Leicestershire Partnership NHS Trust

Alert Management Policy

Incorporating:

Central Alerting System (CAS) and

LPT Internal Alerts (LPTIA)

Key Words:	Alerts, CAS, Learning, Incidents	
Version:	7	
Adopted by:	Trust Policy Committee	
Date this version was adopted:	24 May 2021	
Name of Author:	Jennie Palmer-Vines – Risk and Assurance Lead Fern Barrell – Risk Manager	
Name of responsible Committee:	Patient Safety Improvement Group (PSIG)	
Please state if there is a reason for not publishing on website:	None	
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Target audience:	All staff who receive and manage alerts	
Type of Policy:	Clinical ✔	Non Clinical ✔
Which Relevant CQC Fundamental Standards:	Regulation 17 – Good Governance Regulation 12 – Safe Care and Treatment Regulation 15 – Premises and Equipment.	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
2	February 2012	Updated to reflect Divisions inclusion of Security Alerts
3	March 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.
7	April 2021	Significant amendments to the whole Policy to reflect changes to operational practices, governance and responsibilities

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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 Trust's 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 Trust's 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 7 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.
CAS	Central Alerting System
CASLO	Central Alerting System Liaison Officer – an Officer of the Trust designated as the lead contact with the Department of Health for receiving and responding to CAS alerts.
CMO	Chief Medical Officer
DH	Department of Health
LPTIA	Internal Alert, created and issued from within the Trust
MDA	Medical Device Alert, issued by the Medicines and Healthcare Products Regulatory Agency
MHRA	Medicines and Healthcare Products Regulatory Agency
NPSA	National Patient Safety Alert
PSIG	Patient Safety Improvement Group
WAR	Weekly Alerts Review Group

1.0 Purpose of Policy

This policy explains the Trust's effective, systematic and auditable approach to the distribution and action requirements of alerts, which have been issued either via the Central Alerting System (CAS) or internally.

2.0 Summary and Scope of Policy

The Central Alerting System (CAS) is a web-based system for issuing patient safety alerts and other safety critical guidance to the NHS and other health and social care providers. Safety alerts, emergency alerts, drug alerts, Dear Doctor letters and medical device alerts are received via the CAS website on behalf of various agencies including:

- Medicines and Healthcare Products Regulatory Agency (MHRA)
- NHS England and NHS Improvement (NHSE/I)
- DH Estates and Facilities

CAS is a key means to communicate important safety information to the NHS, requiring action to address risks to patient safety. There is a distinction between the two types of alerts sent via CAS – those that require an external response (on the CAS website) and those that do not.

Alerts issued on behalf of MHRA Medical Devices, NHS England & Improvement and DH Estates & Facilities, have set deadlines for acknowledgement and completion of actions. NHS Trusts are required to submit responses on the action they have taken on alerts and are monitored on their compliance with completing such alerts within agreed deadlines.

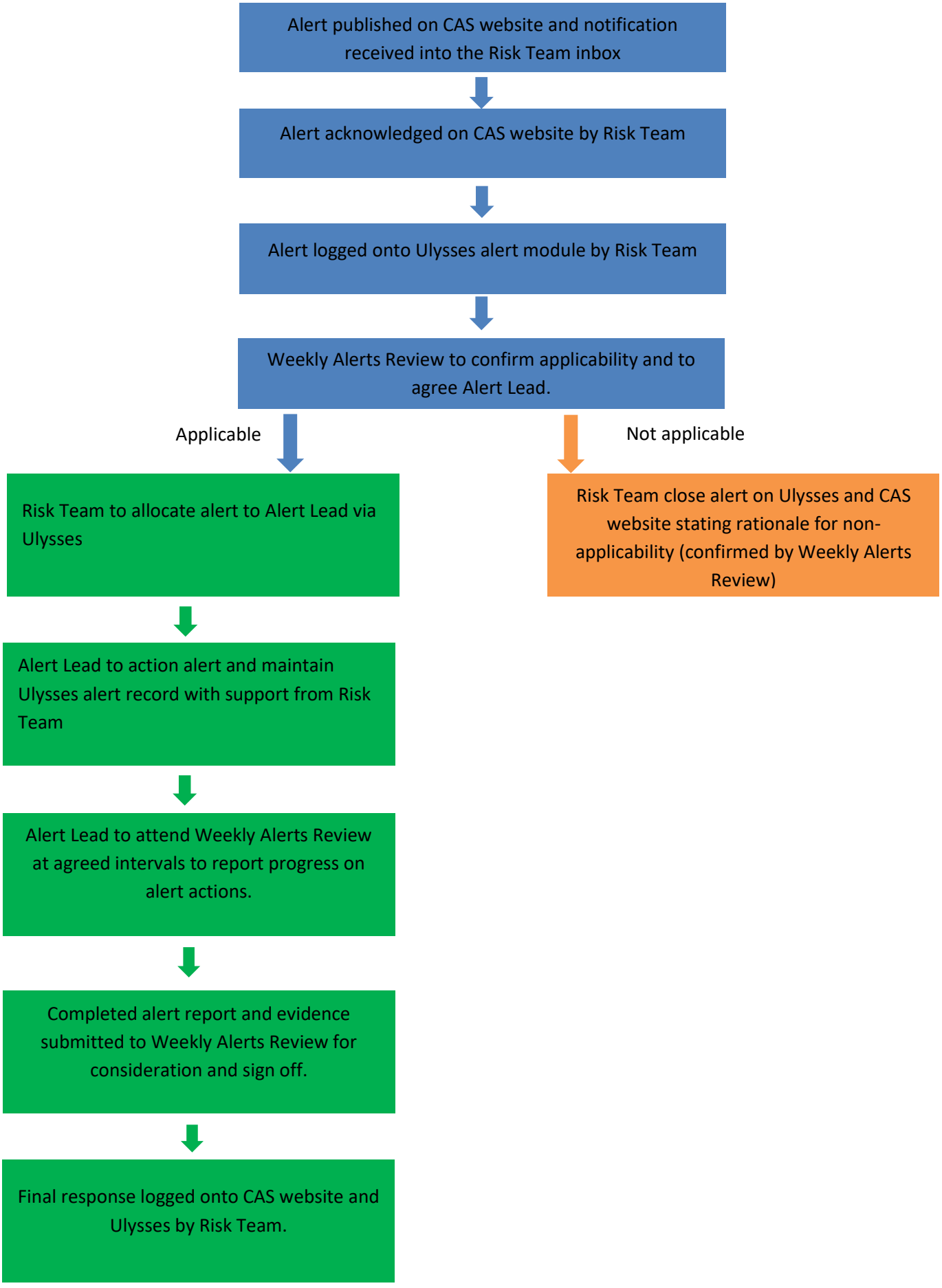
MHRA Drug Alerts and CMO Messaging do not require an external response. These are managed via the alerts process in the same way.

The Trust's nominated CAS Liaison Officer is responsible for acknowledging, disseminating, closing off safety alerts and providing feedback to relevant committees within designated timescales.

3.0 Introduction

This policy details the processes required for the management of alerts issued via CAS and alerts identified within the Trust (Internal Alerts). This is a Trust-wide policy which applies to all areas. It does not replace the duty and professional accountability of staff to report any adverse incidents with a medical device, hazardous product or unsafe procedure.

4.0 Flowchart/Process



5.0 Scope of the Policy

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

6.0 Duties within the Organisation

6.1 Quality Forum

The committee, through its chair, will seek assurance from the Patient Safety Improvement Group (PSIG) that all alerts are appropriately managed in an effective and timely manner.

6.2 Patient Safety Improvement Group (PSIG)

The Patient Safety Improvement Group (PSIG) receives the monthly Alerts Report and the chair is responsible for assuring that all alerts are appropriately managed in an effective and timely manner.

PSIG will recommend that where appropriate, existing policies are reviewed by the relevant corporate governance group in light of new evidence from any alerts or, where necessary, recommend the creation of new policies. PSIG will request assurance that reviews have been completed and amendments made as required.

6.3 Corporate Governance Groups

Where appropriate other corporate governance groups, e.g. Health and Safety Committee and Medicines Management Group, will receive alerts relevant to their agenda and the chair is responsible for ensuring that they are managed in an effective and timely manner.

6.4 Weekly Alerts Review (WAR)

The Weekly Alerts Review Group (appendix 2) is a sub-group of PSIG. Key identified staff meet weekly to review the new and ongoing alerts and will authorise the allocation of these to individuals and/or groups for action. WAR will authorise and agree all alerts which have been generated internally or via professional networks. The group will also confirm and challenge action taken in respect of individual alerts as well as agreeing closure on both Ulysses and the CAS website when actions have been satisfactorily completed.

6.5 Director of Nursing, AHP's and Quality

The Director of Nursing, AHP's and Quality holds executive responsibility for the oversight of the alerts management process, alert compliance, implementation and sign off within the Trust.

6.6 Risk Manager

The Risk Manager is the nominated CAS Liaison Officer (CASLO). The Risk Manager receives the CAS alerts and internal alerts where appropriate. The Risk Manager ensures that Ulysses and the CAS website are updated within the required timeframes as instructed by WAR.

The Risk Manager is responsible for generating alerts reports for governance groups as required.

6.7 Alert Leads

An Alert Lead for each alert will be identified by the Weekly Alerts Review. They are responsible for ensuring that the relevant actions are taken and that the alert is signed off within the necessary timescale.

The Alert Lead is responsible for completing the alert report in Ulysses with support from the Risk Team, identifying current practice, any gaps in practice, action required and action taken. This will be subject to presentation and scrutiny at the Weekly Alerts Review at agreed intervals when the Alert Lead would report progress on alert actions.

The Alert Lead for a multi-faceted alert will be determined by the type of alert issued. As above this individual is responsible for ensuring that action is taken within the necessary timescale but is not responsible for undertaking the action themselves if this is outside of their sphere of responsibility.

6.8 All Staff

If, following the implementation of alert, information needs to be shared to identified staff, this will be done so via the most appropriate method of communication. All staff who receive information are responsible for ensuring they understand and apply to their practice.

7.0 Training needs

No formal training is required to support the implementation of this policy.

8.0 Monitoring Compliance and Effectiveness

There will be an internal annual audit of identified previously published alerts (internal and external) to assess ongoing compliance with actions and timeframes. The Chair of PSIG will be responsible for finalising the full list of alerts to be audited, overseeing the audits and reporting the results to the Quality Forum.

9.0 References and Bibliography

- NHS Improvement: Our approach to patient safety (October 2017)
- NHS Improvement: Patient safety alerts (website resources)
- Medicines and Healthcare Products Regulatory Agency (MHRA) (website resources)
- NHS Improvement: Estates & Facilities Alert NHSI/2018/001 - Reporting of Defects and Failures and disseminating Estates and Facilities Alerts (January 2018)

Related LPT Policies:

- Medical Device Management Policy
- Incident Reporting Policy

Appendix 1 – Internal Alert Proforma

Leicestershire Partnership NHS
NHS Trust

LPT Internal Alert - xxxxxx	
Issue:	
Date issued:	
Action Complete by Deadline:	
Required Actions:	

Appendix 2 - Weekly Alerts Review (WAR) Terms of Reference

Leicestershire Partnership NHS Trust

Weekly Alerts Review (WAR)

Terms of Reference

References to "the Group" shall mean the Weekly Alerts Review (WAR) Group.

1.0 Purpose of the Group

1.1 To monitor the application of the Trust's Alerts Policy in relation to the management of alerts as a sub group of the Patient Safety and Improvement Group (PSIG).

1.2 To review new and ongoing alerts and authorise the allocation of these to individuals and/or groups for action.

1.3 To authorise and agree the generation and dissemination of internal alerts as well as alerts received via professional networks.

1.4 To approve the action plan and receive assurance from the nominated Alert Lead in relation to the management of individual alerts.

1.5 To agree closure on both Ulysses and the Central Alerting System (CAS) website when actions have been satisfactorily completed.

2.0 Membership

2.1 The membership of the Group is:

- Risk and Assurance Lead
- Risk Manager
- Risk Coordinator
- MH Clinical Governance Team
- FYPC/LD Clinical Governance Team
- CHS Clinical Governance Team
- Head of Health and Safety Compliance
- Head of Patient Safety

2.2 If any of the regular members of the group are unable to attend it is expected that they will send an alternative senior representative in their absence.

2.3 Only members of the Group have the right to attend Group meetings. Other individuals and officers of the Trust may be invited to attend for all or part of any meeting as deemed appropriate, e.g. Estates and Incident Control Centre (ICC) Leads.

2.4 The Chair of the Group will be the Risk and Assurance Lead. In the absence of the Risk and Assurance Lead, the Group will be chaired by the Head of Patient Safety.

3.0 Quorum

3.1 The quorum necessary for the transaction of business shall be one representative from two of the three Clinical Directorates, one representative from the Health and Safety team, the Patient Safety team, the Risk Team plus the Chair.

4.0 Frequency of Meetings

4.1 The group will meet weekly every Thursday morning.

4.2 If required due to an urgent alert being received, extraordinary meetings can be called or actions can be agreed via email.

5.0 Notice of Meetings

5.1 Notice of each meeting confirming the venue, time and date together with a brief alerts report shall be made available to each member of the group, and any other invitees, no later than one working day before the date of the meeting.

5.2 The report will contain information about alerts issued within the last seven days, alerts due to be closed within the next fourteen days as well as alerts that have breached deadlines.

6.0 Records of Meetings

6.1 The Risk Coordinator will record action notes and decisions. In their absence, another member of the Group will be appointed to this role.

6.2 The appointed note taker shall record the action notes and decisions of all group meetings, including the names of those present and in attendance..

7.0 Duties

7.1 The Group will monitor the application of the Trust's Alerts Policy in relation to the management of alerts.

7.2 The Group will monitor the management of alerts and the way these are disseminated and actioned.

7.3 To provide assurance on the effectiveness of the Trust's Alerts Policy ensuring there is a consistent approach on the management of alerts throughout the Trust.

7.4 To receive a weekly report of all new and outstanding alerts and advise on any actions required to progress these.

8.0 Reporting Responsibilities

8.1 The Group shall make whatever recommendations that it deems appropriate on any area within its remit where action or improvement is needed.

8.2 The Chair will be responsible for the direction of any recommendations and for reporting to the Patient Safety Improvement Group (PSIG), determining any issues for escalation and action as appropriate.

9.0 Review

9.1 These Terms of Reference will be reviewed annually by the Group or sooner if required. alert and where necessary to identify actions for improvement.

Leicestershire Partnership NHS Trust

Appendix 3 – Post-implementation Review Report

NHS Central Alerting System (CAS)

Post-implementation Review Report

Alert reference number: EXAMPLE

Title of alert

Date alert issued: 09/04/2021

Introduction

The purpose of this review was to examine practice within the Trust in relation to this particular CAS alert, to assess the level of compliance with the requirements of the alert and where necessary to identify actions for improvement.

The required actions can be found in appendix 1.

Alert summary

Summary of alert as described in CAS alert

Improvement Actions

1 Where the review has identified compliance gaps, improvement actions should be identified

Conclusions

Include a summary of findings.

Appendix 1

Actions Required (as reported on CAS)

Action 1

List actions here which are published in alert complete with target date (in line with alert completion date)

Owner Fern Barrell

Target Date / /

Completed Date / /

Summary of action taken

Appendix 4

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 5 - Stakeholders and Consultation

Key individuals involved in developing the document

Name	Designation
Fern Barrell	Risk Manager
Jennie Palmer-Vines	Risk and Assurance Lead
Nicola Jackson	Risk Assurance Co-ordinator

Circulated to the following for comment

Name	Designation
	Members of PSIG
Kate Dyer	Head of Governance and Interim Company Secretary
Anthony Oxley	Head of Pharmacy
Andrew Moonesinghe	Pharmacy Services Manager
Bernadette Keavney	Head of Health and Safety
Maureen Poyzer	Health & Safety Administrator
Helen Walton	Estates & Facilities Property Manager
Anne Scott	Director of Nursing, AHP's and Quality
Richard Brown	Associate Director of Estates and Facilities
Deanne Rennie	Interim Deputy Director of Nursing, AHPs and Quality

Appendix 6 - Due Regard Screening Template

Section 1	
Name of activity/proposal	Alerts Policy
Date Screening commenced	15.01.2021
Service carrying out the assessment	Risk Team
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 complying 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 protected 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.			
		No	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	**X**

Section 4			
If this proposal is low risk please give evidence or justification for how you reached this decision:			
Neutral impact on protected characteristics and improvements to existing alerts process.			
Signed by reviewer/assessor	Fern Barrell	**Date**	15/01/2021
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed	Jennie Palmer-Vines	**Date**	15/01/2021

Appendix 7 - 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 15/01/2021**
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.		No	
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.		No	
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?		No	
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?		No	
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.		No	
6. Will the process outlined in this document result in decisions being made or action		No	

taken against individuals in ways which can have a significant impact on them?		
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.	No	
8. Will the process require you to contact individuals in ways which they may find intrusive?	No	
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:	**N/A**	
Date of approval	**N/A**	

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