

An introduction  
to the NHS  
England  
National Patient  
Safety Alerting  
System

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# **An introduction to the NHS England Patient Safety Alerting System**

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## Introduction

In January 2014 the NHS England Patient Safety Domain launched the National Patient Safety Alerting System (NPSAS), an improved three-level system for highlighting patient safety risks in NHS organisations, and implementing action to reduce risk. This guide will help you understand the new system and provide support to ensure your organisation is equipped to act on and implement each stage of the new NHS England patient safety alerts.

**At the end of this guide you will find a checklist to identify any steps your organisation needs to take to be ready to receive and implement alerts from the new National Patient Safety Alerting System.**

## Background

NHS England has a vital role in identifying, understanding and managing risks that pose a danger to patients. The major tool in identifying these risks is the National Reporting and Learning System (NRLS). Prior to June 2012, information regarding risk identified by NRLS was disseminated by various mechanisms developed and operated by the National Patient Safety Agency (NPSA)<sup>1</sup>, including issuing Patient Safety Alerts and Rapid Response Reports. This system was effective, however, the development process was lengthy often making it difficult to issue timely alerts.

The re-launch of a patient safety alert system was part of the government's response to the Francis report. The response stated:

*'NHS England will re-launch the patient safety alerts system by the end of 2013 in a clearer framework that will support organisations to understand and take rapid action in relation to patient safety risks. This new system will include greater clarity about how organisations can assess their compliance with alerts and other notifications and ensure they are appropriately implemented.'*

The new NPSAS is a three-stage system, based on that used in other high risk industries such as aviation. The system is used to disseminate patient safety information at different stages of development to NHS organisations providing care across all settings. It will differ from the previous NPSA system by allowing more rapid dissemination of urgent information via the [Central Alerting System \(CAS\)](#), as well as encouraging information sharing between organisations and providing useful education and implementation resources to support providers in reducing risks to patients. Crucially it will provide patients and their carers with greater confidence that the NHS is able to react quickly and rapidly to risks that are identified.

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<sup>1</sup> The key functions and expertise for patient safety developed by the former National Patient Safety Agency (NPSA) have now been transferred to NHS England.

For primary care, relevant alerts will be cascaded via NHS England Area Teams.

### Why the new system?

- **Get alerts out quicker** – the [first alert](#) using the new system was issued within 10 days of the risk being identified.
- **Allows more flexibility in issues suitable for alerts** – the flexibility of the system will allow for a wider range of issues to be addressed.
- **Recognises good practice** – those providers who have already addressed identified risks through good practice should not find the new system burdensome.
- **Shares learning of good practice from local to national** – where good practice is identified this will be shared across the wider NHS.
- **Allows solutions to be tailored to local need** – less directive in that where issues have already been addressed locally no further specific actions may be necessary.
- **Less directive and more facilitative** – more ‘bottom up’ than ‘top down’.
- **Opportunities to learn from each other.**
- **Allows flexibility of approach** – ‘mix and match’ of different stages of alert will allow a much more flexible approach, e.g. it may not be necessary to use all three stages of alerts for a particular issue.
- **Clarity around expectations to implement solutions.**
- **Provides patients with confidence that risks are identified and acted upon rapidly and robustly**

### The role of the NHS England Patient Safety Expert Groups

In general, each alert will be owned and developed by the most relevant of the six NHS England [patient safety expert groups \(PSEGs\)](#), which are made up of a core multi-professional membership including representation from relevant colleges and associations, patient and carer groups, NHS England and CCGs. Wider membership for individual groups includes relevant organisations in a position to promote learning and provide data on patient safety priorities.

### Final approval to release an alert

Final approval for all NHS England patient safety alerts will come from the Director of Patient Safety before they are released.

## **The three stages of patient safety alerts**

The new NPSAS is a three stage system, based on that used in other high risk industries, and is used to disseminate patient safety information at different stages of development.

### **Stage One Alert: Warning**

This stage will 'warn' organisations of emerging risk. It can be issued very quickly once a new risk has been identified to allow rapid dissemination of information. In the interests of timeliness, extensive consultation at this stage is not envisaged. The warning may include a statement that further information and potential solutions may follow once additional work has been completed and feedback received. Recipients will be required to sign-off the warning in accordance with the CAS sign-off process in a set timeframe. Typical actions required of organisations in a stage one alert would include:

- Consider if this (the risk issue) could happen/has happened locally;
- Consider if action can be taken locally to reduce the risk;
- Disseminate the warning to relevant staff, departments and organisations.

Recipients will also be asked to share information with NHS England that may help to inform the development of stage two and three alerts, and potentially for wider dissemination to other providers. This might include:

- Sharing of learning from any root cause analysis (RCA);
- Sharing of local good practice that may act as a useful example to other providers.

The requirement to assess the extent of a problem on a local basis allows excellent providers to demonstrate that they need not take further action as the risk was already addressed locally, and provides all providers with confirmation as to the presence or extent of a problem.

### **A Stage One Alert: Warning, could look like the following:**

A review of the NRLS identified that there were a number of patient safety incidents reported related to devices as causing severe harm between January 2013 and December 2013. Of these, xx number of incidents were specially related to '*condition x*' relieving devices; with availability of '*condition x*' relieving devices being the most frequently reported issue, followed by a delay in accessing the appropriate device, and then incorrect use of devices.

Discussions with frontline staff, specialist nurses and regional improvement leads have confirmed that this is a well-recognised '*condition x*' prevention and management issue that occurs across a wide range of care settings, with transition between care settings frequently identified as a key area of risk.

#### **Actions**

- Establish if '*condition x*' relieving devices are used within your organisation and if similar incidents have occurred;
- Consider if any action needs to be taken locally to reduce the risk of incidents occurring related to '*condition x*' relieving devices;
- If your organisation uses '*condition x*' relieving devices, share this alert with all nursing, medical and therapy staff;
- Share any learning from local investigations or locally developed good practice resources with the national Patient Safety Domain.

### **Stage Two Alert: Resource**

This may be issued some weeks or months after the stage one alert. It may consist of:

- Sharing of relevant local information identified by providers from a stage one alert;
- Sharing of examples of local good practice that mitigates the risk identified in the stage one alert;
- Access to tools/resources that will help providers implement solutions to the stage one alert;
- Access to learning resources. Ultimately, we plan to offer continuing professional development (CPD) credits on topics relevant to the alert. These learning resources will be relevant to all healthcare workers and can be used as evidence of continued professional development.

The resource will contain guidance as to what actions should be completed before sign-off. Sign-off will occur in accordance with the CAS sign-off process and a timeframe will be set to complete this process. Typical actions required of organisations in a stage two alert would include:

- Disseminating alert information to relevant staff;
- Confirming the tools and resources have been (and/or will be) used to reduce risk locally if relevant.

**An example of a Stage Two Alert: Resource, issued following a stage one alert based on ‘*condition x*’ relieving devices, could look like the following:**

The Patient Safety Domain of NHS England issued alert No. 12345 to acute trusts, regional and area teams to outline the continuing incidence of reports involving ‘*condition x*’ relieving devices, resulting in harm to patients.

Since this alert, further work has taken place involving:

- national experts;
- focus groups of trust staff.

As a result of this work:

- a ‘community of interest’ has been developed to progress work in this area;
- the following tools have been developed / piloted / evaluated (available online);
- improvement strategies have been developed with the potential for adoption by other organisations (available online).

**Stage Three Alert: Directive**

At this stage organisations will be required to confirm they have implemented specific solutions or actions to mitigate the risk. For those organisations that have already demonstrated good practice and locally developed appropriate risk mitigating strategies at stages one or two, sign-off should be a formality.

Providers will be issued with a checklist of required actions to be signed-off in a set timeframe in accordance with the CAS sign-off process. The actions will be tailored to the specific patient safety issue.

**An example of a Stage Three Alert: Directive, issued following a stage one and stage two alert, could look like the following:**

A requirement to implement specific actions drawn from the response of local organisations to the stage one and stage two alerts, identified through the literature or developed centrally. In the intervening period between stage two and stage three alerts, these potential solutions will have been consulted on, debated and have consensus agreement.

**Action**

- Confirmation of implementation of specific actions

All three stages of alert are likely to be used for issues representing a major risk, however, on occasions it may only be necessary to use only part of the alert process. For example, issues of a widespread and well known nature may not require a Stage One Alert: Warning, while those where a clear and specific solution exists may be addressed only with a Stage Three Alert: Directive.

**Dr Frances Healey, Senior Head of Patient Safety Intelligence, Research and Evaluation at NHS England, puts the need for and the benefits of the new alerting system into context:**

*“Reflection and feedback on the past system of NPSA alerts was part of what underpinned the development of the new three-stage alerting system. A key example from the past was the NPSA Rapid Response Report: [Essential Care after an inpatient fall](#). The alert was triggered by a coroner’s case and NRLS analysis that indicated in about 20 per cent of cases where patients were seriously injured in a fall in hospital, we were adding insult to injury through delays in detecting and treating head injury or fracture, and at times were causing pain or even increasing the risk of serious harm by using hoists that were fine for routine patient movement on the wards, but were neither safe nor comfortable for a patient who could have a serious injury. Because the alerting system at that time sought to identify clear and specific actions to address the risk, there was a delay in making frontline staff aware of the scale of harm whilst consensus was sought on the best way to tackle it. That consensus included a requirement for flat-lifting equipment, and a local protocol to guide staff on steps to take, but the timescales in which the alert required these to be in place meant most organisations had to work on this on their own. And they got brilliant results, but there was undoubtedly duplication of effort.*”

*“If we’d had a three-stage alerting system at that time, we could have made the NHS aware much sooner with a **Stage One Alert: Warning**, and many organisations may have taken early actions that worked locally to reduce the risk, even if those were actions that couldn’t have been nationally prescribed as suitable for everyone to take. More importantly, a call for sharing of resources in that stage one alert would have helped us collect local formats for neurological observations, to share experience on the range of equipment that could be used to safely move a patient with a suspected hip fracture off the floor, and to set up collaboration on the design of protocols and flow charts to guide staff on what to do after an inpatient fall. We could have given the NHS access to the best of these through a **Stage Two Alert: Resource**. And for the small minority of organisations who didn’t take and adapt these resources for local use, a final **Stage Three Alert: Directive** would have made absolutely explicit that core steps to reduce the risk of harm to patients, including access to flat-lifting equipment and a post-fall protocol, had to be achieved by a certain date.”*

### **Confirming compliance with alerts via Central Alerting System**

When a patient safety alert has been received, healthcare providers should implement all the actions that are relevant to them and ensure that all relevant parts of their organisation and staff are aware of the information and/or the required changes. Once satisfied that the actions in an alert, including sharing of information, have been implemented in full, typically via board-level scrutiny, providers are required to mark the alert as ‘complete’ on the Central Alerting System. There will be a set deadline for organisations to sign-off each alert as complete.

### **Failure to comply with sign-off by the designated deadline**

By April 2014, we will begin to publish data monthly on the NHS England website about any trusts who have failed to declare compliance with stage one, two, or three NPSAS alerts by their set due date. Failure to comply is likely to be used by the CQC in their Intelligent Monitoring System and as an integral part of commissioners’ responsibilities for improving quality. Failure to comply with a Stage Three Alert: Directive within deadline in particular will be a cause for significant concern on the part of regulators, commissioners and most importantly, patients.

## **Consultation on patient safety alerts**

Where possible, there will be a period of consultation on each alert prior to publication to seek views from healthcare professionals or anyone who has an interest in the area in question. This will help to get further feedback on the issue to help refine the alert and ensure any relevant additional information can be considered, making the final alert as impactful as possible in preventing the associated risk.

In the interests of timeliness, extensive consultation may not be required where an issue is considered particularly urgent.

## **What constitutes an alert?**

Alerts are likely to be required on a number of different types of issue. Potential areas addressed by alerts include but are not limited to:

- **Alerts for new or under recognised patient safety issues**  
Where there is potential for a patient safety issue to cause death or severe harm, but most healthcare providers will not have knowledge or experience of the risk, and are unaware it could occur locally. In this situation an alert may need to be issued very quickly.
- **Alerts for widespread, common and challenging patient safety issues, not solved by alerts in isolation**  
Alerts can be an important part of a wider programme of work, either to initiate, reinforce or bring 'late adopters' on board.
- **Alerts aimed at improving systems for clinical governance, reporting and learning**  
Systems to manage patient safety in the NHS can be subject to latent error, poor design and human factors causing errors as in other healthcare activities. These alerts would aim to address significant risks in patient safety management systems.

## National Patient Safety Alerting System checklist

Follow the checklist below to make sure your organisation is 'alert ready' and set up to receive alerts from the National Patient Safety Alerting System:

Action	
1. Do you have an identified CAS officer?	✓
2. Based on the specific issue of each individual patient safety alert, it is likely that senior clinical advice will be required within your organisation on how the alert should best be acted upon. It is also likely you will require an identified individual to lead on the practical implementation of any necessary actions resulting from each alert. Do you have systems in place to identify the right people to provide senior clinical advice, and also those that will lead on any required action following each alert?	✓
3. It is very important that staff, including the whole multidisciplinary team, are made aware of alerts that are relevant to their work area as quickly as possible. However, distributing all patient safety alerts to all staff may cause 'alert fatigue' and there could be a risk that staff will overlook the alerts that are important to the safety of the specific patients they care for. Do you have systems in place for identifying and categorising which groups of staff will need to know about each alert? Do you also have quick and effective dissemination routes for getting the details of alerts to relevant groups of staff?	✓
4. Ownership at very senior level is important if alerts are to be successful in reducing harm to patients. Have you identified a board member (or a senior official in the case of primary care organisations) who has personal oversight of alert compliance, implementation and sign-off?	✓
5. Stage One Alert: Warning and Stage Two Alert: Resources will not be prescriptive on exactly how the risk to patients should be addressed locally. Do your staff understand this means they have the freedom to take the right appropriate actions for your organisation, but not the freedom to avoid taking any action at all? Do you have systems in place to quickly identify and coordinate what actions are needed locally?	✓

Action	
6. The new alert system will ask you to share any relevant local learning or resources. Has the message gone out to your staff that they will be expected to share any existing local learning and resources relating to an individual patient safety alert with the NHS England Patient Safety Domain; and that this sharing of good practice will contribute to the reduction or elimination of the identified risk across the NHS as a whole? <sup>2</sup>	✓
7. Do you have an agreed mechanism in place for confirming the effective implementation of alerts?	✓
8. Signing off any patient safety alerts as 'action completed' in the Central Alerting System is an important step that should only be taken when the leadership of an organisation has assurance that all the actions required have been completed in the spirit that they were intended; this may be reviewed by commissioners and regulators. Have you got an agreed 'sign-off' process for alerts by a relevant committee, including for 'Stage One Alert: Warning', where urgent action may be required, with short timescales for completing the necessary actions?	✓
9. Have your local policies, procedures and guidance documents been updated to refer to the new <i>National Patient Safety Alerting System</i> rather than the former <i>National Patient Safety Agency Rapid Response Reports</i> and <i>Patient Safety Alerts and Notices</i> ?	✓
10. Do you have mechanisms in place for updating your internal policies and procedures so they reflect the issues and recommendations in any patient safety alert that is issued? This will ensure the latest guidance contained within a patient safety alert becomes standard procedure and supersedes any previous guidance?	✓

## Further information

If you require any further information on the National Patient Safety Alerting System, please email the NHS England Patient Safety Domain by emailing: [patientsafety.enquiries@nhs.net](mailto:patientsafety.enquiries@nhs.net).

<sup>2</sup> NHS England will only ever use examples of learning and resources with the permission of the provider. Investigation reports will be kept confidential and used for learning not performance management. We will also ensure organisations who have shared resources are credited.