



## Alert from the Central Alerting System Helpdesk Team The introduction of National Patient Safety Alerts

Alert ref: CHT/2019/001

Issued: 17/09/2019

Deadline: 16/12/2019

### Summary

CAS users will shortly begin to see changes in what we issue.

The National Patient Safety Alerting Committee ([NaPSAC](#)), which consists of representation from all organisations that issue safety information to the NHS, is working to ensure that all future National Patient Safety Alerts set out clear and effective system-wide actions that providers must take on critical patient safety issues.

NaPSAC have developed and agreed common standards and thresholds for National Patient Safety Alerts to align all organisations that issue national alerts. A new consistent format for National Patient Safety Alerts has also been agreed by the committee.

Each alert issuer is now going through the process of reaching these common standards and thresholds and being assessed to ensure these are met via an accreditation process.

Once accredited, alert issuers will use the new National Patient Safety Alert template when issuing alerts. National Patient Safety Alerts will have the following logo on them as well as that of the issuing organisation(s):



NHS Improvement Patient Safety Team are the first alerting body to go through the accreditation process. They have been accredited to issue National Patient Safety Alerts for 3 years from July 2019. All alerts that are issued by NHSI Patient Safety will come through in the new format. The safety messages of other issuers will come through in this format following successful accreditation.

### What does this mean for me?

- Alerts will have clear, effective actions, requiring senior oversight, that you must take on safety-critical issues<sup>1</sup>.
- The standards and thresholds agreed by NaPSAC will underpin the CQC inspection of National Patient Safety Alerts and the potential for regulatory response for non-compliance.
- Responses to National Patient Safety Alerts will still need to be made via the CAS system.
- There will be a period of dual running whilst all organisations go through the accreditation process. This means you will see a mixture of National Patient Safety Alerts and existing alerts over the next 12 months. Over time, the volume of alerts that are not National Patient Safety Alerts will diminish as more organisations receive accredited status.
- During the period of dual running: continue to action all alerts issued through the CAS system.
- More information including "Frequently asked questions" will be published on the [NaPSAC](#) webpage. Please refer to this for regular updates.
- The process for communicating safety information that does not meet the criteria of a National Patient Safety Alert is under discussion. We will communicate further on this in early 2020.

### Action

- Identify appropriate escalation routes for National Patient Safety Alerts to ensure senior oversight.
- Note the dual running period and action all alerts in the appropriate manner.
- Embed process for ensuring senior oversight and actioning National Patient Safety Alerts within your internal SOPs.

Contact us: [safetyalerts@mhra.gov.uk](mailto:safetyalerts@mhra.gov.uk)

<sup>1</sup> As National Patient Safety Alerts are issued for serious safety-critical issues requiring system level change, senior oversight is expected to be at the level of Director/Board Member/ Head of Profession/CEO as appropriate.