NHS

National Patient Safety Agency

Documenting progress

Annual report and summary financial statements 2003 – 2004

Introduction to the NPSA

Every day more than a million people are treated safely and successfully in the NHS. In a complex healthcare system, things can and do go wrong, no matter how dedicated and professional the staff. The NPSA aims to help the NHS cut the number of safety failures, reduce harm, improve care and save lives.

The role of the NPSA is to help the NHS learn when things go wrong and introduce preventative measures nationwide so they do not happen again. Our priority is to develop a culture of safety and openness so that incidents and concerns are not overlooked but acknowledged, investigated and learnt from.

We do not investigate individual cases or complaints because our remit is to look at improving systems rather than individuals. We do listen to public concerns, however, so we can use the information to help improve safety. We involve patients, carers and the public in all aspects of the NPSA's work.

The NPSA is putting into place a system to gather and analyse information about safety problems. We will use this system to help the NHS focus on solutions that will produce the most benefit for patients. The NPSA is promoting increased openness about patient safety at all levels of the NHS and greater accountability for addressing the problems it identifies.

We are also working to develop and implement educational and training programmes to support boards and staff in developing a safer NHS for patients.

Foreword by the Chair

Lord Philip Hunt of Kings Heath, OBE

Our Annual Report gives me the opportunity to look back at a year of achievement as well as look forward to a future of continuing challenge and improvement to patient safety.

In my first year at the NPSA I have already seen immense strides towards our goal of an NHS where the safety of the patient is the first priority.

Our greatest challenge and success to date has been to establish patient safety firmly on the health agenda. This has been helped by the strong support of the Department of Health and Welsh Assembly Government. Safety is the first of England's seven health standard domains, which will benchmark the quality of care for many years to come. In Wales the All Wales Advisory Group has been established to steer and integrate the patient safety agenda in all aspects of Welsh healthcare.

There can be no doubting the commitment to safety. As Sir Nigel Crisp, Chief Executive of the NHS, said at the *Leading change – delivering health together* conference in February 2004, 'The bottom line from a professional standpoint is that of patient safety. This is central to our duty of care'.

This comes as no surprise to me. Everyone I have met within government, the NHS and patient groups has, without exception, matched the NPSA's desire to improve patient safety and put people at the heart of the NHS. This desire was no more clearly expressed than at our *Patient Safety 2004* Conference in February, where 900 people gathered to further the cause of patient safety. I would like to express my gratitude to all who have worked so hard to progress our shared goal in the last year.

Similarly, I would like to thank those who work at the NPSA, board members, NHS staff and those patients who have worked with us. They have shown immense skill, commitment and passion for improving patient safety.

I have no doubt that together we can move forward, making the NHS an even safer place to be.

In particular I would like to thank my predecessor, Professor Rory Shaw, who did so much to build the NPSA into the organisation I am proud to chair today.

Lord Philip Hunt

Introduction by the Joint Chief Executives

Sue Osborn, Susan Williams

The NPSA has completed a year of change, challenge and progress. We began the last year with a sense of anticipation and excitement as we considered the challenges ahead. A year hence we can see that much has been achieved, but this is no time for complacency.

The last year has seen the publication of new patient safety alerts and the introduction of new information formats, designed to help the NHS implement change quickly and effectively. The coming year will see a significant expansion in these services.

The National Reporting and Learning System is now a reality, beginning to deliver the information that will help establish a safer patient environment. We are now working with NHS organisations and risk software vendors to connect local health organisations to the system. This is the culmination of a massive body of work at the NPSA, in close partnership with the NHS, and it is something that will build to become the most comprehensive patient safety information resource in the world.

We continue to expand the availability of our advice, training and tools. Since September 2003 our Patient Safety Managers, based around England and Wales, have been supporting NHS organisations in establishing a patient safety culture. They are at the sharp end of delivering improvement and a vital new resource for the NHS.

We could not look back on the year without welcoming Lord Hunt as our new Chair and we thoroughly endorse his thanks to Professor Rory Shaw. We know that Lord Hunt shares our view that the organisation he chairs is made up of staff who unceasingly inspire us with their drive, determination and skill.

The NPSA is continuing to evolve and grow and will take a number of additional responsibilities following the findings of the Department of Health's review of Arm's Length Bodies.

The future holds the same challenge and opportunity to make healthcare safer for the patient.

Sue Osborn

Susan Williams

Message from Lord Warner of Brockley

Parliamentary under Secretary of State (Lord)

The health service has undergone massive change in the last seven years, with huge increases in funding that have seen the health budget double in this period, from £33 billion to over £67 billion.

But increased investment is only half the story. As startling as the change in funding has been, it is matched by the change in the way that the NHS thinks – a smarter head is as significant as a bigger wallet. The NPSA is a tangible example of this shift in thinking; patient safety was not even on the agenda in 1997 and now the NPSA is establishing itself as a leading patient safety light and international trailblazer.

With this leading role comes great responsibility. I am not overstating the case by saying that the success of the NPSA is a vital part of the new quality agenda. The Arm's Length Bodies review explains how burdens must be lifted from frontline staff, helping them to deliver ever improving levels of patient care. In the 21st century NHS the NPSA must play its part in ensuring that frontline staff are free to ensure that patient safety is the first priority. There is already evidence that the NPSA is delivering in this duty, with the National Reporting and Learning System placing the minimum possible burden on frontline staff.

This report details significant achievement and continuing ambition. The NPSA will need both to continue its work to co-ordinate system-wide efforts to improve the safety of care and reduce the number of mistakes that result in injury to harm patients.

Message from Jane Hutt, AM

Health and Social Services Minister, Welsh Assembly Government

In Wales we see the patient safety agenda as a tremendous opportunity to improve the quality of patient care in the NHS and we value our very strong links with, and input to, the NPSA's work.

Welsh NHS bodies are forging ahead in connecting to the National Reporting and Learning System and working in partnership with the NPSA, as evidenced by Cardiff and Vale NHS Trust's piloting of the project to reduce errors in the use of infusion devices.

I was pleased that we had the opportunity to meet Lord Hunt and the Joint Chief Executive in February to discuss how we can further our work together – it underlined the fact that patient safety is the highest priority. We engage with the NPSA across the service and this is overseen by the Agency's All Wales Advisory Group, which met for the first time in April and will ensure that patient safety is integrated into everything we do.

The links we have forged are already bringing benefit and I firmly believe that the coming year will see a strengthening of our relationship and continuing improvement to patient safety in Wales.

Sharing the safety message

We have worked hard to achieve understanding of our aims and objectives across the health service.

Patient safety concerns everyone in the health service, and raising the patient safety issue to the top of the healthcare agenda has been a major priority and challenge this year. To achieve this we have been working to ensure that there is widespread and collective understanding of patient safety issues and our work in the healthcare environment.

Patient safety campaign and seven steps to patient safety

In November we launched our patient safety campaign with the publication of the evidence-based good practice guide, *Seven steps to patient safety. Seven steps* describes the actions that NHS organisations need to take to improve safety. By following these steps the NHS will help to ensure that the care provided is as safe as possible, and that when things do go wrong the right action is taken.

More than 20,000 editions of the summary of *Seven steps to patient safety* have been distributed throughout the NHS and demand remains high. The full 190 page guide is available from our website www.npsa.nhs.uk/sevensteps

Patient safety events

In September 2003 we held a joint one day conference with the Royal College of General Practitioners called *In safer hands*, for GPs, practice managers, nurses and other primary care professionals. The event successfully covered topics including managing high risk medication and focused on our early work on oral methotrexate.

February saw the first national conference run by the NPSA. *Patient Safety 2004* drew together over 900 professionals from across the NHS to discuss patient safety issues and learn about the NPSA. Delegates included heads of clinical governance, patient safety leads and risk managers.

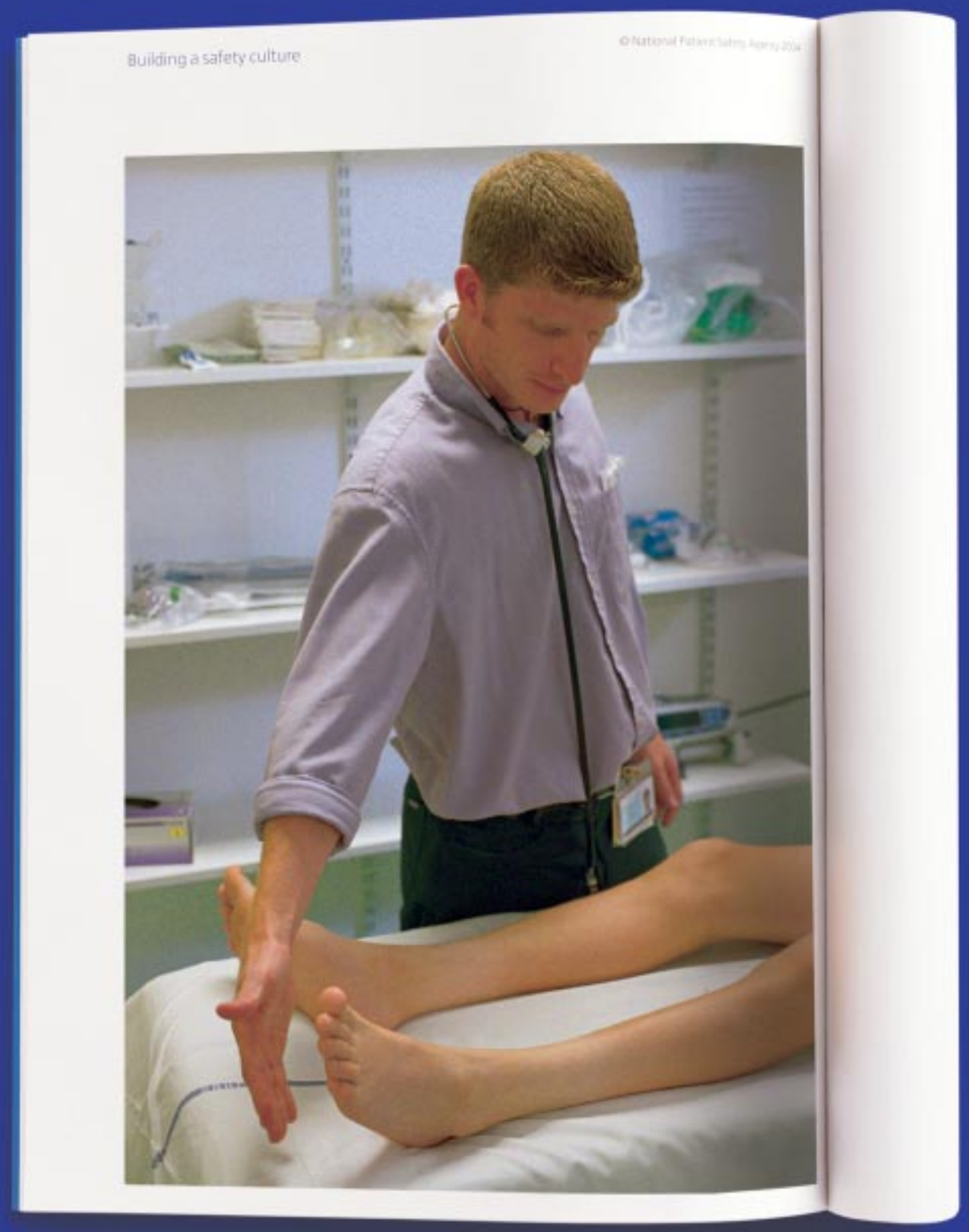
The event included workshops on mistake-proofing healthcare systems, creating an open and fair culture and patient choice. Keynote speakers included England's Chief Medical Officer, Sir Liam Donaldson, and Professor Onora O'Neil, Principal of Newnham College, Cambridge. With 96% of delegates rating the event 'good to excellent' the event was successful, both in spreading the patient safety message and sharing learning.

Alerts and other safety information

We have created three distinct formats to ensure the fast and effective sharing of patient safety information across the NHS. The formats are: *patient safety alert*, which requires prompt action to address high risk safety problems; s*afer practice notice*, which strongly advises implementing particular recommendations or solutions; *and patient safety information*, which suggests issues or effective techniques that healthcare staff might consider to enhance safety.

Patient Safety Portal

During 2003-04 we have worked closely with the Institute of Health Improvement and the British Medical Journal in the development of our Patient Safety Portal. The web portal will be our primary online communications channel with healthcare professionals, enabling feedback of data from the NRLS to frontline staff. The portal will provide staff with access to the latest news on patient safety, our safety solutions, online learning and interactive tools to promote best practice, with a view to improve the safety of patients and the quality of care.



Seven steps to patient safety

Promoting patient safety among junior hospital doctors at Wrightington, Wigan and Leigh NHS Trust

Pat O'Brien, Clinical Risk Manager at the Royal Albert Edward Infirmary in Wigan is using our *Seven steps to patient safety* good practice guidance to help educate staff and improve patient safety.

Junior doctors at the trust receive weekly protected teaching time that covers clinical training and professional development as well as sessions on patient safety.

Pat says: 'Sometimes there seems to be so much to do to build a safety culture that you don't know where to start. The *Seven steps* gives you a structure'.

The course uses real patient safety incidents that have taken place at the trust. Junior doctors are encouraged to recognise the contributory factors and identify what could have been done to prevent the incident. For example, by working through a case study on mistaken identity, the doctors discuss the importance of checking case note numbers and ID wristbands.

The sessions are also an opportunity to promote reporting. The trust has been successful in raising reporting levels but is keen to embed it in the organisation's culture.

Pat O'Brien continues: 'Junior doctors do not always realise the importance of reporting incidents where there is no harm to patients – such as when a patient is mistakenly given pain killers and suffers no ill effects. This could point to systems failures which might result in more powerful drugs being given to the wrong patient in future with serious consequences'.

In one of these patient safety sessions, the junior doctors said that they needed information about protocols to be readily available and easy to find in an emergency. They suggested having a special junior doctors' site on the trust intranet – nurses and midwives already have their own site. This is being built and will include out-of-hours contacts and telephone numbers and a site map to help junior doctors in their first few weeks.

Understanding safety

As part of our mandate to improve patient safety we are developing a Patient Safety Observatory to increase understanding of the risks presented by healthcare.

To improve safety we must first understand the risks that patients face in the healthcare environment. Currently there is no one source of information that can inform the NHS about patient safety and so we are establishing a Patient Safety Observatory. The Observatory will assimilate information from other sources, and in new ways quantify, characterise and prioritise patient safety issues. In broad terms, the Patient Safety Observatory will enhance the availability, use and usefulness of information about patient safety at a national level in order to help make patient care safer.

To oversee the Observatory we have appointed Professor Richard Thomson as Director of Epidemiology and Research.

National reporting and learning

A major component of the Observatory is the National Reporting and Learning System (NRLS). The NRLS gathers data from local NHS organisations, either through existing electronic risk management systems or our world wide web based eForm (launched late 2004), into a central repository in an anonymous form. The NRLS is capable of processing and analysing the information it receives. This information can then be shared across the NHS in England and Wales and inform the patient safety solutions we develop.

The NRLS was launched on 25 February 2004 by Lord Warner, Health Minister in England, and Jane Hutt, Health and Social Services Minister in Wales.

The launch of the NRLS was informed by a testing and development phase of the system, carried out in 2003, involving 37 NHS organisations across England and Wales. Lessons learnt during the testing and development have led to improvements in the dataset and to the eForm. The *Testing and Development Report* was published in July 2004.

Careful implementation of the NRLS, in close partnership with the NHS, has been a key programme in 2003-04. During 2004-05 we will work with NHS organisations and the local risk management systems' vendors to connect to the NRLS.

Developing the NRLS has been a major work programme for our Knowledge and Information Management team. This has included: fundamental work creating a unified dataset that covers all care settings; work on ensuring the effectiveness of the eForm; and ensuring that data can easily be sent to the NRLS via an organisation's local risk management system, avoiding duplication of data entry.

In the last year we have purchased and installed an analytical software tool capable of powerful statistical and free text analysis. To support this, we have established a series of statistical policies governing, for example, privacy of data and release of analysis into the public domain.

Ensuring that the information technology infrastructure is in place to support the NRLS has also led to the delivery of a number of significant projects in the past year. The key objective and major work programme has been to provide ongoing NRLS systems development and technical backup, including design, coding, testing and quality assurance.

Feeding back lessons

It is important for us to feed back the information we receive from staff and patients. Consequently we will, once the NRLS has matured, produce regular reports.

'A national reporting system, backed up by a sophisticated analysis of safety information from many sources, is needed to provide a broad picture of safety issues across the whole NHS.'

Charles Vincent, Smith and Nephew Foundation
Professor of Clinical Safety Research, Imperial College London

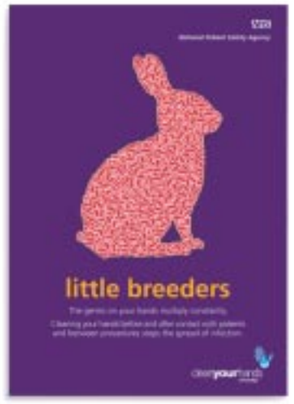
Maximising reporting, protecting the public interest

We need to be careful to balance the public interest in protecting the confidentiality of the information we hold. The particular challenge is to encourage reporting without fear while protecting the public interest in accessing this information in certain circumstances. Getting this balance right is a challenge facing all large incident reporting systems worldwide. Owing to the importance of these issues, we have decided to conduct a public consultation in early 2005 on the public interest issues associated with how we manage the confidentiality of patient safety information.

We see the consultation as an opportunity for all interested parties to contribute to developing a considered approach to understanding and serving the public interest. This includes the NHS, patients, carers, the public, government and non-government organisations, industry, media, professional organisations and interested individuals.

Safety solutions

Collecting and analysing evidence provided by the healthcare community allows us to develop solutions to improve the safety of patients.



To inform our solutions work we gather information from a variety of sources, including individual patients, patient groups, the NRLS, clinical experts, coroners and healthcare professionals from around the world. Having identified an issue, we work in partnership to build up a complete picture and pilot proposed solutions in NHS organisations. By learning from these pilots we can ensure that we provide the most effective solutions to the NHS and improve the safety of patient care.

Standardising the crash call number

In 2003 we were asked to carry out a feasibility study into standardising crash call numbers, following the publication in July 2002 of the joint Department of Health and Cabinet Office report *Making a Difference: Reducing Burdens in Hospital*.

A crash call, or cardiac arrest call, number is used by hospital staff to summon an emergency care team to patients suffering a cardiac arrest. An NPSA study showed that there were 27 different crash call numbers in use across the NHS, potentially causing confusion and delay in summoning specialist help.

We issued a *patient safety alert* in February 2004 to every acute trust in England and Wales, advising standardising the crash call number to 2222.

Dr David Gabbott, Consultant Anaesthetist at the Gloucestershire Royal Hospitals NHS Trust, said, 'Having a single number for the crash team is a logical thing to do for patient safety and for the sake of doctors and nurses who will not have to face committing to memory a new number every time they start work in a different hospital.'

Hand hygiene

Health Care Associated Infections (HCAI) cost the NHS £1billion a year, affect around 10% of hospital in-patients and are thought to lead to the death of 5,000 patients annually. A proportion of HCAI are preventable and hand hygiene is possibly the most effective way of combating these.

We have developed the clean**your**hands campaign to help improve hand hygiene in the NHS. Initial findings from the six acute trusts which took part in the July 2003 to January 2004 pilot show that, on average, staff increased hand cleaning between each patient contact from 28% to 76% of the time. An economic assessment has indicated that if this success were reflected nationally, an estimated 450 lives and £140 million a year might be saved.

Having implemented learning from the pilot sites in 2003-04, the campaign was launched in September 2004.

Improving the safety of infusion devices

In the last year we have been involved in a major project to reduce errors associated with infusion devices in the NHS.

Most infusion treatment is delivered safely. However, patient safety issues involving infusion devices have been identified by the NPSA, the Medicines and Healthcare products Regulatory Agency (MHRA) and the Royal College of Nursing (RCN).

We have worked with the NHS Purchasing and Supply Agency (NHS PASA), Welsh Health Supplies and six NHS trusts to develop and test solutions. Our joint study identified: 321 incidents a year linked to infusion devices from the six pilot sites; an average of 31 different types of infusion device available per trust, with 65% of these idle at any one time; and a potential cost saving of £120,000 to each trust if they reduced their infusion device stock by 10%.

Learning from the pilot led to a significant project in 2003-04 to develop a package of practical solutions to help trusts take action to improve the way that infusion devices are purchased, used, stored and maintained. This project has led directly to the issuing of a *safer practice notice* to every acute trust in England and Wales in May 2004.

Oral methotrexate

Oral methotrexate is a drug largely given to patients who have moderate or severe rheumatoid arthritis. It is generally safe as long as it is used properly – there are around 50,000 prescriptions to NHS patients per year.

We have found, however, that serious problems can occur if the proper treatment routine is not followed. Over a ten year period in England 25 patients died, with a further 26 suffering serious harm, because the drug had either not been used or monitored properly.

Work in partnership with patients, clinicians and pharmaceutical companies in 2003-04 has led to the development of practical solutions. This work included a workshop with patients and clinicians on developing improvements, and agreement with the pharmaceutical industry to change the shape, content and design of their packaging. The work carried out in 2003-04 has culminated in a *patient safety alert* in July 2004.

Improving safety for spinal injuries patients

2003-04 has also seen us working in close partnership with the Spinal Injuries Association (SIA). Together, we have identified that some spinal injuries patients are being denied a procedure known as 'manual bowel evacuation' when staying in a general NHS hospital. For people with established spinal cord lesions, this is often an essential part of their bowel care routine and interrupting it can have potentially fatal consequences.

The reason for the refusal to perform manual bowel evacuation is often because healthcare staff are unfamiliar with the procedure and unaware of existing guidance. In 2003-04 we developed *patient safety information* which was issued in September 2004 and we will continue to work with the SIA on producing a personal patient information card.

Other solutions work

Existing solutions work is already bringing benefits to the NHS:

> We issued a *patient safety alert* on improving safety in the use of potassium chloride in 2002. In 2003 NPSA and independent evaluations showed that the number of hospitals implementing formal safety controls on potassium chloride rose from 25% to 68% six months after the alert. This figure is expected to continue to rise.

> In 2001 and 2003 the Department of Health issued national guidance to eliminate the incidence of paralysis or death as a result of maladministered spinal injections. In 2002-03 we risk assessed proposed solutions. The results of this risk assessment are now being tested.

> We have worked with the University of York to investigate solutions to stop tampering or sabotage of anaesthetic tubing.

> We have also successfully worked to ensure that all NHS ambulance trusts make the drug Naloxone, used to reverse the effects of narcotic drugs, available to ambulance crews.

In the coming year we will examine safety issues in areas including: medication; primary care; anaesthetics and surgery; women and children; ambulance and A&E services; and wrong site surgery.

'Thanks to the support of the NPSA, we are optimistic that spinal cord injured people's fears about their treatment in some hospitals will be a thing of the past.'

Paul Smith Chief Executive of the Spinal Injuries Association

Building a safety culture

One of our most important objectives is to foster a safety culture, where error is met with investigation, learning and solutions, rather than simply blame and punishment. A safety culture is also one where patients and staff are always vigilant and alert to the possibility that things may go wrong.

Education and training

Ensuring that patient safety principles are learned from the very beginning of a staff member's professional life is an important way of building a safety culture. We are working to introduce the subject as part of all undergraduate clinical curricula, and have awarded three grants to the universities of Newcastle upon Tyne, Aberdeen and Leicester. The grants will assist in the development of training modules, and these will then be evaluated.

We also developed, produced and distributed a patient safety induction video across the NHS. This 20 minute film provides a practical introduction to patient safety and its relevance to NHS staff.

Patient Safety Managers

Since September 2003 we have employed 32 Patient Safety Managers (PSMs), one for every Strategic Health Authority in England and NHS Region in Wales. PSMs are the local face of the NPSA and are on hand to support NHS organisations in implementing a patient safety orientated culture. Their role is a vital one in helping the NHS to implement many of the safety culture tools we develop, and in listening to feedback from the service.

Root cause analysis

A major body of work has been training NHS organisations in how to perform a technique known as root cause analysis (RCA). Put simply, RCA allows the thorough investigation of an incident when something has gone wrong and the identification of ways of ensuring that it does not happen again. RCA is fundamental to creating the patient safety culture.

We have developed a three day RCA training course to provide a comprehensive grounding in the technique. Once trained, NHS staff are encouraged to cascade their learning throughout their organisation, ensuring widespread understanding. Organisations are trained in regional groups to ensure that they can support each other and share learning following the training. This is a significant logistical task for the patient safety managers, with the training of over 5,000 members of staff across the NHS.

To support the RCA training days, we have also developed and launched the RCA e-learning tool, available from our website.

Incident Decision Tree (IDT)

Critical to building a safety culture is the fostering of an environment where NHS staff feel confident to report patient safety incidents. To achieve this, staff must believe that in the event of their making an error, they will be treated fairly.

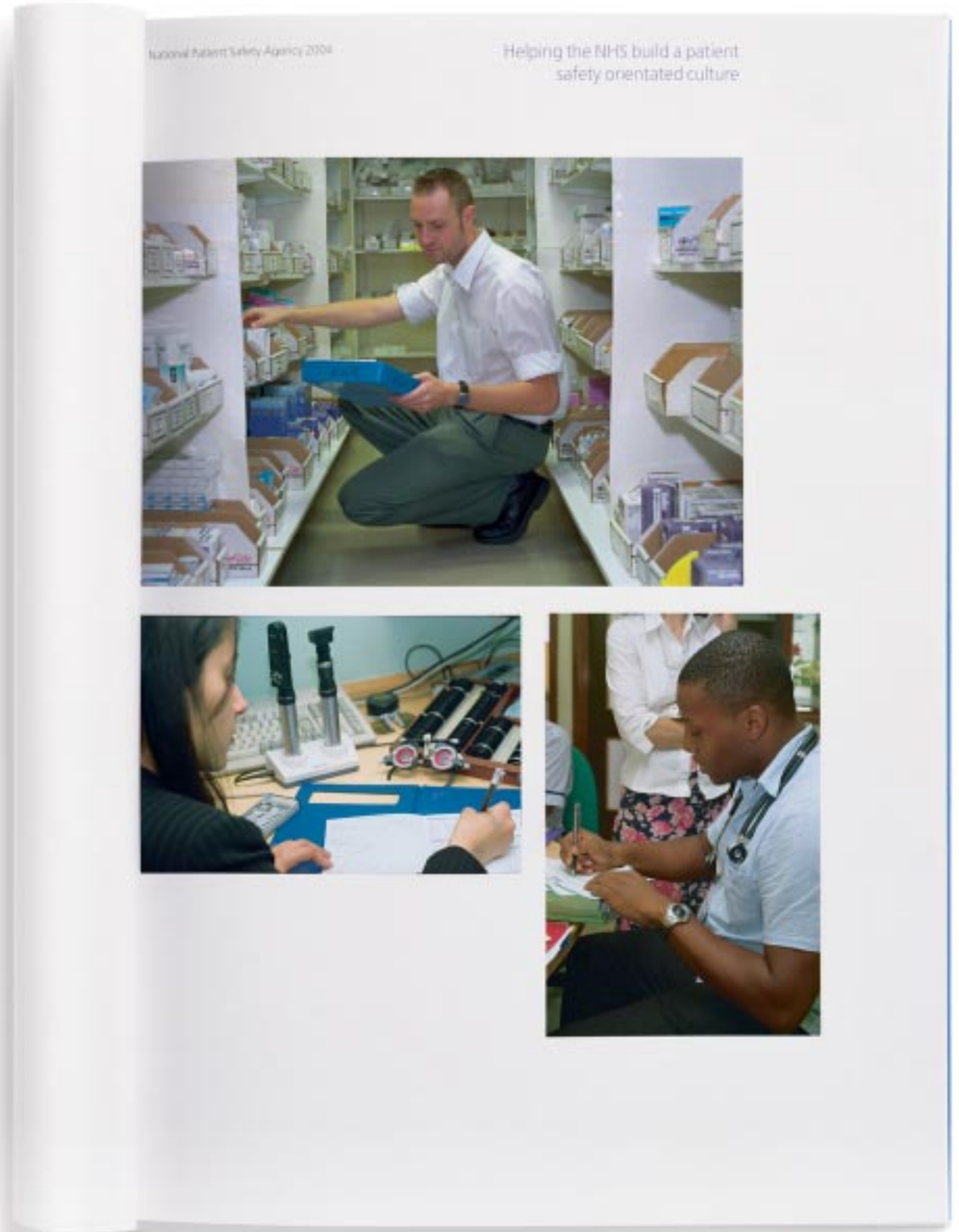
Furthering the support offered to NHS organisations we have developed the Incident Decision Tree. The Incident Decision Tree provides a framework for human resource and NHS managers to apply a consistent and fair approach to staff who have been involved in a patient safety incident.

The IDT has been piloted in 2003-04 and the results have been positive. Participants in the evaluation suggest that it aids easier and more consistent decision making, is less punitive and helps NHS organisations to identify system failures rather than simply punishing individuals. Additionally, use of the IDT may lead to a reduction in the numbers of suspended nurses. A National Audit Office report in November 2003 estimated that unnecessary suspensions cost the NHS £29 million.

This work in 2003-04 led to the launch of IDT later in 2004.

Being open

The NPSA is committed to helping local organisations involve patients and the public in patient safety. The NPSA is now developing guidance and training tools to help healthcare professionals communicate with patients when things go wrong with their care. This includes: a *Being open* policy, following consultation developed with patients and NHS professionals, which provides an effective framework for communication; and an e-learning tool and training video to raise awareness and understanding among healthcare professionals on the principles of *Being open*.



Incident Decision Tree

Dealing with staff involved in error at Queen Elizabeth Hospital NHS Trust, London

Queen Elizabeth Hospital is a district general hospital in south east London. The trust had been interested for some time in the development of models to aid decision making when faced with incidents involving concerns about patient safety, and a number of senior clinical and non-clinical managers within the trust had already been trained in root cause analysis.

When the opportunity arose for involvement in the NPSA's Incident Decision Tree pilot in July 2003, this was very welcome. A broad range of managers were trained in the use of the tool and many of them, including executive directors, used the tool within the pilot phase. They considered it so useful that it was subsequently built into the trust's procedures in response to the National Audit Office report published in December 2003 into the number, cost, and impact of exclusions of healthcare staff from work, and the subsequent Health Service Circular (HSC) 2003/012 *Maintaining High Professional Standards in the Modern NHS.*

Within these procedures, the IDT is now an integral part of the trust's framework for the initial handling of serious concerns.

Sally Storey
Director of Human Resources and Organisational Development

Partnerships

The goal of improving patient safety can only be achieved by working in partnership with other national organisations. Building effective relationships is a high priority.

Partnership is a vital component of achieving our goal of improving patient safety. We are working to ensure that we have, and continue to build, effective and valuable working relationships with many healthcare organisations.

We have been pursuing Memoranda of Understanding, joint working agreements that will enable us to further our patient safety goals, with key partner organisations.

In May 2003 we agreed a Memoranda of Understanding with the National Clinical Assessment Authority (NCAA), which will, amongst other benefits, help us to share good practice and encourage the use of root cause analysis and Incident Decision Tree techniques. This relationship will change in light of the Arm's Length Body review as the NCAA will become part of the NPSA. A memorandum was also signed with the Royal Pharmaceutical Society of Great Britain in June 2003. We continued working to build on our already strong and important relationship with the Healthcare Commission, the new body created to review the quality of healthcare.

We have been working in partnership with other bodies on individual projects. This has seen the development of relationships with a host of organisations, including the Health and Safety Executive, NHS Purchasing and Supply Agency, the Royal College of General Practitioners, Healthcare Inspectorate Wales, the Royal College of Nursing, Welsh Health Supplies, Welsh Health Estates, Community Health Councils Wales, NHS Information Authority, British Medical Association, NHS Design Authority and NHS Estates.

As a result of the Arm's Length Body review the NPSA will also be taking the lead on hospital food, cleanliness and safe hospital design currently performed by NHS Estates. We will also take on three national confidential enquires currently overseen by the National Institute for Clinical Excellence. Additional responsibilities will be taking the national lead in supporting the development of ethics committees that review clinical trials with medicines, and also the NHS research ethics committees.

Clinical Specialty Advisers

We originally established 17 Clinical Specialty Advisors (CSAs), who were appointed to the NPSA directly or through their Royal Colleges or associated organisation. Their role was to: ensure the sharing of information within their specialty; support the flow of information on patient safety issues within their specialty; encourage a collaborative approach in both the identification of issues and development of solutions; and place patient safety at the centre of their Royal College or decision making body.

We have since decided to expand this group of professional advisers to include other organisations represented on the Academy of Medical Royal Colleges and other professional groups on a larger Professional Advisory Panel.

We have also appointed Professor Sir John Lilleyman to head our Clinical Programmes Directorate, who as well as leading the CSAs will ensure effective liaison with the Royal Colleges, the British Medical Association and the General Medical Council.

Wales

We continue to work closely with the Welsh Assembly Government and the service in Wales, ensuring that we cement and build upon our already strong relationships.

In February 2004 our Chair and Joint Chief Executives met and briefed Jane Hutt AM, Minister for Health and Social Services and Dr Ruth Hall, Chief Medical Officer for Wales. The meeting was an opportunity to reinforce our commitment to Wales and to engage support for patient safety and our programme at the highest level of policy making.

In April the first meeting of the All Wales Advisory Group was held, chaired by Lord Hunt. The advisory group provides advice and a sounding board on all aspects of our work, helping to ensure that we are as effective as possible in Wales.

Healthcare Industries Task Force

During the last year we have been involved in the Healthcare Industries Task Force (HITF), which was set up to bring together government and industry leaders to identify steps to develop and strengthen the performance of the UK healthcare industry.

Members of the NPSA were involved in a variety of working groups and sub groups, ensuring that patient safety is high on the agenda. The main areas were:

> regulation;

> innovation;

> purchasing;

> design for patient safety;

> matching of patients to care (to reduce misidentification).

Message from Professor Sir Ian Kennedy

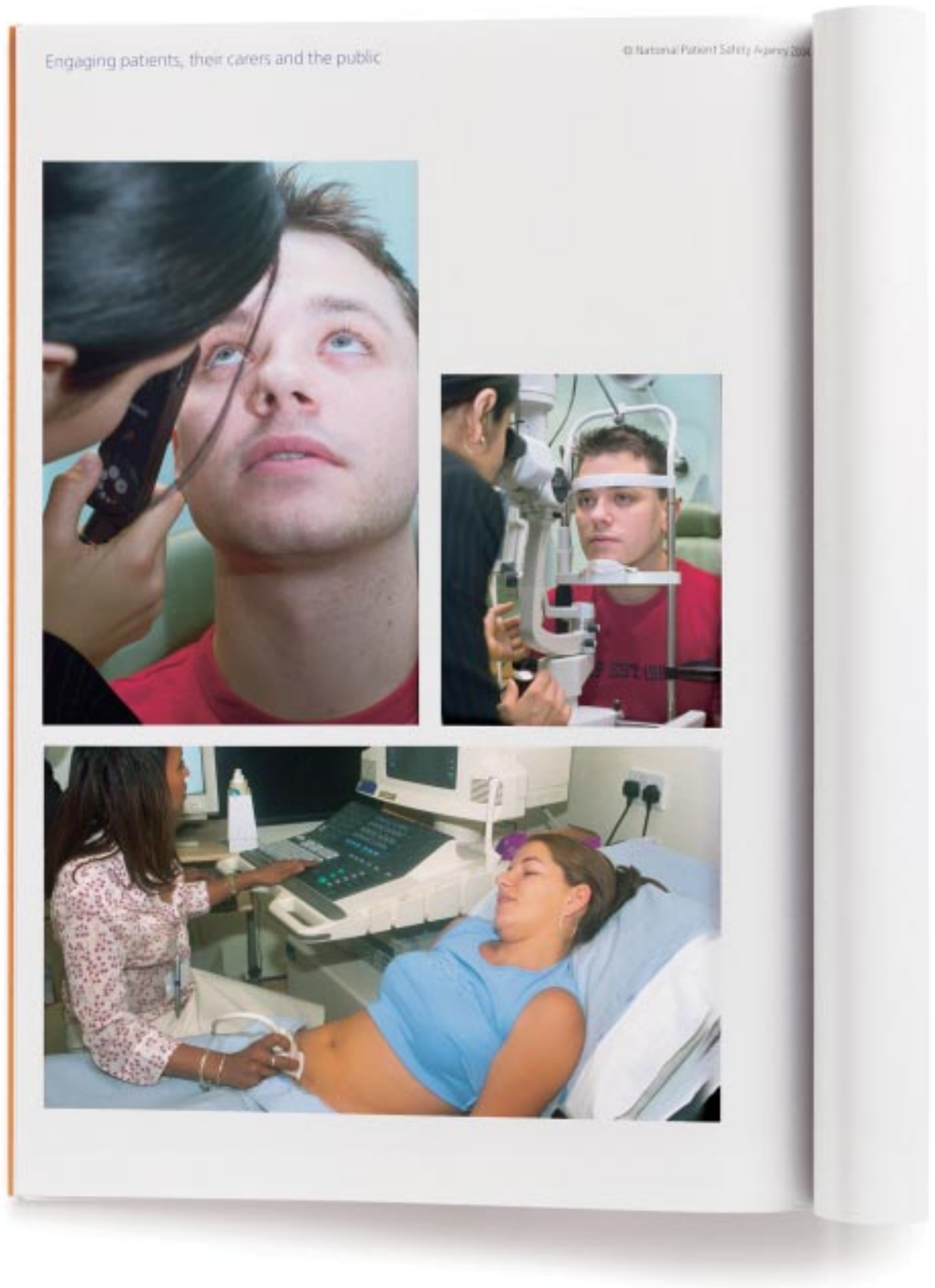
Chair, Healthcare Commission

In July 2001 the Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995 recommended that, 'Every effort should be made to create in the NHS an open and non-punitive environment in which it is safe to report and admit sentinel events.'

It was and remains my opinion that the NHS must create this new environment if it is to provide the highest levels of quality and safety to its patients. The Bristol report also mentioned the then fledgling National Patient Safety Agency; I am delighted to see that the Agency has grown from the idea that it then was into the effective organisation it is today. I have every confidence that the NPSA will play a significant role in bringing about the open and fair culture I called for.

The new Healthcare Commission, which I chair, will promote improvement in the provision of healthcare through ensuring compliance with the government's standards for healthcare of good quality, complementing the NPSA's goal of ensuring the highest possible levels of safety for patients.

I look forward to furthering the already strong relationship that we have forged between the Commission and the NPSA and working together to build a better NHS.



Patient experience and public involvement

We have worked to see how we can best engage with patients because without the patient's perspective we can never truly understand the nature of patient safety incidents.

The Department of Health's NHS Plan consultation found that patients put being involved in their own treatment as their second most important desire, closely behind 'getting better and feeling better'. It is therefore clear that we have a responsibility to engage with patients, their carers and the public.

In 2003-04 we have formally worked with over 140 patients on projects ranging from looking at the packaging of medicines through to developing our process for prioritising work. This helped make the projects more robust and influenced the NPSA's culture to be patient centred. This will help us to achieve our goal of sustaining public trust in the NHS.

Our solutions work to date has benefited from patient experience and public involvement in almost all of its projects. As an example, our clean**your**hands campaign encourages patients to ask healthcare professionals to clean their hands before treatment. The pilot surveys show that patients appreciated being responsible for their own care and their input has contributed significantly to the campaign's success.

As well as working with individuals we have worked with many charities and self help groups, ranging from the Spinal Injuries Association to Action Against Medical Accidents.

As an example, we have worked in partnership with the UK disability self advocacy charity *Speaking Up!*, being one of the first patient safety organisations in the world to look at the specific risks associated with patients with learning disabilities, an often vulnerable and socially excluded group. In February 2004 we published a report, *Understanding the Patient Safety Issues for People with Learning Disabilities*, which gathered the experiences of people with learning disabilities and their carers across England and Wales.

The report has given the NPSA a much clearer understanding of the patient safety issues that affect this group and allowed us to identify the five most serious elements of risk from the perspective of patients. In turn, this has given us information to assist in developing solutions to reduce or eliminate risk.

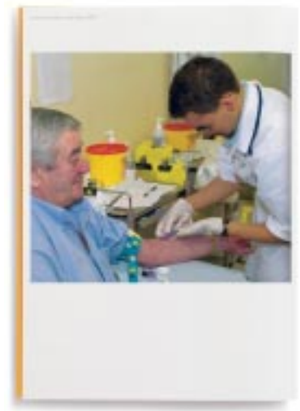
It is clear from our work so far that lay reporting of incidents and lay views of the causes and issues surrounding patient safety incidents do add value, by either providing a different perspective in regards to patient safety incidents or confirming staff views.

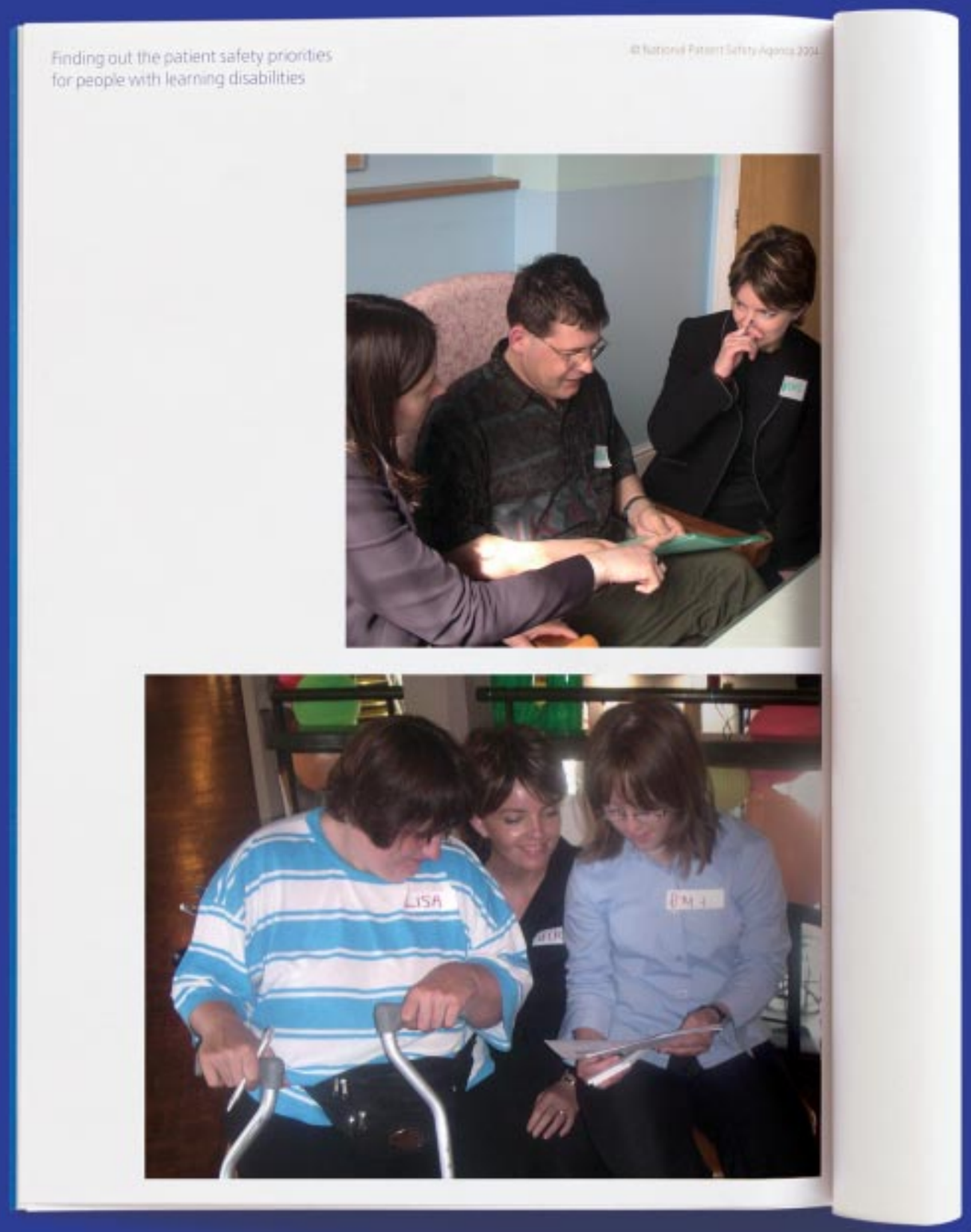
We are also ensuring that patients and the public are involved in the methods we adopt for prioritising our work. A prioritisation document was widely disseminated to key stakeholder groups including patients, voluntary organisations, healthcare professionals, NHS boards, local government health scrutiny committees and social care providers.

The consultation was held from 1 November 2003 to 31 January 2004 and was supported by an additional series of regional workshops.

The workshops were designed to engage a mix of patient and voluntary groups, as well as healthcare professionals and ran from 26 February to 15 March 2004.

The results of this prioritisation consultation will significantly inform the direction of our solutions work in the future.





‘If I could change health services, I would make bigger labels on medicine bottles, especially for people with learning disabilities who can’t read them properly. Instructions for taking tablets need to be explained to people who cannot read.’

Comment from a person with learning disabilities

‘We are grateful to people with learning disabilities who met us and shared their stories about healthcare safety. Concerns raised have been reflected in the five priority areas that the NPSA has identified and we look forward to seeing improvements in safety.’

Craig Dearden Chief Executive of *Speaking Up!*

Research and international learning

Improving patient safety is a challenge faced by many other healthcare systems across the world. We work to gather information from the experiences of other countries' patient safety work and share our own learning.

Research

One of our key strategic objectives is the promotion of research and development in patient safety. This is vital for the NPSA to understand the issues of patient safety and to inform future work.

We have established a strong and fruitful working relationship with the Department of Health's Patient Safety Research Programme, which is charged with responding to the research needs of the NHS through its commissioning programme.

Examples of our research work to date, either in-house or collaboratively, include: the commencement of a programme on best practice in communicating with patients who have been harmed as a result of patient safety incidents; identifying and reducing errors in the operating theatre; reducing prescribing errors in primary care; reducing medication errors in nursing homes; and understanding paediatric medication errors.

We have formed national and international links with research institutes and funding bodies. This includes the cross-council Medical Research Council/Economic and Social Research Council/ Engineering and Physical Science Research Council patient safety networks (set up in September 2003), the Agency for Health Care Research and Quality (AHRQ) in the USA, and the journal *Quality and Safety in Health Care*.

To support our research activities we have developed a Research and Development Strategy. We have developed the strategy with the aim of promoting R&D to inform our work and support the pursuit of patient safety within the NHS.

In developing the strategy we sought the views of other government agencies, professional bodies, patients and the public, academics working in the field of patient safety and non-healthcare industries, healthcare professionals and medical equipment manufacturers.

International learning

In the past year we have been working towards becoming a World Health Organisation (WHO) Collaborating Centre for patient safety. Gaining Collaborating Centre status in patient safety will offer enormous benefits to the NHS. Not least of these will be the expansion in our ability to influence both the international and domestic patient safety agenda.

We continue to work towards Collaborating Centre status and will progress our application in 2004-05.

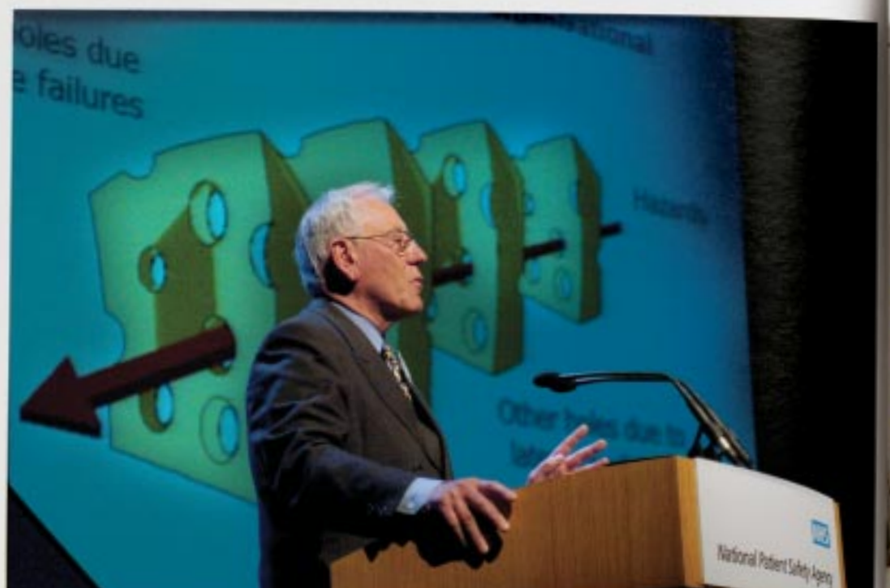
In May 2002 the World Health Alliance (WHA) passed a resolution that urged countries to pay the greatest possible attention to patient safety and requested the Director of WHO to carry out actions including: the development of global norms and standards; the promotion of evidence-based policies and mechanisms to recognise excellence in patient safety internationally; the encouragement of research on the subject; and to give assistance to countries in several key areas.

In November 2003 an international meeting took place at our head office in London on the theme of patient safety, during which England's Chief Medical Officer, Professor Sir Liam Donaldson, proposed that an International Alliance for Patient Safety be established. This will be formally launched in Washington on 27 October 2004. The International Alliance will be of fundamental importance in promoting the development of patient safety policy and practice in all member states of the WHO.

We are also working internationally with the Institute of Medicine (data standards committee), National Patient Safety Network (USA) and the WHO patient safety taxonomy group.

We continue to engage and build relationships with healthcare organisations around the world to share patient safety learning. We have participated in discussions and events with countries including Australia, China, Denmark, France, Germany, Holland, Thailand and the US.

Engaging and building relationships with healthcare organisations around the world.



Our organisation

We must ensure that the culture we promote in the NHS is reflected in our own staff and practices, and that the frontline work we undertake is supported by an effective infrastructure.

Our aim is to build the NPSA into an authoritative and influential organisation in the field of patient safety. We will do this by recruiting the highest quality staff and ensuring that they work in an environment that allows them to operate effectively. In the last year we have made good progress in addressing the NHS human resources agenda, including accreditation for *Two Ticks,* which acknowledges our commitments to both employing and retaining people with disabilities, and we are working towards accreditation for *Improving Working Lives, Achieving a Balance* and *A Positively Diverse Workforce.*

To progress this aim we have undertaken a detailed review of our staffing structure, roles and ways of working. This is also due in part to ensuring that the NPSA remains 'fit for purpose' as well as a need to respond to other changes in the environment within which we operate.

We continue to ensure that equality and diversity has a high profile in the NPSA and that we comply with the Race Relations Act. We have made good progress towards achieving the agreed action plan for the Race Equality Scheme. Analysis shows that in our employment of people from ethnic communities, we compare favourably with national census data for England and Wales on ethnic groups. Ethnic data is also collected and reviewed as part of our recruitment process.

We have a duty to communicate our activity effectively because our work needs to be known about and understood in order for it to be acted upon. Our communications strategy has now been agreed and details how we plan to engage with the full spectrum of our audiences. These cover: patients and the public; the NHS (including local stakeholders); senior management and NHS staff; and national policy and opinion formers, including the Department of Health, Welsh Assembly Government, NHS agencies (e.g. Healthcare Commission and the Modernisation Agency), the Royal Colleges and NHS Confederation.

Information Technology and Management (IT&M) and Knowledge Information Management are also key to our successful infrastructure. Major projects, in addition to the significant NRLS related work detailed on page 8, have included: development of a resilient internal system and network infrastructure with secure broadband remote access; design activity for our contact management system; compliance with NHS Information Authority (NHSIA) security guidelines and technical engagement with the National Programme for IT (NPfIT); design for our web and intranet sites; and work on our Freedom of Information (FOI) publication schedule and action plan.

In the last year we have also appointed our first design manager. His role is to assist in the design of solutions and work on practical measures to enhance patient safety.

Organisation structure

The following is the NPSA's organisation structure as at 1 September 2004

Joint Chief Executive Sue Osborn Susan Williams	
Director for Patient and Public Involvement Peter Mansell	Establishing, leading and developing networks and processes for ensuring our work reflects the perspective and experiences of patients, carers and the general public
Medical Director * John Lilleyman	Safer Practice Solutions to promote safer practice Clinical specialty advice Working with Royal Colleges and other professional bodies
Director of Safer Practice Helen Glenister	
Director of Epidemiology and Research ** Richard Thomson	Observatory Prioritisation Statistics Research and Development
Director of National Programmes Susan Burnett	Planning Policy & Partnership NRLS IT NHS Affairs
Director of Communications Jenny Grey	Marketing Web Strategy Strategic Communications Media & Parliamentary affairs
Director of Finance and Facilities * Noel Plumridge	Finance Facilities
Organisational Development Advisor Sandra Meadows	Human Resources Organisational Development

*From 1 April 2004 **From 1 February 2004

Please note that Helen Hughes was Director of Operations until 31 March 2004

Chair

Professor Rory Shaw
(until 31 December 2003)

Lord Philip Hunt
(from 1 January 2004)

Non-Executive Directors

Dr Anthony Butler

Mr Jeremy Butler
(end of term 30 June 2004
extended to 30 June 2005)

Mr Laurence Goldberg
(end of term 30 June 2004
extended to 30 June 2005)

Ms Dianne Hayter
(until 30 January 2004)

Ms Sue Leggate
(until 30 January 2004)

Dr Eve Miller
(until 26 March 2004)

Prof Tricia Murphy-Black
(until 30 June 2003)

Dr Umesh Prabhu
(until 30 June 2003)

Mr Andrew Probert

Mr Arnold Simanowitz
(end of term 30 June 2004
extended to 30 June 2005)

Dr Gilbert Smith

Dr Susan Whalley-Lloyd
(until 30 June 2003)

Appointment of board members

The NPSA board members were appointed in line with the following:

Directions to the
NPSA – NHS Act 1977;

Statutory instrument 2001 No. 1742;

Statutory instrument 2001 No. 1743.

Please note that although the Statutory Instrument states that between 8-11 non-executive board members should be appointed to the NPSA, the Secretary of State decided that there should be a moratorium on all non-executive appointments pending the outcome of the Arm's Length Bodies review published in July 2004. Organisations were advised, via the Department of Health, that they should only fill vacancies if they ceased to be quorate. The NPSA's Standing Orders state that the NPSA can manage business with a minimum of three of the remaining six non-executive directors present. The NHS Appointments Commission then extended the terms of three existing non-executive directors due to end their terms on 30 June 2004, to ensure that the NPSA remained quorate during this period.

In addition to the chair and non-executive directors, the composition of the NPSA board as at 31 March 2004 was:

Executive Directors

Sue Osborn and Susan Williams
Joint Chief Executives

Helen Hughes
Director of Operations

Dr Helen Glenister
Director of Safety Solutions

Professor Richard Thomson
Director of Research and Epidemiology

Management team

Susan Burnett
Director of Interagency Working

Jenny Grey
Director of Communications

Peter Mansell
Director of Patient Experience and Public Involvement

Gay Kennedy
Secretary to the board also in attendance.

Please note: Director of Operations (Finance) Helen Hughes left on 31 March 2004; Professor Richard Thomson has been Director of Research and Epidemiology since 1 February 2004, Noel Plumridge has been Director of Finance and Facilities since 1 April 2004; Susan Burnett has been Director of National Programmes since 1 April 2004, and Medical Director Professor Sir John Lilleyman joined on 1 April 2004.

Remuneration

The Chair and Non-Executive board members were remunerated in line with Department of Health guidance that applies to all NHS bodies. They were appointed before the inaugural meeting of the NPSA board in October 2001 and therefore before the Pay and Remuneration Committee was established. Full details of senior managers' renumeration are given on page 35.

Statutory committees

There are two statutory committees of the NPSA board:

Audit committee

Anthony Butler (Chair),
Andrew Probert, Dianne Hayter
(until 30 January 2004),
replaced by Gilbert Smith.

Pay and remuneration committee

Prof Rory Shaw (Chair until 31 December 2003) replaced by Lord Philip Hunt, Arnold Simanowitz, Sue Leggate (until 30 January 2004) replaced by Anthony Butler.

Register of interests

In line with other NHS organisations, the NPSA holds a register of interests with information provided by board members and other NPSA staff. A statement to the effect that 'all board members should declare interests which are relevant and material to the NHS board of which they are a member' is contained in the NPSA board agenda and members are expected to declare any interest on any agenda item before discussion commences.

Biographies

Chair and non-executive directors' biographies

Lord Philip Hunt OBE, Chair

Philip Hunt is a member of the House of Lords and chairs the Select Committee on the Merits of Statutory Instruments. He was a member of the Government for five years from 1998-2003, serving four years as a health minister and one year as a whip. He was the first Chief Executive of the NHS Confederation, and previously director of the National Association of Health Authorities and Trusts (NAHAT) from its formation in 1990. He was President of the Family Planning Association 1997-98. He was co-chair of the Association for Public Health from 1994-98. From 1980-82 he was a member of Birmingham City Council and a member of Oxford City Council from 1973-79. He also served as a member of Council of the International Hospital Federation from 1986-91.

Professor Rory Shaw, Chair (July 2001- January 2004)

Professor Rory Shaw is the Medical Director of the Hammersmith Hospitals Trust, comprising Hammersmith, Queen Charlotte's and Charing Cross hospitals. Professor Shaw has a particular interest in clinical governance and how IT can support the implementation of clinical governance. Professor Shaw graduated from St Bartholomew's Hospital Medical School in 1977. He undertook postgraduate training at the Brompton and St George's Hospitals. He obtained an MD following a period as Wellcome Research Fellow in the Department of Allergy and Clinical Immunology at the Brompton. He was a Senior Registrar in Respiratory Medicine at St Mary's Hospital and an MRC and Royal College of Physicians travelling fellow at the National Jewish Centre for Immunology and Respiratory Medicine in Denver, Colorado. Following his return as a senior lecturer and consultant in respiratory medicine at St Mary's, he undertook a part time executive MBA at the Imperial College Management School. He has subsequently played an important role in the development of undergraduate medical education within the new Imperial College Faculty of Medicine as Director of Clinical Studies and Director of the Medical Education Unit.

Mr Jeremy Butler Non-Executive Director

Jeremy Butler is a former pilot with 38 years commercial and military experience. He was a general manager at British Airways, responsible for flight crew training and the audit and appraisal of operational standards in the airline. He specialised in the interactions between individuals and teams within complex technological systems in a safety critical enviroment. He is a past Chair of the International Air Transport Association Human Factors Group and Chair of the Royal Aeronautical Society Human Factors Group. He consults on aviation flight operations and he is a Non-Executive Director of Berkshire Healthcare NHS Trust and has substantial involvement with the NHS as a carer.

Dr Anthony Butler Non-Executive Director

Until 2001, Dr Butler was Deputy Director of the Advertising Standards Authority and Secretary of the Committee of Advertising Practice. He has considerable expertise of financial, performance and change management, evolving strategy through corporate planning and business re-engineering, including identifying and implementing IT systems which improve efficiency and effectiveness. He was responsible for developing and managing internal communications and external media policy for both Her Majesty's Inspectorate of Pollution (HMIP) and the Crown Prosecution Service (CPS). From his time as Project Manager for the Privatisation of the Water Industry, he understands the pressures relating to delivering objectives and targets to time and within budget. He is currently also a lay observer for the Preliminary Investigation Committee for the Royal College of Veterinary Surgeons.

Mr Laurence Goldberg Non-Executive Director

Laurence Goldberg is a former NHS hospital pharmacist now working as a consultant to the pharmaceutical industry. He has been interested in medication errors for many years and is currently working in the area of medication error reduction, including liaison with the Institute of Safe Medication Practice in the USA. He has a particular interest in design solutions and automated systems that will help to reduce medication errors.

Ms Dianne Hayter Non-Executive Director

Dianne Hayter is a member of the Board of the National Consumer Council, on the Consumer Panel of the Financial Services Authority and a member of the Dr Foster's Ethics Committee. She is also a research student at Queen Mary College, University of London. She has previously been: Chief Executive of the Pelican Centre (a national cancer charity), Director of Corporate Affairs at the Wellcome Trust, Chief Executive of the European Parliamentary Labour Party, Director of Alcohol Concern, General Secretary of the Fabian Society, a journalist and a trade union research officer. She was for many years a JP in inner London, was a member of the Royal Commission on Criminal Procedure and the first Vice-Chair of the Association of Chief Executives of National Voluntary Organisations. She is currently a member of Labour's National Executive Committee.

Ms Sue Leggate
Non-Executive Director

Sue Leggate is a consumer advocate and consultant with 30 years experience of dealing with consumer policy and research. She was, until 1995, Editor of *Which?* magazine, and Editorial Director of the Consumer's Association. She has since served as a Non-Executive Director of North Essex Health Authority, and as the Chair of Epping Forest Primary Care Trust – one of only 16 first wave PCTs in England. She has served as a lay member of the General Medical Council, where among other activities, she chaired the Patient Reference Group. She is currently a Council Member of the Consumer's Association and a member of the Council for the Regulation of Health Professionals.

Dr Diana (Eve) Miller
Non-Executive Director

Dr Miller is Senior Adviser in Professional Performance at Avon, Gloucestershire and Wiltshire Strategic Health Authority, and medical advisor and member of the risk management team at Capsticks solicitors with a particular interest in developing practical solutions for system failures in clinical practice. Dr Miller is also a member of the professional conduct and performance committees of the General Medical Council and a past medical adviser to the Health Ombudsman. She was a consultant anaesthetist at Victoria Hospital, Swindon until March 2004.

Professor Tricia Murphy-Black
Non-Executive Director
(until 30 June 2003)

As Professor of Midwifery, she is involved in research and the education of midwives and nurses. Previous experience includes: varied clinical posts in nursing and midwifery in the NHS (1965-1982); research experience in both NHS and higher education (1977-1995); elected and appointed to membership of the National Board of Nursing, Midwifery and Health Visiting for Scotland and its committees (1983-1995); and commissioner of research in the same organisation (1995-97) prior to her appointment as the first midwife Professor of Midwifery in Scotland at the University of Stirling.

Dr P Umesh Prabhu
Non-Executive Director

Dr Prabhu graduated in India in 1972 and trained in paediatrics in India, Edinburgh, Oxford and Leeds. In 1992 he was appointed as Consultant Paediatrician and became the Lead Clinician in 1993. In 1998 he was appointed the Medical Director of Bury NHS Trust. He was the Medical Director until Bury, Rochdale, North Manchester and Oldham merged in 2003, creating Pennine Acute Hospitals Trust. As the MD he conducted an audit of medico-legal cases, complaints and incidence reporting. Dr Prabhu strongly believes protecting patients and supporting doctors are two sides of the same coin. He joined the NPSA as a non-executive member in August 2001. In July 2003 he was appointed as a National Clinical Assessment Authority (NCAA) advisor.

Mr Andrew Probert
Non-Executive Director

Andrew Probert is Senior Policy Advisor on local governance at the Countryside Agency. A specialist in marketing and advertising, he was previously at the Judge Institute at Cambridge University researching transport quality, and lectured in marketing communications. He advises senior MPs on transport, planning, local government and education policy, and is developing the use of social marketing within health policy. Disabled by polio and asthma as a child, he helps bring the patients' viewpoint to the NPSA. An advocate of participation in sport, he coxed Cambridge in the Boat Race and for Great Britain at the World Rowing Championships.

Mr Arnold Simanowitz OBE
Non-Executive Director

Formerly a practising solicitor, Arnold Simanowitz was a founding member of the charity Action for Victims of Medical Accidents and was its Chief Officer for 20 years until December 2002. He was a member of the Chief Medical Officer's Working Party on clinical negligence reform which led to the publication of the report *Making Amends*. He is a Commissioner on the Commission for Patient and Public Safety in Health and co-opted member of the Professional Conduct Committee of the General Medical Council. He is a founder member of the Clinical Disputes Forum as well as on the editorial board of Clinical Risk. He is also a trained mediator. In 2001 Mr Simanowitz received an OBE for services to victims of medical accidents.

Dr Gilbert Smith
Non-Executive Director

Dr Gilbert Smith is a writer and former Deputy Director of Research and Development at the Department of Health, chairman of a health authority and university vice-chancellor. He is currently Vice-Chair of the theatre company Northern Stage. He has wide experience of working at board level.

Dr Susan Whalley-Lloyd
Non-Executive Director

Dr Whalley-Lloyd has been an ergonomist and human reliability consultant for over 20 years. She has been the managing director of her own company for over five years. She previously worked in senior management positions working on the development of systems to reduce human error in a number of high risk industries.

Investing in patient safety

Statutory background

The accounts for the year ended 31 March 2004 have been prepared in accordance with the direction given by the Secretary of State in accordance with section 98(1C) of the NHS Act 1977 and in a format as instructed by the Department of Health with the approval of H M Treasury.

The National Patient Safety Agency (NPSA) was set up in July 2001 by the NPSA 2001 regulations. The statutory duties of the NPSA are set out in these regulations and include/refer to the requirement to remain within revenue and capital resource limits (as appropriate). The accounts have been audited by the Comptroller and Auditor General in accordance with the National Health Service Act 1977.

Annual accountability review 2003-04

The Agency presented its year end progress report for 2003-04 to Lord Warner, Parliamentary Under Secretary of State for Health on 23 March 2004 which demonstrated that its agreed business plan targets had been achieved and that the organisation had remained within budget. The Business Plan targets are in the Annual Accountability Review, available on the NPSA website.

During the year, the NPSA worked well in underpinning the NHS patient safety agenda, particularly in driving forward the very complex programme of work in developing and launching the National Reporting and Learning System (NRLS) for patient safety incidents.

The Agency has also been developing over twenty patient safety solutions. These address specific types of avoidable errors.

Having spent the past year implementing the architecture for patient safety, the NPSA's business plan for 2004-05 will focus on how the Agency will prioritise, deliver and demonstrate the impact of its work in terms of safer care for NHS patients. It will include the following targets:

> prioritise and deliver at least four patient safety solutions to the NHS including the delivery of the NPSA's clean**your**hands campaign to help reduce the risks of healthcare associated infection; and work to reduce wrong site surgery;

> contribute to the two remaining national priority areas identified for action by 2005 in the Chief Medical Officer's report, *An organisation with a memory*;

> ensure that mechanisms are in place to assess the impact of each of the Agency's solutions to demonstrate how each has improved patient safety; and

> ensure that the NPSA, in liaison with the NHS Purchasing and Supply Agency (NHS PASA, works to deliver more effective purchasing as a means of improving patient safety.

Arm's Length Bodies Review

As a Special Health Authority, the National Patient Safety Agency is classed as an Arm's Length Body. In October 2003, the Secretary of State announced his intention to review the Department of Health's Arm's Length Bodies. On 20 May 2004, the Secretary of State for Health outlined the first stage of this review.

There are 42 separate Arm's Length Bodies which employ 22,000 staff with a combined budget of £2.5bn. The Secretary of State announced that by 2007-08 there will be a 50% reduction in the number of Arm's Length Bodies reducing total expenditure by £0.5bn and staff posts by 25%.

The Secretary of State recently outlined the findings of the Arm's Length Body review. The National Clinical Assessment Authority will be brought into the National Patient Safety Agency. The Agency will also support the independent ethical review of all research that could affect patients. It will also take on from NHS Estates overseeing of cleaning, the Better Hospital Food Programme and work on hospital design impacting on patient safety and well being. No timescale has yet been announced for these changes.

Financial results for the year

The NPSA undershot its revised revenue resource limit of £16.850 million and its capital resource limit of £0.400 million with total expenditure of £16.840 million and £0.396 million respectively.

Better Payment Practice Code

The NPSA is required to pay its non-NHS trade creditors in accordance with the Better Payment Practice Code. The target is to pay non-NHS trade creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier. Of total relevant bills, 89% of bills, representing 87% by value, were paid within the target.

Joint Chief Executive
and Accounting Officer

23 September 2004

Statement of the Joint Chief Executive's responsibilities as the Accounting Officer of the National Patient Safety Agency

The Secretary of State has directed that the Joint Chief Executives should be the Accounting Officer to the National Patient Safety Agency. The relevant responsibilities of Accounting Officers are set out in the Accounting Officer Memorandum issued by the Department of Health. These include ensuring that:

> there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;

> value for money is achieved from the resources available to the authority;

> the expenditure and income of the authority has been applied to the purposes intended by Parliament and conform to the authorities which govern them;

> effective and sound financial management systems are in place; and

> annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

To the best of our knowledge and belief, we have properly discharged the responsibilities set out in our letter of appointment as Accounting Officer.

Joint Chief Executive
and Accounting Officer

23 September 2004

Supplementary information

The summary financial statements are merely a summary of the information contained in the full accounts of the Special Health Authority. The Audit Report on the full accounts was unqualified. A full set of the Annual Accounts for the NPSA for 2003-04 is obtainable from:

Technical Accountant
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

Telephone 020 7927 9567
Fax 020 7927 9501
email collette.bent@npsa.nhs.uk

Statement on Internal Control 2003-04

National Patient Safety Agency

1 Scope of responsibility

As Joint Accounting Officer, and Joint Chief Executives, we have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. We also have responsibility for safeguarding the public funds and the organisation's assets for which we are personally responsible as set out in the Accounting Officer Memorandum.

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

> identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives

> evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the National Patient Safety Agency for the year ended 31 March 2004 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

The NPSA has a risk management organisation whereby the responsibility for risk management and the ownership of risks and their controls lie with ourselves, the directors and the line management. To support those responsible for assessing and managing risks, the NPSA has provided training through its Management Development Programme and separate risk management training sessions. In addition, the organisation has risk management expertise available for all members of staff to consult.

The Agency has established a robust approach to handling risk which is overseen by directors and the Management Team.

The Director of Finance & Facilities is the designated executive with overall responsibility for implementing an Agency-wide system of internal controls encompassing governance, financial management and risk management and for reporting to the Board.

The Management Team, led by ourselves, reviews and monitors progress with action plans, assists with the development and implementation of treatment plans, and provides a resource group for directorate/teams to raise local risk management issues that are, or are proving, difficult to resolve.

The Assistant Director – Business Planning is the designated senior manager lead for the Controls Assurance programme, and is responsible for ensuring the establishment and maintenance of the Agency's risk management system.

Risk management is part of all staff induction.

The Board continues to take an active role in risk management, receiving reports at Board meetings, reviewing the Board Assurance Framework and annually reviewing its risk management policy and strategy.

4 The risk and control framework

It is clearly recognised by the NPSA that the Board has overall responsibility for risk management and that there needs to be clear lines of individual accountability for managing risk throughout the organisation, leading up to the Board. The Board has nominated the Director of Operations as the Responsible Officer for Risk Management. With effect from 1 April 2004, it has confirmed that the responsible officer is the Director of Finance and Facilities.

The Audit Committee is the Board's sub committee that overviews risk and ensures that the systems are in place to ensure effective risk management. The Board retains responsibility for risk management and governance. The flow of information to the Audit Committee and the Board needs to be sufficient to ensure that they are confident that risks are being identified, assessed and managed appropriately.

The key elements of the risk management strategy are:

> On an annual basis the NPSA will identify and evaluate financial and non-financial risks that may threaten the achievement of its strategic objectives, and any gaps in the mechanisms for control and assurance of those risks.

> The management and development of the Board Assurance Framework which are monitored by the Management Team and Board.

- Compliance with the Controls Assurance Standards applicable to the NPSA, with particular emphasis upon the core Standards (Governance, Financial Management, and Risk Management).
- The management and development of Directorate Risk Registers which are monitored by directors and the Management Team Management Committee and will serve to populate and update directorate risk management action plans.
- The increasing integration of risk management into the overall NPSA planning and performance management activities.
- The NPSA continues to develop training programmes for new and existing staff to help raise awareness of risk management, and train staff to fulfil their specific responsibilities in a manner which minimises risk.
- A risk management policy is established and is routinely reviewed. This policy identifies the processes of identifying risks, maintaining progress and monitoring the assurance framework, directorate risk registers and plans.
- The NPSA actively communicates its risk management policy and strategy to staff. This includes staff induction and briefings at staff meetings and publication on the NPSA's intranet site.
- The public and stakeholders are aware of the NPSA. The NPSA has a public and patient engagement strategy which includes the active participation of patients in developing safety solutions for the NHS and as such the patients and public assist us in ensuring that solutions delivered to the NHS have patient safety risks appropriately minimised.

5 Review of effectiveness

As Joint Accounting Officer, we have responsibility for reviewing the effectiveness of the system of internal control. Our review is informed in a number of ways. The head of internal audit provides us with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide us with assurance. The Assurance Framework itself provides us with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. Our review is also informed by the comments made by the National Patient Safety Agency's internal and external auditors and risk management advisors.

We have been advised on the implications of the result of our review of the effectiveness of the system of internal control by the Audit Committee and Board. A plan to address weaknesses and ensure continuous improvement of the system is in place.

As outlined above, the Audit Committee and Board review the effectiveness of the system of internal control.

As planned in 2003/04, the organisation has further developed the following actions from 2002/03:

- The organisation has undertaken a self assessment exercise against the core Controls Assurance standards (Governance, Financial Management and Risk Management). An action plan has been developed and is being implemented to bridge any gaps.
- The organisation has in place arrangements to monitor, as part of its risk identification and management processes, compliance with other key standards, including relevant Controls Assurance standards covering areas of potentially significant organisational risk.
- Risk management consultants have been commissioned to assist with the development of risk management arrangements both within the Agency and as part of its wider remit relating to patient safety.

In addition in 2003/04, the organisation has ensured:

- The identification of key controls in place to manage each of the principal risks and the assurance that the Audit Committee and Board receives on each in order to complete the Assurance Framework.
- Development of an action plan to address gaps in controls and gaps in assurance, and the following-through of these actions.
- Formalisation of the reporting process to the Board to ensure that risk and assurance are reviewed on a regular basis and that the action plan is being implemented.
- The risk management policy and strategy has been further developed. Supporting guidance and training has been developed to assist directors, designated risk co-ordinators and all staff in risk identification, assessment, control and assurance.

In 2004/05 it is planned to optimise further our risk management processes.

Joint Chief Executive
and Accounting Officer

14 July 2004

Operating cost statement
for the year ended 31 March 2004

Continuing operations	2003-04 £000	2002-03 £000
Programme costs	17,142	11,666
Operating income	(302)	(20)
Net operating cost	16,840	11,646
Net resource outturn	16,840	11,646

The National Patient Safety Agency's external auditor is the Comptroller and Auditor Gerneral.
The cost of the audit for 2003-04 was £29,000.
No work was undertaken outside the scope of the statutory audit.

Statement of recognised gains and losses
for the year ended 31 March 2004

There were no recognised gains or losses in the financial year 2003-04 (2002-03 £nil)

Cash flow statement
for the year ended 31 March 2004

	2003-04 £000	2002-03 £000
Net cash (outflow) from operating activities	(16,623)	(11,834)
Capital expenditure and financial investment:		
(Payments) to acquire intangible fixed assets	(237)	(55)
(Payments) to acquire tangible fixed assets	(197)	(299)
Net cash (outflow) from investing activities	(434)	(354)
Net cash (outflow) before financing	(17,057)	(12,188)
Financing		
Net Parliamentary funding	17,000	12,000
(Decrease) in cash in the period	(57)	(188)

Balance sheet
as at 31 March 2004

	31 03 2004 £000	31 03 2003 £000
Fixed assets:		
Intangible assets	**252**	64
Tangible assets	**426**	314
	678	378
Current assets		
Stocks	**13**	7
Debtors	**1,199**	1,338
Cash at bank and in hand	**0**	57
	1,212	1,402
Creditors: amounts falling due within one year	**(1,413)**	(1,469)
Net current assets/(liabilities)	**(201)**	(67)
Total assets less current liabilities	**477**	311
Creditors: amounts falling due after more than one year	**0**	0
	477	311
Taxpayers' equity		
General Fund	**477**	311
	477	311

Joint Chief Executive and Accounting Officer

23 September 2004

Reconciliation of net operating cost to net resource outturn and revenue resource limit

	2003-04 £000	2002-03 £000
Net operating cost	**16,840**	11,646
Net resource outturn	**16,840**	11,646
Revenue resource limit	**16,850**	12,100
Underspend against revenue resource limit	**10**	454

Salary and pension entitlements
of senior managers 2003-04

Name	Position held	Age years	Salary in £5k bands £000	Real increase in pension at age 60 in £2.5k bands £000	Total accrued pension at age 60 at 31/03/04 in £5k bands £000	Benefits in kind (rounded to the nearest £00) £00
R Shaw	Chair *01/04/03 - 31/12/03 **	50	20-25	N/A	N/A	0
Lord P Hunt	Chair *01/01/04 - 31/03/04	54	10-15	N/A	N/A	0
A D Butler	Non-Executive Director	58	5-10	N/A	N/A	0
A J Butler	Non-Executive Director	66	5-10	N/A	N/A	1
L Goldberg	Non-Executive Director	60	5-10	N/A	N/A	1
D Hayter	Non-Executive Director *01/04/03 - 30/01/04	54	0-5	N/A	N/A	0
S R Leggate	Non-Executive Director *01/04/03 - 30/01/04	57	0-5	N/A	N/A	0
DE Miller	Non-Executive Director	60	5-10	N/A	N/A	2
T Murphy-Black	Non-Executive Director *01/04/03 - 30/06/03	58	0-5	N/A	N/A	0
P Prabhu	Non-Executive Director *01/04/03 - 30/06/03	48	0-5	N/A	N/A	0
A W Probert	Non-Executive Director	50	5-10	N/A	N/A	0
A Simanowitz	Non-Executive Director	65	5-10	N/A	N/A	0
G Smith	Non-Executive Director	59	5-10	N/A	N/A	1
S Whalley-Lloyd	Non-Executive Director *01/04/03 - 30/06/03	42	0-5	N/A	N/A	0
S Osborn	Joint Chief Executive	51	85-90	7.5-10	20-25	8
S Williams	Joint Chief Executive	51	85-90	5-7.5	15-20	1
H Hughes	Executive Director of Operations	44	95-100	0-2.5	25-30	28
S Burnett	Director of Interagency Working	43	90-95	5-7.5	15-20	0
H Glenister	Executive Director of Safety Solutions	44	90-95	2.5-5	15-20	1
J Grey	Director of Communications	32	80-85	0-2.5	0-5	0
P Mansell	Director of Patient Experience & Public Involvement	46	90-95	0-2.5	0-5	2
R Thomson	Executive Director of Epidemiology & Research *02/02/04 - 31/03/04 ***	55	15-20	0	0	0

* Only employed for part of the financial year 2003/04

** The Chairman's entitlement is paid directly to Hammersmith Hospitals NHS Trust

*** The Executive Director of Epidemiology & Research's salary is paid directly to University of Newcastle Upon Tyne

Comptroller and Auditor General's statement to the Houses of Parliament

I have examined the summary financial statement for the National Patient Safety Agency set out on pages 29 to 36 which has been prepared in a form consistent with the full financial statements.

Respective responsibilities of the Chief Executive and Auditors

The summary financial statement is the responsibility of the Chief Executive as Accounting Officer.

My responsibility is to report to you my opinion on its preparation and consistency with the full financial statements and foreword. I also read the other information contained in the Annual Report and consider the implications for my report on the summary financial statement if I become aware of any apparent misstatements or material inconsistencies with the summary financial statement.

Basis of opinion

I conducted my audit having regard to Bulletin 1999/6 *'The auditor's statement on the summary financial statement'* issued by the Auditing Practices Board for use in the United Kingdom.

Opinion

In my opinion the summary financial statement on pages 29 to 36 is consistent with the full financial statements and foreword of the National Patient Safety Agency for the year ended 31 March 2004 and has been properly prepared in a form consistent with the full financial statements.

for Comptroller and Auditor General
24 September 2004

National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Related party transactions

In accordance with Note 19 of the annual accounts the NPSA has disclosed the following significant material related party transactions

Organisation	Payments in year 2003-04 £	Receipts in year 2003-04 £	Debtor at 31 03 04 £	Creditor at 31 03 04 £
B H & S NHS Trust	16,629	0	0	0
Bolton Hospitals NHS Trust	18,051	0	87	4,923
Essex Rivers Healthcare NHS Trust	28,549	200	0	0
Hammersmith Hospital NHS Trust	24,358	87	0	0
Hull & East Yorkshire NHS Trust	35,236	0	0	5,471
Kent & Medway Health Authority	0	27,196	511	0
Langbaurgh PCT	24,950	0	0	0
Leeds Teaching Hospital NHS Trust	25,696	0	0	94
NE London Strategic Health Authority	0	20,000	0	0
NHS Logistics Authority	10,432	0	0	0
NHSU	0	0	10,243	0
Nottingham City Hospital NHS Trust	0	0	0	29,075
Oxford Radcliffe Hospitals	39,844	0	87	7,971
Prescription Pricing Authority	20,110	173	0	0
South Birmingham PCT	25,000	0	87	0
South Downs Health NHS Trust	29,202	0	0	11,699
South West Kent PCT	14,950	0	0	0
The Whittington Hospital NHS Trust	17,899	0	0	(184)
Torbay PCT	19,540	0	0	0
Trent Health Authority	0	0	11,277	0
West London Mental Health NHS Trust	142,954	0	0	7,676
York Health Services NHS Trust	7,045	0	0	18,266

Designed by Crescent Lodge, London.

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