Leicestershire Partnership NHS Trust

Alert Systems Policy

Incorporating:

DoH Central Alerting System (CAS)
Public Health Link Bulletins (PHLB)
NHS England's National Patient Safety Alerting System (NPSAS)
Drug Alerts (DA)
Security Alerts (SA)
LPT Internal Alerts (IA)
MHRA One Liners

Key Words:	Alerts, CAS, Learning, incidents	
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Adopted by:	Quality Assurance Committee	
Date Adopted:	19 February 2019	
Name of Author:	Fern Barrell	
Name of responsible Committee:	Patient Safety Improvement Group	
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Target audience:	All Staff involved with the Alerts Process	
Type of Policy	Clinical ✔	Non Clinical ✔
Which Relevant CQC Fundamental Standards?		

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
2	February 27th 2012	Updated to reflect Divisions inclusion of Security Alerts
3	March 20th 2012	Responsibilities expanded, UHL's role in Drug alerts specified
4	March 2014	Overall review incorporating response to NHS England's introduction of the National patient Safety Alerting System
5	August 2016	Revised in line with the new guidance from DoH. The policy now reflects that Health and Safety Committee receives estates and Medical Devices Alerts
6	January 2019	Patient safety alert process updated to clarify referral to Lead Nurses or Specialist nurse as appropriate revised governance process. Internal alert proforma included in appendices for clarification. Drugs alert process updated to reflect use of Ulysses alerts module.

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Contents

Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area.

This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

The Trusts commitment to equality means that this policy has been screened in relation to paying due regard to the general duty of the Equality Act 2010 to eliminate unlawful discrimination, harassment, victimisation; advance equality of opportunity and foster good relations.

This Policy is not public facing however it does require the regular transmission of critical information throughout the organisation sometimes at very short notice. All such communications are carried out in context of the Trusts communication and accessibility policies which minimise any adverse impact. For example all members of staff undertake a desk top audit to ensure any accessibility issues are identified and mitigated wherever possible.

The Due regard assessment template is Appendix 10 of this document

Definitions that apply to this Policy

Alert	Communication, normally related to safety, which must be distributed to appropriate personnel. Some alerts may require acknowledgment or actions to take place within a defined timescale.
DoH CAS	Department of Health Central Alerting System
NPSAS	National Patient Safety Alerting System
PHLB	Public Health Link Bulletins
DA	Drug Alert
SA	Security Alert
MHRA One Liner	Medical and Healthcare Products regulatory Agency, advice
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
CLO	CAS Liaison Officer – an Officer of the Trust designated as the leadcontact with the Department of Health for receiving and responding to CAS alerts
MDSO	Medical Device Safety Officer
MSO	Medication Safety Officer
MDA	Medical Device Alert, issued by the Medical and Healthcare Products Regulatory agency
IA	Internal Alert, created and issued from within the Trust
LSMS	Local Security Management Specialist
PSG	Patient Safety Group
HSC	Health and Safety Committee

1.0 Purpose of the Policy

This purpose of the policy is to provide a framework for the management of all alerts. Leicestershire Partnership NHS Trust is committed to continuous improvement of patient, visitor and staff safety by identifying, managing and reducing risks to safety, to this end the Trust will endeavour to comply with the requirements of all alerts in an effective and timely manner.

2.0 Summary and Key Points

The Trust has processes in place for the receipt, creation, distribution of alerts and reporting consequent risks.

3.0 Introduction

This policy aims to provide a framework for the management of all alerts incorporating:

- NHS England National Patient Safety Alerting System (NPSAS)
- Department of Health Estates Alerts
- Medical Device Alerts (MDA's) issued by the Medicines and Healthcare Products Regulatory Agency (MHRA)
- Public Health Link Bulletins (PHLB's) issued by the Department of Health, Drug Alerts (DA's) ,
- Security Alerts (SA),
- MHRA One Liners
- Internal Alert (IA) that may be created from within the Trust

Within this policy all NPSAS, CAS, PHLB, DA, MDA, SA, MHRA One Liners and IA will be referred to collectively as 'alerts') .

All alerts will be received and managed via a single process (Appendix 1) with the exception of Drug Alerts, which are directly received and dealt with by the responsible pharmacy–
Mental Health, Learning Disabilities and Community Hospitals – LPT Pharmacy (see Appendix 2)
Community Services – Independent Pharmacists

N.B. Dear Doctor and Dear Colleague letters from the Chief Medical Officer (CMO) are NOT covered by this policy. The Trusts Medical Director receives and distributes CMO correspondence.

4.0 Scope of the Policy

The Policy shall apply to all staff working for, or in partnership with, Leicestershire Partnership NHS Trust.

5.0 Alert Governance

5.1 Quality Assurance Committee (QAC)

The committee, through its chairman, will seek assurance from the Patient Safety Improvement Group (PSIG) and Health & Safety Committee that the alerts are appropriately managed in an effective and timely manner:

5.2 Patient Safety Improvement Group (PSIG)

The Patient Safety Group (PSIG) is responsible for assuring that the following alert types are appropriately managed in an effective and timely manner:

- MDA
- NHS England
- Internal alerts applicable to patient safety

PSIG will ensure where appropriate that existing policies are amended in light of new evidence from any alerts, or where necessary commission the creation of new policy.

5.3 Health & Safety Committee (HSC)

The Health & Safety Committee (HSC) is responsible for assuring that the following alert types are appropriately managed in an effective and timely manner:

- Security Management
- Department of Health Estates
- Internal alerts applicable to health & safety

5.4 Trust wide Medication Risk Reduction Working Group (TWMRRWG)

TWMRRWG reports concerns to its parent group the PSIG regularly and for the purposes of compliance with NHS England Directives shall act as the Trusts *Medication Safety Committee - responsibilities include::*
identifying, developing and promoting best practice for medication safety. This will include supporting the implementation of external patient safety guidance from NHS England, MHRA, NICE and other organisations - implementation will require coordination and support for process and system changes to reduce the likelihood of serious medication errors occurring and recurring, providing regular feedback to clinical staff, patient care areas and hospital committees on medication risks and planned action to minimise these risks.

6.0 Duties within the Organisation

6.1 All Staff

Staff are responsible for ensuring compliance with all alerts brought to their attention and highlighting areas of non-compliance where this exists via their line manager and where appropriate through the incident reporting system.

In complying with an alert staff have the freedom to take the right appropriate actions, based on professional judgement and available evidence. No member of

staff retains the freedom to avoid taking action detailed within an alert.

Staff should be willing to share best-practice and existing local learning from alerts both within the Trust and where appropriate with other organisations including NHS England.

6.2 Chief Nurse

The Chief Nurse holds executive responsibility for the oversight of the alerts management process, alert compliance, implementation and sign-off within the Trust.

6.3 CAS Liaison Officer (CLO), and Medical Devices Safety Officer (MDSO) Roles

6.3.1 CAS Liaison Officer (CLO) responsibilities include:

i. The CLO shall be the Risk Manager.
ii. The Deputy CLO shall be the Risk Assurance Co-ordinator.
iii. The CLO or their deputy will be responsible for receiving alerts from the Department of Health, the LSMS and Internal Alerts and managing them in accordance with the process given in appendices 1 and 2.
iv. The CLO will make available to the PSG, HSC and MDG reports on alerts received and compliance with alert timescales.
v. The CLO is responsible for annually reviewing the alerts process given in appendices 1 and 2 to ensure it remains suitable.
vi. The CLO will ensure effective joint working for the resolution of alerts with partner organisations and neighbouring NHS Trusts where appropriate

The Risk Manager/CLO will additionally undertake the role of Medical Device Safety Officer accountable for ensuring a process for the reporting of medical device incidents both internally and where required onwards to the MHRA.

6.3.2 MDSO Role responsibilities include:

i. Active membership of the National Medical Devices Safety Network;
ii. Improve reporting of and learning from medical devices incidents in the organisation;
iii. Manage medical device incident reporting in the organisation, review all medical devices incident reports to ensure data quality for local and national learning, where necessary investigate and get additional information from reporters;
iv. Make sure that medical device incidents are sent to the NRLS as soon as possible and a least every week;
v. Receive and respond to requests for more information from the Patient Safety Domain in NHS England and the MHRA about medical device incident reports;
vi. Work as a member of the medical devices safety committee to deliver the responsibilities listed in 9.1.4;
vii. Act as an additional senior point of contact for manufacturers and support local actions on Field Safety Notices; and,
viii. Improve reporting of medical devices incidents and support the dissemination

6.4 Executive Directors

Each Executive Director of the Trust will ensure that each management team under their control has suitable systems in place for the management of any alerts.

6.5 Directors and Heads of Enabling Services

Director / Heads of Enabling Services will ensure that each department, building, and management team under their control has suitable systems in place for the management of any alerts.

They may appoint a Directorate/Enabling Service CAS Lead Officer in order to discharge this duty.

Each director will be responsible for reviewing their internal process at least annually to ensure they remain suitable.

6.6 Clinical Directors

Clinical Directors will advise their local CAS Lead on the relevance of any PHLB's to the service.

6.7 Enabling & Directorate CAS Lead Officers, & their Deputies

i. In accordance with 6.4 above, each enabling service and directorate will nominate a CAS lead officer, and a deputy, to manage the effective and timely processing of each alert within their area of responsibility.
ii. To ensure the CAS Lead Officer for the Trust has a continuously updated alerts distribution list for their service / Division.
iii. Will support the Director, the Heads of Service, and the alerts process. They will support and advise service leads, monitor the reporting process, and support the CLO.

6.8 Heads of Service

Head of the Service will be responsible for the effective communication and implementation of alerts and necessary actions within their service. They will ensure that alerts responses are timely, complete and compliant with the alert requirements.

6.9 Local Security Management Specialist (LSMS)

The LSMS may receive security alerts from other NHS Trusts and will assess for relevance to the Trust, forwarding to the CLO for distribution if appropriate.

6.10 Specialist Advisors

The CLO may call upon the advice and guidance of a number of specialists within the trust to advise on the applicability of any alert, as well as any suitable options for risk management, these advisors include, but are not limited to the following:

i. Medical Devices Asset Manager

ii. Patient Safety Lead
iii. Service Lead Clinicians
iv. Medical Director
v. Specialist Fire Safety Advisor
vi. Associate Director of Medicines Management
vii. Health and Safety Advisors
viii. Head of Professional Practice and Education
ix. Clinical Directorate Governance Leads
x. Local Security Management Specialist

6.11 Head of Pharmacy

Drug Alerts are issued by the MHRA directly to all registered Pharmacists. The supplier of a drug (i.e. the issuing pharmacy) has responsibility for the actions prescribed under a Drug Alert (as opposed to the provider of care to patients in receipt of those drugs).

The Head of Pharmacy for LPT will have in place a process for the receipt and distribution of Drug Alerts pertinent to those drugs supplied by LPTs Pharmacy (see appendix 2). This process will be subject to revision dependant on the scope and nature of the services provided by LPT Pharmacy and may be updated accordingly.

The Head of Pharmacy will undertake the new national role of Medication Safety Officer (MSO). One of the MSOs' key roles is to promote the safe use of medicines across their organisations, and be the main expert in this area. In addition to improving the quality of reporting, the MSO will serve as the essential link between the identification and implementation of (local and national) medication safety initiatives and the daily operations to improve patient safety with the use of medicines.

MSO Responsibilities include the following:

i. Active membership of the National Medication Safety Network;
ii. Improving reporting and learning of medication error incidents in the organisation;
iii. Managing medication incident reporting in the organisation. This may entail reviewing all medication incident reports to ensure data quality for local and national learning and where necessary to investigate and find additional information from reporters. Also, to authorise the release of medication error reports to the NRLS each week;
iv. Receiving and responding to requests for more information about medication error incident reports from the Patient Safety Doman in NHS England and the MHRA;
v. Work as a member of the medication safety committee.
vi. Supporting the dissemination of medication safety communications from NHS England and the MHRA throughout the organisation.

6.12 Head of Estates (UHL FM)

Will ensure that the estates alerts and notification responses are time complete and compliant with the alert requirements.

7.0 Procedures

On receipt of any alert the CLO will initiate the relevant process as described in appendices 1 and 2, the CLO will seek advice and guidance in respect of the management actions to be taken to minimise risks associated with the alert.
Where risks identified by the alert cannot be adequately controlled within a reasonable timeframe the CLO will bring this to the attention of the relevant executive director.

8.0 Deadlines

Deadlines for completing alert actions will be stipulated on each alert, these must be adhered to, and breaching a deadline constitutes a risk to the Trust. Where compliance with an alert is not possible within defined timescales the CLO will advise the appropriate Executive Director of the risk posed to the organisation and will facilitate a corresponding entry on the trust's Risk Register.

9.0 Training and Education

The Enabling and Divisional CAS Leads and the CLO will ensure those staff with designated responsibilities for the receipt and distribution of alerts and for reporting back on compliance with alert actions under this policy receive suitable training. (See appendix 4 for Training Needs Analysis).

10.0 Audit

The CLO will undertake an annual audit equal to 5% all CAS alerts received and report accordingly to the Patient Safety & Improvement Group.

11.0 Standards/Performance Indicators

TARGET/STANDARDS	KEY PERFORMANCE INDICATOR
Completion of alerts within the timescale stipulated on the CAS website.	Ulysses alerts reports confirm target date and actual closure date

12.0 References and Bibliography

12.1 The policy was drafted with reference to the following:

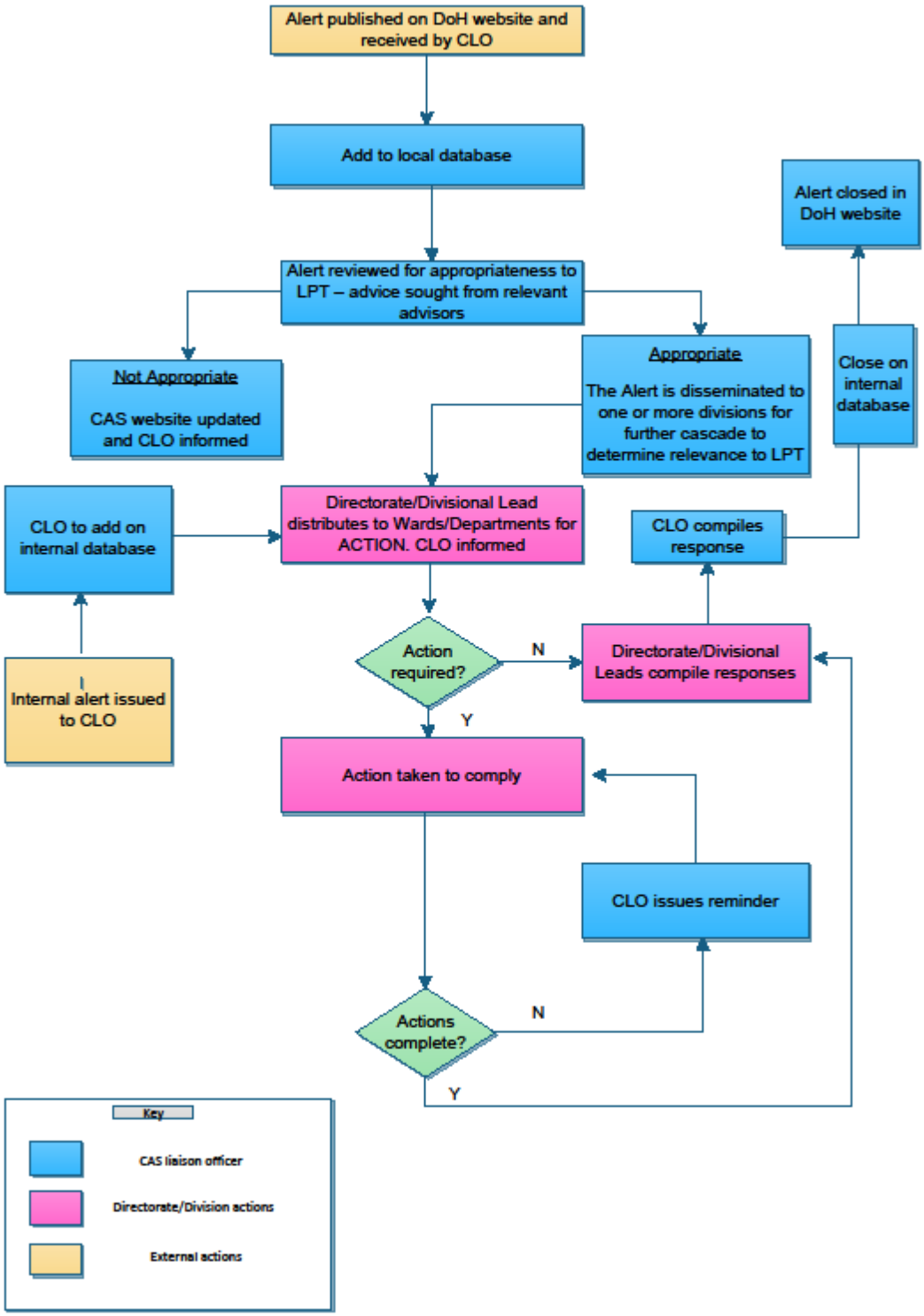
- http://www.nrls.npsa.nhs.uk/patient-safety-data/#cas
- http://www.mhra.gov.uk/Aboutus/index.htm
- http://www.mhra.gov.uk/Safetyinformation/Generalsafetyinformationandadvice/MedicalDeviceLiaisonOfficerinformation/index.htm
- http://www.nrls.npsa.nhs.uk/portal/error/?ReturnUrl=/report-a-patient-

safety-incident/patient-safety-direct/
- http://www.nhsbsa.nhs.uk/Protect.aspx
- http://www.england.nhs.uk/ourwork/patientsafety/psa/national-psa-system/

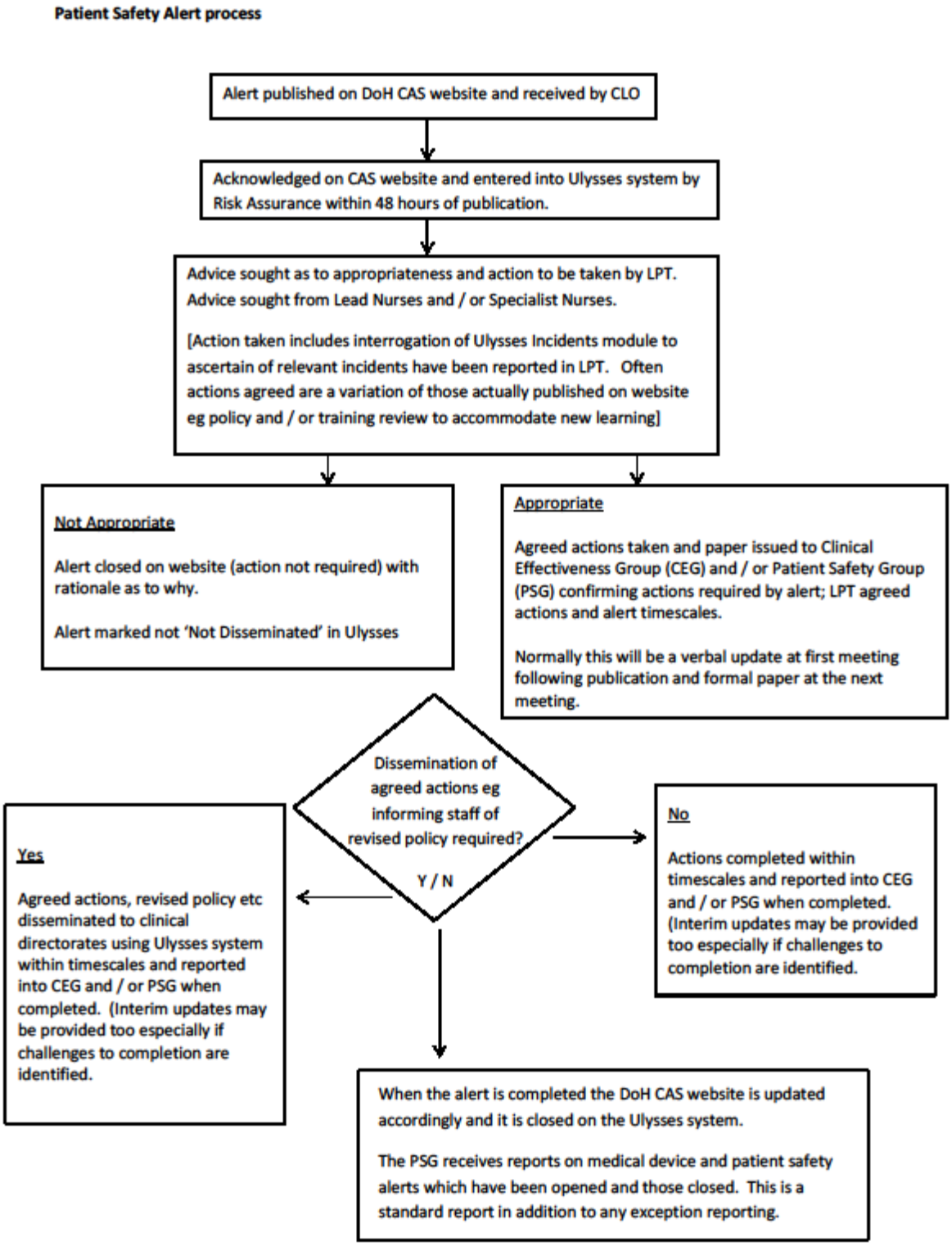
12.2 Associated Documents

- Medical Devices Policy

Appendix 1 Medical Device Alerts process



Appendix 2 Patient Safety Alert process



Appendix 2a Patient Safety Alert operating procedure (including internal alerts)

Patient Safety Alert Standing Operating Procedure

Patient safety alerts are issued via the Central Alerting System (CAS). Incidents are identified using the National Reporting and Learning System (NRLS) and three types of alert are issued:

Warning Alerts

These are issued in response to a new or under-recognised patient safety issue with the potential to cause death or severe harm.

Resource Alerts

Typically issued in response to a patient safety issue that is already well-known, either because an earlier warning alert has been issued or because they address a widespread patient safety issue. They are designed to ensure healthcare providers are aware of any substantial new resources that will help to improve patient safety, and ask healthcare providers to plan implementation in a way that ensures sustainable improvement.

Directive Alerts

Typically issued because a specific, defined action to reduce harm has been developed and tested to the point where it can be universally adopted, or when an improvement to patient safety relies on standardisation (all healthcare providers changing practice or equipment to be consistent with each other) by a set date

Irrespective of the three alert types they are all managed in exactly the same way.

Alert published on CAS website

When a patient safety alert is published on the CAS website it is acknowledged by the Risk Assurance Department with 48 hours of publication. This process compromises of choosing assessing relevance on the alert; the details of the alert should also be entered into the Ulysses system.

Once it has been acknowledged an initial review of the alert is conducted as to its relevance. Each alert confirms for which organisation types(s) it is aimed at or the relevant service and it is feasible that the relevance to the trust can be determined at this stage as many are aimed solely at acute trusts. **If is definitely not relevant to LPT the alert is closed on the CAS website at this stage confirming action not required and the rationale why; it should also be closed in Ulysses confirming not disseminated.**

Referral for trust relevance and required actions

If the Risk Assurance department is able to identify the appropriate lead nurse specialist the alert is referred to him / her for advice as to action to be taken. If relevance to the trust or the particular service(s) cannot be identified the alert is referred to the lead nurses for the clinical directorates.

If the alert is found to not to be relevant at this stage then the appropriate not applicability closure processes should be followed in the CAS website and Ulysses.

Alert relevant to LPT and actions agreed

Where possible the actions are agreed with the Lead Nurses and / or Specialist Nurse and paper issued to Clinical Effectiveness Group (CEG) and / or Patient Safety & Improvement Group (PSIG) confirming actions required by alert; LPT agreed actions and alert timescales. Required actions may include e.g. policy and / or training review to accommodate new learning.

If a policy revision is required then this will need to go through the policy approval process including adoption by QAC. If the policy will not be adopted within alert timescales the position is communicated on the CAS website in the free text box with assurance as to trust timescales.

Interim updates may be provided too especially if challenges to completion are identified.

It may be required for the exception paper to request alert lead and / or identification of actions.

Internal Alerts

Periodically it is necessary for an internal alert to be issued; their need is usually borne of learning from an incident. Dissemination is targeted; it is therefore expected that receiving teams and services will confirm applicability.

The content of the alert including actions is agreed with all parties concerned prior to dissemination. A proforma is used for the compilation of the alert (this can be found in appendix 2c).

Alert dissemination

Alert dissemination required

If the alert is disseminated this is completed using the Ulysses system. Dissemination is usually required when a policy or process has been reviewed and updated to meet the needs of the alert. This may take place outside of the alert timescale depending on the policy and the level of change required.

Alert dissemination not required

Alert dissemination will not be required if current policy and processes are concluded to meet the terms of the alert. In this scenario the alert should be closed on the CAS website with **action completed**. The free text box should confirm that trust policy and processes have been reviewed along the side the alert and it has been concluded that the requirements of the alert are accommodated for.

Appendix 2 Internal Alert proforma

Leicestershire Partnership NHS Trust

LPT Internal Alert

Problem:	
Originating Department / Division:	Risk Assurance
Date issued:	
Acknowledgement Deadline	
Action Underway Deadline:	
Action Complete by Deadline	
Risk:	
Required Actions:	

Trust contact name and details for further information:

Risk Co-Ordinator

Leicestershire Partnership NHS Trust
Room 170
Penn Lloyd Building
County Hall
Leicestershire
LE3 8TH
Tel: 0116 295 0863

Alert Reference Number (given by Trust Alerts Administrator):

Appendix 3 Drug Alerts

The Medicines & Healthcare products Regulatory Agency (MRHA) periodically send through details of any defective medication or device or problems with particular devices or batches of medication by email or out-of-hours by contact with the LPT on-call pharmacist via the UHL on-call pharmacist. Acknowledgement of receipt must be within 1 hour of contact.

It is the responsibility of the pharmacy services manager / Head of Pharmacy (or the on-call pharmacist out of hours) to check the stock, if any, and to deal with the drug recall. In the absence of the pharmacy services manager the duty manager for the department should identify the most appropriate individual to deal with the recall.

(A corresponding alert is published on the CAS website. Using this drug alert information the alert is replicated in Ulysses and cascaded to the LPT Pharmacy management team).

Documentation should clearly state the receipt and action date/time. This should also be documented in the first alert response (action required and underway).

PROCEDURE FOR DRUG RECALLS

The computer must be searched to check if the LPT pharmacy has stocked the particular product. The computer system does not record batch numbers, so if the affected product has been received between the date of issue of affected stock and the date of the drug recall, the order paperwork must be checked to see if the offending batch(es) have been received. If the batch number(s) have been received, access the TRANS/TRACE program, from the General Reporting Folder in the JAC system to find which wards/patients received the product.

The drug recalls are coded according to their severity.

Class 1 recall	immediate action required
Class 2 recall	action within 48 hours required
Class 3 recall	action within 5 days required
Class 4 recall	caution in use required

The advice on the recall sheet must be followed to see what action is required for each drug/batch.

If the TRACE programme reveals that there is a potential for affected stock to have been issued to wards or departments the nurse-in-charge of the affected wards/departments must be contacted with details of the recall and asked to check their stock at once. They must confirm whether or not they hold stock and this should be documented on the drug alert. If they do hold stock they should be instructed to return it and the date when the affected stock was received in pharmacy should also be documented on the drug alert.

If the drug is a stock line in any of the Out of Hours cupboards, and the computer indicates that the affected batch was issued to that location, then those stocks must be checked.

In some recalls, the drug must be retrieved from the patient but these are for very serious recalls only. Often it is only the stocks in the dispensary or at ward level that must be returned. Check the recall notice carefully to check which is the case.

Any affected batches for recall must be segregated and handed to the Pharmacy Assistant in charge of ‘booking-in’ for return to the wholesaler, or as instructed on the Drug Recall sheet. If the drugs concerned are Controlled Drugs (CD), the pharmacist on duty must take responsibility for this, and store the affected batches in the CD cupboard with the recall paperwork attached.

The Drug Recall paperwork must be annotated to show details of any stock held and the Pharmacist must sign and date the sheet to show that the recall has been acted on. The drug recall paperwork must then be passed to the Head of Pharmacy for storage in the Drug Recall Folder, located on the bookshelf behind the Pharmacist’s desk in the dispensary. Any drug recalls affecting vaccines will also be forwarded to the Lead Pharmacist for Families, Young People and Children and the Immunisations Manager so that stocks held in Bridge Park Plaza can be checked.

These details must be stored for 5 years from receipt of last recall notice.

Once the alert has been completed in should be marked as action completed in Ulysses. Confirmation of action required should be included.

Appendix 4 Procedure For Dealing With DoH Estates & Facilities Alerts and Notifications

These are periodically issued and once registered on the Ulysses module they are disseminated to the Estates and Facilities teams at both LPT and UHL.

Estates & Facilities Alerts (EFAs) (LPT Estates)

Used where the recipient is expected to take action on the advice, where it is necessary to repeat warnings on long standing problems, or to support or follow-up manufacturers' field modifications.

Estates and Facilities Notifications (EFNs) (UHL & LPT Estates)

- Dangerous Incident Notification (DIN)
- National Equipment Defect Report (NEDeR)

Note: The Action will be deemed to be completed when the Authorising Engineer Electrical), or his nominated deputy, has confirmed receipt of the Alert

Appendix 5 Alert Categories and Deadlines

Department of Health Central Alerting System – incorporating MHRA Medical Device Alerts, NPSA Rapid Response Alerts, Estates & Facilities Alerts and Estates & Facilities Notifications

Categories of Alerts:

Immediate Action: Used in cases where there is a risk of death or serious injury and where the recipient is expected to take immediate action on the advice.

Action: Used where the recipient is expected to take action on the advice, where it is necessary to repeat warnings on long standing problems, or to support or follow-up manufacturers' field modifications.

Update: Used to update the recipient about previously reported incidents or series of incidents, possibly on a topical or device group basis, and where further follow-up safety information is judged to be beneficial.

Information Request: Used to alert users about a specific issue that may become a problem and where we are requesting feedback. These alerts will be sent out with additional questions to be completed.

Categories of response back to DoH (each with a respective deadline)

Acknowledgement of receipt of alert *(deadline for)*

Action Underway *(deadline for)*

Action Complete *(deadline for)*

Department of Health Public Health Link Bulletins - incorporating MHRA Drug Alerts.

Categories of Alerts and respective deadlines:

Immediate: Cascade within 6 hours. To be used infrequently in exceptional cases where potentially serious health risks are implicated.

Urgent: Cascade within 24 hours. The most common category.

Non-urgent: Cascade within 48 hours.

For information: This is used in circumstances where there is no need to cascade the information and only those who receive the message directly need to be aware of its content.

NHS England National Patient Safety Alerting System: The three stages of NPSAS alerts

Stage One Alert: Warning

This stage ‘warns’ organisations of emerging risk. It can be issued very quickly once a new risk has been identified to allow rapid dissemination of information.

Stage Two Alert: Resource

This alert may be issued some weeks or months after the stage one alert, and could consist of:

- sharing of relevant local information identified by providers following a stage one alert;
- sharing of examples of local good practice that mitigates the risk identified in the stage one alert;
- access to tools and resources that help providers implement solutions to the stage one alert; and
- access to learning resources that are relevant to all healthcare workers and can be used as evidence of continued professional development.

Stage Three Alert: Directive

When this stage of alert is issued, organisations will be required to confirm they have implemented specific solutions or actions to mitigate the risk. A checklist will be issued of required actions to be signed-off in a set timeframe. These actions will be tailored to the patient safety issue.

Appendix 6 Training Requirements

Training Needs Analysis

Training Required	YES ✓	NO
Training topic:	Alerts process	
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☒ Role specific ☐ Personal development	
Division(s) to which the training is applicable:	☒ Adult Mental Health & Learning Disability Services ☒ Community Health Services ☒ Enabling Services ☒ Families Young People Children ☒ Hosted Services	
Staff groups who require the training:	Those staff identified by the division as needing to receive, distribute and respond to the alerts.	
Regularity of Update requirement:	As required	
Who is responsible for delivery of this training?	CAS Liaison Officer or their deputy	
Have resources been identified?	Yes	
Has a training plan been agreed?	Yes – provided as necessary	
Where will completion of this training be recorded?	☐ ULearn ☒ Other (please specify) local Risk Assurance records	
How is this training going to be monitored?	Responses to the cascaded alerts.	

Appendix 7 The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☒
Respond to different needs of different sectors of the population	☐
Work continuously to improve quality services and to minimise errors	☒
Support and value its staff	☒
Work together with others to ensure a seamless service for patients	☒
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐

Appendix 8 Monitoring section

Where monitoring identifies any shortfall in compliance the group responsible for the Policy (as identified on the policy cover) shall be responsible for developing and monitoring any action plans to ensure future compliance

Minimum Requirements	Self assessment evidence	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
All alerts received by the Trust (except drug alerts and estates alerts) via the CAS website are received and assessed for relevance	6.3 page 9 Appendix 1	Entered into Ulysses alerts module and assessment outcome recorded Reporting to Patient Safety & Improvement Group 5% annual audit	CAS Liaison Officer CAS Liaison Officer	As required Monthly Annual
All alerts (except drug alerts) issued are closed within designated timescales	6.3 page 9 Appendix 1	Entered into Ulysses alerts module and assessment outcome recorded Reporting to Patient Safety & Improvement Group 5% annual audit	CAS Liaison Officer CAS Liaison Officer	As required Monthly Annual
All internal alerts issued are closed within designated timescales	6.3 page 9 Appendix 1	Entered into Ulysses alerts module and assessment outcome recorded Reporting to Patient Safety & Improvement Group and Medical Devices Group 5% annual audit	CAS Liaison Officer CAS Liaison Officer	As required Monthly Annual
Drug alerts received by the Trust via the CAS website are received and assessed for relevance	6.11 page 11 Appendix 2	Medicine Information Dept ensures LPT Pharmacy are aware of alert by faxing it. Signed fax copy returned to confirm acknowledgement Medicine Information Dept at UHL log details of all drug recalls. This information can be sourced by	UHL Medicine Information Dept Pharmacy Dept	As required

		LPT pharmacy at any time.		
Estates alerts received by the Trust via the CAS website are received and assessed for relevance	6.12 page 11	Head of Estates (UHL FM) (based with Estates & Facilities Team, UHL) receives alerts. Reporting to Health & Safety Committee 5% annual audit	Estates & Facilities CAS Liaison Officer	As required Quarterly

Appendix 9 Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Fern Barrell	Risk Manager

Circulated to the following individuals for comment

Name	Designation
Members of PSIG	

Appendix 10 Due Regard Screening Template

Section 1	
Name of activity/proposal	Alerts Policy
Date Screening commenced	15.01.2019
Directorate / Service carrying out the assessment	Risk Assurance
Name and role of person undertaking this Due Regard (Equality Analysis)	Fern Barrell
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: This policy aims to provide a framework for the management of all alerts.	
OBJECTIVES: The objective of the policy is to ensure continuous improvement of patient, visitor and staff safety by identifying, managing and reducing risks to safety and that the Trust comply with the requirements of all alerts in an effective and timely manner.	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	Neutral Impact on all the characteristics
Disability	
Gender reassignment	
Marriage & Civil Partnership	
Pregnancy & Maternity	
Race	
Religion and Belief	
Sex	
Sexual Orientation	
Other equality groups?	

Section 3			
Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please <u>tick</u> appropriate box below.			
Yes		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Signed by reviewer/assessor		**Date**	
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Appendix 11 - Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy. **The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.**			
Name of Document:	**Alerts policy**		
Completed by:	**Fern Barrell**		
Job title	**Risk Manager**		**Date 21/1/19**
Screening Questions		**Yes / No**	**Explanatory Note**
1. Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document.		N	
2. Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document.		N	
3. Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document?		N	
4. Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used?		N	
5. Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics.		N	
6. Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them?		N	
7. As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private.		N	
8. Will the process require you to contact individuals in ways which they may find intrusive?		N	
If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk **In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.**			
Data Privacy approval name:			
Date of approval			

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust