The National Health Service Litigation Authority

Report and Accounts 2006

HC 1179

AIMS AND OBJECTIVES

The NHS Litigation Authority is a Special Health Authority, responsible for handling negligence claims made against NHS bodies. When we were first created in 1995 our main functions were to administer schemes under which NHS bodies could pool their clinical negligence liabilities and to promote high standards of risk management in the NHS. Since then, our work has expanded to include schemes and risk management standards for non-clinical liabilities, the provision of an information service for the NHS on human rights case-law, dispute resolution between primary care practitioners and their local Primary Care Trusts, and advice and assistance to NHS bodies when handling equal pay litigation.

Our aims and objectives are set out in our current *Framework Document*:

"The Secretary of State's overall aims for the Authority in administering the schemes are to promote the highest possible standards of patient care and to minimise the suffering resulting from any adverse incidents which do nevertheless occur. In particular, the Authority will contribute to these aims by its efficient, effective and impartial administration of the schemes, and by advising the Secretary of State on any changes that may be needed in the light of experience in running the schemes and of changing circumstances."

In pursuit of this overriding aim, we seek to:

" … maximise the resources available for patient care, by defending unjustified actions robustly, settling justified actions efficiently, and contributing to the incentives for reducing the number of negligent or preventable incidents … "

" … ensure that, where liability has been established, patients have appropriate access to remedies including, where proper, financial compensation … "

" … contribute to the improvement of the quality of patient care by providing incentives within the schemes for NHS bodies to improve cost effective clinical and non clinical risk management … "

" … minimise the cost to the NHS of obtaining legal advice in relation to the *Human Rights Act 1998*, by providing NHS bodies with access to a centrally coordinated information service … "

" … provide mechanisms for the proper, prompt and cost-effective resolution of disputes between NHS primary care organisations and the practitioners and organisations that provide or seek to provide services for patients … "

" … advise and assist [NHS bodies] in connection with any matter arising out of or in connection with any equal pay litigation … "

Abbreviations used in this Report

CNST – Clinical Negligence Scheme for Trusts
ELS – Existing Liabilities Scheme
Ex-RHA – Scheme covering liabilities against the former Regional Health Authorities
LTPS – Liabilities to Third Parties Scheme
PCTs – Primary Care Trusts
PES – Property Expenses Scheme
RPST – Risk Pooling Schemes for Trusts (collective term for LTPS and PES)

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CONTENTS

KEY ACHIEVEMENTS

Following the Department of Health's review of its "Arm's Length Bodies", we have continued to expand our role, taking on the functions of the former Family Health Services Appeal Authority and providing new assistance to NHS bodies in the area of Equal Pay litigation.

All NHS trusts and PCTs, including Foundation trusts, continue to be members of our Clinical Negligence Scheme for Trusts (CNST).

Despite wide-spread concerns about a "compensation culture" in the UK, claims numbers remain very steady: a 1.6% increase in clinical claims in 2005/06 over 2004/05 was balanced by a 7.1% decrease in non-clinical claims over the same period.

96% of our cases are settled out of court through a variety of methods of "alternative dispute resolution" (ADR), such as negotiation, round-table meetings or mediation. A further 3% only go to court for procedural reasons, such as where court approval of a settlement on behalf of a child is required. Fewer than 50 clinical negligence cases a year are contested in court.

The High Court has praised our "sympathetic, helpful and constructive" approach in devising a system to guarantee the security of periodical payments in the event of a Foundation trust choosing to leave CNST in the future.

We have succeeded in a number of instances in capping excessive legal costs incurred on behalf of claimants, thus avoiding NHS funding being unnecessarily diverted from patient care.

In line with the Department of Health policy of reducing the burden of data collection placed on NHS bodies, we have succeeded in minimising the information we have to request from our members when setting contribution levels.

The NHS performance "star ratings" for the 2004/05 financial year published by the Healthcare Commission in July 2005 incorporated the level achieved by each trust in the CNST general, CNST maternity, NHSLA ambulance and PCT standards at 31 March 2005. The number of NHS bodies achieving the higher levels in these standards is steadily increasing.

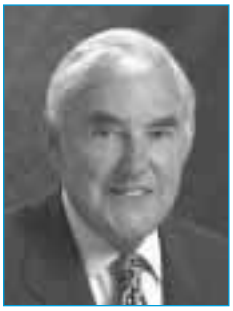
New clinical risk management standards have been introduced for mental health and learning disability trusts, and the work involved in creating a single set of standards for each type of trust incorporating organisational, clinical and health & safety risks is progressing well.

Over 95% of cases handled by the FHS Appeal Unit were determined within the key target times.

The FHS Appeal Unit successfully ensured that all Primary Care Trusts were aware of their statutory obligation to notify us of regulatory decisions affecting primary care practitioners. In doing so we verified the substantial amount of data currently held on our database.

We have created a database of over 300 Human Rights Act cases of relevance to NHS staff, which is publicly available at www.nhsla.com/hra.

CHAIRMAN'S STATEMENT



Ron Bradshaw
Chairman

I am pleased to make this statement on behalf of the Board of the NHS Litigation Authority, summarising its activities for the period from 1st April 2005 to 31st March 2006.

In previous statements I have included a brief summary about the Authority's claims handling functions, highlighting key figures, particularly numbers of claims and payments of compensation and costs. This is unnecessary in this statement since there are detailed facts and figures, as well as explanations, later in this Report. For those interested or concerned about such matters I refer them to the sections entitled "Handling claims" and "Volume of claims" in pages 9 to 11. The Accounts, of course, also include relevant statistics.

So much for what might be described as "the day job". The Board has, however, been very occupied in considering and dealing with those initiatives and policies which have affected all NHS bodies during the year 2005/06. These include, in particular, "Agenda for Change" which covers this Authority despite the "service industry" nature of its activities, none of the staff being front-line in the sense that they deliver healthcare to patients. Indeed it has been difficult for some staff to understand why, as claims handlers or engaged in risk management, they should be included in Agenda for Change issues, save that the Authority is (as its name implies) an element of the NHS.

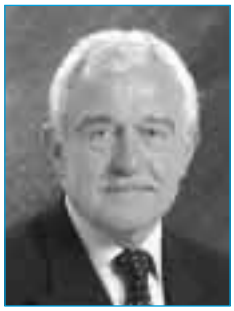
Other matters which continue to be addressed by the Board include relocation (in particular the Croydon office) and restructuring, once Agenda for Change and relocation problems have been overcome. These are all matters which cause uncertainty and concern to the staff, of which the Board is fully aware and which it is attempting to address sympathetically.

The Authority continues to work with and be grateful to the solicitors' panels, risk assessors (Willis Ltd), actuaries (Lane, Clark & Peacock) and to the Professional Advisory Panel (PAP) and the Policy Advisory Group (PAG). As ever, however, the Board's greatest appreciation and gratitude is to the members of staff.

Finally, since this is my last Chairman's Statement before retirement after two terms, I wish to record my thanks to all my fellow Board Members, not least John Speedman (Deputy Chairman) who retired on 31 March 2006 after ten years as a non-executive director. In addition, I wish to make special mention of Steve Walker (Chief Executive) and Tom Fothergill (Director of Finance), with whom I have enjoyed a happy and harmonious relationship, and to both of whom much of the success of the Authority in its ten years' existence is due. It is, therefore, pleasing that literally as this Report goes to press Steve Walker's services to the NHS have been recognised by his inclusion in Her Majesty's Birthday Honours List as a Commander of the British Empire. That is well earned and reflects great credit on Steve Walker himself, as Chief Executive and (I would like to think) also on the Authority as a whole.

Ron Bradshaw
Chairman

CHIEF EXECUTIVE'S STATEMENT



Steve Walker
Chief Executive

It is customary to review the previous financial year in this article. This year it seems appropriate to review the last ten, since November 21st 2005 marked the 10th anniversary of the creation of the NHSLA as a Special Health Authority to manage the Clinical Negligence Scheme for Trusts (CNST) and the Existing Liabilities Scheme (ELS). Both schemes provide indemnity in respect of claims, but CNST, in particular, also has a major risk management function.

Initially NHSLA managed two external scheme managers: the Medical Protection Society (MPS) handled claims and Willis assessed trusts against our risk management standards. In addition, Lane Clark & Peacock were appointed actuaries to CNST and created a model to predict outlay and thereby inform contribution setting for scheme members. As we acquired our own technical staff we assumed the claims management role direct, but Willis and LCP remain with us after successive tenders. Since April 1st 1999 we have also provided indemnity cover for members in respect of non clinical risks including employers' and public liability and property cover.

New readers may need to learn that none of our schemes is written as insurance. They are pay-as-you-go schemes, such that members only contribute in any year sufficient for us to meet payments in year. We do not retain any surplus or reserves as an insurer would, which means that cash remains within the service, locally, unless and until it is needed. Not only does this assist cash-flow for the service, but it enables us to provide affordable protection to members whatever the state of the insurance market at any given time.

Almost simultaneously, Lord Woolf was publishing *Access to Justice*, in which he devoted a chapter to his concerns about clinical negligence litigation. He criticised its cost and delays and the unnecessarily confrontational attitude adopted by the opposing lawyers. Unfortunately, he was right.

We quickly became aware that a chaotic, even anarchic, situation prevailed. We inherited 98 firms of solicitors acting on behalf of English trusts and health authorities. Some were good, some were less so, some were not even that good. In consequence we created a panel of specialists, now down to twelve practices after successive panel reviews, and published a protocol to which they adhere in respect of reporting and case management. The initiative has proved successful and now seems so obvious a step to take. In 1999 it was seen as confrontational, unnecessary and politically risky. One practice even threatened us with judicial review.

We also prepared guidelines for trust staff to assist them in preparing cases for CNST, a task in which we were greatly assisted by our Policy Advisory Group (PAG) and the Association of Litigation and Risk Managers (ALARM).

Although we would deprecate the term "Mission Statement", we said at our early conferences that we aimed to "Get the right money to the right people at the right time" and that remains an objective for all of us. We attempt to do that by establishing, as early as possible, whether or not there is a liability to compensate. If there is, we say so. If not, we explain why. If payment is to be made, we try to quantify the claim as early as possible and make an offer. The delays, largely inherited, described by the NAO in 2001 in *Handling clinical negligence claims in England*, are now a thing of the past; today, we are more likely to press a claimant lawyer about delay than the reverse.

We try to avoid litigation in the courts, the most expensive and slowest means of dispute resolution. Less than 1% of our cases are now tested before a judge, although another 3% go before the court for approval of negotiated settlements. We also positively encourage apologies and explanations, locally, when things do go wrong. The current *Compensation Bill* advocates

apologies and will give statutory weight to the idea that an apology is not an admission of liability. We have been saying so since 1997. We advocate mediation and round-table meetings, with or without the claimant's attendance. Both are powerful tools to resolve disputes, but they are not cost neutral, only cheaper than the worst alternative. The Authority was Public Sector Mediator of the Year in 2004.

Although seeking to avoid litigation, NHSLA will defend actions through the courts in a number of circumstances. Sometimes there is genuine disagreement about liability, causation or quantum and both sides effectively ask the judge for a ruling. These cases are rare. Sometimes it is necessary to defend a specific case to create or to protect a legal precedent for the NHS at large.

Examples of financial savings include *Heil v Rankin & others*, in which we mounted the first pan-NHS defence and were successful in persuading the Court of Appeal to moderate considerably proposals by the Law Commission to increase general damages. That saved hundreds of millions of pounds per annum for the foreseeable future against the outcome sought by our opponents. Similar cases involving seven figure savings per annum include *Cooke v United Bristol Health Care*, where our success saved almost £2m in that case and an estimated £700m per annum thereafter, and *Page v Plymouth Hospitals NHS Trust*, where a one-off saving of £1m extrapolates into annual savings of hundreds of millions of pounds.

In terms of clinical practice, we might point to *Bolitho v City & Hackney Health Authority* which largely maintained the defence position of professionals established before our existence in *Bolam*, or to *JD v East Berkshire Community Health NHS Trust & others* in which the House of Lords ruled that clinicians acting in good faith to protect a child would not be liable to that child's parents if those parents were harmed by proper child protection procedures.

The risk management standards which were a feature of CNST from the beginning have significantly raised both awareness of risk and systematic appraisal and management of risk within the NHS in England. They have been reviewed and adapted over time with input from colleagues in the NHS, the Royal Colleges, Willis, and others. Discounts against contributions no doubt supplement the genuine desire to improve patient and staff welfare to which they contribute, and we and Willis organise extensive training seminars and workshops every year.

Everything we do is done on the assumption that we should be a resource for the NHS in England. In 2000 we were asked to publicise the impending implementation of the *Human Rights Act 1998* to the NHS which we did with a series of seminars and the creation of a Human Rights Act Information Service (HRAIS) which issues regular information to the service as this area of law evolves. In 2005 we absorbed the functions of the former Family Health Services Appeal Authority, learned that the Authority would manage the proposed NHS Redress Scheme and were asked to manage a series of staff claims against the NHS in relation to allegations of pay inequality.

We have always assumed that successive expansion of our functions represents a vote of confidence in the Authority and its staff. This therefore seems an appropriate moment to add my oft-repeated assertion that the staff of the Authority represent a great asset for the service and that none of our achievements would have been achieved without them.

Similarly, as we look forward to the next ten years, they remain the basis of anything we can achieve.

Steve Walker
Chief Executive

DIRECTOR OF FINANCE'S REPORT

Business changes

Tom Fothergill
Director of Finance

As previously reported and also referred to elsewhere within the report, 2005/06 has seen a continuation of the change environment resulting from various NHS and cross-Government initiatives.

Arm's Length Bodies (ALB) Review

The Authority has welcomed colleagues from the former Family Health Services Appeal Authority (FHSAA) which merged with the NHS Litigation Authority as at 1st April 2005. The function, which remains within its original Harrogate base, is now referred to as the Family Health Services Appeal Unit (FHSAU) and continues to perform the role it had prior to the ALB Review, ably led by Paul Burns. My personal thanks are due to Paul and the team who have embraced the merger and immersed themselves into the new organisation with minimal or no disruption to service provision.

During 2005/06 the Authority continued to work with colleagues from the ALB team in conjunction with our sponsor branch of the Department of Health. The impact on the Authority of the continued work of the team has been to establish maximum headcount and running costs which have been achieved in 2005/06 and incorporated into strategic planning for the coming three financial years. Our strategic and business plan is published on our website at www.nhsla.com.

The Authority remains committed to the overall aims of the various reviews which I badge here under ALB, although it has to be reported that the impacts of some continue to have adverse effects on staff morale. In particular, the longer-term requirement to relocate posts out of the South East (under the cross-Government Lyons review) leaves our staff, who generally seem unlikely to welcome such a move, feeling vulnerable and consequently has seen an increase in staff turnover in this financial year as staff opt to seek pastures new rather than await delivery of the proposals.

Agenda for Change (AfC)

The continued roll out of AfC (the new pay and conditions of service for NHS staff) has equally been a difficult area for the Authority. Our experiences suggest that our lack of clinical activity makes it difficult for administrative or office-based staff to fare well under a programme which feels clinically biased. The Authority is continuing its efforts, in partnership with staff representatives, to conclude the assimilation process during early 2006/07.

Accounting Changes

Rather than offer an overview within this report I suggest those interested in our financial reporting turn to the Accounts where we attempt to offer clear description of adjustments alongside the statutory reporting requirements. I draw particular attention to notes 17 and 18 on page 64 where we discuss relevant accounting adjustments reported in these Accounts and also the new "Management commentary" (pages 33 to 40). This commentary flows from the requirements of Reporting Statement which has been globally adopted by the public sector and aims to provide readers of the Accounts with a more descriptive oversight of recent and predicted performance as compared with previous reporting which tended to focus on purely historical performance.

As in all previous years, my sincere thanks to the staff of the Authority for their continued efforts during the past twelve months.

Tom Fothergill
Director of Finance

CLAIMS

Our schemes

The NHS Litigation Authority administers four schemes to handle negligence claims against NHS bodies. Three cover clinical claims, while the fourth covers non clinical incidents, such as accidental injury to visitors or staff. A fifth scheme provides "first party" insurance-type cover for NHS bodies' property and expenses.

The **Clinical Negligence Scheme for Trusts** (CNST) is a voluntary membership scheme, to which all NHS trusts, Foundation trusts and Primary Care Trusts (PCTs) in England currently belong. It covers all clinical claims where the allegedly negligent incident took place on or after 1 April 1995. The costs of meeting these claims are met through members' contributions on a "pay-as-you-go" basis.

The **Existing Liabilities Scheme** (ELS) is centrally funded by the Department of Health and covers clinical claims against NHS bodies where the incident took place before April 1995.

The **Ex-RHAs Scheme** is a relatively small scheme covering clinical claims made against the former Regional Health Authorities, which were abolished in 1996. Like the ELS it is centrally funded by the Department of Health. It differs from the NHSLA's other schemes in that NHSLA is the legal defendant in any action.

The **Liabilities to Third Parties Scheme** (LTPS) and the **Property Expenses Scheme** (PES), known collectively as the **Risk Pooling Schemes for Trusts** (RPST), are two voluntary membership schemes covering non clinical claims where the incident occurred on or after 1 April 1999. Costs are met through members' contributions.

Important cases for the NHS in 2005/06

London Borough of Islington v University College London Hospitals NHS Trust – A local authority which had provided free care to the victim of clinical negligence, but was unable to recover its costs under statute, argued that the NHS owed the council a duty in negligence. This contention was soundly rejected by the Court of Appeal in June 2005, with the appeal judges ruling that there were important and overriding considerations why the council's arguments should fail.

Keown v Coventry Healthcare NHS Trust – a boy aged 11 was trespassing in student accommodation sited in hospital grounds. He climbed a barred fire escape and fell some 30 feet, suffering serious injury including brain damage which allegedly led to him committing a number of sexual offences. It was claimed that the area was an allurement to youths, but the Court of Appeal decided in February 2006 that the claimant knew that what he was doing was dangerous but nonetheless chose to carry on. There was no duty on an occupier of premises to protect against obvious risks in such circumstances, and NHS resources were much more sensibly utilised in the treatment and care of patients.

Sheppard v Essex Strategic Health Authority – The Authority has long been concerned that claimants' costs in clinical negligence actions have the potential to escalate alarmingly and, sometimes, disproportionately. One mechanism to control this problem is the costs cap. We have succeeded in obtaining such caps in group litigation, such as the Ledward and Retained Organs cases, but had not been able to secure one in an individual claim until Mrs Justice Hallett agreed our request in this case. We hope that it will be the first of many!

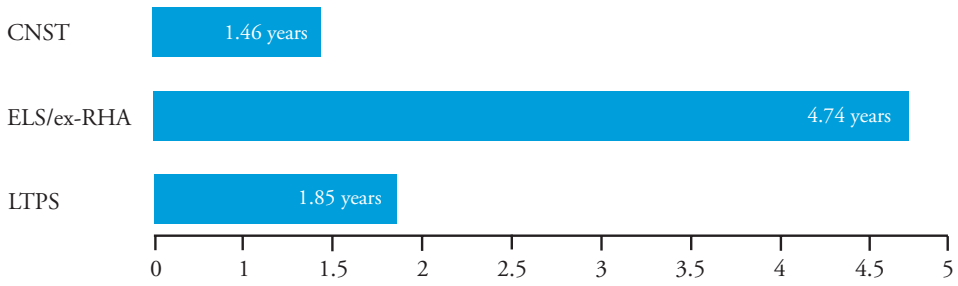
Handling claims

Avoiding litigation

Our remit when handling claims against NHS bodies is to "maximise the resources available for patient care, by defending unjustified actions robustly [and] settling justified actions efficiently". We aim to settle claims as promptly as possible and we encourage NHS bodies to offer patients explanations and apologies. We seek to avoid formal litigation as much as we can: indeed only 4% of our cases on average go to court, and this figure includes settlements made on behalf of minor children which **must** be approved by a court to ensure that the child's interests have been properly protected. This means that 96% of our cases are settled by some form of "alternative dispute resolution" (ADR) such as negotiation, round-table meetings or mediation.

Period between notification and resolution of claims

The following chart shows the average time we have taken to deal with the claims we settled during 2005/06, showing each of our schemes separately. We calculate this figure from the date when a claim is first notified to the NHS body concerned (for ELS claims)[1] or to the Authority (for our other schemes), until the date when damages are agreed or the claimant discontinues their claim.

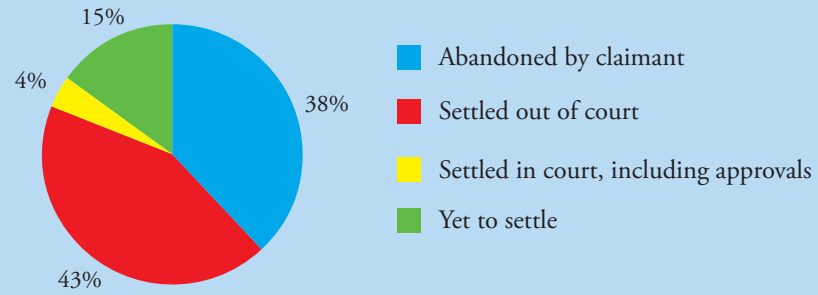


Outcome of claims

We seek, wherever possible and appropriate, to settle claims without litigation. The following chart provides a breakdown by outcome of the cases handled over the past ten years by the Authority under the Clinical Negligence Scheme for Trusts, excluding the lower-value CNST claims which in the past were handled by trusts themselves.

1 It should be noted that the National Audit Office, in its 2001 report *Handling clinical negligence claims in England*, was obliged to use an estimated date for the notification of ELS claims to the NHS when calculating the shelf-life of ELS claims. This was because at the time the Authority's systems did not record this notification date in all instances. As we possess reliable notification dates for all the ELS claims closed in 2005/06, it is no longer necessary to use estimated dates. However, this change in methodology means that direct comparisons cannot be drawn between the figures cited in the NAO report and the figures presented here.

Outcome of claims for clinical negligence made against the NHS between 01/04/96 and 31/03/06



(These data do not include claims settled by individual NHS bodies within their excess[2] and open incidents investigated but not yet proceeded with as a claim.)

The category of cases "settled in court" includes both "litigated cases" (cases where key issues such as liability or damages are determined by a judge) and cases where a settlement has been negotiated out of court, but court approval is still required, typically in order to ensure a minor child's interests are protected. Of the 87 clinical negligence cases actually litigated in court in the last two financial years, 26% were settled in court in favour of the claimant and 68% in favour of the NHS, with 6% being settled mid-trial.

Volume of claims

The number of claims we receive has remained very steady with a 1.6% increase in the number of clinical claims in 2005/06 over 2004/05 and a 7.1% decrease in the number of non clinical claims over the same period.

The tables opposite show the number of claims received under each of our five schemes over the past three years.

2 Until the "call-in" of all CNST claims in April 2002, trusts handled and funded lower-value claims themselves.

Clinical Negligence Scheme for Trusts

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	1,607	4,168	5,775
2004/05	957	4,316	5,273
2005/06	911	4,516	5,427

Existing Liabilities Scheme

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	140	334	474
2004/05	33	296	329
2005/06	109	161	270

Ex-Regional Health Authorities Scheme

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	0	2	2
2004/05	0	7	7
2005/06	0	0	0

Liabilities to Third Parties Scheme

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	33	3,682	3,715
2004/05	11	3,634	3,645
2005/06	10	3,409	3,419

Property Expenses Scheme

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	0	104	104
2004/05	0	121	121
2005/06	0	78	78

Claims outstanding at year end

The number of outstanding claims at the end of 2005/06 shows a slight drop by comparison with the end of 2004/05. The tables below show the number of claims outstanding under each of the schemes at the end of the past three financial years.

Clinical Negligence Scheme for Trusts

Year ended	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	2,769	9,317	12,086
2004/05	1,891	8,775	10,666
2005/06	1,625	8,822	10,447

Existing Liabilities Scheme

Year ended	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	621	2,213	2,834
2004/05	274	1,815	2,089
2005/06	264	1,501	1,765

Ex-Regional Health Authorities Scheme

Year ended	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	13	33	46
2004/05	5	34	39
2005/06	3	28	31

Liabilities to Third Parties Scheme

Year ended	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	58	7,918	7,976
2004/05	19	7,796	7,815
2005/06	22	8,191	8,213

Property Expenses Scheme

	Incidents under investigation	Claims where formal letter of claim has been received	Total
2003/04	0	225	225
2004/05	0	215	215
2005/06	0	206	206

Settlement of claims

Payments made

The following tables shows how much has been paid out by the Authority in respect of claims, by scheme, during 2005/06. It should be emphasised that these figures do not represent the value of claims *made* during 2005/06, since many of those claims will not yet have been settled. Hence these figures should not be equated in any way with the figures given above for the volume of claims in 2005/06 as the two sets of figures relate to two quite distinct cohorts of claims.

The amounts shown include both damages paid to patients and the legal costs incurred on both sides where these are met by the NHSLA. Figures are also given for 2003/04 and 2004/05.

Payments made, by year and scheme

	2003/04 £	2004/05 £	2005/06 £
CNST	293,384,000	329,412,000	384,390,000
ELS	128,071,000	169,414,000	168,203,000
Ex-RHA	1,059,000	4,068,000	7,716,000
Total	**422,514,000**	**502,894,000**	**560,309,000**
LTPS	7,395,000*	21,280,000	26,692,000
PES	2,735,000	3,839,000	4,586,000
Total	**10,130,000**	**25,119,000**	**31,278,000**
Grand total	**432,644,000**	**528,013,000**	**591,587,000**

(Expenditure relates to paid and accrued but excludes reserves)
* the unusually low net figure for LTPS in 2003/04 was due to a change in invoicing policy after the introduction of our new database which resulted in an influx of cash offsetting expenditure.

Legal costs

The Authority remains concerned about the relatively high legal costs which are often incurred in clinical negligence claims, and which do not benefit either injured patients or the NHS. The costs incurred by claimant lawyers continue to be significantly higher than those incurred on our behalf by our panel solicitors, although we continue to seek to have claimants' costs capped where this is appropriate. Indeed, in 2005/06 we succeeded for the first time in obtaining a capping order in an individual claim; capping orders in the past have only been granted in group actions. The following table sets out the ratios between the damages paid to patients in clinical negligence claims and the legal costs paid to defence and claimant lawyers.[3]

Clinical Negligence Scheme for Trusts: claims closed in 2005/06

No. of claims	Damages	Defence costs	Claimant costs	Total costs	Defence costs as % of damages	Claimant costs as % of damages
	£	£	£	£		
6,261	245,844,124	39,391,251	69,757,289	109,148,540	16.02%	28.37%

Existing Liabilities Scheme: claims closed in 2005/06

No. of claims	Damages	Defence costs	Claimant costs	Total costs	Defence costs as % of damages	Claimant costs as % of damages
	£	£	£	£		
834	160,184,322	15,186,072	20,862,695	36,048,767	9.48%	13.02%

Total damages and legal costs in respect of clinical negligence claims closed in 2005/06

No. of claims	Damages	Defence costs	Claimant costs	Total costs	Defence costs as % of damages	Claimant costs as % of damages
	£	£	£	£		
7,095	406,028,446	54,577,323	90,619,984	145,197,307	13.44%	22.32%

(This table includes all claims closed in 2005/06 irrespective of whether they closed with or without damages and costs. 26.3% of total outlay on this cohort of claims is in respect of costs.)

3 Again, these figures cannot be equated with the figures given above for the total amounts paid out by the Authority in 2005/06 because they relate to another cohort of claims: that of claims closed during 2005/06. This is because it is only possible to provide meaningful data on the ratio between costs and damages where a claim has been closed and all payments made.

Periodical payments

The Authority continues to consider the use of periodical payments[4] in appropriate cases: as at 31 March 2006, we were making periodical payments in 410 cases, the provisions for which total £524,684,212.[5] We believe that these payments are the fairest method of settling most, if not all, large personal injury claims, when future costs are so significant.

The *Courts Act 2003* now provides the judiciary with the power to impose periodical payments upon the parties; however as the relevant provisions only came into force on 1 April 2005, it is still too early to see what effect this power may have on the number of cases settled by the use of such payments.

A key issue which arose during 2005/06, however, was the need for courts to be satisfied that the NHS bodies liable to make the payments could guarantee security of payment: under section 2(3) of the *Damages Act 1996* a judge can only make such an award if satisfied that the payment regime is "reasonably secure". Two important cases in 2005/06 helped clarify the position for the NHS. In December 2005, in the case of *Begum v Barnet and Chase Farm Hospitals NHS Trust*, the High Court held that the Existing Liabilities Scheme provided the required level of security, given that funding was from the Department of Health rather than from members.

Subsequently, in the cases of *YM v Gloucestershire Hospitals NHS Foundation Trust and Kanu v King's College Hospital Trust*, the High Court considered the same issue in relation to CNST. The Authority had identified a potential problem as to security should a member leave CNST and then, as a Foundation trust, fail financially, given that trusts leaving the scheme must take their outstanding liabilities with them. This difficulty was solved by the Authority, in conjunction with the Department of Health, devising an agreement to be offered to all trusts whereby they pay the Authority their liability to meet outgoing payments before leaving the scheme. In return the Authority agrees to meet the ongoing payments as required. This solution was praised by Mr. Justice Forbes, who commented on our "sympathetic, helpful and constructive" approach.

4 Periodical payments (formerly known as structured settlements) are damages settlements which include payments made on a regular basis usually throughout the claimant's life in place of the traditional single lump sum to cover all future needs.

5 See note 18 to the Accounts for more information on provisions for periodical payments.

EQUAL PAY

In 2005, the Litigation Authority was asked by the Department of Health to become involved in the management of claims for equal pay being made against NHS bodies in England. Such claims arise out of the *Equal Pay Act 1970* and are being lodged in large numbers, both by solicitors instructed by trade unions and by non-union firms. Publicity surrounding the settlement in North Cumbria, which was arranged prior to our involvement, has had the effect of augmenting claim numbers.

John Mead
Technical Claims Director

We were happy to accept this challenge, albeit in a new area for the Authority. Our experience of group litigation meant that we immediately identified the need to manage these cases in a similar way, and we have established a significant measure of agreement with the main claimant representatives as to the way forward. We have made joint recommendations to the President of the Employment Tribunals on case management issues.

We have established a group of recommended defence solicitors, with particular expertise in this field, and are working closely with the Department generally, particularly on Agenda for Change issues: an increasing number of claimants are using this process as a basis either for alleging pre-AfC discrimination or for claiming that the AfC process itself is discriminatory in certain respects.

We anticipate that various test cases will be heard over the next two years, which should clarify the law for the thousands of other claims which, it is expected, will be stayed by the tribunals pending their outcome.

It is premature even to attempt to quantify the potential outlay for these claims. It may ultimately be substantial in view of the possible number of such claims and the periods they cover, as well as the basis on which compensation may be awarded.

RISK MANAGEMENT

The NHSLA *Framework Document* requires the Authority to "provide incentives within the schemes for NHS bodies to improve cost effective clinical and non clinical risk management". This objective is mainly achieved through the provision of risk management standards against which all trusts are assessed. The standards address organisational, clinical and non clinical risks and most are set at three levels, with trusts receiving increasing discounts on their contributions to the NHSLA schemes as they progress from level 0 to level 3.

Alison Bartholomew
Risk Management Director

Standards and assessments

The risk management standards are reviewed each year, and updated versions of the CNST general, CNST maternity, NHSLA ambulance and NHSLA PCT standards were posted on our website (www.nhsla.com/riskmanagement) in April 2005. The final version of the new CNST mental health & learning disability standards was issued in June 2005.

More than 500 assessments against the standards were completed during the year. Although some trusts failed to maintain their previous assessment level, the overall outcome was the best ever achieved by trusts, maintaining the trend set in previous years. Details of the level(s) achieved by each trust in relation to the standards are made available via our website in NHSLA Factsheet 4 which is updated every month.

The NHS performance "star ratings" for the 2004/05 financial year published by the Healthcare Commission in July 2005 incorporated the level achieved by each trust in the CNST general, CNST maternity, NHSLA ambulance and PCT standards at 31 March 2005. Going forward, the outcomes of NHSLA assessments can be used by trusts to support their declaration to the Healthcare Commission as part of the annual health check and will be used by the Commission in their verification process.

Details of the CNST general levels achieved by trusts in the years 2001/02 to 2005/06 are shown in *figure 1*. It is pleasing to report that for the second consecutive year there are no level 0 acute or specialist hospital trusts, and the number of trusts at levels 2 and 3 has risen from 35% in 2004/05 to 49% at the end of March 2006.

Figure 1.
Comparison of levels achieved in the CNST general standards - acute and specialist hospitals

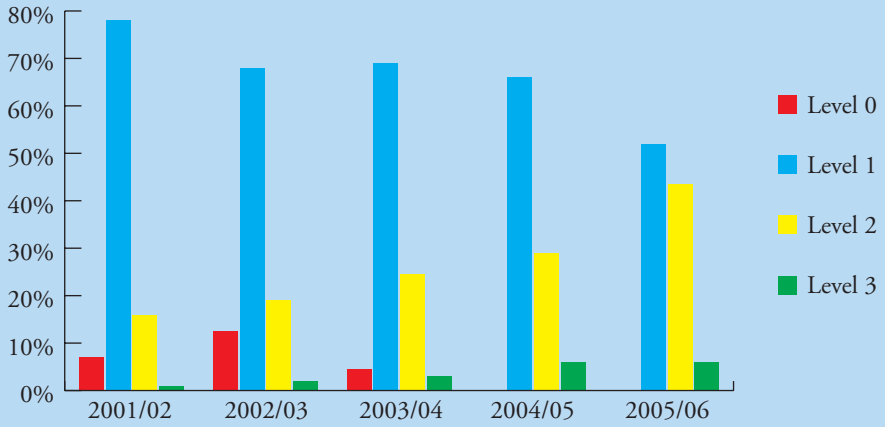
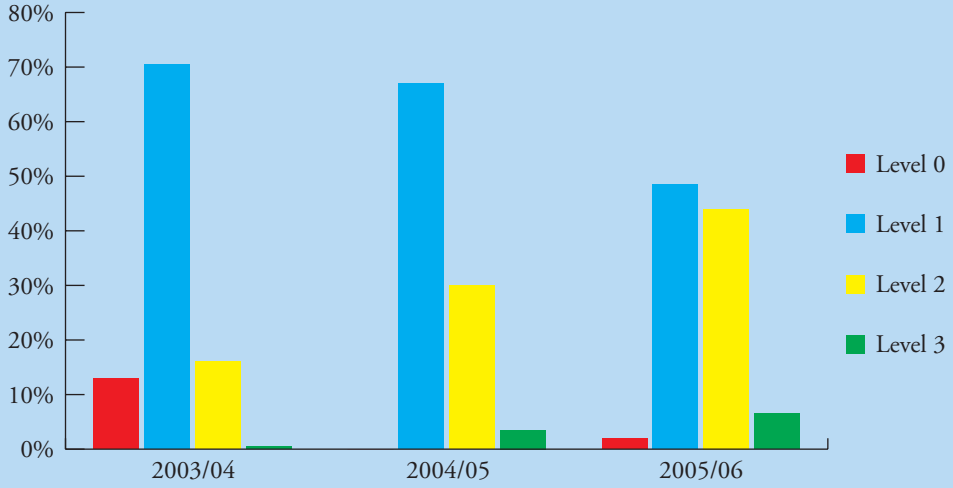


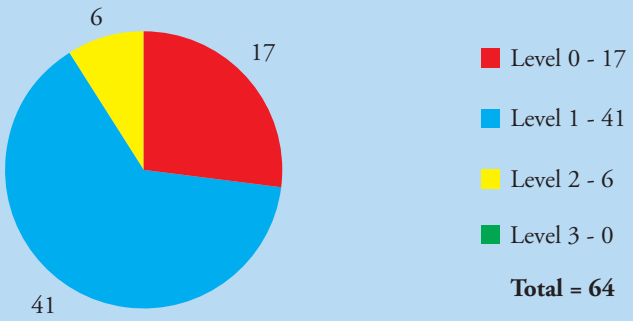
Figure 2 shows the levels achieved by trusts in the CNST maternity standards since these were introduced in 2003/04. From the beginning the performance of maternity services in relation to these standards has been encouraging and now, just three years later, 50% have achieved levels 2 or 3.

Figure 2.
Comparison of levels achieved in the CNST maternity standards



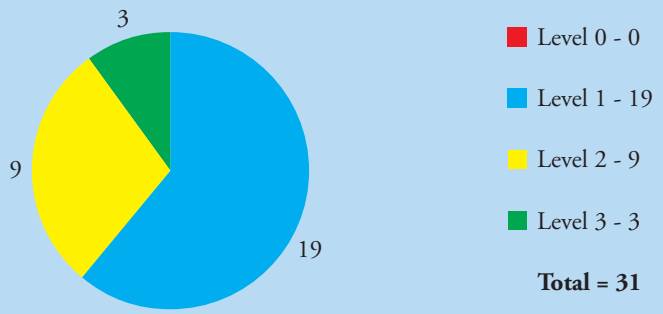
2005/06 was the first year of assessment against the new CNST mental health and learning disability clinical risk management standards and the results are shown in *figure 3*. Although it is good to note that six trusts achieved level 2, and the majority level 1, a significant number failed to demonstrate compliance with the standards and are at level 0. These trusts will be offered support to help them achieve level 1 during the following financial year.

Figure 3.
Attainment against the CNST MH & LD standards at 31/03/2006



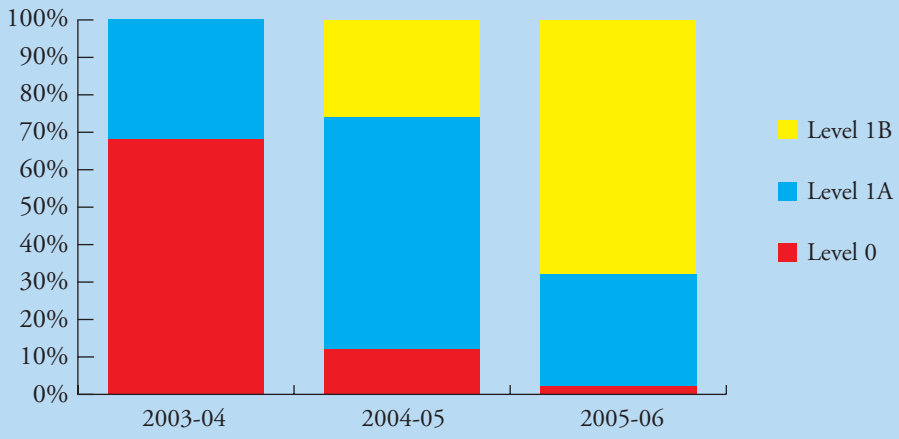
The positive start to assessments against the NHSLA ambulance standard when it was introduced in 2004/05 has continued. Although just eight trusts were assessed against the standard in 2005/06, all previously level 0 trusts attained level 1 and the number of level 2 and 3 trusts increased. The current assessment level of all ambulance trusts is illustrated in *figure 4*.

Figure 4.
Attainment against the NHSLA ambulance standard at 31/03/2006



The levels achieved by PCTs in the NHSLA PCT standard since it was introduced in 2003/04 are shown in *figure 5*. The number of PCTs achieving level 1B rose to two-thirds by the end of 2005/06 reflecting an improvement in the risk management systems in place within these trusts.

Figure 5.
Comparison of levels achieved in the NHSLA standard for PCTs



Future strategy

Throughout the year work has been done on developing the revised NHSLA risk management standards and assessment process in line with the strategy agreed by the Board in November 2004. This approach allows the positive features of the CNST and former RPST standards and assessment processes to be retained, provides an opportunity to address the limitations of these arrangements, and complements the wider changes in the NHS. A single set of standards is being developed for each type of trust incorporating organisational, clinical and health & safety risks. Separate CNST maternity standards will be retained for those organisations providing maternity services. The new standards will be introduced on a rolling basis with those for acute and specialist hospital trusts being piloted during 2006/07.

The revised approach to standards and assessments has been developed through a review of assessment outcomes and claims data, literature searches, and a questionnaire to which over 150 organisations responded. Proposals were published in July 2005 and further feedback invited through focus groups and an email consultation exercise. External organisations, including *Concordat* signatories and those with a specific clinical focus, were also involved. The pilot manual for the new NHSLA Risk Management Standards for Acute Trusts was published in April 2006.

Training

The content of the training programme for 2005/06 was informed both by the feedback from the previous year's programme and the need for input from organisations into the development of the revised standards and assessments. The programme included a national conference held in Birmingham, PCT seminars, service-specific workshops, focus groups and one-day courses for new risk managers. The delegate evaluation for all the events was positive.

Concordat

The NHSLA was an original signatory to the *Concordat between bodies inspecting, regulating and auditing healthcare* which is a voluntary agreement designed to coordinate and improve the impact and value for money of inspections. Throughout the year the Authority has continued to contribute to various Concordat initiatives, including the website (www.concordat.org.uk) launched in March which incorporates an innovative activity scheduling tool containing details of inspections planned by signatories, including the NHSLA. The Authority has also been working to ensure that its own risk management programme complies with the objectives and practices of the Concordat and several examples of notable practice by the NHSLA are listed on the Concordat website.

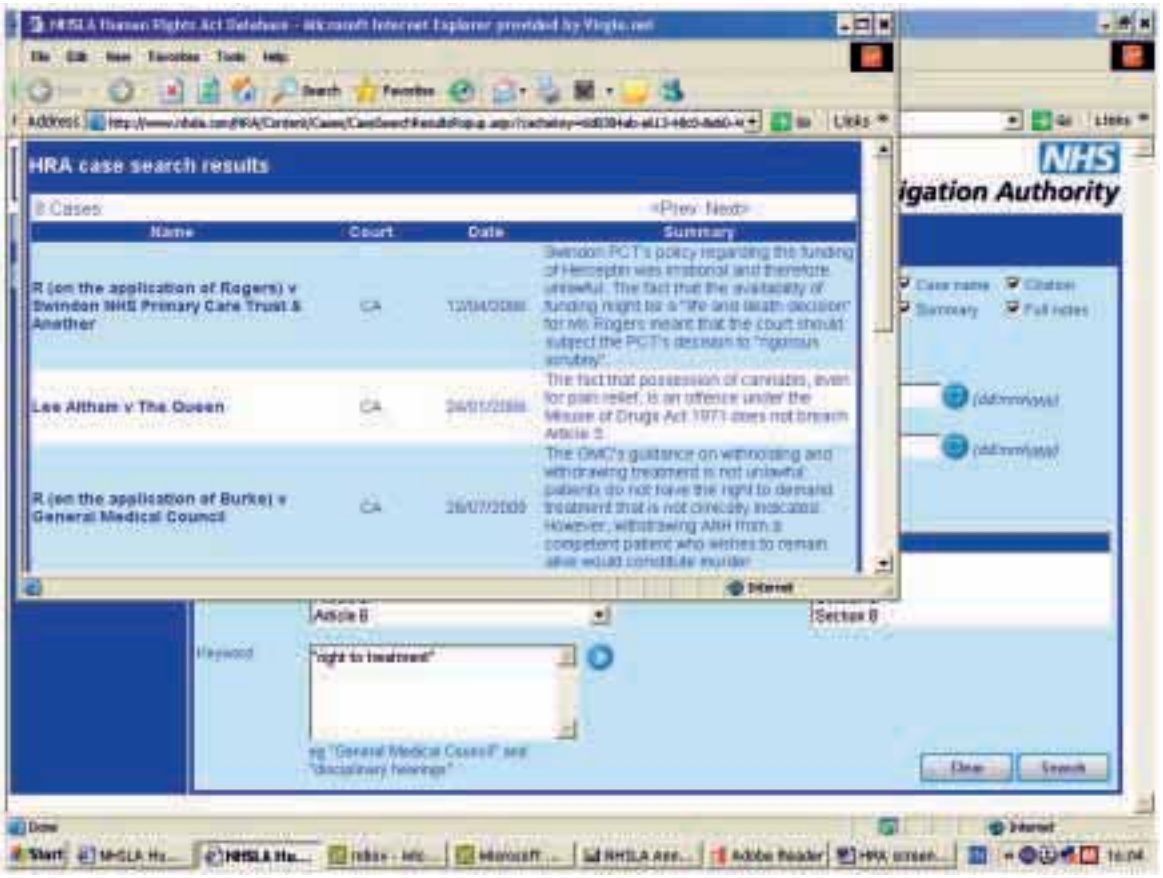
Willis

Willis Ltd are appointed by the NHSLA to provide external risk management services. These comprise the development and maintenance of our risk management standards, the assessment of trusts against those standards, and the provision of advice and training to trusts in relation to the standards and assessments. During 2005/06 Willis met or exceeded virtually all their agreed Key Performance Indicators: in particular, the annual assessment programme was completed; all assessment reports were issued within the agreed timescales; standards were developed on schedule; all training was successfully delivered; and all enquiries to the Willis Helpdesk were dealt with promptly.

HUMAN RIGHTS ACT INFORMATION SERVICE

In 2003, the Authority was given the new function of "minimis[ing] the cost to the NHS of obtaining legal advice in relation to the *Human Rights Act 1998*, by providing NHS bodies with access to a centrally coordinated information service". In September 2004, we launched our human rights database on our website (www.nhsla.com/hra), making detailed information about human rights case-law of relevance to the NHS available not only to NHS staff but also to the public at large. During the financial year 2005/06, 670 individuals, mainly health professionals, accessed the database directly. Over one thousand NHS staff are on our mailing list to receive our quarterly newsletter, which contains similarly detailed information about the most significant recent cases to be added to the database. In addition, NHS users are free to email the Authority directly at humanrights@nhsla.com to seek any information they cannot find for themselves, and the Human Rights specialist is happy to lead seminars/training sessions on human rights case-law for NHS staff on request. Feedback on the information service has been uniformly positive.

Katharine Wright
Human Rights specialist



FAMILY HEALTH SERVICES APPEAL UNIT

Paul Burns
Head of Appeal Unit

In April 2005, the role of the Authority expanded to include the Secretary of State's "appellate and other functions" in connection with the decisions and functions of PCTs, formerly carried out by a separate Special Health Authority, the Family Health Services Appeal Authority. These functions are now performed by the Authority's Family Health Services Appeal Unit, which is based in Harrogate and has retained the expertise of the officers of the former Special Health Authority.[6]

The role of the Appeal Unit is to provide mechanisms for the proper, prompt and cost-effective resolution of disputes between NHS primary care organisations and the practitioners and organisations that provide or seek to provide services for patients. The largest areas of work concern the provision of pharmaceutical services and the resolution of disputes between GPs and their local PCTs. Further details on these, and on other areas of the Appeal Unit's work, are given below.

The overall number of cases determined in 2005/06 (506) did not vary significantly from the Appeal Unit's previous level of activity, with individual work streams showing a combination of increases and decreases against projection. The capability of the Appeal Unit to be flexible between work areas has maintained good performance figures with the average time taken to issue decisions being in line with recent years.

Pharmaceutical regulations

The Appeal Unit's largest area of work concerns the handling of appeals against decisions by PCTs under the *NHS (Pharmaceutical Services) Regulations 1992* and the *NHS (Pharmaceutical Services) Regulations 2005*. Such appeals are determined by the Appeal Unit's Pharmacy Appeals Committee. The Committee may either make a decision on the papers or may appoint a Panel to hear oral representations and then to report back to the Committee.

The pharmaceutical regulations control pharmaceutical services in a particular area, by requiring the PCT to consider local needs for these services before permitting a new pharmacy to open, or to consider whether statutory criteria are met before allowing an existing pharmacy to move premises. The Regulations also control how, in rural areas, GPs may be permitted to dispense prescriptions themselves. While the 2005 Regulations replaced the 1992 Regulations in April 2005, the Appeal Unit still continues to hear appeals under the 1992 Regulations where the initial decision was made under these Regulations. However, only eleven such cases remain.

The main area of challenge under the 2005 Regulations has proved to be the "control of entry" provisions under Regulation 12. The relevant test is whether the proposed new NHS pharmaceutical services are "necessary or desirable". As this test requires more factors to be considered than the previous test under the 1992 Regulations, it has been a source of new challenges, with particular emphasis being placed by the parties on the rights of patients to

6 The separate tribunal known as the Family Health Services Appeal Authority remains an independent entity. Although the Appeal Unit continues to provide secretariat services for the tribunal, the President of the tribunal produces his own separate annual report, which is published on the tribunal's web-site at www.fhsaa.org.uk.

"choice". As more cases have been considered, both the Committee and Panels have developed their ability to deal with these new arguments. However, the Appeal Unit recognises that there are differing views on how to interpret these new factors and that this is likely to continue until there is judicial guidance on the matter.

The Appeal Unit experienced a similar number of appeals to recent years. A three-year comparison is shown below, together with the outcome of appeals closed in 2005/06. The average time taken to decide appeals in 2005/06 was two weeks for cases summarily dismissed, 12 weeks for cases decided on the papers and 23 weeks for cases decided after an oral hearing. 80 cases were in hand at the end of the financial year.

Year	Appeals received under 1992 Regs	Appeals received under 2005 Regs	Appeals received: total	Appeals closed under 1992 Regs	Appeals closed under 2005 Regs	Appeals closed: total
2003/04	317	N/A	317	309	N/A	309
2004/05	298	N/A	298	301	N/A	301
2005/06	137	163	300	196	94	290

2005/06 Appeals	Appeals deemed withdrawn or not valid	Appeals determined on the papers (number allowed)	Appeals determined following a hearing (number allowed)
Under 1992 Regs	20	126 (27)	50 (20)
Under 2005 Regs	25	59 (11)	10 (2)

GP dispute resolution

The new GP contract came into force on 1 April 2004, under two sets of regulations: the *NHS (General Medical Services Contracts) Regulations 2004* and the *NHS (Personal Medical Services Agreements) Regulations 2004*. The contract includes new dispute resolution procedures between GPs and PCTs. These procedures have effectively replaced the former system of appeals and representations concerning the application of the Statement of Fees and Allowances (SFA) which in the past determined payments to GPs. 21 appeals relating to the SFA were received in 2005/06, with just two remaining outstanding.

Many of the applications for dispute resolution are proving more complex than appeals under the former system, usually requiring a hearing. This may be because there is now a formal contract between GPs and PCTs, resulting in allegations of interference with or frustration of that contract. 46 applications for dispute resolution were closed in 2005/06, 32 in relation to national "GMS" contracts and 14 to locally-agreed "PMS" agreements. The table below sets out the outcome of those cases.

Appeals deemed withdrawn or not valid	Appeals determined on the papers (number allowed)	Appeals determined following a hearing (number allowed)
13	23 (12)	10 (7)

The average time taken to decide appeals in 2005/06 for the "GMS" GP contract cases was 9 weeks for cases decided on the papers and 24 weeks for cases where an oral hearing was required. The equivalent time for the "PMS" cases was 13 weeks and 23 weeks respectively.

Dental dispute resolution

The new dental contract came into force on 1 April 2006 under the *NHS (General Dental Services Contracts) Regulations 2005* and the *NHS (Personal Dental Services Agreements) Regulations 2005*. As in the case of the new GP contract, these regulations introduce new dispute resolution procedures, which replace the former system of appeals under the *NHS (Service Committees and Tribunal) Regulations 1992.*[7] The new dental contract allows for pre-contract/agreement dispute resolution and by 31st March 2006 the Appeal Unit had received 86 such applications and closed one. A further 62 applications are on hold, pending the outcome of local dispute resolution with the PCT.

GP registrar Directions and GP vocational training

The Authority is responsible for determining disputes over the assessment of GP registrars' remuneration, under the terms of the *Directions to Strategic Health Authorities concerning GP Registrars,* which came into force on 3 November 2003. Issues to be determined include the salary to be paid to a GP registrar whose previous post was outside the NHS, and entitlement to allowances such as removal expenses.

Until October 2005, the Authority was also responsible for handling appeals concerning GP vocational training. However, this function has now been taken over by the new Postgraduate Medical Education Training Board, although there remain transitional provisions for applications previously received.

Payments to suspended "performers"

The National Health Service (Performers Lists) Regulations 2004 currently apply just to GPs, although they may, in future, be extended to other primary care practitioners.[8] In order to be permitted to provide GP services under the NHS, GPs must be on their local PCT's "performers' list". The independent Family Health Services Appeal Tribunal deals with appeals by GPs against PCT decisions to exclude them from these lists. However, it is the responsibility of the Authority's Appeal Unit to determine appeals concerning payments to a doctor who has been suspended from the performers' list. It is also for the Appeal Unit to decide whether or not to consent to the voluntary withdrawal of a performer from the list during suspension. During 2005/06, the Appeal Unit determined two cases concerning payments during suspension and one case concerning withdrawal.

"Fitness to practise": PCT notifications and checks

Under the "fitness to practise" provisions of the *Health and Social Care Act 2001*, the Appeal Unit holds a central database for England of regulatory decisions regarding primary care practitioners, notified to it by primary care organisations throughout the United Kingdom. This central record enables PCTs to check whether there are any restrictions on a particular practitioner's ability to practise within the NHS. In 2005/06, 14448 requests for such information were received from PCTs.

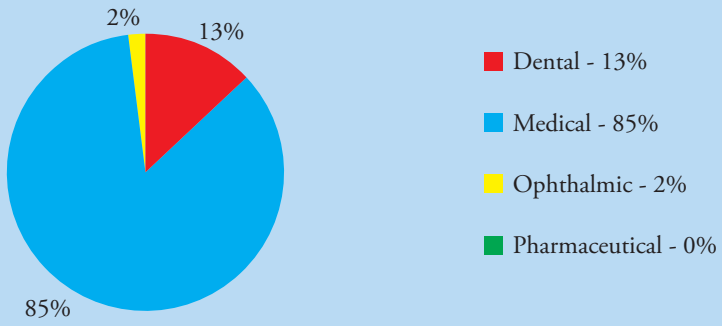
7 These Regulations remain in place for handling disciplinary appeals concerning the ophthalmic and pharmaceutical professions; however, such appeals have always been very few in number with only two being received in 2005/06.

8 Separate regulations currently cover dentists, opticians and pharmacists; however, a common factor between GPs and the other three professions is that all such practitioners must be included on the relevant local "list" before being permitted to provide NHS primary care services.

Notifications held on the database relate to suspensions, removals from local lists, contingent removals from local lists, refusals to include on local lists and conditional inclusions on local lists. Information stored includes the statutory reason given for the primary care organisation's action, such as fraud, inefficiency or unsuitability. The database also includes information about practitioners who have been nationally disqualified from practising in the NHS, of whom there are currently 29. During 2005/06, the Appeal Unit contacted all English PCTs to verify information already held and to ensure that PCTs were aware of their obligations to make such notifications.

During 2005/06, 78 notifications of suspension were received. These break down by profession as follows:

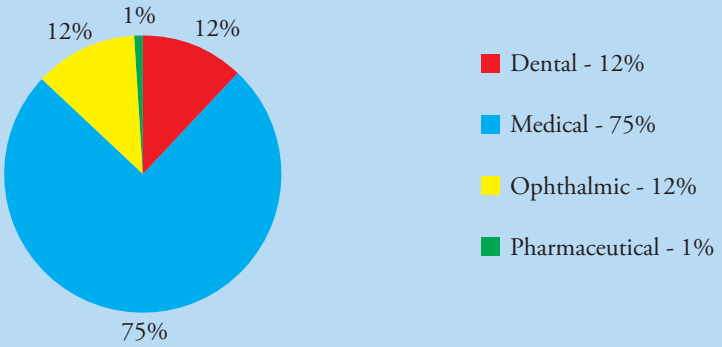
Notifications of suspensions by profession in 2005/06



The Appeal Unit monitors the number of suspensions remaining in force (80 at 31st March 2006) and a PCT may be contacted where it appears that a suspension has lapsed or has been in force for over a year.

In addition to receiving notification of suspensions, the Appeal Unit received 332 other notifications in 2005/06: 209 concerning removals from lists, 33 concerning contingent removals, 41 concerning refusals to include practitioners in lists and 49 conditional inclusions. The following chart breaks down these notifications by profession:

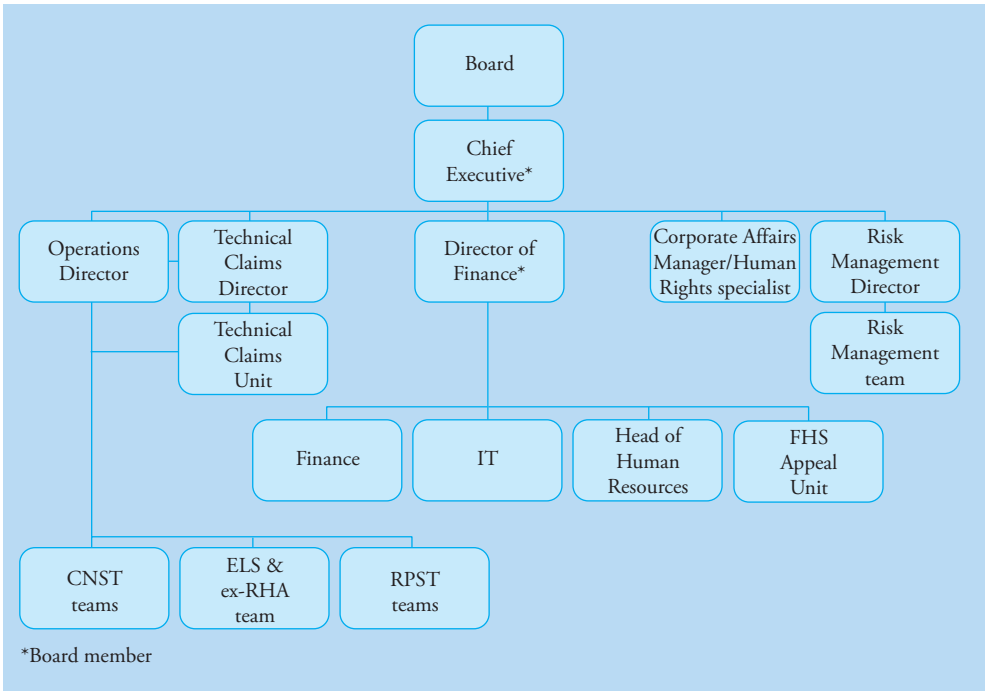
Notifications (other than suspensions) by profession in 2005/06



OUR STAFF

As at 31 March 2006, the NHSLA employs 165 whole-time equivalent staff, of whom 110 are directly involved in handling claims under our five schemes. The structure of the Authority is shown below.

David Bell
Head of Human Resources



Relocation

As a result of the Department of Health's review of all its arm's length bodies, it was announced in March that the Authority's offices in Croydon would be closing by the end of December 2006. The Authority is working with employees and their representatives to minimise the impact of the closure and to find alternative employment wherever possible.

Agenda for Change

Significant progress was made during the year in the implementation, in partnership with Unison, of Agenda for Change, the new national NHS pay and terms and conditions arrangements, which replace the Whitley Councils. Around 30% of the Authority's employees were assimilated by 31 March 2006 and the remainder are due to follow.

The Agenda for Change agreement includes the development of a Knowledge and Skills Framework (KSF) outline for every employee, which for the first time introduces a standard form of assessment of an employee's knowledge and skills against a model agreed in partnership between management and trade union representatives.

Partnership working

During the year, the Authority transformed its consultation and partnership working arrangements with employees, seeking to involve and engage them in the delivery of services and in issues which affect their working lives, as envisaged by the national Agenda for Change agreement. Firstly, we have reached a partnership agreement with Unison, the largest public sector trade union, which has led to the establishment of a Joint Negotiating Committee and, secondly, we have established a separate Staff Council, which comprises employee representatives appointed after a process overseen by the Electoral Reform Society.

Equality and diversity

As a public authority, the NHSLA has particular obligations to promote equality and diversity in its workforce and in how that workforce provides services. The Authority is committed to supporting a diverse workforce and to ensuring that all employees and job applicants are treated fairly and openly and are not subject to unfair discrimination or bias on the basis of their race, colour, ethnic or national origin, sex, marital status, responsibility for children or other dependants, age, disability, sexual orientation, religious or political beliefs, class or membership or otherwise of a trade union. Employees took part in diversity awareness sessions during the year and our aim is to integrate fully equality and diversity into our employment and other policies and into all our work.

One of the six core elements of the new Knowledge and Skills Framework requires every employee in the Authority to be assessed annually against standards which support, promote and develop a culture of equality and diversity.

The Authority's Race Equality Scheme was reviewed during the year and is published on our website. Comments on its effectiveness and operation are invited in the scheme from interested stakeholders.

ADVISORY GROUPS

Professional Advisory Panel

Acting Chairman

Professor Sir Alan W Craft	President, Royal College of Paediatrics & Child Health

Members

Dr Dennis Cox	Royal College of General Practitioners
Ms Frances Day-Stirk	Director of Midwifery Affairs, Royal College of Midwives
Dr Andrew Fairbairn	Royal College of Psychiatrists
Professor Shelley Heard	Conference of Postgraduate Medical Deans of the United Kingdom
Dr Henry Irving	Royal College of Radiologists
Mr Warren Jones	Faculty of Dental Surgery, Royal College of Surgeons of England
Professor Ian Lauder	Council of Heads of Medical Schools
Professor Sir John Lilleyman	Medical Director, National Patient Safety Agency
Professor Valerie Lund	Royal College of Surgeons of England
Dr Alastair McGowan	President, Faculty of Accident and Emergency Medicine
Ms Kellie Norris	Royal College of Nursing
Dr David Saunders	Royal College of Anaesthetists
Dr. John Scarpello	Royal College of Physicians
Mr Peter Sharott	Royal Pharmaceutical Society
Professor Allan Templeton	President, Royal College of Obstetricians and Gynaecologists
Professor Sir James Underwood	President, Royal College of Pathologists

The role of the Professional Advisory Panel is to advise the NHSLA on the implications of its work by providing clinical input into litigation and risk management issues, both at an operational and strategic level. During 2005, the previous Chair of the PAP, Professor William Dunlop, thought it prudent to revisit the membership to confirm whether members were still able to attend PAP meetings and to ensure that they had an interest in claims and risk management. Discussions with the various Colleges and faculties resulted in membership changes from the Royal College of Anaesthetists, the Royal College of Radiologists and the Royal College of Physicians. In addition, Professor Sir James Underwood joined the PAP representing the Royal College of Pathologists. The Authority was saddened to learn that Ms Karen Ehlert who had represented the British Psychological Society had died.

Given the changes to the membership, the PAP did not meet for some time. The most recent meeting was held in February 2006, chaired by Professor Sir Alan Craft. The Panel discussed the future of the PAP in terms of its role and purpose. A draft business plan was outlined and Panel members were asked to consider revised aims:

- to promote and contribute to education about potential litigation and ways of coping with it;
- to influence the Academy of Medical Royal Colleges to promote understanding and education;
- to build on the work already in progress in relation to areas associated with litigation;
- to help the Authority and health service professionals to understand the implications of rulings on cases of note in terms of health service practice and vice versa;
- to comment on and support the review of the NHSLA standards.

Alongside the need for the PAP to be clear with regard to its purpose, it was also proposed to review the membership further. The future function and membership of the PAP will be more closely aligned to information arising out of claims.

Policy Advisory Group

Chairman

Dr John Drury	Director of Pathology, South Tees Acute Hospitals NHS Trust

Members

Mrs Elizabeth Butler	Chair, Bromley PCT
Mrs Jacqui Camfield	Legal Services Manager, Royal Surrey County Hospital
Ms Jane Cant	Head of Clinical Risk, Southampton University Hospitals NHS Trust
Dr Terry Matthews	Clinical Risk Adviser, Havering PCT
Mrs Elaine Miller	Assistant Director of Risk and Legal Services, York Health Services NHS Trust (resigned April 2006)
Mr Andy Morris	Assistant Risk Manager, Calderdale & Huddersfield NHS Trust
Ms Jill Moseley	Clinical Services Director, Bedfordshire and Hertfordshire Ambulance and Paramedic Service NHS Trust
Ms Melanie Ogden	Associate Director of Clinical Governance, Greater Manchester Strategic Health Authority
Ms Carole Pearson	Deputy Director of Clinical Governance, North Tees and Hartlepool NHS Trust
Dr Ashok Rai	Consultant Rheumatologist, Worcestershire Acute Hospitals NHS Trust
Mr Daniel Smith	Health and Safety Adviser, North Staffs Combined Healthcare NHS Trust
Mr Derek Tuffnell	Consultant Obstetrician, Bradford Teaching Hospitals NHS Foundation Trust
Ms Sarah Williamson	Clinical Risk Manager, Sheffield Teaching Hospitals NHS Foundation Trust

The PAG's role, as set out in the NHSLA's *Framework Document*, is: "To articulate to the Board of the NHSLA the view of member bodies on the development of all schemes under the Authority's administration …, providing advice and feedback in such areas as the procedures used for handling claims, risk management criteria and other matters appertaining to the trusts more generally."

PAG members, under the Chair of Dr Drury, continue to take a great interest in the work of the Authority and are keen to offer their support on any aspects of the proposed Redress Scheme, which at the time of writing is passing through Parliament and may be implemented in 2007. The aim of such a scheme is to fast-track small clinical negligence claims, combining monetary compensation with physical assistance, such as physiotherapy. The Authority would envisage PAG members having a key role in disseminating information and ascertaining what information trusts will require under the Redress Scheme.

With regard to the revised NHSLA risk management standard for acute trusts, which will be piloted later this year, the PAG continues to contribute to the process and has communicated developments back to trusts. The outcome of the pilot phase will be discussed at subsequent PAG meetings.

PAG members have highlighted the need to consider future healthcare risks, given advances in technology and organisational changes within the NHS, not least with its interface with the independent sector. As a consequence, this is now a regular agenda item at each meeting. To date, risks associated with radiology (reviewing x-rays as computerised images), the developing role of emergency care practitioners, and the Independent Sector Treatment Centre (ISTC) programme have all been discussed.

During the year, Mrs Elizabeth Butler joined the PAG in her capacity as a non-executive representative to the Group, Dr Terry Matthews, Clinical Risk Adviser from Havering PCT, announced his forthcoming retirement, and Mrs Elaine Miller, Assistant Director of Risk and Legal Services at York Health Services NHS Trust, tendered her resignation. The Chair of the PAG and the NHSLA noted their appreciation to Dr Matthews and Mrs Miller for their considerable input into the PAG.

PROFESSIONAL ADVISERS

The Authority maintains two panels of solicitors, the first specialising in clinical claims and the second in non clinical claims. Current membership is given below. The clinical panel was first established in 1998 through an open tender. It was reviewed in 2001 and 2005, with the next review due before April 2008. The non clinical panel was appointed in April 2003, following a limited tender process and was reviewed in 2006.

Clinical negligence claims: panel of solicitors

Barlow Lyde & Gilbert
Beachcroft Wansboroughs (Beachcroft LLP since 1 May 2006)
Bevan Brittan
Brachers
Browne Jacobson
Capsticks
Eversheds
Hempsons
Hill Dickinson
Kennedys
Ward Hadaway
Weightmans

Non clinical claims: panel of solicitors

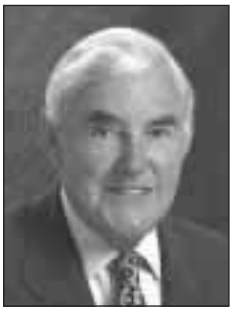
Barlow Lyde & Gilbert
Brachers
Browne Jacobson
Eversheds
Hill Dickinson
Veitch Penny
Ward Hadaway
Watmores
Weightmans

Actuaries

Lane, Clark & Peacock

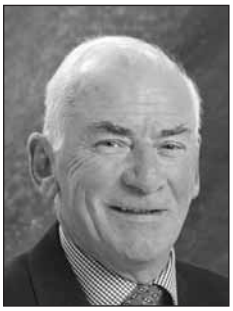
BOARD MEMBERS

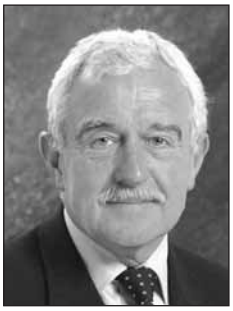
The NHSLA is managed by a Board, made up of executive (full-time employees) and non-executive members, under the chairmanship of Ron Bradshaw. The non-executive directors are members of the community who have been appointed by the NHS Appointments Commission to bring their personal qualities and experience to the Board. All executive directors have been appointed through open competition and in accordance with the Authority's recruitment and selection policies and Department of Health guidance. All current executive director posts are permanent appointments. Full details of directors' remuneration is given in the Management commentary on page 37.



Ron Bradshaw
Chairman
Born and educated in Liverpool where he practised as a solicitor from 1956, latterly as Senior Partner engaged in contentious litigation, particularly professional negligence for various professions excluding medical; retired in 1996 and now part-time Employment Tribunals Chairman.

John Speedman
Deputy Chairman (retired 31 March 2006)
An accountant who has spent most of his working life in the insurance industry, specialising in professional indemnity and financial risks and, until his retirement, the Managing Director of Solicitors Indemnity Fund Ltd.





Steve Walker CBE
Chief Executive
MA, LLB (Hons), FCII, JP
Formerly UK Claims Manager in the insurance industry; accredited mediator; member of the Chief Medical Officer's working parties which produced *Organisation with a Memory* and *Making Amends*; member of the Clinical Disputes Forum, the Ogden Committee, the Clinical Negligence and Serious Injuries Committee of the Civil Justice Council, and the Master of the Rolls' committee on structured settlements.

Tom Fothergill
Director of Finance
CPFA BA (Hons)
A qualified accountant with extensive experience of the public sector having worked in both local government and the NHS; employed by the NHSLA since September 1997 having first joined as Financial Controller.

Dr Carole Kaplan
Non-Executive Member
Senior lecturer and consultant in child and adolescent psychiatry; former member of the Lord Chancellor's Advisory Board on Family Law and the Council on Tribunals.

Mehmuda Mian Pritchard
Non-Executive Member
Formerly a commercial litigation solicitor, senior caseworker in the Office for Supervision of Solicitors and non-executive director of a large mental health trust; currently a Commissioner at the Independent Police Complaints Commission.

Patricia Steel OBE
Non-Executive Member
Pursued a career in the organisation, operation and policy of highways and public transport; former Vice Chairman of an acute NHS Trust; currently a Member of the Transport Tribunal.

MANAGEMENT COMMENTARY

Operating and Financial Review

Statutory background

The NHS Litigation Authority was set up by the *National Health Service Act 1977* (as amended) and Regulations made under that Act. The statutory duties of the NHS Litigation Authority are set out in the *National Health Service Act 1977* (as amended) and refer to a requirement to remain within revenue and capital resource limits.

Main functions of the Authority

The Authority is a Special Health Authority and its primary function is to manage, on behalf of member trusts, claims arising from clinical negligence incidents post 1 April 1995 (the Clinical Negligence Scheme for Trusts or CNST). In addition, the Authority is responsible for managing clinical negligence claims against the NHS for incidents pre 1 April 1995 (the Existing Liabilities Scheme or ELS), clinical negligence claims against the former Regional Health Authorities (the ex-RHA Scheme) and the non clinical risks of member trusts with the exception of motor vehicle claims. The Authority is also responsible for promoting high standards of risk management throughout the NHS.

Review of activities and performance against targets

During the year, the Authority's net Operating Costs amounted to £1,179m, which represents a reported increase of £695m on the figure for the previous year. It should however be noted that some £635m of this movement is the direct impact of the change in discount rate set by the Treasury from 3.5% to 2.2% on 1 April 2005. Other impacts relate to a review of the accounting treatment of provisions relating to structured settlements (also referred to as periodic payments) and the merger of the activities of the Family Health Services Appeals Authority.

The Authority's net Operating Costs are required to be managed within a Revenue Resource Limit (RRL) agreed with the Department of Health. For 2005/06 the agreed RRL was £1,384m; thus an under spend of £205m is reported.

The Authority is required to pay its creditors in accordance with the Better Payment Practice Code. The target is to pay creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier. Of relevant bills, 80.5% (2004/2005 83.4%), representing 90.1% (2004/2005 88.7%) by value, were paid within the 30 day target.

The Authority is required to manage within its cash limits as agreed with the Department of Health. For 2005/06 the Authority had a revenue cash limit of £159m and during the year utilised £159m of that funding thus reporting a break even position. Capital limits for the year were £280,000 with reported spend at £182,000 showing an under spend of £98,000.

The balance sheet as at 31 March 2006 shows net liabilities of £8.3 billion. This reflects the inclusion of provisions that will crystallize in future years and will be funded by future contribution payments or departmental funding. This future income is calculated to fund annual outgoings, and in the case of the departmental funding is subject to parliamentary control. There is no reason to believe that this future funding, future parliamentary authority, and the contribution payments from members will not be forthcoming. It has therefore been considered appropriate to adopt a going concern basis for the preparation of these accounts. In addition, the *NHS (Residual Liabilities) Act 1996* requires the Secretary of State to exercise his statutory powers to deal with the reported liabilities of this Special Health Authority if it ceases to exist.

These provisions relate predominately to clinical negligence claims which have either already been made or which are considered to have been incurred via treatment delivered by the NHS but yet to be reported as claims. Inevitably these claims will take time to progress to settlement and so these provisions are recorded using Financial Reporting Standard 12 (FRS 12) to give readers a clear indication of the likely value of these claims were they all made and settled today.

It is often misreported that these provisions represent the value of damage to patients caused by the NHS in any given period whereas they are an accumulated value of all known and potential claims which will be processed in future financial periods going forward a number of years.

The Operating Cost Statement quotes a value of £37m for "unwinding of discounts". This sum relates to the maturing of provisions recorded in accordance with FRS 12. As the claims of the Authority near the expected date of settlement, the discounts previously applied to them to take account of the "time value of money" are slowly unwound and thus the provisions within the accounts are increased each year until maturity when the full value of the claim is recorded as a provision.

Another key balance sheet movement is the increase in cash balances held at the year end (£85.9m compared with £21.9m in 2004/05). Essentially this cash position relates to contributions collected for the Clinical Negligence Scheme for Trusts (CNST) which were not utilised in 2005/06. All of the contribution schemes managed by the Authority are on a "pay as you go" basis, thereby minimising the impact on cash available for patient care in any given financial period although, inevitably, managing such schemes requires the Authority to take into account possible variations to planned expenditure, for example where a case is concluded earlier than originally forecast, by collecting sufficient contributions to cover eventualities which have an adverse impact on cash flow. Where more cash is collected than is utilised in year, the Authority builds that into its forecasts for the coming financial year and thus the proposed collection of contributions in 2006/07 was adjusted to recognise these cash balances had accumulated.

Financial standing

As at 1 April 2005 the Authority merged with the former Family Health Services Appeals Authority (FHSAA) and thus the "Restated accounts" for 2004/05 incorporate the accounts of that body whilst the accounts for 2005/06 represent the activities of both units. The FHSAA is a relatively small function and thus the merger has not led to a significant change in the fixed assets and liabilities owned by the Authority.

Key Performance Indicators (KPIs)

In addition to the above statutory financial targets the Authority has agreed a number of KPIs with the Department of Health which are used to measure performance against business objectives in year.

For the Litigation Authority arm of the new Authority these include ratios of defence and claimant legal costs to damages paid i.e. we attempt to settle claims with minimum payments to third parties and also targets re "shelf life" of claims i.e. the period of time the matter is open and managed by the Authority. Performance in year on all KPIs was satisfactory but due to the adversarial nature of the claims against the NHS the Authority does not publish its KPIs since it may prevent appropriate management of claims as opponents may seek to use KPIs as a bargaining tool in negotiations. There are, however, a number of other indicative statistics reported under the claims section of this Report and Accounts.

Shelf life KPIs also exist for the Appeals Function of the Authority and are shown below:

Regulations/Directions	Target time to settle (weeks)	% within target	Average time taken to settle (weeks)
Pharmacy Regulations			
Summary dismissal	4	100%	2
On the papers	15	98%	12
Oral hearing	26	95%	23
GP Regs 2004 ("GMS")			
On the papers	15	100%	9
Oral hearing	26	83%	24
GP Regs 2004 ("PMS")			
On the papers	15	83%	13
Oral hearing	26	100%	23
Dental Regs 2005	26	*All cases withdrawn*	*All cases withdrawn*
GP Registrar 2003			
Salaries	4	100%	1
Representations	15	100%	8
Statement of Fees & Allowances	26	100%	13
Vocational Training 1992	26	100%	19
Service Committee & Tribunal 1992	26	*All cases withdrawn*	*All cases withdrawn*

Government Reviews

The Authority is subject to various Government efficiency reviews including Lyons (relocating Government posts out of the South East), the Arm's Length Bodies (ALB) Review (streamlining services and maximising efficiency within ALBs) and Gershon (corporate services efficiency in the public sector).

So far all targets set for the Authority have been achieved with the exception of the Lyons target which remains on the agenda but is not formally deliverable until 2010.

With the exception of its estate (see the section "Forward look", below) the Authority is within all Gershon associated targets currently being used for the public sector. As part of the ALB Review, the Authority has merged with the FHSAA and lived within the financial targets set by the review team.

Agenda for Change has been partially completed during 2005/06 and although the assimilation of all staff was not completed by 31 March 2006, as planned, the Authority has agreed a managed timetable with the Department of Health which aims to complete the process in early 2006/07.

New responsibilities

With effect from 1 August 2005 the Authority has been charged with managing Equal Pay claims against the NHS in England by the Secretary of State for Health, via the Department of Health. During the year the Authority began by identifying legal advisers to the process, establishing the position across the country, and opening channels of communication with those parties representing employees who are bringing, or proposing to bring, claims against their employers and also with the President of the Employment Tribunal Service (ETS).

Forward look

During 2006/07 the Authority remains committed to its generic business and the associated targets set and agreed with the Department of Health. In short these are to settle claims against the NHS as promptly as possible whilst ensuring that correct damages are paid to patients and that additional, third party, costs are minimised.

The Authority is not forecasting any significant adjustments to either volumes or likely values of claims likely to be settled in future financial periods. However it has agreed with the Department of Health to review at least twice per annum the volume of claim notifications against forecasts and also settlement and reserving values of claims, in order to ensure any changes are dealt with as early as possible. Unfortunately, since the majority of impacting factors tend to be outside the control of the Authority (for example Court decisions when awarding damages to claimants), these reviews can do little to forecast the future accurately re cost and volumes of claims. They are, therefore, inevitably backward looking and thus reactive rather than proactive. Where likely changes are spotted in advance, for example policy changes within the NHS, the Authority works with the Department of Health to attempt to ensure appropriate funding is set aside for any associated costs regarding the schemes it manages on behalf of the service.

In regard to family health services appeals, the Authority will continue to strive to meet its KPIs for resolution.

The ALB Review has fixed the administrative budgets of the Authority for the next three years and has also stipulated maximum headcount for the same periods. These targets have been set with the agreement of the Board of the Authority.

In regard to Gershon efficiencies, the Authority plans to close its Croydon office during 2006/07 thereby enabling it to meet the targets set in regard to space per employee. This closure also fits within the wider strategy of relocation since the transfer of posts out of the South East will require a consolidation of accommodation although the longer term Lyons target will not be delivered in 2006/07.

In regard to Equal Pay, the Authority is hopeful that a jointly agreed methodology for resolving claims can be agreed between the relevant parties and the President of the ETS. Early indications are that the President is keen to see a structured approach to minimise the impact on the ETS. This will have the added benefit of streamlining management arrangements and associated costs for both defendant trusts and the solicitors representing NHS employees.

With effect from April 2006, new dental dispute resolution procedures take effect and are to lead to a new stream of potential appeals for the appeals function of the Authority. The impact will not be known for some time as such new legislation often leads to a number of "test" arguments in early periods before a clear pattern of areas for appeal is established. This function may well show a short term increase in throughput at the appeals function offices in Harrogate but it is anticipated that this will level off during the financial year, allowing appropriate decisions to be made re resource requirements going forwards.

Remuneration Report

The Authority has a Remuneration and Terms of Service Committee which is made up of the non Executive Directors of the Authority who in 2005/06 were:

John Speedman	Chairman of the Committee and Deputy Chairman of the Authority
Ron Bradshaw	Chairman of the Authority
Mehmuda Mian Pritchard	Non Executive Director
Patricia A Steel	Non Executive Director
Carole Kaplan	Non Executive Director

The Committee meets at least annually to set the remuneration of the senior managers of the Authority, who are employees whom the Board has determined are not covered by the national Agenda for Change arrangements, and to oversee their terms and conditions where scope for local interpretation exists. The remuneration of senior managers is reviewed in conjunction with advice and guidance received from the Department of Health and will include a review of the assessment of performance during the relevant financial period including achievement of specific performance targets. The Committee does not employ a specific performance related pay arrangement for staff but does take into account annual appraisal outcomes when making any decisions. All Senior Managers have indefinite contracts i.e. there are no fixed term or rolling contracts.

No bonus payments have been made to Senior Managers during 2005/06 nor have any expenses, other than reimbursement of those actually incurred, been paid.

The Committee is also responsible for managing arrangements re early terminations of employment of senior managers and would apply approved arrangements, currently dictated by the ALB Review, although none has been made to date.

Below are the contractual, salary and pension details of those senior managers who had control over the major activities of the Authority during 2005/06.

Salaries and allowances

	2005/06			2004/05		
Name and title	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (rounded to the nearest £00)	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind (rounded to the nearest £00)
		£000	£00	£000	£000	£00
Ron Bradshaw *(Chairman)*	20 – 25	N/A	N/A	20 – 25	N/A	N/A
Stephen Walker *(Chief Executive)*	150 – 155	N/A	62 *	145 – 150	N/A	59*
Tom Fothergill *(Director of Finance)*	115 – 120	N/A	58 *	100 – 105	N/A	54*
Carole Kaplan *(Non-Executive)*	5 – 10	N/A	N/A	5 – 10	N/A	N/A
Mehmuda Mian Pritchard *(Non-Executive)*	5 – 10	N/A	N/A	5 – 10	N/A	N/A
John Speedman *(Non-Executive)*	5 – 10	N/A	N/A	5 – 10	N/A	N/A
Patricia Steel *(Non-Executive)*	5 – 10	N/A	N/A	5 – 10	N/A	N/A

*Benefits in kind relate solely to lease cars.

Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2006 (bands of £2,500)	Lump sum at age 60 related to accrued pension at 31 March 2006 (bands of £2,500)	Cash Equivalent Transfer Value at 31 March 2006	Cash Equivalent Transfer Value at 31 March 2005	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£00
Ron Bradshaw *(Chairman)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Stephen Walker *(Chief Executive)*	0 – 2.5	5 – 7.5	47.5 – 50	142.5 – 145	0**	818	N/A	148
Tom Fothergill *(Director of Finance)*	0 – 2.5	2.5 – 5	17.5 – 20	55 – 57.5	207	180	23	148
Carole Kaplan *(Non-Executive)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mehmuda Mian Pritchard *(Non-Executive)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
John Speedman *(Non-Executive)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Patricia Steel *(Non-Executive)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

**When an employee reaches the eligible retirement age, the CETV becomes £0 since the pension benefits can no longer be transferred.

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

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Other statutory disclosures

A Register of Interests is maintained by the Authority which details company directorships and other significant interests held by Board members. There are no interests logged on the register which have any bearing on the activities of the Authority. Access to the Register is available by contacting the Chief Executive's PA at the Authority's headquarters.

Committees

In addition to the Remuneration Committee, the Audit and Risk Management Committees exist in order to help the Board work effectively and ensure appropriate governance arrangements exist.

The Authority's Audit Committee met three times in 2005/06 in order to ensure that an effective system of internal control covering all risks was maintained. The Committee's duties include consideration of any matters concerning the external auditors, together with the adequacy of the Authority's internal audit arrangements. Its members in 2005/06 were John Speedman (Chair), Patricia Steel and Mehmuda Mian Pritchard. Patricia Steel took over the Chair in April 2006 following John Speedman's retirement.

The Risk Management Committee is chaired by the Director of Finance and comprises the Chief Executive, Patricia Steel, Non-Executive Director, and members of the NHSLA risk management team. The role of the Committee, which met three times in 2005/06 and reports directly to the Board, is to ensure that all areas of risk to the organisation are managed appropriately.

Consultation with staff

The Authority currently consults with its staff via a Joint Negotiating Committee and also a Staff Council on issues relating to information provision and consultation on health, safety and welfare at work.

Equality and diversity

The Authority is committed to ensuring that all staff and job applicants are treated fairly and openly and are not subject to unfair discrimination or bias. The Authority has integrated equality and diversity into its employment policies and embeds these values into its work.

The Authority has a Race Equality Scheme.

Comments and complaints

The Authority received just two complaints in 2005/06, excluding correspondence about the management of particular claims files. The 29 "complaints" cited in our 2005 Annual Report included such correspondence; the number of true complaints in 2004/05 was again just two.

Freedom of information

The Authority handled 195 requests for information under the *Freedom of Information Act 2000* in 2005/06, of which 93% received substantive responses within the 20 days prescribed by the Act.

Charitable donations

The Authority has not made any charitable donations.

Audit services

The Comptroller and Auditor General has provided the Authority's audit services at a cost of £85,000 for the current year.

The Authority can confirm that there is no relevant audit information of which the auditors are unaware: the Accounting Officer has taken all the steps he ought to ensure that they are aware of relevant audit information.

Chief Executive

27 June 2006

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the Accounting Officer of this Special Health Authority

The Secretary of State has directed that the Chief Executive should be the Accounting Officer to the Special Health Authority. The relevant responsibilities of Accounting Officers are set out in the Accounting Officers' Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the authority;
- the expenditure and income of the authority has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the net operating cost, recognised gains and losses and cash flows for the year.

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

Chief Executive

27 June 2006

STATEMENT ON INTERNAL CONTROL

Scope of responsibility

1. The Secretary of State has appointed the Chief Executive as the Authority's Accounting Officer. As Accounting Officer, and Chief Executive of this Authority, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Authority's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accounting Officer Memorandum.

2. As Chief Executive I have operational responsibility for the delivery of all aspects of governance and the provision, oversight and effective working of the systems of internal control, in particular the risk management process, the Authority's claims database and financial system. The Executive supported by the Audit and Risk Management Committees makes recommendations to the Board on matters related to governance. Operational responsibility for the Authority's governance systems is delegated to the Director of Finance who is also the link between the Audit Committee, Risk Management Committee and the Board. The Risk Management Team is responsible for the co-ordination of risk management activity within the Authority. The lead responsibility within that Team is vested in the Risk Management Director.

3. "Governance and Assurance" including risk are fully integrated within our overall business-planning process. Planning and risk processes are co-ordinated through the Strategic Management Team, of which I am the Chair, and which reports to the Board. The Risk Management Team facilitates the spread of good practice through its knowledge and learning from experience via liaison with key managers and other staff within the Authority and regular reviews of risk policy. Close working and networking arrangements exist with Internal Auditors, Department of Health and other agencies to ensure that the Authority draws on experience in the wider NHS.

4. Corporate performance is reported to the Board on a regular basis. Variations from anticipated performance will usually be accompanied by reports from either the Audit or the Risk Management Committee giving the Board assurance on progress and relevant action to be taken.

The purpose of the system of internal control

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

- identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

6. The broad system of internal control has been in place in the NHS Litigation Authority for the year ended 31 March 2006 and up to the date of approval of the annual report and accounts. Following an internal audit review it has been recognised that the link between strategic objectives and the associated risks could be more clearly identified in the assurance framework and thus adjustments will be required during 2006/07.

Capacity to handle risk

7. The Authority's approach to risk is explained in the Risk Management Strategy. It identifies the risk roles and responsibilities of staff at all levels. Training is provided on an ongoing basis to equip staff to carry out their designated responsibilities. In addition the approach to Governance (including risk) is featured in the induction process for all new staff.

8. The Authority's Assurance Framework brings together governance and quality and in effect maps a path from strategic objectives, through the corporate risks and on to the constituent mitigating activities (which are also the activities to deliver that strategic objective). Its purpose is to ensure that systems and information are available to provide the appropriate assurance on the appropriate things (i.e. that risks are being controlled and objectives are being achieved), to the appropriate stakeholders. Subject to the development work identified at paragraph 6, the framework is operating effectively.

9. The Board receives assurance from the Audit and Risk Management Committees on the achievement of corporate objectives and mitigation of corporate risk. The Board is accountable for demonstrating:

- that key controls are in place to assist in securing and delivering of objectives;
- that the controls systems, upon which reliance is placed, are effective;
- any gaps in controls systems or assurances are addressed within an agreed corrective action plan.

The risk and control framework

10. The risk process is effectively integrated into the planning process by which plans are made to deliver objectives through mitigating the risks to their achievement. Risks are identified and evaluated at appropriate levels within the organisation through a uniform system articulated in the Risk Management Strategy. The process is operated and reviewed by the Risk Management Committee, which is accountable to the Board.

11. It is the Authority's policy to involve stakeholders, as appropriate, in all areas of its activities, including informing and consulting on the management of any significant risks.

Review of effectiveness

12. 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 in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

13. My review is also informed by comments made by the external auditors in their management letters and other reports on aspects of the system of internal control. In 2005/06 I received reports from our external auditors and also from Willis Ltd in regard to health and safety within our premises and our internal risk management systems. Our management of the final accounts process will enable us to demonstrate appropriate action has been taken regarding any recommendation made by the external auditors whilst our Risk Management Committee has agreed and implemented action plans to manage issues identified by Willis Ltd.

14. The Audit Committee and Risk Management Committee both meet regularly and report to the Board. The Internal Auditors are present at the Audit Committee meetings and have also specifically reported on Corporate Governance during 2005/06.

15. These arrangements aim to help the Authority maximise its understanding and utilisation of all available information about the quality and effectiveness of our systems to help us improve services and satisfy the increasing need for assurance about the effectiveness of systems of internal control. I have been advised by all of these sources on the implications of the result of my review of the effectiveness of the system of internal control. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Chief Executive and Accounting Officer

27 June 2006

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSE OF COMMONS

I certify that I have audited the financial statements of the NHS Litigation Authority for the year ended 31 March 2006 under the NHS Act 1977. These comprise the Income and Expenditure Account, the Balance Sheet, the Cashflow Statement and Statement of Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them.

Respective responsibilities of the Authority, Chief Executive and Auditor

The Authority and Chief Executive are responsible for preparing the Annual Report, the Remuneration Report and the financial statements in accordance with the NHS Act 1977 and directions made by the Secretary of State with the approval of HM Treasury thereunder and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of the Authority and Chief Executive's Responsibilities.

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the NHS Act 1977 and directions made by the Secretary of State with the approval of HM Treasury thereunder. I also report whether in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. I also report to you if, in my opinion, the Annual Report is not consistent with the financial statements, if the authority has not kept proper accounting records, if I have not received all the information and explanations I require for my audit, or if information specified by relevant authorities regarding remuneration and other transactions is not disclosed.

I review whether the statement on pages 42-44 reflects the authority's compliance with HM Treasury's guidance on the Statement on Internal Control, and I report if it does not. I am not required to consider whether the Accounting Officer's statements on internal control cover all risks and controls, or form an opinion on the effectiveness of the authority's corporate governance procedures or its risk and control procedures.

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

Basis of audit opinion

I conducted my audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. My audit includes examination, on a test basis, of evidence relevant to the amounts, disclosures and regularity of financial transactions included in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the Authority

and Chief Executive in the preparation of the financial statements, and of whether the accounting policies are most appropriate to the Authority's circumstances, consistently applied and adequately disclosed.

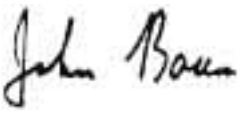
I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that the financial statements and the part of the Remuneration Report to be audited are free from material misstatement,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

Opinions

In my opinion:

- the financial statements give a true and fair view, in accordance with the NHS Act 1977 and directions made thereunder by the Secretary of State with the approval of HM Treasury, of the state of the Authority's affairs as at 31 March 2006 and of its net resource outturn for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the NHS Act 1977 and directions made by the Secretary of State with the approval of HM Treasury thereunder; and
- in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

I have no observations to make on these financial statements.



Sir John Bourn
Comptroller and Auditor General

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

5 July 2006

FINANCIAL ACCOUNTS

Operating Cost Statement for the year ended 31 March 2006

	Notes	2005-06 £000	Re-stated 2004-05 £000
Programme costs			
Authority and claims administration	2.1	**13,445**	13,586
Unwinding of discounts	2.1	**37,359**	8,144
Change in Discount Rate (1 April 2005)	1.9, 9	**634,867**	0
Other claims and associated costs		**1,261,339**	1,127,074
	2.4	**1,933,565**	1,135,218
Cost of capital		**(269,457)**	(234,986)
Total programme costs		**1,677,553**	913,818
Operating income	4	**(498,917)**	(429,734)
Net operating cost		**1,178,636**	484,084
Net resource outturn	3.1	**1,178,636**	484,084

All income and expenditure is derived from continuing operations

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

		2005-06 £000	Re-stated 2004-05 £000
Unrealised surplus/(deficit) on the revaluation of fixed assets	5.2, 11.2	**0**	0
Unrealised surplus/(deficit) on the indexation of fixed assets	5.2, 11.2	**4**	5
Fixed asset impairment losses	5.2, 11.2	**0**	0
Prior Period Adjustment		**0**	(1,486,406)
Recognised gains and (losses) for the financial year		**4**	(1,486,401)

The notes at pages 50 to 66 form part of these accounts.

Balance Sheet as at 31 March 2006

	Notes	31 March 2006 £000	Re-stated 31 March 2005 £000
Fixed assets:			
Intangible assets	5.1	**84**	152
Tangible assets	5.2	**1,192**	1,362
		1,276	1,514
Current assets:			
Debtors	6	**8,077**	8,009
Cash at bank and in hand	7	**85,870**	21,883
		93,947	29,892
Creditors: amounts falling due within one year	8	**(39,545)**	(28,839)
Net current assets/(liabilities)		**54,402**	1,053
Total assets less current liabilities		**55,678**	2,567
Provisions for liabilities and charges	9	**(8,344,980)**	(7,003,001)
		(8,289,302)	(7,000,434)
Taxpayers' equity			
General Fund	11.1	**856**	505
Revaluation reserve	11.2	**48**	44
ELS reserve	11.3	**(1,404,895)**	(1,137,028)
Ex-RHA reserve	11.4	**(28,377)**	(25,309)
CNST reserve	11.5	**(6,734,452)**	(5,732,290)
PES reserve	11.6	**2,641**	5,520
LTPS reserve	11.7	**(125,123)**	(111,876)
		(8,289,302)	(7,000,434)

The financial statements on pages 47 to 66 were approved by the Board on 20 June 2006 and signed by Steve Walker.

The notes at pages 50 to 66 form part of these accounts.

Accounting Officer

27 June 2006

Cash Flow Statement for the year ended 31 March 2006

	Notes	31 March 2006 £000	Re-stated 31 March 2005 £000
Net cash (outflow) from operating activities	12	**(95,053)**	(103,822)
Capital expenditure and financial investment:			
(Payments) to acquire intangible fixed assets		**0**	(79)
(Payments) to acquire tangible fixed assets		**(182)**	(190)
Receipts from disposal of intangible fixed assets		**0**	0
Receipts from disposal of tangible fixed assets		**0**	0
Net cash inflow/(outflow) from investing activities		**(182)**	(269)
Net cash (outflow) before financing		**(95,235)**	(104,091)
Financing			
Net Parliamentary funding	11.1, 11.3, 11.4	**159,222**	104,394
Increase/(decrease) in cash in the period	7	**63,987**	303

The notes at pages 50 to 66 form part of these accounts.

NOTES TO THE ACCOUNTS

1 Accounting policies

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

1.1 Accounting conventions

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

Acquisitions and discontinued operations

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

1.2 Income

Income is accounted for applying the accruals convention. A major 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 funds the ELS and Ex-RHA clinical negligence schemes. Parliamentary funding is recognised in the financial period in which it is received.

Operating income is that which relates directly to the operating activities of the Authority. It principally comprises annual contributions charged to member NHS bodies for likely claims payments in year. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

1.3 Taxation

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

1.4 Capital charges

The treatment of fixed assets in the account is in accordance with the principal capital charges objective to ensure that such charges are fully reflected in the cost of capital. The interest rate applied to capital charges in the financial year 2005/2006 was 3.5% (2004/05 3.5%) on all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General (OPG), where the charge is nil.

The nature of the NHSLA requires the full recognition of liabilities under the various schemes but does not recognise the relevant future income receivable for these liabilities. Thus the NHSLA carries a substantial liability in the accounts. The application of the principles of capital charging as set out in the Resource Accounting Manual produces a negative capital charge which is represented as a large credit to expenditure in note 2.1.

1.5 Fixed assets

(a) Capitalisation

All assets falling into the following categories are capitalised:

(i) Intangible assets where they are capable of being used for more than one year and have a cost, individually or as a group, equal to or greater than £5,000.

(ii) Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred.

(iii) Tangible assets which are capable of being used for more than one year, and they:

- individually have a cost equal to or greater than £5,000; 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 had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building or unit irrespective of their individual or collective cost.

(iv) Donated fixed assets are capitalised at their current value on receipt, and this value is credited to the donated asset reserve.

(b) Valuation

Intangible fixed assets

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

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

Tangible fixed assets

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

(i) Operational equipment is valued at net current replacement costs through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

(ii) Assets in the course of construction are valued at current cost, using the index as for land and buildings. These assets include any existing land or buildings under the control of a contractor.

(iii) All adjustments arising from indexation and five-yearly revaluations are taken to the Revaluation Reserve. All impairments resulting from price changes are charged to the Statement of Recognised Gains and Losses. Falls in value when newly constructed assets are brought into use are also charged there. These falls in value result from the adoption of ideal conditions as the basis for depreciated replacement cost valuations.

(c) Depreciation and amortisation

Depreciation is charged on each individual fixed asset as follows:

(i) Intangible assets are amortised, on a straight line basis, over the estimated lives of the assets.

(ii) Purchased computer software licences are amortised over the shorter of the term of the licence and their useful economic lives.

(iii) Each equipment asset is depreciated evenly over the expected useful life:

	Years
Furniture and fittings	10
Information technology	5*

*The £24k of assets relating to the former Family Health Services Appeal Authority were previously depreciated over 3 years but have been in adjusted in 2005/06 to the NHSLA's rates.

1.6 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 15 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.7 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. As a consequence it is not possible for the Special Health Authority to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period. The total employer contributions paid in 2005/06 were £716,000 (2004/05 £758,000)

The scheme is subject to a full valuation for FRS17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employers' contribution rates. This valuation took place as at 31 March 2004 and has yet to be finalised. The last published valuation on which contributions were based covered the period 1 April 1994 to 31 March 1999. Between valuations the Government Actuary provides an update of the scheme liabilities on an annual basis. The latest assessment of the liabilities of the scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions Agency website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

The conclusion of the 1999 valuation was that the scheme continues to operate on a sound financial basis and the notional surplus of the scheme is £1.1 billion. It was recommended that employers' contributions are set at 14% of pensionable pay with effect from 1 April 2003. On advice from the actuary the contribution may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions of 6% (manual staff 5%) of their pensionable pay.

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

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

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

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

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

1.8 Leases

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

1.9 Provisions

The Authority provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms. This is a change from the rate of 3.5% applied from 2003/04. The effect of the change is to increase the carrying value of the provisions; this is shown in note 9.

The ELS and Ex-RHA schemes are funded by the Department of Health, CNST, LTPS and PES from Trust contributions, and the accounts for the schemes are prepared in accordance with FRS12. A provision for these schemes is calculated in accordance with FRS12 by discounting the gross value of all claims received; this is disclosed in note 9.

The calculation is made using:

(i) probability factors. The probability of each claim having to be settled is assessed between 10% and 94%. This probability is applied to the gross value to give the probable cost of each claim; and

(ii) a discount factor calculated using the real discount rate of 2.2%, RPI of 3% and claims inflation (varying between schemes) of between 3% and 6%, is applied to the probable cost to take into account the likely time to settlement.

The difference between the gross value of claims and the amount of the provision calculated above is also discounted, taking into account the likely time to settlement, and is included in contingent liabilities as set out in note 13.

Existing Liabilities Scheme (ELS) and Ex-Regional Health Authorities (Ex-RHA) Scheme

Claims are included in the ELS provision on the basis that the incident ocurred on or before 31st March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to the Authority with effect from 1st April 1996.

The *NHS (Residual Liabilities) Act 1996* requires the Secretary of State to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This would include the liabilities assumed by the Litigation Authority in respect of these schemes.

Clinical Negligence Scheme for Trusts (CNST)

A provision for this scheme is calculated in accordance with FRS12 by discounting the gross value of all claims received relating to incidents which occurred on or before 31 March 2006 and after 1 April 1995. This is disclosed in note 9.

Claims are included in the provision on the basis that the CNST members have assessed:–

(a) the probable cost and time to settlement in accordance with scheme guidelines;

(b) that they are qualifying incidents; and

(c) that the Trust remains a member of the scheme.

As at 31st March 2002 all outstanding claims for incidents post 1st April 1995 became the direct responsibility of the NHSLA. This "call in" of CNST claims effectively means that member trusts are no longer reponsible for accounting for claims made against them although they do remain the legal defendant.

The *NHS (Residual Liabilities) Act 1996* requires the Secretary of State to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This would include the liabilities assumed by the Authority in respect of this scheme.

Property Expenses Scheme (PES) and Liability to Third Parties Scheme (LTPS)

In April 1999 the Authority introduced the PES and LTPS following the Secretary of State's decision that NHS Trusts should not insure with commercial companies for non clinical risks, other than motor vehicles and other defined areas (eg PFI schemes).

The schemes are managed and funded via the same mechanisms as the CNST except that specific excesses exist for some types of claims. Thus the provision recorded in these accounts relates only to the NHSLA proportion of each claim. The accounts for these schemes have been prepared in accordance with FRS12.

Incidents incurred but not reported (IBNR)

FRS12 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to the NHS Litigation Authority as at 31 March 2006 where the following can be reasonably forecast:

(a) that an adverse incident has occurred; and

(b) that a transfer of economic benefit will occur; and

(c) that a reasonable estimate of the likely value can be made.

The NHSLA uses its actuaries, Lane, Clark & Peacock, to assess the potential value of IBNRs against each of the schemes it operates. The actuaries review existing claims records, and using an appropriate model, calculate values in respect of IBNRs for all schemes. The provisions and contingent liabilities arising are shown in notes 9 and 13 respectively. The sums concerned are accounting estimates, and although determined on the basis of information currently available, the ultimate liabilities may vary as a result of subsequent developments.

2.1 Authority programme expenditure

	Notes	£000	2005-06 £000	Re-stated 2004-05 £000
Non-executive members' remuneration	2.2		**47**	72
Other salaries and wages	2.2		**7,144**	7,657
Supplies and services – general			**6**	4
Establishment expenses			**836**	659
Transport and moveable plant			**58**	54
Premises and fixed plant			**1,944**	1,852
External contractors				
Actuary's advice			**173**	155
Risk management			**2,485**	2,222
Other			**191**	384
Miscellaneous			**14**	18
Capital: Depreciation and amortisation	5.1, 5.2	**415**		388
Impairments	5.1, 5.2	**0**		0
Capital charges interest		**(269,457)**		(234,986)
(Profit)/loss on disposal	5.3	**8**		0
			(269,034)	(234,598)
Other finance costs – unwinding of discount	9		**37,359**	8,144
– change in discount rate	9		**634,867**	0
Auditor's remuneration: audit fees			**85**	88
Auditor's remuneration: other fees*			**0**	0
Internal audit fees			**39**	33
Claims expenditure			**591,586**	528,013
Increase in provision for known claims (excl. unwinding of discounts)			**288,978**	211,561
Increase/(decrease) in the provision for IBNR			**380,775**	387,500
			1,677,553	913,818

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

2.2 Staff numbers and related costs

	2005-06 Total £000	Permanently employed staff £000	Other £000	Re-stated 2004-05 £000
Salaries and wages	**5,761**	5,761		6,080
Social security costs	**500**	500		527
Employer contributions to NHSPA	**716**	716		758
Other pension costs	**0**	0		0
Agency Staff	**214**		214	364
	7,191	**6,977**	**214**	7,729

The average number of employees during the year was:

	Total Number	Permanently employed staff	Other	Re-stated 2004-05
	167	160	7	196

Expenditure on staff benefits

The amount spent on staff benefits during the year mainly on lease cars totalled £44,922 (2004/05: £32,925).

Retirements due to ill-health

During 2005-06 there were no early retirements from the NHS Litigation Authority on the grounds of ill-health.

2.3 Better Payment Practice Code – measure of compliance

	Number	£000
Total non NHS bills paid 2005/06	22,022	641,135
Total non NHS bills paid within target	17,736	577,526
Percentage of non NHS bills paid within target	80.5%	90.1%

	Number	£000
Total NHS bills paid 2005/06	130	3,841
Total NHS bills paid within target	119	3,541
Percentage of NHS bills paid within target	91.5%	92.2%

	Re-stated Number	Re-stated £000
Total non NHS bills paid 2004/05	21,104	573,734
Total non NHS bills paid within target	17,601	508,728
Percentage of bills paid within target	83.4%	88.7%

The Better Payment Practice Code requires the NHSLA to aim to pay all valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Only comparatives for non NHS bills are shown as the NHS bills disclosure was only required from 2005/06.

The Late Payment of Commercial Debts (Interest) Act 1998

No interest was paid under the legislation.

2.4 Allocation of Income and Expenditure to the schemes

	Ex-RHA £000	ELS £000	CNST £000	PES £000	LTPS £000	FHSAA £000	Total £000	Re-stated 2004-05 Total £000
Expenditure								
Authority and claims administration	53	999	7,059	759	3,611	965	13,445	13,586
Claims and associated costs								
*Claims expenditure	7,716	168,203	384,390	4,586	26,691	0	591,586	528,013
Increase in provision for known claims	(871)	84,052	232,027	14	11,115	0	326,337	219,705
Increase/(decrease) in the provision for IBNR	2,775	112,000	270,000	0	(4,000)	0	380,775	387,500
Change in Discount Rate	1,195	52,719	576,953	0	4,000	0	634,867	0
	10,815	416,974	1,463,370	4,600	37,806	0	1,933,565	1,135,218
Cost of capital	(3,460)	(75,356)	(174,335)	(2,381)	(13,495)	(430)	(269,457)	(234,986)
	7,408	342,617	1,296,094	2,978	27,922	535	1,677,553	913,818
Income								
Scheme income	0	0	(468,267)	(2,480)	(28,170)	0	(498,917)	(429,734)
	0	0	(468,267)	(2,480)	(28,170)	0	(498,917)	(429,734)
Net operating cost – (surplus)/deficit	7,408	342,617	827,827	498	(248)	535	1,178,636	484,084

*Claims expenditure represents payments made in year to settle claims, including legal and other costs. This cost has been separately disclosed to improve the clarity of the accounts, although it is largely covered by the established provisions. The provision utilised in the year of £586,354,000 (note 9) differs from the disclosure in note 2.4 due mainly to the inclusion of accruals.

3.1 Reconciliation of net operating cost to net resource outturn

	2005-06 £000	Re-stated 2004-05 £000
Net operating cost	**1,178,636**	484,084
Net resource outturn	**1,178,636**	484,084
Revenue resource limit	**1,383,962**	484,128
(Over)/under spend against revenue resource limit	**205,326**	44

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2005-06 £000	Re-stated 2004-05 £000
Gross capital expenditure	**182**	269
NBV of assets disposed	**(7)**	0
(loss) on disposal of donated assets	**0**	0
Net capital resource outturn	**175**	269
Capital resource limit	**280**	281
(Over)/under spend against limit	**105**	12

4 Operating income

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

	Appropriated in aid £000	Re-stated 2004-05 £000
Programme income:		
CNST contributions	468,267	406,820
PES contributions	2,480	2,065
LTPS contributions	28,170	20,849
Total	**498,917**	429,734

5.1 Intangible fixed assets

	Software licences £000	Total £000
Gross cost at 31 March 2005	467	467
Indexation	0	0
Impairments	0	0
Other revaluations	0	0
Additions – purchased	0	0
Additions – donated	0	0
Reclassification	0	0
Disposals	0	0
Gross cost at 31 March 2006	**467**	**467**
Accumulated amortisation at 31 March 2005	315	315
Indexation	0	0
Impairments	0	0
Other revaluations	0	0
Charged during the year	68	68
Reclassification	0	0
Disposals	0	0
Accumulated amortisation at 31 March 2006	**383**	**383**
Net book value:		
Purchased at 31 March 2005	152	152
Donated at 31 March 2005	0	0
Total at 31 March 2005	152	152
Net book value:		
Purchased at 31 March 2006	**84**	**84**
Donated at 31 March 2006	**0**	**0**
Total at 31 March 2006	**84**	**84**

5.2 Tangible fixed assets

	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 31 March 2005	2,013	384	2,397
Additions – purchased	182	0	182
Additions – donated	0	0	0
Impairments	0	0	0
Reclassification	0	0	0
Indexation	0	6	6
Other in year revaluations	0	0	0
Disposals	(210)	(19)	(229)
Gross cost at 31 March 2006	**1,985**	**371**	**2,356**
Accumulated depreciation at 31 March 2005	840	195	1,035
Charged during the year	308	39	347
Impairments	0		0
Reclassification	0	0	0
Indexation	0	2	2
Other in year revaluation	0	0	0
Disposals	(203)	(17)	(220)
Accumulated depreciation at 31 March 2006	**945**	**219**	**1,164**
Net book value:			
Purchased at 31 March 2005	1,173	189	1,362
Donated at 31 March 2005	0	0	0
Total at 31 March 2005	1,173	189	1,362
Net book value:			
Purchased at 31 March 2006	**1,040**	**152**	**1,192**
Donated at 31 March 2006	**0**	**0**	**0**
Total at 31 March 2006	**1,040**	**152**	**1,192**

No assets are held under finance leases or hire purchase contracts and the NHSLA does not own any land or buildings.

Capital commitments: The NHSLA has no capital commitments at 31/03/06.

5.3 Profit/(loss) on disposal of fixed assets

	2005-06 £000	Re-stated 2004-05 £000
(Loss) on disposal of plant and equipment	**(8)**	
	(8)	0

6 Debtors

Amounts falling due within one year

	2005-06 £000	Re-stated 2004-05 £000
NHS debtors	**4,542**	4,902
Accrued Income	**12**	0
Prepayments	**1,380**	1,290
Other debtors	**2,143**	1,817
	8,077	8,009

7 Analysis of changes in cash

	Restated At 31 March 2005 £000	Change during the year £000	At 31 March 2006 £000
Cash at OPG	21,883	**63,987**	**85,870**
	21,883	**63,987**	**85,870**

8 Creditors

Amounts falling due within one year

	2005-06 £000	Re-stated 2004-05 £000
NHS creditors	**1,310**	617
Tax and social security	**247**	252
Other creditors	**0**	3
Accruals	**37,988**	27,967
	39,545	28,839

9 Provisions for liabilities and charges

	Ex-RHA Scheme £000	ELS Scheme £000	CNST Scheme £000	PES Scheme £000	LTPS Scheme £000	Total £000
At 31 March 2005	**(25,608)**	**(1,153,366)**	**(5,709,628)**	**(8,975)**	**(105,424)**	**(7,003,001)**
Discounting	20,275	867,791	493,159	0	20	**1,381,245**
Arising during the year	(30,237)	(1,198,747)	(1,274,468)	(6,488)	(52,515)	**(2,562,455)**
Utilised during the year	7,676	165,324	382,284	4,566	26,504	**586,354**
Reversed unused	3,564	100,617	184,809	1,908	14,980	**305,878**
Change in the discount rate	*(1,195)*	*(52,719)*	*(576,953)*	*0*	*(4,000)*	***(634,867)***
Unwinding of discount	(407)	(19,037)	(17,811)	0	(104)	**(37,359)**
Movement in net IBNR	(2,775)	(112,000)	(270,000)	0	4,000	**(380,775)**
At 31 March 2006	**(28,707)**	**(1,402,137)**	**(6,788,608)**	**(8,989)**	**(116,539)**	**(8,344,980)**
Expected timing of cash flows:						
Within 1 year	3,711	275,305	618,593	7,989	51,917	**957,515**
1-5 years	8,047	503,871	1,642,483	1,000	32,622	**2,188,023**
Over 5 years	16,949	622,961	4,527,532	0	32,000	**5,199,442**
	28,707	**1,402,137**	**6,788,608**	**8,989**	**116,539**	**8,344,980**

10 Movements in working capital other than cash

	2005-06 £000	Re-stated 2004-05 £000
Increase/(decrease) in debtors	**68**	(1,853)
(Increase)/decrease in creditors	**(10,706)**	(5,802)
	(10,638)	(7,655)

11 Movements on reserves

11.1 General Fund

	2005-06 £000
Balance at 31 March 2005	505
Net operating costs for the year	(535)
Capital charge interest	**(430)**
Net Parliamentary funding	**1,316**
Balance at 31 March 2006	**856**

11.2 Revaluation reserve

	£000
Balance at 31 March 2005	44
Impairments	0
Indexation of fixed assets	4
Revaluation of fixed assets	0
Transfer to general fund of realised elements of revaluation reserve	0
Balance at 31 March 2006	**48**

11.3 The movement on the ELS reserve in the year comprised:

	2005-06 £000
Balance at 31 March 2005	(1,137,028)
Transfer from Operating Cost Statement	(342,617)
Capital charge interest	(75,356)
Net Parliamentary funding	150,106
Balance at 31 March 2006	**(1,404,895)**

11.4 The movement on the Ex-RHA reserve in the year comprised:

	2005-06 £000
Balance at 31 March 2005	(25,309)
Transfer from Operating Cost Statement	(7,408)
Capital charge interest	(3,460)
Net Parliamentary funding	7,800
Balance at 31 March 2006	**(28,377)**

11.5 The movement on the CNST reserve in the year comprised:

	2005-06 £000
Balance at 31 March 2005	(5,732,290)
Transfer from Operating Cost Statement	(827,827)
Capital charge interest	(174,335)
Balance at 31 March 2006	**(6,734,452)**

11.6 The movement on the PES reserve in the year comprised:

	2005-06 £000
Balance at 31 March 2005	**5,520**
Transfer from Operating Cost Statement	**(498)**
Capital charge interest	**(2,381)**
Balance at 31 March 2006	**2,641**

11.7 The movement on the LTPS reserve in the year comprised:

	2005-06 £000
Balance at 31 March 2005	**(111,876)**
Transfer from Operating Cost Statement	**248**
Capital charge interest	**(13,495)**
Balance at 31 March 2006	**(125,123)**

12 Reconciliation of operating costs to operating cash flows

	Notes	2005-06 £000	Re-stated 2004-05 £000
Net operating cost before interest for the year		**(1,178,636)**	(484,084)
Adjust for non-cash transactions	2.1	**(269,034)**	(234,598)
Adjust for movements in working capital other than cash	10	**10,638**	7,655
Increase/(decrease) in provisions	9	**1,341,979**	607,205
Net cash outflow from operating activities		**(95,053)**	(103,822)

13 Contingent liabilities

	Ex-RHA Scheme £000	ELS Scheme £000	CNST Scheme £000	PES Scheme £000	LTPS Scheme £000	Total £000
Contingent liability for claims	10,736	602,674	3,586,962	4,505	64,811	4,269,688

As can be seen in note 1.9 the Authority has made a provision in its accounts for the likely value of future claims payments. The contingent liabilities note recognises possible additional claims payments to those already provided for. These are shown as a note to the accounts because a transfer of economic benefit is not deemed likely.

14 Commitments under operating leases

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

	2005-06 £000	Re-stated 2004-05 £000
Hire of plant and machinery	**0**	9
Other operating leases	**898**	986
	898	995

Commitments under non-cancellable operating leases:

Commitments under operating leases to pay rentals during the year following the year of these accounts are given in the table below, analysed according to the period in which the lease expires.

		£000	£000
Land and buildings			
Operating leases which expire:	within 1 year	**163**	39
	between 1 and 5 years	**0**	0
	after 5 years	**736**	908
		899	947
Other leases			
Operating leases which expire:	within 1 year	**19**	25
	between 1 and 5 years	**19**	25
	after 5 years	**0**	0
		38	50

15 Losses and special payments

There were 2 cases of losses and special payments (prior year: 0 cases) totalling £1,783 (prior year £0) approved during 2005/06.

16 Related parties

The NHS Litigation Authority 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 NHS Litigation Authority has had a significant number of material transactions with the Department, and with other entities, to whom the NHSLA provides clinical and non clinical risk pooling services, for which the Department is regarded as the parent Department, i.e.:

	Charge to the Operating Cost Statement		
NHS Body	**Income £000**	**Expenditure £000**	**Provision £000**
All English Strategic Health Authorities	194	7	753,905
All English NHS Trusts and PCTs	511,549	6,337	2,062,183
The National Blood Authority			315
The National Patient Safety Agency	15		22
NHS Logistics	84		117
NHS Appointments Commission	3		
Health Protection Agency	97		685
NHSU	24		29
NHS Direct	67		29
NHS CFSMS	9		10
NHS Pensions Agency	17		1

The NHSLA also charged to the OCS a provision for those incidents that have been incurred but not yet reported in the sum of £381m (2004/05 £387m).

In addition Dr C Kaplan, a non executive director of the NHSLA is also employed by Newcastle, North Tyneside and Northumberland Mental Health NHS Trust as a Senior Lecturer and consultant in child and adolescent psychiatry. The contractual relationship is between the NHSLA and Dr Kaplan. The NHSLA paid Dr Kaplan £5,778 in 2005/06.

17 FHSAA

As noted in the 2004/05 accounts, the Family Health Services Appeal Authority ceased to exist as a separate body at 31 March 2005, with the transfer of its functions into the NHS Litigation Authority with effect from 1 April 2005. The prior year comparator figures in these accounts have been adjusted to incorporate the prior year figures of the former Family Health Services Appeal Authority and hence the columns throughout the accounts are headed "Re-stated". The gross expenditure of the FHSAA for 2004/05 was £1.047m and net assets at 31 March 2005 were £34k.

18 Periodical payments

The Authority has reviewed its accounting methodology in respect of periodical payments (previously referred to as structured settlements). These are claims against the NHS where a staged settlement has actually been agreed with the claimant. The revised methodology takes into account the actual payments that will be incurred each year whilst making an adjustment for risk and the 2.2% Treasury discount rate. The impact of the change in accounting methodology is an extra charge to the operating cost statement and an increased provision of £104m.

19 Agenda for change

The new Agenda for Change pay arrangements for all NHS employees, except very senior managers, are currently being implemented by the Authority. The new rates of pay will be effective from 1 October 2004, with any increases payable with effect from that date. As at the 31 March 2006, 36% of NHSLA employees have been assimilated to the new rates of pay with 47% on protected pay, 30% maintaining the same salary and 23% receiving an increase of an average 16%. The remaining employees will progress to assimilation during July 2006. No provision has been made for the likely pay implications of the assimilation of remaining employees since there remains some doubt about the new salaries payable under Agenda for Change.
It is anticipated that a net pay increase will occur across the remaining staff group and that an element of back pay will fall due to account for the above implementation date of 1st October 2004. The actual values remain difficult to estimate but current forecasts suggest a total back pay bill of approximately £600,000.

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20 Equal Pay Claims

With effect from the 1st August 2005 the NHSLA has been charged with coordinating equal pay claims on behalf of the NHS in England. The powers leading to these new responsibilities were implemented via a Statutory Instrument which came into effect on the 1st of July 2005. The Department of Health issued formal directions to the NHSLA which came into effect from the 16th July 2005.

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21 Financial instruments

FRS 13, Derivatives and Other Financial Instruments, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way Special Health Authorities are financed, the NHS Litigation Authority is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 13 mainly applies. The NHS Litigation Authority 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 NHS Litigation Authority in undertaking its activities.

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

Liquidity risk

The NHS Litigation Authority's net operating costs are financed from resources voted annually by Parliament and scheme contributions from member NHS Trusts. The NHS Litigation Authority finances its capital expenditure from funds made available from Government under an agreed capital resource limit. The NHS Litigation Authority is not, therefore, exposed to significant liquidity risks.

Interest-rate risk

None of the Authority's financial assets and liabilities carry fixed rates of interest. NHS Litigation Authority is not, therefore, exposed to significant interest-rate risk.

Foreign Currency risk

The Authority has negligible foreign currency expenditure.

Fair Values

Fair Values are not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury real discount rate of 2.2%, adjusted for claims inflation and the Retail Price Index.

22 Intra-government balances

	Debtors: Amounts falling due within one year £000	Debtors: Amounts falling due after more than one year £000	Creditors: Amounts falling due within one year £000	Creditors: Amounts falling due after more than one year £000
Balances with other central government bodies	2,090		247	
Balances with local authorities				
Balances with NHS Trusts	4,478		1,310	
Balances with public corporations and trading funds				
Balances with bodies external to government				
At 31 March 2006	**6,568**	**0**	**1,557**	**0**
Balances with other central government bodies	1,716		252	
Balances with local authorities				
Balances with NHS Trusts	4,902		598	
Balances with public corporations and trading funds				
Balances with bodies external to government				
At 31 March 2005	6,618	0	850	0

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