

Our Aims

In 2000, the Chief Medical Officer in England chaired an expert group on learning from adverse events in the NHS. The report it published, *'An Organisation with a Memory'*, highlighted the importance of patient safety and a culture in which people feel comfortable reporting things that go wrong. In 2001, the Department of Health created the National Patient Safety Agency (NPSA) as an NHS special health authority with a remit to improve patient safety and promote a more open and fair culture in which risk is proactively assessed and patient safety is a high priority for everyone.

The NPSA aims to promote patient safety by:

- establishing and managing a national reporting and learning system for incidents that affect patient safety
- assimilating safety-related information from other organisations
- designing solutions that prevent harm
- setting targets and monitoring progress
- promoting research
- advising ministers and others on patient safety issues
- promoting an open and fair culture in the NHS
- developing memoranda of understanding with other key healthcare organisations that have an interest or involvement in patient safety.

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Foreword by the Chairman

Professor Rory Shaw

The NPSA has completed its second year of working towards making patient care in the NHS safer. It has been a successful year and our major activities and achievements are found here. For more detail see our annual accountability review on our website at www.npsa.nhs.uk

As you will read, in the last year we have made considerable progress in establishing the NPSA's role in improving patient safety. This has included developing the National Reporting and Learning System, which is now ready to be launched, and more work to find solutions to patient safety issues.

Our annual report reflects a high level of NPSA staff commitment and I would like to congratulate all staff for their hard work over the past year. I would also like to thank all those who have helped us achieve our targets. This includes many NHS organisations, national bodies, royal colleges, trade unions, patient groups and other healthcare-related organisations. We are also working with colleagues in the international field of patient safety, many of whom share similar

issues, despite the different healthcare systems that they are working in. Our achievements, in many cases, are joint efforts, and we value these partnerships.

Finally, once again I would like to thank the Chief Medical Officer for England, Professor Sir Liam Donaldson; and Chief Medical Officer for Wales, Dr Ruth Hall, for their continuing enthusiasm and support for our work.

I have decided to stand down as Chairman of the NPSA in 2003. It has been an enormous privilege to have had the opportunity to lead the NPSA from its conception to its development as a thriving organisation at the forefront of patient safety internationally as well as in the UK. I look forward to seeing the NPSA build on its success in the years to come.

Professor Rory Shaw
Chairman



Professor Rory Shaw

Introduction by the Joint Chief Executive

Sue Osborn, Susan Williams

The NPSA has made a great deal of progress in its first full year. We have developed the National Reporting and Learning System (NRLS) for incidents that compromise patient safety in the light of the previous year's pilot and during the year we gained HM Treasury approval for the business case for the full system. We have also made significant progress in our work to understand patient safety issues and to develop solution projects. In 2002-2003, we had 25 projects up and running that were either investigating patient safety issues or implementing solutions. These included issuing our first patient safety alert in July 2002.

An important development during the year was the signing of the agreement with the National Assembly for Wales to develop the patient safety agenda in Wales. We have maintained close contact with colleagues in Scotland and Northern Ireland, and we look forward to developing these relationships in the year ahead.

In 2002-03, we made significant progress towards becoming a World Health Organisation Collaborating Centre.

The NRLS will be implemented across the NHS in England and Wales from late 2003. Work is now progressing to ensure that the system, when launched, will be fully supported.

An important part of this has been the appointment of 31 Patient Safety Managers who joined us in September 2003. They will be located across England and Wales and will support the rollout of the NRLS throughout the NHS. They will also be providing training for staff and facilitating the introduction of solutions to patient safety problems.

Not only do we reflect on the last year in this report, we also look forward to important work in the coming year that will make further strides towards safer healthcare for all.

We will miss the consistent support and encouragement of our Chairman Professor Rory Shaw after he leaves the organisation and wish him well with his other commitments.

Thank you to all those who have helped us achieve our targets over the last year.

Sue Osborn and Susan Williams
Joint Chief Executive



Sue Osborn
Susan Williams

National Reporting and Learning System

The National Reporting and Learning System (NRLS) is the first of its kind in the world: a system that collates information on incidents that affect patient safety and then identifies any emerging patterns that may not be apparent at a local level.

Ready for the national launch

In 2001-02, we conducted a pilot of the NRLS that yielded 29,000 reports. This demonstrated that it is possible to collect information electronically on incidents that affect patient safety from the NHS. The learning from the pilot data audit, published in our business plan for 2003-04, helped us to develop the system further. The business plan is on our website at www.npsa.nhs.uk

In January 2003, the Department of Health and HM Treasury granted approval for our business case for the development, testing and implementation of the NRLS. In 2002-03, we tested and refined the system to prepare for its launch across the NHS, and to ensure we have methods in place to provide a sophisticated and accurate analysis of the information that we receive.

The NRLS was tested in 39 NHS organisations across England and Wales in the last quarter of the financial year and this included making sure the reporting form is user-friendly for staff whether they are working in an acute NHS Trust or a primary care organisation.

Towards the end of 2003, we will begin rolling the NRLS out across the whole NHS with the help of the 31 patient safety managers that we are appointing in England and Wales. We will also launch detailed guidance on managing and reporting incidents, developed to support staff in the NHS in their work to improve patient safety, and to promote local best practice.

Making a report

NHS staff will be able to make reports via their local risk management systems, or direct to the NPSA via a web-based e-form. To achieve this, we have been working with all the major commercial local risk management vendors to integrate the NRLS into all existing systems to avoid the need for duplicating reports.

We will encourage those who choose to report directly to the NPSA to tell their local organisations about incidents so that they can be investigated, resolved and any lessons learned.

As a patient-focused organisation, we want to provide patients and the public with the opportunity to report to us. We are considering carefully

how best to receive patient and public reports, while making it clear that we do not investigate individual incidents. See page 12 for more about patient and public involvement.

Maximising reporting

The role of the NPSA is not to investigate individual incidents or to attribute blame: we are interested in the 'how' not the 'who'.

The experience of reporting systems in healthcare and other industries tells us how important it is for the NRLS to be anonymous and confidential if we are to maximise the number of reports and get the national picture that we need. Similar evidence from other systems suggests that people will report if they have confidence in the reporting system and if they see the information being used to improve services. It also shows that people will stop reporting if confidence is broken, for example if someone is identified.

During 2002-03, we started exploring the ethical and legal issues surrounding this and the policies that the NPSA should adopt to build trust in the NRLS and maximise reporting.

The NRLS: creating a clearer picture

South Manchester University Hospitals NHS Trust is one of the 39 NHS organisations that have been working closely with the NPSA to test and develop the NRLS.

The trust has already shown how it is possible to make significant changes in its reporting culture, and then identify and tackle systems issues to improve the quality of care for patients.

The trust installed a fully electronic web-enabled reporting data capture system three years ago, giving all front-line staff access to the system.

Paul Moore, Clinical Governance Manager at the trust, says: "We are hearing about more near misses than before and more incidents. We have trebled the number of reports in the past eight months, but there is still room for improvement. We believe we have made a lot of progress and taken positive moves towards an open incident reporting and learning culture in our trust.

"We have been showing staff that we have a system-based approach to incident investigation and management," says Paul. Although staff have the option of reporting anonymously, the vast majority of reports received have come from named members of staff. "We want to encourage staff to come forward and report adverse events. Our goal is to protect the public, mitigate risk and learn from errors." The system has meant that lessons learned in one environment can be used for the benefit of the whole trust.

The trust's significant increase in reports received since the NRLS was introduced is not an indication that standards have fallen, simply that staff are more willing to make reports. Similar patterns have been seen in other industries when reporting systems are introduced.

Solutions for improving patient safety

Developing solutions for improving patient safety is our prime motivation for capturing information about things that go wrong and those incidents that were prevented from occurring by some form of intervention.

We have been analysing data from the NRLS and from other organisations that collect safety data to find out where we should concentrate our efforts.

During the last year, work focused on the development of our processes for the design of solutions, including how we will risk-assess these solutions to make sure they really are safer than the existing systems. We have now established a process for developing and issuing patient safety alerts, including how we will consult stakeholders before any guidance is issued.

In July 2002, we released our first patient safety alert. It advised on preventing accidental overdose with intravenous potassium solutions; the possible risks associated with concentrated potassium; and the need for additional safety precautions.

An evaluation of the alert shows that it was an effective way of communicating patient safety controls and changing clinical practice. The number of hospitals with formal written safety controls on potassium chloride more

than doubled after the alert. By January 2003, it had prompted a 27 per cent drop in the use of undiluted potassium chloride, which is being replaced with safer formulations. We are already encouraging those organisations that haven't yet changed their practices to do so and are promoting the implementation of our advice.

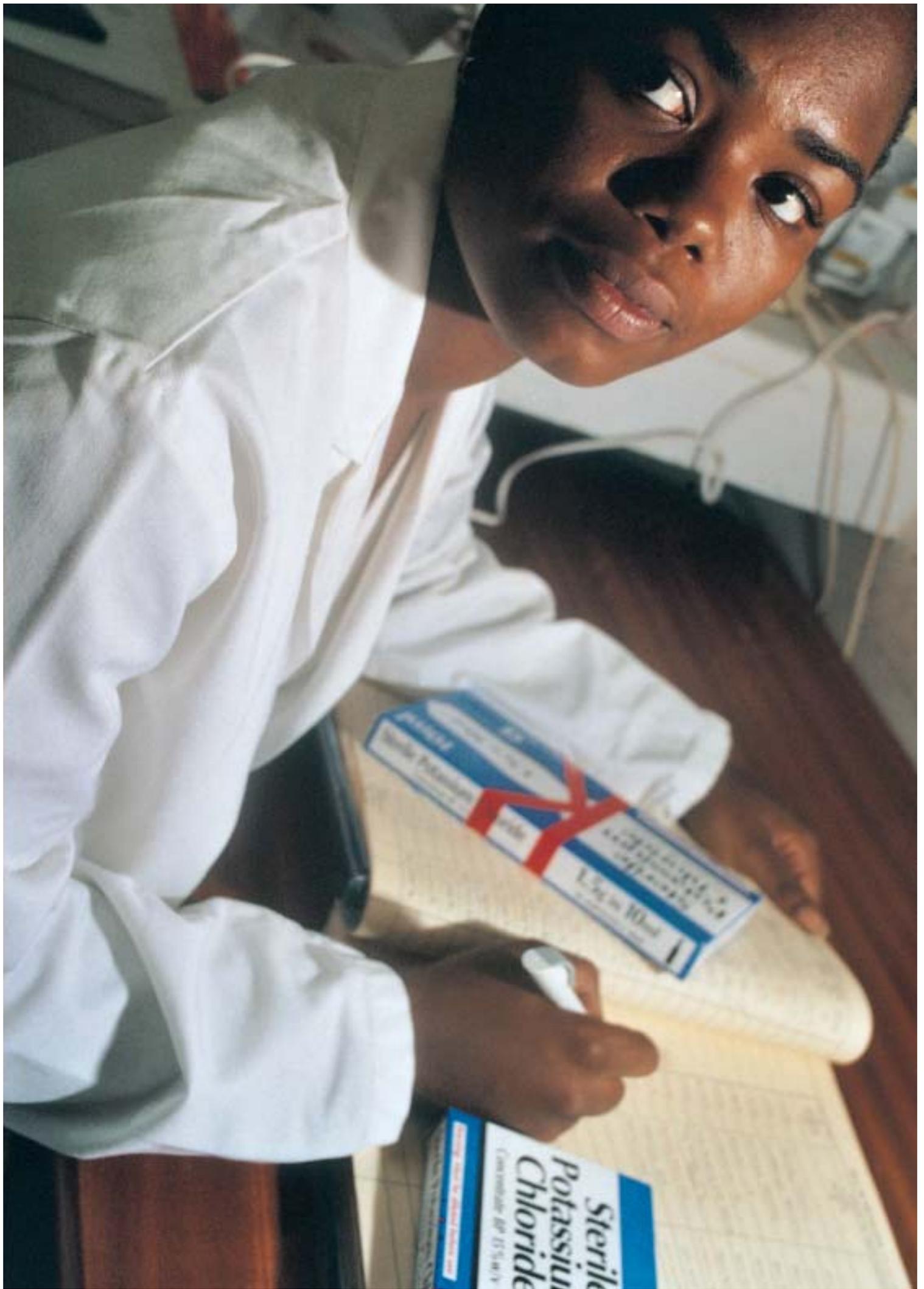
We considerably strengthened our work in 2002-03 through the joint appointments with the Royal Colleges of nine Clinical Speciality Advisors (see appendix two for a full list of the advisors). They began work informing the national agenda for patient safety and responding to requests for advice on potential solutions or areas of concern within their specialties that have come to our attention. We have also started developing a primary care strategy to look at patient safety issues in primary care settings.

In 2002-03, we agreed an internal process for prioritising which problem areas we will investigate for potential solutions and we are planning public

consultation on this during the coming year.

We have identified more than 20 areas of work that we are pursuing in 2003-04. These include the labelling and packaging of medicines, wrong site surgery and the risks associated with the anaesthetics process. Other projects are referred to throughout this report.

Each project encompasses work with patients and other organisations – over 100 to date – from healthcare, industry and the voluntary sector. A full list of projects is in appendix one.



The infusion device project: solution work making a difference

Infusion devices are commonly used to deliver fluids and drugs via a drip into the veins of patients receiving rehydration therapy or chemotherapy treatment. Most infusion treatment is delivered safely. However, we have identified safety problems involving infusion devices from a number of sources including data from the Medicines and Healthcare products Regulatory Agency (MHRA).

In 2002-03, we worked to establish the root causes of problems surrounding infusion device use and to identify possible solutions. We reviewed the global evidence on infusion device user error, looked at best practice already taking place in the NHS, sought feedback from health professionals, interviewed patients and reviewed data from the incidents reported to the NPSA in our pilot study.

We are now working with manufacturers and the NHS Purchasing and Supply Agency (NHS PASA) to improve the way devices are purchased, used, stored and maintained. This has involved the development of a purchasing checklist, a usability evaluation questionnaire, a guide to developing an equipment library, and interactive web-based training.

Chris Quinn, a former charge nurse in intensive care who is leading the NPSA's project, says that as well as improving patient safety, a central equipment library could save NHS organisations money by ensuring more widespread use of the devices available. "If one hospital has 1,000 devices, each costing £1,000, that's £1 million worth of equipment. If half of these are not being used at any time, that's £500,000 potentially wasted."

Colin Hont, a nurse who co-ordinates medical devices at North Cheshire NHS Hospitals Trust, works in one of the six trusts piloting the solutions. He says: "From a nursing point of view, infusion is one of the key areas. If nurses can get competency training and access to standardised equipment, it will give them more confidence in their practice and enable them to deliver better care to patients."

Steve Keay, Medical Equipment Training Officer at Cardiff and Vale NHS Trust, another of the trusts piloting the solutions, says: "Staff are being encouraged to challenge their ways of working, look at the consequences of their actions and the impact infusion devices can have on patients."

We have fed back the results of our work so far to the patients whom we interviewed. One participant responded: "It was amazing to know that guidelines have been drawn up already from our interviews and wonderful to know that people are prepared to work so hard to improve patient care. Thank you for listening and asking."



Open and fair culture

We have been working to support the development of an open and fair culture across the NHS, where risks are assessed proactively and patient safety is a high priority for everyone.

An open and fair culture will encourage the reporting of incidents that affect patient safety. It will also foster the right environment for staff to learn from things that go wrong. We have been promoting this message at NHS events throughout 2002-03.

We have also been listening to the views of a wide range of organisations on this issue. In partnership with the NHS Confederation we held two seminars about an open and fair NHS among NHS organisations, patient groups, staff organisations and regulatory bodies. NHS Confederation Chief Executive, Dr Gill Morgan says: "There is a clear relationship between an open and fair culture and patient safety. Employers must create effective reporting systems and use open and fair methods for investigations to gain the trust of staff and achieve a climate which allows real learning and thus delivers a safer service for patients."

Patient groups have told us they believe that an open and fair culture should encourage NHS staff to be open with patients who have been harmed as a result of accidents and

errors. Peter Walsh, Chief Executive of Action for Victims of Medical Accidents, says: "I'd like to say how much I welcome the creation of the NPSA. My organisation is an independent charity which promotes patient safety and justice for patients when things do go wrong, and the creation of something like the NPSA is something we called for, for years. Now the challenge for the NPSA is to demonstrate results in improving safety."

In 2002-03, we started work on a package of tools to help the NHS create a more open and fair culture. We are introducing staff to the key concepts of patient safety, including open and fair methods of investigation.

Induction to patient safety

We have developed an induction programme on patient safety that aims to ensure all staff are aware of their role, and that of their organisation, in improving patient safety. The main elements are a video and an e-learning programme designed to be incorporated into individual and corporate inductions.

It will be introduced across the NHS in 2003-04.

The Incident Decision Tree

The Incident Decision Tree is a decision-making framework for helping NHS managers deal with staff in a consistent and fair way when they report things that have gone wrong. It has been produced with the help of a range of organisations including the NHS Confederation, National Clinical Assessment Authority (NCAA), trade unions and selected NHS trusts.

It is being piloted and will be introduced across the NHS in 2003-04.

Root cause analysis

We have developed a root cause analysis toolkit and web-based learning programme to introduce across the NHS a consistent approach to investigating incidents that affect patient safety. It looks beyond the staff involved in the incident to the underlying causes and environmental context in which the incident occurred. This will be introduced across the NHS in 2003-04, supported by a training programme.

Root Cause Analysis: finding the underlying causes

As one of the first pilot sites for the NPSA, Barts and The London NHS Trust was invited to send key staff on a training programme covering Root Cause Analysis (RCA) theory and how to apply it in real-life investigations.

Says Judith Chadwick, Head of Clinical Governance: "Before we attended training sessions and implemented the RCA tools, incident investigation within the trust was undertaken without the benefit of any systematic investigatory tools or training in the investigation process; and the quality of the resulting reports varied.

"The use of RCA and the structured approach that it brings has resulted in a more consistent process. It has also encouraged more input from the multi-disciplinary teams involved in the incident and an increased willingness of staff to share learning. Investigating staff are able to identify the gaps in the systems that allowed the incidents to occur and the recommendations and strategies are now more consistently focused on the root causes.

"It has had a hugely positive impact on patient safety. The overall quality of the investigations, reports and resulting strategies to prevent incidents that affect patient safety recurring has improved. This has provided invaluable risk management information for the coroner and inquests as well as the risk management function within the trust.

"The feedback from staff within the trust was also positive and there is an increased willingness to be involved in improving the safety of services. It is, however, important to be aware that all staff involved in undertaking or participating in RCAs do need practical hands-on support from someone proficient in these methodologies to help build their confidence and credibility in RCA. A core team of staff with these skills is needed to build a critical mass of staff who are happy and confident to implement RCA."

Patient and public involvement

We are committed to involving patients and the public in our work and have been exploring the best ways of enabling them to raise issues with us.

We have been finding out patient and public perceptions of the NPSA's role and have identified three main areas to focus on: patients and the public reporting incidents to us, developing solutions and prioritising our work.

In 2002-03 we agreed the principles that underpin our approach. The principles focus on transparency and equity in involving patients and the public. For example, we will give equal weight to professionals and the public and avoid being dominated by any single interest group. We are also mindful that some of our decisions will be unpalatable to some groups and that we must make all reasonable efforts to elicit the views of hard-to-reach groups.

We are committed to including reports of incidents from patients and the public in the National Reporting and Learning System. We have been working with patients and patients' groups to develop our ideas on patient and public reporting. This identified some challenges that we are addressing. Amongst these, are how to be clear that we do not investigate individual cases and have

processes in place to direct people to other appropriate organisations if they wish to make a complaint or have an incident investigated. We are also exploring reporting via third parties such as NHS Direct, Community Health Councils in Wales and the incoming Commission for Healthcare Audit and Inspection (CHAI).

Preparation for public consultation on identifying priorities for developing solutions began with a number of workshops, leading to the publication of an internal report, *'Engaging stakeholders in establishing patient safety solutions in healthcare'*.

We have also developed methodologies to hear the views of a diverse range of people including ethnic minorities, older people, children, those with low levels of literacy, sensory impairment and learning disabilities. This includes developing a partnership with the advocacy charity, Speaking Up, to work with patients and carers to find out the patient safety priorities of people with learning disabilities.



Patients at the heart of the solution

Oral methotrexate is taken in tablet form by thousands of people in the UK, usually for the treatment of moderate to severe rheumatoid arthritis and severe psoriasis. It is a safe and effective medication if taken at the right frequency and in the right dose, and with appropriate monitoring. However, the NPSA has identified 25 patient deaths and 26 cases of serious harm linked to the use of oral methotrexate in a community setting over a 10-year period in England. The problem is also well documented in the United States and Australia.

Detailed analysis by the NPSA has identified key underlying factors including: patients not being sufficiently informed about how the drug should be taken, for example on a weekly and not a daily basis; a lack of clear packaging or eye-catching messages on packaging; and variations in patient monitoring and treatment reviews.

A key strand of our programme was working with 22 charities to get patients' and carers' comments on using the drug. This began with interviewing patients about treatment, availability of information and understanding of the risks associated with oral methotrexate.

The findings have helped us understand patients' issues. For example, they commented on the similarity in appearance of the different dosages of the drug and suggested ways to reduce the risk of error. Oral methotrexate is taken weekly and it was very useful to find out how users manage their lives so that they don't miss a dose or take too much medication.

We were able to take these views into account when we came to developing solutions in July 2003. We held a workshop with patients and clinicians and discussed one of our proposed solutions: a patient-held diary containing key messages about risks, information on side effects, and a record of their dosage and monitoring results.

Patients and healthcare professionals have been supportive of the diary concept. Their comments will be used to refine a prototype that will be used in the project's pilot study.

Amanda, one of the people working with us on the project, lost her father as a result of a medical complication he developed whilst taking oral methotrexate. She says: "The NPSA project to make the prescribing of oral methotrexate safer should have the support of all patients and families who have been adversely affected by treatment with this drug."

Partnerships

Working with other national organisations with an interest or expertise in a particular area of patient safety gives us an invaluable wealth of knowledge and experience.

In 2002-03, we signed agreements to work on joint projects with the National Institute for Clinical Excellence (NICE) and the Medicines and Healthcare products Regulatory Agency (MHRA).

Agreements are being finalised with the General Medical Council (GMC), the National Clinical Assessment Authority (NCAA) and the Royal Pharmaceutical Society of Great Britain.

Working with the devolved administrations

Wales

Following the signing of the agreement with the National Assembly for Wales in May 2002, we have the same functions in Wales as we do in England. In 2002-03, progress was made in building effective relationships with the Welsh Assembly and the NHS in Wales. We also began preparation for a Welsh Language Scheme, and the appointment of an Assistant Director of Patient Safety and three patient safety managers for Wales.

Northern Ireland

A working group, chaired by the Northern Ireland Deputy Chief Medical Officer, Dr Ian Carson, has been established to oversee patients' and users' safety in health and social care.

The group is reviewing existing reporting systems with a view to developing a region-wide strategic approach to monitoring incidents which compromise patient safety. We are continuing to liaise on areas of potential co-operation and sharing any learning from our work.

Scotland

The Scottish Executive Health Department has consulted on its document *'Learning From Experience. How to improve patient safety in Scotland'* which identifies the necessary steps to achieve this. These include proposals to link with the NPSA's work and provide education which will help staff work together to identify problems, learn from them and work on solutions. The consultation's outcomes were broadly in favour of the proposals. The new Scottish body, NHS Quality Improvement, has been asked to develop final proposals in consultation with the NPSA.



Purchasing power to boost safety

Patient safety is clearly linked to purchasing decisions and, given that the NHS is one of the biggest purchasers of healthcare equipment in the world, well-informed decisions are critical.

Continually advancing technology means that those responsible for purchasing in NHS organisations are faced with ever more choices. We are working closely with the NHS Purchasing and Supply Agency (NHS PASA) to ensure that purchasing decisions made at local and national levels address patient safety issues and help NHS staff provide the safest possible care for patients.

Says David Brassington, Purchasing Executive at NHS PASA: "Purchasing the right products and the right equipment is important to patient safety and there is no doubt that purchasing decisions affect the delivery of patient care and clinical practice in the NHS. By working collaboratively with the NPSA we can make a real difference to patient and staff safety in the healthcare environment."

In addition to the infusion devices project (see page 8), NHS PASA is working with the NPSA on the 'clean**your**hands' campaign – an integrated campaign to improve hand hygiene in hospitals. Says David: "The campaign is a natural progression of our own work on hand hygiene. We are delighted to be working jointly with the NPSA on the hand hygiene improvement agenda during 2003. Infection control teams in NHS acute trusts are helping to develop best practice and, in turn, frontline staff are helping us test and develop a range of products and practical measures to improve hand hygiene in healthcare."

International learning

The NPSA is working at the forefront of the international effort to improve patient safety in healthcare systems across the world.

We are committed to sharing our findings for the benefit of patients all over the world and to learning from healthcare organisations in other countries.

We have been working with the American organisation, Veterans' Health Administration, and sharing information on patient safety experience. This includes collaborative work on the experience of patients who fall in hospitals; and how technology is being used in the United States to reduce the risk of mismatching patients with aspects of their care.

We have also been working with the Agency for Healthcare Research and Quality in America on the expert reference panel for their adverse event reporting system integration project.

We have established valuable links with the Australian Patient Safety Foundation and progress has been made in establishing a closer relationship with the Australian Council for Safety and Quality in Health Care.

We have also worked at European level on a project (co-sponsored by the Council of Europe and the World Health Organisation) on medication safety which has led to the adoption of an Expert Consensus Document on Medication Safety.

In November 2002, we began a collaboration with Professor Didier Pittet from the University Hospitals of Geneva – a global authority on hand hygiene improvement – who agreed to join the external reference group for our hand hygiene project.

Collaborating with the World Health Organisation

In 2002-03, the NPSA and the World Health Organisation (WHO) made a commitment towards establishing the NPSA as a WHO Collaborating Centre. This initiative will deliver a joint programme on patient safety and is an outstanding opportunity to create a platform for sharing the best of patient safety innovation and research worldwide.

The agreement sets out how we will work together to promote a culture of reporting and learning from incidents

that affect patient safety and the development of national reporting systems to achieve this, which will lead to the delivery of safer health services.

Mr Orville Adams, WHO Director of Health Service Provisions, says, "WHO greatly welcomes this partnership. It will play a significant role in helping us to implement the 55th World Health Assembly resolution on 'quality of care: patient safety'."

International electronic library of solutions

In 2002-03 the NPSA agreed to support the patient safety domain on the internationally respected QualityHealthCare.org website in order to fulfil its objective to develop an international electronic library of solutions. The domain will be developed in partnership with the British Medical Journal and the Institute of Healthcare Improvement. It offers healthcare professionals a world-class online resource for improving healthcare and patient safety.

Don Berwick, President of the US organisation Institute for Healthcare

“I have long admired the NHS and its commitment to equality. There is no doubt in my mind that this country – and the NPSA in particular – is in the lead on patient safety.”

Don Berwick

President, Institute for Healthcare Improvement

Improvement and founding member of QualityHealthCare.org said at its launch: “We have not seen patient safety tackled with the same scale of ambition, commitment, leadership and investment anywhere else in the world.”

Research and development

We are promoting the benefits of collaborative research, both in the UK and overseas, as a way of maximising findings and advancing patient safety.

Promoting research

We have worked closely with Professor Richard Lilford, Director of the Department of Health’s Patient Safety Research Programme. We have met the main research funding bodies to develop a research agenda.

Developing an R&D strategy

We are developing our research and development strategy with the help of Charles Vincent, Professor of Clinical Safety Research at the Smith and Nephew Foundation of Imperial College in London. A discussion paper has been prepared which will inform the consultation process with our key stakeholders.



Our organisation

Our commitment to creating an open and fair culture in the NHS starts with the way that we look after our own staff.

Permanent offices

In December 2002, the NPSA moved to permanent offices in Maple Street, central London. Our address and contact details are on the back of this annual report.

Looking after our staff

Upon starting at the NPSA, all staff, whether on permanent or temporary contracts, join an induction programme which gives them an overview of the organisation and explains the policies that underpin the way that staff work and interact with each other.

In the past year, we have introduced a code of conduct and policies that set out to staff our position on confidentiality, use of the computer system and our approach to achieving a work/life balance.

The NPSA is committed to the principle that all staff should be given the opportunity to develop their skills. An appraisal and personal development system has been introduced to help staff track their progress.

A staff council has also been established so that staff can all participate in creating a long-term vision for the kind of employer they want the NPSA to be.

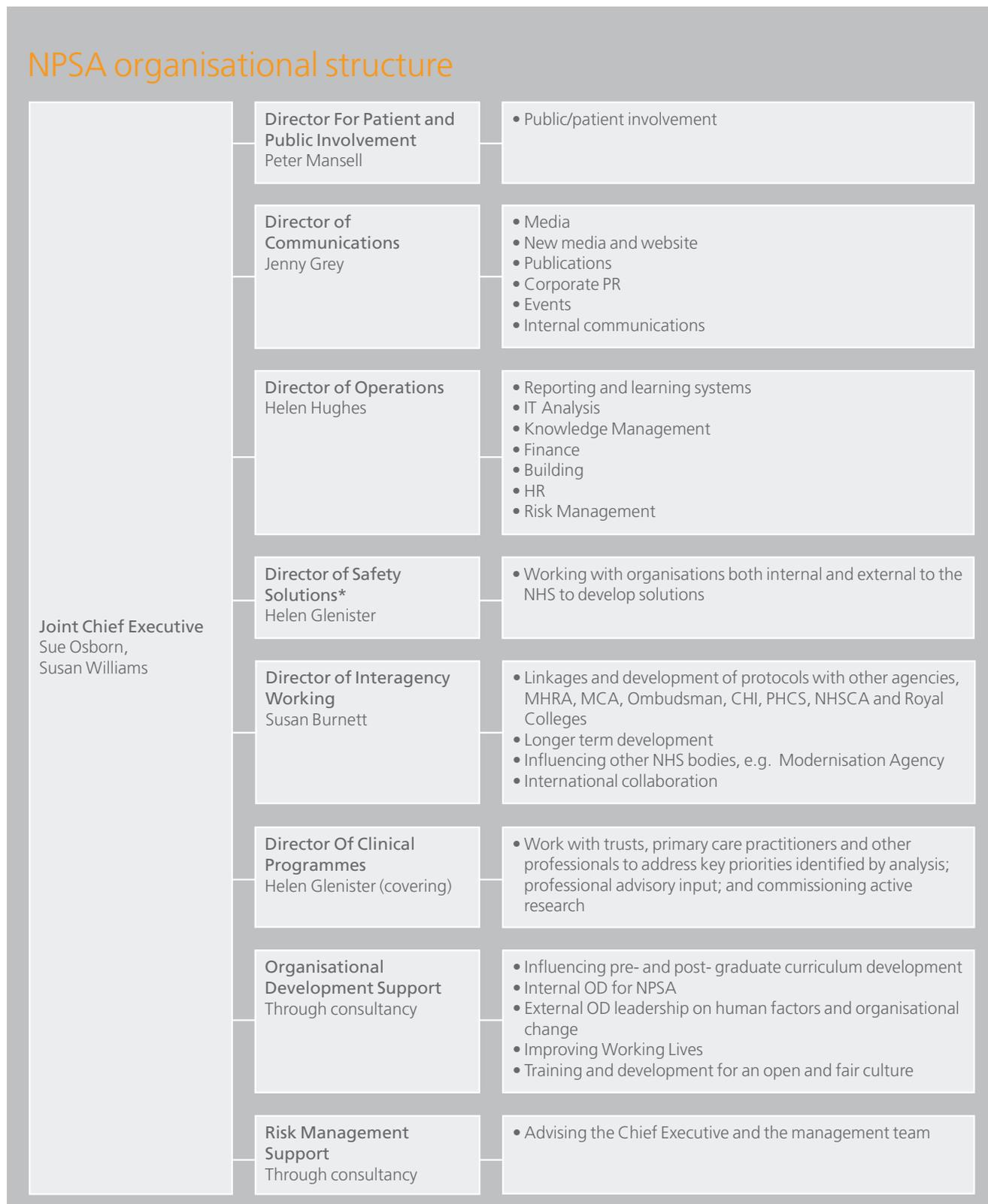
Equality and diversity

The NPSA is an equal opportunities employer and all staff attend a compulsory training day and are actively encouraged to contribute to the promotion of equality and diversity. We have achieved the Employment Service's 'two ticks, positive about disabled people' accreditation.

Good progress has been made in working towards 'Improving Working Lives' and we will be implementing a race equality scheme next year, working in partnership with the Commission for Racial Equality.



NPSA organisational structure



“I’d like to say how much I welcome the creation of the NPSA. My organisation is an independent charity which promotes patient safety and justice for patients when things do go wrong, and the creation of something like the NPSA is something we called for, for years. Now the challenge for the NPSA is to demonstrate results in improving safety.”

Peter Walsh

Chief Executive of Action for Victims of Medical Accidents

Executive Directors

Sue Osborn and Susan Williams
Joint Chief Executive

Helen Hughes
Director of Operations

Management Team

Susan Burnett
Director of Interagency Working

Helen Glenister
Director of Modernisation* (the department was renamed Safety Solutions in July 2003)

Jenny Grey
Director of Communications

Peter Mansell
Director of Patient Experience and Public Involvement

Please note, the Director of Communications was Steve Wedgewood until June 2002; Steve O’Neill from July 2002 to March 2003; and Jenny Grey from March 2003 onwards.

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; and
- Statutory Instrument 2001 No. 1743.

The Chairman and non-executive board members, a total of 12, were appointed by the Secretary of State for Health in July 2001 for either a two- or three-year term.

The Joint Chief Executive were appointed by the Department of Health and took up their post in September 2001.

The Director of Operations (Finance) was appointed by the NPSA and took up the post in February 2002.

As from 1 April 2003, the NHS Appointments Commission took responsibility for appointing chairs and non-executive board members and they are currently managing the appointments process on behalf of the NPSA for two vacancies: NPSA chair and one non-executive board member.

The Establishment and Constitution Amendment Order 2003 (Statutory Instrument 2003 No. 1077) allowed changes to the membership of the NPSA board from 2 July 2003 to between 8-11 non-executive board members plus four executive officers. This increased the executive membership by two and reduced the non-executives by the same number. The composition of the NPSA is currently:

- NPSA Chair (vacancy)
- Executive Officers (4): Joint Chief Executive, Director of Operations (Finance) and two vacancies.
- Directors (4) in attendance.
- Secretary to the Board also in attendance.

Remuneration

The Chairman 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.

“Thank you for listening and asking.”

Patient

Interviewed as part of the infusion device project

Statutory committees

There are two statutory committees of the NPSA Board:

Audit Committee: Tony Butler (Chair), Dianne Hayter and Andrew Probert.

Pay and Remuneration Committee: Professor Rory Shaw (Chair), Sue Leggate and Arnold Simanowitz.

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

The NPSA chair and non-executive directors

Professor Rory Shaw, Chairman – is also 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. He has also continued his interests in the area of tuberculosis.

Dr Tony Butler – until recently was Deputy Director of the Advertising Standards Authority, the private company enforcing the codes for self regulation of advertising in the non-broadcast media, and Secretary of the Committee of Advertising Practice, the body writing these codes. He has also been a senior civil servant in four central government departments (the Crown Prosecution Service (CPS), Her Majesty's Inspectorate of Pollution (HMIP), and the Departments of the Environment and Transport). He is a member of the Government Statistical Service and Chartered Statistician of the Royal Statistical Society and has experience in sample design, collection and analysis of data. He has considerable expertise in financial, performance and change management, evolving strategy through corporate planning and business re-engineering, and has identified and implemented IT systems that improve efficiency and effectiveness. He was responsible for developing and managing internal communications and external media policy for both HMIP and CPS. As project manager for the privatisation of the water industry, he well understands the pressures relating to delivering objectives and targets to time and within budget.

Laurence Goldberg – is a former NHS hospital pharmacy manager now working as a consultant to the

pharmaceutical industry. Mr Goldberg has held several part-time academic appointments and is currently a freelance writer and lecturer. He has been interested in medication errors for many years and is currently working in the area of medication error reduction. He has a particular interest in design solutions and automated systems which will help to reduce medication errors. He is a board member of the European Foundation for the Advancement of Healthcare Practitioners and serves on a Council of Europe expert group on medication safety. He is a founder member of the United Kingdom Clinical Pharmacy Association.

Arnold Simanowitz OBE – formerly a practising solicitor – 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'* and was also a member of the Legal Services Commission's London Regional Legal Services Committee. He is now a Commissioner on the Commission for Patient and Public Safety in Health and a 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 Susan Whalley-Lloyd – is a professionally qualified ergonomist and human reliability consultant, with over 20 years' experience in this area, whose PhD (awarded 1987) addresses factors affecting human reliability. She has been managing director of her own company for the past five years having previously worked in senior management positions for a number of consultancy companies. Her expertise has included the development of systems to identify and reduce human error in a number of high-risk industries. She regularly chairs international conferences relating to safety and reliability and publishes in the area of human and system reliability. She maintains an academic link as an external examiner for research theses and as a visiting lecturer at a number of universities. Prior to joining the NPSA, Dr Whalley-Lloyd also worked for several years as a conciliator for Brent and Harrow Health Authority, facilitating communication between complainants and medical practitioners as part of the complaints process.

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 Dr Foster's ethics committee. She is also a research student at Queen Mary, University of London. She has also 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.

Professor Tricia Murphy-Black – professor of midwifery 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 membership of the National Board for 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.

Andrew Probert – senior policy advisor to the Countryside Agency, specialises in the analysis of service quality and the development of the Government's rural policy. After a career in advertising and marketing, he was at Cambridge University's Judge Institute of Management, researching transport quality assessment and lecturing in marketing communications.

He also advises senior MPs on future policy based on social marketing techniques. Disabled by polio and asthma as a child, he helps bring the patient's viewpoint to the NPSA, and is a keen advocate of participating in sport, having coxed rowing crews in both the World Championships and the Boat Race. He is the board member with responsibility for Welsh issues.

Dr P Umesh Prabhu – graduated from India in 1972 and subsequently trained in paediatrics in India as well as

in 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 Hospital Trust. As the MD he conducted an audit of medico-legal cases, complaints and clinical 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 an National Clinical Assessment Authority (NCAA) advisor.

Dr Diana (Eve) Miller – is a consultant anaesthetist at Victoria Hospital, Swindon; and medical advisor and member of the risk management team at Capsticks solicitors, with a particular interest in developing practical solutions for systems 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.

Dr Gilbert Smith – was previously Deputy Director of Research and Development, Department of Health and a University Vice Chancellor. He is now a writer and member of the Board of Northern Stage. Formerly he was Research Fellow, Medical Research Council Medical Sociology Unit; Senior Research Officer, Scottish Office; Reader, University of Glasgow; Professor, University of Hull; Association of Commonwealth Universities Senior Travelling Fellow; and Chairman of a Health Authority. He has had wide experience of board membership at regional and national

“By working collaboratively with the NPSA we can make a real difference to patient and staff safety in the healthcare environment.”

David Brassington

Purchasing Executive at NHS PASA

levels in agencies of regional development, the arts, health, social care and higher education as well as numerous advisory appointments to research councils, government departments, and overseas universities. His substantial publications include *Assessing Health Care; A Study in Organisational Evaluation* and numerous scientific papers in the professional journals of sociology and social policy. He has undertaken lecture tours in Japan, South Korea, Taiwan, Hong Kong and mainland China. His published work has been translated into Korean and Japanese. Most recently, Foundation Trustee, Social Care Institute for Excellence.

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 Consumers’ 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 Consumers’ Association and a member of the

Council for the Regulation of Health Professionals.

Jeremy Butler – is a pilot with 38 years’ commercial and military experience. Formerly general manager at British Airways, he was responsible for flight crew training and appraisal of operational standards. He is a former chair of the International Air Transport Association, Human Factors Group and chair of the Royal Aeronautical Society Human Factors Group of which he remains a member. He consults on aviation flight operations and has substantial involvement with the NHS as a carer. He is a non-executive director of Berkshire Healthcare NHS Trust.

Professor Tricia Murphy-Black, Dr Umesh Prabhu and Dr Susan Whalley-Lloyd’s terms of office on the NPSA Board will be coming to an end in 2003. The NPSA Board, Management Team and staff wish to express their gratitude for their contributions to the organisation’s development during its crucial early years.

Investing in patient safety

Statutory Background

The accounts for the year ended 31 March 2003 have been prepared in accordance with the direction given by the Secretary of State in accordance with section 98(2) of the NHS Act 1977 and in a format as instructed by the Department of Health with the approval of HM Treasury.

The National Patient Safety Agency (NPSA) was set up in July 2001 by The National Patient Safety Agency (Establishment and Constitution Order) 2001. 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).

Financial Results for the Year

The NPSA undershot its resource limit of £12.100 million with total expenditure of £12.040 million, consisting of revenue expenditure of £11.646 million and capital expenditure of £0.394 million. The NPSA also agreed brokerage of £4.650 million into 2003/04 with the Department of Health. The NPSA has entered into a long-term lease for its accommodation.

The NPSA has received total funding of £13.863 million and £0.020 million of other operating income since its establishment in July 2001. The surplus

to date consists of the undershoot on the resource limit in 2002/03 of £0.060 million.

Better Payment Practice Code

The Authority 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, 83% of bills, representing 85% by value, were paid within the target.

Statement of the Joint Chief Executive's Responsibilities as the Accountable Officer of the Organisation.

The Secretary of State has directed that the Joint Chief Executives should be the Accountable Officers to the organisation. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers' Memorandum issued by the Department of Health. These include ensuring that:

- i There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- ii Value for money is achieved from the resources available to the authority;
- iii The expenditure and income of the authority has been applied to the

purposes intended by Parliament and conform to the authorities which govern them;

- iv Effective and sound financial management systems are in place; and
- v 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.

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

Statement of Directors Responsibilities in Respect of the Accounts.

The Directors are required under the National Health Service Act 1977 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the organisation and of the net operating cost, recognised gains and losses and cash flows for the year. In preparing these accounts, Directors are required to:

- i Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- ii Make judgements and estimates which are reasonable and prudent;

- iii State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The Directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the organisation and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the health authority and hence for taking reasonable steps for the prevention of fraud and other irregularities.

The Directors confirm that to the best of their knowledge and belief that they have complied with the above requirements in preparing the financial statements.

By order of the Board

Statement on Internal Control

The Board is accountable for internal control. As Accountable Officer, and Joint Chief Executive Officer of this Board, we have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's objectives, and for reviewing its effectiveness. The system of internal control is designed to manage rather than eliminate the risk of failure to achieve these objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing risk management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and

economically. The system of internal control is underpinned by compliance with the requirements of the core Controls Assurance standards:

- Governance
- Financial Management
- Risk Management

As Accountable Officer, we also have responsibility for reviewing the effectiveness of the system of internal control. Our review of the effectiveness of the system of internal control has taken account of the work of the executive management team within the organisation who have responsibility for the development and maintenance of the internal control framework, and of the internal auditors. We have also taken account of comments made by external auditors and other review bodies in their reports.

The assurance framework is still being finalised and will be fully embedded during 2003-04 to provide the necessary evidence of an effective system of internal control.

The actions taken so far include:

- 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 implemented to meet 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.
- A Management Team risk management workshop followed by facilitated sessions in each department to identify objectives

and the principal risks to the achievement of those objectives in order to populate a risk register.

- Commissioning project work from external Risk Management consultants to assist with the development of risk management arrangements both within the Agency and as part of its wider remit relating to patient safety. This has included regular risk management workshops that are open to all staff in order to raise awareness.

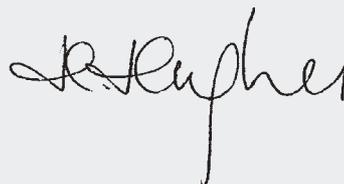
In addition to the actions outlined above, in the coming year it is planned to undertake:

- The identification of key controls in place to manage each of the principal risks and the assurance that the Board receives on each in order to complete the Assurance Framework. (Qtr 03 2003-04)
- Development of an action plan to address gaps in control and gaps in assurance. (Qtr 03 2003-04)
- 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. (Qtr 03 2003/04)

14 July 2003
Signed



Susan Williams Sue Osborn
Joint Chief Executive



Helen Hughes
Director of Operations

Independent Auditor's Report to the Directors of the Board of the National Patient Safety Agency on the Summary Financial Statements

I have examined the summary financial statements set out on pages 28 to 30.

This report is made solely to the Board of the National Patient Safety Agency in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 54 of the Statement of Responsibilities of Auditors and of Audited Bodies, prepared by the Audit Commission.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report. My responsibility is to report to you my opinion on the consistency of the summary financial statements with the statutory financial statements. I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statements.

Basis of opinion

I conducted my work in accordance with Bulletin 1999/6 'The auditor's statement on the summary financial statements' issued by the Auditing Practices Board for use in the United Kingdom.

Related Party Transactions

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

Organisation	Payment in year £000	Year End Debtor £000	Year End Creditor £000
Department of Health	387	365	0
Newcastle Upon Tyne Hospital	41	0	0
Prescription Pricing Authority	39	0	0
Hammersmith Hospital	31	0	1
Oxford Radcliffe Hospital	29	0	0
West London Mental Health Trust	25	0	22
North East London Strategic Health Authority	20	20	39
South West London Health Authority	0	0	86
Chelsea and Westminster Healthcare NHS Trust	30	0	0

Opinion

In my opinion, the summary financial statements are consistent with the statutory financial statements of the Agency for the year ended 31 March 2003 on which I have issued an unqualified opinion.

Marghanita Muris

Date: July 2003
Audit Manager
Audit Commission
4th Floor, Millbank Tower
LONDON SW1P 4QP

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 2002-03 is obtainable from:

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

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

Operating Cost Statement for the year ended 31 March 2003

Continuing Operations	2001-02	2002-03
	£000	£000
Programme costs	1,763	11,666
Operating income	0	(20)
Net operating cost	1,763	11,646
Net resource outturn	1,763	11,646

Statement of Recognised Gains and Losses for the year ended 31 March 2003

	2001-02	2002-03
	£000	£000
Unrealised surplus/(deficit) on the indexation and revaluation of fixed assets	0	0
Fixed asset impairment losses	0	0
Recognised gains and losses for the financial year	0	0

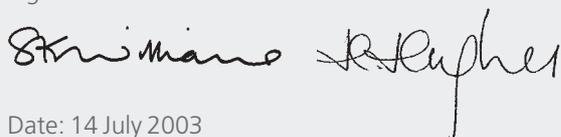
Cash Flow Statement for the year ended 31 March 2003

	2001-02	2002-03
	£000	£000
Net cash outflow from operating activities	1,470	11,834
Capital expenditure and financial investment:		
Payments to acquire intangible fixed assets	0	55
Payments to acquire tangible fixed assets	0	299
Receipts from disposal of fixed assets	0	0
Net cash outflow from investing activities	0	354
Net cash outflow before financing	1,470	12,188
Financing		
Net Parliamentary funding	1,715	12,000
(Increase)/Decrease in cash in the period	(245)	188

Balance Sheet as at 31 March 2003

	2001-02	2002-03
	£000	£000
Fixed assets		
Intangible assets	0	64
Tangible assets	0	314
	0	378
Current assets		
Stocks	0	7
Debtors	200	1,338
Cash at bank and in hand	245	57
	445	1,402
Creditors: amounts falling due within one year	(493)	(1,469)
Net current assets/liabilities	(48)	(67)
Total assets less current liabilities	(48)	311
Creditors: amounts falling due after more than one year	0	0
	(48)	311
Taxpayers' equity		
General fund	(48)	311
	(48)	311

Signed:


Date: 14 July 2003
Accountable Officer

Reconciliation of net operating cost to net resource outturn and Revenue Resource Limit

	2001-02	2002-03
	£000	£000
Net operating cost	1,763	11,646
Net resource outturn	1,763	11,646
Revenue resource limit	1,763	12,100
(Over)/under spend against limit	0	454

Senior staff and members' remuneration

The salary and pension entitlements of the most senior managers of the NPSA were as follows:

Name	Position held	Age years	Salary in £5k bands £000	Benefits in kind £00	real increase in pension in £2.5k bands £000	Pension at age 60 at 31.3.2003 £000
R Shaw	Chairman	49	25-30**	0	n/a	n/a
H Hughes	Executive Director	43	90-95	0	2.5-5.0	20-25
S Osborn	Executive Director	50	60-65	10	0-2.5	10-15
S Williams	Executive Director	50	60-65	0	0-2.5	10-15
S Burnett	Director*	42	65-70	0	0-2.5	10-15
H Glenister	Director*	43	75-80	0	12.6-15.0	10-15
J Grey	Director*	31	0-5	0	(B)	(B)
P Mansell	Director*	45	80-85	3	0-2.5	0-5
S O'Neill	Director*	(A)	(A)	(A)	(A)	(A)
J Shanks	Director*	(A)	(A)	(A)	(A)	(A)
S Wedgewood	Director*†	39	15-20	4	(2.5-5.0)	0-5
A Butler	Non-Executive Director	57	5-10	0	n/a	n/a
A Simanowitz	Non-Executive Director	64	5-10	0	n/a	n/a
A J Butler	Non-Executive Director	65	5-10	1	n/a	n/a
A W Probert	Non-Executive Director	49	5-10	0	n/a	n/a
D Hayter	Non-Executive Director	53	5-10	0	n/a	n/a
D E Miller	Non-Executive Director	59	5-10	2	n/a	n/a
G Smith	Non-Executive Director	58	5-10	1	n/a	n/a
L Goldberg	Non-Executive Director	59	5-10	0	n/a	n/a
P Prabhu	Non-Executive Director	47	5-10	0	n/a	n/a
S Whalley-Lloyd	Non-Executive Director	41	5-10	0	n/a	n/a
S R Leggate	Non-Executive Director	56	5-10	0	n/a	n/a
T Murphy-Black	Non-Executive Director	57	5-10	0	n/a	n/a

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

* Only employed for part of the financial year 2002/3

(A) Consent to disclose information not received

(B) Information not available from Pensions Agency

† This denotes an additional compensation for loss of office payment of £33,000

Appendices

Appendix 1

NPSA projects started in 2002-03

For more information please email the project leaders at the addresses given.

Solution projects

1) Determining the patient safety priorities for people with learning disabilities

We are researching the impact of things going wrong on people with learning disabilities.

vicky.stobbert@npsa.nhs.uk

2) Use of non-latex products in the care of latex-sensitive patients

We were contacted by a member of the public about the lack of appropriate healthcare provision for his wife who suffers from a severe form of latex allergy. Latex is present in many healthcare products and there can be serious consequences. We are exploring the extent of the problem.

chris.ranger@npsa.nhs.uk

3) Paediatric drug dosage calculation errors

We are exploring a number of initiatives associated with the use of medicines in neonates and children.

suzan.smallman@npsa.nhs.uk

4) Maternity: exploring concerns regarding collection, processing and storage of expressed breast milk

The Department of Health plans to take this forward.

sara.johnson@npsa.nhs.uk

5) Mental Health

A programme of initiatives to improve patient safety for mental health patients.

kathryn.hill@npsa.nhs.uk

6) Untoward incidents involving Percutaneous Endoscopically Guided (PEG) gastrostomy feeds

This work was initiated in response to a written request from a director of public health in a strategic health authority. We have been working with manufacturers to explore the possibility of modifying the pump that delivers the feeds.

joanne.parker@npsa.nhs.uk

7) Diathermy

A review of equipment and processes to prevent burns.

paul.moore@npsa.nhs.uk

8) Burns/scalds arising from hot water in baths/pipes

These types of injuries still occur in acute and residential care settings despite legislation and the ready availability of simple solutions. Burns and scalds were reported in the pilot data and a number of causes identified. We will be monitoring the situation in 2003-04.

elaine.stevenson@npsa.nhs.uk

Identifying areas for solution development

9) Wrong site surgery

In March 2003, we continued to look at examples of best practice for

avoiding wrong-site surgery, mainly from the United States, and are developing guidelines and a checklist.

clive.tomsett@npsa.nhs.uk

10) Anaesthetics

In 2002-03 we completed research into blocked anaesthetic tubes and in 2003-04 we will be producing risk identification tools for the anaesthetic process.

clive.tomsett@npsa.nhs.uk

11) Serious hazards of transfusion

SHOT has told us that giving the wrong blood is still the most common error reported to them and at the end of 2002-03 we were discussing areas for joint work.

maggie.odonovan@npsa.nhs.uk

Exploring possible solutions

12) Incorrect matching of patient with aspects of care

Misidentifying a patient can result in the wrong treatment. In 2002-03, we began investigating the extent of the problem.

chris.ranger@npsa.nhs.uk

13) Use of clinician identifier ink stamps in health records

After an investigation, we decided that there were no benefits to be gained from taking this project further.

14) Purchasing for patient safety

We are exploring processes to enable purchasing for patient safety.

maggie.odonovan@npsa.nhs.uk

15) Standardising the crash call number

There is a range of numbers for calling cardiac arrest teams and using the wrong one can cause delay and jeopardise patient safety. In 2002-03 we identified the benefits of standardising the number and began weighing these up against technical and financial implications.
chris.ranger@npsa.nhs.uk

16) Use of hip protectors to prevent fractured neck of femur in patients in acute care setting

There is research evidence on the importance of hip protectors for older people living in the community and in residential settings. In 2002-03, we identified a lack of research on their potential benefit for acute care patients.
elaine.stevenson@npsa.nhs.uk

17) Identifying visually impaired patients by use of stickers on hospital and GP records

An ophthalmic surgeon suggested placing stickers highlighting visual impairment on patients' records. In 2002-03, it was agreed that it was not appropriate to introduce this across the NHS. However, in 2003-04, we are looking at difficulties with pharmaceutical packaging.
jo.parker@npsa.nhs.uk

18) Design for patient safety

The current standard for labelling generic injection ampoules is uniform black text on a yellow background. This can lead to misidentification and in 2002-03 we discussed a joint project with the NHS Purchasing and Supplies Agency on improving labelling.
david.cousins@npsa.nhs.uk

19) Children's information/return cards

Many parents and carers want reassurance after their child has been sent home from departments such as

accident and emergency. In 2002-03, we began looking at information they could be given on symptoms to look out for and how they could be given speedy access if a return visit is required.
suzan.smallman@npsa.nhs.uk

20) Reducing the risk of oral methotrexate dosage error

We are investigating ways of reducing the number of patients taking the wrong dosage of oral methotrexate tablets. See page 13 for a more in depth account of this project.
wendy.harris@npsa.nhs.uk

Testing and Refinement of Solutions

21) Infusion devices

In 2002-03, we identified the root causes of infusion device incidents and planned a toolkit for NHS staff with various solutions. See page 8 for a more in depth account of this project.
chris.quinn@npsa.nhs.uk

22) Bowel care/management for people with an established spinal cord lesion in district general hospitals.

In 2002-03, we discovered that patients with a spinal cord injury are rarely offered bowel management in district general hospitals. This can put them at risk of cardiac arrest and stroke. Guidelines are available and in 2002-03 we began looking at better ways of promoting them.
jo.parker@npsa.nhs.uk

23) Hand hygiene

Low compliance with hand hygiene contributes to healthcare associated infections. In 2002-03, we began producing a toolkit which in 2003 is being piloted in six NHS trusts.
julie.storr@npsa.nhs.uk

24) Naloxone provision by all ambulance trusts

In 2002-03 we campaigned for all ambulance staff to be able to administer Naloxone.
elaine.stevenson@npsa.nhs.uk

Follow up of solutions

25) Learning and sharing initiative following Patient Safety Alert 01 on potassium chloride concentrate solutions.

Appendix 2 – Clinical Speciality Advisors

The Clinical Speciality Advisors	Speciality
Started financial year 2002-2003	
Dr John Dyet	Radiology
Dr Victor Barley	Clinical Oncology
Dr John Scarpello	Medicine
Prof Paul Lelliott	Mental Health
Mr David Morgan	Surgery
Mr Michael Bishop	Surgery
Mr Simon Kelly	Ophthalmology
Dr Brian Ayers	Radiology
Started financial year 2003-2004	
Prof Terence Stevenson	Paediatrics and child health
Prof James Walker	Obstetrics
Mr Marcus Setchell	Gynaecology
Dr Ian Woods	Anaesthetics
Prof Peter Furness	Pathology
Carol Paeglis	Midwifery
There will be further appointments in the areas of social care, nursing and learning disabilities.	

The NPSA would like to thank staff and patients at St George's NHS Trust, Tooting, London, Cardiff and Vale NHS Trust and Essex Rivers NHS Trust for their help with photography in this Annual Report.

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