NHS
National Patient Safety Agency

The National Patient Safety Agency
Annual Report and Accounts 2005-2006

The National Patient Safety Agency Annual Report and Accounts 2005-2006

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Chairman's introduction

I have come to the National Patient Safety Agency (NPSA) at a time of consolidation, progress and continuing challenge.

April 2005 saw the NPSA assume responsibility for the National Clinical Assessment Service (NCAS), the Central Office for Research Ethics Committees (COREC), specific aspects of hospital nutrition, cleaning and design, and responsibility for the three national Confidential Enquiries. Much of the last year has seen the agency reconfigure itself to accommodate its expanded functions and realise efficiencies.

All NHS organisations connected to our National Reporting and Learning System (NRLS) in 2005-06 and we have received over 650,000 patient safety incident reports. This rapidly expanding resource gives us the data we need to spot trends, identify areas of concern and develop solutions to improve patient safety. This data is fed back to the NHS through a variety of methods, including our Patient Safety Observatory reports. The first report, *Building a memory: preventing harm, reducing risk and improving patient safety*, was published in July 2005.

Our continuing challenge is to help the NHS embed patient safety at the heart of all that it does. The legislative, financial and professional environment in which we, and our colleagues on the frontline of patient care, work is constantly changing and it is our task to anticipate and keep pace with this change. The Department of Health's review of organisational arrangements to support patient safety is ongoing as I write this introduction and will present new challenges to the agency – challenges that I know the NPSA and its staff will face with energy and commitment in the coming year.

Lord Naren Patel of Dunkeld
Chairman
National Patient Safety Agency

Chief Executive's introduction

This Annual Report and Accounts illustrates another year of challenge and success. The challenges faced by the NPSA have been both in relation to our core patient safety business and in building an organisation that continues to deliver in the constantly evolving healthcare sector.

Patient safety has come a long way in the five years since the NPSA's inception, but continued and focused effort will be needed if we are to create a truly safety-centred NHS. In 2005-06 the NPSA has graduated from its initial phase of introducing ideas, concepts and methods, to the next stage of its development: embedding patient safety throughout the NHS to ensure it makes a real and sustainable difference.

Perhaps more than any other, 2005-06 has been a year of important milestones. The NPSA has now achieved a key objective by feeding back the data we receive from the NHS with the publication of the first of our Patient Safety Observatory reports. The report is the culmination of work in developing a world leading patient safety incident reporting system, the tools to effectively analyse the data it collects and the expertise to provide solutions to the NHS. Work has continued this year on the development of an extranet site that enables NHS organisations to access their incident report data (launched in May 2006) and our patient safety alerts, safer practice notices and patient safety information continue to be disseminated to the NHS.

Our new functions have been involved in key projects ultimately aimed at improving safety in the NHS. Our Central Office for Research Ethics Committees has successfully drawn up and consulted on an implementation plan following recommendations made in a major Department of Health review in 2005. The National Clinical Assessment Service is forging ahead with its groundbreaking *Back on Track* programme designed to help doctors and dentists back into safe professional practice. Both will make major contributions to a safer NHS for patients.

Patient safety touches every aspect of healthcare and the diversity of our work and the people we work with reflects this. We have faced and addressed many challenges in the five years of our existence – the new challenge will be to maintain momentum and ensure that what we have already achieved is sustained.

Bill Murray OBE
Interim Chief Executive
National Patient Safety Agency

Management commentary

The NPSA is a Special Health Authority that was established in 2001 to improve patient safety in the NHS. Since April 2005, following the Department of Health's *Arm's Length Bodies Review*, the NPSA has also been responsible for helping NHS organisations deal with performance concerns of individual doctors and dentists through the National Clinical Assessment Service (NCAS); overseeing ethical safeguards for those involved in NHS research through the Central Office for Research Ethics Committees (COREC), specific aspects of hospital nutrition, cleaning and design, and managing the contracts with the three national Confidential Enquiries.

Aims and objectives

The NPSA aims to ensure that:

- lessons are learnt when things go wrong in the NHS and that the risk of avoidable harm to patients is minimised;
- concerns about the performance of individual doctors and dentists are resolved so that opportunities for a return to safe practice are maximised;
- those participating in research are protected through an ethics system that treats applications fairly, transparently, quickly and efficiently.

Our objectives are to:

- embed patient safety wherever NHS patients are treated;
- increase knowledge about patient safety through our National Reporting and Learning System (NRLS) and other sources;
- deliver the results of national learning;
- develop and implement national safety solutions and initiatives;
- provide an advice, assessment and support service to healthcare organisations and healthcare professionals;
- promote ethical research in the UK and continue to improve the efficiency and effectiveness of the Research Ethics Committee system.

Progress report

During 2005-06 the NPSA has continued to work to help NHS organisations protect patients from harm. We have disseminated safety messages to a wider audience, developed guidance and practical solutions that have real impact on safety, advised the NHS on how to manage practitioners whose performance gives cause for concern, and overseen the rights, dignity and welfare of those involved in NHS research. All of this work has required staff to understand how equality and diversity play a part in the agency's work and how our different activities affect groups and individuals with specific profiles.

1 Collecting and analysing patient safety incident reports

The data from our NRLS help us to identify key safety issues and develop effective local and national solutions.

1.1 National Reporting and Learning System

All NHS organisations in England and Wales are able to report patient safety incidents to us via the NRLS. From 31 March 2006, 94 per cent of NHS organisations were using their chosen route to report to the NRLS.

1.2 Expanding sources of reports

All four main commercial community pharmacy organisations are able to report patient safety incidents to us: two are connected via their local risk management systems and two are using the electronic reporting form whilst working towards connection of their local systems.

1.3 Patient and public reporting

Patients and the public have always been able to report their experiences, and any safety issues, to us. They are now able to share their safety concerns with us via a dedicated online reporting tool. The Patient and Public Reporting eForm was previewed to the NHS on 1 February 2006 and launched in England and Wales on 5 April 2006.

1.4 Quantity and quality of data

By the end of January 2006, all 607 NHS organisations in England and Wales had submitted incident reports, either via their local risk management system or the eForm: we are now receiving, on average, between 40,000 and 60,000 incident reports a month. A monitoring group has been set up to review the quality of the data we receive.

2 Disseminating knowledge and learning

Incidents reported to the NRLS provide a unique national picture of patient safety and it is essential that this learning is fed back to healthcare professionals and interested patients. Our knowledge, tools and resources are regularly shared with NHS staff and the wider community.

2.1 Patient Safety Observatory report

Our Patient Safety Observatory combines data from the NRLS with other sources to provide a comprehensive overview of patient safety. The first report from the Observatory was published in July 2005. *Building a memory: preventing harm, reducing risk and improving patient safety* analysed reported incidents and emerging trends, allowing the NHS to learn lessons and take action. We also published the first issue of the *Patient Safety Bulletin*, designed to rapidly feed back data and safety concerns to the NHS.

2.2 Feedback to reporters

Following a successful pilot, we have launched a secure extranet site that allows NHS organisations to access their incident report data and compare them with data from other similar-sized organisations. The pilot with eight NHS trusts ran from May to August 2005 and the site has been available to all reporting organisations from May 2006.

2.3 saferhealthcare.org.uk

The web portal **www.saferhealthcare.org.uk** is a major new online resource that we launched in August 2005. This joint project between the NPSA, the BMJ Publishing Group and the Institute for Healthcare Improvement provides healthcare professionals with a one-stop site for knowledge and innovation in safer healthcare. By the end of March 2006 there were 120,000 visitors and 4,100 registered users on the site.

2.4 Local dissemination

Our patient safety managers have worked with local NHS organisations across England and Wales to help implement the *Seven steps to patient safety* and produce tailored action plans for increasing the reporting of incidents.

2.5 Non-Executive training

From September 2005 to March 2006, we provided training for 320 NHS Non-Executive Directors. This involved one-day training sessions covering the spectrum of the NPSA's work, tailored for Board-level individuals.

3 Promoting patient safety

We have undertaken campaigns to embed safety messages, increase awareness of patient safety and improve incident reporting rates.

3.1 Junior doctors campaign

We have successfully worked to improve junior doctors' awareness of patient safety and helped stimulate reporting of incidents by this group of healthcare professionals. More than 10,000 junior doctors participated in online learning as part of our campaign with **www.doctors.net.uk**

We also worked with the Medical Defence Union and the Medical Protection Society to publish a handbook, *Medical error*, which provides junior doctors with advice on how to reduce risk and highlights the importance of reporting incidents.

3.2 *Please ask*

Our patient-focused campaign, *Please ask*, has been launched in England and Wales. The campaign aims to empower patients to take a more active role in managing their healthcare. The *Please ask* magazine has been distributed to GP practices and the website features individual tip sheets for each stage of the patient journey.

3.3 *Patient Safety 2006*

Our second major patient safety event was held in Birmingham in February 2006. *Patient Safety 2006* attracted more than 900 attendees from more than 30 countries and saw the exchange of knowledge and ideas of how healthcare can be made safer for patients.

4 Safety tools

Our resources, tools and guidance, which have been developed with the help and support of patients and NHS staff, help NHS organisations develop and maintain a culture that is safe, open and fair.

4.1 Root cause analysis

Aggregate root cause analyses have been undertaken on missing patients and hospital-acquired infections. Solutions identified through these analyses will be developed and embedded during 2006.

Independent evaluation reports of our three day networked root cause analysis training concluded that the training was of high quality. A report of this evaluation was published in March 2006.

4.2 *Being open*

We developed and launched our *Being open* policy and guidance as part of a national drive to help healthcare staff communicate with patients and their families following a patient safety incident. A safer practice notice was issued in September 2005 advising NHS organisations to develop a local policy based on *Being open* and to promote the policy with staff. Training tools and resources to help staff put the *Being open* policy into practice were launched in November 2005 and include a one day training session involving video and forum theatre workshops, and an elearning toolkit.

4.3 Manchester Patient Safety Framework

The Manchester Patient Safety Framework (MaPSaF) can help NHS organisations understand what a patient safety culture is and assess their progress in developing a safety culture in their organisation. The framework was distributed to all trusts in England and Wales in February 2006.

5 Confidential Enquiries

Following the Department of Health's *Arm's Length Bodies Review* we now manage the contracts for the three Confidential Enquiries. Governance and assurance arrangements for the Confidential Enquiries were agreed by the NPSA Board and sent to the Department of Health in November 2005.

6 Central Office for Research Ethics Committees

The Central Office for Research Ethics Committees (COREC) oversees the ethical rights, dignity and welfare of people participating in research. An independent report commissioned by the Department of Health, *Report of the Ad Hoc Advisory Group on the Operation of NHS Research Ethics Committees*, was published in June 2005. A consultation was undertaken on implementing the recommendations and the resulting consultation document, *Implementing the recommendations of the Report of the Ad Hoc Advisory Group on the Operation of NHS Research Ethics Committees: a consultation*, has been published. The consultation was open from 20 January 2006 to 21 April 2006. Wales have also consulted on the document and responses will inform development in Wales.

7 National Clinical Assessment Service

The National Clinical Assessment Service (NCAS) works with NHS organisations and individual practitioners in England, Wales and Northern Ireland where concerns have been raised about the performance of a doctor or dentist. It does this by providing confidential advice and support and by undertaking assessments of practitioners' performance.

7.1 Casework activity

Casework/adviser teams have been reconfigured to improve the management of cases and delivery against activity targets. In 2005-06, NCAS dealt with more than 750 requests for help and completed 47 assessments. Completion time for assessments has improved by 30 per cent compared with the previous year, bringing the mean time for completion of an assessment to 24 weeks. We continue to work to reduce this further.

7.2 *Maintaining High Professional Standards in the Modern NHS (MHPS)*

In 2005, further responsibilities were given to NCAS, under the new NHS disciplinary framework in England, with the publication of the framework covering health, conduct and capability. From 2004, these responsibilities had included requirements for NHS bodies to consult NCAS under the arrangements for suspension or exclusion of employed practitioners. The purpose of this was to avoid inappropriate use of exclusion, and the year saw the number of long term (more than six months) exclusions dropping further – to their lowest level since national reporting arrangements were put in place in 1994. Parallel procedures are in place in Northern Ireland, and negotiations on a framework continue in Wales.

7.3 *Back on Track*

NCAS has led work on developing a national framework for the re-entry of practitioners to the workplace following assessment or a long period of absence. A consultation and framework document, *Back on Track: restoring doctors and dentists to safe professional practice*, was launched at the NCAS conference in October 2005. Consultation was completed in December 2005 and a consensus framework was published in 2006. NCAS launched a web-based directory of resources to support practitioners to implement recommendations after an assessment (**www.ncas-resource.npsa.nhs.uk**).

7.4 Dental service

The remit of NCAS has been extended to include general dental practitioners in England, Wales and Northern Ireland. Procedures for advice, support and assessment services for dentists have been developed in line with the rest of NCAS.

7.5 Education

NCAS provided a series of education workshops to support senior clinicians and health service managers in dealing with concerns about the performance of doctors and dentists. This included nine regional workshops and workshops for trusts. NCAS convened a conference for colleagues from Europe, Australia, New Zealand and North America to explore approaches to assessment and support for doctors and dentists in difficulty. NCAS' web-based educational toolkit continues to be a popular guide (**www.ncas.npsa.nhs.uk/toolkit**).

7.6 Evaluation, research and development

As one of our evaluation, research and development projects, NCAS completed and published an analysis of the themes emerging from its first 50 assessment cases and looked at progress following assessment. This study has helped evaluate the effectiveness of the NCAS assessment and informed further development. A book, *Understanding Doctors' Performance*, was published in November 2005.

7.7 Work with other healthcare professionals

NCAS was commissioned by the Chief Nursing Officer (CNO) to co-chair (with the Department of Health) a group to consider principles and good practice in handling concerns across the breadth of healthcare professions. The report has been submitted to the CNO.

7.8 Extending the remit of NCAS

During the year, NCAS coverage has extended from its existing service in England, Wales and Northern Ireland. Requests for help have been accepted on a case-by-case basis from health services in Scotland, the Channel Islands, the Isle of Man and Gibraltar and formal service agreements are pending .

8 Safety solutions

As part of our role in helping the NHS to make healthcare safer, we prioritise, develop and launch solutions to address the safety issues that we identify.

8.1 Prioritisation process

An evaluation of our prioritisation process was undertaken and presented to the NPSA Board in May 2005 and key areas for action were agreed.

8.2 Practical patient safety solutions

The following four safety solutions were launched to the NHS in 2005-06:

- ### Safer practice with Repevax® and Revaxis® vaccines

  We worked with the Medicines and Healthcare products Regulatory Agency (MHRA) to jointly issue a safer practice notice in April 2005 advising NHS organisations on how to minimise the risk of the childhood vaccines Repevax® and Revaxis® being mistaken for one another.

- ### Protecting people with allergy associated with latex

  We issued information to NHS organisations in May 2005 advising them to take steps to better protect patients with latex allergy. A survey, conducted in conjunction with the Latex Allergy Support Group and the National Association of Theatre Nurses, found that 40 per cent of NHS trusts and primary care organisations do not have local policies on managing latex allergy; potentially putting sensitised patients at risk of harm.

- ### Reducing harm caused by misplaced naso and orogastric feeding tubes in neonates

  Thousands of gastric feeding tubes are safely inserted each day on neonatal units. However, there is a small risk that the tube can be misplaced into the lungs during insertion or move out of the stomach at a later stage. We issued an alert that set out actions for the NHS to reduce this risk.

- ### Safer patient identification

  All hospital inpatients should wear wristbands with accurate details to identify them and match them to their care. We issued a safer practice notice that set out recommendations for NHS organisations providing acute services.

8.3 clean**your**hands

Only one acute NHS organisation did not become an implementing site (as they already had a local hand hygiene project in place) for our hand hygiene campaign, clean**your**hands, across England and Wales as it rolled out in five phases over the past year.

A review was undertaken during 2005 to assess frontline experience and perspectives on the campaign, its usability and appropriateness, and areas for improvement. This feedback was used to identify where support and resources should be focused in the future, and informed the strategy for the campaign's second year.

An assessment of the expansion of the campaign to non-acute sectors concluded in February 2006. Following a report on its feasibility and appropriateness, the development of a phased programme was approved.

8.4 Food, design and cleanliness

Following the Department of Health's *Arm's Length Bodies Review* we took on responsibility for specific aspects of hospital design, cleanliness and food.

- **Food**

  A work programme has been discussed with the Department of Health and was presented to the NPSA Board in September 2005. It includes establishing the cost of malnourished patients admitted to hospital; emphasising the importance of food in health and recovery; carrying out nutritional assessments on admission to hospital; and reviewing protected mealtimes.

- **Design**

  A Design and Built Environment programme was presented to the NPSA Board in March 2006. It will develop an evidence base for design guidance for architects and contractors working on hospital builds that are focused on patient safety, and will run exemplar projects to highlight how design can contribute to safer healthcare.

- **Cleanliness**

  A Cleaner Hospitals programme was presented to the NPSA Board in November 2005. It includes a Clean Care programme to raise public confidence.

9 Working in partnership

We have worked closely with the Department of Health and the Welsh Assembly Government to implement our projects and campaigns across England and Wales.

We have continued to work with a wide variety of organisations and stakeholders, including patients and those close to them, voluntary organisations, the National Institute for Health and Clinical Excellence, Connecting for Health, Medicines and Healthcare products Regulatory Agency, NHS Litigation Authority, Medical Protection Society, Medical Defence Union, Informing Healthcare, the Healthcare Commission, Healthcare Inspectorate Wales, NHS Purchasing and Supply Agency, and Welsh Health Supplies.

During the UK Presidency of the EU in 2005, we supported the Department of Health as they hosted meetings of health policy officials from across Europe. We contributed to the Patient Safety Summit in November 2005 and jointly led a session on reporting patient safety incidents.

10 Recognising diversity and working towards equality

The range of people the NPSA has worked with is vast. Our last staff survey indicated that staff are aware of the need to work with a diverse range of people and that issues such as race, religion, age, disability, health, sexuality, literacy and gender all are important aspects of who they are and play a part in patient safety. We involve many people in our work and their contribution is not only to the specific work areas, but to the wider level of awareness within the agency. Equality and diversity is overseen within the agency by an equality and diversity group.

Operating environment

The NPSA operates primarily within the healthcare systems in England, Wales and Northern Ireland. Our work must be responsive to changes in the healthcare systems in these countries and there will be a number of developments in the future that are likely to impact on our work:

1 Increased plurality of provision and the continued drive towards introducing competition within the NHS will require us to assess how to continue to effectively embed patient safety and how we can maximise reports to the NRLS from wherever healthcare is delivered.

2 The recent reconfigurations at strategic health authority, primary care trust and ambulance trust levels mean we will need to assess the way healthcare organisations are connected to the NRLS. We will establish a new set of mechanisms through which we can maintain and improve the levels of reporting.

3 NHS Connecting for Health (CfH) has opened up new opportunities for us to embed safety into the fabric of the NHS and to reduce clinical risk. We will continue to work closely with CfH in the future to maximise these opportunities.

4 The Welsh Assembly Government's strategy for health and social care, *Designed for Life,* sets out the policy direction for Wales and will influence our work in this area.

5 The patient choice agenda and practice-based commissioning create incentives for improving safety by making compliance with safety standards part of the decision making of commissioners and patients.

6 There are a number of reviews of the regulatory and quality improvement environment in which we work that are due to report over the next year. The Chief Medical Officer's review of medical revalidation and regulation, the Foster review of regulation of non-medical healthcare professionals, and the Department of Health's review of the organisational arrangements for patient safety, all have the potential to impact on our organisational strategy.

Resources

Implementation of the *Arm's Length Bodies Review*, including taking on responsibility for NCAS and COREC and the resulting consolidation of our office functions, has delivered significant efficiency savings and a consequent reduction in our budget.

During our annual planning cycle we review our organisational strategy in light of current and anticipated future situations, and decide how to allocate resources based on organisational priorities. From these we develop a three year corporate plan setting out our long term strategy and a one year business plan. We manage our resources against this plan throughout the year, with regular reports to our Board and Management Team, and quarterly reviews of resource deployment.

Risks

The NPSA Board annually agrees a corporate risk policy and strategy that sets out the methods of risk identification, evaluation, thresholds and mechanisms for risk treatment. Risks are assessed during strategic and operational planning, and during implementation, and are recorded in departmental risk registers. Each risk and its controls, contingencies and actions are allocated responsible parties. Dependent on risk severity, these are escalated to management at the appropriate level.

Significant risks that emerge are included in our assurance framework and are independently reviewed by our Management Team and Board to monitor their effective management.

Stakeholders and corporate citizenship

The NPSA is dependent on a number of key stakeholders to help develop our work and to act on our behalf in areas where they have responsibility.

We are developing joint working agreements and memoranda of understanding to set out how we work with key partners such as the Healthcare Commission, Healthcare Inspectorate Wales and the General Medical Council. The NPSA All Wales Advisory Group is a key stakeholder. We have established professional advisory groups for medicine, nursing, midwifery and allied health professionals as formal mechanisms to seek input from the representative bodies of these healthcare professionals. We have also adopted methodologies for patient involvement across all projects and programmes.

We have assessed our operations against the NHS's good corporate citizenship self-assessment model, and identified areas where we can improve transport and procurement practice, and the ways in which we manage our staff and infrastructure responsibly. Our procurement policies and decision making in relation to our key suppliers acknowledge the impact our business has on the environment and sustainability.

We place great importance on caring for our staff and involving them in developing our business. We are working towards *Improving Working Lives* accreditation and have established a Staff Council that ensures staff have input into the development of the organisation's plans, policies and processes. The NPSA provides staff with a number of benefits including supporting learning and development and providing gym membership, massage sessions, a free confidential counselling service, active health promotion initiatives and season ticket loans.

Emergency preparedness

The NPSA maintains a business continuity strategy that will allow us to continue operations in the event of an emergency. Our business continuity strategy includes plans of how to respond to major incidents. We conduct an annual review of the robustness of these plans and report this to the NPSA Board.

Our organisation

During 2005-06, the NPSA's human resources department has focused on implementing *Agenda for Change* throughout the organisation.

We successfully assimilated over 200 staff onto new pay bands and have agreed a Knowledge and Skills profile for over 90 per cent of posts. Job evaluations will continue to be a significant part of our work. To ensure consistency of job evaluations in the NPSA, we have set up a group to oversee them. We are also training new evaluators in order to ensure that our successful partnership working arrangements continue.

Following the Department of Health's *Arm's Length Bodies Review*, we have worked since April 2005 to integrate our corporate services, including finance, facilities and IT, human resources, communications, and policy and planning.

In order to harmonise human resource practice and procedures across the organisation, statutory human resource polices are now agreed and others are being finalised.

Throughout 2005-06 we have continued to involve staff in the way the organisation is run, including holding regular staff meetings, a Staff Council, a monthly online newsletter and several staff development days.

Quality is important to us and we are working to achieve the *Investors in People* quality standard, using the work we have already undertaken for *Improving Working Lives*.

Organisation chart

Joint Chief Executive Ms Sue Osborn Ms Susan Williams	
Director of National Programmes Ms Susan Burnett	NHS affairs National programmes
Deputy Chief Executive/ Director of Safer Practice and Nursing Dr Helen Glenister	Safer practice Solutions to promote safer practice Clinical specialty advice Working with royal colleges and other professional bodies Food, cleaning and design
Director of Strategy and Communications Ms Jenny Grey	Policy, planning, projects and partnerships Marketing Web strategy Strategic communications Media and parliamentary affairs
Director of Finance, Facilities and IT* Mr John Hennessey (January 2005 – October 2005)	Finance Facilities IT
Medical Director Professor Sir John Lilleyman	Safer practice Solutions to promote safer practice Clinical specialty advice Working with royal colleges and other professional bodies Confidential Enquiries COREC strategy
Director for Patient Experience 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
Organisational Development Advisor Ms Sandra Meadows	Human resources Organisational development Open and fair culture
Director, National Clinical Assessment Service Professor Alastair Scotland	Promoting confidence in doctors and dentists Advising NHS organisations to help them deal fairly and effectively with performance concerns of practitioners
Director of Epidemiology and Research Professor Richard Thomson	Patient Safety Observatory Prioritisation Analysis Research and development
Operations Director, Central Office for Research Ethics Committees Dr Janet Wisely	Providing support for research ethics committees to ensure the ethical rights, dignity and welfare of people participating in research

* Acting Director: Vanessa Perry (October 2005 – 7 April 2006)

Chairman

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

Dr Gilbert Smith (from 10 May 2005 to 10 November 2005) Interim Chairman

Lord Naren Patel (11 November 2005 – current)

Non-Executive Directors

Dr Tony Butler

Mr Jeremy Butler

Professor Hamid Ghodse (from 1 August 2005)

Mr Laurence Goldberg

Mr Andrew Probert

Mr Arnold Simanowitz

Dr Gilbert Smith (see above)

Appointment of Board members

The NHS Appointments Commission have appointed three new Non-Executive Directors from 1 April 2006:

Ms Gill Edelman

Miss Georgina Gardiner

Dr Linda Patterson

In addition to the Chairman and Non-Executive Directors, the composition of the NPSA Board since 1 April 2005 was:

Executive Directors

Sue Osborn and Susan Williams
Joint Chief Executives

Bill Murray (from August 2006)
Interim Chief Executive

Dr Helen Glenister
Deputy Chief Executive/ Director of Safer Practice and Nursing

Professor Richard Thomson
Director of Epidemiology and Research

John Hennessey
(1 January – October 2005)
Director of Finance, Facilities and IT

Vanessa Perry
(October 2005 – 9 April 2006)
Acting Director of Finance, Facilities and IT

Dave Bell
(from 10 April 2006)
Director of Finance, Facilities and IT

Professor Alastair Scotland
Director, National Clinical Assessment Service

Management Team

Susan Burnett
Director of National Programmes

Jenny Grey
Director of Strategy and Communications

Peter Mansell
Director for Patient Experience

Professor Sir John Lilleyman
Medical Director

Gay Kennedy
Corporate Affairs Manager
(in attendance)

Remuneration report

The Chairman and Non-Executive Board members are remunerated in line with Department of Health guidance that applies to all NHS bodies. Details of senior managers' remuneration are given on the following page.

In addition to the remuneration disclosed within the tables of this report, a one-off payment was made during the year to a former senior manager in relation to the new consultant contract under which this person became entitled to a further payment.

Statutory committees

There are two statutory committees of the NPSA Board:

Audit committee

Tony Butler (Chair)

Andrew Probert

Gill Edelman (from July 2006)

Pay and remuneration committee

Lord Naren Patel

Arnold Simanowitz (until June 2006)

Tony Butler (until June 2006)

Georgina Gardiner (from July 2006)

Hamid Ghodse (from July 2006)

Remuneration

Salaries and allowances

Name and title	2005-06 Salary (bands of £5,000) £000	2005-06 Other remuneration (A) £000	2005-06 Benefits in kind £00	2004-05 Salary (bands of £5,000) £000	2004-05 Other remuneration (A) £000	2004-05 Benefits in kind £00
Non-Executive Directors						
Lord N Patel, Chairman (started 11/11/2005)	20-25	0	0	**N/A**	**N/A**	**N/A**
Lord P Hunt, Chairman (left 09/05/2005)	5-10	0	0	60-65	0	0
G Smith, Chairman (from 10/05/2005 - 10/11/2005)	25-30	0	0	**N/A**	**N/A**	**N/A**
G Smith, Non-Executive Director (became chairman on 10/05/2005)	0-5	0	0	5-10	0	0
AJ Butler, Non-Executive Director	5-10	0	0	5-10	0	0
A Simanowitz, Non-Executive Director	5-10	0	0	5-10	0	0
A Butler, Non-Executive Director	5-10	0	0	5-10	0	0
AW Probert, Non-Executive Director	5-10	0	0	5-10	0	0
L Goldberg, Non-Executive Director	5-10	0	0	5-10	0	0
H Ghodse, Non-Executive Director (started 01/08/2005)	0-5	0	0	5-10	0	0
Directors						
S Osborn, Joint Chief Executive*	90-95	0	0	75-80	0	0
S Williams, Joint Chief Executive*	90-95	0	0	75-80	0	0
H Glenister, Deputy Chief Executive/ Director of Safer Practice and Nursing	90-95	0	0	80-85	0	0
S Burnett, Director of National Programmes	70-75	0	0	95-100	0	0
P Mansell, Director for Patient Experience	100-105	0	0	95-100	0	0
J Grey, Director of Strategy and Communications	90-95	0	0	85-90	0	0
J Lilleyman, Medical Director	90-95	0	0	85-90	0	0
R Thomson, Director of Epidemiology and Research	105-110	0	0	105-110	0	0
J Hennessey, Director of Finance, Facilities and IT (left 30/09/2005)	50-55	0	0	95-100	0	0
A Scotland, Director, National Clinical Assessment Service	125-130	50-55	0	125-130	50-55	0
V Perry, Acting Director of Finance, Facilities and IT (started 01/10/2005)	40-45	0	0	**N/A**	**N/A**	**N/A**
J Wisely, Operations Director, Central Office for Research Ethics Committees	70-75	0	0	**N/A**	**N/A**	**N/A**

(A) Other remuneration consists of a Clinical Excellence Award separately funded by the Advisory Committee on Clinical Excellence Awards.

* Mr WW Murray took up the post of Interim Chief Executive and was appointed Accounting Officer in August 2006. S Osborn and S Williams began a period of extended leave in July 2006 and requested that they be granted voluntary early retirement in November 2006. Following receipt of approval from the Treasury, this request was granted, in principle and arrangements are being finalised.

Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at aged 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2006 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2006 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2006 £000	Cash Equivalent Transfer Value at 31 March 2005 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
S Osborn, Joint Chief Executive	30.0-32.5	22.5-25.0	40-45	120-125	676	519	101	0
S Williams, Joint Chief Executive	62.5-65.0	47.5-50.0	35-40	115-120	647	354	199	0
H Glenister, Deputy Chief Executive/ Director of Safer Practice and Nursing	10.0-12.5	7.5-10.0	20-25	60-65	278	226	32	0
S Burnett, Director of National Programmes	5.0-7.5	2.5-5.0	25-30	75-80	351	314	20	0
P Mansell, Director for Patient Experience	5.0-7.5	2.5-5.0	0-5	10-15	71	50	14	0
J Grey, Director of Strategy and Communications	5.0-7.5	2.5-5.0	0-5	10-15	36	21	10	0
J Lilleyman, Medical Director	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
R Thomson, Director of Epidemiology and Research	10.0-12.5	7.5-10.0	30-35	95-100	466	398	41	0
J Hennessey, Director of Finance, Facilities and IT (left 30/09/2005)	7.5-10.0	5.0-7.5	10-15	35-40	173	133	25	0
A Scotland, Director, National Clinical Assessment Service	2.5-5.0	0.0-2.5	75-80	225-230	1291	1233	19	0
V Perry, Acting Director of Finance, Facilities and IT (started 01/10/2005)	7.5-10.0	5.0-7.5	5-10	25-30	143	97	30	0
J Wisely, Operations Director, Central Office for Research Ethics Committees	17.5-20.0	12.5-15.0	10-15	30-35	133	70	43	0

(A) Consent has been given but the information has not been received from the Pensions Agency.

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

Cash Equivalent Transfer Values
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 member's 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 benefits accrued in their 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 figures and 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. CETVs 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 the period.

Public interest and other

1 History and statutory background

The NPSA is a Special Health Authority created in July 2001 to improve the safety of NHS patients.

From 1 April 2005 the NPSA was given additional functions giving it greater scope to improve patient safety in the NHS. The NPSA's new functions include: safety aspects of hospital design, cleanliness and food (transferred from NHS Estates); ensuring research is carried out safely, through its responsibility for the Central Office for Research Ethics Committees (COREC); and supporting local NHS organisations in addressing their concerns about the performance of individual doctors and dentists, through its responsibility for the National Clinical Assessment Service (NCAS), formerly the National Clinical Assessment Authority. It also manages the contracts with the three Confidential Enquiries: the Confidential Enquiry into Maternal and Child Health (CEMACH); the National Confidential Enquiry into Patient Outcome and Death (NCEPOD); and the National Confidential Inquiry into Suicide and Homicide by people with mental illness (NCISH).

2 Consultation with employees

The Staff Council was set up to encourage open channels of communication and aims to ensure that everyone knows what is happening in the NPSA, how the NPSA is performing and what our goals are.

Representatives are elected for a maximum period of two years, with four representatives being re-elected after one year. This allows for continuity and experience to remain within the Staff Council. The nomination process is open to all staff. However, in the interests of continuity, nominees should have a contract with the NPSA for at least one year.

The role of a representative is to:

- agree with other representatives the particular constituency of staff to be represented;
- seek the views of staff represented;
- agree time to seek staff views with appropriate managers;
- represent the interests of all constituent staff to the Staff Council;
- ensure timely feedback to staff.

3 Disabled employees

The NPSA was awarded the Disability Symbol (two ticks) in January 2003. This symbol is awarded by Jobcentre Plus to employers who make five commitments to the employment, retention, training and career development of people with disabilities, including mental health difficulties. These five commitments are:

- to interview all applicants with a disability who meet the minimum criteria for a job vacancy and consider them on their abilities;
- to ensure there is a mechanism in place to discuss, at any time, but at least once a year, with disabled employees what you and they can do to make sure they can develop and use their abilities;
- to make every effort when employees become disabled to make sure they stay in employment;

- to take action to ensure that all employees develop the appropriate level of disability awareness needed to make your commitments work;
- each year, to review the five commitments and what has been achieved, to plan ways to improve on them and let employees and the Employment Service know about progress and future plans.

4 Equal opportunities

Our Race Equality Action Plan is used to monitor the NPSA's work, both at a strategic and operational level.

5 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 later) unless other payment terms have been agreed with the supplier. Details of compliance with the code are given in note 2.3 to the Accounts.

6 External audit

The accounts have been audited by the Comptroller and Audit General in accordance with the National Health Service Act 1977 at a cost of £50,000. The audit certificate can be found on pages xxx to xxxi.

So far as the Chief Executive is aware, there is no relevant audit information of which the entity's auditors are unaware, and the Chief Executive has taken all the steps that he ought to have taken to make himself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

7 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.

8 Interests in land

Not applicable.

9 Pension liabilities

NPSA past and present employees are covered by the provision of the NHS Pension Scheme. Details of the scheme are given in note 1.9 of the Accounts. The senior managers' pension liabilities are disclosed within the remuneration report.

Signed  Interim Chief Executive

Dated **6 December 2006**

Statement of the Board and Chief Executive's 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 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 Officer's Memorandum issued by the Department of Health.

Statement on Internal Control 2005-06

National Patient Safety Agency

1 Scope of responsibility

This Statement has been prepared in accordance with guidance published by the Department of Health. As Accounting Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding public funds and the organisation's assets for which I am personally responsible as set out in the Accounting Officer Memorandum.

This Statement needs to be considered in light of the challenges and opportunities arising from a period of significant organisational change following the Department of Health's *Arms Length Bodies Review*. From April 2005, this resulted in the NPSA assuming responsibility for the Central Office for Research Ethics (COREC); the National Clinical Assessment Service (NCAS); and other responsibilities for the safety aspects of hospital design, cleanliness and food, and the management of contracts for three Confidential Enquiries.

The system of internal control has been in place in the National Patient Safety Agency for the year ended 31 March 2006 and up to the date of approval of the Annual Report and Accounts.

The system of internal control can provide only reasonable assurance and not absolute assurance that assets are safeguarded, that transactions are authorised and properly recorded, and that material errors or irregularities are either prevented or would be detected within a timely basis.

2 The purpose of the system of internal control

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 as set out in the Corporate Plan;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

3 Internal control environment

The internal control environment is the supporting infrastructure that monitors progress made towards achieving key aims and objectives. It also monitors adherence to key external regulation and internal policies and procedures.

Key internal mechanisms include:

- business planning and budget management, etc;
- risk management;
- financial management and control;
- codes of conduct and HR standards;
- procurement policies and procedures;
- performance management framework;

- internal audit;
- involvement of Non-Executives in scrutinising aspects of the agency's work.

A performance management culture is under continuous development and reporting arrangements currently extend to the Chief Executive, Management Team and Board with regard to the achievement of performance targets. The NPSA is also committed to ensuring economy, efficiency and effectiveness in its use of resources. This is achieved by service reviews and targets built into the budget setting process and as part of medium term financial and business planning. This has contributed to identifying Gershon efficiencies.

External scrutiny is via the Department of Health and the National Audit Office.

From these sources, various policies, procedures, codes and protocols have been developed to ensure compliance with key governance arrangements e.g. Code of Conduct, Financial Standards and Procedures, Procurement Policies and Procedures, Scheme of Delegation and Human Resource Management Frameworks.

In addition, the financial management and reporting arrangements are subject to continuous improvement and have been aligned to the development of Business Plans and priorities, allowing them to effectively monitor revenue and capital commitments and compliance with good financial management.

4 Capacity to handle risk

The NPSA has approved a Risk Management Strategy to support this process which is currently being implemented across all directorates. This was subject to on-going review during 2005-06 to align with NPSA's medium term aspirations as set out in strategies and plans; to support the annual business planning and budgetary cycles; to embed the risk management process; and support managers to exploit risk management techniques as a performance management tool.

The responsibility for risk management and the ownership of risks and their controls lie with myself, the directors and line management. To support those responsible for assessing and managing risks, the NPSA has:

- in each directorate, and for the organisation as a whole, nominated 'risk champions' to drive their directorate's and the organisation's risk management activities;
- 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 an effective approach to handling risk which is overseen by Directors and the Management Team.

Throughout 2005-06 the Joint Chief Executives were the designated executive with overall responsibility for implementing the risk management component of the agency-wide system of internal control, and for reporting to the Board. From 1 April 2006 the newly appointed Director of Finance, Facilities and IT is the designated executive with operational responsibility for implementing the agency-wide system of internal control encompassing governance, financial management and risk management and for reporting to the Board.

The Management Team, led by myself, reviews and monitors progress with 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 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.

5 The risk and control framework

It is recognised that the Board has overall responsibility for risk management and that there needs to be clear lines of individual accountability for managing risk throughout the organisation, leading up to the Board.

The 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 overall 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. To this end, the Board has regularly overviewed the risks identified and their management to ensure effective risk management action has been taken.

The key elements of the risk management strategy are:

- As an integral part of the annual planning process the NPSA identifies and evaluates 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 will serve to populate and update department risk management action plans that are currently under development.
- 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 and the public 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.

6 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me 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 me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the comments made by the NPSA's external auditors and risk management advisers.

Internal Audit is a key element of the NPSA's internal control framework because it examines, evaluates and reports on the adequacy and effectiveness of key controls in operation. The Internal Audit function is provided by South Coast Audit and its work is conducted to professional standards as outlined in the NHS internal Audit Manual. Through the implementation of audit recommendations by Directorates internal controls and operational effectiveness and efficiency are strengthened.

The following is the Head of Internal Audit's opinion on this Statement on Internal Control and the assurance framework:

'The purpose of the annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control.

The overall opinion is that limited assurance can be given as weaknesses in the design, and/or inconsistent application of controls, put the achievement of the organisation's objectives at risk in one of the areas reviewed.

The assurance is limited due to the results of our review on procurement, which addressed significant control issues. It is also limited due to the limitations in third party assurance that can be obtained from the Department of Health's Internal Auditors. In other areas reviewed, we were able to provide significant assurance.'

I have been advised on the implications of the result of my 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.

Risk management – As planned in 2005-06, the organisation has taken actions to optimise our risk management processes. Actions included:

- The organisation continued implementing actions resulting to bridge the gaps identified by the 2004-05 self assessment exercise against NAO's 'Good practice in the application of risk management – self-assessment questions for departments'.
- Risk management advisers 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 2005-06, 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;
- the development of an action plan to address gaps in controls and gaps in assurance, and the following-through of these actions;
- the 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;
- that learning from business incidents and near misses has been attained and our systems improved based on our learning, e.g. improvements to the process for fast tracking patient safety notices;
- the risk management policy and strategy has been reviewed and updated;
- that supporting guidance which assists directors, designated risk champions and all staff in risk identification, assessment, control and assurance has been reviewed and updated.

In 2006-07 it is planned to optimise further our risk management processes. This includes:

- integrating the governance, financial management and risk management systems;
- reviewing and updating the risk management policy and strategy, and the risk management guidance documents, and implementing resulting changes;
- continued training for staff in risk management.
- strengthening IT disaster recovery arrangements

Procurement – Early in the year, procurement was included in the Internal Audit Work Plan as compliance with procedures was weak in a number of areas. The needs of a new organisation for appropriate and speciality capacity and the drive for delivery coupled with an increasing workload and the assimilation of NCAS and COREC had led to organisational needs outpacing administrative procedures. A Task Force led by a Non-Executive reviewed key areas of expenditure and the Audit Committee agreed an Action Plan with recommendations that were being implemented during the last quarter of the year. This work will continue into next year with a focus on providing training and support to all NPSA managers and staff involved in procurement. In addition, a report on procurement undertaken by the Department of Health's Auditors was received in June 2006 and an action plan prepared.

Special payment – Included in the special payment note to the Annual Accounts for 2005-06 is a special payment for £277,000 that is agreed to be made as a result of the termination of a contract entered into in 2002. This payment has, in part, been capitalised to reflect the receipt of software to the value of £92,000. The circumstances surrounding this payment have been scrutinised by the Audit Committee and the Board's Non-Executive Directors following the completion of a review by the Department of Health's Auditors in May 2006. Department of Health approval to make the payment was received in June 2006.

NAO review of patient safety – In November 2005 the NAO published *A Safer Place for Patients: Learning to improve patient safety*. The report contained five recommendations specific to the agency. These recommendations are addressed in the agency's Business Plan for 2006-07. The report was also the subject of a Public Accounts Committee hearing, which was published in July 2006 and the Department of Health's response was published as a Treasury minute on 12 October 2006.

Review of Internal Control: other key systems – Areas where (continued) improvements will lead to the strengthening of the control environment and where action plans have been put into place include:

- improved consistency with which controls are applied across the organisation, e.g. budgetary control and procurement;
- introduction of purchase order processing system – developed in the last quarter;
- enhanced capital expenditure controls;
- improved project management for capital schemes and patient safety projects;
- embedding of revised procurement and contract management policies and procedures introduced in the last quarter as 'the way we work';
- strengthening of financial policies and procedures to reflect improvements in controls and ensure consistency across the enlarged organisation;
- embedding the development and use of risk management action plans at directorate level;
- ensuring agreed internal audit recommendations are implemented on time.

This statement was originally prepared by my predecessors prior to them starting a period of extended leave in July 2006. I have reviewed the statement, updated it where appropriate, and have taken advice from senior officers in order to ensure it is accurate.

Interim Chief Executive and Accounting Officer
6 December 2006

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

I certify that I have audited the financial statements of the National Patient Safety Agency for the year ended 31 March 2006 under the National Health Service Act 1977. These comprise the Operating Cost Statement, the Balance Sheet, the Cashflow Statement and Statement of Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them.

Respective responsibilities of the Chief Executive and Auditor

The Chief Executive is responsible for preparing the Annual Report, the Remuneration report and the financial statements in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Chief Executives' responsibilities.

My responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements, and with International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration report to be audited have been properly prepared in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury. I also report 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 to you if, in my opinion, the Annual Report is not consistent with the financial statements, if the National Patient Safety Agency has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by relevant authorities regarding remuneration and other transactions is not disclosed.

I review whether the statement on page xxiv reflects the National Patient Safety Agency's compliance with HM Treasury's guidance on the Statement on Internal Control, and I report if it does not. I am not required to consider whether the Accounting Officer's statements on internal control cover all risks and controls, or form an opinion on the effectiveness of the National Patient Safety Agency's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises only the Remuneration report and the Management commentary. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration report to be audited. It also includes an assessment of the significant estimates and judgments made by the Chief Executive in the preparation of the financial statements, and of whether the accounting policies are most appropriate to the National Patient Safety 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 and the part of the Remuneration report to be audited are free from material misstatement, whether caused by fraud or error 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 also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration report to be audited.

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State with the approval of the Treasury, of the state of the National Patient Safety Agency's affairs as at 31 March 2006 and of its net resource outturn, recognised gains and losses and cashflows for the year then ended;
- the financial statements and the part of the Remuneration report to be audited have been properly prepared in accordance with the National Health Service Act 1977 and directions made thereunder by the Secretary of State 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
14 December 2006

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

The National Patient Safety Agency
Annual Accounts 2005-2006

Operating Cost Statement for the year ended 31 March 2006

	Notes	**2005-06 £000**	2004-05 £000
Programme costs	2.1	**33,748**	30,464
Operating income	4	**(2,836)**	(6,625)
Net operating cost before interest		**30,912**	23,839
Interest payable		**3**	1
Loss on Disposal of Asset	5.4	**507**	10
Net operating cost		**31,422**	23,850
Less: Expenditure not counting against Resource Limit (*)		**(147)**	0
Net resource outturn	3.1	**31,275**	23,850

All income and expenditure is derived from continuing operations

(*) The net operating cost has been reduced by expenditure undertaken from April 05 - August 05 by NHS Estates. Under merger accounting the National Patient Safety Agency is required to report the full year costs of organisations assimilated during the year. However, the NHS Estates net operating cost from April 05 to August 05 was funded by grant from Department of Health. This amount was not subject to resource limit control and the net operating cost has therefore been removed.

Under merger accounting, FRS6, the National Patient Safety Agency is required to show the comparative figures for those functions transferred to them during the financial year. Therefore the 2004-05 figures have been amended to include the balances for COREC, NHS Estates and the National Clinical Assessment Authority.

Statement of Recognised Gains and Losses for the year ended 31 March 2006

		2005-06 £000	2004-05 £000
Unrealised surplus on the indexation of fixed assets	12.2, 12.3	**21**	82
Recognised gains and (losses) for the financial year		**21**	82

The notes at pages 5 to 23 form part of these accounts.

Balance Sheet as at 31 March 2006

	Notes	31 March 2006 £000	31 March 2005 £000
Fixed assets:			
Intangible assets	5.1	**300**	192
Tangible assets	5.2	**1,971**	1,844
		2,271	2,036
Current assets:			
Stocks	6	**0**	8
Debtors	7	**4,826**	3,278
Cash at bank and in hand	8	**5**	2
		4,831	3,288
Creditors: amounts falling due within one year	9.1	**(4,350)**	(4,338)
Net current assets/(liabilities)		**481**	(1,050)
Total assets less current liabilities		**2,751**	986
Provisions for liabilities and charges	10	**(229)**	(203)
		2,522	783
Taxpayers' equity			
General Fund	12.1	**2,486**	530
Revaluation reserve	12.2	**36**	253
		2,522	783

Signed: Bill Stewart Date: 6th December 2006

Accounting Officer

Cash Flow Statement for the year ended 31 March 2006

	Notes	**2005-06 £000**	2004-05 £000
Net cash (outflow) from operating activities	13	**(32,276)**	**(23,146)**
Servicing of finance			
Interest paid		**3**	1
Net cash (outflow) from servicing finance		**(3)**	(1)
Capital expenditure and financial investment:			
(Payments) to acquire intangible fixed assets		**(325)**	(90)
(Payments) to acquire tangible fixed assets		**(328)**	(369)
Net cash (outflow) from investing activities		**(653)**	(459)
Net cash (outflow) before financing		**(32,932)**	(23,606)
Financing			
Net Parliamentary funding	12.1	**32,935**	23,559
Increase in cash in the period	8	**3**	**(47)**

The notes at pages 5 to 23 form part of these accounts.

Notes to the Accounts

Accounting policies

The financial statements have been prepared in accordance with the Government Financial Reporting 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.

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.

Merger accounting, as per FRS 6, requires that the National Patient Safety Agency to show the transactions and balances for the transferrred functions (i.e. National Clinical Assessment Authority, the Central Office of Research Ethics Committee (COREC) and a number of NHS estates functions) for the whole financial year in which the transfer takes place. The standard also requires that the comparators are amended to show the transactions and balances for the preceding financial year, with any balances pertaining to the transferred function being removed.

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 orgnaisations. It includes both income appropriated-in-aid and income to the Consolidated Fund which HM Treasury has agreed should be treated as operating income. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

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 2005-2006 was 3.5% (2004-05 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.

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

i Land and buildings (including dwellings)

Valuations are carried out by the District Valuer of HM Revenue and Customs government department at five yearly intervals in accordance with FRS 15. Between valuations price indices appropriate to the catergory of asset are applied to arrive at the current value. The buildings indexation is based on the All in Tender Price Index published by the Building Cost Information Service (BCIS). The land index is based on the residential building land values reported in the Property Market Report published by the Valuation Office. The valuations were carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. In accordance with the requirements of the Department of Health, the asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005 .

The valuations have been carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. In respect of non-operational properties, including surplus land, the valuations have been carried out at Open Market Value. The value of land for existing use purposes is assessed to Existing Use Value. The valuations do not include notional directly attributable acquisition costs nor have selling costs been deducted, since they are regarded as not material.

To meet the underlying objectives established by the Department of Health the following accepted variations of the RICS Appraisal and Valuation Manual have been required:

- specialised operational assets have been valued on a replacement rather than modern substitute basis;
- no adjustment has been made to the cost figures of operational assets in respect of dilapidations; and
- additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

ii 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.

iii Assets in the course of construction 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

iv Subsequent revaluations to donated fixed assets are taken to the donated asset reserve.

v

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.

	Years
Software licences	3
Bespoke software licences	7
Bespoke database	7

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:

	Years
Furniture and fittings	10
Transport Equipment	5
Information technology	5

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 items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the operating cost statement on an accruals basis, 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). However, note 18 is compiled directly from the losses and compensations register which is prepared on a cash basis.

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 Scheme is subject to a full valuation for FRS17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to asses the scheme's assets and liabilities to allow a review of the employers contribution rates, this valuation took place as at 31 March 2004 and has yet to be finalised. The last published valuation on which contributions were based 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.nhspa.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 are set at 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% (manual staff 5%) of their pensionable pay.

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

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 2.2% in real terms. This is a change from the rate of 3.5% applied from 2003-04. The effect of the change is to increase the carrying value of the provisions, this is shown in note 10.

2.1 Authority programme expenditure

	Notes	£000	2005-06 £000	2004-05 £000
Non-executive members' remuneration			**101**	179
Other salaries and wages	2.2		**16,262**	15,748
Supplies and services - general			**235**	231
Establishment Expenses			**5,442**	5,460
Transport and moveable plant			**43**	32
Premises and fixed plant			**3,177**	3,057
External contractors (*)			**7,382**	4,272
Capital: Depreciation and amortisation	5.1, 5.2	**421**		381
Capital charges interest		**58**		30
			479	411
Auditor's remuneration: Audit Fees (**)			**50**	62
Services from other NHS bodies			**0**	39
Writing off Bad Debts			**2**	127
Other Miscellaneous			**575**	846
			33,748	30,464

(*) This includes payments of £3,034k for the three Confidential Enquiries from 01/04/2005.
(**) The Authority did not make any payments to Auditors for non audit work.

2.2 Staff numbers and related costs

	2005-06 Total	Permanently employed staff	Other	2004-05
	£000	£000	£000	£000
Salaries and wages	**13,885**	10,486	3,399	13,497
Social security costs	**1,012**	1,012	0	964
Employer contributions to NHSPA	**1,365**	1,365	0	1,287
	16,262	**12,863**	**3,399**	15,748

The average number of employees during the year was:

	Total Number	Permanently employed staff Number	Other Number	2004-05 Number
Total	**304**	233	71	291

Expenditure on staff benefits

The amount spent on staff benefits during the year totalled £83,471 (2004-05: £117,947).

Retirements due to ill-health

During 2005-06 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 Better Payment Practice Code - measure of compliance

	Number	£000
Total non NHS bills paid 2005-06	**10,244**	**21,412**
Total non NHS bills paid within target	**9,097**	**18,433**
Percentage of non NHS bills paid within target	**88.8%**	**86.1%**

	Number	£000
Total NHS bills paid 2005-06	**382**	**5,458**
Total NHS bills paid within target	**308**	**4,836**
Percentage of NHS bills paid within target	**80.6%**	**88.6%**

The Late Payment of Commercial Debts (Interest) Act 1998

	2005-06 £000	2004-05 £000
Amounts included within interest payable arising from claims made under this legislation	3	1
	3	1

3.1 Reconciliation of net operating cost to net resource outturn

	2005-06 £000	2004-05 £000
Net operating cost	**31,422**	23,850
Less: Expenditure not counting against Resource Limit (*)	**(147)**	0
Net resource outturn subject to Resource Limit (*)	**31,275**	**23,850**
Revenue resource limit	**31,326**	24,220
Under spend against revenue resource limit	**51**	370

(*) The net operating cost has been reduced by expenditure undertaken from April 05 - August 05 by NHS Estates. Under merger accounting the National Patient Safety Agency is required to report the full year cost of organisations assimilated during the year. However, the NHS Estates net operating cost from April 05 to August 05 was funded by grant from the Department of Health. This amount was not subject to resource limit control and the net operating cost has therefore been removed.

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2005-06 £000	2004-05 £000
Gross capital expenditure	**1,143**	532
NBV of assets disposed	**(507)**	(10)
Net capital resource outturn	**636**	522
Capital resource limit	**1,056**	545
Under spend against limit	**420**	23
Less: Payment to acquire fixed assets (COREC) **	(308)	0
Under spend against limit *	**112**	**23**

* The £112,000 underspend relates to an underspend on the COREC capital programme of £82,000 and £30,000 relating to the National Patient Safety Agency.

** Under merger accounting rules, as per FRS 6, the fixed assets transferred from COREC on 1 April 2005 have been included in the NPSA's opening balances for 2005-06. The payment of £308k made for these assets is not therefore included in gross capital expenditure for the year.

4 Operating income

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

	Appropriated in aid £000	Not Appropriated in aid £000	Total £000	2004-05 £000
Programme income:				
Fees & charges to external customers	335	**0**	**335**	125
Income received from National Assembly for Wales	1631	**0**	**1,631**	517
Income received from Northern Ireland Assembly	350	**0**	**350**	146
Income received from other Departments	0	**520**	**520**	5,824
Other	0	**0**	**0**	13
Total	**2,316**	**520**	**2,836**	6,625

5.1 Intangible fixed assets

	Software licences £000	Total £000
Gross cost at 31 March 2005	295	**295**
Additions - purchased	**124**	**124**
Reclassification	**88**	**88**
Gross cost at 31 March 2006	**507**	**507**
Accumulated amortisation at 31 March 2005	103	**103**
Charged during the year	**104**	**104**
Accumulated amortisation at 31 March 2006	**207**	**207**
Net book value:		
Purchased at 31 March 2005	192	**192**
Total at 31 March 2005	192	192
Net book value:		
Purchased at 31 March 2006	**300**	**300**
Total at 31 March 2006	**300**	**300**

5.2 Tangible fixed assets

	Assets under construction	Buildings exc dwellings	Information technology	Total
	£000	**£000**	**£000**	**£000**
Cost or Valuation at 31 March 2005	233	1,456	751	**2,440**
Additions - purchased	**641**	**11**	**367**	**1,019**
Reclassification	**(233)**	**0**	**145**	**(88)**
Indexation	**0**	**27**	**0**	**27**
Disposals	**0**	**(808)**	**0**	**(808)**
Gross cost at 31 March 2006	**641**	**686**	**1,263**	**2,590**
Accumulated depreciation at 31 March 2005		391	205	**596**
Charged during the year		126	191	**317**
Indexation		7	0	**7**
Disposals		(301)	0	**(301)**
Accumulated depreciation at 31 March 2006		**223**	**396**	**619**
Net book value:				
Purchased at 31 March 2005	233	1,065	546	**1,844**
Total at 31 March 2005	233	1,065	546	1,844
Net book value:				
Purchased at 31 March 2006	**641**	**463**	**867**	**1,971**
Total at 31 March 2006	**641**	**463**	**867**	**1,971**

5.2 Tangible fixed assets (continued)

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

5.3 Net Book Value of land and buildings

The net book value of land, buildings and dwellings as at 31 March 2006 comprises:

	31 March 2006	31 March 2005
	£000	£000
Short leasehold	**463**	1,065
	463	1,065

5.4 Profit/(loss) on disposal of fixed assets

	2005-06	2004-05
	£000	£000
(Loss) on disposal of intangible fixed assets	0	(10)
(Loss) on disposal of land and buildings	(507)	0
	(507)	(10)

6 Stocks and work in progress

	31 March 2006	31 March 2005
	£000	£000
Raw materials and consumables	0	8
	0	8

7 Debtors

7.1 Amounts falling due within one year

	31 March 2006	31 March 2005
	£000	£000
NHS debtors	274	541
Provision for irrecoverable debts	(1)	(1)
Prepayments	2,839	825
Other debtors	1,673	1,913
Accrued Income	41	0
	4,826	3,278

7.2 Amounts falling due after more than one year

At 31 March 2006 the Authority had no debtors falling due after more than one year (2004-05: £Nil).

8 Analysis of changes in cash

	At 31 March 2005 £000	**Change during the year £000**	**At 31 March 2006 £000**
Cash at OPG	1	**3**	**4**
Cash at commercial banks and in hand	1	**0**	**1**
	2	**3**	**5**

9 Creditors:

9.1 Amounts falling due within one year

	31 March 2006 £000	31 March 2005 £000
NHS creditors	**1,056**	1,262
Capital creditors	**574**	86
Tax and social security	**316**	141
Other creditors	**1,247**	770
Accruals	**1,142**	1,737
Deferred income	**15**	342
	4,350	4,338

9.2 Amounts falling due after more than one year

At 31 March 2006 the Authority had no creditors falling due after more than one year (2004-05: £Nil).

9.3 Finance lease obligations

At 31 March 2006 the Authority had no finance lease obligations (2004-05 £Nil).

10 Provisions for liabilities and charges

	Legal claims	Other	Total
	£000	**£000**	**£000**
At 31 March 2005	0	203	203
Arising during the year	**211**	**18**	**229**
Utilised during the year	**0**	**(134)**	**(134)**
Reversed unused	**0**	**(69)**	**(69)**
At 31 March 2006	**211**	**18**	**229**
Expected timing of cash flows:			
Within 1 year	211	18	**229**

The provision of £211,000 included in 'Legal claims' is made up of the special payment disclosed in note 18 and a provision in relation to two cases. The provision of £18,000 included in 'Other' category relates to back payment of staff that will be required as a result of Agenda for Change.

11 Movements in working capital other than cash

	2005-06	2004-05
	£000	£000
(Decrease) in stocks	**(8)**	(5)
Increase in debtors	**1,548**	2,031
(Increase) / Decrease in creditors	**476**	(2,105)
	2,016	(79)

12 Movements on reserves

12.1 General Fund

	2005-06 £000	2004-05 £000
Balance at 31 March 2005	530	791
Net operating costs for the year	**(31,422)**	(23,850)
Add: NHS Estates expenditure not counting against Resource Limit	**147**	0
Net Parliamentary funding	**32,935**	23,559
Transfer of realised profits/losses from revaluation reserve	**238**	0
Non-cash items: Capital charge interest	**58**	30
Balance at 31 March 2006	**2,486**	530

12.2 Revaluation reserve

	2005-06 £000	2004-05 £000
Balance at 31 March 2005	253	171
Indexation of fixed assets	**21**	82
Transfer to general fund of realised elements of revaluation reserve	**(238)**	0
Balance at 31 March 2006	**36**	253

12.3 Donated asset reserve

The National Patient Safety Agency did not hold a donated asset reserve at the end of the financial year 2005-06.

13 Reconciliation of operating costs to operating cash flows

	Notes	2005-06 £000	2004-05 £000
Net operating cost before interest for the year		**30,912**	23,839
against Resource Limit		**(147)**	0
Adjust for non-cash transactions	2.1	**(479)**	(411)
Adjust for movements in working capital other than cash	11	**2,016**	(79)
(Increase) in provisions	10	**(26)**	(203)
Net cash outflow from operating activities		**32,276**	23,146

14 Contingent liabilities

As a result of the merger of former bodies on 1st April 2005 there remains one outstanding employment issue which could result in a redundancy and a cost to the Agency of £365,000. The employee and the Agency are discussing alternative solutions.

The National Patient Safety Agency believes that it is unlikely that the final solution will require the Agency to make

15 Capital commitments

At 31 March 2006 the value of contracted capital commitments was £518,442. This relates to £92,000 software for

16 Commitments under operating leases

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

	2005-06 £000	2004-05 £000
Hire of plant and machinery	**37**	12
Other operating leases	**1,154**	1,361
	1,191	1,373

Commitments under non-cancellable operating leases:
accounts are given in the table below, analysed according to the period in which the lease expires.

Land and buildings		**2005-06 £000**	2004-05 £000
Operating leases which expire:	within 1 year	**40**	0
	between 1 and 5 years	**163**	0
	after 5 years	**919**	1,311
		1,122	1,311
Other leases			
Operating leases which expire:	within 1 year	**41**	2
	between 1 and 5 years	**46**	75
	after 5 years	**0**	10
		87	87

17 Other commitments

The National Patient Safety Agency has entered into a contract to the value of £839,412 with the University of Manchester for one of the three confidential enquiries for 2006-07. The other two confidential enquiry contracts for 2006-07 were paid on the 31st March 2006 and have been included within prepayments.

18 Losses and special payments

The total value of the losses and special payments were £14,162.43 and £302,860 respectively. These figures include the payment for software described in the following paragraph.

The Authority entered into a contract to supply IT services and software in 2002 which the suppliers claim was wrongly terminated by the Agency. A settlement has been made with the contractor in the sum of £277,000. This included a payment of £92,000 for software. The software provides an essential tool to enable the Authority to manage its websites and as such generates a fixed asset. The Authority has undertaken a comparative exercise to assure itself that the software with this functionality can not be obtained from another source at better value.The software will become operational in 2006/7 and will be included as capital expenditure in that year and therefore forms part of the capital commitments reported at note 15 above. The balance of the payment is included as a provision in 2005/06.

As these circumstances are novel the matter was referred to the Department of Health for approval, which was given in June 2006. The payment was agreed in principle prior to 31st March and is therefore included in these accounts as a provision.

19 Related parties

The National Patient Safety Agency 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 National Patient Safety Agency 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.

The National Patient Safety Agency has considered materiality in line with the manual for accounts guidelines for agreeing creditor and debtor balances (£20k) and income and expenditure balances (£50k).

	Payments in Year 05/06 £000	Receipts in Year 05/06 £000	Debtor @ 31.03.06 £000	Creditor @ 31.03.06 £000
Barnet Enfield & Haringey Mental Health NHS Trust	91	0	0	13
Birmingham And The Black Country Strategic HA	116	0	0	37
Brighton & Sussex University Hospitals NHS Trust	56	0	0	3
Department Of Health	184	85	69	0
Greater Manchester Strategic HA	91	0	0	28
Healthcare Commision	0	0	21	0
Kent & Medway Strategic Health Authority	114	0	1	37
Mersey Care NHS Trust	77	0	0	27
NHS Connecting For Health	0	0	118	0
NHS Institute For Innovation And Improvement	0	20	20	0
NHS Logistics Authority	75	0	0	0
North West London Hospitals NHS Trust	131	0	0	36
Northumberland, Tyne & Wear SHA	94	0	0	40
Oxfordshire Mental Healthcare NHS Trust	57	0	0	0
Papworth Hospital NHS Trust	87	0	0	23
Reading Primary Care Trust	55	0	0	46
South Downs Health NHS Trust	49	0	0	1
South Hams And West Devon PCT	61	0	0	0
South Huddersfield PCT	79	0	0	19
South Warwickshire General Hospital NHS Trust	65	0	0	0
The Pennine Acute Hospital NHS Trust	59	0	0	0
The Whittington Hospital NHS	67	0	0	0
Trent Strategic Health Authority	71	0	0	24
West London Mental Health NHS	159	0	0	0

20 Post balance sheet events

In March 2006 the Chief Medical Officer announced a review of the organisational arrangements that are in place to support patient safety. The outcome of the review is expected to be published in December 2006.

In July 2006 the Joint Chief Executives started a period of extended leave and in November 2006 requested that they be granted Voluntary Early Retirement. The Authority, following receipt of approval from HM Treasury, granted this request in principle and arrangements were being finalised.

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

represents less than 1% 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	875	0	461	0
Balances with local authorities	0	0	0	0
Balances with NHS Trusts	240	0	851	0
Balances with public corporations and trading funds	0	0	0	0
Balances with bodies external to government	3,711	0	3,038	0
At 31 March 2006	**4,826**	**0**	**4,350**	**0**
Balances with other central government bodies	745	0	422	0
Balances with local authorities	200	0	1	0
Balances with NHS Trusts	1,261	0	1,147	0
Balances with public corporations and trading funds	0	0	16	0
Balances with bodies external to government	1,072	0	2,752	0
At 31 March 2005	3,278	0	4,338	0

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