NHS CENTRAL ALERTING SYSTEM (CAS) MANAGEMENT POLICY

POLICY

Reference	G/CAS		
Approving Body	Patient Safety Committee		
Date Approved	09/02/2026		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
	x		
Issue Date	February 2026		
Version	V5		
Summary of Changes from Previous Version	Update of roles and responsibilities		
Supersedes	N/A		
Document Category	Governance		
Consultation Undertaken	Medical Device Safety Officer (MDSO); Divisional Clinical Chairs		
Date of Completion of Equality Impact Assessment	January 2026		
Date of Environmental Impact Assessment (if applicable)	N/A – this is an internal management policy		
Legal and/or Accreditation Implications	CAS compliance data is a mandatory return under the Review of Central Returns (ROCR) Schedule of Approved Collections, Ref: ROCR/OR/0110/006MAND		
Target Audience	Division & Corporate Services Management Teams and Safety & Governance Leads.		
Review Date	09 /02/2029		
Sponsor (Position)	Chief Medical Officer		
Author (Position & Name)	Candice Smith, Director of Nursing Quality & Governance		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Governance		
Position of Person able to provide Further Guidance/Information	Director of Nursing Quality & Governance		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
NONE	
Template control	April 2024

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1.0 INTRODUCTION

The NHS Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care. It is managed by NHS Improvement, with those organisations that are in receipt of alerts being required to update the CAS system with their responses in a timely manner.

2.0 POLICY STATEMENT

Sherwood Forest Hospitals NHS Foundation Trust (the Trust) recognises the importance of responding appropriately to safety alerts issued through the CAS system, and the value of having in place clearly defined responsibilities supported by efficient and effective processes to ensure that any actions required to reduce the risk of harm or incident are identified and implemented wherever necessary.

3.0 DEFINITIONS/ ABBREVIATIONS

The following terms and abbreviations are used within this policy:

The Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employees of the Trust, including those managed by a third-party organisation on behalf of the Trust
PSC	Patient Safety Committee
CQC	Care Quality Commission
CAS	The NHS Central Alerting System
CAS Alerts Officer	The nominated individual within the Trust responsible for managing the response to CAS alerts
CAS Alerts Administrator	The nominated individual(s) who support the CAS Alerts Officer in the implementation of alerts
PSA	Patient Safety Alert
MHRA	Medicines & Healthcare Products Regulatory Agency
MDA	Medical Device Alert
MDSO	Medical Device Safety Officer
MSO	Medication Safety Officer
EFA	Estates & Facilities Alert
Risk	An uncertain future event which, if it occurred would have an impact on objectives
GSU	Governance Support Unit
CNH	Central Nottinghamshire Hospital plc (also known as 'Project Co.')
NSDR	National Supply Disruption Response

4.0 ROLES AND RESPONSIBILITIES

Patient Safety Committee (PSC)

The PSC is responsible for:

- Approving this Policy
- Strategic oversight of compliance with CAS requirements
- Maintaining operational oversight of CAS Alert compliance, which is achieved through the receipt of a periodic compliance report from the Director of Nursing Quality & Governance, as part of its annual work programme
- Formally signing off as complete the internal action plans developed in relation to alerts
- Providing support and guidance where necessary

Director of Nursing Quality & Governance

The Director of Nursing Quality & Governance is the Trust's CAS Alert Officer and is responsible for managing and coordinating the Trust's response to all CAS Alerts, including:

- Acknowledging all alerts on the CAS system within 2 working days
- Updating the CAS system with the status of each alert
- Maintaining an up-to-date central Action Plan detailing the Trust response to all alerts requiring action
- Providing a quarterly compliance report to the PSC to enable completed action plans to be signed off
- Providing details of CAS compliance to other internal management groups within the Trust as and when required
- Coordinating the response to alerts that have a mandatory 'action completion deadline' in conjunction with the relevant specialist lead or management group
- Providing evidence of the Trust's management of CAS alerts to support inspections carried out by the Care Quality Commission (CQC)

Medical Devices Safety Officer (MDSO)

The Trust's nominated MDSO is a CAS Alerts Administrator responsible for coordinating the response to all Medical Device Alerts (MDAs) issued by the Medicines & Healthcare products Regulatory Agency (MHRA), in conjunction with relevant clinical equipment leads within affected Divisions.

Medical Device & Equipment Group

The Medical Device & Equipment Group is responsible for maintaining oversight of the implementation of all MDAs.

Medicines Safety Officer (MSO)

The Trust's nominated MSO is a CAS Alert Administrator responsible for coordinating the response to all medication related PSAs and Drug Safety Updates issued by the MHRA, in conjunction with relevant medicine safety leads within affected divisions.

Medicines Safety Group

The Medicines Safety Group is responsible for maintaining oversight of the implementation of all Drug Alerts.

Estates & Facilities Governance Committee

The Estates & Facilities Governance Group is responsible for maintaining oversight of the implementation of all EFAs.

5.0 APPROVAL

A formal process for consultation and approval is required for both the initial production and subsequent reviews of this policy.

Name of individuals: groups of staff: Trust groups/committees	Timing(s)
V1.0 - Governance directorate management team; Medical Device Safety Officer (MDSO); Medication Safety Officer (MSO); Estates & Facilities management team; CNH management team; CA&EG members; PSQB members	January 2018
V2 - Medical Device Safety Officer (MDSO); Medication Safety Officer (MSO); Estates & Facilities management team; Improvement and Clinical Audit Group members	January 2020
V3 - Medical Device Safety Officer (MDSO); Divisional Clinical Chairs	December 2021
V3.1 - Medical Device Safety Officer (MDSO); Divisional Clinical Chairs	January 2024

6.0 DOCUMENT REQUIREMENTS

The Trust will respond appropriately and promptly to all alerts that are issued through the NHS CAS system. All alerts will be acknowledged within 2 working days of issue. It is the Director of Nursing Quality

& Governance responsibility to ensure that there is sufficient access to the CAS system amongst members of the Governance Team to enable this to happen.
The status of each alert will be updated on the CAS system as appropriate, from the following options:

- No response (this is the default until another status is chosen)
- Acknowledged
- Assessed – relevant to organisation services
- Assessed – not relevant to organisation services
- Action completed

Risks identified by the National Patient Safety Team and received in the Trust via email/letter will be acted on as directed within the communication received.

All alerts are categorised as 'Safety-Critical' and therefore have equal priority upon receipt into the organisation.

Any alerts that require action by the Trust will be included on the centrally held CAS Action Plan, which will be maintained by the GSU.

Alerts issued with a mandatory 'action completion deadline' and which are relevant to the Trust, require senior oversight and are to be signed off by the relevant director once complete.

Drug Alerts do not require a formal response on the CAS system and will not be added to the Action Plan. The Pharmacy Stores Team will maintain a record of all Drug Alerts received and responded to.

The Trust will also, where resources allow, include within its internal audit plan sufficient time to enable a targeted review to be commissioned in relation to a specific alert. Where a particular alert is deemed to be suitable for internal audit review, this will be identified on the CAS Action Plan and a recommendation made to the PSC for decision.

To support the CAS management process, the Trust will maintain a central account for accessing the CAS system, which will be arranged with the CAS Team at NHS Improvement. The use of this account will be managed by the Director of Nursing Quality & Governance.

Data on the number of alerts received, by originating body along with an update on compliance with individual alerts will be provided to the PSC every 4 months.

Information on any alerts that are overdue their deadline at the end of each month is provided to the Governance Support Unit for inclusion in the quarterly Single Oversight Framework (SOF) performance report.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (e.g. verbal, formal report etc.) and by who)
Alerts with an 'action completion deadline' outstanding (overdue)	Director of Nursing Quality & Governance	Data extracted from CAS system and provided to Governance Support Unit	Monthly	Board of Directors (Single Oversight Framework) Performance Report
Number of alerts received, by source	Director of Nursing Quality & Governance	Data extracted from CAS system	4-monthly	Patient Safety Committee (PSC) CAS Compliance Report
Compliance with individual alerts	Director of Nursing Quality & Governance	Central CAS Action Plan	4-monthly	Patient Safety Committee (PSC) CAS Compliance Report
Compliance with individual alerts	Director of Nursing Quality & Governance	Central CAS Action Plan and provided to Governance Support Unit	Monthly	Divisional Clinical Governance Report

8.0 TRAINING AND IMPLEMENTATION

- No formal training is required to support the implementation of this policy
- Members of the Governance Support Unit who support the application of this policy will receive all necessary training and support from within the department, as part of their normal duties
  A Standard Operating Procedure (SOP) describing the internal processes that are to be followed when responding to alerts will be maintained and held for reference within the GSU

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 1
- This document is not subject to an Environmental Impact Assessment

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- 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 SFHFT Documents:

- Medical Device Management Policy
- Risk Management and Assurance Policy
- Incident Reporting Policy
- Central Alerting System (CAS) Patient Safety Alert Review (360 Assurance) February 2018
- Patient Safety Alerts (360 Assurance) May 2019

11.0 APPENDICES

- Appendix 1 – Equality Impact Assessment

APPENDIX 1 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: NHS Central Alerting System (CAS) Management Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: January 2024			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	No potential inequalities identified	None
Gender	None	No potential inequalities identified	None
Age	None	No potential inequalities identified	None
Religion	None	No potential inequalities identified	None
Disability	None	No potential inequalities identified	None
Sexuality	None	No potential inequalities identified	None
Pregnancy and Maternity	None	No potential inequalities identified	None
Gender Reassignment	None	No potential inequalities identified	None

Marriage and Civil Partnership	None	No potential inequalities identified	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	No potential inequalities identified	None

What consultation with protected characteristic groups including patient groups have you carried out?

None. This is an internal process management policy.

What data or information did you use in support of this EqIA?

None.

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

No.

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

Name of Responsible Person undertaking this assessment: Candice Smith, Director of Nursing Quality & Governance

Signature: C Smith

Date: January 2026