Provider process flow for National Patient Safety Alerts

ALERT ISSUED

CAS Officers

Designated Executive & Patient Safety Specialist

Received and acknowledged (3 working days - CAS functionality)

CAS officer to update CAS

Recorded on CAS as 'Acknowledged'

This tells us that the organisation acknowledges receipt of the alert.

Designated Executive & PSS to assess if the alert is relevant?

YES

CAS officer to update CAS

Recorded on CAS as 'Assessed - relevant to organisation services'

This tells us that the actions in the alert are relavent to your organisation and the alert remains open in CAS.

NO

CAS officer to update CAS

Recorded on CAS as actions 'Assessed - not relevant to organisation services'

This tells us that the actions in the alert are not relavent to your organisation and closes the alert in CAS.

Is the alert straightforward or complex?

Straightforward alert?

This means that the alert may be actioned by a single agreed senior leader eg pharmacy removing a drug from pharmacy.

Complex alert?

This means that the executive lead and/or PSS nominates a senior clinical leader relavent to the alert to coordinate delivery across all the directorates/divisions eg a coordinated change across the whole organisation.

***Plan to implement alert actions**

***All actions complete**

YES

***Executive lead confirms all alert actions have been completed**

CAS officer to update CAS - recorded as 'Action completed' on CAS

This tells us that the actions in the alert were relavent to your organisation and these have been completed. The alert is closed on CAS.

NO

Regular update to Executive/PSS

If unable to complete actions, please contact the alert issuer.

*How this is managed will vary due to the difference in organisation type. However, there is an expectation that NatSPAs are discussed on relavent committees where the appropriate executive sits on/chairs.

Supporting information for providers to manage National Patient Safety Alerts

All safety-critical information that meets predetermined, nationally agreed thresholds and standards, and requires coordinated implementation of trust-wide actions by providers, will be issued as a National Patient Safety Alert (NatPSA). These thresholds and standards include working with patients, frontline staff and experts to ensure alerts provide clear, effective actions to reduce the risk of death or disability. The thresholds include an assessment of whether the patient safety issue is 'more likely than not of one or more potentially avoidable deaths or disability in healthcare in England in a year'.

This is to ensure that National Patient Safety Alerts:

- are only issued for safety-critical issues (those that have a risk of death or disability) that need organisations to act
- clearly and effectively explain the identified risk
- include actions that have been assessed for feasibility, safety, efficacy, and cost-effectiveness
- can be quickly recognised and actioned by senior personnel
- have actions that are SMART (specific, measurable, achievable, realistic, and timely).

System level change requires coordinated action and executive level oversight

All NatPSAs need executive level oversight; as NatPSAs are issued for serious safety-critical issues, requiring system level change, senior oversight is expected to be at the level of executive director/ Board Member and supported by the Patient Safety Specialist(s). The appropriate executive needs to assess the relevance of an alert and have oversight of the governance systems to ensure that the required actions have been fully completed before any NatPSA is recorded as 'Action Completed' on the Central Alerting System (CAS).

National Patient Safety Alert oversight

- **Providers:** Each organisation has a process for the receipt, assessment of relevance, and actioning of NatPSAs. This process should include the coordination of an organisational-wide response, with executive oversight, led by appropriate senior healthcare professional(s) and that this system can respond to alerts designated as 'complex' or 'straightforward' – see NHS England » Introducing National Patient Safety Alerts.
- **CQC:** Inspection will focus on implementation of NatPSAs; they have responsibility to ensure that providers have a mechanism in place to action alerts and that they can evidence that specific actions have been implemented with the potential for regulatory actions for non-compliance.
- **ICB:** Ensure local mechanisms exist to support compliance with the actions required in NatPSAs, in line with the NHS standard contract and the NHS national patient safety strategy.
- **Regions:** Oversight of National Patient Safety Alert implementation.

New principles of National Patient Safety Alert management

- Senior assessment of relevance and oversight of Alert management process.
- Carefully plan and coordinate who the alerts should be shared with; avoid blanket emailing of Alerts and ensure any information sent out contains a plan.
- Centrally coordinate actions; avoid forwarding to multiple directorates or divisions.
- Agree on nominated leads/coordinators for each alert; alert issuers may not match trusts departments/heads of services effectively, e.g the estates alert on oxygen may have significant implications for clinical practice.

If there are any concerns that an alert does not meet the standards, please contact the alert issuer via the email on the individual alert.