unit of time.
54	Estimate the patient's age	
55	What is the patient's sex?	
56	Was the service user detained under the Mental Health Act at the time of the event?	
57	Was the service user subject to Deprivation of Liberty Safeguards at the time of the event?	
59	What is the patient's self-identified ethnicity?	This may be in their record, or you can ask them or a family member. If this information has not been provided by the patient or their family, please select 'I don't know'.
63	At what point was the outcome detected?	
64	Please specify	
122	Which of these best describes your role?	
123	Please specify	
127	Which organisation are you reporting from?	Start typing and select the organisation from the list. If you are unsure of your organisation's ODS code, you can use the ODS portal here to find it.
128	Or specify other	

Incident Oversight from InPhase migration guidance

Common Ref	LFPSE Outcome event Questions	LFPSE Guidance Text
129	Why are you recording this anonymously today?	Select all that apply.
130	Please specify	
143	Did this happen today?	
144	When do you think the outcome happened?	Give the approximate month and year it happened.
145	What was the date of the outcome?	For example, 16 3 1985

This migration guide was developed in conjunction within material from NHS England and Improvement, with special thanks Marcos Manhaes and the NRLS and LFPSE team for their assistance and support in developing Incident Oversight from InPhase.

A more comprehensive Customisation spreadsheet tool is available on request from InPhase to define your local questions and answers fully for implementation of Incident Oversight.

For further assistance please contact Paul Clinton at InPhase on 01753 480480.



**For more information, please
email us at hello@inphase.com
or call us on **01753 480480****

