NHS
National Patient Safety Agency

NPSA Annual Report & Accounts 2009/10

- Supporting the NHS in providing safer care for all
- Helping resolve performance concerns about dentists, doctors and pharmacists
- Protecting research participants and facilitating ethical research

The National Patient Safety Agency Annual Report and Accounts 2009/10

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Chairman's introduction

Lord Naren Patel of Dunkeld, KT

In November 2005 I was appointed Chairman of the National Patient Safety Agency (NPSA). This year I announced my intention to step down from the post. Looking back over my time as Chairman, I am proud of the dramatic changes that have been made to the organisation and the steps that have been taken to help improve patient safety across the NHS.

Patient safety is now becoming the top priority for NHS staff and organisations and, in particular, boards and management of NHS organisations have begun to realise the importance of embedding a patient safety culture within their organisation.

During 2009/10 the Agency has continued to drive the patient safety agenda forward with authority and purpose.

Our collection of patient safety incident data through our uniquely-positioned national reporting system continues to form the backbone of our patient safety work, by providing the evidence that dictates our work and priorities. However, it has become clear that the NHS needs us to work more closely with them to develop solutions that will be easy to implement and, importantly in these pressing economic times, financially-viable.

Working with a variety of professional organisations, as well as with frontline NHS staff, we have issued practical and solution-oriented patient safety guidance and recommendations on areas including the safety of children and young people, the prevention of suicide in mental health organisations and improving patient safety on maternity wards.

The Patient Safety area of our work has undergone significant internal changes over the last year; in particular the re-organisation of itself in order to focus on providing implementation-ready solutions to the NHS, and to enable itself to concentrate on a targeted programme of work during 2010/11. I am confident that these changes will enable the division to continue to help improve the safety of patients in NHS healthcare organisations.

The protection of patients depends on the professional, committed performance of the healthcare staff who care for them. The work of the National Clinical Assessment Service (NCAS) in helping resolve performance concerns has continued to support frontline services in delivering high quality care.

The detailed analysis of medical and dental performance concerns over eight years is a fascinating look into the reasons behind performance concerns; it provides valuable insight that will help healthcare organisations identify, manage and prevent such concerns so that the safety of patients can be assured. The report of this analysis, *NCAS Casework – The first eight years,* demonstrates the importance of the service and, with the introduction of revalidation, its contribution will increase in maintaining professional, highly-performing practitioners.

An ambitious change programme for the National Research Ethics Service (NRES) has seen the drive towards greater efficiencies and standardisation continue this year. The work that has been done over the last year has taken the service even further along the road to becoming an internationally recognised system of ethical review, and is one of the key organisations in making the NHS a centre for research excellence.

It is with great pride that I can look back over what has been achieved by the NPSA during my time as Chairman, and I look forward to seeing how it will continue to help the NHS to protect patient safety and deliver high quality healthcare over the coming years.

I would like to thank everyone involved in the Agency for another successful year, and for the dedication and commitment that they have shown during my time as Chairman.

Chairman

Chief Executive's introduction

Sarndrah Horsfall

Ensuring patients are cared for safely in the NHS requires a culture that puts patient safety at its core and promotes learning from patient safety incidents. The NPSA is in a unique position in that we are able to see a national picture of patient safety, allowing us to work with the NHS to capture, analyse and interpret data to facilitate learning and ensure patient safety is considered at every step of the healthcare journey.

Protecting research participants and facilitating ethical review is a central part of the NPSA's work and, this year, in response to *Best Research for Best Health*, NRES has made a series of significant changes to create a more streamlined, efficient and responsive service. This has included the creation of more Research Ethics Committee (REC) centres and the introduction of the expedited ethical review service. This service was used for the first time in May 2009 to ensure that all research applications on swine flu were processed rapidly.

Our ability to respond quickly is testament to the robust systems and procedures in place at NRES. These have now been recognised externally by the British Standards Institute, and we are proud to have achieved ISO 9001 certification in October 2009.

It has been a challenging year for NRES, with considerable change and reorganisation, and I would like to thank everyone involved in the service for their commitment and professionalism.

There have also been substantial changes taking place in the practice of pharmacy and its regulation and, to reflect this, NCAS has extended its service to include pharmacists. Work has been undertaken to support the local management of concerns about pharmacists' performance, with emphasis placed on ensuring that our services take into account the scope and context of pharmacy practice. To assist with its implementation we have drawn on the learning from the services we provide to doctors and dentists.

Our support for doctors and dentists has also continued to grow this year, with over 900 new cases referred to NCAS. In order to provide the best possible service, we are continually evaluating our performance and exploring new ways in which we can support the NHS. We published *NCAS Casework – The first eight years*, the largest study of medical and dental performance concerns ever carried out in the UK, in September 2009.

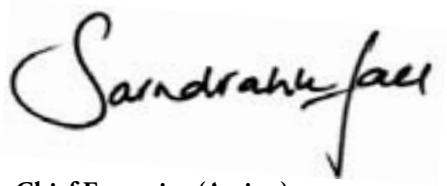
The number of incident reports that our Patient Safety division receives has increased year-on-year, and we have recently begun to see a decrease in the number of reports of serious incidents. The announcement that we will be taking over control of the Central Alerting System from the Department of Health in 2010 will help us to work closely with the NHS to analyse patient safety data and support local action planning.

Building on the National Reporting and Learning System (NRLS), we have made significant steps in developing our Patient Safety Direct programme. This will provide the NHS with a customised, accessible and streamlined reporting process and strengthen its capacity to learn from the most serious incidents. In addition, it will enable quick and convenient access to patient safety resources to help support local actions to improve patient safety.

We have continued to work collaboratively with other organisations to ensure patient safety is at the top of the healthcare agenda. In particular, we have begun sharing our data on patient safety incidents with the Care Quality Commission (CQC) so that we can work together to identify areas for improvement. Through key campaigns such as Patient Safety First, 1000 Lives and clean**your**hands, we have worked at a local level to influence practice and heighten patient safety awareness.

None of the achievements outlined in this Annual Report would have been possible without the dedication of the Agency's staff, and I congratulate them for another busy and effective year.

Finally I would also like to take this opportunity to thank Lord Patel for his unwavering commitment to the Agency and strategic direction he has provided over the years in which he has overseen the NPSA as Chairman. It has been a pleasure to work alongside him and I wish him all the best for the future. I would also like to thank the Board and the Senior Management Group for their support and direction over the last year.



Chief Executive (Acting)

Patient Safety

Supporting the NHS in providing safer care for all

Highlights 2009/10:

- Supported large scale change across the NHS through patient safety improvement programmes, including Matching Michigan
- Improved reporting through specialty-specific systems and the Never Events framework
- Designed a transformational change programme, Patient Safety Direct, to improve capture, analysis and intelligent feedback on patient safety
- Increased awareness of the scale of risk and harm across England and Wales with release of organisation level incident reporting data
- Released guidance on designing out error and risks to patient safety
- Supported the Patient Safety First campaign in England and 1000 Lives Campaign in Wales
- Re-released *Being open* to improve communication with patients and their families following patient safety incidents

The publication of *An organisation with a memory* in 2000 signalled the start of a patient safety journey for the NHS; one in which the NPSA has played a leading role. This year, our Patient Safety work has concentrated on providing practical tools and knowledge that NHS staff, management and boards can use to embed patient safety within their organisations.

PATIENT SAFETY

Leading the patient safety agenda

The Patient Safety division is the leading voice for patient safety in the NHS, working collaboratively at a national, regional and local level to ensure patient safety is healthcare's top priority. During the year it has contributed to and advised the Health Select Committee, the National Quality Board and the National Patient Safety Forum.

In addition, the Patient Safety division supported Patient Safety First in England, providing leadership and direction for this unique campaign which used social movement principles to create large scale change. This was in partnership with the NHS Institute for Innovation and Improvement and the Health Foundation. The Patient Safety division was also a key contributor to the 1000 Lives Campaign in Wales.

Patient Safety Direct

Building on the current NRLS, our Patient Safety Direct programme will further develop how the NHS learns from patient safety incidents and improves patient safety by creating:

- **a customised and simpler incident reporting process, accessible and relevant to all healthcare practitioners;**
- **strengthened arrangements for reporting and learning from the most serious incidents, with quicker notification and feedback of the relevant lessons learned (and related national resources), and the distribution of relevant incidents to the CQC/Medicines and Healthcare products Regulatory Agency (MHRA);**
- **instant access to patient safety resources and improved collaboration between healthcare practitioners to enhance national learning;**
- **improved feedback, insight and intelligence on patient safety risks, and increased transparency of patient safety information, to support and enhance local priority setting and action.**

Work to deliver the benefits of Patient Safety Direct will continue during 2010/11.

Reporting and learning

Patient safety can only be improved if we know the scale and scope of the problem, and what can be done to prevent risk occurring and harm from happening. We have continued this year to encourage NHS staff to report patient safety incidents to us, so that we can analyse these data on a national level and identify key themes and trends for priority action.

In the busy healthcare environment, it is vital for it to be easy and quick to report incidents. We have worked with healthcare staff to develop specialty-specific reporting tools tailored to their needs. Reporting forms for anaesthesia and a revised form for GPs were launched in November 2009.

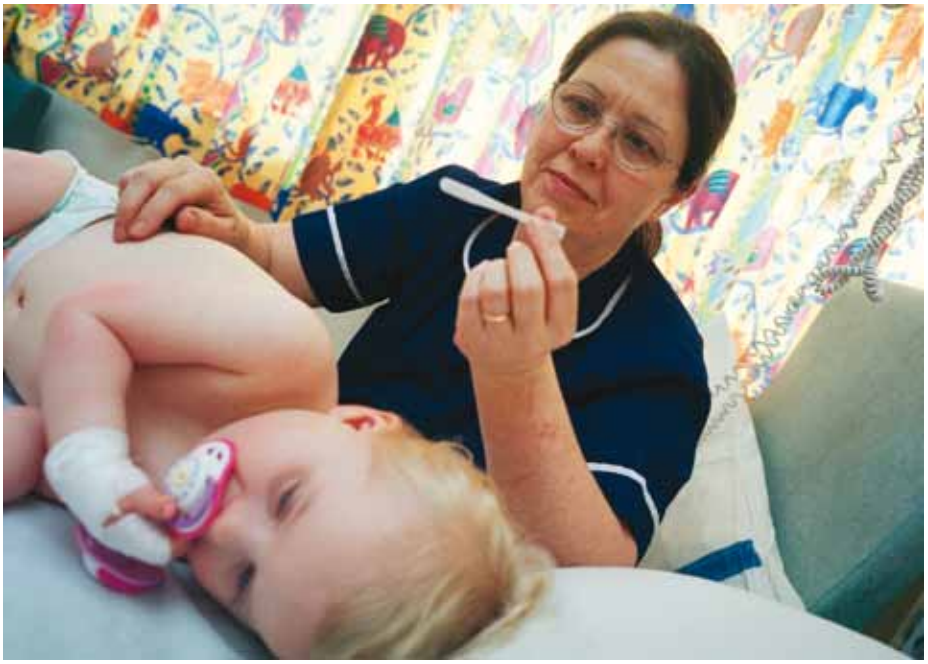
In order to reduce inconsistency and improve reporting of serious incidents, we consulted with key NHS stakeholders, including the CQC, the Department of Health, the MHRA, the NHS Litigation Authority, Monitor and the Independent Healthcare Advisory Services. This resulted in the publication of the *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation* in England. This replaces individual strategic health authority and commissioning primary care trust (PCT) serious untoward incident policies, and provides guidance on notification, management and learning from serious incidents.

The framework is the first stage in the development of a consolidated Serious Incident Management System, a key output of Patient Safety Direct, that will replace the current Strategic Executive Information System (STEIS) in 2010.

Between April 2009 and March 2010, 1,190,475 reports of patient safety incidents were received by the NRLS. These incidents are scrutinised to extract key safety issues and learning. Our team of experts individually review all incidents that are reported to have resulted in serious harm or death of a patient. A wide-ranging and extensive scoping exercise then takes place, including consultation with relevant clinical specialists and expert organisations.

For those risks that are not well recognised by staff, and for which there are clear actions available to prevent harm, Rapid Response Reports (RRRs) are issued. Nine RRRs were issued during 2009/10, with diverse topics ranging from the incorrect storage of vaccines, to tourniquets being left on following toe or finger surgery.

The NRLS now holds just over four million patient safety incidents. Given the large number of incidents, in September 2009 we began a pilot of an electronic bulletin, *Signals,* which highlights emerging issues from national review of serious patient safety incidents. We hope to evaluate the impact of the pilot in 2010.



Matching Michigan

Eighty per cent of intensive care units (ICUs) in England are participating in Matching Michigan.

This patient safety project is based on a model developed in the US which, over 18 months, saved around 1,500 patient lives by introducing measures that reduced central venous catheter bloodstream infections (CVC-BSI) in ICUs.

This quality improvement project started with data collection to identify, measure and monitor infection rates. In many cases, it is the first time this type of data has been collected. ICU staff are also trained in techniques to improve safety culture and safe use of central lines.

Patient safety statistics

The NPSA's regular publication of summary reports of patient safety incident data for each NHS organisation in England and Wales has continued in 2009/10, with two releases of data.

The latest release of these official statistics in March 2010 showed that, since the previous release in October 2009, the number of incidents that were reported to have resulted in the death of the patient has fallen significantly, from 2,124 (October 2008 to March 2009) to 1,215 (April 2009 to September 2009), and the number of reports of incidents overall has risen sharply, from 486,449 (October 2008 to March 2009) to 536,010 (April 2009 to September 2009).

Detailed themed analysis of data and other sources of safety information continue to be a priority, and March 2010 saw the release of *Delayed diagnosis of cancer: Thematic review* which presented the findings of an NPSA project to explore patient safety issues around delayed diagnosis, and provide the NHS with potential solutions.

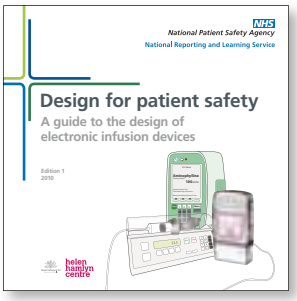
Safety in Doses, published September 2009, included analysis of 72,482 medication incidents reported to the NRLS by NHS staff in acute, mental health and primary care sectors, and identified key learning from these incidents.

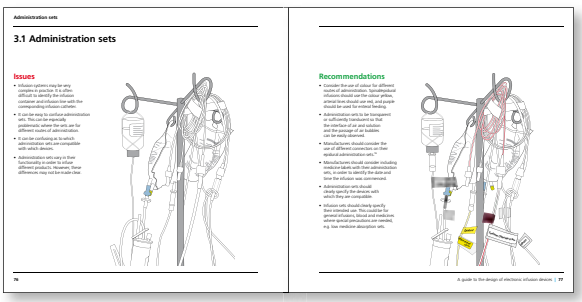
Supported by the release of *Seven steps to patient safety in general practice* in June 2009, the last year also saw an increase in the number of incident reports received from the primary care sector.

Design for patient safety

Our *Design for patient safety* series looks at how better design can reduce risk, improve the working environment and ensure improved, patient-centred care.

This year we launched further practical guides on designing for patient safety in a range of areas, including a guide on the design of electronic infusion devices, and the safe onscreen display of medicines information.



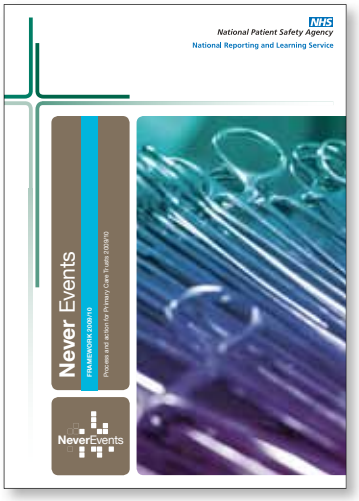


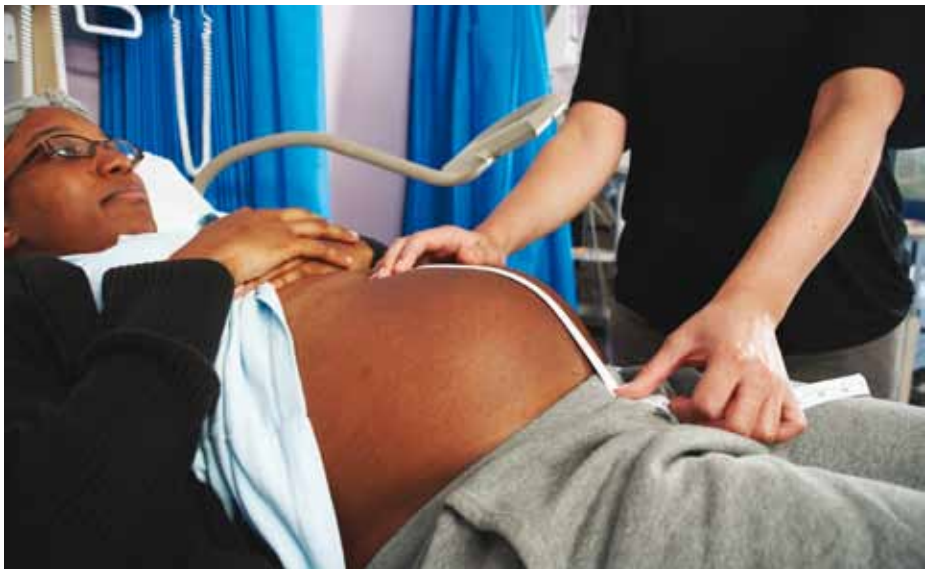
Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

A policy on Never Events was introduced in the NHS in England from April 2009, following its proposal in *High Quality Care for All: NHS Next Stage Review* (Department of Health, June 2008). The policy is designed to promote transparency and accountability when serious patient safety incidents occur.

Implementation of the Never Events policy is phased: the first phase was from April 2009 to March 2010, during which time PCTs have been monitoring Never Events within commissioned services.





Collaboration to produce practical solutions

Identifying, establishing and embedding patient safety improvements is a joint effort. We have continued to work alongside NHS staff, experts and other healthcare organisations to ensure our tools and guidance are relevant, practical and transformational.

Working with a variety of organisations, in June 2009 we launched a review of patient safety for children and young people, while in February 2010 we launched the intrapartum scorecard for use by maternity services to monitor and improve patient safety on labour wards. The scorecard helps teams identify patient safety issues in advance so timely and appropriate action is taken to ensure safe maternity care.

This year we have also developed and launched:

- care bundles on gentamicin for neonates and placenta praevia after Caesarean section;
- a toolkit for the prevention of suicide in mental health services;
- an online resource to support hydration best practice in hospitals.

In November 2009 we announced a purchasing for safety initiative for safer spinal (intrathecal), epidural and regional devices. The objective of this is to eliminate the use of luer universal connectors and intravenous infusion spikes in spinal (intrathecal), epidural and regional devices across NHS organisations in England and Wales, in order to prevent risk to patients.

To help management and board members lead the safety culture in their organisation, we worked with the NHS Confederation and the Appointments Commission to produce factsheets setting out seven questions for NHS board members across the different care settings. In answering the questions they are able to identify gaps in their safety culture and work towards improving it.

We also held two national training events for NHS non-executive directors, to demonstrate how they can lead and influence a patient safety culture within their organisation.

Saying sorry when things go wrong

Open and honest communication with patients is at the heart of healthcare. In 2005 we issued guidance on communicating effectively with patients and their families following a patient safety incident. In November 2009 this guidance was reviewed and re-launched as the new *Being open* framework.

This is a best practice guide for all healthcare staff, including boards, clinicians, and patient advice and liaison services. It explains the principles behind *Being open* and outlines how best to communicate with patients and their families and carers following harm. The guidance and actions outlined in the accompanying Patient Safety Alert provide reassurance that *Being open* is the right thing to do; encouraging NHS boards to make public commitments to openness, honesty and transparency.

Campaign progress

Hand hygiene to reduce healthcare-associated infection

2009 saw the fourth year of the clean**your**hands campaign in acute trusts, and the second stage of the campaign in primary care, mental health, ambulance and care trusts. It was a year of greater integration for the campaign across all trust types, with the *Five Moments for hand hygiene* forming the central theme for activity.

To help healthcare staff better understand when they need to clean their hands during patient interaction and why, the clean**your**hands campaign has embraced the *Five Moments for hand hygiene,* developed by the World Health Organization. A toolkit of resources has been developed to assist infection control staff in understanding the approach and applying it locally. Roll-out of the toolkit was supported by a programme of regional workshops across England and Wales: 286 infection control staff from 239 NHS trusts attended the workshops.

Making the safety of patients everyone's highest priority

Patient Safety First in England is a campaign that aims to make the safety of patients everyone's highest priority. At its heart is a vision of an NHS with no avoidable harm and no avoidable death. Through its website, networking, webinars and contact with trusts, Patient Safety First provides practical guides and tools to encourage the use of evidence-based interventions to improve patient safety, and promotes an improvement methodology approach to create safer, more reliable care for patients.

Since the launch of the campaign in June 2008, more than 96 per cent of acute and 64 per cent of non-acute trusts have committed to Patient Safety First, and more than 120 trusts have set long-term strategic aims for patient safety improvement.

The NPSA will be working, together with the other supporters of the campaign, to provide support to enable trusts to build on the excellent achievements made to date.

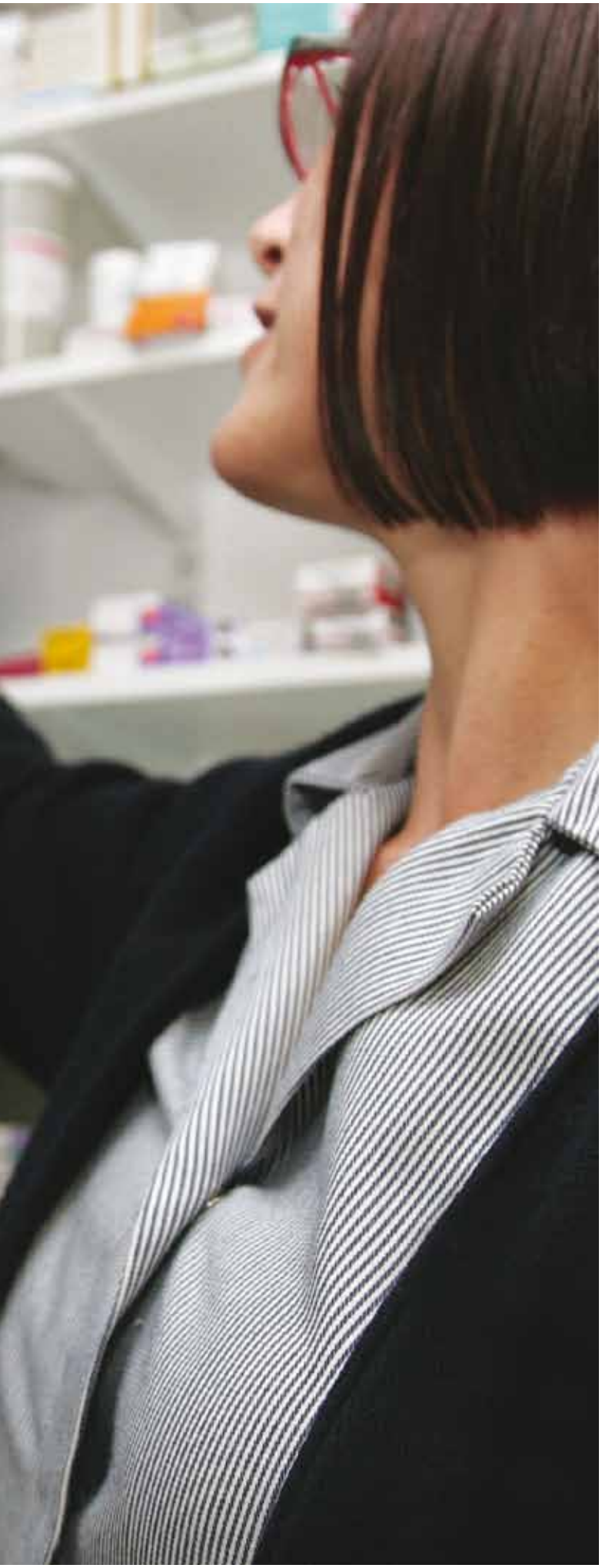
The evidence-based interventions promoted by Patient Safety First are:

- leadership for safety, including patient safety walkrounds;
- reducing harm from deterioration;
- reducing harm in perioperative care, which includes supporting the implementation of the Surgical Safety Checklist;
- reducing harm in critical care;
- reducing harm from high-risk medicines.

1000 Lives Campaign: delivering safer patient care in Wales

The 1000 Lives Campaign has been an outstanding national effort to improve the safety and quality of healthcare in Wales. Every health board and trust in Wales has got involved in the campaign, which focused on six key action areas, including reducing healthcare-associated infections and surgical complications, and improving critical care and medicines management.

The campaign will be succeeded in May 2010 by 1000 Lives Plus, a five-year programme which aims to embed patient safety and the pursuit of higher quality standards in Welsh healthcare.



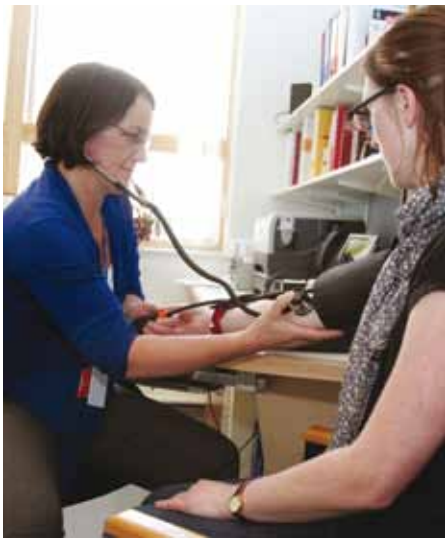
National Clinical Assessment Service

Helping resolve performance concerns about dentists, doctors and pharmacists

Highlights 2009/10:

- Over 900 new cases referred to NCAS
- Launch of NCAS service for pharmacists, with 49 referrals made in the first year
- Publication of report reviewing the first eight years of NCAS activity; the largest study of medical and dental performance concerns carried out in the UK
- NCAS statistics recognised as official statistics
- Development work for NCAS's role in revalidation and extension to other professionals
- Extensive programme of educational workshops to promote effective systems of professional governance.

This year we have continued to provide advice and specialist intervention to help resolve performance concerns. Our service for pharmacists was launched and we published detailed analysis of referrals to NCAS during our first eight years.

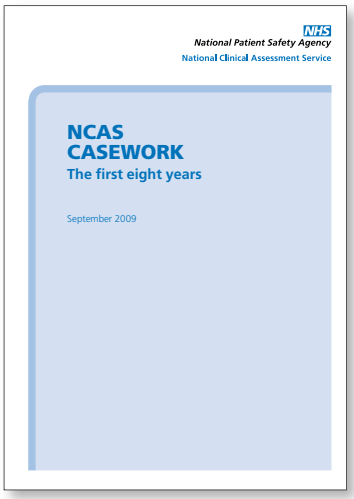


Analysing NCAS casework

In September 2009 NCAS published the largest study of medical and dental performance concerns ever carried out in the UK.

NCAS Casework – The first eight years **used information about just over 4,500 practitioners referred to NCAS by March 2009 to identify which groups were more likely to be referred and what can be learned from referral patterns. It also examined episodes of suspension and exclusion, and analysed the nature of concerns in nearly 1,500 cases active between December 2007 and March 2009.**

NCAS statistics are designated 'official statistics' in the Official Statistics Order 2009, and we release a publication plan for the coming 12 months on our website



NATIONAL CLINICAL ASSESSMENT SERVICE

Helping resolve performance concerns

NCAS works with healthcare organisations and individual practitioners to advise on handling concerns about the performance of dentists, doctors and pharmacists. We help to clarify the concerns, understand what is leading to them and support their resolution. Our aim is to get involved early in order to restore safe and valued practice wherever possible.

Core clinical assessment work

NCAS priorities:

- *Advice* – from experts with backgrounds in clinical practice, healthcare and human resources management, who also signpost to other resources to help manage the concern.
- *Specialist interventions* – including facilitation, mediation, performance assessment, action planning, back to work support and advice on access to team reviews.
- *Shared learning* – workshops and conferences to develop local skills, drawing on our case experience, evaluation and research.

We work with NHS organisations and the independent sector across the UK and associated island states, with offices in Belfast, Cardiff, Edinburgh and London. All our services to the NHS are provided free at the point of delivery.

We offer advice to managers on managing suspension and exclusion to help ensure that these measures are used effectively and only when absolutely necessary.

We develop assessment methods for reviewing clinical performance, drawing on worldwide best practice. We also recruit specialist assessors and train them in the use of these methods.

Underpinning our initiatives and services is a programme of evaluation, research and development.

Casework activity 2009/10

In 2009/10, 909 new cases were referred to NCAS, bringing the total number of referrals over the last nine years to 5,662.

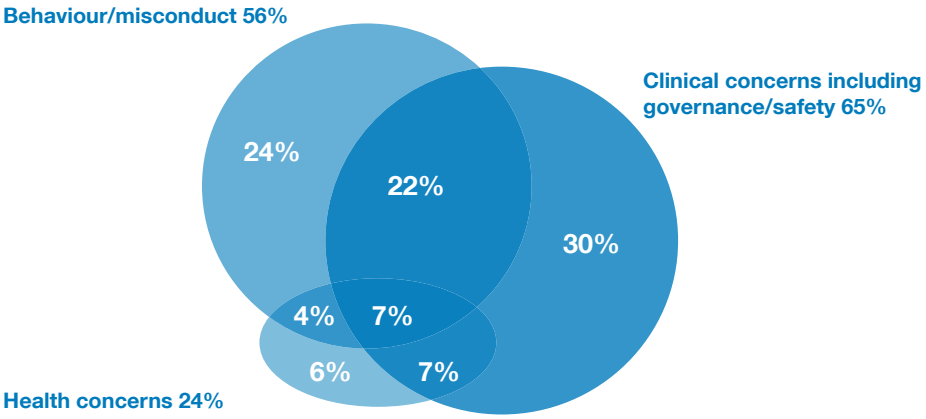
Our service for pharmacists was launched on 1 April 2009. In this first year we received 49 pharmacy referrals; 42 of which were from England. Forty of the 49 were community pharmacists and the remainder worked in hospitals. About two-thirds of community pharmacy referrals were made by their NHS contracting bodies, but we worked with community pharmacies directly in some cases. A small number of self-referrals are included in the pharmacy case total.

Most referrals of dentists, doctors and pharmacists can be resolved with advice and support from NCAS, but a small number require performance assessment to identify the scope and nature of the concerns and factors that may be contributing to them. During 2009/10 we conducted 38 assessments.

During the year we have brought greater structure to our support for plans to help practitioners return to safe practice. These plans may be needed after an NCAS assessment, or following a career break or a period of ill health. We have assisted practitioners and healthcare organisations in planning programmes for over 80 cases, advising on resourcing and implementing the programme, and monitoring outcomes.

The General Dental Council (GDC) has a service level agreement with NCAS that enables the GDC to commission a clinical performance assessment from NCAS as part of its consideration of the fitness to practise of a dentist. During 2009/10, three cases were referred by the GDC to NCAS for assessment.

Presenting concerns in 1,472 cases handled by NCAS between December 2007 and March 2009



Relevant to service needs

Our focus is on providing an effective service to healthcare organisations. We aim to contribute to frontline healthcare by supporting local governance arrangements, providing a central resource and acting as an independent third party.

We seek, take very seriously and act upon feedback from organisations and practitioners who use our services. During the last year we have conducted further surveys of those using our advice and support services. These have demonstrated continuing high levels of satisfaction in terms of accessibility and efficiency of the service, helpfulness of advice and the extent to which advice given was in line with regulations and best practice.

We are considering the suggestions offered by some respondents on how NCAS could be more helpful, for example in terms of additional services we might provide, offering closer or more continuing contact with healthcare organisations, and greater clarity about the role of NCAS.

We have also sought feedback about the assessments we provide. Again, levels of satisfaction from referring organisations and practitioners are good with regard to the handling of the assessment and clarity of the report.

However, the feedback did point to the need to reduce further the time of an assessment. We have worked to achieve this over the last year and we continue to seek ways to reduce the assessment time even further, but it does present us with a challenge. To deliver robust assessments, NCAS depends on a panel of trained and quality-assured assessors who are in active clinical practice. Their employers or practice normally require six-to-eight weeks' notice for cancellation of clinical activities so that they can make themselves available to NCAS, introducing inevitable delay into the scheduling of assessments.

The validity and reliability of an NCAS assessment depends on wide sampling across a practitioner's practice, using 10 components for reviewing a practitioner's performance; these are included in a report which usually contains several hundred findings, providing evidence of satisfactory or unsatisfactory performance. The writing, checking and reviewing of the assessment report is a time-consuming process which we now manage intensively with the aim of delivering the draft report within eight weeks of the assessment.

Analysis of referrals to NCAS

- About one doctor in 200 is now referred to NCAS each year, and about one dentist in 250.
- 5,662 referrals have been made since 2001:
  - three in four NHS organisations make at least one referral each year;
  - more than half of NHS organisations are working with us at any time;
  - organisations providing primary care and acute services use us equally, as do foundation and non-foundation trusts in England;
  - there is a small but consistent self-referral rate of about three per cent;
  - any overlap with professional regulators is now very small.
- Cases are being referred earlier – 84 per cent of NCAS referrals in 2009/10 involved concerns that had only become apparent in the past year, compared with 36 per cent in 2002/03.
- Certain groups are more likely to be referred:
  - older practitioners;
  - consultants, contractor providers in general practice, and career grades generally;
  - male practitioners.
- For hospital and community doctors in England, high rates of referral and exclusion have been found amongst non-white doctors who qualified outside the UK, but not amongst non-white UK-qualified doctors.

Developing methods and services

Assessment for pharmacists

Developing a workplace-based assessment for community pharmacists presented us with distinct challenges to overcome, including the fact that 35 per cent of pharmacists work as locums without a regular workplace.

Simulation of practice is already used by NCAS for other assessments where direct observation of practice is not feasible. We have now developed and trialled a high fidelity simulated community pharmacy. In addition, we have successfully tested our full workplace-based assessment for community pharmacists working in their own pharmacy on two reference case assessments. We have also worked with a group of hospital pharmacists to develop an assessment framework, which is now ready for testing.

Medical revalidation

NCAS has been very much aware of the policy developments with regard to medical revalidation in the last year and we have a work programme to consider how we can best meet the requirements placed on NCAS during the piloting and implementation phases. Our role will focus on our core purpose, to advise on the handling of performance concerns and help develop local expertise.

We envisage that we will provide a service to Responsible Officers, who will be handling concerns about individuals' performance; we will advise on managing concerns about individual doctors, including conducting an investigation, the use of local performance procedures and local remediation programmes. We have begun work to devise a portfolio of workshops which draw on our experience in each of these areas.

We have also considered how we could develop a method and training around a local focused review of a doctor's practice where further information is required for a Responsible Officer to establish whether there is a concern about an individual's performance which needs referral for more detailed assessment.

NCAS (Scotland) has completed a programme of Board visits, and met with both Dental and Medical Postgraduate Deans across Scotland to discuss issues around resources for remediation, reskilling and rehabilitation.

Extending NCAS to other health professions

Following a request from the Chief Nursing Officer, we undertook preliminary work on whether to extend our services to include other health professionals. The first stage of this focused on the needs of specialist nurses and midwives.

Health Professionals Alert Notices

NCAS holds a database of Alert Notices issued about health professionals and has agreed with the Department of Health to develop an electronic searchable database of these notices to improve access by potential employers or contracting organisations. Work to build this database was taken forward during the year.

Health of health professionals

NCAS experience

About a quarter of cases coming to NCAS involve some concern about an individual's health. NCAS's role is to advise the healthcare organisation on handling the health concern from a management perspective, not to provide diagnosis and treatment. However, we have identified that often it is difficult for health professionals to access specialist health services, particularly for mental illness or addiction.

Health of Health Professionals working group

Professor Alastair Scotland, Director of NCAS, was invited by the Department of Health to chair a working group on the health of health professionals. NCAS supported him in this work during 2009/10 by commissioning literature reviews and a survey of the public about health concerns in health professionals. These informed a proposed framework for improving health and healthcare for all regulated health professionals. The report proposed specialist health services for health professionals where they are not able to access local NHS services. This should help reduce the cost of sickness absence in the NHS (estimated to be over £1.7 billion) and reduce the risk of health problems adversely affecting patient care.

Practitioner Health Programme

NCAS was responsible for the design and commissioning of the London-based Practitioner Health Programme (PHP), an example of a specialist health service for health professionals. During its first 18 months (to March 2010), the service had 338 initial contacts, saw 178 sick doctors and dentists, and conducted 2,350 consultations.

Two-thirds of cases related to mental health problems and one-third to addiction. Outcomes for treating addiction in these health professionals were very good. At one year, 42 out of 51 (82 per cent) patients with alcohol addiction were abstinent and attending PHP on a regular basis (compared with an expected 10 per cent amongst those treated for alcohol addiction in the general population), and 14 out of 16 (88 per cent) were abstinent from illicit drugs (compared with 10-20 per cent in the general population).

Seventy-seven per cent of practitioner-patients remained in or returned to work after contact with PHP. Forty-six per cent of practitioner-patients who were not working whilst attending PHP, have returned to work.

A preliminary estimate of cost-benefit of the London PHP suggests that it can result in significant savings for the NHS.

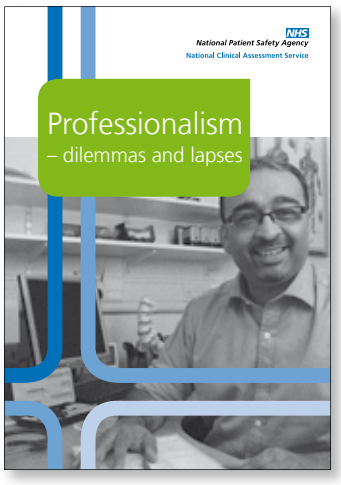
Workshops and the NCAS conference

Our external education programme supports a key objective for NCAS: to promote effective systems of professional governance across the NHS.

We run educational workshops across the UK, provided at no charge to participants. These normally involve case studies and interactive small group work. They provide an opportunity to share lessons from our case experience, evaluation and research, and to introduce NCAS to health professionals and managers who may not be familiar with what the service offers. For example, this year we provided four workshops specifically aimed at pharmacists and those managing pharmacy services. In all, we provided 72 external education and training events, attended by over 2,400 participants.

This year we published good practice guides on conducting a local investigation and handling performance concerns in primary care, and a booklet on *Professionalism – dilemmas and lapses.*

On 30 March 2010, we held our annual conference. This year the theme was *Challenges and Opportunities 2010: Responding to concerns about practitioner performance,* and it was attended by 511 delegates.



National Research Ethics Service

Protecting research participants and facilitating ethical research

Highlights 2009/10:

- Progress against *Building on Improvement* with further implementation of REC centres and enhancing efficiency of the service
- Expedited review adopted for the first time in response to the flu epidemic
- Formation of the National Research Ethics Advisors' Panel
- Piloting of the Proportionate Review Service that aims to ensure an appropriate level of review for low-risk studies
- Certified ISO 9001 for NRES quality assurance department

NRES has a dual mission: to protect the rights, safety, dignity and well-being of research participants; and to facilitate and promote ethical research in the UK.

NATIONAL RESEARCH ETHICS SERVICE

Protecting research participants and facilitating ethical research

Launched in 2006, *Best Research for Best Health* is a strategy aimed at making the NHS an internationally recognised centre for research excellence. Since its introduction, NRES has continued to contribute to its implementation. During 2009/10, NRES has undergone an ambitious change programme to improve the research ethics service, in order to protect the rights, safety, dignity and well-being of research participants, and facilitate ethical research which is of potential benefit to participants, science and society.

Operations and efficiencies

During the past year NRES has continued to improve the efficiency, value and quality of the ethics service.

Building on the reduction of the number of research applications in previous years, for example by eliminating duplication of reviews, we have streamlined the service further this year by merging and closing RECs. The number of committees currently stands at 87, down from 200 in 2004.

REC centres are single office bases to support groups of RECs. As well as increasing the efficiency of the ethical review service, these centres enable all REC co-ordinators to work as part of a fully supported team, and provide the opportunity to share best practice.

We have continued to streamline operations through consolidating the number of RECs managed by the centres in 2009/10. A further five will be opened in 2010/11, bringing the total to 10. NRES continues to provide effective and efficient operational and advisory support to RECs in Wales, Scotland and Northern Ireland to provide a UK-wide service.

NRES: the journey so far; efficiency, value and quality

Metric	Start point (2004)	Current point	Target/expected (April 2011)
Timeline – time from submission to full approval	Unknown, much criticised	35-40 days	60 (policy), 40 (operationally)
Proportionate review – time from submission to full approval	N/A	N/A (in pilot phase)	10 days
No. of applications[1]	9,760	6,321	5,000
Site approvals	12,000	0 (NHS sites)	0 (NHS sites)
No. of RECs	200	85	82
Employers	70+	22	8
No. of staff locations	100+	24	9
The service	Secretariat support to REC	Comprehensive service	Comprehensive service

1. Over the last few years NRES has reduced the number of required applications by eliminating duplication of reviews and other efficiencies.

National Research Ethics Advisors' Panel

A key success this year has been the establishment of the National Research Ethics Advisors' Panel (NREAP) to fill an identified gap in the service. The panel provides top-level strategic guidance and support; offering a proactive means of identifying and developing ways to improve the system, and look at matters relating to policy, training, ethical debates and stakeholder engagement.

The expert panel is independent but hosted within NRES, and is a resource available to all UK RECs and their appointing authorities. Twelve advisors currently sit on the panel, and are appointed on behalf of the UK health departments, enabling a beneficial distance of independence.

Proportionate review

This year we have also made significant progress against our objective of providing a Proportionate Review Service. This service is designed to ensure an appropriate level of ethical review for low-risk research studies and at reduced timelines, and also ensures committee time is focused on research applications presenting more complex ethical issues.

Following an initial pilot launched in London in September 2009, we extended the pilot of the service to the East Midlands in March 2010. This second pilot scheme is now well established and will be further expanded in 2010/11.

Policy and guidance to ensure a robust service

As well as developing Standard Operating Procedures and guidance for the pilot scheme of the Proportionate Review Service, we have created guidance for RECs in response to changes to policy and legislation, including guidance on data monitoring committees in clinical trials, in consultation with the MHRA.

In addition, we have led the review of revised collaboration agreements (between NRES, MHRA, the Gene Therapy Advisory Committee and the Appointing Authority for Phase 1 Ethics Committees) in the review of clinical trials of medicinal products. An online toolkit for RECs and researchers on the *Mental Capacity Act* has also been developed, which includes guidance on research in emergency medicine.

The ethics of using human tissue

Requests for using human tissue in research form a large proportion of applications to RECs. An ethically complex area, we are continually working to help clarify the law and guidelines, and to promote the ethical use of human tissue for research.

The *Human Tissue Act 2004* regulates the storage and use of human tissue in England, Wales and Northern Ireland, and determines the circumstances in which consent and/or ethical approval is required. We work closely with the Human Tissue Authority (HTA), the regulatory body that licenses organisations that store human tissue, to ensure a fair balance between protecting the rights of donors and enabling research.

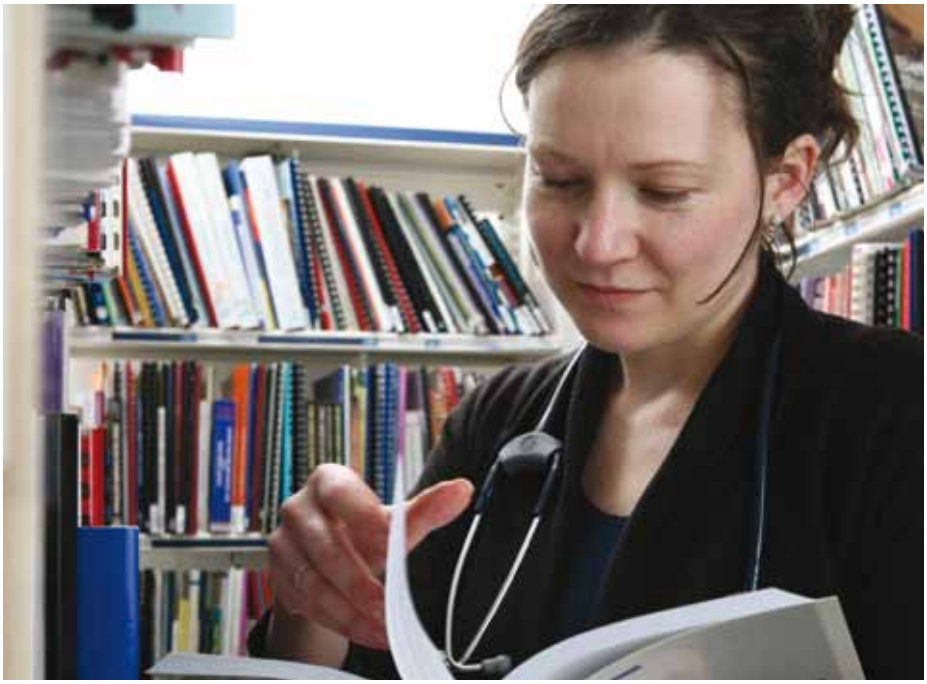
In July 2009, NRES and the HTA released a joint statement clarifying the licensing position on NHS diagnostic archives releasing tissue for research. This stated that purely diagnostic archives of human tissue (i.e. samples taken for the sole purpose of clinical care) do not need to be stored on premises licensed by the HTA. However, where a diagnostic archive functions as a resource for researchers, it must be licensed by the HTA as it falls under the category of a research tissue bank (RTB).

This year we also reviewed the application form and guidance for RTBs with the aim of making the process more suitable for diagnostic archives, ensuring the REC has adequate information (especially on clinical data stored with samples) and including a summary for publication so that researchers can find out how to access samples from approved banks.

Building on existing training, we are collaborating with the National Cancer Research Institute and onCore UK on a series of additional workshops for REC members and researchers to explore the legal and ethical issues around the storage of tissue and consent for use in research.

Key highlights from the quality assurance framework

- Quality management of our product-ethical review:
  - Extension of shared ethical debate that supports consistency of decision-making and reflects on issues raised and their relationship to available guidance and published evidence
  - Analysis of appeals
- Quality management of NRES support systems:
  - Accreditation: NRES operates the only REC accreditation scheme in Europe
  - Development and monitoring of quality control conducted by operational teams
- Feedback from internal and external customers:
  - Feedback from users of our service
  - Feedback from REC members
  - Analysis of complaints from users of our service
- Quality management system and other projects:
  - Quality assurance training
  - Maintenance of IS0 9001 certification and development of processes for NRES.



Ensuring expertise, understanding and transparency

Training is a core function of NRES. It is vital that REC members, staff and researchers keep their skills up-to-date and are aware of the latest legislative and policy developments. This year we provided 1,700 places on training courses for REC members and staff, and in August 2009 launched an online training and events booking system so that all NRES staff and REC members can see the current list of courses available and can book online.

In addition, we have continued to provide training information for applicants and to manage queries from applicants and stakeholders in order to increase understanding about what they can expect when submitting a research ethics application. We have also developed the 'Help' section on the Integrated Research Application System (IRAS) to include a comprehensive educational advice function, and have added an e-learning module to IRAS.

As part of our commitment to promoting transparency in research, we have further developed our web-based publication of research summaries of ethically approved applications, and have this year piloted a framework for the publication of a summary of the ethical opinion.

Building confidence in the research ethics system

An important strategic objective for NRES is our commitment to quality assurance (QA), which is key to ensuring that our ethical review function is supported by robust systems and procedures. We have achieved excellent results in this area over the last year, with accreditation by the British Standards Institute and ISO 9001 certification in October 2009, which is the internationally recognised standard for an organisation's internal quality management.

IRAS
INTEGRATED RESEARCH APPLICATION SYSTEM

QA involving our product: ethical review

Shared ethical debate

Shared ethical debate is a process of ethical review of a single application undertaken by a number of RECs, with the purpose of reviewing consistency of decision-making and of the issues raised at meetings, and to encourage an ethical debate across committees.

The process aims to look for trends in decision-making and key ethical themes, which can then be used to improve consistency. Lessons learned will be used for the continual improvement of ethical review.

The process was developed following the ad hoc review of the operation of NHS RECs and further enhanced and incorporated into the ethics review process in the last year. Genetics research is a good example of where shared ethical debate significantly contributes to quality assurance of sound ethical decision-making:

Case study 1: Genetics

Differentiating between clinical practice and research can be difficult in genetics and it is impossible for many genetic studies to meet current standards for ethical approval. It is therefore vital that there is debate around these issues in order for ethics committees to take into account the special problems of consent and anonymity in research into, for example, rare genetic disorders.

Dr Hugh Davies, NRES Ethics Advisor, says: "We held a workshop earlier this year entitled 'Issues, Guidance and Evidence in Genetic Research'. The workshop stimulated a great deal of debate and the recommendations developed are being taken forward to the wider REC community. I am confident that this will be of tremendous benefit to REC members in considering research applications in this area and will enhance the consistency and quality of decision-making."

Expedited review

NRES exercised the expedited ethical review process for the first time in late May 2009 with the pandemic flu outbreak (see Case study 2). This process was set up to ensure that NRES could efficiently respond and meet urgent requirements when there is a threat to public health. Under these circumstances, it is essential that an application is reviewed urgently to allow a health-related research study to commence as quickly as possible.

Case study 2: Pandemic flu

The recent pandemic flu outbreak was the first public health emergency to trigger the expedited review process for relevant applications. Within 20 minutes of receiving notification that the first two research applications regarding swine flu were ready, NRES scheduled the review of the applications.

One application was for use of an antiviral injection which, once approved, would be available immediately to treat any new patients with swine flu.

As delaying the study would have missed opportunities to test this important research, it was important this application was given priority and NRES organised a REC to review it the next day. In preparation for this, over 50 'standby' REC members are available to review research applications with little warning, which is an outstanding testament to the dedication of the REC members.

MANAGEMENT COMMENTARY

Operating and policy environment

The NPSA operates within the healthcare systems in England, Wales, Scotland and Northern Ireland. Our work must be responsive to changes in the policy environment and healthcare systems in these countries, which continue to develop in markedly different policy directions. It is important that the Agency tailors its plans, products and services in ways that reflect these differences, whilst making best use of the resources available to us.

There are a number of current and future developments that are likely to impact on our work including:

- Reduction in public spending.
- The Department of Health (DH) is currently conducting a review of arm's length bodies (ALBs) to maximise operational efficiency across the ALB sector. It is expected to report in autumn 2010.

Patient Safety division

The main policy direction for patient safety in England was set out in the DH's *Safety First* report (2006). During 2009/10 trusts across England have been participating in the Patient Safety First campaign, which aims to make the safety of patients everyone's highest priority. Our (Patient Safety) work has concentrated on providing practical tools and knowledge that NHS staff, management and boards can use to embed patient safety within their organisations.

In Wales over the last two years, the 1000 Lives Campaign has had a significant effect in reducing harm and improving patient safety. We are working with the Welsh Assembly Government to develop our strategy in line with what is planned for the next phase of the campaign, 1000 Lives Plus.

National Clinical Assessment Service

2009/10 brought further clarity to the work of NCAS around *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century.*

Specific streams of work within NCAS have been centred on:

- supporting work to pilot medical regulation support teams and the role of General Medical Council (GMC) affiliates;
- developing proposals for NCAS to support local governance, revalidation and the work of Responsible Officers;
- a national framework for the health of healthcare professionals, linked to the wider agenda as set out in the Boorman review;
- developing the service for pharmacists to be applicable to the reformed regulatory framework for pharmacists;
- developing a system to make Health Professionals Alert Notices available via a secure and confidential web portal.

NCAS has responded to these and has delivered all those responsibilities laid directly on it by name.

National Research Ethics Service
The NRES agenda will continue to evolve in response to developments in the wider regulatory and governance environment for health research in the UK, as well as to feedback from the research community, patients and the public, and other stakeholders.

During 2010/11, the UK Health Departments are expected to issue a revised UK-wide version of the Governance Arrangements for Research Ethics Committees (GAfREC; first edition published by DH in July 2001) following consultation on the draft published in May 2009. The revised GAfREC will support implementation of procedures for more proportionate review of studies involving no material ethical issues.

Due to a range of external factors there has been a fall in the number of applications to RECs in recent years. This has led to a multi-phased reorganisation of NRES and the closure and merger of RECs in order to match supply and demand more closely. The number of RECs is planned to fall to 82 during 2010/11. Operational needs will be kept under review in the light of the implementation of proportionate review.

NRES will lead on implementing improvements to IRAS approved by the IRAS Management Board. Collaborations with other regulatory and review bodies will be further developed in order to reduce bureaucracy, streamline procedures and ensure effective communications.

The European Commission recently consulted on options for addressing issues arising from the impact of the EU Clinical Trials Directive 2001/20/EC. Further proposals are expected during 2010/11.

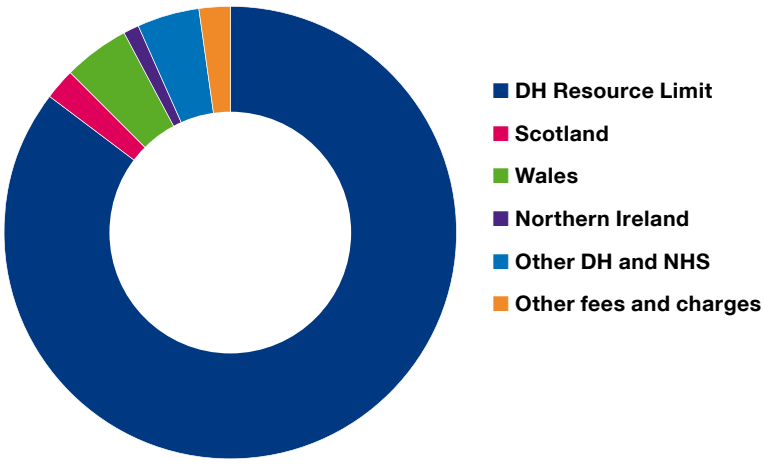
Resources

The Agency receives two resource limits from the DH, one to cover revenue expenditure and one for capital.

The Agency met its financial duties in 2009/10 and spent within the resource limits set. Details of the Accounts of the Agency can be found at the end of this report.

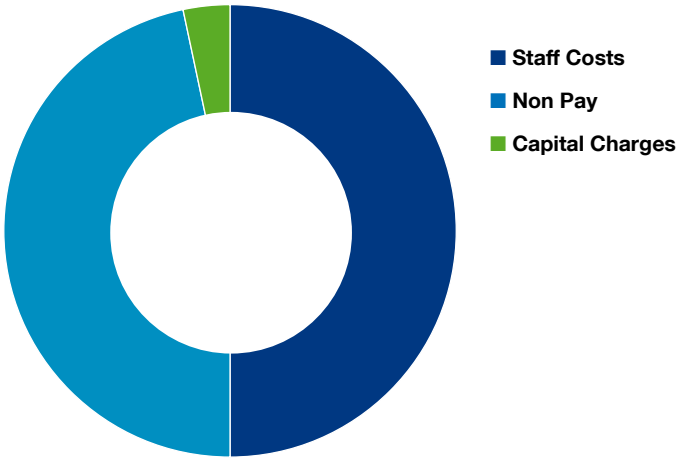
The Agency's total available revenue resources for the year were £38.971m (£33.454m in 2008/09).
As the chart below shows, the vast majority of our income comes from DH by way of a resource limit, with the remainder from the devolved administrations of Wales, Northern Ireland, Scotland and miscellaneous other income. The resource limit represents the maximum the Agency was permitted to utilise.

Income 2009/10
The Agency underspent this allocation in the year by £0.080m.



The Agency's revenue expenditure totalled £38.891m (£33.346m in 2008/09) and is analysed in the chart below, by type of expenditure. Just over half of the total cost is on pay.

Expenditure 2009/10



The Agency's turnover grew by around £5.6m from the previous year due to funding being received from DH to undertake a number of new projects and to expand the remit of the NCAS service to pharmacy. The main areas of increases in funding were for Patient Safety Direct (£2.9m), Matching Michigan (£1m) and for NCAS pharmacy (£0.9m). In addition, the increases in volumes of activity at NCAS were supported by an additional £0.8m.

Risk management

The NPSA Board has overall responsibility for risk management and there are clear lines of responsibility of individual accountability for managing risk throughout the Agency, leading up to the Board.

The Chief Operating Officer is responsible for the overall risk management process within the Agency. Directors lead on the objectives of the Agency as agreed in the Business Plan and, as such, also manage the risks at the workstream, day-to-day operational and project levels, and are recorded in divisional risk registers.

Risks are identified, monitored and managed at divisional level, but escalated for monitoring to the Senior Management Group and entered into the Corporate Assurance Framework.

The Corporate Assurance Framework reports the escalated risks and risk scores, along with the key controls and assurances put in place to mitigate the risks. The Framework is reviewed by our Senior Management Group and Board to monitor the effective management of risks.

The Audit Committee overviews and ensures that systems are in place to ensure effective risk management. The Internal Audit function forms part of the review process and provides assurance on the risk management process, and advises the Audit Committee accordingly.

Stakeholders

The NPSA's primary stakeholders are patients who receive NHS care, NHS staff and organisations, and research participants. We consult with patients and their families and carers when developing recommendations for safety improvements in the NHS. We work closely with NHS staff and organisations in encouraging the reporting and learning from patient safety incidents, developing effective changes in practice to improve safety, and when publishing local incident data. We work directly with NHS organisations and individual staff in helping resolve practitioner performance concerns. Our work with research participants is centred on ensuring we protect their rights, safety, dignity and well-being.

We have a Management Statement in place with DH and a Section 83 agreement with the Welsh Assembly Government as the organisations that provide primary funding for our work and hold us to account. Our divisions have individual agreements in place for the services that they provide in Northern Ireland, Scotland, the Channel Islands, the Isle of Man, the Defence Medical Services and the independent sector throughout the UK.

The three divisions of the Agency work in partnership with a wide variety of organisations. We have joint working agreements and Memoranda of Understanding with key partners.

In developing and delivering our products and services we involve or work with a wide range of stakeholders. For example, by engaging representatives of the medical specialties, nursing, midwifery and allied health professionals via formal advisory groups or through programmes of work with the royal colleges.

We have also adopted methodologies for patient involvement across a wide range of projects and programmes to ensure that our most important stakeholders help shape what we do.

Corporate citizenship

Throughout 2009/10 the NPSA has continued to implement a sustainability strategy and action plan. The plan addresses a number of areas of importance including climate change and energy, sustainable resourcing, ethical issues, employee and community engagement, and business relationships.

Key developments in 2009/10 have been action to increase recycling of waste, implementation of a 'cycle to work' scheme, and the introduction of a 'well-being at work' day. We have also taken steps to start monitoring and reducing our carbon footprint as a result of travel.

Emergency preparedness

The NPSA has contingency plans in place to maintain continuous delivery of some core functions should disaster occur, and to restore other functionality as quickly as possible.

Equality and diversity

The constituent parts of the Agency have, from their inception, been committed to being inclusive: involving the widest range of stakeholders in their work; making the best of stakeholder knowledge, skills and perspectives; and promoting equality and diversity.

The Agency's two-year Equality and Diversity Strategy and Equality Scheme and Action Plan were approved by the Board in December 2009.

The Equality Scheme and Action Plan were developed through consultation with stakeholders and staff across the Agency, taking into consideration our duty to both the three statutory (race, disability and gender), plus the three non-statutory (religion, sexual orientation and age) considerations.

The Agency will continue to monitor progress against the Equality Action Plan, taking into consideration any new developments and changes in legislation.

During 2009/10 training in conducting Equality Impact Assessment was provided to key policy makers, as well as training in equality and diversity for all staff from Board level down.

'We value the differences that exist among people and we have a strong culture of involvement in the development of our vision: To be inclusive to all people - regardless of their background. This vision applies to our staff and the organisations and individuals we provide a service to.'
NPSA Equality Scheme

Sickness absence data

Sickness absence rates for the NPSA for the year 1 January 2009 to 31 December 2009 were 3.5 per cent. During 2009/10 several focused initiatives have been launched, including a new Sickness and Absence Policy, a review of the Occupational Health provision available to staff, workshops providing support and advice on how to manage stress, and a 'well-being at work' day.

Freedom of Information

The NPSA complies with the Freedom of Information Act.

Personal data related incidents

During 2009/10 there were no personal data related incidents that required reporting to the Information Commissioner. The only personal data related incidents in the year were small localised ones not significant enough to have been recorded centrally.

PUBLIC INTEREST

History and statutory background

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

As a result of the review of ALBs undertaken in 2004, the NPSA was reformed with responsibility for three separate divisions, each with distinct functions:

- National Reporting and Learning Service (the former Agency, renamed from 1 April 2010 as Patient Safety);
- National Clinical Assessment Service (formerly the National Clinical Assessment Authority – established in 2001);
- National Research Ethics Service (formerly the Central Office for Research Ethics Committees – established in 2000).

At the same time, the Agency took on responsibility for the safety aspects of hospital design, cleanliness and food, and the management of the contracts with the three National Confidential Enquiries: the Centre for Maternal and Child Enquiries (CMACE), 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).

Staff survey

An annual survey of staff is conducted in line with the national NHS Staff Survey framework so as to gain a full understanding of the experience of staff working within the Agency and to inform action plans to bring about improvements in the Agency as a place of work. Action plans are developed with involvement from staff and by staff in many cases, with progress regularly monitored and reported.

Consultation with staff

The Staff Council was established 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.

In response to the results of the staff survey undertaken during 2009/10, the Staff Council set up a sub-group, the Staff Engagement Group, to explore how best the Agency can engage with and motivate staff.

The staff representative model for the Agency will be fully reviewed during 2010/11. The review will produce recommendations for implementation that may result in a significant change in the constitution of the existing Staff Council.

The current role of a Staff Council 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.

Complaints
The NPSA has a complaints process which has been developed in line with the Ombudsman's 'Principles of Complaints Handling'.

Better Payment Practice Code
The Agency seeks to comply with the Better Payment Practice Code by paying our suppliers within 30 days of the receipt of goods or services, or within 30 days of receipt of an invoice. The performance in meeting this objective is disclosed in note 4.3 to the Accounts.

External audit
The accounts have been prepared according to accounts direction of the Secretary of State, with approval of HM Treasury. The accounts have been audited by the Comptroller and Auditor General in accordance with the National Health Service Act 2006 at the cost of £46,000. The audit certificate can be found on page 35.

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

The Audit Committee comprises of three non-executive directors: Mr Robin Pritchard, Chairman of the committee, Ms Gill Edelman and Mr Trevor Jones.

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.

Interests in land
The Agency values its assets, as shown on the Balance Sheet in the Accounts in accordance with prevailing accounting standards.

Pension liabilities
The Agency participates in the NHS Pension Scheme and in doing so makes contributions based on the salary of individual members. The Agency does not have any liability for future pension costs as these are met by the NHS Pensions Scheme.

REMUNERATION REPORT

Statutory Committees

There are two statutory sub-committees of the NPSA Board: Audit Committee, and Pay and Remuneration Committee.

Pay and Remuneration

The Chairman and Non-Executive Board Members are remunerated in line with Department of Health (DH) guidance that applies to all NHS bodies. Details of senior managers' remuneration are given below. Pay for all senior managers is set and reviewed in line with the DH guidance 'Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts' (VSM). Senior managers employed under the VSM framework are under stated contracts of employment as set out by NHS Employers.

No senior managers were employed on service contracts. No significant awards were made to past senior managers in the past year.

Salaries and allowances

	2009-10			2008-09		
	Salary (bands of £5,000) £000	**Other Remuneration £000**	**Benefits in kind £00**	Salary (bands of £5,000) £000	Other Remuneration £000	Benefits in kind £00
Non-Executive Directors						
Lord N Patel, Chairman	60-65	0	0	60-65	0	0
R Pritchard, Non-Executive Director – Audit Chair	10-15	0	0	10-15	0	0
T Jones, Non-Executive Director	5-10	0	0	5-10	0	0
D Weir-Hughes, Non-Executive Director	5-10	0	0	5-10	0	0
H Ghodse, Non-Executive Director	5-10	0	0	5-10	0	0
G Edelman, Non-Executive Director	5-10	0	0	5-10	0	0
L Patterson, Non-Executive Director	5-10	0	0	5-10	0	0
G Gardiner, Non-Executive Director	5-10	0	0	5-10	0	0
Directors						
Martin Fletcher, Chief Executive (*) (left 17/12/2009)	95-100	1	0	135-140	0	0
Sarndrah Horsfall, Chief Operating Officer /Chief Executive (Acting) (**)	115-120	0	0	110-115	0	0
Kevin Cleary, Medical Director	85-90	0	0	85-90	0	0
Peter Mansell, Director for Patient Experience & Public Involvement (left 31/07/2009)	30-35	0	0	85-90	0	0
Alastair Scotland, Director, National Clinical Assessment Service (***)	145-150	55-60	0	140-145	55-60	0
David Bell, Director of Finance and Facilities	110-115	0	0	110-115	0	0
Janet Wisely, Director, National Research Ethics Service	90-95	0	0	95-100	0	0
Suzette Woodward, Director of Patient Safety Strategy and Nursing Lead for Patient Safety	95-100	0	0	90-95	0	0

(*) Other remuneration consists of a performance related bonus
(**) The post of Acting Chief Executive was taken up on 18/12/2009
(***) Other remuneration consists of a Clinical Excellence Award separately funded by the Advisory Committee on Clinical Excellence Awards

Pension benefits

	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at age 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Martin Fletcher, Chief Executive (left 17/12/2009)	2.5 - 5	2.5 - 5	10 - 15	30 - 35	199	163	21	0
Sarndrah Horsfall, Chief Operating Officer/Chief Executive (Acting) (**)	(A)	(A)	(A)	(A)	(A)	(A)	(A)	(A)
Suzette Woodward, Director of Patient Safety Strategy and Nursing Lead for Patient Safety	0 - 2.5	0 - 2.5	30 - 35	100 - 105	677	609	37	0
Kevin Cleary, Medical Director	0 - 2.5	0 - 2.5	30 - 35	100 - 105	626	557	41	0
Peter Mansell, Director for Patient Safety & Public Involvement (left 31/07/2009)	10 - 12.5	7.5 - 10	15 - 20	55 - 60	0 (*)	213	-75	0
Alastair Scotland, Director, National Clinical Assessment Service	(0) - (2.5)	(0) - (2.5)	95 - 100	295 - 300	2,434	2,240	82	0
David Bell, Director of Finance and Facilities	(2.5) - (5)	(0) - (2.5)	40 - 45	130 - 135	885	822	22	0
Janet Wisely, Director, National Research Ethics Service	0 - 2.5	0 - 2.5	15 - 20	50 - 55	281	247	21	0

(A) Not in Pension Scheme
(*) In receipt of pension, therefore a zero CETV is disclosed as confirmed with the Pensions Agency
(**) The post of Acting Chief Executive was taken up on 18/12/2009
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.

On 1 October 2008, a change in the way the factors used to calculate CETVs came into force as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations. These placed responsibility for the calculation method for CETVs (following actuarial advice) on Scheme Managers or Trustees. Further regulations from the Department for Work and Pensions to determine CETV from Public Sector Pensions Schemes came into force on 13 October 2008.

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.

Sarndrah Horsfall, Chief Executive (Acting),
National Patient Safety Agency
Date: 9 June 2010

Statement of the Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Secretary of State has directed the National Patient Safety Agency to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the National Patient Safety Agency and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by the Secretary of State, with the approval of HM Treasury, 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 as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and
- prepare the accounts on a going concern basis.

The Accounting Officer of the Department of Health has designated the Chief Executive as Accounting Officer of the National Patient Safety Agency. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, for keeping proper records and for safeguarding the National Patient Safety Agency's assets, are set out in Managing Public Money published by the HM Treasury.

Statement on internal control 2009/10

1. Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the National Patient Safety Agency's policies, aims and objectives, whilst safeguarding public funds and the Agency's assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money.

I have been the Accounting Officer since 18th December 2009; Martin Fletcher was Accounting Officer from 21st May 2007 until 17th December 2009.

I am accountable for the discharge of my functions to the Agency's Chairman and its Board. I am also accountable to the Minister of State at the Department of Health. This line of accountability is managed through an Annual Accountability Review with the Minister supported by quarterly reviews with officials at the Department of Health and close working on a day to day basis between my staff and those in the Sponsor Branch at the Department.

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

- Identify and prioritise the risks to achieving the Agency's policies, aims and objectives.

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

The system of internal control has been in place in the National Patient Safety Agency for the year ended March 2010 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance

3. Capacity to handle risk
The Director of Finance and Facilities is the designated executive with operational responsibility for maintaining and developing the organisation wide system of internal control. I was Chief Operating Officer prior to becoming Acting Chief Executive in December 2009 and remain the designated executive with operational responsibility for the system of risk management and risk reporting. I am also the Agency's designated Senior Responsible Information Officer (SIRO) with responsibility for the system of safeguarding and protecting personal indentifiable, confidential and sensitive data.

Since taking on my enhanced role as Acting Chief Executive I have delegated the day to day responsibility for maintaining the system of risk management and risk reporting to the Associate Director, Corporate Services.

The Senior Management Group, led by myself, reviews and monitors progress with action plans and provides a resource group for operating divisions and teams to raise local risk management issues.

The Board takes an active role in risk management, receiving periodic reports and reviewing the Corporate Assurance Framework.

The Audit Committee has the role of overseeing the Governance process and has reviewed the overall Corporate Assurance Framework at its meetings, together with movements in those risks and the management of them.

Each Division prepares local risk registers, reviews them at their regular meetings and manages those risks.

The Head of Internal Audit reviewed the Corporate Assurance Framework during the year and commented that it provided reasonable assurance that there is an effective system of internal control to manage the principal risks identified by the Agency.

4. The risk and control framework
The Board has overall responsibility for risk management and for clear lines of individual accountability for managing risk throughout the organisation, leading up to the Board.

The Audit Committee, which comprises three Non-Executive Directors, 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 key elements of the risk management strategy are:

- As an integral part of the annual planning process, and throughout the year, the NPSA identifies and evaluates financial and non-financial risk 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 Corporate Assurance Framework, which is monitored and regularly updated. This is an integral part of performance reviews and ongoing management activities.

Statement on internal control 2009/10 – *continued*

- The management and development of department risk registers which are monitored by Directors.
- The integration of risk management into the overall NPSA planning and performance management activities.
- The development of staff to fulfill their specific responsibilities in a manner which minimises risk.
- The regular review of risk management policy, which includes the processes of identifying risks, maintaining progress and monitoring the assurance framework, department risk registers and plans.
- Communication of its risk management policy and strategy to staff, including its publication on the NPSA's intranet site.

In response to general concerns surrounding the security of data in the public services, the Agency established a programme of work in 2007/08 to minimise the risk of data loss and to ensure data was retained in accordance with law and best practice. In 2008/09 and in 2009/10 this process has been further strengthened. The appointment of a SIRO, as mentioned in point 3, occurred in 2008/09. A steering group was established in 2008/09, the Information Governance Assurance Group, under the chairmanship of the SIRO, to coordinate activity. This group has met on a monthly basis throughout 2009/10. All of the Agency's Divisions are represented on this group. During the year further steps have been taken to review outstanding governance policies and practices, incident reporting processes have been put in place and all staff have undertaken Information Security training.

In my capacity as SIRO for the National Patient Safety Agency, I have confirmed that the Annual Assessment of Information Risk has been completed and approved by the Board.

5. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of internal auditors and the managers within the agency who have responsibility for the development and maintenance of the internal control framework, and comments made by external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and plans to address weaknesses and ensure continuous improvement are in place.

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. This opinion is one of significant assurance. Senior 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 principle objective have been reviewed. Particular aspects of the Agency's activities are from time to time the subject of external review.

The effectiveness of the system of internal control has been subject to review by our internal auditors who, in liaison with the external auditors, plan and carry out a programme of work that is approved by the Audit Committee, to review the design and operation of the systems of internal control. Where weaknesses have been identified these are reported to the Audit Committee and an action plan agreed with management to implement the recommendations agreed as part of this process.

The Agency reviewed its Corporate Objectives in 2007/08 and has based its Business Plan on those objectives in both 2008/09 and 2009/10. Our Business Plan for 2009/10 flows from these objectives and our Controls Assurance and Risk Management processes are closely aligned to those keys objectives. The organisation reports on achievements and progress against the objectives and plans to the Board on a quarterly basis and this report includes risks and controls in place to mitigate them.

I am not aware of any significant internal control issues.

6. Compliance with NHS Pension Scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension scheme records are accurately updated in accordance with the timescales detailed in regulations.

Sarndrah Horsfall
Acting Chief Executive
Date: 9 June 2010

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 2010 under the National Health Service Act 2006. These comprise Operating Cost Statement, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor
As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the Audit of the Financial Statements
An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the National Patient Safety Agency's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the National Patient Safety Agency; and the overall presentation of the financial statements.

In addition, I am required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on Regularity
In my opinion, 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.

Opinion on financial statements
In my opinion:
- the financial statements give a true and fair view of the state of the National Patient Safety Agency's affairs as at 31 March 2010 and of its net expenditure, changes in taxpayers' equity and cash flows for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and directions issued thereunder by the Secretary of State.

Opinion on other matters
In my opinion:
- the part of the Remuneration Report to be audited has been properly prepared in accordance with the Secretary of State's directions issued under the National Health Service Act 2006; and
- the information given in the Chief Executive's report, management commentary and the unaudited part of the remuneration report, included within the Annual Report, for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception
I have nothing to report in respect of the following matters which I report to you if, in my opinion:
- adequate accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records or returns; or
- I have not received all of the information and explanations I require for my audit; or
- the Statement on Internal Control does not reflect compliance with HM Treasury's guidance.

Report
I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General

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

Signed on 16 June 2010

Operating Cost Statement

for the year ended 31 March 2010

	Notes	**2009-10 £000**	2008-09 £000
Expenditure			
Staff costs	*4.1*	**19,514**	17,244
Depreciation	*4.2*	**1,042**	928
Other expenditure	*4.2*	**18,208**	15,050
		38,764	33,222
Income			
Income from activities	*6*	**5,737**	5,040
		5,737	5,040
Net expenditure		**33,027**	28,182
Cost of capital		**127**	124
Net expenditure after cost of capital charges		**33,154**	28,306
Net resource outturn		**33,154**	28,306

The notes on pages 40 to 60 form part of these accounts.

Statement of Financial Position

as at 31 March 2010

	Notes	**31 March 2010 £000**	31 March 2009 £000	1 April 2008 £000
Non current assets				
Property, plant & equipment	*7.1*	**3,095**	2,635	2,518
Intangible assets	*7.2*	**1,142**	935	905
Total non-current assets		**4,237**	3,570	3,423
Current assets				
Trade and other receivables	*8.1*	**3,452**	4,854	3,684
Cash and cash equivalents	*9*	**375**	7	3
Total current assets		**3,827**	4,861	3,687
Total assets		**8,064**	8,431	**7,110**
Current liabilities				
Trade and other payables	*10.1*	**3,918**	4,633	3,193
Provisions for liabilities and charges	*11*	**0**	0	40
Other liabilities	*10.1*	**0**	325	487
Total current liabilities		**3,918**	4,958	3,720
Non-current assets less net current liabilities		**4,146**	3,473	3,390
Assets less liabilities		**4,146**	3,473	**3,390**
Taxpayers' Equity				
General Fund		**4,108**	3,416	3,309
Revaluation Reserve		**38**	57	81
Total Taxpayers' Equity		**4,146**	3,473	3,390

The financial statements on pages 36 to 39 were signed on behalf of the National Patient Safety Agency by:

Chief Executive (Acting): Date: 9 June 2010

Statement of Cash Flows

for the year ended 31 March 2010

	Notes	**2009-10 £000**	2008-09 £000
Cash flows from operating activities			
Net Surplus after cost of capital and interest		**(33,154)**	(28,306)
Adjustments for cost of capital charge		**1,169**	1,052
(Increase)/Decrease in trade and other receivables		**1,402**	(1,170)
Increase/(Decrease) in trade payables		**(1,040)**	1,213
Less: trade payables not passing through Operating Cost Statement		**156**	0
Add: write off of non current assets		**166**	26
Use of provisions	*11*	**0**	(40)
Net cash (outflow) from operating activities		**(31,301)**	(27,225)
Cash flows from investing activities			
Purchase of plant, property and equipment		**(1,271)**	(384)
Purchase of intangible assets		**(760)**	(652)
Net cash inflow/(outflow) from investing activities		**(2,031)**	(1,036)
Cash flows from financing activities			
Net Parliamentary funding		**33,700**	28,265
Net financing		**33,700**	28,265
Net increase/(decrease) in cash and cash equivalents		**368**	4
Cash and cash equivalents at 31 March 2009		7	3
Cash and cash equivalents at 31 March 2010	*9*	**375**	7

The notes on pages 40 to 60 form part of these accounts.

Statement of Changes in Taxpayers' Equity

for the year ended 31 March 2010

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 31 March 2008 under UK GAAP	3,517	81	3,598
Change in accounting policy under IFRS	(208)	0	(208)
Restated balance at 1 April 2008	3,309	81	3,390
Balance at 1 April 2008			
Changes in reserves 2008/09			
Transfers of realised elements of revaluation reserve	24	(24)	0
Non Cash charges - cost of capital	124	0	124
Retained deficit	(28,306)	0	(28,306)
Total recognised income and expenditure for 2008-09	(28,158)	(24)	(28,182)
Parliamentary Funding from Department of Health	28,265		28,265
Balance as at 31 March 2009	3,416	57	3,473

	General Fund £000	Revaluation Reserve £000	Total Reserves £000
Balance at 1 April 2009	**3,416**	**57**	**3,473**
Changes in reserves 2009/10			
Transfers of realised elements of revaluation reserve	19	(19)	**0**
Non Cash charges - cost of capital	127	0	**127**
Retained deficit	(33,154)	0	**(33,154)**
Total recognised income and expenditure for 2009-10	(33,008)	(19)	**(33,027)**
Parliamentary Funding from Department of Health	33,700		**33,700**
Balance as at 31 March 2010	**4,108**	**38**	**4,146**

Notes to the Accounts

for the year ended 31 March 2010

1. Accounting Policies

These financial statements have been prepared in accordance with the 2009-10 Government Financial Reporting Manual (FReM) issued by HM Treasury. From the current year, the accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the National Patient Safety Agency for the purpose of giving a true and fair view has been selected. The particular policies adopted by the National Patient Safety Agency are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Conventions

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

Acquisitions and Discontinued Operations

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

1.2 Income

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

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

1.3 Taxation

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

1.4 Capital charges

A charge, reflecting the cost of capital utilised by the National Patient Safety Agency, is included in the Expenditure Account. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all asssets less liabilities, except for cash balances with the Office of the Paymaster General, where the charge is nil.

1.5 Property, Plant & Equipment

(a) Capitalisation

Property, Plant & Equipment which is capable of being used for more than one year and they:

- individually have a cost equal to or greater than £5,000; or
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial setting-up cost of a new building, irrespective of their individual or collective cost.

(b) Valuation

Operational and IT assets are carried at depreciated historic cost as this is not considered to be materially different from fair value.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

Assets in the course of contruction are valued at current cost.

(c) Intangible Assets

Intangible assets are capitalised when they have a cost of at least £5,000. Intangible assets acquired separately are initially recognised at historic cost.

Prior to 31 March 2008 Developed Software was capitalised to Property, Plant and Equipment. Under IFRS standards, this is required to be capitalised as Intangible Assets. All Developed Software is valued at depreciated historic cost as this is not considered to be materially different to fair value.

(d) Depreciation, amortisation and impairments

Depreciation is charged on each individual component of fixed assets.

Land and assets under construction are not depreciated.

Intangible assets are amortised on a straight line basis over the estimated lives of the assets.

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 licence	7
Intangible InformationTechnology	5-7

Equipment and IT assets are depreciated evenly over the expected useful life:

	Years
Plant & Machinery	5
Tangible Information Technology	5

Furniture and fittings are depreciated on a straight line basis over the estimated lives of the asset.

1.6 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.7 Cash and cash equivalents

Cash is the balance held with the Office of Paymaster General. Cash in hand are petty cash imprests held within the National Patient Safety Agency as well as vouchers of known amounts of cash with no risk of change in value.

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 16 is compiled directly from the losses and special payments register which is prepared on a cash basis.

1.9 Employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Agency commits itself to the retirement, regardless of the method of payment.

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 should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.11 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Where arrangements are in place that imply a lease arrangement the costs have been charged as an expense on a straight line basis and disclosed as part of note 14.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated where possible. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

1.12 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. Resulting exchange gains and losses are taken to the Operating Cost Statement.

1.13 Provisions

The Authority provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position 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.

1.14 Financial Instruments

Financial assets

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Agency's loans and receivables comprise: cash at bank and in hand, NHS Debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cast receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account.

Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the Agency becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received.

Financial liabilities are derecognised when the liability has been discharged, that is, the liability has been paid or has expired. The Agency's financial liabilities comprise: NHS Creditors, other creditors and accruals.

Financial liabilities are initially recognised at fair value.

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Operating Cost Statement. The net gain or loss incorporates any interest earned on the financial asset.

2. First Time Adoption of IFRS

	General Fund £000	Revaluation Reserve £000	Total Taxpayers' equity £000
Taxpayers equity at 31 March 2009 under UK GAAP	**3,688**	**57**	**3,745**
Adjustments for:			
IAS 19: Recognition of accrued holiday benefits	(189)	0	(189)
IAS 16: Write off of assets	(100)	0	(100)
IAS 16: Write back depreciation relating to assets	17	0	17
Taxpayers equity at 1 April 2009 under IFRS	**3,416**	**57**	**3,473**

	£000
Net Expenditure for 2008 - 09 under UK GAAP	28,246
Adjustments for:	
IAS 19: Recognition of accrued holiday benefits	51
IAS 16: Write off of assets	30
Depreciation for assets written off	(17)
Adjustment for Capital Charges	(4)
Net Expenditure for 2008-09 under IFRS	**28,306**

3. Analysis of Net Expenditure by Segment

The segments are based on the four reporting divisions within the Agency upon which the monthly reporting to the Board is based.

The Income disclosed relates to funding received for each of the divisions to provide specific services. In addition funding is also received from the Wales (£ 1,705k, 2008-09: £1,648k) and Northern Ireland (£385k, 2008-09: £354k) Devolved Nations for the provision of some services. This funding is held within a central income budget and not allocated to specific divisions, and therefore is not shown in this note, but is identified in Note 6.

In addition our main funding supply is Parliamentary Funding which is not treated as income but is allocated directly to the General Fund and therefore is not shown within this note.

	National Reporting Learning Service (*)		**National Clinical Assessment Service**		**National Research Ethics Service**		**Corporate (**)**		**Total**	
	2009-10 £000	2008-09 £000	**2009-10 £000**	2008-09 £000	**2009-10 £000**	2008-09 £000	**2009-10 £000**	2008-09 £000	**2009-10 £000**	2008-09 £000
Gross Expenditure	**14,351**	10,687	**9,795**	8,853	**4,139**	4,073	**10,606**	9,733	**38,891**	33,346
Income	**(1,273)**	(1,264)	**(2,095)**	(1,568)	**(227)**	(206)	**(52)**	0	**(3,647)**	(3,038)
Net Expenditure	**13,078**	9,423	**7,700**	7,285	**3,912**	3,867	**10,554**	9,733	**35,244**	30,308
Net Assets:										
Segment net assets	**0**	0	0	0	**0**	0	**0**	0	**4,146**	3,473

(*) The costs of the 3 Confidential Enquiry contracts are included within the costs reported under NRLS.

(**) The costs for rents, rates and utilities for the Agency are held centrally within the Corporate Division and form part of the Corporate Costs disclosed. The Agency does not report by Division the costs of capital charges and depreciation, which increased by £254k in 2009/10 and reserves, the full costs of these are included within the Corporate Costs disclosed.

The 2008/09 costs have been restated to include the services that were transferred to the corporate division in 2009/10. There were an additional £650k of overhead costs relating to Patient Safety Direct that were incurred during 2009/10 within the corporate division.

The balance sheet net assets are also not reported by Division and therefore these costs have been included in the total column.

4.1. Staff numbers and related costs

Executive members and staff costs:

	2009-10			2008-09		
	Total £000	**Permanently employed £000**	**Other £000**	Total £000	Permanently employed £000	Other £000
Salaries and wages	**16,813**	12,233	4,580	14,881	10,680	4,201
Social security costs	**1,143**	1,143	0	1,012	1,012	0
Employer contributions to NHSPA	**1,558**	1,558	0	1,351	1,351	0
Total	**19,514**	**14,934**	**4,580**	17,244	13,043	4,201

The average number of persons employed during the year was:

	2009-10			2008-09		
	Total Number	**Permanently employed Number**	**Other Number**	Total Number	Permanently employed Number	Other Number
Total	**344**	**264**	**80**	295	228	67

Expenditure of staff benefits

The amount spent on staff benefits, comprising of tax on Non Executive Directors and staff travel and improving working lives for the staff, during the period to 31st March 2010 totalled £46,734 (2008-09: £62,387)

Retirements due to ill-health

This note discloses the number and additional pension costs for individuals who retired early on ill-health grounds during the year. There was 1 retirement, at an additional cost of £85,888.02 during 2009-10 (2008-09: £170,081.31). This information has been supplied by NHS Pensions

Early retirements and redundancies

£171,729 has been charged to the revenue account in 2009-10 in respect of redundancies (2008-09 £10,884).

4.1.1 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting Valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

The Scheme is a final salary scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

Pensions Indexation

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.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

4.2 Other Operating Costs

	Note		2009-10 £000	2008-09 £000
Non-executive members' remuneration			**123**	122
Other salaries and wages	*4.1*		**19,514**	17,244
Total Staff Costs			**19,637**	17,366
Rentals under operating leases			**1,102**	1,099
Supplies and Services - general			**128**	99
Establishment expenses			**5,173**	4,423
Transport and moveable plant			**42**	30
Premises and fixed plant			**3,107**	2,428
External contractors (*)			**7,916**	6,581
Capital: Depreciation		**662**		611
Amortisation		**380**		317
Loss on disposal of non current assets	*7.3*	**166**		26
			1,208	954
Auditors' remuneration: (**) Audit fees			**46**	52
Miscellaneous			**233**	179
Redundancies			**172**	11
Total programme costs			**38,764**	33,222

(*) This includes payments of £3,180k for the three Confidential Enquiries from 01/04/2009 (2008-09: £3,187k). The Confidential Enquiries carry out national audits of NHS care focusing on Acute care, Maternal and Child health and Suicide.

(**) The Authority did not make any payments to Auditors for non-audit work.

4.3 Better Payment Practice Code - measure of compliance

	2009-10 Number	2008-09 Number	**2009-10 £000**	2008-09 £000
Total Non-NHS trade invoices paid in the year	**12,528**	11,196	**22,639**	19,652
Total Non-NHS trade invoices paid within target	**11,050**	9,893	**20,066**	17,731
Percentage of Non-NHS trade invoices paid within target	**88.2%**	88.4%	**88.6%**	90.2%
Total NHS trade invoices in the year	**423**	306	**1,791**	1,478
Total NHS trade invoices paid within target	**338**	258	**1,446**	1,222
Percentage of NHS trade invoices paid within target	**79.9%**	84.3%	**80.7%**	82.7%

The Late Payment of Commercial Debts (Interest) Act 1998

	2009-10 £000	2008-09 £000
Amounts included within interest payable Note 2.12 arising from claims made by small businesses under this legislation	**0**	0

5.1 Reconciliation of net operating cost to net resource outturn

	2009-10 £000	2008-09 £000
Net operating costs for the financial year	**33,154**	28,246
Revenue Resource Limit	**33,234**	28,414
Underspend against Revenue Resource Limit	**80**	**168**

5.2 Reconciliation of gross capital expenditure to capital resource limit

	2009-10 £000	2008-09 £000
Gross Capital Expenditure	**1,876**	1,129
Less: Net Book Value of assets disposed of	**(166)**	(26)
Charge against the Capital Resource Limit	**1,710**	1,103
Capital Resource Limit	**1,876**	1,108
Underspend Against Capital Resource Limit	**166**	**5**

6. Operating revenue

	Appropriated in Aid £000	**Not Appropriated in Aid £000**	**2009-10 £000**	2008-09 £000
Fees & charges to external customers	**848**	**0**	**848**	805
Income received from Scottish Parliament	**0**	**948**	**948**	1,100
Income received from National Assembly for Wales	**0**	**1,771**	**1,771**	1,710
Income received from Northern Ireland Assembly	**0**	**423**	**423**	391
Income received from other Departments	**0**	**1,747**	**1,747**	1,034
Total Operating revenue	**848**	**4,889**	**5,737**	5,040

£5,680k (2008-09: £4,787k) of the total operating income for the Agency is funding that was received for the provision of specific services rather than under income generation powers. This income therefore is equal to the expenditure incurred directly on the service including appropriate overheads.

7.1 Property, Plant and Equipment

	Assets under construction & payments on account £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or Valuation at 1 April 2009	862	50	3,105	679	**4,696**
Additions - purchased	915	26	620	0	**1,561**
Transfers	(1,233)	0	865	0	**(368)**
Disposals	0	0	(298)	0	**(298)**
Gross cost at 31 March 2010	**544**	**76**	**4,292**	**679**	**5,591**
Depreciation					
Accumulated depreciation at 1 April 2009	0	19	1,605	437	**2,061**
Charged during the year	0	11	573	78	**662**
Disposals	0	0	(227)	0	**(227)**
Accumulated depreciation at 31 March 2010	**0**	**30**	**1,951**	**515**	**2,496**
Net book value at 1 April 2009	862	31	1,500	242	2,635
Net book value at 31 March 2010	**544**	**46**	**2,341**	**164**	**3,095**

	Assets under construction & payments on account £000	Plant & machinery £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or Valuation at 1 April 2008	483	44	2,778	679	**3,984**
Additions - purchased	854	6	85	0	**945**
Transfers	(475)	0	262	0	**(213)**
Disposals	0	0	(20)	0	**(20)**
Gross cost at 31 March 2009	**862**	**50**	**3,105**	**679**	**4,696**
Depreciation					
Accumulated depreciation at 1 April 2008	0	9	1,098	358	1,465
Disposals	0	0	(15)	0	(15)
Charged during the year	0	10	522	79	611
Accumulated depreciation at 31 March 2009	**0**	**19**	**1,605**	**437**	**2,061**
Net book value at 1 April 2008	483	35	1,679	321	2,518
Net book value at 31 March 2009	**862**	**31**	**1,500**	**242**	**2,635**

Assets are held at depreciated historic cost as this has been determined as representing the fair value of assets due to the short lives and nature of the assets. Previously historic Furniture and Fittings were valued using appropriate indices, this method of valuation was removed in 2008-09.

Assets previously categorised under Building exc dwellings, has been reclassified as Furniture & Fittings for the purposes of the opening balances.

7.1.1 Property, Plant and Equipment

Leasehold land and buildings have a net book value of £0 (2008: £297,000); this is due to the reclassification of assets previously categorised as Buildings exc dwellings to Furniture and Fittings.

7.2 Intangible assets

	Software licences £000	Information Technology £000	Total £000
Gross cost at 1 April 2009	595	1,295	**1,890**
Additions - purchased	113	201	**314**
Transfers	0	368	**368**
Disposals	(95)	(132)	**(227)**
Gross cost at 31 March 2010	**613**	**1,732**	**2,345**
Amortisation			
Accumulated amortisation at 1 April 2009	438	517	**955**
Charged during the year	76	304	**380**
Disposals	(55)	(77)	**(132)**
Accumulated amortisation at 31 March 2010	**459**	**744**	**1,203**
Net book value at 31 March 2009	157	778	935
Net book value at 31 March 2010	**154**	**988**	**1,142**

	Software licences £000	Information Technology £000	Total £000
Gross cost at 1 April 2008	542	1,068	**1,610**
Additions - purchased	23	131	**154**
Transfers	95	117	**212**
Disposals	(65)	(21)	**(86)**
Gross cost at 31 March 2009	**595**	**1,295**	**1,890**
Amortisation			
Accumulated amortisation at 1 April 2008	401	303	**704**
Charged during the year	89	228	**317**
Disposals	(52)	(14)	**(66)**
Accumulated amortisation at 31 March 2009	**438**	**517**	**955**
Net book value at 31 March 2008	141	764	905
Net book value at 31 March 2009	**157**	**778**	**935**

Assets are held at depreciated historic cost as this has been determined as representing the fair value of assets due to the short lives and nature of the assets.

The useful live of software licences has been determined to be 3 years. For information technology the useful life is either 5 years or 7 years dependant on the expected life of the asset. This is assessed for each asset that is generated.

7.3 Profit / (loss) on disposal of fixed assets

	2009-10 £000	2008-09 £000
(Loss) on disposal of intangible fixed assets	(95)	(18)
(Loss) on disposal of tangible fixed assets	(71)	(8)
	(166)	**(26)**

8. Trade Receivables

8.1 Amounts falling due within one year

	31st March 2010 £000	31st March 2009 £000	1st April 2008 £000
Trade Receivables	**679**	442	622
Other receivables	**718**	620	712
Prepayments and accrued income	**2,055**	3,792	2,350
Trade and other receivables	**3,452**	4,854	3,684

9. Cash and Cash equivalents

	As at 1 April 2009 £000	Change in year £000	As at 31 Mar 2010 £000	As at 1 April 2008 £000
OPG cash at bank	4	368	**372**	0
Commercial cash at bank and in hand	3	0	**3**	3
Total	**7**	**368**	**375**	3

Comprising:

Held with office of HM paymaster general	**372**
Commercial banks and cash in hand	**3**
Balance at 31 March 2010	**375**

10. Trade Payables and other current liabilities

10.1 Amounts falling due within one year

	31st March 2010 £000	31st March 2009 £000	1 April 2008 £000
Trade payables	**436**	1,634	1,114
Accruals and deferred income	**3,482**	2,999	2,079
Trade and other payables	**3,918**	4,633	3,193
Other taxation and social security	**0**	325	487
Other Current Liabilities	**0**	325	487
Total Trade Payables and other current liabilities	**3,918**	**4,958**	**3,680**

11. Provisions for liabilities and charges

	Legal claims £000	Other £000	Total £000	31 March 2009 £000
At 1 April 2009	0	0	**0**	40
Arising during the year	0	0	**0**	0
Reversed unused	0	0	**0**	(40)
At 31 March 2010	**0**	**0**	**0**	**0**

12. Contingent Liabilities

At 31 March 2010, there were no known contingent liabilities (2008-09: £nil).

13. Capital commitments

At 31 March 2010 the value of contracted capital commitments was £3,500 (2008-09 £289,243).

14. Commitments under leases

Operating leases

Total future minimum lease payments under operating leases are given in the table below for each of the following periods

	2009-10 £000	2008-09 £000
Obligations under operating leases comprise:		
Buildings		
Not later than one year	961	1,066
Later than one year and not later than five years	2,380	3,230
Later than five years	0	112
	3,341	4,408
Other Leases		
Not later than one year	45	2
Later than one year and not later than five years	0	43
	45	45

15. Other financial commitments

The National Patient Safety Agency has entered into 2 contracts, one relating to the provision of payroll services commencing on 1 April 2007 for 6 years and one relating to the support of the business management system commencing on 1 January 2008 for three years. The total cost over the life of the contracts is £244,000.

	2009-10 £000	2008-09 £000
Not later than one year	45	150
Later than one year and not later than five years	49	94
	94	244

16. Losses and special payments

There were 3 cases of losses (Prior year: 3 cases) totalling £647 (Prior year £1,686) approved to the 31 March 2010 and 1 special payment totalling £27,900 (Prior year £nil)

17. Related Party Transactions

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 signficant 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 (£50k) and income and expenditure balances (£100k).

	Payments in Year 09/10 £000	Receipts in year 09/10 £000	Debtor @ 31.03.10 £000	Creditor @ 31.03.10 £000
Connecting For Health	0	0	72	0
Department of Health	320	1,204	68	0
Imperial College Healthcare NHS Trust	167	0	0	9
NHS Institute for Innovation and Improvement	0	530	0	0
Oxford Radcliffe Hospitals NHS Trust	181	0	0	0
West London Mental Health NHS Trust	141	0	0	0

No Board Member or key manager has undertaken any material transactions with the National Patient Safety Agency during the year.

18. Events after the reporting period

There are no events after the reporting period to report.

19. Financial Instruments

Financial risk management
Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. As the cash requirements of the Agency are met through Parliamentary Funding, financial instruments play a more limited role in creating risk that would apply to a non-public sector body of a similar size. 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 Agency is undertaking its activities.

The Agency's treasury management operations are carried out by the finance department, within parameters defined formally within the Agency's Standing Financial Instructions and policies agreed by the Board. The Agency's treasury management activity is subject to review by the Agency's internal auditors

Foreign Currency risk
The National Patient Safety Agency takes measures to minimise all foreign currency risk. The National Patient Safety Agency has negligible foreign currency risk.

Interest rate risk
100 per cent of the Authority's financial assets and 100 per cent 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.

Liquidity Risk
The National Patient Safety Agency's 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.

Credit Risk
The National Patient Safety Agency operates primarily within the NHS market and receives the majority of its income from the Department of Health and Devolved Administrations. Bad debt provisions are calculated based on the type of debtor, ageing or the outstanding debt and knowledge of specific queries on the balances. The ageing of trade debtors at the reporting date was:

	£000
Not past due	436
Past due 0-30 days	81
Past due 31-120 days	371
More than 121 days	74

The National Patient Safety Agency has made a provision for £2,303 relating to 2 invoices over 121 days old. The NPSA does not believe that any provision is required in respect of other trade debtors past 31 days due to the majority relating to NHS Customers.

Supplier Risk
The National Patient Safety Agency operates within both the NHS and non NHS market for the supplies of goods and services .

The ageing of NHS and Non NHS Trade creditors at the reporting date was:

	£000
Not past due	161
Past due 0-30 days	79
Past due 31-120 days	26
More than 121 days	10

Fair values
The National Patient Safety Agency has no significant long term debtors and creditors and therefore the book values are not different from the fair value.

20. Intra-government balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with other central government bodies	253	0	55	0
Balances with local authorities	0	0	0	0
Balances with NHS Trusts	33	0	338	0
Balances with public corporations and trading funds	0	0	0	0
	286	**0**	**393**	**0**
Balances with bodies external to government	3,166	0	3,525	0
At 31 March 2010	**3,452**	**0**	**3,918**	**0**
Balances with other central government bodies	732	0	622	0
Balances with local authorities	0	0	0	0
Balances with NHS Trusts	1	0	299	0
Balances with public corporations and trading funds	0	0	0	0
	733	**0**	**921**	**0**
Balances with bodies external to government	4,121	0	4,037	0
At 31 March 2009	**4,854**	**0**	**4,958**	**0**
Balances with other central government bodies	806	0	705	0
Balances with local authorities	0	0	0	0
Balances with NHS Trusts	17	0	227	0
Balances with public corporations and trading funds	0	0	11 0	0
	823	**0**	**943**	**0**
Balances with bodies external to government	2,861	0	2,737	0
At 1 April 2008	**3,684**	**0**	**3,680**	**0**

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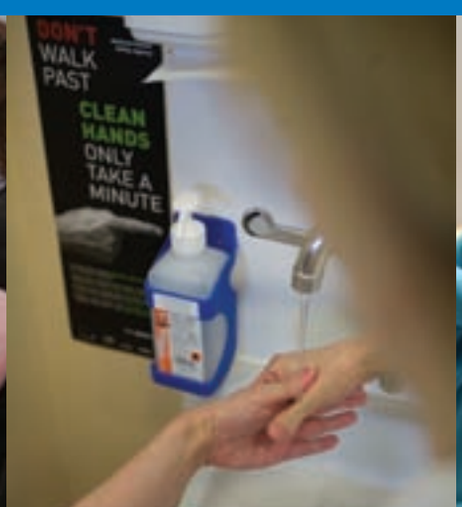

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