

The National Patient Safety Agency Annual Report and Accounts 2004-2005



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Introduction from the Chair

One of the major challenges that we face in building an NHS for the 21st century is that of constant change. In the past year the NPSA has initiated and experienced change in equal measure.

Fundamental and sustainable change is most often achieved through working in partnership. An excellent example of this has been the way in which, throughout 2004-05, all NHS organisations in England and Wales connected to the NPSA's National Reporting and Learning System. This achievement, allied to the establishment of our Patient Safety Observatory, means that the NHS now possesses an ever growing information resource available to help improve patient safety.

This resource is already being used to promote service improvement. We have, for example, issued alerts on correct site surgery and on safety issues surrounding the use of nasogastric feeding tubes. The potential to provide information, guidance and training is there and we can save lives. Over the coming months I look forward to the NPSA being able to provide information and guidance on a regular basis to the NHS so as to build a sound knowledge base for the improvement of safe treatment and care.

Through this past year, the NPSA has also been presented with a tremendous opportunity to broaden the scope of patient safety activity. The outcome of the Department of Health's Arms Length Body Review has underlined the benefits of bringing concerns within the NHS for safe practitioners, safe systems, safe research and safe design and environments within the ambit of a single organisation. The determination to improve safety across healthcare could not have been stated more clearly.

The year ahead will no doubt present us with further challenges and no doubt the staff at NPSA will seize the opportunities that are offered. I look forward to working with them as interim Chair.

And I would not wish to conclude without paying tribute to Lord Hunt of Kings Heath. He most ably chaired the NPSA throughout 2004-05 and did much to put patient safety at the heart of the NHS.

Gilbert Smith, Ph.D.,
Chair, National Patient Safety Agency
Date: 12 July 2005

Introduction from the Joint Chief Executive

The NPSA has made significant progress during the last year. We have achieved all of our key objectives agreed with the Department of Health aimed at promoting patient safety and improving the quality of health services in all organisations delivering NHS care.

We have continued to meet our commitments throughout a period of significant organisational change associated with the Department of Health's *Arm's Length Bodies Review*. This has led to the NPSA assuming responsibility for: the Central Office for Research Ethics Committees (COREC); the National Clinical Assessment Service (formerly the National Clinical Assessment Authority); safety aspects of hospital design, cleanliness and food; and management of contracts for the three confidential enquiries. We welcome the opportunities this gives to broaden the patient safety agenda.

The last year has seen an important milestone being reached as all NHS trusts in England and Wales are now able to report to us via the National Reporting and Learning System (NRLS). In addition, we have now established the Patient Safety Observatory, our central intelligence function that will collate and analyse data from a range of sources, including the NRLS.

We continued, in 2004-05, to provide advice and information to the NHS on making patient safety improvements and have developed a series of guidance tools for promoting a patient safety culture.

We wish to thank the Board for their support, the staff of the NPSA and the NHS, along with the patients and their relatives who have worked with us over the last year.

As the newly expanded NPSA we look forward to the year ahead and to being able to continue the development of national learning to reduce the risk of harm through error, and, through our new responsibilities, to have a greater impact on safer care for patients.

Sue Osborn, Susan Williams

Joint Chief Executive

Date: 12 July 2005

Progress report

1 Reporting and analysing patient safety incidents

One of our key functions is to collect and analyse information on reported patient safety incidents and other material relevant to patient safety. This information is then used to identify key problems that are actionable at a national and local level.

1.1 National Reporting and Learning System

All NHS trusts in England and Wales are now connected to the National Reporting and Learning System (NRLS). Implementation of the NRLS was completed on 31 December 2004, enabling all local NHS organisations to report patient safety incidents to us.

In addition, NHS staff can now report anonymously to the NRLS using the eForm, which was launched in September 2004. NHS staff reporting using the eForm have the opportunity to also manually share their report with their NHS organisation. We have been working with NHS organisations and the vendors of the electronic risk management systems to ensure that data can be directly transferred to us. This allows staff to report locally, as well as to the NRLS, without placing any extra burden on them.

1.2 Patient Safety Observatory

We have now established our central intelligence function: the Patient Safety Observatory. This is a systematic approach to the collation, analysis and use of data on patient safety, drawing together information from a range of sources to quantify, characterise and prioritise patient safety issues. We do this in partnership with other key agencies and professional bodies, as well as by looking at patient experience information. This is consistent with our mandate to assimilate safety-related information in this country and abroad, as set out in the Government report, *Building a Safer NHS for Patients* (2001).

The first report from the Patient Safety Observatory will be published in 2005.

1.3 Public reporting

We have worked closely with patients and their representative organisations to develop an effective and user-friendly patient and public reporting tool, which we are currently piloting. This will help us learn about patient safety from the perspective of patients, the public and representative organisations and will therefore provide us with a more complete picture of patient safety.

2 Patient safety improvements

The actions required to improve patient safety can be practical solutions which we will develop; solutions which we will work with others to develop; or guidance aimed at supporting the development of a more open and fair culture, which we will develop in partnership with patients and NHS staff.

2.1 The prioritisation process

We have piloted a prioritisation process, involving an External Advisory Panel, for the selection of areas for which we will develop solutions. The pilot began in August 2004 and the recommendations of the panel were fed into the NPSA's Business Plan for 2005-06.

2.2 Priority areas

There are two remaining national priority areas identified for action by 2005 in the Chief Medical Officer's report, *An Organisation with a Memory* (November 2003):

- to reduce by 25 per cent the number of instances of harm in the field of obstetrics and gynaecology which result in litigation. The Department of Health held a meeting to discuss this target and we have been able to share our work programme in this area with them;
- to reduce by 40 per cent the number of serious errors in the use of prescribed drugs. We have taken action on 78 of the 126 recommendations in the Chief Pharmaceutical Officer's report *Building a Safer NHS for Patients – improving medication safety* (January 2004). Patient safety initiatives have also been proposed to minimise the top ten medication error risks.

2.3 Safety solutions

We have undertaken a series of work programmes aimed at helping us to understand patient safety issues so that practical solutions can be developed. We often find that guidance already exists but that it is not being followed. Where this is the case, we look to work with staff and patients to understand the barriers to implementation and provide practical implementation solutions. Five safety solutions were prioritised, developed and delivered in 2004-05 in collaboration with patients, carers and NHS organisations:

- **cleanyourhands** – One hundred per cent of acute trusts in England and Wales have signed up to become cleanyourhands partners. This national campaign to promote hand hygiene was launched along with a patient safety alert, *Clean hands helps to save lives*, in September 2004. Recruiting to the final phase of the campaign was completed in February 2005
- **Correct site surgery** – A patient safety alert, *Correct site surgery*, was launched in March 2005. We worked in partnership with the Royal College of Surgeons of England and the work has also been endorsed by a number of other royal colleges and associations with professional interests in ensuring correct site surgery.
- **Safe use of infusion devices** – We advised NHS organisations to review the way they purchase and manage infusion devices. A safer practice notice, *Improving infusion device safety*, was issued in May 2004 to NHS organisations providing acute care in England and Wales.
- **Safer use of methotrexate** – We issued advice to the NHS aimed at reducing the risks associated with oral methotrexate. A patient safety alert was issued in July 2004 setting out the actions for NHS acute trusts, primary care organisations and local health boards in England and Wales. Responses on action taken by medical directors was required to be placed on the Safety Alert Broadcast System by 31 March 2005. Fifty per cent of NHS organisations completed the actions required ahead of this deadline.
- **Reducing harm caused by the misplacement of nasogastric feeding tubes** – We issued an alert aimed at reducing the harm caused by the misplacement of nasogastric feeding tubes. This patient safety alert, issued in February 2005, set out actions for NHS acute trusts, primary care organisations and local health boards in England and Wales.

2.4 Promoting a patient safety culture

We are continuing to promote an open and fair culture in all NHS organisations and have developed six areas of guidance in 2004-05:

- **Incident Decision Tree** – Our Incident Decision Tree, a decision-making tool to reduce unnecessary suspensions and support a safety culture, was launched to the NHS in May 2004. The tool was endorsed by the NHS Confederation and was developed through extensive consultation with the National Clinical Assessment Authority, the royal colleges, the National Audit Office, staff-side organisations and clinicians. The tool is designed for use in secondary/tertiary care, mental health and ambulance services. We are currently adapting the tool for primary care organisations.
- **Manchester Patient Safety Framework** – The Manchester Patient Safety Framework (MaPSaF) tool allows organisations to self-assess themselves against a number of patient safety culture issues and to chart their movement in line with our guidance document on how to improve patient safety: *Seven steps to patient safety*. The MaPSaF is currently being piloted across all care settings and will be launched in July 2005.
- **Being Open** – We have developed *Being Open* guidance to NHS staff on how to communicate appropriately with patients and/or their carers following a patient safety incident. An e-learning toolkit and video-based training workshop have been developed to support this work. A *Being Open* policy and safer practice notice have been developed and consulted on and we received endorsements for the policy from the NHS Litigation Authority, the Healthcare Commission, Action against Medical Accidents, the British Medical Association and several royal colleges.
- **Introduction to Patient Safety E-Learning Programme** – This interactive e-learning tool for NHS staff to help raise their awareness of patient safety was launched in August 2004. The 'Introduction to Patient Safety E-Learning Programme' (IPSEL) tool is available on our website and can be adapted for different users, depending on their area of interest, healthcare setting and professional role.
- **Seven steps for CEO's** – A leadership checklist for NHS chief executives, *Delivering safer healthcare*, which gives guidance on their leadership role and personal contribution to the patient safety agenda, was circulated to all NHS chief executives in October 2004.
- **Seven steps to patient safety for primary care** – *Seven steps to patient safety for primary care* is a guide to patient safety that is relevant to all staff who provide care for patients in a primary care setting, and in particular those who are responsible for clinical governance and risk management in primary care organisations. The guide will be launched during 2005.

2.5 Demonstrating impact

We have begun work on an evaluation framework which will support internal evaluation of our activities and solutions. We have also further strengthened our work with the NHS Research and Development Patient Safety Research Programme to commission evaluation of key components of our work programme.

2.6 Effective purchasing

We have worked with the NHS Purchasing and Supply Agency (NHS PaSA) to encourage more effective purchasing as a means to improving patient safety. Encouragingly, NHS PaSA found that to date, over 50 per cent of trusts in England have already begun introducing alcohol-based disinfectants at the point of care, and a further 20 per cent plan to implement this in the near future.

3 Working in partnership

We work with others to deliver the action required to improve patient safety through building capability and capacity throughout the NHS and embedding patient safety into everyday practice.

3.1 Targeted safety campaigns

- A campaign focused on engaging doctors-in-training in patient safety was launched in March 2005. The campaign involves work with the British Medical Association Junior Doctors' Committee, the royal colleges and medical defence organisations.
- Our *Please Ask* campaign to engage patients and the public in patient safety was piloted in 2004-05 and is being launched in 2005.
- We have worked with the National Programme for IT in the NHS (NPfIT) to regulate the use of GP computer systems to improve patient safety when prescribing drugs. We have also worked with NPfIT to assess the potential of new technologies to prevent the mis-matching of patients and their care.

3.2 Implementing *Seven steps to patient safety*

- Our guidance document to all NHS staff on how to improve patient safety, *Seven steps to patient safety*, has been used as a framework for discussions and presentations by our 32 patient safety managers (PSMs) with local NHS organisations across England and Wales. The PSMs are the local face of the NPSA and are on hand to support NHS organisations in implementing a safety culture. The PSMs have, to date, delivered training to over 47,000 frontline staff in local clinical governance seminars and conferences on the contents of *Seven steps*.
- Root Cause Analysis (RCA) training is used to drive key components including RCA tools and techniques, *Being Open* and the Incident Decision Tree, as well as raising awareness of cultural issues. Our PSMs had a target of training over 5,000 NHS staff across NHS organisations in England and Wales; almost 6,000 have been trained to date.

4 Continuous learning

We are continuously learning about how to improve patient safety by:

- promoting an active research and development programme;
- looking at the experiences of other countries' patient safety work;
- looking at the experiences of other industries;
- evaluating our work.

4.1 Research and development strategy

Our research and development strategy was published in July 2004. The document sets out a broad framework for prioritisation and delivery of a wide-ranging research and development agenda.

4.2 World Health Organisation

We participated in two video-link conferences and attended the first meeting of the World Alliance for Patient Safety in Shanghai in September 2004. We also co-hosted a video link to the World Health Organisation (WHO) which launched the 'World Alliance for Patient Safety' in October 2004. We actively contributed to the development of the 'Patients for Patient Safety' strand of work by supporting the steering group. A senior member of staff is seconded to WHO in Geneva and the Joint Chief Executives participated in a master class for ten developing nations as part of the 'International Society for Quality in Healthcare' programme.

Our organisation

In 2004-05 we have made good progress in addressing the NHS human resources agenda.

We have also responded to changes in the working environment including the *Arm's Length Bodies Review*. A comprehensive consultation process was undertaken and we implemented a policy to keep staff informed and to obtain views on the proposed approaches to implement changes. The consultation and communication has included discussions, briefings and bulletins. There have also been discussions with staff forums and consultations with trade unions.

We are committed to involving staff in the way the organisation is run. Initiatives we have undertaken on staff involvement include fortnightly staff meetings, a staff council, several off-site all staff development days each year, and a monthly newsletter to update staff on change.

Agenda for Change is a key element of the Government's plans for modernising the NHS. During 2004-05 we have developed a programme for the project management and implementation of this development. We have delivered training on *Agenda for Change* and established working groups.

We have a real and tangible commitment to recognising and valuing the diversity of the stakeholders we work with and employ. We have a formal principle of making reasonable adjustments to meet people's needs and have actively developed and continue to monitor our Race Equality Scheme Action Plan.

Knowledge information management is of significant importance to our infrastructure and we have done significant work on our Freedom of Information (FOI) policy. A programme of work has been established and training provided to all staff. A publications scheme has been created, along with an official complaints policy and a formal procedure for handling FOI requests. Following the *Arm's Length Bodies Review*, the policies have been harmonised and a combined team from across all the bodies created.

From 1 April 2005 all the corporate services, i.e., Finance and Facilities, HR, Communications, IT, Planning and Policy, were integrated across the full range of our responsibilities.

Organisation chart

Joint Chief Executive Ms Sue Osborn Ms Susan Williams	Director for Patient Experience and Public Involvement Mr 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 Prof. Sir John Lilleyman	Safer Practice Solutions to promote safer practice Clinical specialty advice
	Director of Safer Practice Dr Helen Glenister	Working with Royal Colleges and other professional bodies
	Director of Epidemiology and Research Prof. Richard Thomson	Observatory Prioritisation Statistics Research and Development
	Director of National Programmes Ms Susan Burnett	Planning Policy & Partnership NRLS IT NHS Affairs
	Director of Communications Ms Jenny Grey	Marketing Web Strategy Strategic Communications Media & Parliamentary affairs
	Acting Director of Finance and Facilities* Mr John Hennessey	Finance Facilities
	Organisational Development Advisor Ms Sandra Meadows	Human Resources Organisational Development

* from 1 January 2005

Chair

Lord Philip Hunt
(from 1 January 2004
to 9 May 2005)

Dr Gilbert Smith
Acting Chair (from 10 May
to 10 November 2005)

A new Chair will be recruited in
November 2005.

Non-Executive Directors

Dr Tony Butler
Mr Jeremy Butler
Mr Laurence Goldberg
Mr Andrew Probert
Mr Arnold Simanowitz
Dr Gilbert Smith (see above)

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 7-9 non-executive board
members should be appointed to
the NPSA, 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 are
currently appointing three new non-
executive directors.

In addition to the chair and
non-executive directors,
the composition of the NPSA
board as at 31 March
2005 was:

Executive Directors

Sue Osborn and Susan Williams
Joint Chief Executives

Dr Helen Glenister
Director of Safer Practice

Professor Richard Thomson
**Director of Research
and Epidemiology**

Noel Plumridge
(1 April – 31 December 2004)
John Hennessey
(1 January 31 March 2005)
**Director of Finance and
Facilities**

Management team

Susan Burnett
**Director of National
Programmes**

Jenny Grey
Director of Communications

Peter Mansell
**Director of Patient Experience
and Public Involvement**

Prof. Sir John Lilleyman
Medical Director

Gay Kennedy
**Corporate Affairs
Manager in attendance**

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' remuneration are
given on page 34.

Statutory committees

There are two statutory
committees of the NPSA board:

Audit committee

Tony Butler (Chair)
Andrew Probert
Gilbert Smith

Pay and remuneration committee

Lord Phillip Hunt
Arnold Simanowitz
Tony 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 interests
on any agenda item before
discussion commences.

The National Patient Safety Agency 2004-2005 Annual Accounts

Foreword

Statutory background

The accounts for the year ended 31 March 2005 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 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. The audit certificate can be found on pages 22 to 23

Financial performance

The Board reported net operating cost of £15,339,000 during financial year (FY) 2005 (£16,840,000 in FY2004) against an agreed resource limit of £15,397,000; effectively the NPSA's revised budget.

The NPSA incurred £263,000 in capital expenditure in FY2005 against a capital funding resource limit of £280,000. Capital expenditure in FY2004 was £396,000. Overall, the NPSA's fixed assets increased from £678,000 to £769,000, which was primarily the addition of computer software and hardware.

Details of the remuneration of the senior management of the NPSA can be found in note 2.3 on page 34.

Consultation with staff

The NPSA has established a Staff Council, which is used for provision of information to, and consultation with, staff regarding health, safety and welfare at work.

Equality and diversity

The NPSA has been committed to developing an inclusive organisation that recognises the barriers and potential barriers its staff and wider stakeholders may experience, and removing or addressing them from the very beginning. This has meant that we have worked on projects affecting, for example, people with disabilities and older people. We have monitored the profiles of those people we have involved, appointed, promoted and dismissed to ensure they are representative of a wide range of profiles. We run equality training and have developed actions plans as part of our Race Equality Scheme.

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, 83.4 per cent of bills, representing 86.8 per cent by value, were paid within the target.

Audit services

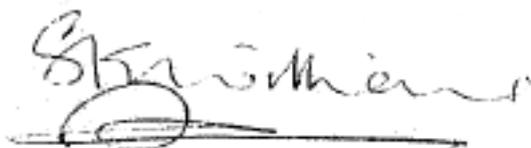
The accounts have been audited by the Comptroller and Auditor General in accordance with the National Health Service Act 1977 at a cost of £31,000. The audit certificate can be found on pages 22 to 23

Absorption and transfer of new functions

On 22 July 2004, the Secretary of State for Health announced in a written statement to the House of Commons that the number of NHS bodies that work at 'arm's length' from the Department of Health would be reduced. A report, *Reconfiguring the Department of Health's Arm's Length Bodies*, was published which detailed the bodies that would merge, be abolished or see their functions transferred.

On 30 November 2004, the Secretary of State published *An Implementation Framework for Reconfiguring the Department of Health's Arm's Length Bodies* setting out the principles, processes and timescales by which the change programme would be implemented. This resulted in the dissolution of the National Clinical Assessment Authority (NCAA) as a separate body at 31 March 2005, with the transfer of its functions into the NPSA with effect from 1 April 2005. In addition, from 1 April 2005 the NPSA assumed responsibility for three confidential enquires, previously the responsibility of the National Institute for Clinical Excellence (NICE), the Central Office of Research Ethics Committees (COREC), previously the responsibility of the Department of Health, and a number of functions previously managed by the Department of Health through NHS Estates. Additionally, the NPSA has commissioned the University of Birmingham's Patient Safety Research Programme to undertake a scoping study to determine the feasibility and remit of a new confidential enquiry into early deaths of people with learning disabilities.

Signed:



Accounting Officer

Date: 12 July 2005

Statement of the Boards and Chief Executives responsibilities

Under the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of Treasury, the National Patient Safety Agency is required to prepare a statement of accounts for each financial year in the form and on the basis determined by the Secretary of State, with the approval of Treasury. The accounts are prepared on an accruals basis and must give a true and fair view of the National Patient Safety Agency's state of affairs at the year end and of its net resource outturn, recognised gains and losses and cash flows for the financial year.

The Accounting Officer for the Department of Health has appointed the Chief Executive of the National Patient Safety Agency as the Accounting Officer, with responsibility for preparing the National Patient Safety Agency's accounts and for transmitting them to the Comptroller and Auditor General.

In preparing the accounts, the Board and Accounting Officer are required to:

- observe the accounts direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards have been followed and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis, unless it is inappropriate to presume that the National Patient Safety Agency will continue in operation.

The Chief Executive's relevant responsibilities as Accounting Officer, including responsibility for the propriety and regularity of the public funds and assets vested in the National Patient Safety Agency, and for the keeping of proper records, are set out in the Accounting Officers' Memorandum issued by the Department of Health.

Statement on Internal Control 2004-05

National Patient Safety Agency

1 Scope of responsibility

As Joint Accounting Officer and Joint Chief Executive, together with the Board of the National Patient Safety Agency, 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's Memorandum, issued by the Department of Health.

We were accountable to the Secretary of State and to Parliament for the performance of our functions and for meeting our statutory duties. To facilitate this, routine meetings were held with the Chief Medical Officer, who was the Authority's Senior Departmental Sponsor and with members of the Authority's Sponsor Branch. The Sponsor Branch also attended all Board meetings for this purpose.

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 2005 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

The NPSA has a risk management system 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 made risk management expertise available for all members of staff to consult. This has included the coaching and mentoring of staff in assessing and managing risk.

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

The Director of Finance and 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 action plans, and provides a resource group for departments/teams to raise local risk management issues that are, or are proving, difficult to resolve.

The Director of Finance and Facilities 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. For the year ended 31 March 2005 the Board has nominated the Joint Chief Executive as the Responsible Officer for Risk Management. With effect from 1 April 2005, 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. From 1 April 2005 a Board Governance sub committee has been created. This change has been made as a result of the expanded responsibilities of the NPSA resulting from the changes made following the Government's review of Arms Length Bodies. This committee overviews the risks identified and their management, to further ensure effective risk management within the NPSA.

The key elements of the risk management strategy are:

- As an integral part of the annual planning process 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 is monitored and regularly updated by the Management Team and Board to reflect the current situation. This is an integral part of performance reviews and ongoing management activities.
- The management and development of department risk registers which are monitored by directors and the Management Team, and will serve to populate and update department risk management action plans.
- The integration of risk management into the overall NPSA planning and performance management activities.
- The NPSA continues to develop 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, department risk registers and plans.
- The NPSA actively communicates its risk management policy and strategy to staff. This includes staff induction, 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. In addition the NPSA engages with NHS staff, suppliers, and other stakeholders in the development of safety solutions to ensure our solutions are both practical and appropriately minimise patient safety risks.

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.

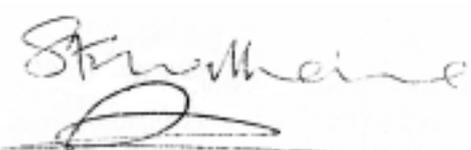
As planned in 2004/05, the organisation has taken actions to optimise our risk management processes. Actions included:

- The organisation has undertaken a self assessment exercise against NAO's "Good practice in the application of risk management - self-assessment questions for departments". An action plan has been developed and is being implemented to bridge gaps identified.
- 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.
- Staff have received one on one coaching and mentoring for their risk management activities.

In addition in 2004/05, 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. The developments address changes resulting from the Government's ALB review and included drawing learning and best practices from the ALBs being assimilated into the NPSA. Supporting guidance has been developed to assist directors, designated risk champions and all staff in risk identification, assessment, control and assurance.

In 2004/05 it is planned to optimise further our risk management processes and to fully align the risk management activities of original and assimilated parts of the NPSA.

Signed:  Joint Chief Executive and Accounting Officer

Date: 12/7/05

The Certificate and Report of the Comptroller and Auditor General to the Houses of Parliament

I certify that I have audited the financial statements on pages 24 to 47 under the National Health Service Act 1977. These financial statements have been prepared under the historical cost convention as modified by the revaluation of certain fixed assets and the accounting policies set out on pages 27 to 31.

Respective responsibilities of the Chief Executive and Auditor

As described on page 18, the Chief Executive is responsible for the preparation of the financial statements in accordance with the National Health Service Act 1977 and directions made by the Secretary of State for Health with the approval of the Treasury thereunder and for ensuring the regularity of financial transactions. The Chief Executive is also responsible for the preparation of the Foreword. My responsibilities, as independent auditor, are established by statute and I have regard to the standards and guidance issued by the Auditing Practices Board and the ethical guidance applicable to the auditing profession.

I report my opinion as to whether the financial statements give a true and fair view and are properly prepared in accordance with the National Health Service Act 1977 and directions made by the Secretary of State for Health with the approval of the Treasury thereunder, and whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. I also report if, in my opinion, the Foreword is not consistent with the financial statements, if the Agency has not kept proper accounting records, or if I have not received all the information and explanations I require for my audit.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. I consider the implications for my certificate if I become aware of any apparent misstatements or material inconsistencies with the financial statements.

I review whether the statement on pages 19 to 21 reflects the Agency's compliance with Treasury's guidance on the Statement on Internal Control. I report if it does not meet the requirements specified by Treasury, or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered whether the Accounting Officer's Statement on Internal Control covers all risks and controls. I am also not required to form an opinion on the effectiveness of the Agency's corporate governance procedures or its risk and control procedures.

Basis of audit opinion

I conducted my audit in accordance with United Kingdom Auditing Standards issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Chief Executive in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Agency's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements are free from material misstatement, whether caused by error, or by fraud or other irregularity and that, in all material respects, the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. In forming my opinion I have also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of the National Patient Safety Agency at 31 March 2005 and of the net resource outturn, recognised gains and losses and cash flows for the year then ended and have been properly prepared in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State for Health with the approval of the Treasury; and
- in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

I have no observations to make on these financial statements.



John Bourn
Comptroller and Auditor General
14th July 2005

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

Supplementary Statement by the Comptroller and Auditor General

The maintenance and integrity of the National Patient Safety Agency's website is the responsibility of the Accounting Officer; my work does not involve consideration of these matters and accordingly I accept no responsibility for any changes that may have occurred to the financial statements of the National Patient Safety Agency since they were initially presented on the web site.

Operating cost statement for the year ended 31 March 2005

	Notes	2004-05 £000	2003-04 £000
Programme costs	2.1	16,769	17,142
Operating income	4	(1,431)	(302)
Net operating cost before interest		15,338	16,840
Interest payable		1	0
Net operating cost		15,339	16,840
Net resource outturn	3.1	15,339	16,840

All income and expenditure is derived from continuing operations

Statement of Recognised Gains and Losses for the year ended 31 March 2005

There were no recognised gains or losses in the financial year 2004-05 (2003-04 £nil)

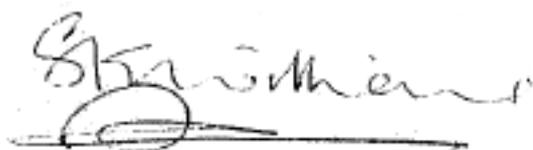
The notes at pages 27 to 47 form part of this account.

Balance sheet as at 31 March 2005

	Notes	31 March 2005 £000	31 March 2004 £000
Fixed assets:			
Intangible assets	5.1	192	252
Tangible assets	5.2	577	426
		<u>769</u>	<u>678</u>
Current assets			
Stocks	6	8	13
Debtors	7	1,643	1,199
Cash at bank and in hand	8	0	0
		<u>1,651</u>	<u>1,212</u>
Creditors: amounts falling due within one year	9.1	(1,790)	(1,413)
Net current assets/(liabilities)		(139)	(201)
Total assets less current liabilities		630	477
Creditors: amounts falling due after more than one year	9.2	0	0
Provisions for liabilities and charges	10	(90)	0
		<u>540</u>	<u>477</u>
Taxpayers' equity			
General Fund	12.1	540	477
		<u>540</u>	<u>477</u>

The notes at pages 27 to 47 form part of this account.

Signed:



Date:

12/7/05

Joint Chief Executive and Accounting Officer

Cash flow statement for the year ended 31 March 2005

	Notes	2004-05 £000	2003-04 £000
Net cash (outflow) from operating activities	13	(15,183)	(16,623)
Servicing of finance			
Interest paid		1	0
Net cash (outflow) from servicing finance		(1)	0
Capital expenditure and financial investment:			
(Payments) to acquire intangible fixed assets		(90)	(237)
(Payments) to acquire tangible fixed assets		(110)	(197)
Net cash (outflow) from investing activities		(200)	(434)
Net cash (outflow) before financing		(15,384)	(17,057)
Financing			
Net Parliamentary funding	12.1	15,384	17,000
Increase/(decrease) in cash in the period	8	0	(57)

The notes at pages 27 to 47 form part of this account.

Notes to the accounts

1 Accounting policies

The financial statements have been prepared in accordance with the 2004-05 Resource Accounting Manual issued by HM Treasury. The particular accounting policies adopted by the Authority are described below. They have been consistently applied in dealing with items considered material in relation to the accounts.

1.1 Accounting conventions

This account is prepared under the historical cost convention, modified to account for the revaluation of tangible fixed assets and stock where material, at their value to the business by reference to current cost. This is in accordance with directions issued by the Secretary of State for Health and approved by HM Treasury.

Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are acquired from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one NHS body to another.

1.2 Income

Income is accounted for applying the accruals convention. The main source of funding for the Special Health Authority is Parliamentary grant from the Department of Health from Request for Resources 1 within an approved cash limit, which is credited to the general fund. Parliamentary funding is recognised in the financial period in which it is received.

Operating income is income which relates directly to the operating activities of the authority. It principally comprises fees and charges for services provided on a full-cost basis to external customers, as well as public repayment work, but it also includes other income such as that from investments and from other NHS organisations. It includes both income appropriated-in-aid and income to the Consolidated Fund which HM Treasury has agreed should be treated as miscellaneous income. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Taxation

The Authority is not liable to pay corporation tax. Expenditure is shown net of recoverable VAT. Irrecoverable VAT is charged to the most appropriate expenditure heading or capitalised if it relates to an asset.

1.4 Capital charges

The treatment of fixed assets in the account is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. The interest rate applied to capital charges in the financial year 2004-2005 was 3.5% (2003-04 3.5%) on all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General, (OPG), where the charge is nil.

1.5 Fixed assets

a. Capitalisation

All assets falling into the following categories are capitalised:

- i Intangible assets where they are capable of being used for more than one year and have a cost, individually or as a group, equal to or greater than £5,000.
- ii Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred.
- iii Tangible assets which are capable of being used for more than one year, and they:
 - individually have a cost equal to or greater than £5,000;
 - collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
 - form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.
- iv Donated fixed assets are capitalised at their current value on receipt, and this value is credited to the donated asset reserve.

b. Valuation

Intangible fixed assets

Intangible fixed assets held for operational use are valued at historical cost, except Research and Development which is revalued using an appropriate index figure. Surplus intangible assets are valued at the net recoverable amount.

The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Tangible fixed assets

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost (for leased assets, fair value) including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

- i Operational equipment is valued at net current replacement costs through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.
- ii Assets in the course of construction, other than I.T. assets are valued at current cost, using the index as for land and buildings. These assets include any existing land or buildings under the control of a contractor.
- iii Subsequent revaluations to donated fixed assets are taken to the donated asset reserve.
- iv All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. All impairments resulting from price changes are charged to the Statement of Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

c. Depreciation and amortisation

Depreciation is charged on each individual fixed asset as follows:

- i Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets.
- ii Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives.
 - Software licences 3 years
 - Bespoke software licences 7 years
- iii Land and assets in the course of construction are not depreciated.
- iv Buildings are depreciated evenly on their revalued amount over the assessed remaining life of the asset as advised by the District Valuer. Leaseholds are depreciated over the primary lease term.
- v Each equipment asset is depreciated evenly over the expected useful life:
 - Information technology 5 years

1.6 Donated fixed assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the Donated Asset Reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the Donated Asset Reserve and, each year, an amount equal to the depreciation charge on the asset is released from the Donated Asset Reserve to the Operating Cost Statement. Similarly, any impairment on donated assets charged to the Operating Cost Statement is matched by a transfer from the Donated Asset Reserve. On sale of donated assets, the value of the sale proceeds is transferred from the Donated Asset Reserve to the General Fund.

1.7 Stocks and work in progress

Stocks and work in progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work in progress comprises goods in intermediate stages of production.

1.8 Losses and special payments

Losses and special payments are charged to the relevant functional headings, including losses which would have been made good through insurance cover had the Authority not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.9 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. As a consequence it is not possible for the Special Health Authority to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period. The total employer contributions payable in 2004-05 was £729,485 (2003-04 £290,494).

The Scheme is subject to a full valuation by the Government Actuary every four years which is followed by a review of the employer contribution rates. The last valuation took place as at 31 March 2003 and has yet to be finalised. The last published valuation covered the period 1 April 1994 to 31 March 1999. Between valuations the Government Actuary provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhs.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers' contributions remain at 7% of pensionable pay until 31 March 2003 and then be increased to 14% of pensionable pay with effect from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% of their pensionable pay.

NHS bodies are directed by the Secretary of State to charge employers pension costs contributions to operating expenses as and when they become due. Until 2002-03 HM Treasury paid the Retail Price Indexation costs of the NHS Pension scheme direct but as part of the Spending Review Settlement, these costs have been devolved in full. For 2003-04 the additional funding was retained as a Central Budget by the Department of Health and was paid direct to the NHS Pensions Agency and the employers' contribution remained at 7%. From 2004-05 this funding was devolved in full to NHS Pension Scheme employers and the employers' contribution rate rose to 14%.

The Scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. Additional pension liabilities arising from early retirement are not funded by the scheme except where the retirement is due to ill-health. For early retirements not funded by the scheme, the full amount of the liability for the additional costs is charged to the Operating Cost Statement account at the time the Authority commits itself to the retirement, regardless of the method of payment.

A death gratuity of twice final years pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pensions already paid, subject to a maximum amount equal to twice the member's final years pensionable pay less their retirement lump sum for those who die after retirement is payable.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

1.10 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation should be calculated on the same basis as used for depreciation i.e., on a quarterly basis.

1.11 Foreign exchange

Transactions which are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the date of each transaction, except where rates do not fluctuate significantly, in which case an average rate for a period is used.

1.12 Leases

Assets held under finance leases and hire purchase contracts are capitalised in the balance sheet and are depreciated over their useful lives or primary lease term. Rentals under operating leases are charged on a straight line basis over the terms of the lease.

1.13 Provisions

The Authority provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 3.5% in real terms.

2.1 Authority programme expenditure

	Notes	£000	2004-05 £000	2003-04 £000
Non-executive members' remuneration			93	89
Other salaries and wages	2.2		8,737	8,211
Supplies and services - general			196	142
Supplies and services - clinical			0	11
Establishment expenses			2,504	2,471
Transport and moveable plant			32	33
Premises and fixed plant			1,685	1,969
External contractors			3,091	3,540
Capital: Depreciation and amortisation	5.1, 5.2	172		96
Capital charges interest		18		6
Loss on disposal	5.4	10		0
			200	102
Auditor's remuneration: Audit Fees (*)			31	29
: Fees relating to previous year			0	5
Services from other NHS bodies			39	463
Other miscellaneous			161	77
			16,769	17,142

The Authority did not make any payments to Auditors for non audit work

2.2 Staff numbers and related costs

	2004-05 Total £000	Permanently employed Staff £000	Other £000	2003-04 £000
Salaries and wages	7,473	5,741	1,732	7,500
Social security costs	535	535	0	421
Employer contributions to NHSPA	729	729	0	290
	8,737	7,005	1,732	8,211

The average number of employees during the year was:

	2004-05 Total Number	Permanently employed Staff Number	Other Number	2003-04 Number
Total	156	122	34	149

Expenditure on staff benefits

The amount spent on staff benefits during the year totalled £20,989 (2003-04: £1,747)

Retirements due to ill-health

During 2004-05 there were nil early retirements from the Special Health Authority on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements (calculated on an average basis and borne by the NHS Pensions Scheme) will be £nil.

2.3 Salary and pension entitlement of senior managers

a. Remuneration

Name and title	2004-05			2003-04		
	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind (rounded to the nearest £00) £00	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind (rounded to the nearest £00) £00
Lord P Hunt Chairman	60-65	0	0	10-15	0	0
A Butler Non-Executive Director	5-10	0	0	5-10	0	0
AJ Butler Non-Executive Director	5-10	0	0	5-10	0	1
L Goldberg Non-Executive Director	5-10	0	1	5-10	0	1
AW Probert Non-Executive Director	5-10	0	0	5-10	0	0
A Simanowitz Non-Executive Director	5-10	0	0	5-10	0	0
G Smith Non-Executive Director	5-10	0	0	5-10	0	1
Directors						
Sue Osborn – Joint Chief Executive	75-80	0	8	85-90	0	8
Susan Williams – Joint Chief Executive	75-80	0	0	85-90	0	1
Helen Glenister – Director of Safer Practice	80-85	0	1	90-95	0	1
Susan Burnett – Director of National Programmes	95-100	0	0	90-95	0	0
Peter Mansell – Director of PEPI	95-100	0	3	90-95	0	2
Jenny Grey – Director of Communications	85-90	0	0	80-85	0	0
John Lilleyman Medical Director	85-90	0	0	0	0	0
R Thomson – Director of Epidemiology & Research	105-110	0	0	15-20	0	0
Noel Plumridge – Acting Director of Finance (01.04.04 - 17.01.05)	40-45	0	0	0	0	0
John Hennessey – Acting Director of Finance (01.01.05 - 31.03.05)	0-5	0	0	0	0	0

b. Pension benefits

Name and title	Real Increase in pension and related lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2005 and related lump sum (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2005 £000	Cash Equivalent Transfer Value at 31 March 2004 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension (rounded to nearest £00) £
Sue Osborn Joint Chief Executive	0-2.5	130-135	519	580	0	0
Susan Williams Joint Chief Executive	0-2.5	85-90	354	326	18	0
Helen Glenister Director of Safer Practice	0-2.5	65-70	226	223	0	0
Susan Burnett Director of National Programmes	7.5-10	95-100	314	265	42	0
Peter Mansell Director of PEPI	2.5-5	10-15	50	30	19	0
Jenny Grey Director of Communications	2.5-5	5-10	21	10	11	0
Noel Plumridge Acting Director of Finance	0	0	0	0	0	0
John Lilleyman Medical Director	(A)	(A)	(A)	(A)	(A)	(A)
R Thomson Director of Epidemiology & Research	0	115-120	398	378	9	0

(A) Consent to disclose information withheld.

As they do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

The benefits disclosed in note 2.3 relates to car mileage reimbursement rates.

Cash Equivalent Transfer Value

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members' accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefit accrued in the former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figure, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of period.

2.4 Better Payment Practice Code - measure of compliance

	Number	£000
Total bills paid 2004-05	6,441	9,761
Total bills paid within target	<u>5,371</u>	<u>8,473</u>
Percentage of bills paid within target	<u>83.4</u>	<u>86.8</u>

The Late Payment of Commercial Debts (Interest) Act 1998

	2004-05 £000	2003-04 £000
Amounts included within interest payable arising from claims made under this legislation	<u>1</u>	<u>0</u>
	<u>1</u>	<u>0</u>

3.1 Reconciliation of net operating cost to net resource outturn

	2004-05 £000	2003-04 £000
Net operating cost	<u>15,339</u>	16,840
Net resource outturn	<u>15,339</u>	<u>16,840</u>
Revenue resource limit	<u>15,397</u>	16,850
Under spend against revenue resource limit	<u>58</u>	10

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2004-05 £000	2003-04 £000
Gross capital expenditure	<u>273</u>	396
NBV of assets disposed	<u>(10)</u>	0
Net capital resource outturn	<u>263</u>	396
Capital resource limit	<u>280</u>	400
Underspend against limit	<u>17</u>	4

4 Operating income

Operating income analysed by classification and activity, is as follows:

	Appropriated in aid £000	Not Appropriated in aid £000	Total £000	2003-04 £000
Programme income:				
Fees & charges to external customers	125	0	125	302
Income received from other departments,	1,246	60	1,306	0
Total	1,371	60	1,431	302

5.1 Intangible fixed assets

	Software Licences £000	Total £000
Gross cost at 31 March 2004	284	284
Additions - purchased	11	11
Gross cost at 31 March 2005	295	295
Accumulated amortisation at 31 March 2004	32	32
Provided during the year	71	71
Accumulated amortisation at 31 March 2005	103	103
Net book value:		
Purchased at 31 March 2004	252	252
Total at 31 March 2004	252	252
Purchased at 31 March 2005	192	192
Total at 31 March 2005	192	192

5.2 Tangible fixed assets

	Assets under construction £000	Information Technology £000	Total £000
Cost or Valuation at 31 March 2004	10	496	506
Additions - purchased	233	29	262
Disposals	(10)	0	(10)
Gross cost at 31 March 2005	<u>233</u>	<u>525</u>	<u>758</u>
Accumulated depreciation at 31 March 2004		80	80
Provided during the year		101	101
Accumulated depreciation at 31 March 2005		<u>181</u>	<u>181</u>
Net book value:			
Purchased at 31 March 2004	<u>10</u>	<u>416</u>	<u>426</u>
Total at 31 March 2004	<u>10</u>	<u>416</u>	<u>426</u>
Purchased at 31 March 2005	<u>233</u>	<u>344</u>	<u>577</u>
Total at 31 March 2005	<u>233</u>	<u>344</u>	<u>577</u>

The National Patient Safety Agency held no assets under finance leases and hire purchase contracts at the balance sheet date.

5.3 Net Book Value of land and buildings

The net book value of land and buildings at the balance sheet date was £nil (2003-04 £nil).

5.4 Profit/loss on disposal of fixed assets

	2004-05 £000	2003-04 £000
(Loss) on disposal of intangible fixed assets	(10)	0
	<u>(10)</u>	<u>0</u>

6 Stocks and work in progress

	31 March 2005 £000	31 March 2004 £000
Raw materials and consumables	8	13
	<u>8</u>	<u>13</u>

7 Debtors

7.1 Amounts falling due within one year

	31 March 2005 £000	31 March 2004 £000
NHS debtors	432	33
Provision for irrecoverable debts	(1)	(1)
Prepayments	621	289
Other debtors	591	878
	<u>1,643</u>	<u>1,199</u>

8 Analysis of changes in cash

	At 31 March 2004 £000	Change during the year £000	At 31 March 2005 £000
Cash at OPG	(2)	1	(1)
Cash at commercial banks and in hand	2	(1)	1
	<u>0</u>	<u>0</u>	<u>0</u>

9 Creditors:

9.1 Amounts falling due within one year

	31 March 2005 £000	31 March 2004 £000
NHS creditors	51	127
Capital creditors	75	2
Tax and social security	12	167
Other creditors	544	186
Accruals	766	930
Deferred income	342	1
	<u>1,790</u>	<u>1,413</u>

9.2 Amounts falling due after more than one year

The National Patient Safety Agency held £nil creditors falling due after more than one year at the end of the financial year 2004-05 (2003-04: £nil).

9.3 Finance lease obligations

The National Patient Safety Agency has not entered into any finance lease obligations (2003-04: £nil).

10 Provisions for liabilities and charges

	Other £000	Total £000
At 31 March 2004	0	0
Arising during the year	90	90
At 31 March 2005	90	90

Expected timing of cash flows:

Within 1 year	90	90
1-5 years	0	0
Over 5 years	0	0

£nil is included in the provisions of the NHS Litigation Authority at 31st March 2005 in respect of clinical negligence liabilities of the Special Health Authority.

11 Movements in working capital other than cash

	2004-05 £000	2003-04 £000
Increase/(decrease) in stocks	(5)	6
Increase/(decrease) in debtors	444	(139)
(Increase)/decrease in creditors	(304)	18
	135	(115)

12 Movements on reserves

12.1 General Fund

	2004-05 £000	2003-04 £000
Balance at 31 March 2004	477	311
Net operating costs for the year	(15,339)	(16,840)
Net Parliamentary funding	15,384	17,000
Non-cash items: Capital charge interest	18	6
Balance at 31 March 2005	<u>540</u>	<u>477</u>

12.2 Revaluation reserve

The National Patient Safety Agency did not hold a revaluation reserve at the end of the financial year 2004-05 (2003-04 £nil).

12.3 Donated asset reserve

The National Patient Safety Agency did not hold a donated asset reserve at the end of the financial year 2004-05 (2003-04 £nil).

13 Reconciliation of operating costs to operating cash flows

	2004-05 £000	2003-04 £000
Net operating cost before interest for the year	15,338	16,840
Adjust for non-cash transactions	2.1 (200)	(102)
Adjust for movements in working capital other than cash	11 135	(115)
(Increase) in provisions	10 (90)	0
Net cash outflow from operating activities	<u>15,183</u>	<u>16,623</u>

14 Contingent liabilities

At 31 March 2005, there were no known contingent liabilities (2003-04: £nil).

15 Capital commitments

At 31 March 2005, the value of contracted capital commitments was £34,000 relating to Information Technology expenditure for the National Reporting and Learning System (2003-04 £nil).

16 Commitments under operating leases

Expenses of the Authority include the following in respect of hire and operating lease rentals:

	2004-05 £000	2003-04 £000
Hire of plant and machinery	3	7
Other operating leases	765	685
	<u>768</u>	<u>692</u>

Commitments under non-cancellable operating leases:

Land and buildings

		£000	£000
Operating leases which expire:	within 1 year	0	0
	between 1 and 5 years	0	0
	after 5 years	676	714
		<u>676</u>	<u>714</u>

Other leases

Operating leases which expire:	within 1 year	2	0
	between 1 and 5 years	66	68
	after 5 years	10	0
		<u>78</u>	<u>68</u>

17 Other commitments

The Authority has not entered into non-cancellable contracts (which are not operating leases) as at 31 March 2005 (2003-04 £nil).

18 Losses and special payments

The authority incurred a total of ten losses and two special payment during the financial year to the 31st March 2005.

The total value of the losses and special payments were £10,640.65 and £25,150 respectively.

19 Related parties

The Authority/Board is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a controlling related party. During the year the Authority/Board has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department, i.e.:

National Clinical Assessment Authority

The Authority received income totalling £331,019.22 relating to the *Arm's Length Bodies Review* assimilation costs.

Other

The Authority has considered material transactions as those with a value above £10,000.

	Payments in Year 04/05 £	Receipts in Year 04/05 £	Debtor @ 31.03.05 £	Creditor @ 31.03.05 £
Kings College London	9,995	87	0	0
London & Sussex Uni Hospital	0	0	0	10,477
Lincolnshire NHS Shared Service	0	11,277	0	0
Oxleas NHS Trust	11,050	2,073	0	-1,105
South Tyneside PCT	12,428	0	0	0
North East London Mental Health NHS Trust	14,568	0	0	0
Hull & East Yorkshire NHS Trust	17,681	0	0	0
Leeds Teaching Hospital NHS	13,269	95	0	4,357
University Hosp Of North Staffordshire NHS	14,448	0	0	4,816
South London & Maudsley NHS Trust	19,728	87	0	1,881
NW Surrey Mental Health NHS Trust	19,704	0	0	4,379
Bolton Hospital NHS Trust	24,294	182	0	1,761
U H L NHS Trust	29,884	0	0	0
Modernisation Agency	0	0	30,000	0
Brighton & Sussex University Hospital	31,430	0	0	0
Cumbria And Lancashire HA	0	31,440	0	0
Department Of Health	0	575,421	52,923	0
York Health Services NHS Trust	47,658	0	0	0
South Downs Health NHS Trust	49,594	0	0	850
Nottingham City Hospital NHS Trust	54,136	0	0	2,278
West London Mental Health	152,814	0	0	13,096
National Clinical Assessment Authority	531	0	331,019	3,170
NHSU	0	610,743	0	0

20 Post balance sheet events

From 1 April 2005 HM Treasury changed the discount rate used in calculating provision from 3.5% to 2.2%. This change will result in an increase in our provisions of £nil which will be charged to the Income and Expenditure account in 2005/06. National funding of NHS commissioners will be increased by the total estimated effect to offset this charge.

As discussed in the Foreword, the Secretary of State announced that the NPSA would absorb the functions of the National Clinical Assessment Authority from 1 April 2005, following the dissolution of the National Clinical Assessment Authority as a separate body at 31 March 2005. In addition, the functions of COREC, the three confidential enquiries and part of NHS Estates were also to be absorbed by the NPSA.

21 Financial instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way Special Health Authorities are financed, the National Patient Safety Agency is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The National Patient Safety Agency has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the National Patient Safety Agency in undertaking its activities.

As allowed by FRS 13, debtors and creditors that are due to mature or become payable within 12 months from the balance sheet date have been omitted from all disclosures other than from the currency profile.

Liquidity risk

The National Patient Safety Agency net operating costs are financed from resources voted annually by Parliament. The National Patient Safety Agency largely finances its capital expenditure from funds made available from Government under an agreed capital resource limit. The National Patient Safety Agency is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

100% of the Authority's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. The National Patient Safety Agency is not, therefore, exposed to significant interest-rate risk.

Foreign currency risk

The National Patient Safety Agency has negligible foreign currency income. Foreign currency expenditure represents 2.5% of total expenditure and is therefore not significant.

Fair values

Fair values are not significantly different from book values and therefore, no additional disclosure is required.

22 Intra-government balances

	Debtors: Amounts falling due within one year £000	Debtors: Amounts falling due after more than one year £000	Creditors Amounts falling due within one year £000	Creditors Amounts falling due after more than one year £000
Balances with other central government bodies	891	0	15	0
Balances with local authorities	200	0	1	0
Balances with NHS Trusts	15	0	48	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	537	0	1,726	0
At 31 March 2005	1,643	0	1,790	0

	Debtors: Amounts falling due within one year £000	Debtors: Amounts falling due after more than one year £000	Creditors Amounts falling due within one year £000	Creditors Amounts falling due after more than one year £000
Balances with other central government bodies	501	0	167	0
Balances with local authorities	0	0	0	0
Balances with NHS Trusts	22	0	127	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	676	0	1,119	0
At 31 March 2004	1,199	0	1,413	0

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