Title:	**CENTRAL ALERT SYSTEM (CAS), MANAGEMENT OF**	Ref No: 0984 Version 8
		Classification: Guideline
Directorate:	Organisation Wide	
		Due for Review: 20/07/2021
Responsible for review:	Patient Safety Lead	Document Control
Ratified by:	Chief Nurse Care and Clinical Policies Group Quality Improvement Group	
Applicability	As indicated	

1 Introduction

1.1 What is the Central Alerting System?

The Central Alert System (CAS) is a central electronic distribution system for safety alerts issued by the Department of Health and other Agencies.

The aim of CAS is to improve the way safety alerts and notices are disseminated and dealt with throughout the NHS by bringing them together on one electronic system and providing evidence of actions taken.

1.2 What type messages are sent using CAS?

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:

Non-emergency alerts – issued on behalf of MHRA Medical Devices, NHS Improvement, NHS Estates and Facilities, they have set deadlines for acknowledgment 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.

Emergency alerts - are currently sent by the following originators – MHRA Drug Alerts, and CMO Messaging. Although these alerts do have deadlines, these relate to how quickly the information contained should be cascaded onwards and do not require a response. As a matter of course they are

sent to all Medical Directors and Chief Executives of NHS Trusts. Drug alerts are also received by the Trust's Medicines Optimisation Team directly from CAS.

The Trust's nominated CAS Liaison Officer (CASLO) is responsible for cascading such alerts to the relevant groups and individuals and entering responses into CAS.

1.3 Care Quality Commission (CQC) requirements

The CQC has implemented a new inspection process in response to the Francis Report (2013). For each of the core services five key questions are asked.

- Are we Safe?
- Are we Effective?
- Are we Caring?
- Are we Responsive?
- Are we Well- Led?

Underpinning these five core questions are key lines of enquiry. The below, Key Lines of Enquiry makes specific reference to safety and communication concerning patient safety.

S1. What is the track record on safety?

S2. Are lessons learned and improvements made when things go wrong?

S3. How are risks to people who use services assessed, and their safety monitored and maintained?

S4. How well are potential risks to the service anticipated and planned for in advance?

Fundamental Standards these Key Lines of Enquiry relate to are:

- Regulation 12 Safe Care and Treatment
- Regulation 20 Duty of Candour

1.4 Requirements of the process

- The appointment of a CASLO.
- Arrangements for a deputy to act in the CASLO's absence.
- A lead person for each Service Delivery Unit (SDU) Zone and/or speciality. (i.e. the General Manager and/or Zone Lead, Matron, Department Manager, Clinical Governance Co-ordinator, Medical Director, etc.)
- Medicines Optimisation Team for medicines alerts.
- A system to maintain a complete record of alerts issued.
- A system of distribution of alerts and monitoring and review of actions taken to comply with alerts.
- Procedures (flow chart) to record actions taken following the receipt of an alert.
- Procedures to ensure that all staff are made aware of relevant alerts.
- A mechanism to regularly review compliance with alerts.

Trusts are also required to report to the Medicines and Healthcare products Regulatory Agency (MHRA) any actual or potential failures of products used by the Trust. The MHRA investigates these reports and takes appropriate action which may result in an alert being sent out nationally via CAS.

2. Statement/Objective

2.1 Torbay and South Devon NHS Foundation Trust (TSDFT) (the Trust) is committed to protecting its staff, service users and visitors through systems which ensure that patient safety notices, alerts and other communications concerning safety are acted upon within the required timescales.

The policy will ensure that the Trust has a:

- Clearly defined identified alerts communications system
- System for distributing alerts and obtaining responses.
- System for monitoring that actions identified in the alerts have been taken, to ensure the safety of all those who deliver and receive services from the Trust.

3. Roles and Responsibilities

3.1 Chief Executive

The Chief Executive has overall responsibility for ensuring effective arrangements for dissemination, action and review of CAS Alerts.

3.2 CAS Liaison Officer (CASLO)

The CAS Liaison Officer is accountable for ensuring the arrangements are in place. Responsibilities include:

- Receiving alerts via CAS on behalf of the Trust.
- Maintaining a central record of alerts.
- Distributing relevant alerts as required throughout the Trust.
- Maintaining records confirming actions.
- Providing a monthly summary of CAS alerts.
- Updating the status of alerts within the Trust to the CAS system.
- Providing support and guidance to Trust personnel regarding alerts.
- Notifying CAS of any changes to the CAS Liaison Officer.
- Providing training regarding CAS alert processes for relevant members of staff.
- Maintaining an up to date distribution list.

3.3 Medicines Governance Team

The Medicines Governance Team receives CAS Alerts directly. The team are responsible for distributing relevant alerts as necessary and to receive the responses from SDU's in relation to alerts to confirm what actions have been taken.

3.4 SDU Managers, Matrons and Leads or other nominated person

Managers have responsibility for ensuring that alerts are completed within specified time in the areas that they have operational responsibility for and ensuring that arrangements are in place for the dissemination, action, and review of alerts within zones. In addition all staff with responsibility for managing alerts must be appropriately resourced and provided with support and guidance in relation to the management of alerts. Responsibilities include:

- Responding to alerts in a timely fashion.
- Maintaining records confirming distribution and actions taken.
- Notifying the CAS Liaison Officer of changes to the Manager/Matron or Lead.

- Providing the CAS Liaison Officer with confirmation of completed actions by the timely completion of alert response forms.
- Ensuring actions are taken within area of responsibility to enable compliance with the alert.
- Ensuring dissemination of information within alerts to relevant personnel within the department using appropriate methods of communication.
- Maintaining a "library" of alerts, allowing departmental staff easy reference.
- To support any review process performed to assess compliance with the CAS policy / process.

3.6 Community Hospital Matrons/ Acute Ward Matrons / Department Managers

Responsibilities include:

- Responding to alerts in a timely fashion.
- Ensuring actions are taken within area of responsibility to enable compliance with the alert.
- Providing documented evidence of actions taken, if requested by the CASLO.
- Ensuring dissemination of information within alerts to relevant personnel within the community hospital using appropriate methods of communication.
- Maintaining a "library" of alerts, allowing departmental staff easy reference.
- Notifying the CASLO of any changes to position.
- To support any review process performed to assess compliance with the CAS policy / process.

3.7 Head of Estates

The Head of Estates must ensure arrangements are in place for the effective management of estates alerts. Responsibilities include:

- Ensuring actions are taken within area of responsibility to enable compliance with the alert
- Maintaining a robust system for distribution of alerts to appropriate Trust sites, premises and departments.
- Maintaining records confirming distribution.
- Maintaining a "library" of alerts and detailing records of actions taken within sites, premises and departments.
- To support any review process performed to assess compliance with the CAS policy / process.

3.8 All staff

All staff, where appropriate, will ensure that they are aware of their responsibilities in relation to the management of CAS alerts and act accordingly. On receipt of an alert they will take the necessary actions within the required timeframes and submit response to the CASLO.

4. Definitions- Types of Alert and Sources.

- The NHS Improvement -
    - *Patient safety alert (PSA)* - requires prompt action to address high risk safety problems. *Each patient safety alert comes with its own level and own response that we are charged to comply with.*
    - *Safer practice notice (SPN)* - strongly advises implementing particular recommendations or solutions.
    - *Patient safety information (PSI)* **-** suggests issues or effective techniques that healthcare staff might consider to enhance safety.

- *Rapid Response Report (RRR)* **-** may require prompt action or raise awareness of a current issue for which there may not currently be an identifiable resolution

- The Medicines and Healthcare products Regulatory Agency (MHRA)-
  - Drug/Medication Alerts. Sent directly to the Medicines Governance Team
- Chief Medical Officer Messaging-
  - (CMO). Sent directly to the Medical Director.
- DH Estates and Facilities Alerts-
  - EFA
- Medical Device Alerts-
  - MDAs
- NHS England/others/Internal-
  - Security, Fraud etc

Alerts are received through a single contact point (CAS NHS email inbox). CAS alerts have applicability for the Provider Services (TSDFT).

5. Procedure

5.1 During normal working hours (Monday to Friday from 0800 – 1600) alerts are checked for daily by the CASLO on the CAS web site and CAS NHS email account and are also received by the Quality and Experience lead's NHS email account. In the absence of the CASLO, the nominated deputy will check daily during normal working hours for alerts. It is the responsibility of the CASLO to ensure that there is adequate cover to respond to alerts during the normal hours.

5.2 There is a separate procedure for out of hours (OOH) and this can be found in the OOH Manager's pack.

5.3 Upon receipt, the CAS Liaison Officer will acknowledge on behalf of the Trust the receipt of the alert via the CAS web site. This will be within the prescribed timeframe of 48 hours. **There are a number of responses and these are detailed in Appendix 2.**

5.4 The CASLO will assess relevance of the alert with the Patient Safety Lead. In the absence of these persons, the CASLO will obtain guidance from the speciality lead or service manager of which the alert may relate to or obtain advice from senior managers within professional practice directorate.

5.5 From their recommendation the alert will be sent to relevant operational leads and contacts. The alert will be sent with request for confirmation of relevance and proposed cascade list.

5.6 Additional advice on cascade is supplied on the alert. Wherever possible blanket distribution should be avoided.

5.7 On receipt of relevance and proposed cascade list the alert will be sent to Operational/Zone/Service Managers and/or leads and Matrons of the relevant SDU where appropriate. Relevant contacts will receive the alert, a specified timeframe and response template to record their action.

5.8 Where alerts are deemed not relevant by the operational leads the Patient Safety Lead will give authority for the CASLO to close the alert.

5.9 The CASLO will collate responses for the alert from SDU Operational/Zone/Service Managers and/or leads and Matrons and record these for audit purposes. If necessary a reminder email will be sent to the cascade list if responses are not received.

5.10 Once responses have been collated the CASLO will require authority from the Patient Safety Lead. Reasonable assurance of actions taken must be received for the alert to be closed.

5.11 The CASLO is responsible for formal closure and updating the CAS website.

6. Training

The effectiveness of this procedure and the general level of compliance with its **requirements will** be monitored by the CASLO. Training requirements and levels of compliance will form part of the Trusts normal performance monitoring arrangements.

Managers at all levels must ensure that appropriate staff, (including new staff) are aware of their responsibilities in relation the management of CAS alerts. The implementation of this policy has no additional resource requirements. The revised policy will improve the management of safety alerts throughout the Trust and streamline previous processes, therefore saving time and positively contribute to our statutory duty and common law duty of care requirements.

7. Reporting

A monthly report will be taken to the Quality Improvement Group which will highlight alerts, alert type, issue dates, status, response status and deadline.

Any issues re any of the alerts will also be raised at QIG.

8. Audit, monitoring and review

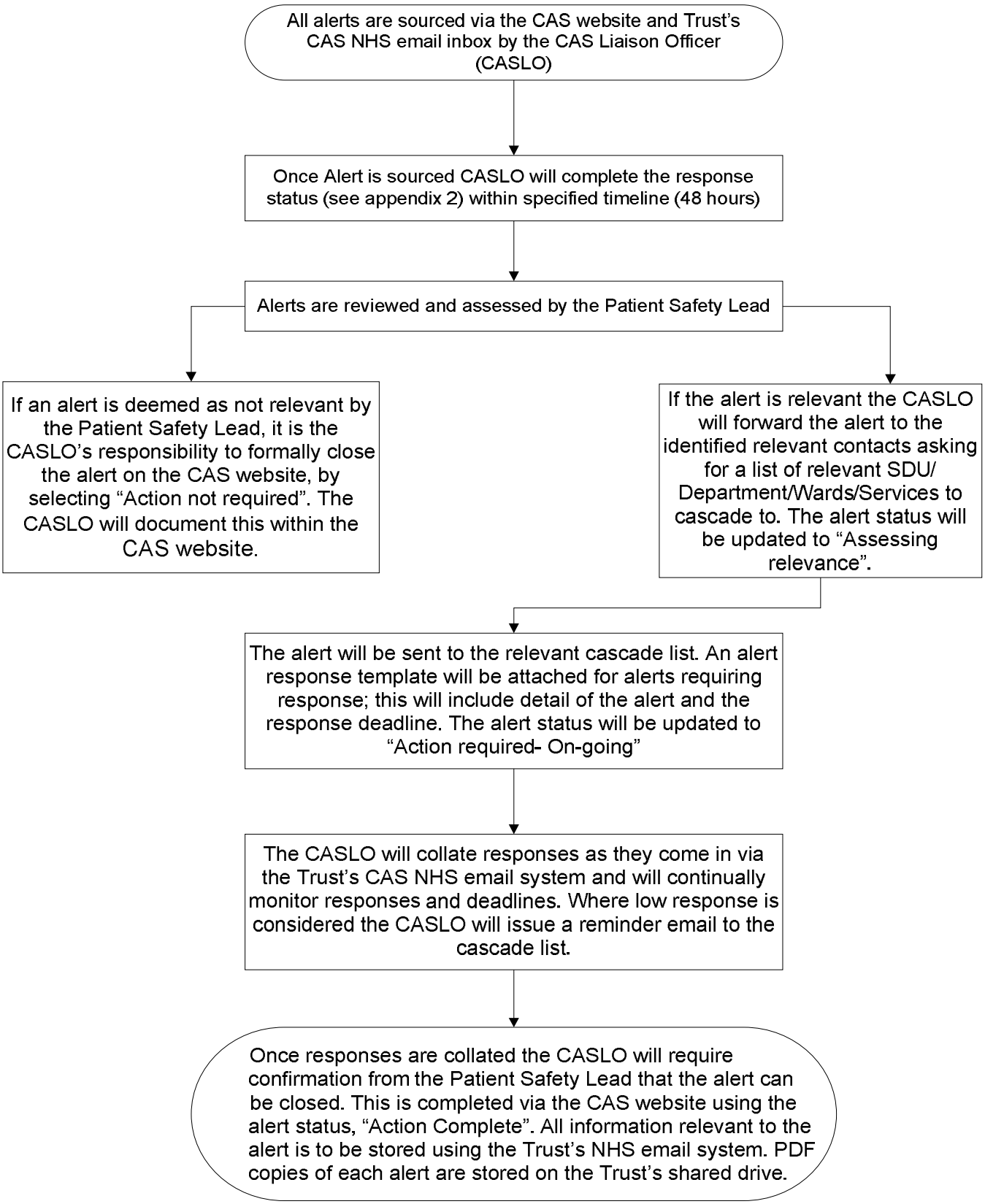
This procedure will be reviewed by the Patient Safety Lead, in accordance with the scheduled date or if, for any reason (e.g. changes in legislation, NHS guidance, etc.), it is no longer considered to be valid, by the Trust's Senior Management Team. A sample number of completed alerts will be audited as part of the Clinical Audit Plan.

9. References

- Care Quality Commission (2014) Regulation 20: Duty of Candour. http://www.cqc.org.uk/content/regulation-20-duty-candour (accessed: 27/09/2017)
- Care Quality Commission (2014) Regulation 12: Safe care and treatment. http://www.cqc.org.uk/content/regulation-12-safe-care-and-treatment. (accessed: 27/09/2017).
- Department of Health (2015). Central Alerting System. https://www.cas.dh.gov.uk/Home.aspx (accessed: 27/09/2017)
- Francis. R. (2013) The Mid Staffordshire NHS Foundation Trust Public Enquiry. Press Statement. 6th February 2013. Available at: www.midstaffspublicinquiry.com.
- Medicines and Healthcare products Regulatory Agency (2015). Alerts and recalls for drugs and medical devices. https://www.gov.uk/drug-device-alerts (accessed: 27/09/2017)
- NHS England (2015) Patient Safety Alerts. http://www.england.nhs.uk/ourwork/patientsafety/psa/. (accessed: 27/09/2017).

Appendix 1

CAS Alert Flowchart



Appendix 2

Central Alerting System (CAS) Response Status Definitions

Acknowledged

CAS Liaison Officers are required to confirm receipt of alerts within two working days (i.e. Monday to Friday) from the issue date. The Acknowledged response confirms you have received and read the alert. After two working days, a reminder email will be sent out by the system if you have not confirmed receipt. Unacknowledged alerts and those acknowledged after the 48hr deadline will also be highlighted on relevant CAS reports you run. This should help to ensure that you do not miss alerts sent to your organisation (for example due to IT system failures etc.). Although it is good practice for Liaison Officers to confirm receipt by selecting the "Acknowledged" response status, selecting any alternative response as the first step within CAS will also automatically mark the alert as acknowledged.

Assessing Relevance

This option indicates that you are making enquiries within your organisation to determine whether action is required. We would expect this option to be used for as brief a period as possible, and should not remain at this status beyond the action underway deadline date.

Action Not Started

This option indicates that there is agreement within your organisation that action is required to address the issues raised in the alert. Planning of action may already be taking place; however, the work required has not yet started.

Action Required: On-going

This option indicates that the people in your organisation who need to take action in response to the alert have started to implement the agreed action plan.
Where all the actions for compliance have been implemented, but an on-going requirement is anticipated, for example the periodic checking of equipment, the Action Completed option should be selected. For guidance, alerts will clearly state an action underway deadline (a deadline by which you would normally be expected to have an action plan in place and to have begun the work required). You would be expected to have moved your status to "action required: on-going" by this date. You may wish to give any reasons for missing this deadline in the text box provided.

Action Not Required

Select this response if, having considered the alert carefully and having consulted colleagues as necessary, it is clear that the action required in the alert is not relevant to your organisation. You should provide a brief, clear explanation as to why no action is necessary in the response notes text box. Also use this response if the alert is for information only, but only after you have distributed the alert to the appropriate people in your organisation.
(Note on re-issued alerts: if an alert is re-issued due to an error in the original please select „Action Not Required" to close the original, with a note in the text box, indicating that it has been replaced by a later alert.)

Action Completed

This option indicates that your NHS organisation considers that it has carried out all the actions stated in the alert that are applicable. Your organisation should be fully compliant with the requirements set out in the alert and processes should be in place to address on-going requirements, such as training.

Free text response notes box

It is recommended that Liaison Officers use the free text boxes to record actions taken, or to note the reasons why any part of an alert has not been implemented. Where more than one person responds to alerts in CAS, initials can be added to assist in developing a local

Appendix 3

Provider CAS Alert Response Template

Alert Reference Code/ Title:

Action Deadlines for the Central Alerts System	
Deadline for Action (Underway):	
Deadline for Action (Completed):	

If you have received this alert then please return your response via EMAIL to sabs.sdhct@nhs.net signed with your actions recorded *despite* relevance to you:

I acknowledge receipt of this alert:	
	PLEASE PUT X
Relevant to my Hospital/Department/Service/Ward: Please give reasons and state what actions have been taken:	
Not relevant to my Hospital/Department/Service/Ward: Please give reasons and state what actions have been taken:	

Signed:		**Date:**	
Job Title:			
Hospital/Department/ Service/Ward:			

Any queries regarding alert process or completion of this process please contact the team on the above email address.

11. Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

Ref No:	0984		
Document title:	Central Alert System (CAS)		
Purpose of document:	The Chief Medical Officer developed a Department of Health (DH) Central Alerting System – merging existing systems – to provide a robust and streamlined means of distributing safety alerts to the NHS and other health and social care providers, with the potential to expand as needs arise. It provides other benefits such as much enhanced search facilities and better reporting systems. The CAS system also provides an electronic feedback form that is required to be completed to confirm that the Trust has received the alert and to demonstrate that response and compliance to it are actioned.		
Date of issue:	20 July 2018	**Next review date:**	20 July 2021
Version:	8	**Last review date:**	July 2018
Author:	Patient Safety Lead		
Directorate:	Organisation Wide		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Chief Nurse Care and Clinical Policies Group Quality Improvement Group		
Date approved:	17 February 2016		
Links or overlaps with other policies:	All TSDFT Trust Strategies, policies and procedure documents		

	Please select	
	Yes	*No*
Does this document have training implications? *If yes please state:*	☐	☐
Does this document have financial implications? *If yes please state:*	☐	☐
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
24 May 2007	1	New	Medical Director Director of Nursing and Quality
26 March 2009	2	Policy rewritten re DoH change to CAS, also title change	Medical Director Director of Nursing and Quality
4 February 2010	2	Document history added	
7 April 2011	3	Revised	Medical Director
1 November 2013	3	Withdrawn	
28 November 2013	4	Reinstated and revised	Director of Nursing and Quality
15 January 2016	5	Revised	Chief Nurse Care and Clinical Policies Group Quality Improvement Group
22 January 2016	6	Amended - minor amendment to Section 7	Chief Nurse Quality Improvement Group Care and Clinical Policies Group
2 October 2017	7	Amended	Patient Safety Lead
19 February 2018	7	Review Date Extended - 2 Years to 3 Years	
20 July 2018	8	Appendix 2 Amended (Action Completed)	Patient Safety Lead

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

NHS South Devon and Torbay Clinical Commissioning Group Torbay and South Devon NHS NHS Foundation Trust

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	**Person responsible**	**Completion date**

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:
For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net
This form should be published with the policy and a signed copy sent to your relevant organisation.