The National Health Service Litigation Authority

Report and Accounts 2007

HC 908

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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KEY ACHIEVEMENTS

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

The number of claims being reported to the NHSLA remains remarkably constant with small decreases in both clinical and non-clinical claims being reported in 2006/07 compared with 2005/06.

The number of cases outstanding at year-end continues to fall, demonstrating that the Authority is settling cases faster than they are reported to us.

96% of clinical negligence cases handled by the NHSLA are resolved through negotiation, mediation and other forms of alternative dispute resolution.

The FHS Appeal Unit successfully integrated the new dental dispute resolution procedures into its caseload, achieving prompt determinations for dentists and PCTs despite the significant increase in workload involved.

The Appeal Unit succeeded in determining at least 90% of its cases within key target times in each of the individual areas of dispute resolution for which it is responsible.

Our Human Rights Act Information Service has made comprehensive summaries of almost 400 NHS-related human rights cases available via its database at www.nhsla.com/humanrights,

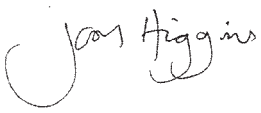
98% of readers of the human rights quarterly newsletter who responded to a recent survey said they found the newsletter helpful in their work.

CHAIR'S STATEMENT

I am very pleased to write the Introduction to the Annual Report for 2006-2007. I took over as Chair of the NHS Litigation Authority on April 1st 2007 and would like to begin by paying tribute to my predecessor, Ron Bradshaw, and to the other members of the Board, Dr Carole Kaplan and Mehmuda Mian Pritchard, who retired earlier in the year. I know they all made a significant contribution to the work of the Authority over many years. I would like to record my personal thanks to Ron Bradshaw for ensuring a smooth transition and for his commitment to the Authority for the last 11 years. He saw the Authority grow from a very small group of people to the important and successful organisation it has become today.

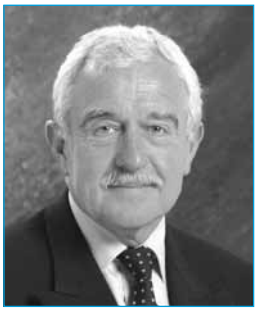
Professor Dame Joan Higgins
Chair

I would also like to thank the staff of the Authority for all their work in 2006/7. It has been a demanding year, with uncertainties about relocation and reorganisation. However, they have continued to maintain very high standards of professionalism and to provide essential services to the NHS and its patients. It is a pleasure and a privilege to have been appointed Chair of the NHS Litigation Authority and I shall look forward to working with colleagues, both inside and outside the Authority, to meet the challenges of the future.



Professor Dame Joan Higgins
Chair

CHIEF EXECUTIVE'S STATEMENT



Stephen Walker CBE
Chief Executive

It has been a year of stability in some respects, and massive change in others. In the last month of the year we have welcomed a new Chair, Professor Dame Joan Higgins, and three new non-executive Board members, Mrs Nina Wrightson, Mr Brian Capstick and Professor Rory Shaw. In the same period we said goodbye to Ron Bradshaw, Carole Kaplan and Mehmuda Mian Pritchard. I would like to welcome our new colleagues, while paying tribute to the efforts of our former colleagues, and in particular, Ron Bradshaw, who had served two terms as a non-executive, and two terms as Chairman, each extended slightly for various reasons.

We have also changed the provider of assessment services within CNST. Willis, who were one of the designers of the scheme, and have carried out that assessment function since inception in 1995 were replaced by Det Norske Veritas Ltd who were successful in a very competitive tender exercise and who have taken over assessment duties since April 1st. We welcome DNV, and thank Willis for their pioneering efforts over the last 12 years.

Equal Pay claims continue to provide a demanding diversion for several members of our senior management team. Our role in respect of these claims is very different to that which we normally perform in respect of clinical negligence and other claims under our schemes. The claims remain the responsibility of individual trusts, and will ultimately be funded by those trusts if compensation has to be paid. Our role is simply to advise and to co-ordinate activities so that the optimum outcome is achieved for the NHS as a whole, while ensuring that the fundamental principles enshrined in the Equal Pay Act, 1970, and fully supported by the current administration, are adhered to. We believe that a series of issues needs to be determined in the Employment Tribunal, and possibly in the Employment Appeals Tribunals thereafter, before advice can be offered as to which, if any, of the outstanding claims will have to be met, and on what terms.

In contrast it has been a relatively quiet year in terms of major litigation affecting the Authority and its interests, with the cases of Crofton and Thompstone being notable exceptions.

Crofton dealt with the vexed question of who should provide for the future care or education costs of an injured party when there were two potential payees; on the one hand a body with the statutory obligation to provide it, e.g. a Local Authority, and on the other the individual who had caused the harm, and therefore created the need, and had either an insurer or an indemnity fund behind him.

In Crofton it was held that where the former is making payments they must be taken into account in assessing compensation, but the issues are likely to run and are unlikely to be resolved ultimately without legislation.

In Thompstone, a second aspect of future loss claims was considered. Claims can now be settled on a periodical payments basis against the wishes of either or even both of the parties. The question arises as to which is the appropriate index to apply to future payments to ensure that a claimant compensated in this fashion will continue to receive sufficient funds to maintain the regime which has been allowed for. The Damages Act refers to the Retail Prices Index (RPI) but allows for the substitution of an alternative index if that seems more appropriate to a Judge who has heard the evidence.

Having heard the evidence in Thompstone the Judge substituted for RPI, ASHE 6115, 75th percentile. Although not strictly an index, the data which goes into this measure can be used to calculate inflation specific to the kind of costs for which much of this compensation is paid, namely domiciliary care staff. The Authority's appeal against that judgment is to be heard in November 2007. See also the note at 13 on page 63.

One of the key aims when CNST was created was to provide financial stability for members. It is therefore a source of considerable pride that for the third year in a row we have been able to maintain aggregate CNST contributions at more or less the same level, despite the impact of both inflation and judicial inflation on compensation and legal costs.

For the second year in a row we have also been able to maintain gross LTPS contributions at broadly the same level. After 7 years of growth we are still not levying from the service the level of insurance premiums being paid in 1998/99 for the same risks.

In terms of legislation, the year saw the passage of the NHS Redress Act, but implementation is not imminent, and a comprehensive consultation is anticipated before Regulations can be drafted to give it effect. Further, it was gratifying to note that the Compensation Act 2006 adopted the view expressed by this Authority since inception that it is not only proper to apologise when a mishap occurs, but that to do so is not necessarily to formally accept legal liability for it. We, of course, go further, and recommend that full explanations should be offered.

In conclusion, 2006/7 appears, in retrospect, to have been a year of maintenance rather than high achievement, but given the responsibilities borne by the Authority, that is no small task. As always, I would like to emphasise that our achievements in maintaining the high standards we have set can only be by virtue of the prodigious efforts made by all of our staff, in London and in Harrogate. Whilst I hope they know the extent to which they are appreciated, this is one of the formal opportunities in the year to expressly say so, and I do so wholeheartedly.

Stephen Walker CBE
Chief Executive

DIRECTOR OF FINANCE'S REPORT

Tom Fothergill
Director of Finance

As previously reported and also referred to elsewhere within the report, 2006/07 has seen a continuation of the change environment resulting from various NHS and cross-Government initiatives, in particular the Arm's Length Bodies (ALB) Review.

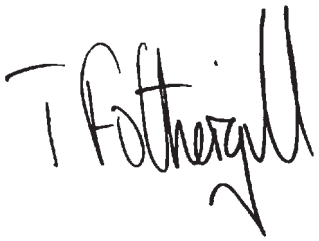
The Authority has once again managed its finances and headcount in line with the agreed levels set by the ALB Review for 2006/07. Our plans for 2007/08 will again aim to deliver against these targets and they are used as the background to our business plan for the year which is published on our website at www.nhsla.com.

During 2006/07 the Authority closed its Croydon offices in order to improve our efficiency ratio regarding space utilised by our staff. Although this was a relatively smooth transition with almost all staff relocating to our Holborn offices it did inevitably create pressures for those staff affected and I wish to record my thanks to all involved in the project for their efforts and attitude throughout a difficult time.

The longer-term requirement to relocate posts out of the South East (under the cross-Government Lyons review) continues to cause concerns for the Authority, not least of which are identifying the funding which will be required should the relocation progress and maintaining business continuity throughout the process. We are again working closely with colleagues from the Department of Health and in particular are keen to establish the position re transitional funding i.e. will it be made available and also to review the original business case for the move as many of the assumptions made in 2003/04 will require updating to reflect our current position.

I am pleased to report that there have been no significant financial impacts on the accounts in 2006/07, particularly because it seems some years since I was able to report such a situation.

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 the 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 2006/07

Majrowski v Guy's and St Thomas' NHS Trust – The House of Lords decided on 12 July 2006 that an employer could be vicariously liable for harassment perpetrated by employees, arising out of and in the course of their employment, under the Protection from Harassment Act 1997. This is likely to lead to increasing numbers of such claims against NHS bodies and others, albeit that the House indicated that for civil liability to attach, the misconduct must have been of an order which would sustain criminal liability under the Act.

Thompstone v Tameside and Glossop Acute Services NHS Trust – This was a decision of Mrs Justice Swift on 23 November 2006. She held that the periodical payment regime which will fund the severely disabled claimant's future care should be linked not to the Retail Prices Index, as all such arrangements had been until then, but rather to a sub-set of the Annual Survey of Hours and Earnings (ASHE). This might seem a rather academic point, but potentially it has enormous adverse financial consequences for the NHS, if adopted in other cases. The case is scheduled to appear, with others, in the Court of Appeal in November 2007.

Ndri v Moorfields Eye Hospital NHS Trust – A case involving infection of corneal graft material, in which Sir Douglas Brown gave judgment in the High Court on 24 November 2006. As well as alleging negligence (dismissed by the judge) the claimant's lawyers argued that there had been breach by the trust of the Control of Substances Hazardous to Health Regulations (COSHH). This was an innovative approach and, had it succeeded, would have set a dangerous precedent for the NHS because claimants would no longer have had to prove negligence in such situations. Fortunately, the judge decided that COSHH was not applicable to patients in hospital.

Savage v South Essex Partnership NHS Trust – Another decision of Mrs Justice Swift, given on 21 December 2006. A detained psychiatric patient walked out of an open ward and jumped in front of a train, suffering fatal injuries. Her daughter alleged breach of Article 2 of the European Convention on Human Rights (right to life). The judge held that the trigger for breach of Article 2 was not "ordinary" clinical negligence but rather gross negligence, such as would sustain a charge of manslaughter. There had been no gross negligence and the claim therefore failed. This was a very important clarification of the applicability of Article 2 to clinical negligence cases. However, the daughter has appealed and the Court of Appeal will hear the case in October 2007.

Crofton v NHSLA – In this case involving treatment of a cardiological condition at the Royal Brompton Hospital, the Court of Appeal on 8 February 2007 upheld our argument that direct payments made by Hampshire County Council, in accordance with their statutory duty, in respect of care/accommodation needed by the claimant as a consequence of clinical negligence, should be taken into account when assessing damages. This applied to both past and future payments, but it was the duty of the defendant to demonstrate that there would be continuity of provision. Potential double recovery was therefore avoided.

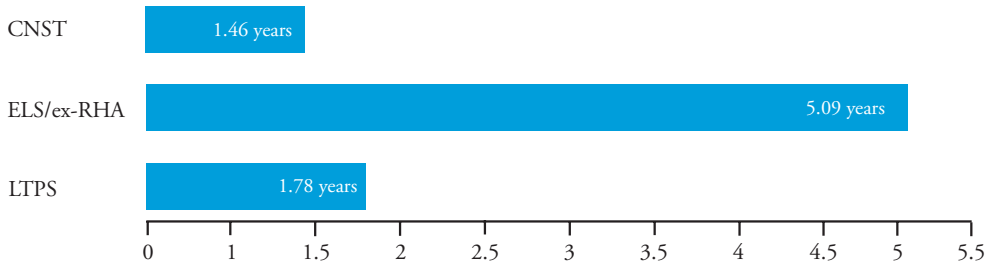
Handling claims

Avoiding litigation

Our remit when handling claims against NHS bodies, as set out in our *Framework Document*, 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 resolved by some form of "alternative dispute resolution" (ADR) such as negotiation, round-table meetings and 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 2006/07, 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.

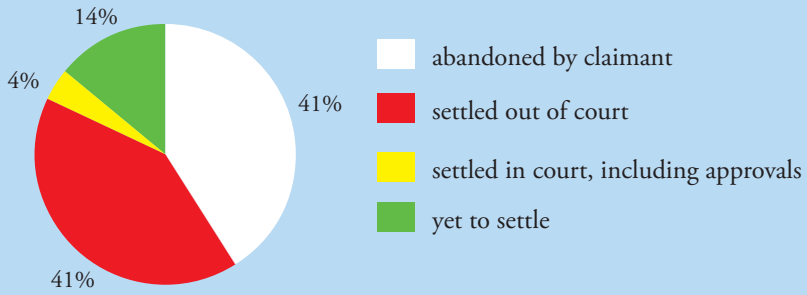


Outcome of claims

We seek, wherever possible and appropriate, to settle claims without litigation. The following chart provides a breakdown by outcome of the clinical negligence cases handled over the past ten years by the Authority, 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 2006/07, 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 received by the NHSLA between 01/04/97 and 31/03/07



(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. There are 4,656 "inherited" claims closed on the database with damages paid but with no status history which we have assumed were settled out of court.)

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 113 clinical negligence claims actually "litigated" in court over the past three financial years, 67% were settled in favour of the NHS, 29% were settled in favour of the patient and 4% were settled mid-trial.

Volume of claims

The number of matters we receive has remained remarkably steady over recent years. This year, there was a small decrease in the number of both clinical and non-clinical matters reported to us: a 4.8% decrease in the number of clinical matters in 2006/07 over 2005/06 and a 5.8% decrease in the number of non-clinical matters over the same period.

The following tables show the number of matters 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
2004/05	957	4,316	5,273
2005/06	911	4,516	5,427
2006/07	714	4,566	5,280

Existing Liabilities Scheme

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2004/05	33	296	329
2005/06	109	161	270
2006/07	38	108	146

Ex-Regional Health Authorities Scheme

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2004/05	0	7	7
2005/06	0	0	0
2006/07	0	0	0

Liabilities to Third Parties Scheme

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2004/05	11	3,634	3,645
2005/06	10	3,409	3,419
2006/07	82	3,138	3,220

Property Expenses Scheme

Year	Incidents under investigation	Claims where formal letter of claim has been received	Total
2004/05	0	121	121
2005/06	0	78	78
2006/07	0	73	73

Claims outstanding at year end

The number of outstanding claims at the year-end continues to fall. 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
2004/05	1,891	8,775	10,666
2005/06	1,625	8,822	10,447
2006/07	1,087	8,333	10,420

Existing Liabilities Scheme

Year ended	Incidents under investigation	Claims where formal letter of claim has been received	Total
2004/05	274	1,815	2,089
2005/06	264	1,501	1,765
2006/07	190	1,342	1,532

Ex-Regional Health Authorities Scheme

Year ended	Incidents under investigation	Claims where formal letter of claim has been received	Total
2004/05	5	34	39
2005/06	3	28	31
2006/07	1	19	20

Liabilities to Third Parties Scheme

Year ended	Incidents under investigation	Claims where formal letter of claim has been received	Total
2004/05	19	7,796	7,815
2005/06	22	8,191	8,213
2006/07	88	7,497	7,585

Property Expenses Scheme

	Incidents under investigation	Claims where formal letter of claim has been received	Total
2004/05	0	215	215
2005/06	0	206	206
2006/07	0	170	170

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 2006/07. It should be emphasised that these figures do not represent the value of claims *made* during 2006/07, 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 2006/07 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 2004/05 and 2005/06.

Payments made, by year and scheme

	2004/05 £	2005/06 £	2006/07 £
CNST	329,412,000	384,390,000	424,351,000
ELS	169,414,000	168,203,000	153,246,000
Ex-RHA	4,068,000	7,716,000	1,794,000
Total	**502,894,000**	**560,309,000**	**579,391,000**
LTPS	21,280,000	26,692,000	29,697,000
PES	3,839,000	4,586,000	4,186,000
Total	**25,119,000**	**31,278,000**	**33,883,000**
Grand total	**528,013,000**	**591,587,000**	**613,274,000**

(Expenditure relates to paid and accrued but excludes reserves)

Legal costs

As noted in previous Annual Reports, 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. 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 2006/07

No. of claims	Damages	Defence costs	Claimant costs	Total costs	Defence costs as % of damages	Claimant costs as % of damages
	£	£	£	£		
6,190	212,112,955	38,424,399	68,577,423	107,001,822	18.12%	32.33%

Existing Liabilities Scheme: claims closed in 2006/07

No. of claims	Damages	Defence costs	Claimant costs	Total costs	Defence costs as % of damages	Claimant costs as % of damages
	£	£	£	£		
337	111,324,323	11,051,812	14,683,546	25,735,358	9.93%	13.19%

Total damages and legal costs in respect of clinical negligence claims closed in 2006/07

No. of claims	Damages	Defence costs	Claimant costs	Total costs	Defence costs as % of damages	Claimant costs as % of damages
	£	£	£	£		
6,527	323,437,278	49,476,211	83,260,969	132,737,180	15.30%	25.74%

(This table includes all claims closed in 2006/07 irrespective of whether they closed with or without damages and costs.)

3 Again, these figures cannot be equated with the figures given above for the total amounts paid out by the Authority in 2006/07 because they relate to another cohort of claims: that of claims closed during 2006/07. 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 2007, we were committed to making periodical payments in 471 cases, the provisions for which total £662,964,855. 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.

As noted under "Important cases for the NHS in 2006/7" (see page 8), the basis for determining how such payments will increase in future years is being challenged. Following the November 2006 decision in Thompstone, there have been other attempts to overturn RPI as the appropriate index, and it is likely that several cases, including possibly three from the NHS, will be heard together by the Court of Appeal in November 2007. It is extremely likely that whichever side loses then will wish to appeal further, to the House of Lords, and therefore the authoritative legal position may not be known until the end of 2008, or possibly even later. In the interim, many cases are being stayed pending the final outcome, although we are continuing to initiate periodical payments, with only the question of indexation being held over. Indeed, some claimants and their lawyers continue to be willing to settle finally with the conventional RPI linking.

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.

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, which is aimed at improving the safety of NHS patients and staff, is mainly achieved through the provision of risk management standards based on the identified causes of claims, against which all trusts are assessed. In addition, the NHSLA provides advice and training to assist trusts in achieving the standards.

Alison Bartholomew
Risk Management Director

Standards and assessments

In November 2004, the Board agreed a revised approach to the NHSLA's risk management standards and assessments. A single set of standards is consequently being developed for each type of trust incorporating organisational, clinical and health & safety risks. These standards combine elements of the Clinical Negligence Scheme for Trusts (CNST) Clinical Risk Management Standards and the more general Risk Pooling Schemes for Trusts (RPST) Risk Management Standard with some new risk areas that have been identified through an analysis of claims data. Separate clinical standards are being retained for trusts providing maternity services.

The standards are being developed, piloted at assessment, and launched over a five year rolling programme as shown in *figure 1.*

Figure 1.
Timetable for development of new standards and assessments

Standards	Year				
	05/06	06/07	07/08	08/09	09/10
Acute	Consult & Develop	Pilot Review & Launch	Implement →		
		Training →			
Ambulance MH & LD PCTs		Consult & Develop	Pilot Review & Launch	Implement →	
			Training →		
Maternity			Consult & Develop	Pilot Review & Launch	Implement
				Training →	

The new standards contain five individual standard areas set at three distinct progressive levels – policy, practice, performance – with ten equally weighted criteria in each. Every risk area is addressed at all three levels and, unlike the previous approach, trusts will only be assessed against the requirements of the level being assessed. Trusts will continue to receive increasing discounts, ranging from 10% - 30%, on their contributions to the NHSLA schemes as they progress from level 0 to level 3. However, the discounts will now relate to all three NHSLA schemes and be applied from the quarter date following an assessment instead of the beginning of the following financial year.

During the pilot assessment year for each set of standards, the normal assessment timetable is being suspended. Thus, during 2006/07 only those acute trusts participating in the pilot exercise were assessed. In addition, the assessment of most PCTs was suspended during the year to allow for the significant reconfiguration of these services. For the same reason, few ambulance assessments were conducted. The CNST assessment of mental health & learning disability trusts and maternity services against the relevant standards continued as usual. Excluding pilots, less than a total of 100 assessments against the standards were completed during the year compared to 500 in 2005/06.

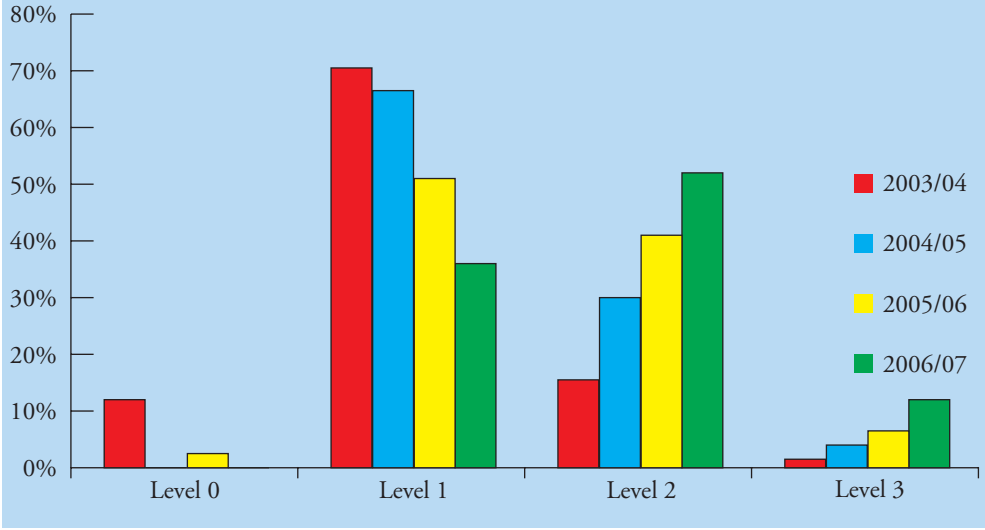
For those assessments that took place, the trend of improvement set in previous years continued. Details of the level(s) achieved by each trust in relation to the standards are made available via our website in NHSLA Factsheet 4 which is updated every month. In addition, copies of assessment reports are now posted on the NHSLA website in a folder under Risk management publications. The NHSLA also provides data on its assessments on the Concordat activity scheduling tool (www.concordat.org.uk/scheduling).

The pilot version of the new NHSLA risk management standards for acute trusts was published in April 2006, closely followed by workshops on the new standards and assessment process. An electronic evidence template was introduced for trusts to use as a self assessment tool and to accompany evidence submitted for assessment. In addition, a Handbook was released containing guidance, reference sources and claims information in support of the standards. In total 60 pilot assessments were completed across all three levels at volunteer trusts in 2006/07 with around 50% of these organisations demonstrating compliance with the standards. The lessons learned from the pilot assessment exercise, together with feedback from consultation with other bodies, were used to inform the final version of the acute standards which were launched at seminars in March and published on the first working day of April 2007.

Updated versions of the CNST maternity, CNST mental health & learning disability and NHSLA ambulance standards for assessment during 2006/07 were released in April 2006. The NHSLA standards for PCTs were not updated for 2006/07 as most assessments were suspended during the year. Work on maintaining the CNST maternity standards continued during 2006/07 and in November 2006 a draft version of these standards for assessment during 2007/08 was released, followed by a final version at the beginning of April 2007. As a result of the consultation and development work that took place during 2006/07, pilot standards for mental health & learning disability trusts, ambulance trusts and PCTs became available at the beginning of May 2007. Copies of all the risk management standards can be found on the NHSLA website under Risk management publications.

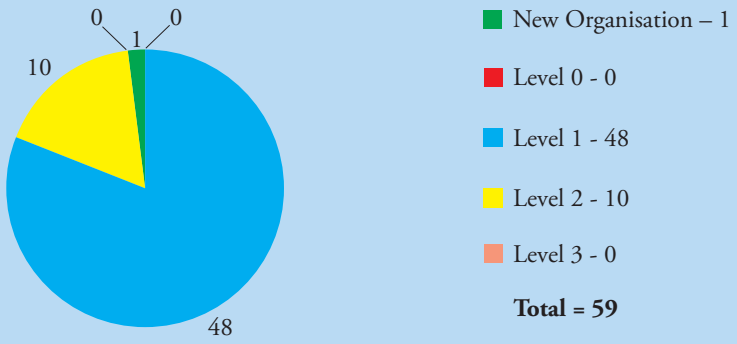
Figure 2 shows the levels achieved by trusts in the CNST maternity standards since these were introduced in 2003/04. At the end of 2006/07 there were no maternity services at Level 0 (2005/06, 2) and 64% (2005/06, 50%) had achieved level 2 or 3. Further improvement is anticipated in 2007/08 as a significant number of CNST maternity level 3 assessments have been booked for the next financial year.

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



2006/07 was the second year of assessments against the CNST clinical risk management standards specifically designed for mental health and learning disability trusts and the results are shown in *figure 3*. At the end of the previous financial year, a significant number of these trusts had failed to demonstrate compliance with the standards and it is pleasing to note, therefore, that there are now no level 0 trusts.

Figure 3.
Attainment against the CNST MH & LD standards at 31/03/2007



Data is not provided on the risk management assessment levels of ambulance trusts and PCTs because few assessments of these organisations took place during 2006/07 due to the significant reconfiguration of services.

Training

The content of the risk management training programme for 2006/07 was informed by the feedback in previous years, the introduction of the new standards and assessments for acute trusts, and the need for input from other trusts into the development of the revised standards and assessments for their types of organisations. The programme included workshops to introduce the new pilot acute standards and assessments followed later in the year by launch seminars, maternity standards workshops, focus groups to consult with mental health & learning disability trusts, ambulance trusts and PCTs on the new standards and assessments, and a one-day course for new risk managers. The delegate evaluation for all the events was positive, with almost 100% indicating that they would recommend the event to a colleague.

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. Information about the Concordat can be found on a dedicated website (www.concordat.org.uk). The NHSLA has continued to contribute to various Concordat initiatives and work to ensure that its own risk management standards and assessments comply with the objectives and practices of the Concordat. For example, joint working with the Audit Commission and the Postgraduate Medical Education and Training Board during 2006/07 has led to the NHSLA placing reliance on the findings of these organisations rather than separately assessing specific criteria within its new standards.

Patient safety

As one of the leaders in advocating patient safety, the NHSLA is increasingly liaising with other agencies on this important issue. In particular, the NHSLA is a member of the Patient Safety Observatory and is actively working with the National Patient Safety Agency to look at ways of using the datasets of both organisations to extend the learning about patient safety.

Risk management services

Following a procurement exercise which took place in 2006/07, the NHSLA entered into a contract with Det Norske Veritas Ltd (DNV) to conduct risk management assessments, develop standards, and provide education and helpdesk services for five years with effect from 1 April 2007. Given DNV's core competency in managing risk, the NHSLA believes the foundation is well placed both to continue the development and delivery of its risk management programme and to enhance value through new ways of working and the provision of additional services.

From the inception of the NHSLA until the end of 2006/07, risk management services were provided by Willis Ltd. Willis input in establishing and developing the NHSLA programme has been invaluable. Despite the inevitable disruption caused by the tender exercise and the NHSLA's decision to transfer the contract for risk management services to a new supplier, Willis met or exceeded virtually all their agreed Key Performance Indicators for 2006/07. The experience and skills of the Willis team who delivered the services were highly valued by the NHSLA and, although it is regrettable that none of the support team were retained, it is pleasing to report that all the assessors and their managers transferred to DNV on 1 April 2007.

FAMILY HEALTH SERVICES APPEAL UNIT

Paul Burns
Head of Appeal Unit

This is the second annual report to include the Authority's wider remit to discharge the Secretary of State's "appellate and other functions" in connection with the decisions and functions of PCTs. These functions are performed by the Authority's Family Health Services Appeal Unit, which is based in Harrogate and has retained the expertise of the officers of and the Panels appointed by the former Family Health Services Appeal Authority (Special Health Authority).[5]

The *National Health Service Act 2006*, which is the primary legislation relating to much of this work, came into force during the year. This is a consolidation Act that repeals and re-enacts in its entirety the *National Health Service Act 1977*, which was itself a consolidation measure. It also incorporates provisions from other relevant Acts pertinent to the Appeal Unit's functions. However, although section numbers have changed, there have been no consequential changes to the secondary legislation governing our work.

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 GP or dental contractors and their local PCTs. Statistics relating both to the determinations of appeals/disputes and to other areas of the Appeal Unit's work are provided in supplementary fact-sheets published on the Authority's website at www.nhsla.com/fhsau.

While individual work streams showed a combination of increases and decreases against projection, the overall number of cases handled in 2006/07 [1,181] showed a significant increase from the Appeal Unit's previous level of activity, which was mostly occasioned by applications for dispute resolution under the new dental contract. This figure includes 350 dental cases not formally entering that process. The capability of the Appeal Unit to be flexible and to target appropriate resources to each work area has maintained good performance figures with the average time taken to issue decisions being in line with recent years. Further details on these work streams are given below.

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.* These regulations introduce new dispute resolution procedures, with the *NHS (Service Committees and Tribunal) Regulations 1992* ceasing for dentists on 31 March 2005 although a final case under the 1992 Regulations was completed during this year.[6] Although the Appeal Unit determined a relatively small number of appeals under the *Transitional Provisions Order*, whereby the issue was whether a dentist was entitled to a new contract at all, the majority of the 202 determinations related to pre-contract/agreement dispute applications. A number of applications [146] were withdrawn during the Authority's

5 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 website at www.fhsaa.org.uk.

6 These Regulations remain in place for handling disciplinary appeals concerning the ophthalmic and pharmaceutical professions; however, no such appeals were received for these professions in 2006/07.

dispute resolution process, often following further local dispute resolution. A further 350 were treated as withdrawn after they had initially been placed on-hold pending local procedures and had not then returned to this Authority with a full and formal application. All determinations were made on the papers and, not including periods pending further local dispute resolution, 90% were within the Authority's target of 15 weeks from receipt of the application.

Medical dispute resolution

The current GP contract completed a third year with the annual number of closures of dispute resolution applications rising to 103, under two sets of regulations: the *NHS (General Medical Services Contracts) Regulations 2004* [38 cases compared with 29 the previous year] and the NHS *(Personal Medical Services Agreements) Regulations 2004* [65 cases compared with 14 the previous year].

The single most commonly occurring theme during 2006 concerned superannuation monies under "PMS" (Personal Medical Services) Agreements. While PMS are local agreements and may vary, the general basis of these determinations was that PCTs should increase the baseline figure for the PMS Agreement in the first year of the agreement to include the disputed monies, but not otherwise. In many cases, the PCT had already done this but the applicant sought to argue a further and on-going obligation on the part of the PCT, which these determinations rejected on the papers.

Where appropriate, legal or other professional advice may be sought where the disputed matter has not previously been before the Authority, raises an important legal question or requires specific professional advice, which is often the case in assessing the current market rent for GP premises.[7] In some cases, the matter may prove more complex or require more elucidation of the issues and therefore a Panel is appointed to adjudicate following oral representations at a hearing. Such matters have included allegations of interference with or frustration of the contract, whether overpayments to the contractor should not be repaid under the principle of "change of position", and the interpretation and application of the Statement of Financial Entitlement. The table below sets out the outcome of those cases

	Disputes deemed withdrawn or not valid appeal	Disputes determined on the papers (allowed or in part)	Disputes determined following a hearing (allowed or in part)
GMS	8	12 (3)	18 (15)
PMS	12	48 (29)	5 (2)

The average time taken to decide appeals in 2006/07 was 11 weeks for cases decided on the papers and 23 weeks [GMS] or 24 weeks [PMS] for cases where an oral hearing was required.

Pharmaceutical regulations

The handling of appeals against decisions by PCTs under the *NHS (Pharmaceutical Services) Regulations 1992 and the NHS (Pharmaceutical Services) Regulations 2005* continues to be an important work stream for the Appeal Unit. The year saw the completion of the 23 appeals remaining under the out-going 1992 Regulations, with 272 determinations under the now established 2005 Regulations. While the Appeal Unit's Pharmacy Appeals Committee continued to determine the majority on the papers, a Panel was appointed to hear oral representations in 91 cases before then reporting back to the Committee.

7 A further five cases regarding rent were completed under transitional provisions from the former GMS Regulations 1992 and the Statement of Fees and Allowances.

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.

The "control of entry" provisions under Regulation 12 of the 2005 Regulations continued to be the main area of challenge, the relevant test being whether the proposed new NHS pharmaceutical services were "necessary or desirable", including amongst other matters the question of reasonable choice. However, the proportion of appeals relating to minor relocations and the "exemptions" to the necessary or desirable test pursuant to Regulation 13 rose compared with the first year of these regulations. A small number of minor relocation appeals related to "under 500 metre" applications, where the PCT had decided that it was necessary to consider the relocation as if it were in fact 500 metres or more. The Committee agreed with the PCT's approach in all cases. An important and new area of appeal impacting upon Regulation 13 applications related to "LPS" chemists (chemists providing services under a local pharmaceutical service agreement); however the Committee found that the wording of the particular LPS Agreement played an important part in the outcome in many cases, which varied depending on that wording.

The Appeal Unit experienced a similar number of pharmaceutical appeals to recent years. A small proportion of these is currently the subject of legal challenge in the courts. Given the differing views on how to interpret Regulation 12, that is likely to continue until there is judicial guidance on the matter. A three-year comparison of the numbers of appeals received and closed is shown below. The average time taken to decide appeals remained as in the preceding year: two weeks for cases summarily dismissed, 12 weeks for cases decided on the papers and 23 weeks for cases decided after an oral hearing.

Year	**2004/05**	**2005/06**	**2006/07**
Appeals received:	298	300	307
Appeals closed:	301	290	295

The National Health Service (Local Pharmaceutical Services etc.) Regulations 2006 came into force on 1 April 2006. These Regulations govern the arrangements for the provision of pharmaceutical services under local agreements, known as LPS schemes, between Primary Care Trusts, who commission the services, and independent contractors, who provide them. The Authority exercises the dispute resolution procedure within the regulations on behalf of the Secretary of State although no applications were received during the year.

GP vocational training and GP Registrar Directions

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 newly created Postgraduate Medical Education Training Board. The transitional provisions for applications received by PMETB's predecessor resulted in the Authority clearing remaining appeals, five during the year, in January 2007.

Under the terms of the *Directions to Strategic Health Authorities concerning GP Registrars*, the Authority is responsible for handling disputes between PCTs and GP Registrars over Registrars' allowances. The main area of work relates to requests [44 during the year] for assessment of the allowance payable where the GP Registrar's last post was outside the NHS. A further 26 representations were received in relation to allowances, such as removal expenses, where the GP Registrar was previously in an NHS hospital post. These matters are determined on the papers and were determined within one week and nine weeks respectively.

"Suspended performers" payments and withdrawal

The National Health Service (Performers Lists) Regulations 2004 currently apply to the medical and dental professions, although they may, in future, be extended to other primary care practitioners.[8] The independent Family Health Services Appeal Authority tribunal deals with appeals by "performers" 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 during suspension from the respective lists. 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 2006/07, the Appeal Unit determined three cases concerning payments during suspension of a GP performer and one case concerning withdrawal of a GP performer from a list. None related to the dental profession during the year.

"Fitness to practise": PCT notifications and checks

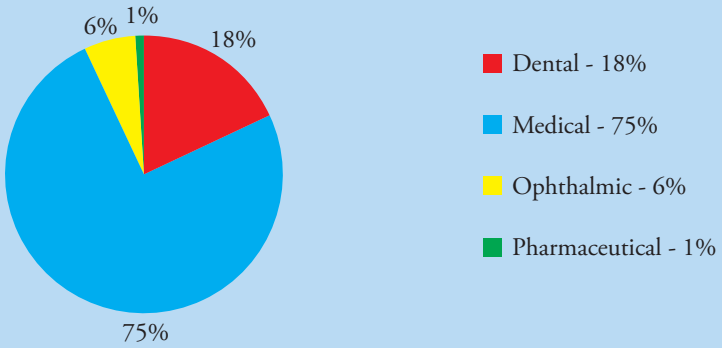
Under the "fitness to practise" provisions of the *Health and Social Care Act 2001*, the Appeal Unit holds a central database for England of regulatory decisions regarding primary care practitioners, notified to it by primary care organisations throughout the United Kingdom. It is vitally important that primary care organisations share information with those NHS bodies and other outside organisations that might employ or contract with a practitioner when they have grounds to take action against that practitioner under these provisions.

In England, a Primary Care Trust is required to share information whenever it makes any decision in relation to any of its lists to refuse admission, to conditionally include, to remove from, to contingently remove from or to suspend a practitioner (or body corporate). During 2006/07, 5 dental, 53 medical and one ophthalmic notification of suspension were received. 84 remained in force at 31st March 2007.

In addition to receiving notification of suspensions, the Appeal Unit received 319 other notifications in 2006/07: 180 concerned removals from lists (a significant proportion of these, however, were for administrative reasons, such as not practising for 12 months in that PCT's area); 28 concerned contingent removal; 47 concerned refusals to include practitioners in lists; and 64 concerned conditional inclusions. The following chart breaks down these notifications by profession:

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

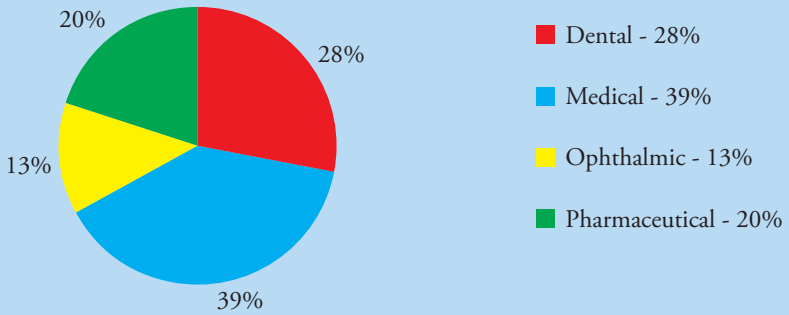
Notifications (other than suspensions) by profession in 2006/07



Following decisions of the tribunal FHSAA, and its predecessor NHS Tribunal, there are currently 45 (36 medical, 7 dental, 2 ophthalmic) performers who have been nationally disqualified from practising in NHS primary care.

During 2006/07, PCTs requested 13,378 checks as to whether there are any restrictions on a particular performer's ability to practise within the NHS. These break down as follows:

Restriction checks by profession 2006/07

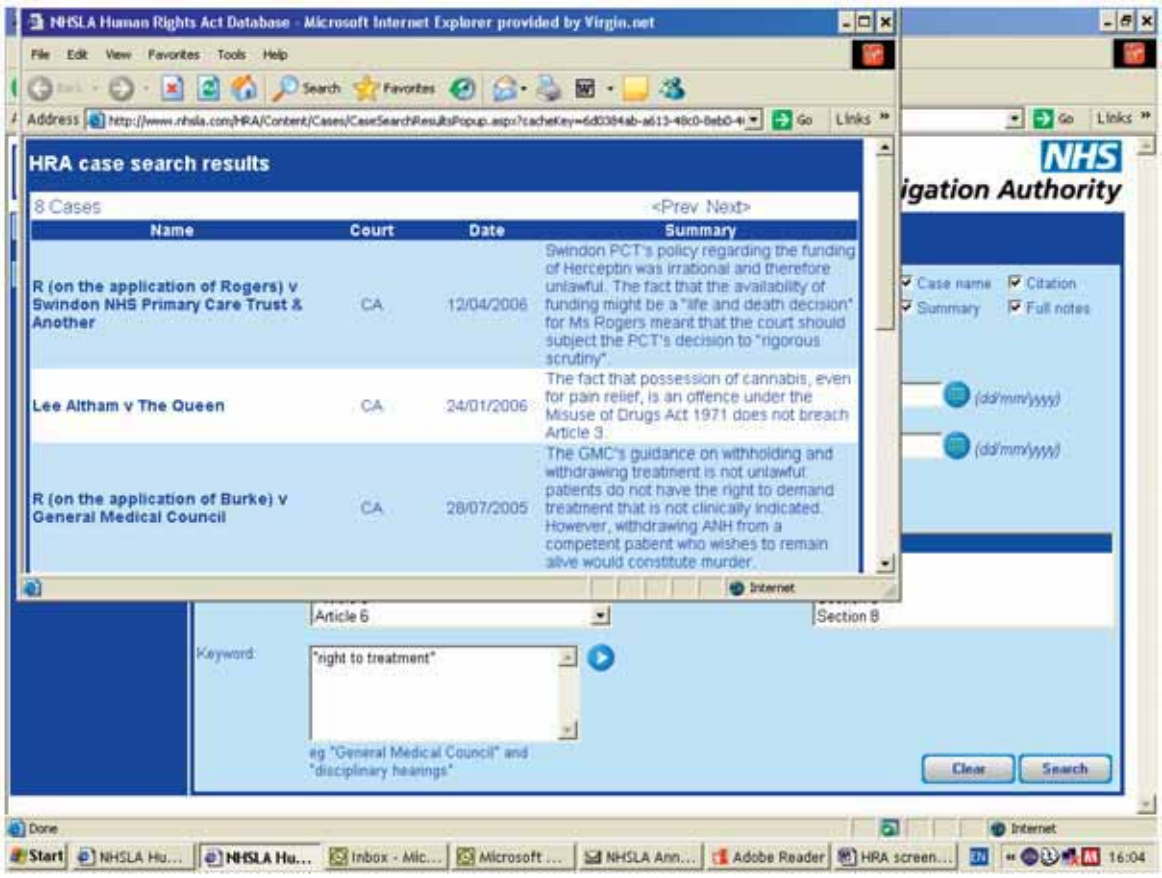


HUMAN RIGHTS ACT INFORMATION SERVICE

In Directions issued in January 2002, the Secretary of State for Health gave the Authority the new function of assisting NHS bodies in England to comply with the *Human Rights Act 1998* by maintaining a database of "relevant cases and information", to which NHS staff should have "uninhibited access". In response, the Authority set up its "Human Rights Act Information Service". The central element of this service is a web-based database (www.nhsla.com/humanrights) to which both NHS colleagues and members of the public have free access. The database currently holds information about almost four hundred human rights cases (both from the English courts and from the European Court of Human Rights in Strasbourg) of particular significance to the NHS. Users of the database can identify relevant cases through keyword or free-text searching; they can then access both a detailed summary of the decision and the full text of the judgement itself.

Katharine Wright
Human Rights specialist

In addition to making the database freely available on the internet, the Information Service produces a quarterly newsletter summarising particularly important cases, which is emailed to around one thousand individuals and can also be accessed via our website. 98% of those responding to a brief electronic survey of newsletter recipients, carried out in December 2006, stated that they found it useful, with 85% noting that they passed it on to at least one other colleague and 24% passing it on regularly to more than five colleagues. The Information Service also produces a series of regularly-updated "case-sheets", which provide brief details of all the important human rights cases in areas such as mental health law, consent and right to treatment.



EQUAL PAY

John Mead
Technical Claims Director

The Litigation Authority has continued to manage claims on behalf of NHS bodies in England. By 31 March 2007, over 13,000 such cases had been recorded, lodged by both trade union retained and non-union solicitors. 75% of trusts and other NHS organisations had signed up for our assistance.

Various test issues are now emerging. Although the pace of litigation has been slower than we originally envisaged, mainly because the Tribunal service has concentrated all administration at one location and because the two main protagonists on the claimant side each have large case loads to tackle, it is likely that several test issues will be heard over the next two years. Many of these will probably in due course proceed to the Employment Appeal Tribunal, and perhaps even higher up the judicial scale, so there will be a measure of uncertainty as to the true legal position applicable to the NHS for the foreseeable future.

We have participated in seminars for trusts across the country and are working closely with our group of recommended defence solicitors and with the Department of Health, who asked us to take on board this project in 2005. The Department's assistance will be critical in defending a major offensive which has been mounted by the leading non-union solicitor, namely an allegation that Agenda for Change is itself discriminatory, partly because it perpetuates pre-existing allegedly discriminatory pay practices.

Unlike our personal injury schemes, this project is not operated on a funded basis, which means that rather than the Authority having a substantial pool of money out of which to pay damages and costs, NHS bodies themselves, as employers, have to meet these expenses. At present, it remains premature to attempt to quantify the potential outlay for the Service, chiefly because the legal test issues have yet to be heard. However, the financial impact upon the NHS, should many of the test issues be lost, could be very adverse indeed.

OUR PEOPLE

David Bell
Head of Human Resources

The people we employ in handling claims and appeals are the face of the Authority for the majority of our contacts, and the services we provide and our reputation depend entirely on their skills and expertise. The Authority is committed to providing a programme of updates for our claim handlers, in partnership with our panel solicitors, on the key developments affecting our work to ensure that this expertise is maintained and developed.

As at 31 March 2007, the Authority employed 145 people (137 whole time equivalents) of whom 122 (115 wte) were directly involved in handling claims or appeals. The remainder were principally involved with risk management and our standards and in providing support services.

Relocation

As part of the Department of Health requirements for Arm's Length Bodies to review and reduce their costs, our Croydon offices were closed during the year. This was inevitably very disruptive for all the people affected, but our services were maintained throughout and every employee was offered the same post in central London, keeping the need for redundancies to an absolute minimum. The teams are now well settled in Holborn. The closure also involved additional work for our IT and facilities teams in decommissioning the Croydon offices to be handed back to the landlord and in managing the move to and reconfiguration of Napier House. Uncertainty about the long-term relocation requirement as part of the review by Sir Michael Lyons continues to be a matter of significant concern to the management team and all our employees.

Agenda for Change

Agenda for Change pay has now been implemented for all the employees affected by the new national NHS terms and conditions. The process of implementing the parallel Knowledge and Skills Framework (KSF) is well underway, with a commitment for all reviews, personal development and objectives to be managed online using the national NHS system e-KSF to streamline and modernise the approach to appraisal and personal development in line with the principles of the national agreement.

Partnership working

During the year, the Authority's employee consultation forums have continued to meet on a regular basis to review and discuss policies, working arrangements, Agenda for Change, relocation and other issues affecting the working lives of our employees.

Equality and diversity

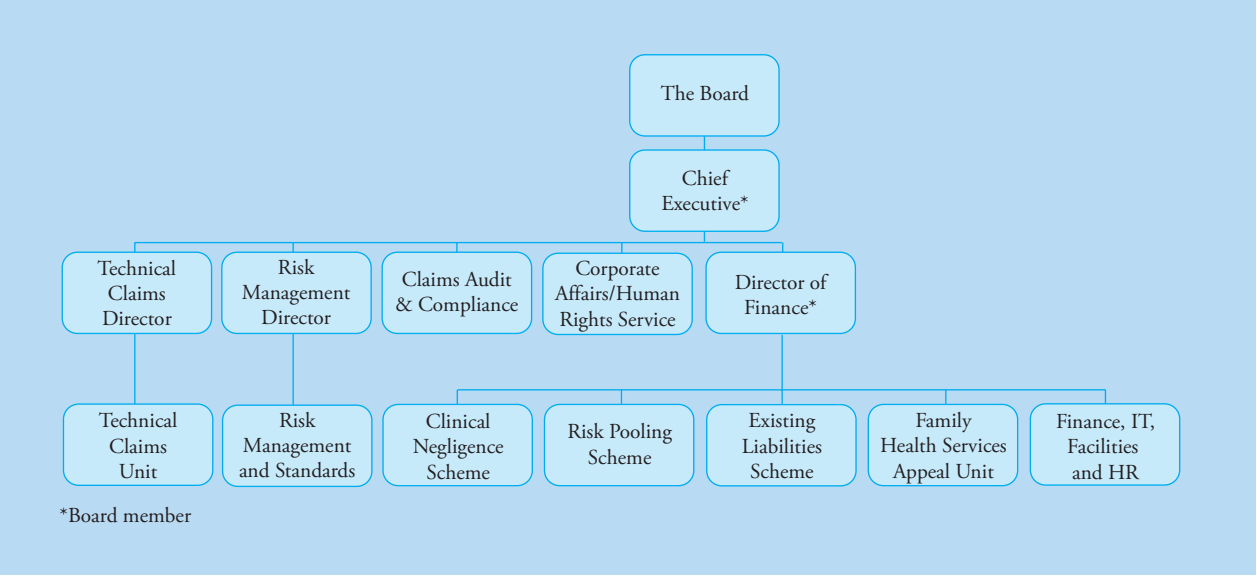
Equality and diversity are of special significance to public bodies like the Authority and during the year the statutory requirements in these areas have been further extended. The key highlight of the year for the Authority has been the development and publication of our single Equality Scheme, covering not only employment issues, but also the delivery of all the Authority's services. The scheme sets out our commitment to equality on the grounds of race, sex, disability, sexual orientation, religious or other belief and age and includes a timetable for review and reporting by the managers responsible for our various schemes and other functions.

The Authority had two equal pay claims at the Employment Tribunal open on 31 March. These are being managed in line with the Authority's advice and support to other NHS organisations throughout England.

Electronic staff record

A project to transfer all our employee data to the national NHS electronic staff record (ESR) HR and payroll system culminated in a successful launch on 1 April 2007, thanks largely to collaboration between our finance team, our external payroll contractor and McKesson, the company commissioned by the Department of Health to develop and manage the system. Our employees and non-executive directors are now all being paid using the system, along with around 700,000 other NHS workers. The use of ESR will also allow for improved reporting and monitoring of employee information by the Authority and the Department of Health directly.

The structure of the Authority at 31 March 2007 is shown below.



ADVISORY GROUPS

Professional Advisory Panel

Acting Chair. Until February 2007

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

Chair. From February 2007

Professor Rod Griffiths	Faculty of Public Health

Members

Professor Sue Bailey	Royal College of Psychiatrists
Dr John Curran	Royal College of Anaesthetists
Ms Frances Day-Stirk	Royal College of Midwives
Dr Patricia Hamilton	Royal College of Paediatrics & Child Health
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
Ms Kellie Norris	Royal College of Nursing
Professor Shaughn O'Brien	Royal College of Obstetricians and Gynaecologists
Dr. John Scarpello	Royal College of Physicians
Mr Peter Sharott	Royal Pharmaceutical Society

The role of the Professional Advisory Panel (PAP) 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. It achieves this in part by commenting on and supporting the review of the NHSLA risk management standards. A functioning PAP also ensures that the Authority has ready access to credible clinical advice.

During 2006 membership of the PAP was reviewed following discussions with the various Colleges and faculties.

The PAP met in September 2006 and more recently in February of this year when Professor Rod Griffiths was appointed as the new Chair. Mr Walker thanked Professor Sir Alan Craft, on behalf of the Authority, for acting as Chair for the past year.

The reconfigured PAP under its new Chair are currently in discussion regarding the future role and direction it should take. Given the emphasis on patient safety and the Chief Medical Officer's commitment to this, the Panel's terms of reference need to be revised. It has been proposed that further work between the NHSLA and the NPSA takes place reviewing claims and incident data in each specialty. Once a particular specialty has been selected, the relevant Royal College or faculty would also be invited to contribute. There is also a need to ensure that the future function of the PAP is more closely aligned to information arising out of claims and this will be reviewed on an on-going basis.

Policy Advisory Group

Chairman

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

Members

Mrs Jacqui Camfield	Legal Services Manager, Royal Surrey County Hospital
Ms Jane Cant	Head of Clinical Risk, Southampton University Hospitals NHS Trust
Ms Jill Moseley	Assistant Director of Clinical Service, 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 NHSLA's *Framework Document,* defines the Policy Advisory Group (PAG)'s role: "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, led by the Chair Dr Drury, have on a continual basis taken a great interest in the work of the Authority and have offered their support on the development and implementation of the revised NHSLA risk management standard for acute trusts. Assessments of acute trusts and independent sector providers will commence in April 2007.

PAG members continue to raise issues concerning future healthcare risks, given advances in technology within the NHS and the expanding input of independent sector providers into NHS care. Such matters are discussed at each meeting and are recorded within the minutes.

During the past year, Mrs Elizabeth Butler, non-executive representative to the Group, tendered her resignation and was replaced for a short period by Mrs Elaine Maxwell, Director of Nursing and Clinical Governance at Barking, Havering and Redbridge Hospitals NHS Trust and visiting Professor of Nursing and Strategic Leadership at London South Bank University, who had to resign from the PAG to accept a secondment to the university.

Mr Andy Morris, Assistant Risk Manager at Calderdale & Huddersfield NHS Trust, also tendered his resignation due to work commitments. Dr Drury thanked these members for their past contributions to the PAG. The PAG has received expressions of interest regarding membership and it is anticipated that two new members will join in June this year.

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 LLP
Beachcroft LLP
Bevan Brittan LLP
Brachers
Browne Jacobson LLP
Capsticks
Eversheds LLP
Hempsons
Hill Dickinson LLP
Kennedys
Ward Hadaway
Weightmans LLP

Non-clinical claims: panel of solicitors

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

Actuaries

Lane, Clark & Peacock LLP

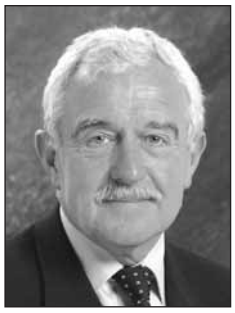
BOARD MEMBERS

The NHSLA is managed by a Board, made up of executive (full-time employees) and non-executive members, chaired since 1 April 2007 by Professor Joan Higgins. 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 Remuneration Report on pages 37 to 39.

Board from 1 April 2007

Professor Dame Joan Higgins
Chair
BA(Hons), Diploma in Social Administration, PhD, DBE
Joan Higgins became Chair of the NHSLA in April 2007. She is a Social Scientist by background and has worked in several Universities, latterly as Professor of Social Policy at the University of Southampton and Professor of Health Policy at the University of Manchester. She has also been a non-executive director in the NHS for the last 26 years. She chaired Manchester Health Authority and Manchester FHSA and was the Regional Chair in the North West. Before joining the NHSLA she was Chair of the Christie NHS Trust, for 5 years. Amongst her current roles she is a member of the QC Appointments Panel and Chair of the Patient Information Advisory Group in the Department of Health. She was awarded the DBE in 2007 for services to healthcare.

Stephen Walker CBE
Chief Executive
MA, LLB (Hons), FCII, JP
Formerly UK Claims Manager in the insurance industry; accredited mediator; member of the Clinical Disputes Forum, the Clinical Negligence and Serious Injuries Committee of the Civil Justice Council, the National Patient Safety Forum and the NPSA Advisory Group on Safety Reporting and Learning.



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.

Brian Capstick
Non-Executive Member
MA Solicitor
Founder and Senior Partner of a solicitors' firm until April 2007. Founded a diploma in clinical risk management in 1993 and the Association of Litigation and Risk Managers ("ALARM") in 1994. Has published extensively on patient safety topics and is a regular speaker at conferences; currently Director of the London office of the European Society for Quality in Healthcare, a charity.

Professor Rory Shaw
Non-Executive Member
Medical Director and latterly Clinical Director for Business Development at the Hammersmith Hospitals NHS Trust for the past 9 years. In September he moves to join the Board of the Royal Berkshire Hospital NHS Foundation Trust as the Chief Medical Officer and Joint Director of Clinical Standards. Professor Shaw has a major interest in clinical quality and patient safety. He was the founding Chairman of the National Patient Safety Agency in 2001. Professor Shaw's clinical and academic area is Respiratory Medicine where he has published extensively on tuberculosis, asthma and lung fibrosis.

Patricia A 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.

Nina Wrightson OBE
Non-Executive Member
Working life began with a career change from the legal profession to HM Factories Inspectorate, which she joined just as the Health and Safety at Work etc Act was being introduced. In 1998 she was appointed Regional Safety Adviser for the Government Office in Yorkshire and Humberside and then went into private industry as a Safety Manager with Nestle UK. Latterly she has been Risk Management Director for Northern Foods plc.

She was President of the Institution of Occupational Safety and Health in 1998/99 and has sat on the CBI and FDF Health and Safety Panels. Currently she is Chairman of the British Safety Council; Chairman of RoSPA's National Occupational Health and Safety Committee and a non-executive Director of Yorkshire Ambulance Service NHS Trust.

Board at 31 March 2007

Ron Bradshaw, Chairman
Dr Carole Kaplan, Deputy Chair
Mehmuda Mian Pritchard, Non-Executive Member
Patricia A Steel OBE, Non-Executive Member
Stephen Walker, Chief Executive
Tom Fothergill, Director of Finance

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.

These financial statements have been prepared according to an accounts direction issued by the Secretary of State with the approval of HM Treasury.

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 £691.5m, which represents a reported decrease of £487m on the figure for the previous year which is mainly due to a one off increase in provisions recorded in last year's accounts as a result of a change in the Discount Rate applied to provisions as at 1st April 2005.

The Authority's net Operating Costs are required to be managed within a Revenue Resource Limit (RRL) agreed with the Department of Health. For 2006/07 the agreed RRL was £700.9m; thus an under spend of £9.4m 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, 76.4% (2005/2006 80.5%), representing 85.7% (2005/2006 90.1%) 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 2006/07 the Authority had a revenue cash limit of £105.5m which was utilised during the year thus reporting a break even position. Capital limits for the year were £280,000 with reported outturn at £149,000 showing an under spend of £131,000.

The balance sheet as at 31 March 2007 shows net liabilities of £9.18billion. 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 predominantly 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, including their associated legal costs.

The Operating Cost Statement quotes a value of £59.6m 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 decrease in cash balances held at the year end (£82.2m compared to £85.9m in 2005/06). Essentially this cash position relates to contributions collected for the Clinical Negligence Scheme for Trusts (CNST) which were not utilised in 2006/07. 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 2007/08 was adjusted to recognise that these cash balances had accumulated.

During 2006/07 the Authority closed its Croydon office and transferred all functions back to its London location. This closure was effected due to the Authority's commitment to demonstrate operational efficiency in managing its estate and was agreed as part of the ongoing cross Government Gershon Review now managed under the Arm's Length Body Review banner.

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 arm of the 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 performance during 2006/07 is shown below:

Regulations/Directions	Target time to settle (weeks)	% within target	Average time taken to settle (weeks)
Pharmacy Regulations 2005/1992			
Summary	4	100%	2
On the papers	15	98%	12
Oral hearing	26	91%	23
Performers Lists Regs			
On the papers	15	100%	9
Medical Regs 2004 ("GMS/PMS")			
On the papers	15	100%	11
Oral hearing	26	100%	23
Dental Regs 2005 ("GMS/PMS")			
On the papers	15	90%	13
GP Registrar 2003			
Salaries	4	100%	1
Representations	15	100%	9
Statement of Fees & Allowances	26	100%	11
Vocational Training 1992	26	100%	16

Government Reviews

The Authority remains committed to its participation in 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. As part of the ALB Review, the Authority has merged with the FHSAA and lived within the financial targets set by the review team.

Forward look

During 2007/08 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 notification 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 2007/08 the Court of Appeal will consider what should be the appropriate index to be applied to damages for future care which are to be paid under a Periodical Payments Order (PPO). The issue arises from section 2(8) and section 2(9) of the Damages Act, 1996. Section 2(8) stipulates that future variation of payments will be based on RPI, but section 2(9) allows judicial discretion to use an alternative index if thought appropriate after hearing the evidence in a particular case. In Thompstone v Thameside & Glossop Acute Services NHS Trust, Swift J concluded that ASHE6115, which is based on the earnings of care assistants and home carers, was more appropriate. We understand that the Court wishes to hear more than one case, possibly to include insurance or similarly funded Employer's Liability and Road Traffic Act matters. Until this decision is received the Authority will continue to value all provisions regarding cases yet to be settled using the standard index of RPI as this has been the preferred, indeed only, relevant index used for structured settlements and PPOs to date.

The decision in Thompstone will, it is hoped, lead to clarity as to which elements of damages, if any, may be subject to a different index and what that index might be amongst other legal issues and this may lead to a revision of the provisions held by the Authority for all claims which might be affected by that clarification. A note identifying this potential has therefore been inserted into the accounts of the Authority at page 63 of this report.

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 until 2008/09 and has also stipulated maximum headcount for the same periods. These targets have been set with the agreement of the Board of the Authority.

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 2006/07 were:

Dr C Kaplan	Chairman of the Committee and Deputy Chairman of the Authority
Mr R Bradshaw	Chairman of the Authority
Ms M Mian Pritchard	Non Executive Director
Miss P A Steel	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.

Below are the contractual, salary and pension details of those senior managers who had control over the major activities of the Authority during 2006/07. This information has been audited.

Salaries and allowances

	2006/07			2005/06		
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	20 – 25	60 *	150 – 155	N/A	62*
Tom Fothergill *(Director of Finance)*	115 – 120	20 – 25	65 *	115 – 120	N/A	58*
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
Patricia A Steel *(Non-Executive)*	10 – 15	N/A	N/A	5 – 10	N/A	N/A

*Benefits in kind relate solely to lease cars.

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.

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 2007 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2007 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2007	Cash Equivalent Transfer Value at 31 March 2006	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	2.5 – 5	50 – 52.5	150 – 152.5	0**	0	N/A	152
Tom Fothergill *(Director of Finance)*	0 – 2.5	2.5 – 5	20 – 22.5	62.5 – 65	234	207	22	152
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
Patricia A 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.

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 four times in 2006/07 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 2006/07 were Patricia Steel (Chair), Carole Kaplan and Mehmuda Mian Pritchard.

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 four times in 2006/07 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 an Equality Scheme.

Comments and complaints

The Authority received just one complaint in 2006/07 (two in 2005/06), excluding correspondence about the management of particular claims files.

Freedom of information

The Authority handled 142 requests for information under the *Freedom of Information Act 2000* in 2006/07, of which 93.7% received substantive responses within the 20 days prescribed by the Act and 100% were dealt with within 30 days.

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; and the Accounting Officer has taken all the steps he ought to establish that the entity's auditors are aware of the information.

Pension Liabilities

NHSLA employees are covered by the provision of the NHS Pension Scheme. Details of the scheme are given in note 1.7 of the accounts. The senior managers pension liabilities are disclosed within the Remuneration Report.

Stephen Walker
Chief Executive

11th July 2007

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THIS SPECIAL HEALTH AUTHORITY

Under the National Health Service Act 2006, the Secretary of State has directed the NHS Litigation Authority to prepare for each financial year a statement of accounts in the form and on the basis directed by the Secretary of State, with the approval of HM Treasury. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS Litigation Authority at the year end and of its net operating cost, recognised gains and losses and cash flows for the financial year.

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

- observe the accounts direction issued by the Secretary of State, with the approval of HM Treasury, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgments and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- prepare the financial statements on the going concern basis unless it is inappropriate to presume that the NHS Litigation Authority will continue in operation; and

The Accounting Officer for the Department of Health has appointed the Chief Executive as Accounting Officer of the NHS Litigation Authority. The responsibilities of an Accounting Officer, including responsibility for the propriety and regularity of the public finances for which the Accounting Officer is answerable, and for the keeping of proper records and for safeguarding the NHS Litigation Authority's assets, are set out in the Accounting Officers' Memorandum issued by the Treasury and published in Government Accounting.

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 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 2007 and up to the date of approval of the annual report and accounts. Internal audit were able to provide significant assurance that there is generally a sound system of internal control within the Authority although they have identified some areas which can be improved which will be addressed during 2007/08.

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 provided significant assurance that there is generally a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. 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 2006/07 the Risk Management Committee monitored implementation of the action plans arising from reviews of Health and Safety risks within the organisation and then carried out a review of these risks in the final quarter of the financial year. 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.

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 2006/07.

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

11th July 2007

THE CERTIFICATE AND REPORT OF THE COMPTROLLER AND AUDITOR GENERAL TO THE HOUSES OF PARLIAMENT

I certify that I have audited the financial statements of the NHS Litigation Authority for the year ended 31 March 2007 under the National Health Service Act 2006. These comprise the Operating Cost Statement, the Balance Sheet, the Cashflow Statement and Statement of Recognised Gains and Losses and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Chief Executive and auditor

The Chief Executive as Accounting Officer is responsible for preparing the Annual Report, which includes the Remuneration Report, and the financial statements in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury and for ensuring the regularity of financial transactions. These responsibilities are set out in the Statement of Chief Executive's Responsibilities.

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

I report to you my opinion as to whether the financial statements give a true and fair view and whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury. I report to you whether, in my opinion, certain information given in the Annual Report, which includes the Management Commentary and the Remuneration Report, is consistent with the financial statements. 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.

In addition, I report to you if the NHS Litigation 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 HM Treasury regarding remuneration and other transactions is not disclosed.

I review whether the Statement on Internal Control reflects the NHS Litigation Authority's compliance with HM Treasury's guidance, and I report if it does not. I am not required to consider whether this statement covers all risks and controls, or form an opinion on the effectiveness of the NHS Litigation 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. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

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

Audit Opinion

In my opinion:

- the financial statements give a true and fair view, in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury, of the state of the NHS Litigation Authority's affairs as at 31 March 2007 and of its net resource outturn, recognised gains and losses and cashflows for the year then ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the National Health Service Act 2006 and directions made thereunder by the Secretary of State with the approval of HM Treasury; and
- the information given within the Annual Report, which includes the Management Commentary and the Remuneration Report, is consistent with the financial statements.

Audit Opinion on Regularity

In my opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report

I have no observations to make on these financial statements.

John Bourn
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London SW1W 9SP

12th July 2007

FINANCIAL ACCOUNTS

Operating Cost Statement for the year ended 31 March 2007

	Notes	2006/07 £000	2005/06 £000
Programme costs			
Authority and claims administration	2.4	**14,212**	13,445
Unwinding of discounts	2.1	**59,555**	37,359
Change in Discount Rate (1 April 2005)	2.4	**0**	634,867
Other claims and associated costs	2.1	**1,433,198**	1,261,339
	2.4	**1,492,753**	1,933,565
Cost of capital	2.1, 2.4	**(308,719)**	(269,457)
Total programme costs	2.1	**1,198,246**	1,677,553
Operating income	4	**(506,768)**	(498,917)
Net operating cost		**691,478**	1,178,636
Net resource outturn	3.1	**691,478**	1,178,636

All income and expenditure is derived from continuing operations

Statement of Recognised Gains and Losses for the year ended 31 March 2007

		2006/07 £000	2005/06 £000
Unrealised surplus/(deficit) on the indexation of fixed assets	5.2, 11.2	**5**	4
Recognised gains and (losses) for the financial year		**5**	4

The notes at pages 51 to 65 form part of these accounts.

Balance Sheet as at 31 March 2007

	Notes	31 March 2007 £000	31 March 2006 £000
Fixed assets:			
Intangible assets	5.1	**49**	84
Tangible assets	5.2	**999**	1,192
		1,048	1,276
Current assets:			
Debtors	6	**27,717**	8,077
Cash at bank and in hand	7	**82,244**	85,870
		109,961	93,947
Creditors: amounts falling due within one year	8	**(70,234)**	(39,545)
Net current assets/(liabilities)		**39,727**	54,402
Total assets less current liabilities		**40,775**	55,678
Provisions for liabilities and charges	9	**(9,224,459)**	(8,344,980)
		(9,183,684)	(8,289,302)
Taxpayers' equity			
General Fund	11.1	**1,112**	856
Revaluation reserve	11.2	**53**	48
ELS Reserve	11.3	**(1,414,538)**	(1,404,895)
ExRHA Reserve	11.4	**(27,794)**	(28,377)
CNST Reserve	11.5	**(7,627,109)**	(6,734,452)
PES Reserve	11.6	**2,886**	2,641
LTPS Reserve	11.7	**(118,294)**	(125,123)
		(9,183,684)	(8,289,302)

The financial statements on pages 48 to 65 were approved by the Board on 6th July 2007 and signed by Stephen Walker

The notes at pages 51 to 65 form part of these accounts.

Accounting Officer

11th July 2007

Cash Flow Statement for the year ended 31 March 2007

	Notes	2006/07 £000	2005/06 £000
Net cash (outflow) from operating activities	12	**(109,180)**	(95,053)
Capital expenditure and financial investment:			
(Payments) to acquire intangible fixed assets	5.1	**(5)**	0
(Payments) to acquire tangible fixed assets	5.2	**(233)**	(182)
Net cash inflow/(outflow) from investing activities		**(238)**	(182)
Net cash (outflow) before financing		**(109,418)**	(95,235)
Financing			
Net Parliamentary funding	11.1, 11.3, 11.4	**105,792**	159,222
Increase/(decrease) in cash in the period	7	**(3,626)**	63,987

The notes at pages 51 to 65 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 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 2006/2007 was 3.5% (2005/06 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;
- 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 irrespective of their individual or collective cost.

(b) Valuation

Intangible fixed assets

Intangible fixed assets held for operational use are valued at historical cost. 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, other than IT equipment which is considered to have nil inflation, is valued at net current replacement cost through annual uplift by the change in the value of the GDP deflator. Equipment surplus to requirements is valued at net recoverable amount.

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

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

	Years
Furniture and fittings	10
Information technology	5

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 Secretary of State, in England and Wales. As a consequence it is not possible for the Special Health Authority to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme and the cost of the scheme is equal to the contributions payable to the scheme for the accounting period.

The Scheme is subject to a full valuation for FRS17 purposes every four years. The last valuation on this basis took place as at 31 March 2003. The scheme is also subject to a full valuation by the Government Actuary to assess the scheme's assets and liabilities to allow a review of the employer's 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 Business Service Authority – Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

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

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

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

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 FRS 12. A provision for these schemes is calculated in accordance with FRS 12 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 2007 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 Liabilities 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 FRS 12.

Incidents Incurred but not reported (IBNR)

FRS 12 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 2007 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	2006/07 £000	2005/06 £000
Non-executive members' remuneration	2.2		**52**	47
Other salaries and wages	2.2		**7,870**	7,144
Supplies and services – general			**8**	6
Establishment expenses			**798**	743
Hire and operating Lease Rental			**1,034**	991
Transport and moveable plant			**2**	16
Premises and fixed plant			**813**	1,088
External contractors				
Actuary's advice			**154**	173
Risk Management			**2,486**	2,485
Other			**364**	191
Miscellaneous			**18**	14
Capital: Depreciation and amortisation	5.1, 5.2	**401**		415
Impairments	5.1, 5.2	**0**		0
Capital charges interest		**(308,719)**		(269,457)
(Profit)/loss on disposal	5.3	**88**		8
			(308,230)	(269,034)
Other finance costs – unwinding of discount	9		**59,555**	37,359
– change in discount rate	2.4			634,867
Auditor's remuneration: audit fees			**85**	85
Auditor's remuneration: other fees *				0
Internal audit fees			**39**	39
Increase in provision for known claims (excl. unwinding of discounts)	2.4		**1,029,198**	880,564
Increase/(decrease) in the provision for IBNR	2.4, 9		**404,000**	380,775
			1,198,246	1,677,553

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

2.2 Staff numbers and related costs

	2006/07 Total £000	Permanently employed staff £000	Other £000	2005/06 £000
Salaries and wages	**6,565**	6,263	302	5,975
Social security costs	**582**	582		500
Employer contributions to NHSPA	**775**	775		716
	7,922	**7,620**	**302**	7,191

The average number of employees during the year was:

	Total Number	Permanently employed staff Number	Other Number	2005/06 Number
Total	**153**	141	12	167

Redundancy Costs

The cost to the NHSLA of redundancies in 2006/07 was £10,800 (2005/06: £0)

Expenditure on staff benefits
The amount spent on staff benefits during the year mainly on lease cars totalled £40,850 (2005/06: £44,922).

Retirements due to ill-health
During 2006/07 there was 1 (2005/06: 0) early retirement from the NHS Litigation Authority on the grounds of ill-health, at an additional cost of £100,676.25 (2005/06: £0). This information has been supplied by NHS Pensions.

2.3 Better Payment Practice Code – measure of compliance

	2006/07		2005/06	
	Number	**£000**	Number	£000
Total non NHS bills paid	**23,048**	**631,915**	22,022	641,135
Total non NHS bills paid within target	**17,602**	**541,332**	17,736	577,526
Percentage of non NHS bills paid within target	**76.4%**	**85.7%**	80.5%	90.1%

	Number	**£000**	Number	£000
Total NHS bills paid	**121**	**5,862**	130	3,841
Total NHS bills paid within target	**103**	**5,270**	119	3,541
Percentage of NHS bills paid within target	**85.1%**	**89.9%**	91.5%	92.2%

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.

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	**ELS**	**CNST**	**PES**	**LTPS**	**Equal Pay**	**FHSAU**	**Total**	2005/06 Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	£000
Expenditure									
Authority and claims administration	**59**	**1,130**	**7,523**	**210**	**3,806**	**139**	**1,345**	**14,212**	13,445
Claims and associated costs									
Increase/(decrease) in provision for known claims	**4,211**	**220,730**	**832,711**	**2,357**	**28,744**	**0**	**0**	**1,088,753**	917,923
Increase/(decrease) in the Provision for IBNR	**(3,000)**	**(110,000)**	**510,000**	**0**	**7,000**	**0**	**0**	**404,000**	380,775
Change in Discount Rate	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	634,867
	1,211	**110,730**	**1,342,711**	**2,357**	**35,744**	**0**	**0**	**1,492,753**	1,933,565
Cost of capital	**(912)**	**(75,952)**	**(212,479)**	**(2,163)**	**(16,483)**	**(68)**	**(662)**	**(308,719)**	(269,457)
	358	**35,908**	**1,137,755**	**404**	**23,067**	**71**	**683**	**1,198,246**	1,677,553
Income									
Scheme income	**0**	**0**	**(457,577)**	**(2,812)**	**(46,379)**	**0**	**0**	**(506,768)**	(498,917)
Net Operating Cost – (surplus)/deficit	**358**	**35,908**	**680,178**	**(2,408)**	**(23,312)**	**71**	**683**	**691,478**	1,178,636

3.1 Reconciliation of net operating cost to net resource outturn

	2006/07	2005/06
	£000	£000
Net operating cost	**691,478**	1,178,636
Net resource outturn	**691,478**	1,178,636
Revenue resource limit	**700,901**	1,383,962
(Over)/under spend against revenue resource limit	**9,423**	205,326

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2006/07	2005/06
	£000	£000
Gross capital expenditure	**238**	182
NBV of assets disposed	**(89)**	(7)
Net capital resource outturn	**149**	175
Capital resource limit	**280**	280
(Over)/under spend against limit	**131**	105

4 Operating income

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

	Appropriated in aid	2005/06
	£000	£000
Programme income:		
CNST contributions	457,577	468,267
PES contributions	2,812	2,480
LTPS contributions	46,379	28,170
Total	**506,768**	**498,917**

5.1 Intangible fixed assets

	Software licences	Total
	£000	£000
Gross cost at 31 March 2005	467	467
Additions – purchased	5	5
Gross cost at 31 March 2007	**472**	**472**
Accumulated amortisation at 31 March 2006	383	383
Charged during the year	40	40
Accumulated amortisation at 31 March 2007	**423**	**423**
Net Book Value at 31 March 2006	84	84
Net Book Value 31 March 2007	**49**	**49**

5.2 Tangible fixed assets

	Information technology	Furniture & fittings	Total
	£000	**£000**	**£000**
Cost or valuation at 31 March 2006	1,985	371	2,356
Additions - purchased	176	57	233
Indexation	0	9	9
In-year transfers to/from NHS bodies	19	0	19
Disposals	(223)	(186)	(409)
Gross cost at 31 March 2007	**1,957**	**251**	**2,208**
Accumulated depreciation at 31 March 2006	945	219	1,164
Charged during the year	322	39	361
Indexation	0	4	4
Disposals	(223)	(97)	(320)
Accumulated depreciation at 31 March 2007	**1,044**	**165**	**1,209**
Net Book Value at 31 March 2006	1,040	152	1,192
Net Book Value at 31 March 2007	**913**	**86**	**999**

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 31/03/07 (2005/06: 0).

5.3 Profit/(loss) on disposal of fixed assets

	2006/07	2005/06
	£000	£000
(Loss) on disposal of plant and equipment	**(88)**	(8)
	(88)	(8)

6 Debtors

Amounts falling due within one year

	2006/07	2005/06
	£000	£000
NHS debtors	**24,889**	4,542
Accrued Income	**–**	12
Prepayments	**1,897**	1,380
Other debtors	**931**	2,143
	27,717	8,077

7 Analysis of changes in cash

	At 31 March 2006	**Change during the year**	**At 31 March 2007**
	£000	**£000**	**£000**
Cash at OPG	85,870	**(3,626)**	**82,244**

8 Creditors:

Amounts falling due within one year

	2006/07	2005/06
	£000	£000
NHS creditors	**4**	1,310
Tax and social security	**163**	247
Accruals	**69,982**	37,988
Other creditors	**85**	0
	70,234	39,545

9 Provisions for liabilities and charges

	Ex RHA Scheme	ELS Scheme	CNST Scheme	PES Scheme	LTPS Scheme	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
At 31 March 2006	**(28,707)**	**(1,402,137)**	**(6,788,608)**	**(8,989)**	**(116,539)**	**(8,344,980)**
Discounting	(3,179)	214,725	202,458	0	186	**414,190**
Arising during the year	(4,961)	(563,949)	(1,264,018)	(4,003)	(49,803)	**(1,886,734)**
Utilised during the year	1,794	153,246	424,351	4,186	29,697	**613,274**
Reversed unused	4,456	172,343	244,011	1,646	20,890	**443,346**
Unwinding of discount	(527)	(43,849)	(15,162)	0	(17)	**(59,555)**
Movement in Net IBNR	3,000	110,000	(510,000)	0	(7,000)	**(404,000)**
At 31 March 2007	**(28,124)**	**(1,359,621)**	**(7,706,968)**	**(7,160)**	**(122,586)**	**(9,224,459)**
Expected timing of cash flows:						
Within 1 year	(10,386)	(299,893)	(662,810)	(7,160)	(53,832)	**(1,034,081)**
1-5 years	(2,560)	(388,104)	(1,953,734)	0	(39,754)	**(2,384,152)**
Over 5 years	(15,178)	(671,624)	(5,090,424)	0	(29,000)	**(5,806,226)**
	(28,124)	**(1,359,621)**	**(7,706,968)**	**(7,160)**	**(122,586)**	**(9,224,459)**

10 Movements in working capital other than cash

	2006/07	2005/06
	£000	£000
Increase/(decrease) in debtors	**19,640**	68
(Increase)/decrease in creditors	**(30,689)**	(10,706)
	(11,049)	(10,638)

11 Movements on reserves

11.1 General Fund

	2006/07
	£000
Balance at 31 March 2006	**856**
Transferred Assets	19
Net operating costs for the year	(754)
Capital charge interest	(731)
Net Parliamentary funding	1,722
Balance at 31 March 2007	**1,112**

11.2 Revaluation reserve

	£000
Balance at 31 March 2006	**48**
Indexation of fixed assets	5
Balance at 31 March 2007	**53**

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

	2006/07 £000
Balance at 31 March 2006	**(1,404,895)**
Transfer from Operating Cost Statement	(35,908)
Capital charge interest	(75,952)
Net Parliamentary funding	102,217
Balance at 31 March 2007	**(1,414,538)**

11.4 The movement on the ExRHA Reserve in the year comprised:

	2006/07 £000
Balance at 31 March 2006	**(28,377)**
Transfer from Operating Cost Statement	(358)
Capital charge interest	(912)
Net Parliamentary funding	1,853
Balance at 31 March 2007	**(27,794)**

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

	2006/07 £000
Balance at 31 March 2006	**(6,734,452)**
Transfer from Operating Cost Statement	(680,178)
Capital charge interest	(212,479)
Balance at 31 March 2007	**(7,627,109)**

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

	2006/07 £000
Balance at 31 March 2006	**2,641**
Transfer from Operating Cost Statement	2,408
Capital charge interest	(2,163)
Balance at 31 March 2007	**2,886**

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

	2006/07 £000
Balance at 31 March 2006	**(125,123)**
Transfer from Operating Cost Statement	23,312
Capital charge interest	(16,483)
Balance at 31 March 2007	**(118,294)**

12 Reconciliation of operating costs to operating cash flows

	Notes	2006/07 £000	2005/06 £000
Net operating cost		**(691,478)**	(1,178,636)
Adjustments for non-cash transactions	2.1	**(308,230)**	(269,034)
Adjustments for movements in working capital other than cash	10	**11,049**	10,638
Increase/(decrease) in provisions	9	**879,479**	1,341,979
Net cash outflow from operating activities		**(109,180)**	**(95,053)**

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 2006/07	**8,493**	**561,216**	**4,065,801**	**3,751**	**66,504**	**4,705,765**
Contingent liability for claims 2005/06	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.

Damages for future care

In November 2006 a decision of Mrs. Justice Swift in Thompstone vs. Tameside & Glossop Acute Services NHS Trust held that the periodical payment regime which will fund the severely disabled claimant's future care should be linked not to the Retail Prices Index (RPI), as all such arrangements had been until then, but rather to a sub-set of the Annual Survey of Hours and Earnings (ASHE).

This decision was appealed by the Authority and is now scheduled to be heard in the Court of Appeal during November 2007. If the original decision is upheld there may be significant financial implications for the Thompstone case and any other cases where an alternative to RPI is sought by the claimants.

The Authority is hopeful that the judgment of the Court of Appeal will assist its understanding of the law on this matter and also enable the likely cost implications, if any, to be clarified thus enabling any other affected claims to be revalued accordingly.

14 Commitments under operating leases

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.

		2006/07 £000	2005/06 £000
Land and buildings			
Operating leases which expire:	within 1 year		163
	between 1 and 5 years		0
	after 5 years	**736**	736
		736	899
Other leases			
Operating leases which expire:	within 1 year	**2**	19
	between 1 and 5 years	**108**	19
	after 5 years		0
		110	38

15 Losses and special payments

There was 1 case of loss and special payments (Prior year: 2 cases) totalling £25,000 (Prior year £1,783) approved during 2006/07.

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**	**Expenditure**	**Provision**
	£'000	**£'000**	**£'000**
All English Strategic Health Authorities	21		815,924
All English NHS Trusts and PCTs	516,662	5,949	2,475,196
NHS Blood and Transplant	451	30	600
The National Patient Safety Agency	12		13
NHS Business Services Authority	370		273
NHS Appointments Commission	4		0
Health Protection Agency	188		902
NHS Institute			0
NHS Direct	3		166
NHS Professionals			30
NHS Pensions Agency		1,121	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 £404m (2005/06 £381m).

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 gross cost to the Authority for the employment of Dr Kaplan was £8,371 in 2006/07.

17 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.

18 Intra-government balances

	Debtors: Amounts falling due within one year £000	Creditors Amounts falling due within one year £000
Balances with other central government bodies	856	163
Balances with local authorities	0	0
Balances with NHS Trusts	24,889	4
Balances with public corporations and trading funds	0	0
Balances with bodies external to government	1,972	70,067
At 31 March 2007	**27,717**	**70,234**
Balances with other central government bodies	2,090	247
Balances with local authorities	0	0
Balances with NHS Trusts	4,478	1,310
Balances with public corporations and trading funds	0	0
Balances with bodies external to government	1,509	37,988
At 31 March 2006	8,077	39,545

There are no debtors or creditors falling due after more than one year.

19 Post Balance Sheet Events

These financial statements were authorised for issue on 19th July 2007 by the Accounting Officer.

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