Annual Review

NHS Litigation Authority
Report and accounts 2013/14

Supporting the NHS

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Contents

At the beginning of the year, we welcomed new colleagues from the National Clinical Assessment Service (NCAS) and the smooth transition is a tribute to the professionalism of everyone involved.

Ian Dilks , Chair

Chair's welcome

The past year has seen continuing change and successful innovation

This is my first report as Chair of the NHS Litigation Authority (NHS LA) following my appointment on 1 April 2014.

The past year has been one of continuing significant change for the NHS LA, taking on new activities and promoting innovation in accordance with our strategic aims to enhance the service we provide to our members – NHS Trusts, Clinical Commissioning Groups (CCGs) and independent healthcare providers to the NHS.

At the beginning of the year, we welcomed new colleagues from the National Clinical Assessment Service (NCAS) and the smooth transition is a tribute to the professionalism of everyone involved. This report highlights the considerable progress that has already been made in looking at how we are working together to further improve patient safety and increase organisational effectiveness.

One key development was the introduction a new extranet service which was rolled out to our members during the year. This provides them with real time access to their claims data together with safety and learning materials, helping them to use the information to reduce patient harm and thereby reduce their claims. This innovative tool, which has received considerable positive feedback, should contribute significantly to improving patient safety. We were delighted that the extranet was selected as a finalist for the British Legal Award for innovation.

We were also nominated for the Government Opportunities (GO) Excellence in Public Procurement Award for our legal tender exercise. This project not only reduced our own legal defence costs but also has enabled other Arm's Length Bodies of the Department of Health to benefit significantly from access to quality legal services at competitive fee rates.

Membership of the Board changed significantly last year. My predecessor as Chair, Professor Dame Joan Higgins, stepped down at the end of 2013 after six years of service. I would like to pay tribute to her many years of dedication and commitment to the NHS and, latterly, to the NHS LA. Her steady and determined leadership has helped transform the organisation into what it is today.

I would also like to thank Nina Wrightson, our deputy Chair, for ably acting as the interim Chair prior to my appointment. Keith Ford retired from the Board and as Chair of the Audit and Risk Committee at the end of his term of office. I take this opportunity to thank Keith for his contributions to the Board and skilful chairing of the Audit and Risk Committee. We were delighted to welcome Andrew Hauser as his successor and Ros Levenson, another new Non-Executive, to further strengthen Board membership.

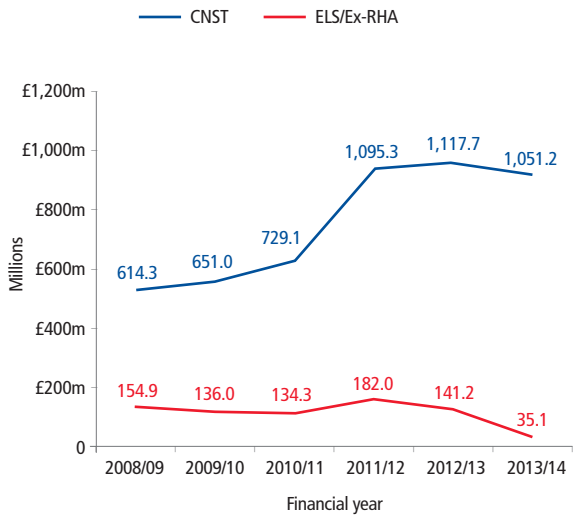
In 2011 the Department of Health asked the well known insurance broker Marsh to review the NHS LA and to make recommendations for improvement where warranted. I am delighted to see the positive approach taken by management to address all the points raised; our response to the Marsh report is available on our website: nhsla.com

The NHS LA was established in 1995 to 'robustly' defend actions against the NHS, but where negligence was proven, to settle actions 'efficiently'. These objectives have not changed but the environment in which we operate has, including a constantly increasing workload. In consultation with our staff, we have set a new and challenging vision for the organisation underpinned by core values that define the way we do our business. I fully expect that the calibre and commitment of our staff, and our skilled leadership mean that we will deliver on this vision and continue to enhance the service to our members.

Ian Dilks
Chair

The year in

Figure 1: Expenditure on clinical claims



The figures exclude £106.2m of expenditure incurred on claims which transferred to the Department of Health on 1 April 2013 as a result of the restructure of the NHS.

Figure 2: Clinical negligence expenditure including interim payments 2013/14

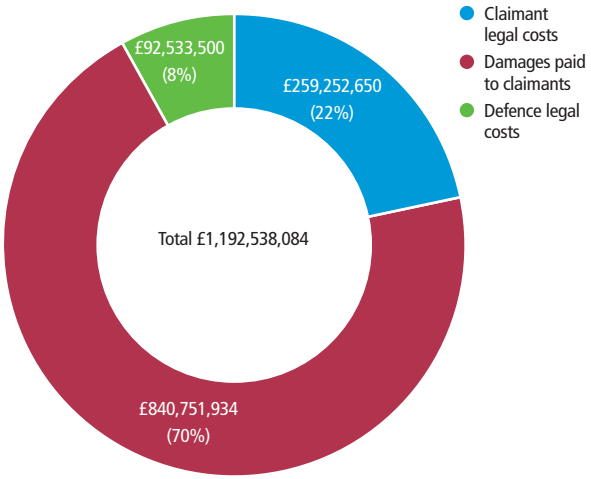
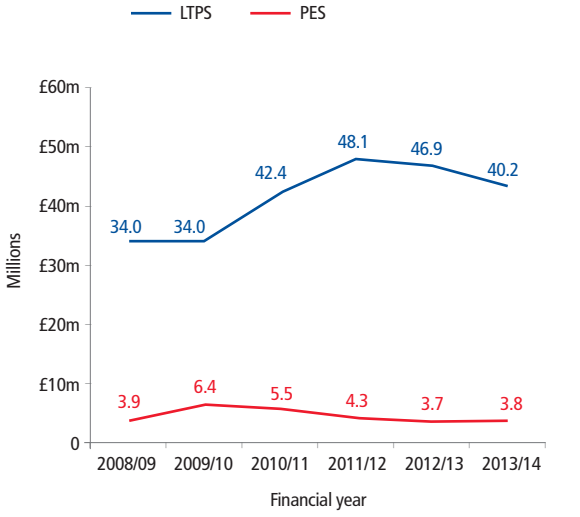
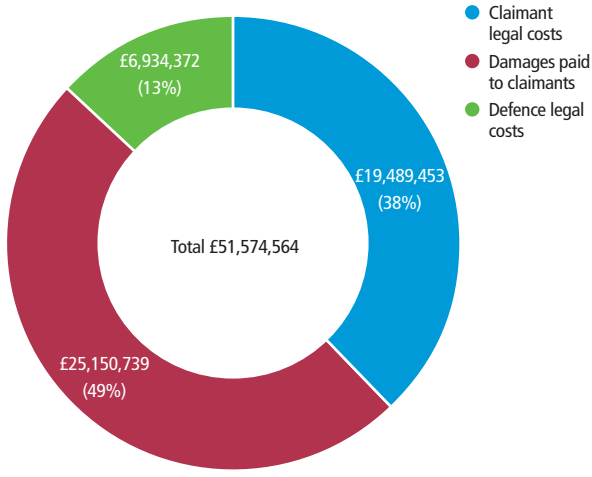


Figure 5: Expenditure on non-clinical claims



The figures exclude £7.5m of expenditure incurred on non-clinical claims which transferred to the Department of Health on 1 April 2013 as a result of the restructure of the NHS.

Figure 6: Non-clinical expenditure 2013/14 including interim payments



summary

Figure 3: Clinical negligence expenditure including interim payments in 2012/13

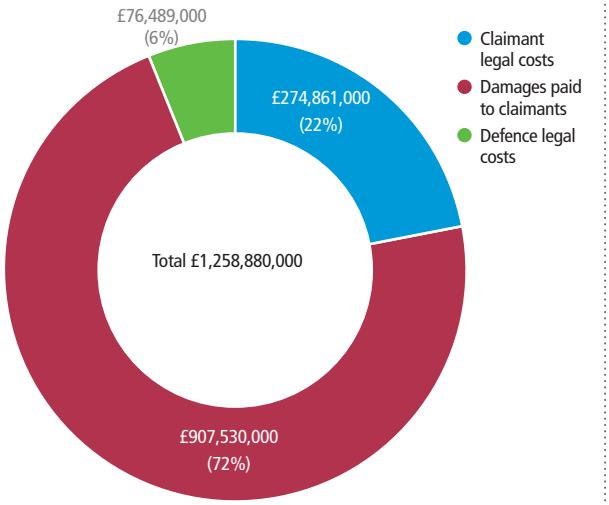
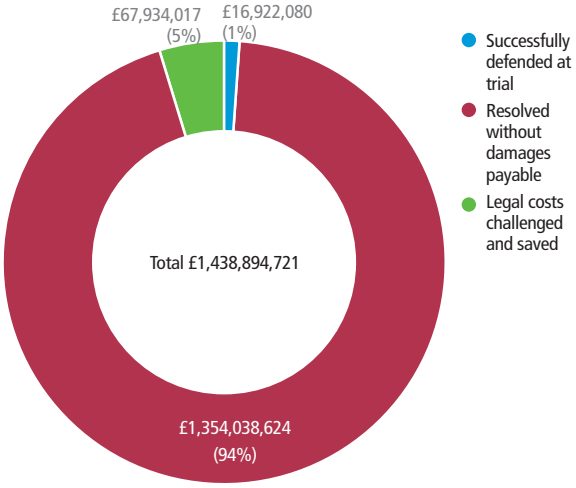


Figure 4: Damages and costs saved in clinical negligence claims resolved in 2013/14



Excludes reductions in settlement values negotiated by the NHS LA and claims for costs under £50,000 negotiated in-house or by panel solicitors

Figure 7: Non-clinical expenditure 2012/13 including interim payments

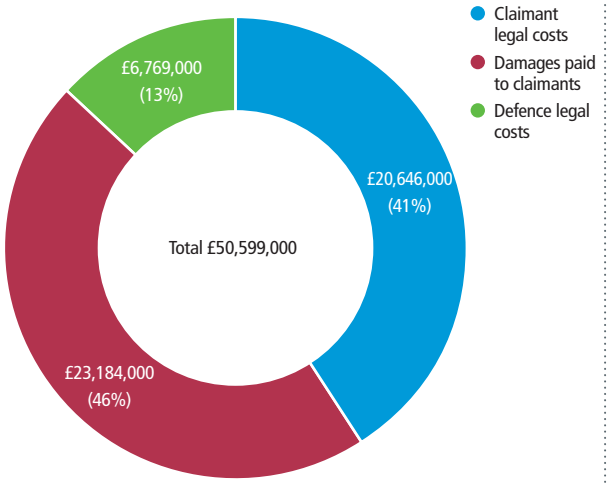
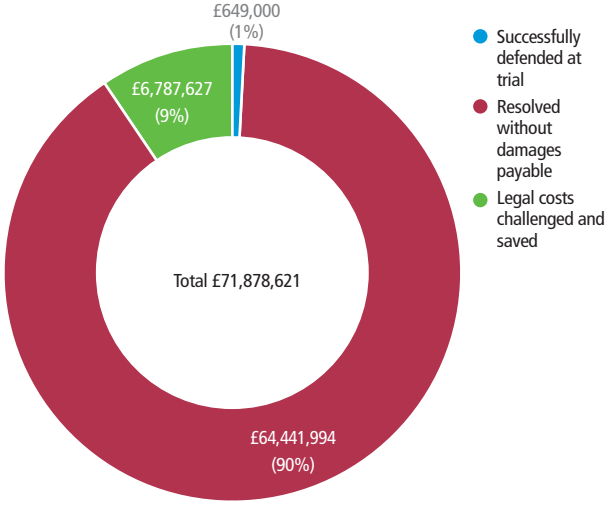


Figure 8: Damages and costs saved in non-clinical claims resolved in 2013/14



Excludes reductions in settlement values negotiated by the NHS LA and claims for costs under £50,000 negotiated in-house or by panel solicitors

Key

Clinical Negligence Scheme for Trusts (CNST) – A voluntary membership scheme to which all NHS Trusts and Foundation Trusts in England currently belong. It covers all clinical claims where the 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.

Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) – Known collectively as the Risk Pooling Schemes for Trusts (RPST), they are two voluntary membership schemes covering non-clinical claims where the incident occurred on or after 1 April 1999. Like CNST, costs are met through members' contributions on a pay-as-you go basis.

Existing Liabilities Scheme (ELS) – ELS is centrally funded by the Department of Health and covers clinical claims against NHS organisations where the incident took place before 1 April 1995.

Ex-RHA Scheme (Ex-RHAS) – Ex-RHAS 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.


We changed the way we price our indemnity cover so that organisations with fewer and less costly claims pay less. This creates an incentive for members to improve patient safety and reduce claims.
Catherine Dixon,
Chief Executive Officer

Chief Executive's report

This year was tremendously busy, with a key focus on communication and engagement with our members

We set ourselves three strategic objectives for the year. The aim of these was to offer the best possible services to the NHS and to focus on preventing patient harm by:

- ensuring we continue to become more efficient and effective whilst valuing and investing in our staff to support continuous improvement.
- developing a safety and learning service and supporting the NHS to learn from things that go wrong in order to improve patient and staff safety.
- integrating and developing our National Clinical Assessment Service (NCAS).

We have had an extremely successful year delivering against our objectives. We launched an extranet that allows our members to track their claims in real time and provides online information and resources that will support them to reduce their negligence claims, thereby improving patient and staff safety. As a result of this work, we were proud to be finalists at the British Legal Awards for Innovation.

We met the challenge of a large rise in claims following changes to 'no win no fee' funding arrangements. Our claims teams, supported by our corporate support teams, dealt with more claims than ever before whilst also improving their performance. This is a testament to the teams' hard work and a reflection of their professionalism and expertise.

We changed the way we price our indemnity cover so that organisations with fewer and less costly claims pay less. This creates an incentive for members to improve patient safety and reduce claims. The change was welcomed by our members, and we are starting to work more closely with organisations with higher levels of claims in order to support them to reduce harm and claims.

We kept 100% of our NHS members and significantly grew our membership, with more than 50 new independent sector members providing NHS care joining our Clinical Negligence Scheme for Trusts (CNST).

In March 2014, we carried out our last risk management assessment. In place of the old system that focused on rigid standards and assessments, we are continuing to develop a robust Safety and Learning Service that actively supports our members to reduce harm and improve patient safety. In order to avoid swings in price for our members as we move away from the old system, we will continue to award discounts connected to our risk management assessments in 2014/15.

We have launched other member services throughout the year, including a new inquest service that supports our members in dealing with inquests that may result in a claim. During the year we supported members

"We kept 100% of our NHS members and significantly grew our membership, with more than 50 new independent sector members providing NHS care joining our Clinical Negligence Scheme for Trusts (CNST)."

PHOTOGRAPHY: NICK DAWE

We are supporting the NHS to be open, transparent and candid with patients, their families and carers. We launched guidance for the NHS on saying sorry and how to give an explanation when things go wrong.

We received positive feedback that the guidance is supporting frontline NHS staff to say sorry when things go wr

Catherine Dixon, Chief Executive Officer

through over 500 inquests. We also took on handling industrial disease claims from the Department of Health (DH) and will deal with any criminal liabilities that may arise following the demise of Strategic Health Authorities, Primary Care Trusts and NHS Direct.

We created Safety and Learning Advisory Groups to analyse the things that go wrong in two priority areas: maternity and surgery. We will share this vital learning with the NHS. We continue to inform the NHS about factors contributing to maternity claims and, in particular, the key issue of failing to monitor and respond to changes in the heart rate of unborn babies.

We put in place a new Legal Panel for all DH agencies. The panel enables them to take advantage of high quality, value-for-money legal services, including discounts for volume and early payment and value added benefits such as secondees, use of legal offices and library services. We were finalists for our collaborative work on establishing the Legal Panel in the GO National Procurement Awards.

The National Clinical Assessment Service (NCAS) joined the NHS LA on 1 April 2013. We immediately began the integration of NCAS as one of our operating divisions and a review of how to develop the important service offered by NCAS to meet the changing needs of the NHS. Following the review, we are taking steps to develop NCAS's services to support the NHS where there are concerns about the performance of doctors, dentists, pharmacists and other healthcare professionals.

We will also develop income generation services to support NCAS's core services, including team and record reviews, and supporting the NHS to reduce claims by improving team performance. NCAS's core services will remain free at the point of delivery. During this period of change for NCAS we successfully dealt with more referrals and completed more assessments than ever before, which is testament to the NCAS team's expertise and dedication to supporting the NHS to improve the performance of practitioners.

We are supporting the NHS to be open, transparent and candid with patients, their families and carers. We launched guidance for the NHS on saying sorry and how to give an explanation when things go wrong. We received positive feedback that the guidance is supporting frontline NHS staff to say sorry when things go wrong.

We take our commitment to the community seriously, raising over £8,800 for our charity of the year, Scope, through fundraising events.

We created our vision in 2013/14 – 'to achieve timely fair resolution, enhance learning and improve safety' – supported by our values of being Professional, Expert, Ethical and Respectful, in line with our commitment to the NHS Constitution. We look forward to continuing to support the NHS to resolve disputes and concerns in 2014/15.

Catherine Dixon
Chief Executive Officer

The year ahead

We provide a range of services to the NHS to benefit patients, professionals and service providers. Our plans over the year ahead aim to make sure we continue to provide these services to the highest standards and to provide excellent value for money.

We will:

- Maintain our record of efficiency and control costs so NHS resources go to front line services whilst also investing in and supporting our staff as the foundation of all our achievements.
- Build on 20 years' experience of handling negligence claims to support the NHS to reduce harm and improve patient safety by reducing claims.
- Develop and improve our work to maintain the professional standards of doctors, dentists, pharmacists and other healthcare professionals.

Safety and learning

We will continue to develop an effective Safety and Learning Service that supports the NHS to improve patient and staff safety and reduce claims.

We will:

- **Develop** our Safety and Learning Service to meet the needs of our members and the NHS. It will bring together the learning from claims as well as the cases dealt with by the National Clinical Assessment Service (NCAS).
- **Explore** the local areas of good practice that could significantly reduce harm, improve safety and thereby reduce claims.
- **Develop** a local events programme of workshops and focus groups and an online webinar programme.
- **Continue** to develop an NHS LA learning system to undertake root cause analysis of claims and cases reported to the NHS LA. We will produce thematic reviews and case studies from this analysis that will help the NHS learn from our experience of claims and cases.
- **Test** specialist support for organisational Board leaders and produce further guidance and other supporting documentation on key topics for the NHS. This includes more materials for the Safety and Learning Library including those related to mental health, learning disabilities, community, ambulance settings as well as non-clinical claims and cases.

National Clinical Assessment Service (NCAS)

We will:

- **Continue** to integrate NCAS and the NHS LA, including data systems and existing technology, to improve efficiency and effectiveness. NCAS Core services will remain free to referring organisations and we will make sure that we are providing a service that is flexible, tailored and innovative, meeting the needs of the changing NHS.
- **Identify** and develop new services that will allow us to income generate to support NCAS's core services and move towards a self-funding model.
- **Raise** NCAS's profile as a valued service improving professional standards and patient safety. We will build on the synergies with the work of the wider NHS LA to enhance learning, and develop a strategy for research and publications.

in 2014/15

Managing claims

We will continue to meet the challenge of rising claim numbers, resolving claims promptly and fairly, and doing everything we can to keep costs down.

We will:

- **Ensure** we are in a position to handle a rising number of claims, building in greater flexibility to respond to changes in workloads whilst equipping staff with the right skills and experience to handle the work.
- **Develop** our own expertise in costs and negotiation so that staff can challenge disproportionate claimant costs effectively and, where appropriate, the proposed level of damages if this appears too high.
- **Work** with the Ministry of Justice, the Department of Health and other key partners to find solutions to ensure legal costs are appropriate, fair and proportionate to the level of damages payable.
- **Develop** a more one-to-one, customer-focused relationship with our members, including obtaining regular feedback so we understand their issues, get direct feedback on our service and act on what they say.
- **Respond** to market changes, ensuring that our non-clinical cover for our employers' liability and public liability indemnity schemes remains fit for purpose by covering areas of risk that may arise in a changed NHS.
- **Meet** new challenges in the changing legal market, such as the expansion of the clinical negligence market to new firms, and continue to develop our response to changes such as the introduction to the new Ministry of Justice Portal, and the faster timescales that these bring to our work on handling non-clinical claims.
- **Improve** the management of our key suppliers, particular experts and counsel to ensure that the NHS and its users receive a high quality service at the best value.

Family Health Services Appeal Unit (FHSAU)

We will:

- **Complete** our governance exercise for the Family Health Services Appeals Unit (FHSAU) panel members by recruiting FHSAU Panel Member Chairs.
- **Streamline** the process for deciding appeals, including distance selling applications, to make decisions clearer to parties following the introduction of the new NHS (Pharmaceutical Services) Regulations 2012 (the Pharmacy Regulations, amended 2013 and 2014).
- **Review** how we obtain advice from consultant surveyors in order to assist in deciding GP premises costs disputes to ensure we obtain value for money.

Corporate Support Services

We will:

- **Develop** and improve our informatics and data analytics capability to support external and internal learning and performance.
- **Continue** to develop and value our people with a programme of learning and development to support our work to achieve the Investors in People accreditation.
- **Improve** our ability to obtain customer feedback to enable us to continue to develop and improve our services to meet the needs of our customers.
- **Continue** to develop our information governance policies and procedures as we work towards ISO 27001 accreditation.
- **Build** on the work of the last two years to continue to improve and develop our communication and engagement with the NHS and other key partners (including patient representation groups) to ensure we are meeting their needs and that they understand our work.

Claims management

In the past year we received an unprecedented number of new clinical negligence claims, which has been challenging for the NHS, our teams and our Legal Panel

Over the past year, we have:

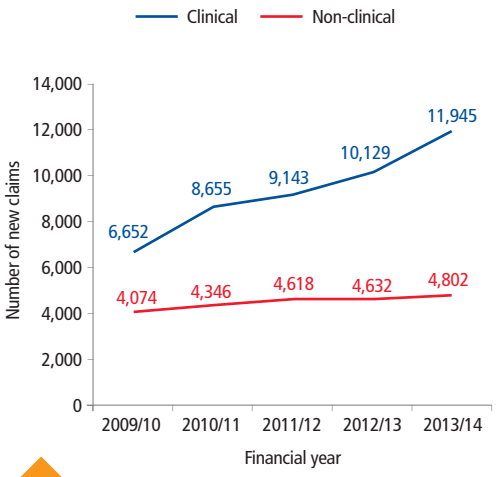
- Dealt effectively with an unprecedented increase in claims while adding more than 50 new members to our indemnity scheme, the Clinical Negligence Scheme for Trusts (CNST), and creating new services, including a new extranet and inquest support service.
- Successfully managed claims expenditure within our financial targets during a period of rapid growth.
- Saved over £1.4 billion for the NHS by robustly defending unjustified clinical negligence claims so that 44% of the clinical claims that we dealt with in the past year were resolved with no payment of damages and 79% of the relatively small proportion of cases that were decided in court were successfully defended at trial.
- Saved more than £74 million for the NHS by appropriately challenging claimants' legal costs, leading to an average 28.8% reduction in bills.
- Continued to resolve justified claims promptly and efficiently, for example, claimants receiving damages of less than £25,000 for clinical negligence received compensation in less than a year.

Growth in new claims

We received an unprecedented number of new clinical negligence claims (11,945) (See Figure 9). For the first time we received more than 1,000 claims per month in six months of the year (See Figure 10).

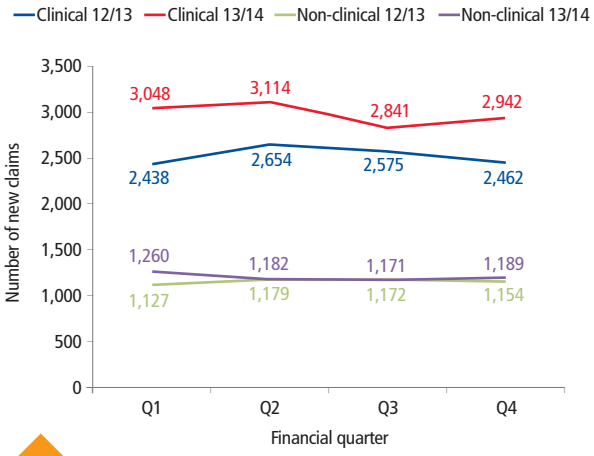
This significant increase in the number of claims coincided with the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) coming into effect on 1 April 2013. This legislation reformed the funding arrangements for civil litigation, including changes to 'no-win, no-fee' arrangements, stopping claimant lawyers charging up to 100% success fees on their costs and banning referral fees.

Figure 9: New claims reported (all members)



New clinical claims rose by 17.9% from 2012/13 to 2013/14

Figure 10: New claims reported 2012/13 to 2013/14



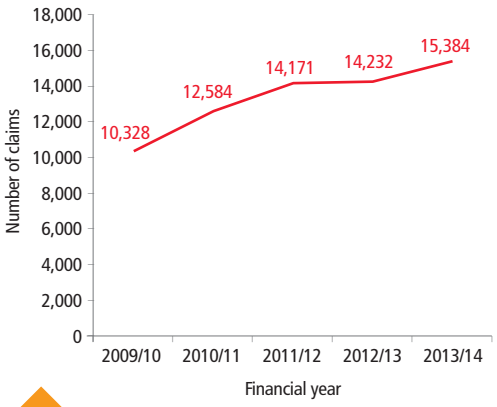
New clinical claims exceeded 1,000 per month in six months of the year

> **"The vast majority of claims reported to us throughout the year have been conducted under the pre-LASPO arrangements."**

Prior to LASPO, we saw significant marketing campaigns by claimant solicitors to ensure claimants signed up to pre-LASPO no-win, no-fee agreements, which still enable claimant solicitors to charge a success fee on their costs. As a result, the vast majority of claims reported to us throughout the year have been conducted under the pre-LASPO arrangements.

The increase in claims received has been challenging for the NHS, our teams and our Legal Panel. It is as a result of their hard work, professional approach and expertise that we have continued to resolve claims quickly and appropriately. On average we resolve CNST claims in 1.26 years and CNST claims valued at £25,000 or less are resolved on average less than one year after we receive them. A total of 15,384 claims were closed in total in 2013/14, more than ever before (Figure 11).

Figure 11: Claims closed in 2013/14



1,152 more claims were resolved in 2013/14 than in 2012/13

Legal market

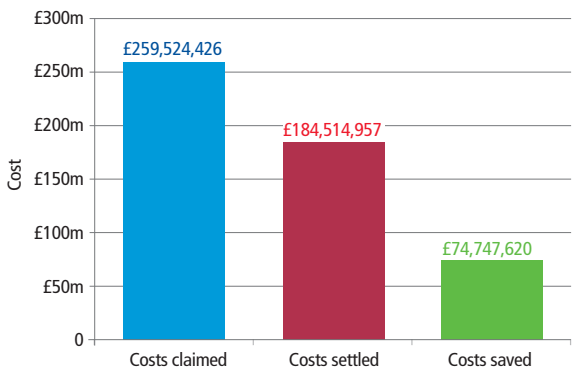
Changes to the legal market, in particular changes to claimant's legal funding arrangements, had a significant impact on our work. For example, reduced fixed costs in motor personal injury claims, have attracted a number of new entrants to the clinical negligence arena as one of the last remaining areas where claimant solicitors can charge an hourly rate, resulting in us having to deal with more than ever new claimant solicitors. We have also seen an increase in poorly investigated claims and claims where the care clearly was not negligent being brought by lawyers who do not specialise in clinical negligence work.

In addition, some claimant solicitor firms are undertaking significant investigations of some claims in the pre-litigation period and pre-notification to the NHS. This means that they are not subject to costs budgeting requirements by the courts, which only apply after the pre-litigation period. This has resulted in the 'front loading' of costs in some cases prior to notification to the NHS LA. Significant costs are often incurred even before the claim reaches us, which can result in a disproportionate costs claim by the claimant's lawyers compared to the damages payable to the claimant and mean that more monies can be paid to lawyers than patients who have been harmed by negligent care (see case study and Figure 13 below).

Claimant solicitors can incur significant costs before notifying the NHS of the claim

A Letter of Claim was served by solicitors in September 2013 together with an offer to settle their client's case for £11,800 damages. After investigation the NHS LA accepted the offer less than four months later and was presented with a bill of costs which included a claim for £175,000 of costs incurred before the Letter of Claim was served. The NHS LA is contesting these costs.

Figure 12: Claimant legal costs on claims resolved in 2013/14



More than £74 million in clinical legal costs saved by challenges to excessive bills

Excludes claims for costs under £50,000 negotiated in-house or by panel solicitors

> **"We have also seen some claimant solicitors attempting to claim excessive and disproportionate costs."**

We have also seen some claimant solicitors attempting to claim excessive and disproportionate costs, in some cases charging £400 per hour with 100% uplift (so £800 per hour) for unqualified lawyers. One firm tried to charge £1,440 per hour. This is well in excess of the guideline hourly rates recommended by the Civil Justice Council (CJC), which suggest £409 per hour for an experienced City of London solicitor and considerably higher than we would pay our defence solicitors. There is no evidence that the claimant solicitors' firms that attempt to charge higher fees are doing a better job for their clients than those that charge lower amounts

Massive reduction in claimant solicitors' bill

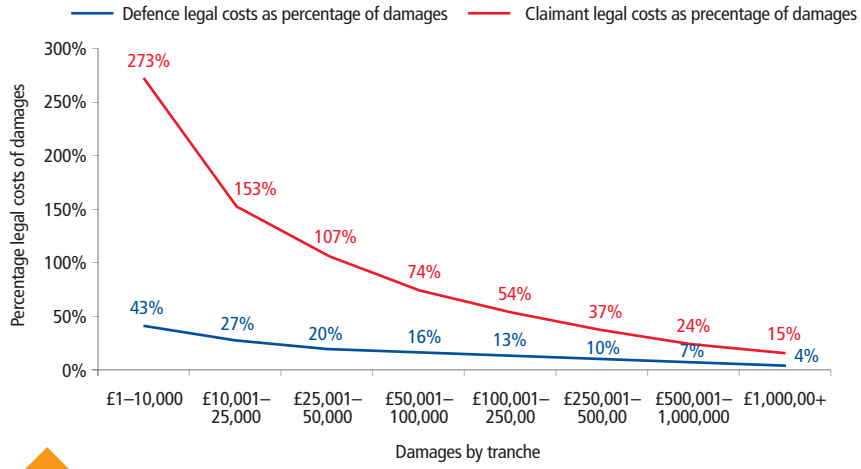
On settlement of a claim, we received a bill from the claimant's solicitors totalling £83,131 on a claims for damages worth £1,000. We regarded this as excessive and contested the bill at court. The judge awarded the solicitors £4,903, just 5.89% of what had been claimed. The saving to the NHS was therefore more than £78,000.

Where appropriate, we have taken a robust approach to claimant solicitors' costs, reducing them by an average of 28.8% (including a 78% reduction for one firm alone). As a result we have saved the NHS over £74 million (See Figure 12). We have taken more claims for costs to assessment by the court with an average saving of 32% on those cases.

We have little control over claimant solicitors' costs incurred before we are notified of a claim. Claimant solicitor costs are in stark contrast to defence legal costs. We have kept defence costs low as a result of a tender exercise that enabled us to agree reasonable rates with our panels of specialist defence lawyers. This includes fixed fees. We also manage claims in-house whenever possible in order to reduce costs for the NHS.

We believe that the right thing to do for patients is to ensure that NHS money is spent on patient care rather than claimant solicitors' costs bills, which are disproportionate to the amount of compensation claimed.

Figure 13: Clinical claims legal costs as a percentage of damages paid by damages tranche for claims closed in 2013/14



Claimant legal costs for lower value claims are disproportionate to damages payable

Increased efficiency

Despite the pressure to handle increasing numbers of claims, we improved our efficiency. We provided exceptional value for our members: the average administration costs per claim in 2013/14 coming down from £498 (2012/13) to £406 (See Figure 14). Administration costs now stand at 0.89% of claims expenditure overall (See Figure 15).

We have improved the way we collate data on our claims in order to monitor and identify trends, as well as improving the quality of analysis for learning purposes. The development of an extranet, which provides real time data on claims, has meant that we can share data on claims as they progress with our members, claims teams and Legal Panels.

Handling claims promptly and fairly

We aim to resolve claims without litigation (i.e. without court proceedings being issued) wherever possible. In 2013/14, 71% of claims were resolved without court proceedings being issued.

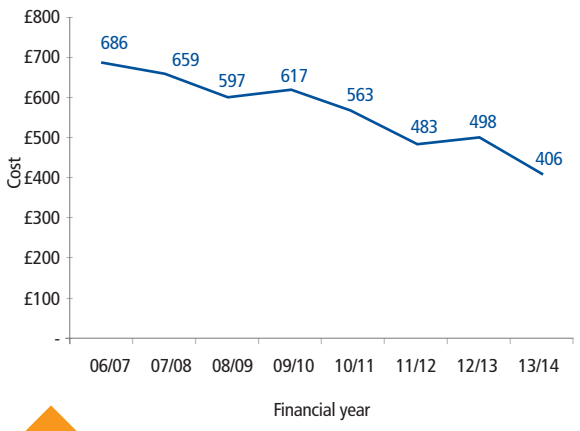
Claim resolved promptly without court proceedings

A patient was treated in hospital due to an underlying medical condition. Unfortunately, he suffered complications. Subsequent treatment fell short of the required standard of care and sadly he died shortly afterwards.

A Letter of Claim was received from solicitors acting for the patient's widow. We fully investigated the claim, obtained expert advice and sent a Letter of Response with an admission of liability within four months. Following receipt of details of the loss from the claimant's solicitor the claim was settled two weeks later by telephone negotiations and for a damages payment of £50,000.

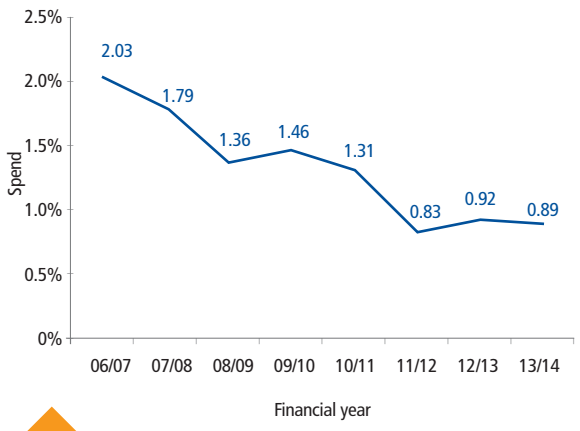
Sometimes, it is necessary for us to defend cases to trial. The following cases are examples. Of those taken to trial in 2013/14, 79% of clinical cases and 72% of non-clinical cases were successfully defended, saving the NHS £17.5 million. The involvement of the NHS member staff and clinical staff in defending claims is critical at every stage, and particularly at trial, in order to reach the right outcome.

Figure 14: Administration cost per claim, excluding legal costs



Administration costs per claim have fallen as the NHS LA has become more efficient

Figure 15: Administration spend, excluding legal costs, as a percentage of total claims expenditure



Administration spend is 0.89% of total claims expenditure

Midwife praised by judge

The claimant suffered complications at birth resulting in significant disability. It was claimed that the midwife who performed the delivery wrongly applied fundal pressure and used excessive force. The value of the claim was £450,000. Based on our assessment of the evidence, we successfully defended the case to trial and will recover costs for the NHS. The judge dismissed the allegations of negligence based on the evidence of the midwife. He found her to be:

"… highly impressive, plainly honest and doing her best to give a clear account of her practice … She struck me as utterly professional and meticulous in all her work. I accept her evidence unreservedly."

In many cases, we seek expert advice early on in order to provide an independent and objective opinion on whether there has been negligence and, if so, whether that negligence caused the injury and loss claimed. A full response is given to injured claimants, in the vast majority of cases within four months of receiving their claim, and admissions of legal liability and apologies and explanations are made promptly.

Judge reiterates 'Bolam Test'

The claimant claimed that the failure to surgically remove her gallbladder in 2002 led to continued symptoms over many years and that she was at increased risk of complications. We disputed the claimant's evidence and took the case to trial, supported by expert evidence that the treatment she received was in accordance with reasonable practice.

The judge agreed and found that the advice given by the patient's surgeon did not fall below the standard of 'ordinary competent consultant surgical practice' In addition he found that the claimant's expert was assessing the case according to best possible practice, rather than the correct (Bolam) test, which states that: 'If a doctor reaches the standard of a responsible body of medical opinion, he is not negligent.'

We are recovering costs for the NHS.

Mediation

We support alternative methods of resolving disputes wherever possible and will offer mediation where appropriate. Following work in 2013/14, we will launch a mediation pilot in 2014/15 to test how effective this is as a way of resolving claims, beginning with fatal claims or those involving elderly care where it is claimed the care fell below standard.

Employers' and public liability

In August 2013 the Ministry of Justice extended its Portal for motor personal injury to employers' liability and public liability (EL and PL). The Portal is now the compulsory route for EL and PL claims valued at up to £25,000 for damages.

We worked closely with our members to ensure that the new timescales set for the introduction of the Portal could be met to achieve the reductions in costs and efficiencies offered by the Portal. We continue to reject the non-clinical claims we see as without merit.

Trust not at fault for fall by employee

The claimant fell down some stairs and sued the NHS trust employing her, claiming that she had snagged her heel on some loose metal nosing. She alleged that she was suffering from chronic pain syndrome as a result of this accident.

The court rejected the allegation that the stairs were defective and dangerous. In addition it preferred the evidence of the orthopaedic expert we instructed that the claimant's symptoms had largely settled within six weeks of the accident and found that any pain she had experienced since was unrelated. The claimant was ordered to pay the trust's costs.

Inquest service

On 1 April 2013, we extended the cover we provide under CNST to include the cost of representation at inquests where there is likely to be a claim for negligent care. This means that we can support our members much earlier in fatal cases and that claims for negligence can be resolved more quickly, including the giving of an apology, explanation and, where appropriate, admission of liability prior to the inquest taking place.

Support was provided for more than 500 inquests in 2013/14.

Inquest funding leads to early resolution

An elderly patient died following a series of falls. The trust's internal investigations showed that the death was avoidable as there had been failures to comply with falls prevention policies. The trust applied for inquest funding and having considered the relevant information, we authorised an early admission, apology and settlement offer. The settlement offer was accepted by the family before the inquest hearing. This meant that the family received an early apology, explanation and compensation, which we hope helped them through a very difficult period, and that the trust could focus on steps to ensure that a similar accident did not occur again.

Maternity claims

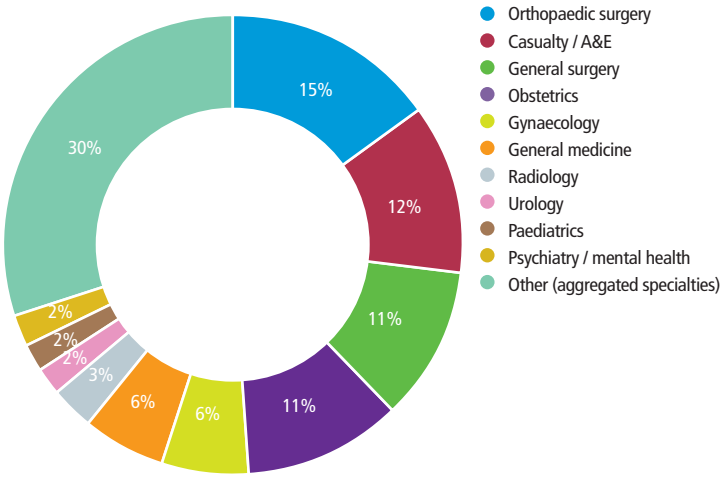
Having a baby in the NHS is very safe, however, things can occasionally go wrong. This can be devastating for the mother, baby and their family as the harm caused can be severe. It is vital that we learn and share lessons from these claims so that professionals can improve their clinical practice in the future to prevent harm.

Maternity claims represent the highest value and third highest number of clinical negligence claims reported to us (See Figure 16 and Figure 17). The value of maternity claims can be very high (sometimes more than £6 million) as the amount paid is for ongoing care, accommodation and specialist equipment needs. The NHS funds these settlements by way of a lump sum, followed by annual payments for life. This ensures that the child has financial security and that compensation that would otherwise be paid upfront is available for patient care.

Maternity claims can take a long time to fully resolve as a child's needs often cannot be assessed until he or she is 5–6 years old. However, pending a final settlement, we will often make an interim payment of damages to ensure that the child's immediate needs are met.

On average, maternity claims are made against the NHS just over two years after an incident has occurred. Within a year of hearing of a claim, on average, where appropriate, we will make an admission of liability.

Figure 16: Number of clinical negligence claims received in 2013/14 by specialty



On average, just over eight months later, we will make a payment of damages (See Figure 18).

We undertook an analysis of 10 years of maternity claims reported from April 2000 to March 2010 and we are making it a priority to support the NHS in reducing harm in this area.

New members

In 2013, we welcomed a number of new members to CNST, including independent sector providers of NHS care. Our teams have continued to develop close working relationships with new members in order to understand the services they provide and what all parties need to do in order to manage claims in the best possible way.

Industrial disease claims

The Department of Health also asked us to take on several hundred industrial disease claims and other historic liabilities. We have called upon existing expertise in our in-house teams and Legal Panel to bring effective management to this complex work.

Figure 18: Life of a CNST maternity claim where an admission has been made

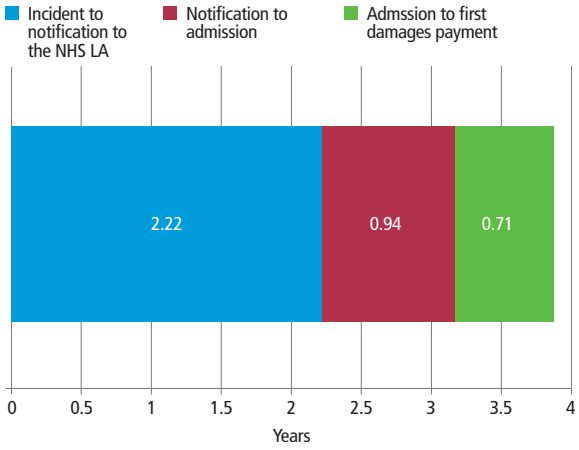
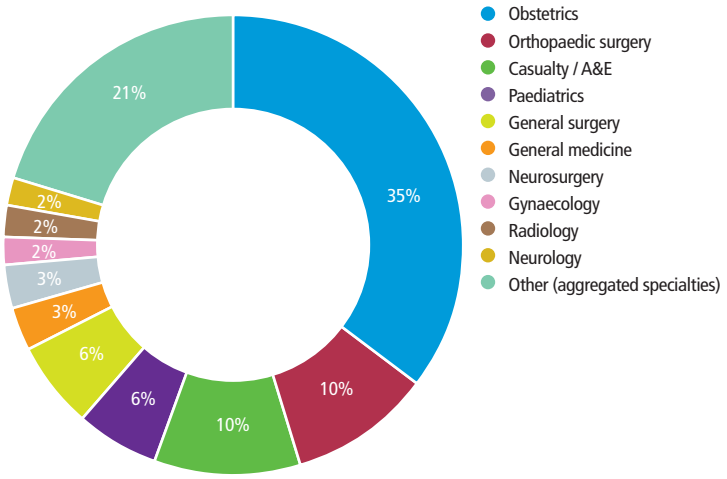


Figure 17: Value of clinical negligence claims received in 2013/14 by specialty



> The NHS LA will support our members as far as the Court of Appeal or Supreme Court in defending unmeritorious claims including lower value claims where this is appropriate.

Legal developments and important cases for the NHS

Over the past year legal reforms and important cases have had a major effect on all types of civil litigation, including the work of the NHS LA

- The Jackson reforms which culminated in the Legal Aid Sentencing and Punishment of Offenders Act 2012 (LASPO), are of major importance to the NHS and their full impact is still being assessed. In the shorter term the introduction of LASPO has increased the number of claims received by the NHS under pre-LASPO funding arrangements.
- The courts are now taking a much tougher line on non-compliance with deadlines following the introduction of LASPO and the case of Mitchell v News Group Newspapers Limited.
- NHS LA will support our members as far as the Court of Appeal or Supreme Court in defending unmeritorious claims including lower value claims where appropriate.
- Involving our members and leading experts is often the key to a successful defence.

Civil Justice Reforms

Numerous changes to procedural rules and the recoverability of costs were introduced with effect from 1 April 2013 following a review of the legal system by Sir Rupert Jackson, a Court of Appeal judge. These included:

- Claimant solicitors can no longer recover success fees from the party found to be negligent in cases where a Conditional Fee Agreement (CFA, otherwise known as 'no win-no fee') was entered into between a claimant and their solicitors on or after 1 April 2013. These had been claimed at up to 100% of solicitors' basic fees under the previous rules resulting in the NHS receiving significant bills for claimant solicitors costs. Claimant lawyers can for CFAs entered into on or after 1 April 2013 charge their client a success fee as a percentage of the claimant's damages – up to 25%.
- The payment of referral fees by law firms to claims management companies or other solicitors was banned.
- Costs budgeting by the courts was introduced in higher value litigated cases for costs incurred after the pre-litigation stage.
- Successful defendants will generally no longer be able to recover their costs from the unsuccessful claimant if a case proceeds to trial (this is known as qualified one-way costs shifting).
- Claimants in personal injury cases will be allowed to enter into Damages-Based Agreements (also known as contingency fee arrangements) with their solicitors under which the solicitors receive a share of any damages recovered.
- Sanctions will be increased if a defendant fails to beat a claimant's offer to settle (known as a Part 36 offer).
- The right of claimants to recover After the Event (ATE) insurance premiums from defendants will be abolished, other than for the cost of expert reports in certain clinical negligence cases.

These reforms have had a major effect on all types of civil litigation. Removing the ability of claimants' solicitors to recover success fees from the defendant is probably the most significant and welcome from the NHS perspective. However, its effects will take a long time to filter through the system. Sir Rupert designed the changes as a package, and both the Civil Justice Council and the Ministry of Justice will periodically review them to assess their overall impact.

Mitchell v News Group Newspapers Limited

Lessons

1. Do not treat procedural deadlines as optional.
2. If an extension is required, apply for permission before the deadline expires.
3. Overwork is not a valid excuse for failing to meet a court deadline.

Perhaps surprisingly, the court decision that has had most impact on the NHS in 2013/14 was not related to healthcare at all. It arose when Andrew Mitchell MP sued a newspaper for defamation as a consequence of its report on an alleged incident in Downing Street. His solicitors failed to serve their costs budget in time, (at least seven days prior to the relevant hearing). Despite an emailed reminder from the judge, this didn't happen until the afternoon before the hearing.

On 27 November 2013, the Court of Appeal held that the £590,000 budget should be struck out because the solicitors had failed to comply with procedural rules and that they could only recover court fees by way of budgeted costs if they won the case. The Master of the Rolls, who is the senior civil judge in the Court of Appeal, said that the courts would now take a tougher line on compliance with deadlines and that excuses such as overwork or waiting for counsel to supply papers would not be accepted in future.

This ruling has galvanised the management of litigation. Parties are concerned that claims or defences may be struck out if they fail to serve documents in time. Our message to members, therefore, is that it is absolutely essential to supply documents to us, or our appointed solicitors, in good time otherwise we run the risk of claims being lost by default. We cannot over-emphasise the significance of this decision: it is undoubtedly the most important judgment on a procedural point since the introduction of Lord Woolf's reforms in 1999.

Meiklejohn v St George's Healthcare NHS Trust and Another

Lessons

1. US experts are not necessarily best placed to comment on UK practice.
2. Lengthy litigation puts a big strain on the clinicians involved as well as the claimant.
3. NHS LA will support our members, in the higher courts if necessary, to defend claims without merit.

This was our own most notable case in the Court of Appeal, with judgment delivered on 13 February 2014. In brief, it was alleged that the diagnosis and treatment of the patient's aplastic anaemia were negligent. The

trial judge found in favour of the NHS trusts. But the claimant appealed, relying upon the views of a US expert. We maintained a robust defence. The clinician who faced the allegations of negligence was one of the UK's leading experts in this highly technical field and was supported by an independent UK specialist.

The Court of Appeal entirely rejected the claimant's arguments, including an allegation that the trust's employee had lied in her evidence and that the defence expert was a disgrace to his profession. The court fully endorsed the trial judge's conclusion that these allegations were totally unfounded.

We were particularly pleased to have been able to support the trust and their clinician through to a result that entirely vindicated their position. The events in question took place in 2003, with proceedings issued in 2007, and therefore this litigation had been a huge burden for those involved for many years.

Woodland v Essex County Council

Lessons

1. The NHS is likely to receive more claims involving allegations of non-delegable duty of care.
2. The Supreme Court formulated clear guidelines for this type of case.
3. Commissioning cases do not fall within the Supreme Court's criteria.

On 23 October 2013 the Supreme Court laid down circumstances in which a public body may be held to owe a non-delegable duty of care towards a claimant, even though the immediate cause of the accident or injury was the action of another party to whom the relevant work was contracted.

This is a significant case because the NHS is increasingly using private sector providers to deliver NHS care. However, our view is that its impact is probably less than might first appear. For example, there is no change to the position regarding commissioners, who will not be held liable for the negligence of their contractors unless they are themselves negligent in selecting an inappropriate contractor. Furthermore, where there is no delegation of a function imposed by statute, the hospital is not assumed to be liable. An example would be if a hospital delegates to an independent laboratory the analysis of a specimen from a foreign patient the hospital is not treating. In any event, since April 2013, private providers of NHS healthcare have been entitled to join our clinical negligence scheme in their own right and over 50 have already done so.

The following cases are first instance rulings which illustrate the variety of claims against our members.

B v Oxleas NHS Foundation Trust

Lessons

1. Unlawful detention attracts damages as of right.
2. Damages will be nominal if the detention would have happened if correct procedure had been followed.
3. Courts can award costs against a claimant even if the claimant has recovered damages.

> **“Cases involving severe brain damage invariably have a high human cost, both for the patient and their relatives. However, a claim will only succeed if a breach of duty and causation can both be proven.”**

This was a ruling of Central London County Court on 4 February 2014. The claimant suffered from schizophrenia and had been detained under section 3 of the Mental Health Act. A tribunal ordered his discharge but postponed it until a Community Treatment Order (CTO) could be put in place. This duly occurred but the trust overlooked the fact that only a person “liable to be detained in a hospital in pursuance of an application for admission for treatment” can be made the subject of a CTO.

The claimant’s condition deteriorated and he was re-detained under the terms of the CTO, ultimately for 442 days. The CTO had never been lawful so this re-detention was technically illegal. This was the case even though the patient would have been re-detained for this period if correct processes had been followed. The trust accepted that an unlawful detention had occurred, but disputed the level of compensation claimed arising from a procedural breach (keeping in mind that it was appropriate to detain the patient).

Unlawful detention attracts damages even in the absence of negligence. The judge analysed recent case law from the Supreme Court and decided that nominal damages of £1 would be appropriate. He awarded costs against the claimant.

We see a number of similar claims and this is a very helpful ruling for our members. It illustrates that where the patient would have been detained in any event but for a technicality, damages will be nominal.

Chappell v Newcastle Upon Tyne Hospitals NHS Foundation Trust

Lessons

1. Expert evidence is key in most clinical negligence cases.
2. Only the best and most knowledgeable experts should be used.
3. Although unfortunate and always tragic, most babies who suffer brain damage do so through non-negligent causes.

Cases involving severe brain damage invariably have a high human cost, both for the patient and their relatives. However, a claim will only succeed if a breach of duty and causation can both be proven.

This case involved a baby who was born in 2000 with extensive harm to his brain. Sadly, he died in 2012, a year before judgment was delivered by the High Court in December 2013.

The main point at issue was causation (i.e. whether the alleged negligent care caused the injuries). Judge McKenna, having heard all the evidence, concluded that the baby's brain damage was caused by infection, leading to meningitis, rather than lack of oxygen as had been alleged on behalf of the claimant. He particularly praised the evidence of Derek Tuffnell, the trust's Obstetric Expert, who was one of the authors of the NICE Guidelines in 2007. Judgment was therefore given in favour of the trust.

E v St George's Healthcare NHS Trust

Lessons

1. The onus is on the claimant to prove her case.
2. Risk assessment is key when introducing a new patient to a course.
3. NHS LA will defend low value claims if our member has not been negligent.

This case involved an elderly patient who suffered a fall whilst attending a falls prevention programme run by physiotherapists. It was alleged that she had not been assessed adequately when she joined the course and that it was negligent to allow her to walk across a mat. Judge Collender QC in Central London County Court ruled on 7 February 2014 that the claimant was undoubtedly at some risk of falling – that was why she was on the course – but she had been properly assessed as being fit to use the mat. She had her stick at the time of the accident and there was no indication that there was anything wrong with the mat or that its use caused the fall. This was a relatively low-value claim but was one that we considered important to defend because there was no evidence that the physiotherapists involved with the patient's care had done anything wrong.

National Clinical Assessment Service (NCAS)

NCAS is changing to meet the needs of a changing NHS

- In the last year NCAS received more referrals, completed more assessments and more action plans than in any previous year in its history.
- The NCAS advisory team has been enhanced by bringing in additional legal expertise to enable us to deal with referrals ever more quickly.
- Average waiting times for assessment have been reduced from longer than one year to 3–4 months.
- An independent review of NCAS conducted by Deloitte was positive and also identified areas where services could be enhanced to meet the changing needs of the NHS.
- There are strong interactions between the work of the NHSLA and NCAS with opportunities to enhance learning, safety and quality development across the NHS.

NCAS supports patient safety across the NHS by helping to resolve concerns about the professional practice of doctors, dentists and pharmacists. This year we responded to a review of our current services and started to make changes so that we can be confident that we are continuing to provide the high quality services the NHS needs and deserves.

NCAS became a part of the NHS LA in April 2013, after which Deloitte were commissioned to independently review our business model. Reporting in December 2013, the review was positive but identified areas where NCAS's services could be changed, developed and enhanced to meet the changing needs of the NHS.

The NCAS Advisory Service consists of clinicians, human resources (HR) practitioners and lawyers with expertise in employment law and performance management. In response to the Deloitte review, the NCAS team has been strengthened by bringing in additional expertise, with particular knowledge of employment law and performance issues. This ensures that NCAS is able to continue to give immediate and timely advice and, if the complexity of the issues demands it, ensure that further specialist expertise and guidance is readily available.

The NCAS Advisory Team has been reorganised and now works on a regional basis with responsibility for building relationships with local trusts and area teams. This enables us to better meet the needs of healthcare organisations and practitioners when delivering our services. By aligning NCAS advisers with NHS LA safety and learning leads on a regional basis, we are building on their experiences to improve safe working practices in the NHS.

We received more referrals, completed more standard assessments and put in place more action plans than in any previous year in our history. For the first time we received more than 1,000 practitioner referrals: 940 doctors, 75 dentists, and 5 pharmacists. During the year, 200 NHS trusts (84% of all trusts in England) and 25 out of 27 NHS England local area teams made a referral to us.

We developed a more flexible and modular approach to assessments. NCAS now offers bespoke support on a range of options for interventions which include record review, record based assessments, action plans, behavioural assessments, occupational health assessments, assessments of communicative competence and clinical skills. These services are in addition to our standard assessment model which incorporates all these elements.

As an immediate outcome of the Deloitte review, we have also changed our assessment processes. Assessment reports are now concise, shorter, more focused and will be produced quickly. During the coming year, we are committed to continually improving our assessment process.

This tailored and flexible approach can, where appropriate, ensure that concerns are dealt with in a more engaged and timely way. We discuss with organisations and practitioners the best intervention to meet their needs

This year we responded to a review of our current services and started to make changes.

Assessment reports are now concise, shorter, more focused and will be produced quickly.

with an overriding objective of ensuring that we support safe practice for patients across the NHS.

We completed more than 60 standard assessments, exceeding the total of any previous year. In the last quarter of the year, we reduced the waiting time for assessment from longer than one year to 3–4 months.

We collaborated with employers, contractors and practitioners to develop more than 100 action plans. Action planning is a highly structured programme of support for practitioners within an organisational framework of detailed targets and timescales, aimed at returning them to safe practice. It is used in situations where concerns about clinical practice have been identified through local processes, invited reviews or assessment and where practitioners are returning to work after a significant period of absence, including following periods of ill health and career breaks.

In addition to the services described above, NCAS has undertaken a number of mediations and team reviews and will be expanding these services.

A study reporting on NCAS' 11-year experience of dealing with concerns about doctors' performance concerns was published in *BMJ Quality and Safety*[1] in October 2013 . This concluded that, by creating a service that helps NHS employers to identify, investigate and deal appropriately with poor practice, the NHS sought to ensure that doctors who might harm patients were prevented from doing so as soon as possible after the problem was recognised. In addition, analysis of a consistently collected national database allows risk groups to be identified so that preventative action and early intervention can be targeted most effectively to reduce harm to patients.

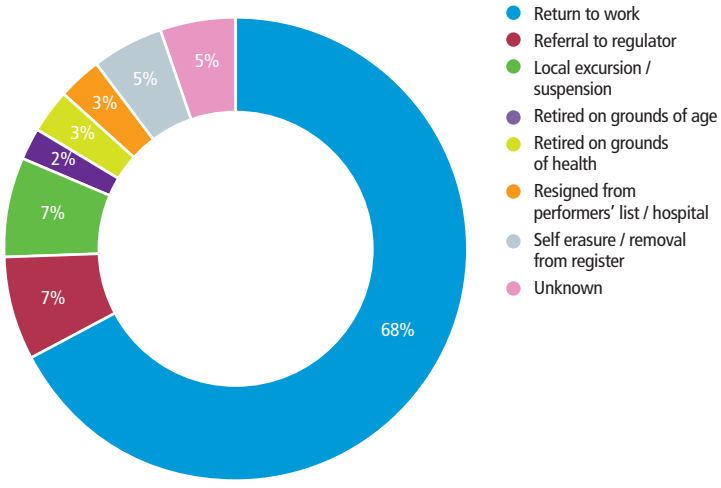
Support in action

Finding innovative solutions for the NHS and for practitioners

Only a few months after commencing their first substantive consultant post in a small hospital, concerns were raised about one area of a practitioner's surgical practice. The practitioner was excluded pending an investigation into the full scope of their practice. The employing trust requested that the practitioner undergo a full NCAS performance assessment. NCAS advised that a plan for a phased return to work would be appropriate to support the practitioner back into clinical practice. In order for an assessment to be undertaken a placement with an independent trust was arranged.

NCAS provided an action plan for the practitioner, which proposed interventions, supervision and means of workplace-based assessment giving the practitioner the opportunity to return to clinical practice in a supportive environment. Through the effective use of regular workplace-based assessments and a sliding scale of supervision and evidence of reflective learning and audit activity, the clinical supervisor at the placement trust was able to assure the employing trust that, over a period of time, the practitioner had consistently demonstrated his ability to perform at the level expected of a consultant surgeon in the department. It was agreed therefore that a full performance assessment was not required. It was anticipated that the practitioner's reintegration to the employing trust posed challenges, and following the successful placement, the practitioner chose to accept a substantive post at the placement trust.

Figure 19: NCAS action plan outcomes 2008–13



1. Donaldson LJ, Panesar SS, McAvoy PA et al. BMJ Qual Saf 2013; 0:1-6:doi:10.1136/bmjqs-2013-002054

Resolving concerns in primary care

A practitioner was a GP in a small practice. There were longstanding concerns about their prescribing of certain medications. Within the practice there were poor working relationships between the GP partners, who did not communicate face to face. There was also a high turnover of practice staff. A referral for an assessment was received and accepted by NCAS.

The practitioner underwent a full NCAS assessment. The practitioner was found to be poor in most areas of clinical practice. The behavioural assessment identified that the practitioner needed to develop in the areas of dealing with conflict, assertiveness, self-awareness, coping with pressure, personal organisation and openness to change. The Occupational Health Assessment identified health issues. NCAS provided an interim local action plan until the practitioner could undertake a placement in a Deanery Advanced Training Practice. The practitioner completed a clinical remediation plan by the midway point and remained in the practice as a locum. At the end of the placement the practitioner secured a salaried post with a primary care organisation.

The case illustrates how a practitioner who had been failing was restored to safe clinical practise in an area of high clinical need with a shortage of primary care services. The input of NCAS working with the primary care organisation, the Deanery and the practitioner in a variety of innovative approaches ensured that some complex obstacles were overcome.

NCAS Action Plan outcomes 2008–13

Figure 19 shows the outcomes of all cases that have been through a NCAS action planning process delivered by a dedicated 'Back on Track' team from late 2008 to the end of March 2013. This includes cases involving an NCAS performance assessment as well as non-assessment cases.

The chart demonstrates the successful return to work of 68% of practitioners who go through an NCAS action planning process; 13% retire, resign or leave the register; and 7% are referred to the regulator.

External education and learning

NCAS has continued its comprehensive programme of education and learning events and activities to ensure the NHS has the right skills to resolve concerns about the performance of doctors, dentists and pharmacists training over 2,500 delegates. All of our training programmes have scored at least 4.0 out of 5.0 for overall standard and content.

Alongside our programme of managing concerns about the performance of practitioners workshops we have, in partnership with NHS England's revalidation support team, delivered a significant programme of training for case investigators and case managers, providing key resources to support the effective implementation of medical revalidation. These workshops have been exceptionally well received. A three-month evaluation showed that all delegates reported an increase in confidence of undertaking the case investigator role, in writing and commenting on robust and effective terms of reference, in demonstrating good practice in managing investigations, in anticipating potential legal challenge and in writing a case investigation report that enabled the case manager to make a decision about the direction of the case.

"NCAS has undertaken a number of mediations and team reviews and will be expanding these services."

We have piloted new workshops for Board members on undertaking the role of a designated Board Member in performance cases and with NHS managers and medical leaders on using Maintaining High Professional Standards (MHPS) effectively.

Delegate feedback from NCAS workshops

- Overall very helpful and thought provoking – stressed the importance of process, but not necessarily only one right answer or approach.
- I feel that I have a much clearer concept of the various mechanisms available to deal with performance issues and of the relative importance of difference elements.
- Truly an excellent course where the obvious depth of experience of the facilitators ensured there were no unanswered questions.
- Excellent course. Fantastic speakers who clearly have a wealth of experience to share – thank you.
- First-class course led by high quality and widely experienced facilitators ready to sharetheir knowledge of real life cases.
- Ths type of learning is an excellent example of how to deliver training.
- I just wanted to say this has been an exemplary learning experience.

HPAN

Health Professional Alert Notices (HPANs) were introduced as part of the NHS Act in 2006 as a pre-employment check when a health professional practitioner was thought to pose a risk to patients or staff and may seek work in the NHS. HPANs apply to all health professionals regulated by a health regulatory body and are intended to be a temporary measure until a regulatory decision is made.

Prior to April 2013, the consideration to issue an HPAN was a duty of Strategic Health Authorities (SHAs) but, following NHS restructure, the responsibility passed to the NHS LA.

When the HPAN database was transferred on 1 April 2013 it contained 228 healthcare practitioners with active HPANs. Our scrutiny of this list revealed some instances where it was no longer appropriate to have the HPAN in place, either because regulatory action had occurred, further information was available removing the need for the HPAN, or the practitioner was no longer considered to pose a risk. We have therefore taken steps to refresh the database so the information is current. Our work to verify the names on the database is continuing.

From 1 April 2013 to 31 March 2014, 41 new HPANs were issued.

“All of our training programmes have scored at least 4.0 out of 5.0 for overall standard and content.”

We expect to move the HPAN database to a web-based system allowing easier access to the information as part of routine pre-employment checks in 2014/15.

NCAS in Northern Ireland and Wales

We received 20 referrals under our service level agreement with the Department of Health, Social Services and Public Safety in Northern Ireland.
Under an agreement with the NHS in Wales, we received 55 practitioner referrals.

Other services

In addition to services provided in Northern Ireland and Wales, we have agreements with Jersey, Guernsey, the Isle of Man and Gibraltar and our advice has been sought by organisations in the Republic of Ireland and Scotland. In total we received 13 referrals.
We also have a contract to provide a clinical review service to the General Dental Council. We reviewed 630 cases in the year.

Preparing NCAS for the future

We will continue in 2014/15 to provide NCAS core services free at the point of delivery to NHS organisations in England. We are also developing a range of services to support the NHS improve and support performance, some of which will be chargeable. These services will be designed to provide additional support to health service providers. They will include further development of team assessments and team dynamics interventions, mediation, case investigator and case management training, support and training for responsible officers and Boards, and access to a network of resources and expertise to support the remediation of practitioners and to help organisations navigate the complex systems governing performance management.

We will continue to build on existing relationships with key partners including regulators, royal colleges, Health Education England and NHS England to support the management and coordination of programmes of remediation for practitioners, drawing on the expertise of other organisations as and when required.

There are strong synergies between the work of the NHS LA and NCAS and aligning information from claims with information about individual practitioner performance creates new opportunities for learning, improving safety and quality across the NHS.

To ensure that we continue to build on our successes and continue to develop our services, Dr. Stephanie Bown has been appointed as the new Director of NCAS, taking up post in March 2014. Stephanie joins NCAS from the Medical Protection Society where she has worked for 19 years, initially as a medico legal adviser and latterly as Director of Communications and Policy. She is a former Vice President of the Faculty of Forensic and Legal Medicine and member of the CQC Advisory Group on General Practice.

Family Health Services Appeal Unit (FHSAU)

We responded to the changes to the NHS Pharmaceutical Regulations and strengthened our governance

- Following the restructuring of the NHS, we saw an increase in applications for dispute resolution by GP contractors.
- We continued to respond to the changes to the NHS (Pharmaceutical Services) Regulations 2012 ('the Pharmacy Regulations', amended in 2013), developing new systems and processes that allow us to determine appeals.
- We strengthened our FHSAU panel member governance by recruiting new lay members and introducing a new appraisal process for panel members.
- We successfully defended an application for costs following an application for Judicial Review on the basis of our neutral stance to the court.

The Family Health Services Appeal Unit (FHSAU) deals with disputes arising from dentists, general practitioners, pharmacists and opticians against the decisions made by NHS England that affect their contracts with the NHS.

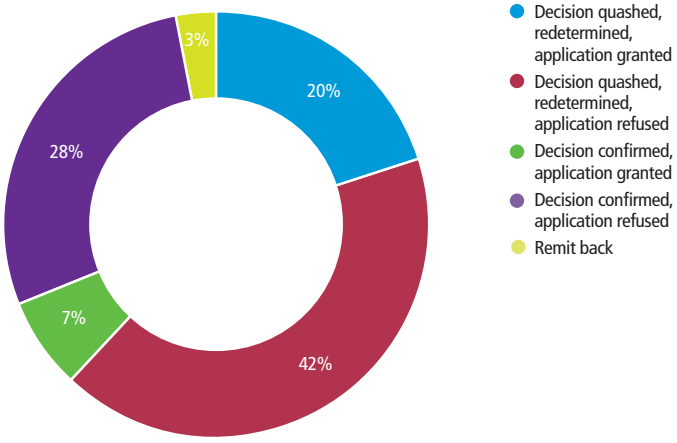
Following a slower start to the year, we received the average number of appeals and disputes. However, the mix of case types varied from previous years, but with pharmacy appeals remaining the busiest work stream with 271 appeals, up from 252 in 2012/13.

Dispute resolution

Disputes relating to general practitioners (GPs) and their contracts were again the main source of applications for dispute resolution. We received 111 disputes across all professions, (GPs, dentists and opticians), compared to 80 in 2012/13. It is not clear what caused this increase but it could have been as a result of the changes in NHS structure and due diligence carried out when contracts were transferred to NHS England from Primary Care Trusts (PCTs) in April 2013.

We received 29 disputes relating to reimbursement of premises costs to GPs. This was marginally more than

Figure 20: Pharmacy decisions in 2013/14 – outcomes



in the same period last year. Fully determined current market rent cases, (i.e. not referred back to NHS England or withdrawn), which numbered 19, were again marginally higher than in 2012/13.

Other medical and dental disputes raised the usual range of issues, such as remuneration, reimbursement, payment of quality outcomes framework monies, and termination of contract.

However, we did see a significant number of disputes following refusals by PCTs (later by NHS England) to pay monies under the Patient Participation Directed Enhanced Service Agreement (14). We also saw a significant increase in disputes involving the Quality Outcome Framework: 22, up from 2 in the previous year. There were 4 'termination of contract' disputes across all professions, compared to 7 in 2012/13.

Saving the NHS money

We determined a number of applications for dispute resolution where contractors had made applications on the basis that they considered that they had not been paid appropriately under the Patient Participation Directed Enhanced Service Agreement (the Agreement). The contractors claimed to have submitted the required evidence in order to meet performance indicators but NHS England considered that the evidence fell short of demonstrating actions under the Agreement.

In determination, we found that NHS England had ensured that contractors were made aware of the requirements of the Agreement and the time limits within which they were supposed to provide their evidence. We found that in most cases the contractors had not complied with the requirements of the Agreement, either by not submitting evidence within the required time limit, or having submitted evidence that it fell short of demonstrating

"Following a slower start to the year, we received the average number of appeals and disputes."

> **“We continued to respond to the introduction of the new Pharmacy Regulations amended in 2013 as a result of NHS restructuring.”**

actions under the Agreement. Where this was the case, contractors were therefore not entitled to any further payments under the terms of the Agreement.

Appeals

We continued to respond to the introduction of the new Pharmacy Regulations amended in 2013 as a result of NHS restructuring. This led to significant changes to work processing and ensuring effective decision making under the terms of these new Pharmacy Regulations, and to targeted training for our staff and FHSAU panel members.

Of those pharmacy appeals that resulted in a substantive determination (i.e. were not withdrawn), 94% were determined on the papers without additional external input and were issued within 15 weeks, meeting our target. For those requiring external input or an oral hearing, the average duration was 19 weeks and, therefore, met our target of 26 weeks.

Of those pharmacy appeals determined under the Pharmacy Regulations:

- 62% of NHS England's decisions were quashed and re-determined, which resulted in 20% of applications being granted.
- 35% of NHS England's decisions were confirmed, which resulted in 7% of applications being granted.
- 3% of appeals resulted in matters being referred back to NHS England for a further notification.

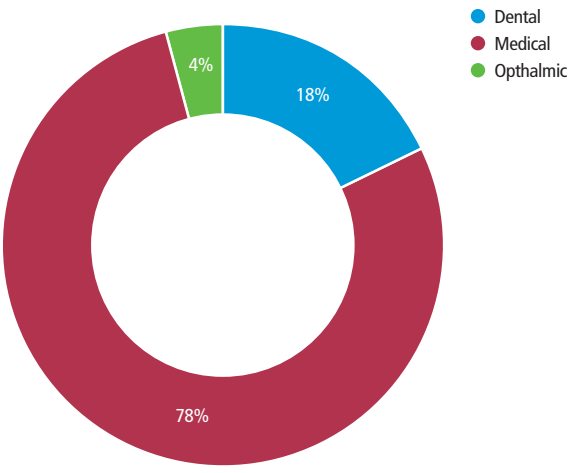
We have continued to embed our governance arrangements for our FHSAU panel members (who hear oral evidence prior to making a decision on appeals) and have during 2013/2014 recruited new lay panel members. We have reappointed two panel members following a robust recruitment and reappointment process and welcomed seven new members. We have also reviewed and implemented a new competency based appraisal process for all our FHSAU panel members.

We take this opportunity to thank all our panel members for all their hard work, particularly those panel members who moved on this year.

Judicial Review

Determination of disputes by the FHSAU may be subject to legal challenge by way of Judicial Review. During 2013/14 there were no such challenges following decisions on applications for dispute resolution.

Figure 21: Notifications of suspensions by profession in 2013/14



Determination of pharmaceutical appeals may also be subject to legal challenge by way of Judicial Review. Following the provision of new information we agreed two consent orders to set aside our decisions, given that all parties were in agreement that new information impacted on the original decision. We also successfully defended a costs application against the NHS LA. In this case, the courts accepted our neutral stance and held that we were not liable to pay the parties' costs.

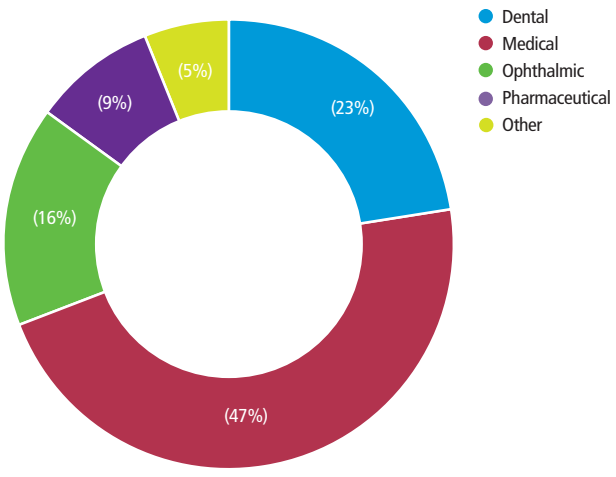
Performers List notifications and checks

The National Health Service (Performers List) (England) Regulations 2013 (the Performers List Regulations) currently apply to the medical, dental and ophthalmic professions, with similar provision for pharmacists in separate regulations. NHS England is required to provide notification to the NHS LA of any adverse decisions relating to those on the lists and those applying to enter them. The NHS LA keeps a list of such notifications. Similar provisions apply for the Health Boards in Northern Ireland, Wales and Scotland.

Before determining new applications to enter the Performers Lists, NHS England is required to check with the NHS LA for any facts relating to investigations or proceedings involving the proposed applicants. Between 1 April 2013 and 31 March 2014 the FHSAU received notification of 50 suspensions, compared to 60 in 2012/13. The breakdown by profession is shown below in Figure 21. There were 51 suspensions still in force as at 31 March 2014. There were also 1,481 other local decisions under the fitness-to-practise procedures, including notifications of withdrawn applications to join a list.

During 2013/14, 10,072 requests for information were processed, compared to 16,251 in 2012/13. A secure online checking system provided immediate clearance for 97% of these checks. The remaining 3% were referred to the NHS LA for further investigation. The breakdown of checks by profession is shown below.

Figure 22: Restrictions checks by profession in 2013/14



We have created a new Safety and Learning Service to support our members to focus on learning from claims in order to improve patient and staff safety and reduce higher value and higher volume claims.

Safety and learning

We are moving away from risk management assessments to supporting the NHS to learn from claims, delivering an outcome-based safety and learning service to reduce harm and improve patient safety

- We have moved away from the system of standards and assessments, significantly reducing duplication with other national assessments processes and reduced the burden on the front line.
- We have created a new safety and learning service to support our members to focus on learning from claims in order to improve patient and staff safety and reduce high value, high volume claims.
- We have significantly increased our influence in the patient safety arena and ensured that we are seen as a respected, credible partner in this field.
- We have ensured our aims and objectives are aligned with national partners and national patient safety policy and initiatives.
- We have provided expert advice in relation to the development of a culture of openness and the Statutory Duty of Candour for the NHS.

One of our strategic aims is to improve patient and staff safety by supporting the NHS to reduce harm through learning and creating effective incentives. We have a unique role in this based on 20 years' experience of managing negligence claims. To support this aim we set up a new Safety and Learning Function.

Safety and Learning Function

The work of the Safety and Learning Function has been influenced by key lessons over 2013/14 including reports by Robert Francis QC, Sir Bruce Keogh, Professor Donald Berwick and the Right Honourable Ann Clwyd MP and Professor Tricia Hart, together with the Government's response to the Francis Report.

In addition, over the year we have carried out a number of local focus group events with member organisations to inform them of the changes at the NHS LA and gain feedback to help shape the safety and learning service.

We have prioritised the areas that lead to the highest number of clinical and non-clinical claims. For clinical claims these are maternity, orthopaedic surgery and accident and emergency. We will focus on a few areas at a time to maximise our impact on improving safety.

The Function includes:

- A Safety and Learning Team of experts with skills in investigation, root cause analysis and patient safety improvement. This team was recruited by the end of March 2014 and during 2014/15 will investigate and analyse claims to discover how and why things go wrong in the NHS.
- Publication of regular reports to generate action and improvement on specific patient and staff safety issues.
- Safety and Learning Advisory Groups of experts in relation to maternity and perioperative practice to help evaluate the findings of the safety and learning team and help determine where to focus attention and solutions.
- A safety and learning service that will help members to learn from claims and reduce harm by proving information, analysis, practical support and help (this includes the new safety and learning library on the extranet).
- Sharing lessons for the NHS and healthcare via our website, conference presentations, local events and

> **“We have moved away from the system of standards and assessments, significantly reducing duplication with other national assessments processes and reduced the burden on the front line.”**

simple and clear leaflets, for example Saying Sorry, which explains that saying sorry and giving an explanation is the right thing to do when things go wrong.

- Using social media to promote our work and gain feedback including the use of twitter, for example posting a tweetstorm (a series of tweets to describe our services), webinars, and a safety blog.
- Over time we will also be helping the NHS to learn from the cases about professional practice that we receive via NCAS. We will not aim to create new interventions but to support the effective implementation of evidence-based solutions known to improve patient and staff safety.

Maternity care

The vast majority of babies born in the NHS are delivered safely but very occasionally things go wrong. The impact of these incidents can be significant for the baby, the family and the staff involved. We have analysed the maternity claims across a 10-year period, identified the priority areas for action and, as a result, focused on reducing hypoxia (oxygen deprivation) in newborn babies. We have worked together with the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwifery, as well as the expert Safety and Learning Advisory Group to explore how we can provide support in this area. For example:

- Understanding the human factors in maternity that could be improved, including communication, handover, observation, team working, recognition and responding to deterioration.
- Sharing and promoting the use of tools to help interpret cardiotocograph (CTG) recordings of the foetal heartbeat and uterine contractions, a key way of preventing hypoxia during birth.
- Understanding the importance of training for staff, response time to theatre, and recognition of at-risk babies and high-risk births.
- Sharing stories and case studies via our secure extranet.
- Influencing national policy in relation to supporting the NHS to improve maternity services.

> “The NHS LA has been bold in its decision to stop standards and assessments; we are so happy that we can now focus on our work improving safety for our patients.”
>
> NHS Obstetrician

In the future we aim to continue to analyse maternity claims, aggregate this data with other data sources such as the national maternity dashboard and the National Reporting and Learning System (NRLS) and use this information to influence key partners. For example, we will work with the Care Quality Commission to ‘ask the right questions’ when reviewing maternity services. We will also influence NHS England to include improving maternity services in the work of the national patient safety campaign and collaboratives.

> We have created a new Safety and Learning Service to support our members to focus on learning from claims in order to improve patient and staff safety and reduce higher value and higher volume claims.

'Needlestick'

'Sharps' injuries typically arise as the result of the inappropriate disposal of a contaminated needle or syringe. This will result in a penetration injury, often accompanied by a psychological injury arising from the fear of having contracted a blood-borne infection. Assuming that the blood test results are negative, it is common for the claimant to be diagnosed with temporary anxiety or 'adjustment disorder' from the incident date until final blood results.

> The vast majority of babies born in the NHS are delivered safely but very occasionally things go wrong.

Case study – needlestick

This case involved a hypodermic needlestick injury to a claimant's wrist when it pierced the rubbish bag that was being disposed of. The claimant, a hospital porter, reported that it was unclear which ward the bag came from but that there were other items inside that should not have been there. The claimant reported being upset that no one had said anything or apologised but was referred to counselling and occupational health services. The claimant suffered an adjustment disorder and depressive episode.

Liability was admitted and damages were settled for an amount of £15,000, which together with legal costs for both parties, totalled £35,500 for this case.

Learning points include promoting the need for appropriate disposal of sharps within the trust with provision of additional training. Tagging of bags would assist with identifying the origin (specific department of the trust) of the sharps. The use of kevlar gloves cannot eliminate the penetration of a needle.

The European Directive regarding sharps, which came into effect in May 2013, aims to ensure that the NHS has robust systems in place to limit the exposure to workers of the risk of blood-borne infection as a direct

> **“The NHS LA has supported learning across the NHS through a number of initiatives and sharing of data.”**

result of contact with sharps. An example is the use of retractable technology and self sheathing safety features. Progressing the requirements of the Directive with trusts will assist in defending future claims.

Between 1 April 2013 and 31 March 2014, 218 claims for needle stick injuries were settled and 30 were discontinued. Settlements ranged between £200 and £15,390 with an average payout of £2,385.

Supporting learning across the NHS

“The NHS LA has been saying that we would have our data shared with us, I didn’t realise this would be so good, and in real time. The extranet is exactly what we need.”

Trust Director of Governance

The NHS LA has supported learning across the NHS through a number of initiatives and sharing of data:

- Claims information involving ‘never events’, which are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implementated, were shared with the never events task force who used them to develop their recommendations for change.
- Claims information was shared with the Quality and Safety Team at the Royal College of Obstetricians and Gynaecologists to support the development of standards and safety indicators for the maternity dashboard as well as the National Audit Office to assist with their invesitagtion into maternity services in the NHS. This data was also shared with policy leads to support a Parliamentary Accounts Committee review of maternity services.
- Claims and risk information was also shared with national inquires including: the Keogh Review; the Hart and Clwyd review of complaints; the Parliamentary Health Service Ombudsman Office inquiry into sepsis; a review of maternity services at Morecambe Bay hospital; and a consultation related to a new statutory Duty of Candour. The information has been used to support policy decisions, recommendations for change andimprovement in both national and local services.

Brain-damage claim settled fairly and learning shared

Polymerised glue rather than contrast medium was inadvertently injected into the patient’s internal carotid artery. Blood transported this into the brain, causing irreversible damage. We admitted liability and settled the claim by way of a Periodical Payments Order, which gives the claimant index-linked payments for life for care and case management. We also shared learning from this tragic event with our members via our Extranet which is used by risk managers and other NHS staff to share the learning from cases with clinicans to stop similar tragic events happening in the future.

The NHS LA has worked in the past with academics supporting studies of claims data and the production of peer reviewed journal publications. A key objective for 2014/15 will be for the Safety and Learning Team to review the human and systems factors related to orthopaedic and other surgical claims to expand and build on these reviews. Examples are set out in the following cases.

Analysis of NHSLA Claims in Orthopaedic Surgery and Hand and Wrist Surgery by Irfan H. Khan et al published in *Orthopaedics and Journal of Hand Surgery.*

With regard to orthopaedic claims, the authors analysed 2,117 NHS Litigation Authority (NHS LA) orthopedic surgery claims between 1995 and 2001 with respect to the emergency department, outpatient care, surgery (elective or trauma operations), and inpatient care. The authors found common causes of claims were postoperative complication; wrong, delayed, or failure of diagnosis; inadequate consent; and wrong-site surgery. Certain surgical specialties, for example spine and lower-limb surgery, were found to have the most claims made during elective surgery, whereas upper-limb surgery has the most claims made during trauma surgery.

In relation to hand and wrist surgery claims from 1995 to 2001, the claims were most commonly attributed to errors at surgery (56%) or in outpatient clinics (24%). The claims were clustered to a few common conditions, particularly the treatment of carpal tunnel syndrome (22%) and wrist fractures (48%). There were no claims related to complex hand surgery. The authors recommended better training for 'routine surgery', better description of distal radius fracture parameters at each clinic visit and better training in emergency departments (ED).

A nationwide analysis of successful litigation claims in neurological practice by Thomas Coysh and David P Breen published in *Journal of the Royal Society of medicine, 2014.*

A retrospective analysis of successful neurology and neurosurgery claims over a 17-year period, occurring between 1995 and 2012 using the NHS Litigation Authority claims database. Four hundred and twenty-three claims were identified during the study period. 63.1% of claims were due to negligence in neurosurgical care, whilst 36.9% were due to negligence in neurological care. Payments were significantly higher in neurosurgery compared to neurology cases. Diagnostic error was the most common cause of litigation. The disease categories with the highest numbers of successful litigation claims were spinal pathology, cerebrovascular disease including subarachnoid haemorrhage, intracranial tumours, hydrocephalus and neuropathy/neuromuscular disease.

Litigation claims relating to venous thromboembolism (blood clots) in the NHS by Victoria White Alexander Nath Gerard Stans published in *Phlebology: The Journal of Venous Disease*

The NHS LA provided de-identified data on individual medical negligence claims against the NHS since 2007. The authors subcategorised the data into: (a) the nature of the venous thromboembolism event; (b) the area of specialist practice; and (c) the damages incurred. In the study period, 189 claims were made. Failure to prevent and to diagnose pulmonary emboli and deep vein thrombosis occurs across the spectrum of clinical specialties. The majority of claims were in surgical specialties. NICE provides comprehensive guidelines on venous thromboembolism risk assessment. Poor compliance has contributed to morbidity and mortality while the cost has continued to escalate. A multimodal approach to education is needed to improve patient outcome. Improved venous thromboembolism prevalence data are also needed.

Working with key partners

We have engaged with our members, patient groups, Royal Colleges, Regulators and other national partner organisations and worked with them to support safer care across the health sector to reduce harm to patients

Over 2013/14 we have worked with national partner organisations such as NHS England, the Care Quality Commission, the Parliamentary Health Service Ombudsman, the NHS Trust Development Authority and Health Education England. We have engaged with patient groups such as Health Watch, the Patients Association and the charity Action against Medical Accidents, and have provided expertise at national advisory groups and roundtable groups.

During the year, we provided specialist support as members of the Duty of Candour Consultation Group co-chaired by Norman Williams, President of the Royal College of Surgeons, and Sir David Dalton, Chief Executive of Salford Royal NHS Foundation Trust.

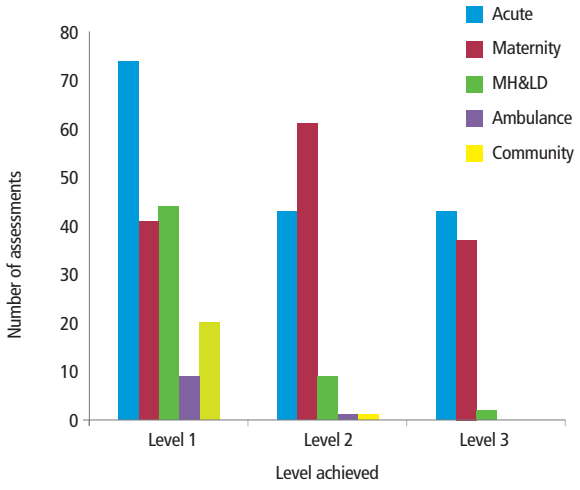
We have set up Advisory Groups with representation across the NHS to provide us with advice and connect us to a broad range of partners across healthcare and other safety critical industries. Members of the Advisory Groups are individuals representing organisations including Royal Colleges, improvement and safety networks, NHS England, the Care Quality Commission, as well as professional groups including doctors in training, patient safety improvers, risk managers and claims managers. They will:

- Provide advice and links to their respective networks and membership groups.
- Provide information for the safety and learning library and share good practice tools, resources, research and relevant literature.
- Review, contribute and add expertise to the root cause analysis of NHS LA's claims to contribute to national learning.
- Help raise awareness across the NHS of the scale and nature of the problem in relation to claims and stress the importance of targeting activity in order to do a few things very well.

Figure 23: Assessment levels as at end March 2014

	Level 1	Level 2	Level 3
Acute	75	43	43
Maternity	41	61	37
MH & LD	44	9	2
Ambulance	9	1	-
Community services	20	1	-
Total	189	115	82

Figure 24: Assessments as at end March 2014



Aligning our work with national initiatives and groups

So that we have the greatest impact, we have made sure we are aligned with and connected to all national patient and staff safety initiatives. We have also identified opportunities to collaborate or add value to other networks, movements, initiatives and organisations. This includes the 'sign up to safety campaign', safety collaboratives currently under design with NHS England, initiatives such as NHS Change Day, and the work of the Clinical Human Factors Group and the Human Factors Concordat.

Move away from Risk Management Standards and Assessments

Following an extensive review, we decided to move away from the system of standards and risk management and in its place develop a safety and learning service. This new approach has many advantages: it is focused on outcomes, suits the needs of our members, and supports the NHS to reduce harm and improve safety and, thereby, start to reduce claims.

We commissioned a final year of assessments from external suppliers Det Norske Veritas (DNV), whose contract ended in March 2014. We would like to take this opportunity to thank DNV and the assessors who have provided a professional, high quality service and have supported members to improve their risk management processes over the last seven years.

The standards will continue to be available as archived documents. We are happy for organisations to use them provided that our permission is asked. Details of assessments undertaken as at end of March 2014 are shown in Figure 23 and Figure 24.

"So that we have the greatest impact, we have made sure we are aligned with and connected to all national patient and staff safety initiatives."

Finance report

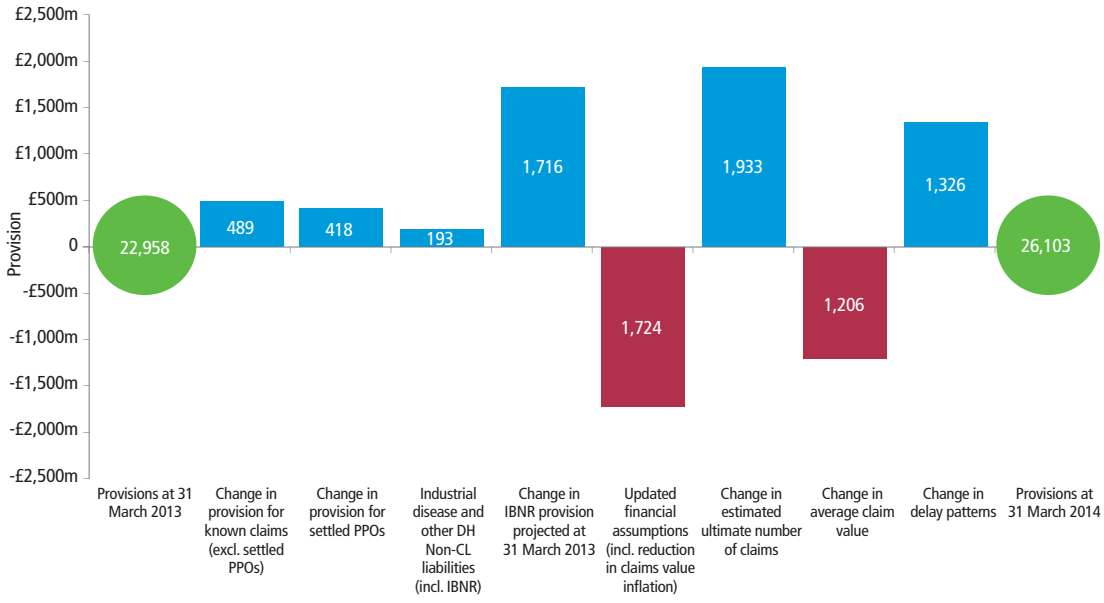
We have revised our approach to pricing to ensure members with fewer less costly claims pay less for their indemnity cover

- We have reported an underspend against our overall resource position, thereby meeting our financial target with the Department of Health, reflecting the accuracy of our forecasting of claims reporting and movements in claims provisions during the financial year.
- We rewarded safer clinical care by changing the way we calculate price for our Clinical Negligence Scheme for Trusts (CNST), which ensures that members with fewer less costly claims pay less for their indemnity cover.
- We introduced revised pricing for our new independent sector members to ensure that they are paying for indemnity cover (for the NHS care they provide) consistently with the NHS.
- We developed a revised pricing methodology for the cost of our indemnity cover for our Liabilities to Third Party Scheme which will enable us to reward organisations with fewer less costly claims by reducing the cost of the premiums in 2014/15.

Despite the continued challenge of increasing claims we met all of our financial targets in 2013/14. We have recorded an underspend of £218.4 million against our revenue resource limit, which is an excellent achievement and reflective of the way we carefully plan and monitor our expenditure.

We have seen a continual rise in clinical negligence claims

Figure 25: Analysis of change in provisions for claims (all schemes) in the year to 31 March 2014



for a number of financial periods. In the past 12 months, 11,945 clinical claims were reported, of which 11,634 were reported against CNST. (See Figure 9 on page 18)

The CNST was the largest element of our annual expenditure (£1.05 billion in 2013/14). Our challenge is to collect enough premiums from our members and the Department of Health to meet claims expenditure that will result from claims settled in that year.

CNST also accounts for more than 88% of our combined £26.1 billion valuation for outstanding claims and estimates of potential future expenditure on claims (known as provisions). The changes to our provisions over the year is detailed in Figure 25.

A typical insurance arrangement would charge premiums set at levels to ensure that enough funds are available to enable the insurance company to meet the complete claims exposure (i.e. claims settled in year and those arising from incidents which occurred whilst the insurance cover was in place). However, our NHS status and our 'pay as you go' approach enables us to help our members maximise the availability of NHS funds to deliver NHS care rather than having to pay us up front for claims that we will settle in future years.

Figure 25 also shows the elements we take into account when forecasting our provisions. However, the estimate of the timing and potential value of claims that have not been reported (and may not be reported) are particularly difficult to forecast. This is because we simply do not know how many claims may be brought in the future so have to provide our best estimate based on trends. The current changes in the legal market, which are outlined above starting on page 20, make it particularly difficult to predict the volume of potential future claims we will receive at this time. In particular, if the growth in the number of claims we are receiving slows as a result of changes resulting from the introduction of LASPO, this will have a direct impact on the value of our provisions.

As at March 2014 it is too early to predict the effect of changes in legal environment and the changes we have made to incentivise safer care through our revised pricing methodology and by supporting the NHS to reduce their claims through initiatives such as the extranet.

We are committed to work diligently with our members to identify ways to support them reduce the volume and financial burden of claims. A key way of achieving this is by learning from the claims to reduce harm and improve patient and staff safety in the NHS.

The NHSLA makes provisions in three areas:

- Known claims: claims we are aware of, but have not yet resolved. We don't know the exact amount of settlement so we provide an estimate.
- Estimated cost of future Periodical Payment Orders) (PPOs): orders made by the court, generally for high-value claims, where the claim is resolved by way of lump sum payment, together with regular payments for the rest of the claimant's life in order to meet their ongoing care needs. This ensures that the claimant is financially secure while also protecting the public purse.
- Claims which may be brought in the future but which haven't been reported: we estimate the value of claims which may be brought based on incidents and current claims trends. We refer to this estimate as incurred but not yet reported (IBNR).

Information and communication

Extranet

We developed a secure extranet that has provided our members with access to real time information about their claims, as well as learning to reduce claims and improve patient and staff safety. The site enables NHS leaders, clinical, claims and risk staff to track ongoing claims and view our library of case studies, helping them learn from examples of good practice. It was launched in September 2013 and we recorded nearly 1,500 logons by users on the first day. A team of NHS LA staff help members with any queries and we have received very positive feedback on the new features and learning materials. Over time we will expand the resources on the extranet, including the further development of benchmarking.

Awards

Following the launch of the extranet we were shortlisted from hundreds of high quality applications across the UK for an innovation award at the prestigious British Legal Awards for 2013, a major achievement and a significant milestone for us. We were the only public sector body to have reached this stage of the awards.

We were also shortlisted for a Government Opportunities (GO) Procurement Innovation Award for Health and Health Related Organisations in relation to the procurement of our Legal Panel.

Focusing on reducing maternity claims

During the year there was continued focus on maternity care in the NHS. The National Audit Office (NAO) conducted a review, which was followed by a Public Accounts Committee. Evidence from our report, Ten Years of Maternity Claims, An Analysis of NHS Litigation Authority Data, was used to demonstrate the scale and nature of the problem. To help the NHS understand the issues further we developed a maternity leaflet.

The key message is that having a baby whilst under the care of NHS doctors and midwives remains very safe. However, when things do go badly wrong it is devastating for the mother, baby and their family because the harm caused can be severe. This is why the value of these claims is high, as the amount paid is for ongoing care needs often for the duration of life and why it is vital that we learn and share lessons from these claims so that professionals can improve their clinical practice in the future and prevent harm.

Engaging our members

Throughout the year we wrote to our members to provide them with updates on the extranet, details of the safety and learning function, updates in relation to our claims, changes to the risk management and assessment processes and information about NCAS. We also wrote to them

about the details of their contributions (i.e. the cost of their indemnity cover) and our revised pricing methodology, which takes greater account of the claims experience of each organisation.
In the autumn we communicated with all organisations about their claims profile, providing them with information to better understand their claims in comparison with others.

> "Thank you so much for the case studies on the extranet. I have downloaded them and used them to raise awareness of claims and learning with clinicians in my trust. They made a big difference."
>
> Clinical Risk Manager

Engaging with key partners

A key achievement this year has been to align our work and take a key role in policy discussions and development with national partners including NHS England, the Care Quality Commission, Monitor, the NHS Trust Development Authority, the Parliamentary Health Service Ombudsman in England and the Department of Health. Our Chief Executive and fellow Directors have delivered keynote presentations including at the Patient Safety Congress, the Foundation Trusts Network Congress, the Healthcare Financial Management Association and the Royal College for Obstetricians and Gynaecologists' international conference, sat on advisory groups and supported key pieces of work such as the Statutory Duty of Candour.

Saying Sorry

We promote openness and transparency in the NHS and believe that healthcare organisations must create an environment in which all staff, whether directly employed or independent contractors of NHS care, are encouraged to report patient safety incidents. It is important not to delay giving a meaningful apology for any reason. To support the NHS, we have updated our previous guidance in the form of a leaflet, Saying Sorry. Saying Sorry supports the NHS to apologise and provide patients with an explanation when things go wrong. We will never refuse to indemnify an organisation that has said sorry.

"A key achievement this year has been to align our work and take a key role in policy discussions and development with national partners."

We developed our vision and values with our staff. This has resulted in a shared vision to achieve timely and fair resolution to enhance learning and improve safety and our values which are:

Professional:
providing a professional, high quality service, working flexibly to find effective and efficient solutions

Expert:
and expertise to everything we do

Ethical:
honesty, integrity and fairness

Respectful:
consideration and respect, and encourage supportive, collaborative and inclusive team working.

People

In 2013, we employed 213 people (198.88 whole time equivalents). All our substantive staff are contracted under the NHS Terms and Conditions of Service. 10 employees are registered with the General Medical Council (GMC). Our 2013/14 business plan budgeted establishment was 240.46 whole time equivalents. The number of agency staff at the NHS LA and NCAS between April 2013 and March 2014 was 58 engaged throughout the year to enable us to use a flexible workforce while the integration, restructure and NCAS business modelling work is underway. As at 31 March 2014 the number of agency staff is nine at the NHS LA and 16 at NCAS.

Staff turnover

Staff turnover during 2013/14 was 14.5%, up from 7.82% in 2012/13. If voluntary resignations and redundancies are removed from these statistics, the turnover rate during 2013/14 was 6%. However, this is markedly less that the turnover rate (to September 2013) for organisations similar to the NHS LA (Special Health Authorities) in England, which was 64% during 2013. There were 21 leavers during the year. The rate of turnover for the last 12 months is:

- NCAS: 22%
- NHS LA: 7%

Work experience

We support students and graduates on work experience placements and paid internships. We employed 11 staff in this way during the year as detailed in Figure 27 below.

Equality and diversity

During 2013 we complied with specific duties under the Equality Act 2010 to publish equality information with regard to our staff and service provision. We have also undertaken equality impact assessments and drawn up action plans for each major change to our service or working arrangements.

The NHS LA will aim to be accredited as a 'Two Ticks Symbol' employer to reflect our compliance with standards on the employment of people with disabilities. As at the end of March 2014, two members of staff had a disability. The NHS LA is ranked 334 out of 369 submissions in the Stonewall Equality Index 2014. Employees were encouraged to update their information, especially in relation to disability, sexual orientation and religion or other belief, in line with our agreed public sector equality duty objective. There has been a slight improvement in reporting rates in these three areas particularly for new staff. The organisational profile as at 31 March 2014:

Figure 26: NHS LA Establishment April 2013 – March 2014

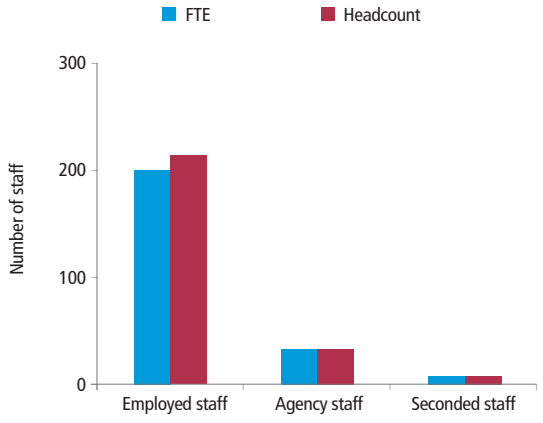


Figure 27: Work experience

Position	Number
Claims admin trainees	1
FHSAU	2
Claims work experience	4
Communications intern	1
Claims intern	1
Work experience from Scope working with people with disabilities	1
NHS Management Scheme Graduate – programme management	1
TOTAL	**11**

- The NHS LA employs slightly more women than men at 56% and 44%, respectively, and this has increased since the last report which showed 53% women and 47% men.
- During this period, 15.7% of staff worked part time. This was more than double the figure during 2012/13, which was 7.5%.
- Black or other minority ethnic employees make up 34% of our workforce. This compares to 32% in 2012/13.
- 26% of our workforce is aged 51 or over.
- Less than 2% of the workforce has declared having a disability.

Sickness

Our target is to have less than 3.2% sickness absence. As at 31 March 2014, we had a rate of 3.65%, which is slightly over target.

The number of employees (headcount) who have reached a Bradford factor score of 128 or more is 16 with a percentage of 7.5% of the workforce. This percentage figure has increased slightly from 6% as at 31 March 2014. It should be noted that processes are in place to actively manage these absences using line manager, occupational health and other forms of support.

Vision and values

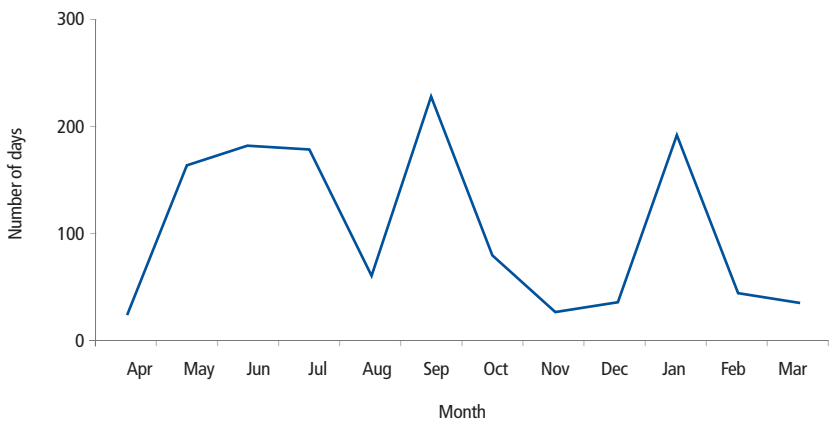
During 2013 we conducted an exercise with our staff to generate our vision and values from the bottom up. This resulted in a shared vision of achieving timely and fair resolution, enhancing learning and improving safety and our values which are:

- Professional: we are dedicated to providing a professional, high quality service, working flexibly to find effective and efficient solutions.
- Expert: we bring unique skills, knowledge and expertise to everything we do.
- Ethical: we are committed to acting with honesty, integrity and fairness.
- Respectful: we treat people with consideration and respect, and encourage supportive, collaborative and inclusive team working.

Investors in People

During the year we made a commitment to support the organisation to achieve the Investors in People framework. In order to begin the initial assessment, we commissioned Inspiring Business Performance to conduct the annual staff survey which began at the end of March 2014.

Figure 28: NHS LA sickness absence April 2013 – March 2014



Learning and Development
The NHS LA has a solid foundation of learning opportunities and encourages learning and development among its staff; promoting exchange of information between staff and creating an effective workforce.

Charity of the Year

In 2013, the NHS Litigation Authority's staff voted to support a charity of the year, which was the disability charity Scope.

Scope's vision statement asserts: "Scope exists to make this country a place where disabled people have the same opportunities as everyone else."

Over the year, NHS LA staff enthusiastically took part in numerous fund raising activities. This provided the added benefit of enabling staff from different office sites to meet up face-to-face and get to know each other.

Some of the fundraising efforts included a 'Great NHS LA Bake Off and cake sale', a raffle and the NHS LA Ten Bridge Challenge, a ten-mile sponsored walk around London following the Thames Path.

In July 2013 the NHS LA Chief Executive, Catherine Dixon, and Tom Fothergill, Director of Finance and Corporate Planning, completed an incredible 24-hour bike ride from London to Paris.

By the end of 2013, staff were proud to have collectively raised an incredible total of £8,869.25 for the well deserving charity Scope.

"During 2013 we conducted an exercise with our staff to generate our vision and values from the bottom up."

Strategic and Directors' Report

Management commentary

Statutory background

The NHS LA is established under the National Health Service Act 2006. These financial statements have been prepared according to an Accounts Direction issued by the Secretary of State with the approval of HM Treasury.

Functions

The NHS LA is a Special Health Authority primarily set up to manage, on behalf of its members, claims arising from clinical negligence incidents post-1 April 1995 under the Clinical Negligence Scheme for Trusts, (CNST). The NHS LA also manages clinical negligence claims against the NHS for incidents pre-1 April 1995 under the Existing Liabilities Scheme (ELS), clinical negligence claims against the former Regional Health Authorities under (the ex-RHA Scheme), funding for which is provided by the Department of Health and the non-clinical claims of NHS members (including employers' liability, public liability and professional indemnity, with the exception of motor vehicle claims) under our Liabilities to Third Parties Scheme (LTPS).

In addition, we manage certain liabilities on behalf of the Department of Health which include historical claims liabilities arising from the demise of Primary Care Trusts (PCTs) and Special Health Authorities (SHAs) and industrial disease claims arising from the activities of the NHS. Any criminal liabilities arising from the activities of SHA's and PCTs were transferred to us on 1 April 2013.

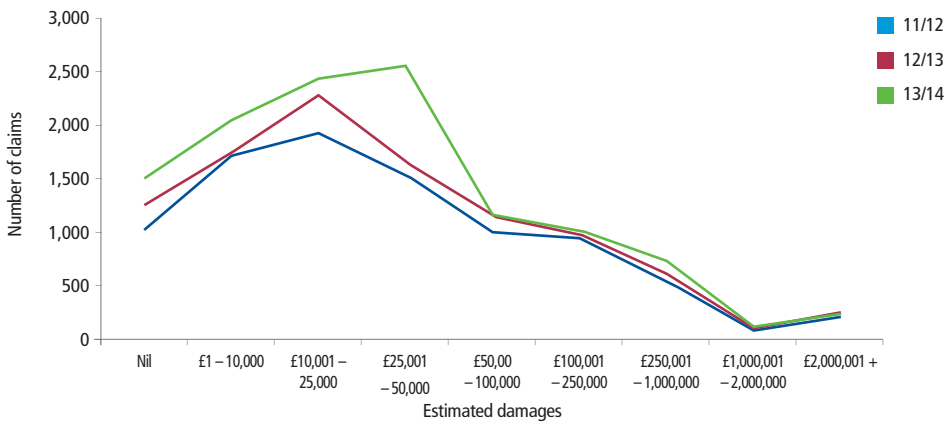
The NHS LA is also responsible for promoting high standards of risk management throughout the NHS and certain appellate functions on behalf of the Department of Health.

As at 1 April 2013 the National Clinical Assessment Service (NCAS) – which works to resolve concerns about the practice of doctors, dentists and pharmacists by providing case management services to healthcare organisations and to individual practitioners – transferred to the NHS LA as an operating division.

Review of activities and performance against targets

During the year, our net operating costs amounted to £3,374.3 million, which represents a decrease of £1,034 million on the figure for the previous year. The NHS LA's net operating costs are required to be managed within a revenue resource limit (RRL) agreed with the

Figure 29: Number of CNST claims received by value of damages



Department of Health. For 2013/14 the agreed RRL was £3,593 million; thus, an underspend of £218.4 million is reported. One of the key factors impacting on the resource limit is the value of claims received in year Figure 29 below shows the number of claims received by the CNST scheme and the associated value of the likely damages. The chart shows that the rising volume of claims received are tending to be valued below £100,000 whilst trends on higher value claims have remained relatively constant.

For 2013/14 we received funding of £228 million from the Department of Health. Capital cash limits for the year were £528,000, with reported outturn at £509,000 showing an underspend of £19,000.

Our financial position as at 31 March 2014, shows net liabilities of £26.1 billion. The global valuation recorded recognises provisions that will crystallise in future years and will be funded by future contribution payments or Department of Health 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, Section 70 of the NHS Act 2006 requires the Secretary of State to exercise his statutory powers to deal with the reported liabilities of this Special Health Authority if it ceases to exist.

These provisions relate predominately to clinical negligence claims that have either already been made, or that are considered to have been incurred through treatment delivered by the NHS but yet to be reported as claims. Inevitably any payments that may arise in the future as a result of these claims will take time so these provisions are recorded using International Accounting Standard 37 (IAS37) to give readers a clear indication of the likely value of these claims were they all made and settled today.

These provisions are essentially a valuation as at 31 March 2014 of all of the clinical and non-clinical liabilities of the NHS in England (excluding primary care delivered by GPs) that are covered by the schemes managed by the NHS LA should they all fall to be settled as at that point in time (i.e. should the NHS LA cease to exist, this is

the estimated value of the liabilities which would need to be met by the NHS relating to treatment delivered up to 31 March 2014).

The NHS LA's own cash balances increased by £2.5 million (£21.5 million is held at year end compared to £18.99 million in 2012/13).

All of the indemnity schemes managed by the NHS LA are managed on a 'pay-as-you-go' basis, meaning that members pay funds into the schemes in the financial year where the payments to resolve the claim are expected to be made. This helps the members to make maximum use of NHS resources for the delivery of patient care.

Pension liabilities

NHS LA employees are covered by the provisions of the NHS Pension Scheme, details of which are given in notes 1.12 of the accounts. Pension liabilities in respect of Board members are given in the Remuneration Report.

Audit Services

The Comptroller and Auditor General has provided the NHS LA's audit services at a cost of £78,000 for the current year. No non-audit work was undertaken.

The NHS LA has confirmed that there is no relevant information of which the auditors are unaware.

The Accounting Officer has taken all the steps she ought to take to ensure that they are aware of relevant audit information and the Accounting Officer has taken all the steps she ought to establish that the entity's auditors are aware of the information.

Remuneration

The NHS LA has a Remuneration and Terms of Service Committee, made up of all our non-executive directors, which considers pay and benefits for employees not covered by the national Agenda for Change arrangements, and makes recommendations to the Department of Health based on the Department's *Pay Framework for Very Senior Managers in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts.*

The Remuneration and Terms of Service Committee met six times during the year. Attendance was as follows:

Figure 30: Remuneration and Terms of Service Committee attendance

Non-executive director	Meetings attended
Joan Higgins	6 of 6
Keith Ford	6 of 6
Rory Shaw	6 of 6
Nina Wrightson	6 of 6
Ros Levenson	1 of 1
Andrew Hauser	1 of 1

All senior managers have indefinite contracts; there are no fixed-term or rolling contracts.

Figures 31, 32 and 33 give the contractual, salary and pension details of those senior managers who had control over the major activities of the NHS LA during 2013/14. The information in the following tables is subject to audit.

Figure 31: Salaries and allowances for 2013/14

Name and title	2013/14					
	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Professor Dame Joan Higgins [1] (Chair)	25 – 30	0	0	0	0	**25 – 30**
Catherine Dixon (Chief Executive)	140 – 145	0	5 - 10	0	32.5 – 35	**180 – 185**
Tom Fothergill (Director of Finance and Corporate Planning)	150 – 155	0	0	0	40 – 42.5	**190 – 195**
Helen Vernon (Executive Director)	95 – 100	0	0	0	72.5 – 75	**165 – 170**
Suzette Woodward (Executive Director)	100 – 105	0	0	0	0	**100 – 105**
Keith A Ford [2] (Non-Executive Member)	5 – 10	0	N/A	N/A	N/A	**5 – 10**
Professor Rory Shaw (Non-Executive Member)	5 – 10	0	N/A	N/A	N/A	**5 – 10**
Nina Wrightson OBE [3] (Acting Chair and Non-Executive Member)	15 – 20	0	N/A	N/A	N/A	**15 – 20**
Ros Levenson [4] (Non-Executive Member)	0 – 5	0	N/A	N/A	N/A	**0 – 5**
Andrew Hauser [5] (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	**N/A**

Band of highest paid director's total remuneration (£000) [1]	150 – 155
Median total remuneration [2]	£42,016
Ratio [2]	3.63[6]

Please see notes on page 64

Figure 32: Salaries and allowances for 2012/13

Name and title	2012/2013					
	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£00	£000	£000	£000	£000
Professor Dame Joan Higgins [1] (Chair)	35 – 40	0	0	0	0	**35 – 40**
Catherine Dixon (Chief Executive)	140 – 145	0	0	0	30 – 32.5	**170 – 175**
Tom Fothergill (Director of Finance and Corporate Planning)	150 – 155	1*	0	0	65 – 67.5	**220 – 225**
Helen Vernon (Executive Director)	N/A	N/A	N/A	N/A	N/A	**N/A**
Suzette Woodward (Executive Director)	N/A	N/A	N/A	N/A	N/A	**N/A**
Keith A Ford [2] (Non-Executive Member)	10 – 15	0	N/A	N/A	N/A	**10 – 15**
Professor Rory Shaw (Non-Executive Member)	5 – 10	0	N/A	N/A	N/A	**5 – 10**
Nina Wrightson OBE [3] (Acting Chair and Non-Executive Member)	5 – 10	0	N/A	N/A	N/A	**5 – 10**
Ros Levenson [4] (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	**N/A**
Andrew Hauser [5] (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	**N/A**

Band of highest paid director's total remuneration (£000) [1]	150–155
Median total remuneration [2]	£42,989
Ratio [2]	3.55[6]

Please see notes on page 64

[1] Joan Higgins retired on 31 December 2013.
[2] Keith Ford's term of office ended on 30 November 2013.
[3] Nina Wrightson was appointed as Acting Chair from 1 January 2014 until 31 March 2014 prior to the appointment of our new Chair, Ian Dilks, on 1 April 2014.
[4] Ros Levenson was appointed to the Board on 1 November 2013.
[5] Andrew Hauser was appointed to the Board and as Chair of the Audit and Risk Committee on 1 December 2013.
[6] The National Clinical Assessment Service (NCAS) became an operating division of the NHS Litigation Authority (NHS LA) on 1 April 2013. Therefore, there has been an increase in the general workforce, which has increased the pay ratio.

* The expense payment is a benefit in kind and relates to mileage allowance
** The expense payment is a benefit in kind and relates to a lease car

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Due to difficulties in separating the agency fee from the actual staff costs, the ratio does not include consideration of agency staff.

Figure 33: Pension benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014	Cash Equivalent Transfer Value at 31 March 2013	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Professor Dame Joan Higgins [1] (Chair)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Catherine Dixon (Chief Executive)	2.5 – 5	0	0 – 5	0	55	25	29	21
Tom Fothergill (Director of Finance and Corporate Performance)	0 – 2.5	5 – 7.5	40 – 45	120 – 125	646	588	45	21
Helen Vernon (Executive Director)	2.5 – 5	10 – 12.5	15 – 20	45 – 50	237	179	54	14
Suzette Woodward (Executive Director)	0 – 2.5	0 – 2.5	40 – 45	125 – 130	839	807	14	14
Keith A Ford [2] (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Professor Rory Shaw (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nina Wrightson OBE [3] (Acting Chair and Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Ros Levenson [4] (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Andrew Hauser [5] (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

Catherine Dixon
Chief Executive and Accounting Officer
Date: 30 June 2014

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Secretary of State has directed the NHS LA to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS LA and of its net expenditure, 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, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis.
- Make judgements and estimates on a reasonable basis.
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts.
- Prepare the accounts on a going concern basis.

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

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

Catherine Dixon
Chief Executive and Accounting Officer
Date: 30 June 2014

Governance statement

Scope of responsibility

I am the Chief Executive and Accounting Officer for the NHS Litigation Authority (NHS LA). I am responsible for maintaining a sound system of internal control that supports compliance with the NHS LA's policies, and the achievement of the NHS LA's objectives, whilst safeguarding public funds and the NHS LA's assets, in accordance with the HM Treasury document titled Managing Public Money. I have operational responsibility for:

- Delivery of the NHS LA's strategic aims and objectives within the NHS LA's legislative and regulatory parameters and as directed by the Department of Health.
- Compliance with and delivery against the NHS LA's Framework Agreement as agreed from time to time with the Department of Health.
- Delivery against key performance indicators as agreed with the Department of Health.
- Delivery, in conjunction with the Board, of effective governance.
- Provision, oversight and effective working of systems of internal control.
- oversight of complaints process and ensuring learning from complaints about our services.
- Risk management processes.
- NHS LA's databases and financial system.

As Accounting Officer, I, supported by the NHS LA senior management team, internal audit and the NHS LA's Audit and Risk Committee, make recommendations to the NHS LA Board on the matters outlined in this statement as they relate to effective NHS LA governance.

I delegate day-to-day operational responsibility for the NHS LA's financial systems and internal risk management arrangements to the Director of Finance and Corporate Planning, who also acts as the senior information risk owner (SIRO) for the NHS LA.

We have established a corporate governance team reporting to the Director of Finance and Corporate Planning to support the SIRO responsibilities for information governance and to coordinate internal NHS LA risk management activity, complaint handling, and freedom of information requests and data protection issues.

We have also established an Information Governance group which meets monthly to review information governance, incidents, risk, good practice, training requirements and matters relating to compliance. This group advises me as Accounting Officer, the NHS LA's SIRO and the Audit Committee on all information governance relevant to the NHS LA. I have also established a Data Reference Group to advise me on governance arrangements for sharing data internally across functional areas and externally in line with the NHS LA's Framework document, regulatory requirements, directions and strategic aims.

Governance, assurance and internal risk management are fully integrated within the NHS LA's business planning process. Planning and risk processes are coordinated through the senior management team, which I chair, and which reports through me to the Board.

The NHS LA's Health, Safety and Risk Committee provides further assurance by reviewing operational risk including health and safety risks, which include business continuity arrangements, incident reporting, complaints (including learning), internal risk and the NHS LA's policies, procedures and guidance on risk management and mitigation. The Health, Safety and Risk Committee ensures that key performance indicators are set and maintained in relation to the management of risk.

An internal audit plan is agreed by me as Accounting Officer and adopted by the Audit and Risk Committee. Close working arrangements exist between internal auditors, Department of Health and other agencies to ensure that the NHS LA draws on experience in the wider NHS.

Corporate performance is reported by me to the Board and to the Department of Health on a regular basis. Variations from anticipated performance will, where appropriate, be accompanied by reports from the Audit and Risk Committee and/or senior management team, giving me, the Board, and, where appropriate, the Department of Health, assurance on progress and the action to be taken.

I have received assurance from the Board that it is satisfied

that its governance arrangements meet the requirements of the Code of Good Practice required within central government departments.

During the year the Board reviewed and revised the information supplied to it to ensure it remains satisfied regarding the quality of information, but also that it is relevant and sufficient to inform the business of the Board. During the year the NHS LA Board met on six occasions and attendance details are as follows:

Figure 34: NHS LA Board meeting attendance

Name	Post	Meetings attended
Joan Higgins *	Chair	4 of 4
Keith Ford **	Non-executive Director	3 of 3
Rory Shaw	Non-executive Director	6 of 6
Nina Wrightson***	Non-executive Director	6 of 6
Ros Levenson****	Non-executive Director	3 of 3
Andrew Hauser*****	Non-executive Director	2 of 2
Catherine Dixon	Chief Executive	6 of 6
Tom Fothergill	Director of Finance & Corporate Planning	6 of 6
Helen Vernon	Director of Claims	6 of 6
Suzette Woodward	Director of Safety, Learning and People	5 of 6

* Joan Higgins retired on 31 December 2013
** Keith Ford's term of office ended on 30 November 2013
*** Nina Wrightson was appointed as Acting Chair from 1 January 2014 until 31 March 2014 prior to the appointment of our new Chair, Ian Dilks on 1 April 2014.
**** Ros Levenson was appointed to the Board on 1 November 2013
***** Andrew Hauser was appointed to the Board and as Chair of the Audit and Risk Committee on 1 December 2013.

The Board also carried out a review of its governance arrangements and effectiveness, including a questionnaire and workshop to consider the questionnaire's findings. This resulted in minor changes to the Board agenda management to ensure openness and transparency and also the creation of a Senior Independent Director role.

Other than those changes the Board was satisfied with its performance and effectiveness.

The purpose of the governance arrangements

The system of internal control is designed to eliminate risk, where possible, and then manage residual risk to a reasonable level, rather than to eliminate all risk of failure to achieve policies, aims and objectives. Therefore, it provides a 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 (both external and internal) to the NHS LA of achieving its aims and objectives.
- Ensure compliance with NHS LA policies.
- Evaluate the likelihood of risks being realised and the impact should they be realised.
- Ensure that the NHS LA is taking appropriate action to eliminate or mitigate against such risks.
- Manage the risk efficiently and effectively.

The system of internal control, which accords with HM Treasury guidance, has been in place in the NHS LA for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts. The internal audit team has provided reasonable assurance that there is a sound system of internal control within the NHS LA.

Capacity to handle risk

The NHS LA's approach to risk is outlined in the NHS LA's risk management strategy, which identifies the roles and responsibilities of staff at all levels relating to risk. Training is provided to support staff to carry out their designated responsibilities. The NHS LA's approach to governance, including risk, is included in the induction process for all new staff.

Information governance

The NHS LA is committed to minimising the risk associated with information handling and to ensuring that all staff are fully aware of their responsibilities in relation to the management of information. The NHS LA has completed the requirements for the Information Governance toolkit and will be delivering training to all staff, and assuring contractors and agency workers have an understanding of the NHS LA's information governance expectations and are trained appropriately.

During the year we have recorded two information handling incidents by the NHS LA Legal Panel members both of which have been reported to the Information Commissioner. As a result we have reinforced to the NHS LA Legal Panel their contractual obligations regarding information governance and security, which were updated and integrated into their contract with the NHS LA as part of our recent Legal Panel tendering exercise.

I am also ensuring that any learning requirements are addressed as part of the NHS LA's Information Governance Strategy and related policies and protocols. The NHS LA is also actioning the recommendations in the 2013/14 internal audit of information governance as reported to the Audit and Risk Committee.

Overall the internal auditors were satisfied with the progress made on information governance following the integration of NCAS into the NHS LA and made three medium-rated and two low-rated recommendations, which have been accepted by the NHS LA.

In addition, the NHS LA has continued to review its information transfer systems in light of the integration of NCAS into the NHS LA. The secure document transfer system (DTS) provides partners with a protected environment to transfer data to and from the NHS LA, minimising the risk of interception of sensitive documents. The NHS LA's IT equipment is appropriately encrypted and the use of portable media such as USB keys is strictly controlled, so when in use it is secure and password protected.

Complaints and feedback

The NHS LA is committed to ensuring that complaints and feedback about our services are reviewed. The Senior Management Team and I review complaints and feedback about our services and report the findings to the Board. I ensure that the NHS LA identifies any learning from complaints and I also review complaints with the Senior Management Team to identify any new risks, which are included in the risk register is appropriate. I am reviewing the NHS LA's complaints' policies and processes in line with the Clwyd/ Hart review of complaints in the NHS to ensure best practice is maintained.

The NHS LA's Assurance Framework brings together governance and quality linked to the NHS LA's strategic objectives. Its purpose is to ensure that systems and information are available to provide assurance on identified corporate risks and that such risks are being controlled and objectives achieved. For example, the NHS LA's financial and operational performance is reported monthly to the Senior Management Team, to the Board and to me. The NHS LA's financial position, together with operational KPIs, is reported quarterly to the Department of Health to demonstrate that expenditure commitments are in line with forecasts and budgetary limits.

The NHS LA Board receives assurance from the Audit and Risk Committee, which in turn receives assurance from me, the NHS LA's Senior Management Team and, where appropriate, the Health, Safety and Risk Committee, Information Governance Group and Data Reference Group on the achievement of objectives and mitigation of risk. I am responsible and accountable for ensuring that:

- Key controls are in place to assist in securing and delivering objectives.
- The controls systems, upon which reliance is placed, are effective.
- Any gaps in controls systems or assurances are addressed within an agreed action plan.

The Board has to be able to demonstrate that it has seen evidence of the above. The Board, therefore, has, in addition to its formal meetings, held several informal sessions, including Board away days, to facilitate dealing with key issues, including reviewing Board governance and the information available to the Board, to ensure its effectiveness.

The risk and control framework

During the financial year 2013/14, the NHS LA has identified and dealt with a number of significant issues (some of which were outside our direct control). Some of the matters are ongoing into 2014/15 and their management is subject to ongoing review. The following issues were considered to be significant:

- The NHS LA has experienced an unprecedented rise in the number of claims in year, which is placing pressure on internal resources and expenditure. I am taking steps to manage expenditure and resources. This includes improving expenditure planning and using Legal Panel firms' capacity and resources to flex our internal capacity. I am hopeful that a change in the law resulting from the Legal Aid, Sentencing and Punishment of Offenders Act 2012, (LASPO) will overtime result in a reduction in the cost of claims in the NHS.
- Following the successful transfer of NCAS into the NHS LA as an operating division the NHS LA will during 2014/15 continue working towards transforming NCAS's service delivery, which is currently funded in part by the Department of Health, with the aim of developing and moving towards a self-funding model when it is safe to do so.
- The NHS LA has expanded its membership by welcoming more than 50 independent sector providers of NHS care and taken the opportunity to revise its

pricing methodology for independent sector members to bring it into line with pricing methodology for our NHS members. This has enabled independent sector organisations that are providing NHS care to receive the same level of indemnity cover at a similar cost to that of the NHS.

- During 2012/13 the audit of our financial accounts identified a number of claims where the date of the alleged incident was incorrect. During the year we have carried out an extensive review of all open claims recorded in our database to ensure that NHS LA key data is accurately recorded and maintained. Internal and external audit reviews of data integrity have given assurance that data accuracy has been adequately addressed.
- In order to ensure that NHS LA members are fully aware of the claims in their organisations and to encourage and support them to take steps, where appropriate, to reduce the number of claims thereby improving patient and staff safety, we have launched a revised extranet giving our members real time access to their claims and shared learning from the claims. We are continuing to develop our informatics and data analytics capabilities to ensure that we are working closely with our members to share learning and identify best practice to support the NHS to reduce harm. The views of our members, via feedback, received from the extranet are enabling us to further develop our services.
- In order to ensure a fair and appropriate pricing across our membership recognising and rewarding those organisations with fewer less costly claims, we have launched a revised pricing methodology for contribution setting in 2013/14 which aims to price incentivise the reduction of claims thereby reducing harm. The NHS LA has continued to communicate its revised approach to our members and other key partners.
- We are working closely with regulators and NHS England to, where it is appropriate, share our information and assist with the NHS quality agenda.
- We are contributing to a Department of Health consultation on the Statutory Duty of Candour and as to whether the NHS LA should introduce reimbursement from Trusts of damage payments if they fail to be candid.
- As with all NHS organisations, the risk of fraud is a significant consideration. The nature of the NHS LA's work inevitably focuses our attention on the risk of fraudulent claims being brought against our members. Great care is taken to review the appropriateness of our systems, with reporting to the Audit and Risk Committee by our Counter Fraud Team. Where possible fraud is identified, the NHS LA immediately involves the appropriate authorities, as well as discussing the matter with any affected stakeholder and their local counter-fraud specialists. Staff awareness regarding fraud is maintained by regular updates, newsletters and training, and, following consideration of the results of a survey, in the past year a number of staff received additional fraud awareness training.
- We are also taking steps to ensure we challenge claimant solicitors' costs where they are disproportionate to damages and defence costs. We have secured significant reductions in claimant solicitors costs in year with an average reduction of 28.8%. We have secured significantly greater discounts from some firms including one claimant firm where we have secured a 78% reduction on all bills submitted. We will continue to develop our expertise in cost management so that we can ensure that we continue to appropriately challenge claimants' solicitors wherever appropriate.
- In order to ensure the services we receive from our Legal Panel remain competitive, we completed a Legal Panel tender to appoint a new Legal Panel for the NHS LA's clinical and non-clinical legal work for all Department of Health agencies (Arm's Length Bodies or ALBs) in respect of health and regulatory work. We were able to secure significant discounts for volume, which we are applying to all Department of Health ALBs, whilst ensuring that the quality and cost of legal services represents value for money and is sustainable. We also secured a significant number of value adds, including use of premises, secondees, library services and services to support the NHS in learning from things that go wrong, with a view to reducing harm and improving patient and staff safety.
- We introduced an inquest service for NHS LA members, which provides advice and support in the event that an inquest is likely to be the precursor to a claim for clinical negligence. In year, we have handled more than 500 inquests on behalf of our members, including supporting members, financially and helping them to support families through a difficult process whilst reducing cost for the NHS by intervening in cases, which are likely to become claims sooner.
- We have worked with the Department of Health and NHS England to agree and allocate the transfer of historic liabilities for outstanding claims and claims arising from incidents prior to 31 March 2013, following the demise of SHAs and PCTs on 31 March 2013. We have successfully allocated historic liabilities appropriately to the Department of Health and NHS England and agreed funding arrangements.

- In response to the NHS LA's membership feedback and following a review of the impact of risk management assessments, we have implemented changes to the NHS LA's approach to risk management by bringing to a close risk management assessments carried out against standards by the NHS LA's contractor, Det Norske Veritas (DNV). The last assessment was carried out in March 2014 and the contract has been successfully brought to an end on 31 March 2014. We have confirmed to our members that we will continue to pay discounts associated with their risk management assessment level for 2013/14, whilst confirming that we will transition away from discounts in 2015/16 while avoiding large swings in member price.
- We have launched a safety and learning service which is designed to help the NHS reduce harm by supporting members to learn from claims. In year, we have established Safety and Learning Advisory Groups for maternity with leading clinicians from the Royal College of Obstetrics and Gynaecology and the Royal College of Midwives. We also established a Safety and Learning Advisory Group for surgery with a variety of representatives, again, including the Royal College of Surgeons. We are using groups to advise us on steps we can take to support and incentivise the NHS to reduce claims, thereby reducing harm.
- We have taken steps to raise the profile of the NHS LA, especially as an organisation with a unique role in patient safety. We were named as a partner on the Human Factors Concordat for the NHS and have recruited Safety and Learning Leads to support learning from claims and NCAS services.
- We have continued to develop our communications, in particular to members by providing them with more information about their claims including a RAG (Red, Amber and Green) rating for each member organisation with claims experience. We hope that this will assist organisations to understand their claims profile and, where appropriate, take steps to reduce claims, thereby reducing harm.
- We have made changes to improve the service delivery of NCAS, including the introduction of a triaging service to ensure that referrals can be dealt with more efficiently and effectively through utilising the employment law expertise of our panel firms and by reducing the waiting times for assessments from over 12 months to below 6 months in year. We have also taken the opportunity to review and restructure assessment reports so that they are shorter and more focussed on key issues arising from the assessments. We are in dialogue with organisations, including NHS England, in relation to NCAS's role in providing services to support organisations and individuals dealing with performance issues, including those arising as a result of the revalidation process.
- We took on the management of Health Professional Alert Notices (HPAN) in accordance with directions given to us from the Department of Health. We reviewed processes to ensure effective governance and developed an online web based portal to enable HPANs to be accessed more effectively. We also reviewed all HPANs to ensure they remain relevant and were accurately recorded.
- We have taken on additional new services on behalf of the Department of Health including the handling of industrial disease claims which we are handling in conjunction with one of our Legal Panel firms. This ensures consistent treatment for those claims across the NHS, enabling us to appropriately reserve for future claims.
- We have responded to changes brought about by the new pharmacy regulations NHS (Pharmaceutical and Local Pharmaceutical Services Regulations, 2013) and have taken steps to strengthen our governance arrangements within our Family Health Services Appeals Unit by undertaking a recruitment process for lay members and introducing regular appraisals to ensure consistency of quality across our panels.
- We have successfully implemented the new employer's liability (EL) and public liability (PL) claims portal which deals with all EL/PL claims below £25,000. We are taking steps to evaluate the operation of the portal, which went live in August 2013, and put in place further steps to mitigate the risk of fraud, including key fraud indicators. In addition, we are making staff aware of potential fraud risk and providing training.
- We have taken opportunities to increase learning and development opportunities for staff to ensure that they can operate as efficiently and effectively as possible. This includes negotiation skills training and mandatory training in relation to the changes following the introduction of the Legal Aid Sentencing and Punishment of Offenders Act (LASPO) and information governance.
- We are continuing dialogue with the Ministry of Justice and the Department of Health in connection with the impact of the Jackson reform changes to ensure the implications of the changes are fully understood and are monitored.
- We have been finalists for two awards – the British Legal Award for Innovation for the NHS LA's extranet and the GO National Procurement Award for

collaborative working for the NHS LA's Legal Panel procurement: this is a testament to the hard work of all those involved.

- We have been asked by the Secretary of State for Health to assist in the approval and evaluation of signup for safety plans. Where such plans can demonstrate the reduction of harm and thereby the reduction of claims, the NHS LA will offer a discount against premiums, thereby supporting the NHS to improve patient safety.
- The NHS LA supports all aspects of the NHS Constitution. In particular, the NHS LA supports the rights of service users to make a claim for judicial review and the right to compensation where the service user has been harmed by negligent treatment and is committed to ensure that lessons for claims are used to improve NHS services. The NHS LA undertook an engagement programme with staff and agreed a vision and values for the NHS LA which reflect the values of the NHS Constitution.
- The NHS LA is committed to taking all appropriate steps within its remits to address health inequalities. The NHS LA supports litigants in person to make claims for negligent treatment, thereby ensuring all service users have access to justice.
- The NHS LA appointed a responsible officer in accordance with the Medical Profession (Responsible Officers) Regulations 2010 (the Responsible Officer Regulations) following the transfer of NCAS to the NHS LA on 1 April 2013 as the NHS LA is a designated body in accordance with these regulations. The NHS LA is undertaking a re-validation programme in accordance with the Responsible Officer Regulations in relation to its employed doctors.

Review of effectiveness

As Accounting Officer, I am responsible for reviewing the effectiveness of the system of internal control. This is undertaken in the following ways:

- The head of internal audit (a role delivered as part of our outsourced internal audit function) that reports to me provides assurance that there is generally a sound system of internal control (designed to meet the organisation's objectives) and that controls are generally applied consistently. During the year there were six assurance based reports produced and all received a positive rating. There were a total of 13 medium rated recommendations and 9 low rated – all of which were accepted by the NHS LA.
- Members of the Senior Management Team, who have responsibility for the development and maintenance of the system of internal control, provide me with assurance.
- The Assurance Framework provides me with evidence of the effectiveness of controls that manage the risks to the organisation, thereby supporting and achieving its objectives.
- I regularly meet with members of the senior management team to discuss the performance of the NHS LA and to receive assurance and feedback on their areas of responsibility. Throughout this financial year we have discussed and agreed the changes we are making to our services, including preparing for the new NHS structure (and new NHS LA members) and also the transition of NCAS from NICE.
- The NHS LA's Reserving Committee and the NHS LA's actuaries support and inform me, as Accounting Officer, of matters that I should consider when agreeing the appropriate level of reserves for the NHS LA.
- I am supported by the SIRO, the Information Governance Group and the Data Reference Group on all aspects of information governance across the NHS LA.
- The Health, Safety and Risk Committee provide me and the Senior Management Team with assurance about the management of operational risk and safety within the organisation.
- I am also informed by the NHS LA's external auditors in their management letters and other reports on aspects of the system of internal control. The final accounts process for 2013/14 incorporated actions identified during the previous audits to improve the presentation and clarity of the accounts including detailed sensitivity analysis regarding our provisions at note 9 in the attached accounts.
- The Audit and Risk Committee meets regularly and reports to the Board and me after each meeting, and also by way of a formal annual report. During the year the Audit and Risk Committee has reviewed its own effectiveness, membership and terms of reference and remains satisfied that it has sufficient flexibility in those areas to deal with the business of the Audit and Risk Committee. In addition, the Audit and Risk Committee has commissioned additional assurance regarding actuarial forecasts by introducing a peer review carried out by an independent firm of actuaries. The Audit and Risk Committee also monitors compliance with all audit recommendations to ensure that they are effectively implemented. Both the internal and external auditors are present at the Audit and Risk Committee's meetings and the Internal Audit Team has reported on corporate governance during 2013/14.

The attendance record for the Audit and Risk Committee's meetings is given in Figure 35 opposite.

Figure 35: Audit and Risk Committee meeting attendance

Name	Post	Meetings attended
Keith Ford *	Non-executive Director	2 of 2
Andrew Hauser **	Non-Executive Director	2 of 2
Nina Wrightson ***	Non-executive Director	3 of 4
Rory Shaw	Non-executive Director	3 of 4
Ros Levenson ****	Non-Executive Director	1 of 1

* Keith Ford's term of office ended on 30 November 2013.
** Andrew Hauser was appointed Chair of the Audit and Risk Committee on 1 December 2013.
*** Nina Wrightson became acting Chair with effect on 1 January 2014 and has not, therefore, been an active member of the Audit and Risk Committee since that date.
**** Ros Levenson, a member of the Rem Co., was appointed to the Audit and Risk Committee on 1 January 2014.

The governance arrangements detailed in this statement aim to support the NHS LA to maximise its understanding and use of all available information about the quality and effectiveness of its systems to help us improve services and satisfy assurance requirements about the effectiveness of our systems of internal control. Based on my review I am not aware of any significant control issues.

Catherine Dixon
Chief Executive
NHS LA
30 June 2014

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 2014 under the National Health Service Act 2006. The financial statements comprise:
Statements of Comprehensive Net Expenditure
Financial Position
Cash Flows
Changes in Taxpayers' Equity
Related notes

These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, certify and report on the financial statements in accordance with the National Health Service Act 2006. I conducted my audit in accordance with International Standards on Auditing (UK and Ireland). Those standards require me and my staff to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Litigation Authority's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Litigation Authority; and the overall presentation of the financial statements. In addition, I read all the financial and non-financial information in the annual review to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by me in the course of performing the audit. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my certificate.

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

Opinion on regularity

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

Opinion on financial statements

In my opinion:

- The financial statements give a true and fair view of the state of the NHS Litigation Authority's affairs as at 31 March 2014 and of the net expenditure for the year then ended.
- The financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Emphasis of matter – provision for Clinical Negligence Scheme for Trusts

Without qualifying my opinion, I draw attention to the disclosures made in note 9 to the financial statements concerning the uncertainties inherent in the incurred but not reported (IBNR) claims provision for the Clinical Negligence Scheme for Trusts. As set out in note 9, given the long-term nature of the liabilities and the number and nature of the assumptions on which the estimate of the provision is based, a considerable degree of uncertainty remains over the value of the liability recorded by the NHS Litigation Authority. Significant changes to the liability could occur as a result of subsequent information and events which are different from the current assumptions adopted by the NHS Litigation Authority

Opinion on other matters

In my opinion:

- The part of the Remuneration Report to be audited has been properly prepared in accordance with Secretary of State directions made under the National Health Services Act 2006.
- The information given in the Strategic and Directors' Reports for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the following matters which I report to you if, in my opinion:

- Adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff.
- The financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records and returns.
- I have not received all of the information and explanations I require for my audit.
- The Governance Statement does not reflect compliance with HM Treasury's guidance.

Report

I have no observations to make on these financial statements.

Sir Amyas C E Morse Date: 1 July 2014
Comptroller and Auditor General
National Audit Office
157–197 Buckingham Palace Road
Victoria
London

Statement of Comprehensive Net Expenditure
for the Year ended 31 March 2014

	Notes	2013/14 £000	2012/13 £000
Programme costs			
Authority and claims administration *	2.1	**20,252**	13,382
Unwinding of discounts	2.1	**(44,609)**	19,209
Change in discount rate **	2.1	**(110,067)**	1,411,694
Other claims and associated costs	2.1	**4,543,931**	3,969,595
		4,389,255	5,400,498
Total programme costs	2.1	**4,409,507**	5,413,880
Operating income	4	**(1,035,203)**	(1,005,743)
Net expenditure	3.1, 10	**3,374,304**	4,408,137
Net gain on transfer of NCAS *	16	**(3)**	0
Total Net Expenditure		**3,374,301**	**4,408,137**

There are no items of expenditure that should be shown as Other Comprehensive Expenditure and therefore this statement is not required.

* Expenditure has increased due to the National Clinical Assessment Service (NCAS) moving from the National Institute for Health and Care excellence (NICE) to become an operating division of the NHS Litigation Authority (NHS LA) on 1 April 2013.
** In December 2013 the Treasury changed the discount rate for general provisions (Note 1.14)

The notes at pages 82 to 112 form part of these accounts.

Statement of financial position
as at 31 March 2014

	Notes	31 March 2014 £000	31 March 2013 £000
Non-current assets:			
Property, plant & equipment	5.3, 5.4	**1,749**	1,737
Intangible assets	5.1, 5.2	**600**	402
Total non-current assets		**2,349**	2,139
Current assets:			
Trade and other receivables	6	**10,855**	6,790
Cash and cash equivalents	7	**21,533**	18,992
Total current assets		**32,388**	25,782
Total assets		**34,737**	27,921
Current liabilities:			
Trade and other payables	8	**(29,335)**	(21,432)
Provisions for liabilities and charges – known claims	9.1, 9.2	**(1,122,000)**	(1,127,693)
Provisions for liabilities and charges – IBNR	9.1, 9.2	**(143,000)**	(105,000)
Total current liabilities		**(1,294,335)**	(1,254,125)
Non-current assets plus/less net current assets/liabilities		**(1,259,598)**	(1,226,204)
Non-current liabilities			
Provisions for liabilities and charges – known claims	9.1, 9.2	**(9,408,097)**	(8,466,262)
Provisions for liabilities and charges – IBNR	9.1, 9.2	**(15,430,000)**	(13,259,000)
Total non-current liabilities		**(24,838,097)**	(21,725,262)
Assets less liabilities		**(26,097,695)**	(22,951,466)
Taxpayers' equity			
General Fund		**(1,587)**	4,613
ELS Reserve		**(579,639)**	(2,238,540)
Ex-RHA Reserve		**(35,889)**	(37,519)
DH Clinical Reserve		**(1,860,892)**	0
DH Non Clinical Reserve		**(193,130)**	0
CNST Reserve		**(23,177,157)**	(20,408,882)
PES Reserve		**1,258**	(1,814)
LTPS Reserve		**(250,659)**	(269,324)
Total taxpayers' equity		**(26,097,695)**	(22,951,466)

The General Fund and individual scheme reserves are used to account for all financial resources. see note 9 for a brief description of each scheme to which the reserves relate. The National Clinical Assessment Service (NCAS) became an operating division of the NHS Litigation Authority (NHS LA) on 1 April 2013. The movement of the Statement of Financial Position relating to NCAS can be found in note 16

The financial statements on pages 78 to 112 were approved by the Board on 30 June 2014 and signed by Catherine Dixon
The notes at pages 82 to 112 form part of these accounts.

Signed: Date: 30 June 2014
Catherine Dixon, Chief Exectutive and Accounting Officer

Statement of Changes in Taxpayers' Equity
for the year ended 31 March 2014

	Notes	General Fund £000	ELS Reserve £000	Ex-RHAS Reserve £000	DH Clinical Reserve £000	DH Clinical Reserve £000	CNST Reserve £000	PES Reserve £000	LTPS Reserve £000	Total Reserves £000
Balance at 1 April 2012		4,374	(2,249,025)	(32,089)	0	0	(16,340,952)	(3,244)	(242,359)	(18,863,295)
Changes in taxpayers' equity for 2012/13										
Net expenditure for the year	9.6	(1,170)	(133,349)	(6,653)	0	0	(4,240,930)	1,430	(27,465)	(4,408,137)
Total recognised income and expense for 2012/13		(1,170)	(133,349)	(6,653)	0	0	(4,240,930)	1,430	(27,465)	(4,408,137)
Net Parliamentary funding *		1,409	143,834	1,223	0	0	173,000	0	500	319,966
Balance at 31 March 2013		**4,613**	**(2,238,540)**	**(37,519)**	**0**	**0**	**(20,408,882)**	**(1,814)**	**(269,324)**	**(22,951,466)**
Changes in taxpayers' equity for 2013/14										
Net expenditure for the year	9.6	(7,869)	1,619,687	(1,790)	(1,967,127)	(200,664)	(2,838,275)	3,072	18,665	(3,374,301)
Total recognised income and expense for 2013/14		(7,869)	1,619,687	(1,790)	(1,967,127)	(200,664)	(2,838,275)	3,072	18,665	(3,374,301)
Net Parliamentary funding **		1,669	39,214	3,420	106,235	7,534	70,000	0	0	228,072
Balance at 31 March 2014		**(1,587)**	**(579,639)**	**(35,889)**	**(1,860,892)**	**(193,130)**	**(23,177,157)**	**1,258**	**(250,659)**	**(26,097,695)**

* During 2012/13 the Department of Health made additional non-refundable cash available to the ELS Scheme (£26.5m) and the member funded CNST (£173m) and LTPS (£0.5m) Schemes.
** During 2013/14 the Department of Health made additional non-refundable cash available to the member funded CNST (£70m)
CNST, LTPS and PES are member funded schemes that can receive additional non-refundable cash from the Department of Health, while the other schemes are grant funded.
The notes at pages *82 to 112* form part of these accounts.

Statement of cash flows
for the year ended 31 March 2014

	Notes	2013/14 £000	2012/13 £000
Cash flows from operating activities			
Net expenditure		**(3,374,304)**	(4,408,137)
Net cash transferred under absorption accounting		**99**	0
Other cash flow adjustments	10	**597**	489
Movement in working capital	10	**3,148,591**	4,085,053
Net cash (outflow) from operating activities		**(225,017)**	(322,595)
Cash flows from investing activities			
Purchase of property, plant and equipment	5.3, 5.4	**(294)**	(72)
Purchase of intangible assets	5.1, 5.2	**(220)**	(167)
Net cash inflow/(outflow) from investing activities	3.2	**(514)**	(239)
Cash flows from financing activities			
Net Parliamentary funding		**228,072**	319,966
Net financing		**228,072**	319,966
Net increase/(decrease) in cash and cash equivalents		**2,541**	(2,868)
Cash and cash equivalents at the beginning of the period		**18,992**	21,860
Cash and cash equivalents at the end of the period	7	**21,533**	18,992

The notes at pages 82 to 112 form part of these accounts.

Notes to the accounts

1 Accounting policies

The financial statements have been prepared in accordance with the 2013/14 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHS LA for the purpose of giving a true and fair view has been selected. The particular policies adopted by the NHS LA are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

The accounts are presented in pounds sterling and all values are rounded to the nearest thousand pound (£'000). The functional currency of the NHS LA is pounds sterling.

1.1 Accounting conventions

This account is prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment and intangible 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.

1.2 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.

1.3 Movement of assets within the DH Group

"Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCNE, and is disclosed separately from operating costs.

Absorption accounting was applied in the transfer of the National Clinical Assessment Service (NCAS) to NHS LA.

1.4 Early adoption of standards, amendments and interpretations

The NHS Litigation Authority has not adopted any IFRSs, amendments or interpretations early.

Standards, amendments and interpretations in issue but not yet effective or adopted

International Accounting Standard 8, accounting policies, changes in accounting estimates and errors, requires disclosure in respect of new IFRSs, amendments and interpretations that are, or will be, applicable after the accounting period. There are a number of IFRSs, amendments and interpretations issued by the International Accounting Standards Board that are effective for financial statements after this accounting period.

The following have not been adopted early in these accounts:

- IFRS 10 Consolidated Financial Statements: Effective date of 2014/15 under EU adoption.
- IFRS 11 Joint Arrangements: Effective date of 2014/15 under EU adoption.
- IFRS 12 Disclosure of Interests in Other Entities: Effective date of 2014/15 under EU adoption.
- IFRS 13 Fair Value Measurement: Effective date of 2013/14 under EU adoption, however this Standard is unlikely to be adopted by HM Treasury until 2014/15.
- IAS 27 Separate Financial Statements: Effective date of 2014/15 under EU adoption.
- IAS 28 Associates and joint ventures: Effective date of 2014/15 under EU adoption.
- IAS 32 Financial Instruments: Presentation - amendment for offsetting financial assets and liabilities: Effective date of 2014/15 under EU adoption.
- IFRS 9 Financial Instruments: The effective date is for accounting periods beginning on, or after 1 January 2015. The timing for EU adoption is uncertain.

None of these new or amended standards and interpretations are anticipated to have future material impact on the financial statements of the NHS Litigation Authority.

1.5 Income

Income is accounted for by applying the accruals convention. A major source of funding for the Special Health Authority is Parliamentary grant from the Department of Health within an approved cash limit, which funds the ELS and Ex-RHA, DH clinical and DH liabilities 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 NHS LA. It principally comprises annual contributions charged to member NHS bodies for the CNST, LTPS and PES schemes 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.

1.6 Taxation

The NHS LA 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.

1.7 Property, Plant and Equipment (PPE)

PPE are measured at cost including any costs such as installation directly attributable to bringing them into working condition. They are restated to current value each year.

i) Capitalisation

Plant, property and equipment are capitalised where they 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.

ii) Valuation

PPE are measured at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Equipment surplus to requirements is valued at net recoverable amount.

iii) Depreciation

Depreciation is charged on a straight-line basis on each main class of fixed asset as follows:

Furniture and fittings	10 years
Information technology	5 years

iv) Leased assets

NHSLA holds no finance leases.

Other leases are regarded as operating leases and the rentals are charged to the Statement of Comprehensive Net Expenditure on a straight line basis over the term of the lease.

1.8 Intangible Assets

i) Capitalisation

Intangible assets which can be valued and are capable of being used in the Authority's activities for more than one year and have a cost equal to or greater than £5,000;

Purchased computer software licences are capitalised where expenditure of at least £5,000 is incurred and the software has service potential for the organisation.

ii) Internally generated intangible assets

Expenditure on research is not capitalised. An internally generated intangible asset arising from the Authority's development is recognised only if all of the following conditions are met:

- an asset is created that can be identified (such as bespoke software);
- it is probable that the asset created will generate future economic benefits; and
- the development cost of the asset can be measured reliably.

Intangible fixed assets are valued at cost .

iii) Amortisation

For intangible assets with finite useful lives, amortisation is calculated so as to write off the cost of an asset, less its estimated residual value, over its useful economic life.

Software is amortised on a straight line basis over five years.

1.9 Impairment of non financial assets

Non financial assets are reviewed at each reporting date for indications of impairment. Where an asset is found to be impaired, it is written down through the Statement of Comprehensive Net Expenditure to its estimated recoverable amount. The recoverable amount is the higher of value in use and the fair value less costs to sell the asset.

Value in use is the net present value of the estimated future cash flows of that asset. Present values are computed using discount rates that reflect the time value of money and the risks specific to the unit whose impairment is being measured.

1.10 Assets Held for Sale

A non-current asset held for sale represents assets whose carrying amount will be recovered principally through a sale transaction rather than through continuing use. Non-current assets held for sale are included in the Statement of Financial Position at fair value less costs to sell, if this is lower than the previous carrying amount. Once an asset is classified as held for sale or included in a group of assets held for sale no further depreciation or amortisation is recorded.

1.11 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 Statement of Comprehensive Net Expenditure (SOCNE) 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 12 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.12 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes was carried out as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

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

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

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

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. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

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

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

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

1.13 Short Term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Leave that has been earned but not taken at the year end is not accrued on the grounds of immateriality.

1.14 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. The Treasury discount rate was adjusted in December 2013 as follows short -1.9% (-1.8% 12/13), medium -0.65% (-1.0% 12/13) and long-term 2.2% (2.2% 12/13).

The ELS, Ex-RHA and DHL 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 IAS 37. A provision for these schemes is calculated in accordance with IAS 37 by discounting the gross value of all claims received: this is disclosed in note 9.1.

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 rates noted above, RPI of 3.5% and claims inflation (varying between schemes) of between 5% and 10%, 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 probable cost of each claim as calculated above is also discounted, taking into account the likely time to settlement, and is included in contingent liabilities as set out in note 9.7.

Resolution of claims is difficult to predict as many factors can lead to delay during the settlement process whilst emerging evidence can alter valuation and thus the Authority makes a best estimate regarding the likely year of settlement and expected value of the claim against each notified claim. These estimates are reviewed throughout the life of the claim and amended to reflect variations in expectations which inevitably alters the value provided.

1.15 Financial Assets and Liabilities

i) Initial Recognition and Measurement

The NHS LA recognise financial assets and liabilities on its Statement of Financial Position when, and only when, it becomes a party to the contractual provisions of the instrument. On initial recognition IAS 39 requires the NHS LA to recognise all financial assets and liabilities at fair value. The fair value of a financial asset on initial recognition is normally represented by the transaction price.

The transaction price for financial assets other than those classified at fair value through profit and loss includes the transaction costs that are directly attributable to the acquisition or issue of the financial asset. Transaction costs incurred on the acquisition or issue of financial assets classified at fair value through profit are expensed immediately.

The NHS LA recognises financial assets using settlement date accounting. The settlement date is the date that an asset is delivered to or by an entity. Settlement date accounting refers to the recognition of an asset on the day it is received by the entity, and the derecognition of an asset and recognition of any gain or loss on disposal on the day that it is delivered by the entity.

ii) Subsequent Measurement

Subsequent measurement of financial assets depends on their classification on initial recognition under IAS 39. The categories relevant to the NHS LA are as follows:

Loans and Receivables: loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. Assets that the NHS LA intends to sell immediately or in the near term cannot be classified in this category. These assets are carried at amortised cost using the effective interest method minus any reduction for impairment or uncollectibility. Interest income is recognised by applying the effective interest rate method, except on short term receivables when the recognition of interest would be immaterial. Impairment charges are provided only when there is objective evidence that an impairment loss has been incurred. If that is the case, the carrying amount of the asset is reduced through use of an allowance account. The amount of the loss is recognised in the Statement of Comprehensive Net Expenditure.

Typically trade and other receivables are classified in this category.

iii) Fair value determination

Whenever available, the fair value of a financial instrument is derived from an active market. The appropriate quoted market price for an asset held or liability to be issued is usually the current bid price and, for an asset to be acquired or liability held, the asking price. If there is no market, or the markets available are not active, the NHS LA establishes fair value by using a valuation technique. Valuation techniques include using recent arm's length market transactions between knowledgeable, willing parties, if available, reference to the current fair value of similar instruments and incorporates all factors that market participants would consider in setting a price and is consistent with accepted economic methodologies for pricing financial instruments. As far as unquoted equity instruments are concerned, in cases where it is not possible to reliably measure the fair value, such instruments are carried at cost.

iv) Derecognition of financial assets

Irrespective of the legal form of the transactions, financial assets are derecognised when they pass the "substance over form" based derecognition test prescribed. That test comprises two different types of evaluations which are applied strictly in sequence:

- Evaluation of the transfer of risks and rewards of ownership
- Evaluation of the transfer of control

Whether the assets is recognised / derecognised in full or recognised to the extent of NHS LA's continuing involvement depends on accurate analysis which is performed on a specific transaction basis.

v) Cash and Cash Equivalents

Cash and Cash Equivalents comprise cash in hand, on demand deposits and other short term highly liquid investments that are readily convertible to a known amount of cash and are subject to insignificant risk of changes in value.

vi) Financial liabilities

Financial liabilities are classified according to the substance of the contractual arrangements entered into. The Authority has the following class of financial liabilities:

Other financial liabilities: all liabilities, which have not been classified at fair value through profit or loss. These liabilities are carried at amortised cost using the effective interest method. Typically, trade and other payables and borrowings are classified in this category.

vii) Derecognition of financial liabilities

The NHS LA derecognises financial liabilities when, and only when, the NHS LA's obligations are discharged, cancelled or they expire.

viii) Embedded derivatives

Derivatives embedded in other financial instruments or other host contracts are treated as separate derivatives when their risks and characteristics are not closely related to those of the host contracts and the host contract is not measured at fair value with changes in fair value recognised in profit or loss.

1.16 Critical Judgements and key sources of estimation uncertainty

In the application of the NHSLA's accounting policies, which are described in note 1, the directors are required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. The judgements that have the most significant effect on the amounts recognised in the financial statements relate to the calculation of the provisions for known claims and for IBNR, as explained in Note 9. Actual results may differ from these estimates.

The estimates and underlying assumptions are reviewed on an ongoing basis by the NHS LA, supported by its actuaries Lane Clark & Peacock and an external peer review carried out by the Government Actuaries Department (GAD) in each financial year end since 2011/12. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

During 2013/14 the NHS LA created a formal Reserving Committee to document this ongoing review process and to facilitate the review of the various assumptions used in constructing the actuarial models which the Accounting Officer relies upon when confirming the estimates used within these accounts. The work of the membership of the Reserving Committee includes the Accounting Officer, as Chair, alongside key exectuive staff from within the NHS LA and also a representative non Executive Director.

2.1 Authority programme expenditure

	Notes	£'000	2013/14 £'000	2012/13 £'000
Non-executive members' remuneration	2.2	**67**		71
Other salaries and wages	2.2	**12,237**		7,163
Redundancy costs	2.2	**527**		91
Supplies and services – general		**5**		2
Establishment expenses		**892**		456
Hire and operating lease rental				
Land & buildings		**708**		404
Lease cars		**4**		5
Photocopiers		**19**		7
Franking machine		**7**		6
Vending machine		**4**		4
Transport and moveable plant		**2**		3
Premises and fixed plant		**2,239**		1,394
External contractors				
Actuary's advice		**926**		579
Appeals Unit advisory expenditure		**112**		131
Consultancy		**120**		185
External Corporate Legal Fees****		**224**		187
NCAS assessment expenditure		**871**		0
Risk management		**520**		1,995
Other***		**110**		90
Auditor's remuneration: audit fees**		**78**		78
Internal audit fees		**27**		38
Bank charges & interest		**(39)**		4
			19,660	12,893
Depreciation	5.3, 5.4	**371**		375
Amortisation	5.1, 5.2	**221**		114
(Profit)/loss on disposal		**0**		0
			592	
			20,252	13,382
Other finance costs – unwinding of discount	9.1, 9.2		**(44,609)**	19,209
Increase in provision for known claims (excl. unwinding of discounts and change in discount rate)	9.1, 9.2	**2,252,590**		2,039,595
Change in the discount rate *		**(31,067)**		458,694
Increase / (decrease) in the provision for IBNR *	9.1, 9.2	**2,209,000**		2,883,000
			4,430,523	
Loss on transfers by absorption			**3,341**	
			4,409,507	5,413,880

* Included within the provision for IBNR is a reduction (£79m) relating to the change in discount rate. The total reduction due to the change in discount rate for known claims and IBNR is (£110m). (2012–13: £1,412m)

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

*** Other expenditure includes counter fraud, payroll and professional services

**** External Corporate Legal Fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included within note 9

Of the £4,409,507k shown above, £7,918k is shown as administration expenditure in the Department of Health consolidated group accounts.

2.2 Staff numbers and related costs

	2013/14 Total	Permanently employed staff	Other*	2012/13 Total
	£000	£000	£000	£000
Salaries and wages	**10,765**	9,936	829	6,071
Social security costs	**912**	912	0	534
Employer contributions to NHS Pensions	**1,154**	1,154	0	720
	12,831	**12,002**	**829**	7,325

The average number of employees during the year was:

	Total	Permanently employed staff	Other *	2012/13 Total
Total	**218**	199	19	132

Redundancy costs

The cost to the NHS LA of redundancies in 2013/14 was £527,079 (2012/13: £90,684)

Expenditure on staff benefits

The amount spent on staff benefits during the year mainly on lease cars totalled £12,186 (2012/13: £8,215).

* Noted under 'other' is the NHS LA's expenditure on temporary members of staff.

Details of the salaries of Board members are contained within the remuneration report.

2.3 Exit Packages for staff leaving in 2013/14

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Payment Bands			
< £10,000	0	0	0
£10,001 – £25,000	1	1	2
£25,001 – £50,000	0	0	0
£50,001 – £100,000	5	0	5
£100,001 – £150,000	1	0	1
£150,001 – £200,000	0	0	0
Total number of exit packages by type	**7**	**1**	**8**
Total cost (£'000s)	**527**	**15**	**542**

Redundancy and other departure costs are all approved by the NHS LA Remuneration Committee and, where delegated limits require it, also reviewed and approved by the Department of Health's Governance and Assurance Committee and if necessary HM Treasury.

2.4 Exit Packages for staff leaving (Prior Year)

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Payment bands			
< £10,000	0	0	0
£10,001 – £25,000	0	0	0
£25,001 – £50,000	0	0	0
£50,001 – £100,000	1	0	1
£100,001 – £150,000	0	0	0
£150,001 – £200,000	0	0	0
Total number of exit packages by type	1	0	1
Total cost (£'000s)	**91**	**0**	**91**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the NHS LA has agreed early retirements, the additional costs are met by the NHS LA and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

2.5 Exit Packages - Other Departures Analysis

	2013–14		2012–13	
	Agreements Number	**Total value of agreements £000s**	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice *	1	11	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	4	0	0
Total	1	15	0	0

* There was one exit package agreed in year totalling £15,000 and split between contractual payments (£11,000) and non-contractual requiring Treasury Approval (£4,000)

3.1 Reconciliation of net expenditure to revenue resource limit

	2013/14 £000
Net expenditure	**3,374,304**
Net expenditure	**3,374,304**
Revenue resource limit	**3,592,748**
Under spend against revenue resource limit	**218,444**

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2013/14 £000
Gross capital expenditure	**514**
NBV of assets disposed	**(5)**
Net capital expenditure	**509**
Capital resource limit	**528**
Underspend against capital resource limit	**19**

4 Operating income

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

	Appropriated in aid 2013/14 £000	 2012/13 £000
Programme income:		
CNST contributions	977,200	957,113
PES contributions	5,441	5,268
LTPS contributions	51,344	43,362
NCAS	1,218	-
Total	**1,035,203**	1,005,743

5.1 Intangible assets

	Information technology £000	Software licences £000	Total £000
Gross cost at 1 April 2013	1,732	447	2,179
Transfers under Modified Absorption Accounting	52	730	782
Additions – purchased	118	102	220
Amounts written back	0	(5)	(5)
Gross cost at 31 March 2014	**1,902**	**1,274**	**3,176**
Accumulated amortisation at 1 April 2013	1,468	309	1,777
Transfers under Modified Absorption Accounting	572	6	578
Charged during the year	175	46	221
Amounts written back	0	0	0
Accumulated amortisation at 31 March 2014	**2,215**	**361**	**2,576**
Net Book Value at 1 April 2013	264	138	402
Net Book Value 31 March 2014	**(313)**	**913**	**600**

5.2 Intangible assets (prior year)

	Information Technology £000	Software Licences £000	Total £000
Gross cost at 1 April 2012	1,655	357	2,012
Additions – purchased	77	90	167
Disposals	0	0	0
Gross cost at 31 March 2013	1,732	447	2,179
Accumulated amortisation at 1 April 2012	1,382	281	1,663
Charged during the year	86	28	114
Disposals	0	0	0
Accumulated amortisation at 31 March 2013	**1,468**	**309**	**1,777**
Net Book Value at 1 April 2012	273	76	349
Net Book Value 31 March 2013	**264**	**138**	**402**

5.3 Property, plant and equipment

	Information technology £000	Furniture & fittings £000	Total £000
Valuation at 1 April 2013	1,321	1,649	2,970
Transfers under Modified Absorption Accounting	167	25	192
Additions – purchased	294	0	294
Disposals	(60)	0	(60)
Valuation at 31 March 2014	**1,722**	**1,674**	**3,396**
Accumulated depreciation at 1 April 2013	859	374	1,233
Transfers under Modified Absorption Accounting	78	25	103
Charged during the year	206	165	371
Disposals	(60)	0	(60)
Accumulated depreciation at 31 March 2014	**1,083**	**564**	**1,647**
Net book value at 1 April 2013	462	1,275	1,737
Net book value at 31 March 2014	**639**	**1,110**	**1,749**

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

Capital commitments: The Authority has no capital commitments at 31 March 2014 (2012/13: nil).

5.4 Property, plant and equipment (prior year)

	Information technology £'000	Furniture & fittings £'000	Total £'000
Valuation at 1 April 2012	1,249	1,649	2,898
Additions – purchased	72	0	72
Disposals	0	0	0
Valuation at 31 March 2013	**1,321**	**1,649**	**2,970**
Accumulated depreciation at 1 April 2012	649	209	858
Charged during the year	210	165	375
Disposals	0	0	0
Accumulated depreciation at 31 March 2013	**859**	**374**	**1,233**
Net Book Value at 1 April 2012	600	1,440	2,040
Net Book Value at 31 March 2013	**462**	**1,275**	**1,737**

6 Receivables

	Ex RHAS	ELS	DH Clinical	DH Non Clinical	CNST	PES	LTPS	Admin	Total 31 March 2014	Total 31 March 2013
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
NHS receivables - revenue	0	0	0	4	135	37	730	39	**945**	1,108
Accrued income	0	0	0	11	1,534	0	37	12	**1,594**	0
Prepayments	34	647	3,655	0	497	0	0	232	**5,065**	2,206
Other receivables	2	367	51	17	2,544	2	113	155	**3,251**	3,476
	36	**1,014**	**3,706**	**32**	**4,710**	**39**	**880**	**438**	**10,855**	**6,790**

Intra-government balances

									£000	£000
Balances with other central government bodies	0	0	0	0	0	0	0	0	**0**	3,150
Balances with NHS Bodies	0	0	0	**4**	135	37	730	39	**945**	1,108
Balances with public corporations and trading funds	0	0	0	0	0	0	0	0	**0**	0
Subtotal of intra-government balances	**0**	**0**	**0**	**4**	**135**	**37**	**730**	**39**	**945**	**4,258**
Balances with bodies external to government	36	1,014	3,706	28	4,575	2	150	399	**9,910**	2,532
	36	**1,014**	**3,706**	**32**	**4,710**	**39**	**880**	**438**	**10,855**	**6,790**

7 Cash and cash equivalents

	Ex RHAS	ELS	DH Clinical	DH Non Clinical	CNST	PES	LTPS	Admin	Total 31 March 2014	Total 31 March 2013
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April	27	2,206	0	0	11,981	**4,493**	142	143	**18,992**	21,860
Change During the year	(14)	**1,338**	0	0	**(11,926)**	**1,550**	**10,746**	847	**2,541**	(2,868)
As 31 March	**13**	**3,544**	**0**	**0**	**55**	**6,043**	**10,888**	**990**	**21,533**	**18,992**
Made up of										
Cash with the Government Banking Service	**13**	**3,544**	**0**	**0**	**55**	**6,043**	**10,888**	**990**	**21,533**	18,992
Cash and cash equivalents as in statement of financial position	**13**	**3,544**	**0**	**0**	**55**	**6,043**	**10,888**	**990**	**21,533**	18,992
Cash and cash equivalents as in statement of cash flows	**13**	**3,544**	**0**	**0**	**55**	**6,043**	**10,888**	**990**	**21,533**	18,992

8 Trade payables and other current liabilities

	Ex RHAS	ELS	DH Clinical	DH Non Clinical	CNST	PES	LTPS	Admin	Total 31 March 2014	Total 31 March 2013
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
NHS payables revenue	0	0	0	0	0	32	170	0	**202**	398
Prepaid Income	0	2,428	0	0	0	0	0	255	**2,683**	5,604
Tax and social security	0	0	0	0	0	0	0	0	**0**	0
Accruals	0	111	2,760	199	11,271	0	745	1,149	**16,235**	9,006
Other payables	0	350	317	75	8,942	0	531	0	**10,215**	6,424
	0	**2,889**	**3,077**	**274**	**20,213**	**32**	**1,446**	**1,404**	**29,335**	21,432

Intra-government balances

									£000	£000
Balances with other central government bodies	0	2,428	0	0	0	0	0	2	**2,430**	0
Balances with NHS Bodies	0	0	0	0	0	32	170	186	**388**	3,295
Balances with public corporations and trading funds	0	0	0	0	0	0	0	0	**0**	83
Subtotal of intra-government balances	**0**	**2,428**	**0**	**0**	**0**	**32**	**170**	**188**	**2,818**	3,378
Balances with bodies external to government	0	461	3,077	274	20,213	0	1,276	1,216	**26,517**	18,054
	0	**2,889**	**3,077**	**274**	**20,213**	**32**	**1,446**	**1,404**	**29,335**	**21,432**

9.1 Provisions for liabilities and charges

	Ex RHAS	ELS	DH Clinical	DH Non Clinical	CNST	PES	LTPS	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Opening Provision for Known Claims	(32,849)	(1,717,187)	0	0	(7,710,481)	(8,255)	(125,183)	(9,593,955)
Opening Provisions for IBNR	(5,000)	(549,000)	0	0	(12,676,000)	(1,000)	(133,000)	(13,364,000)
Total Provisions as at 1 April 2013	**(37,849)**	**(2,266,187)**	**0**	**0**	**(20,386,481)**	**(9,255)**	**(258,183)**	**(22,957,955)**
Transfers from other NHS Bodies	**0**	**0**	**(3,341)**	**0**	**0**	**0**	**0**	**(3,341)**
Transfers Between Schemes	**0**	**1,235,805**	**(1,374,239)**	**(10,965)**	**138,434**	**0**	**10,965**	**0**
Movement in known claims								
Discounting	48,932	310,341	423,084	(643)	3,435,298	(2)	413	**4,217,423**
Arising during the year	(50,010)	(313,716)	(592,248)	(28,458)	(6,291,656)	(4,616)	(81,377)	**(7,362,081)**
Reversed unused	63	38,603	86,467	2,665	722,267	3,308	38,695	**892,068**
Unwinding of discount	(913)	(59,992)	12,421	36	93,091	0	(34)	**44,609**
Change in Discount Rate *	139	1,696	5,032	(15)	24,213	0	2	**31,067**
Utilised during the year	3,419	31,711	106,235	7,534	1,051,173	3,853	40,188	**1,244,113**
	1,630	8,643	40,991	(18,881)	(965,614)	2,543	(2,113)	**(932,801)**
Movement in Net IBNR *	0	407,000	(524,000)	(163,000)	(1,930,000)	(1,000)	2,000	**(2,209,000)**
Closing Provision for Known Claims	(31,219)	(472,739)	(1,336,589)	(29,846)	(8,537,661)	(5,712)	(116,331)	(10,530,097)
Closing Provisions for IBNR	(5,000)	(142,000)	(524,000)	(163,000)	(14,606,000)	(2,000)	(131,000)	**(15,573,000)**
At 31 March 2014	**(36,219)**	**(614,739)**	**(1,860,589)**	**(192,846)**	**(23,143,661)**	**(7,712)**	**(247,331)**	**(26,103,097**
Expected discounted timing of cash flows:								
Within 1 year	(1,000)	(38,000)	(99,000)	(17,000)	(1,050,000)	(5,000)	(55,000)	(1,265,000)
1-5 years	(193)	(101,094)	(356,140)	(58,846)	(8,126,498)	(1,712)	(173,642)	(8,818,125)
Over 5 years	(35,026)	(475,645)	(1,405,449)	(117,000)	(13,967,163)	(1,000)	(18,689)	**(16,019,972)**
	(36,219)	**(614,739)**	**(1,860,589)**	**(192,846)**	**(23,143,661)**	**(7,712)**	**(247,331)**	**(26,103,097**

The provisions relating to the NHS LA's schemes are the only provisions made by the NHS LA.

* Included within Movement in Net IBNR is a reduction of £79m relating to the change in discount rate. The total change in discount rate for known claims and IBNR is a reduction of £110m.

Discounted cashflow timings are based upon actuarial estimates for known claims and IBNR. Actual cashflows will vary due to a number of factors including claims settling on a periodic basis rather than lump sum, claims which take longer than anticipated to resolve and changes in the value and timing of payments.

9.2 Provisions for liabilities and charges (Prior Year)

	Ex RHAS	ELS	DH Clinical	DH Non Clinical	CNST	PES	LTPS	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Opening Provision for Known Claims	(26,419)	(1,686,076)	0	0	(6,540,504)	(8,201)	(124,736)	**(8,385,936)**
Opening Provisions for IBNR	(6,000)	(587,000)	0	0	(9,774,000)	(1,000)	(113,000)	**(10,481,000)**
Total Provisions as at 1 April 2012	**(32,419)**	**(2,273,076)**	**0**	**0**	**(16,314,504)**	**(9,201)**	**(237,736)**	**(18,866,936)**
Movement in known claims								
Discounting	(12,016)	97,778	0	0	453,631	0	1,316	**540,709**
Arising during the year	(6,047)	(736,842)	0	0	(4,346,829)	(6,301)	(90,793)	**(5,186,812)**
Reversed unused	13,675	606,731	0	0	1,941,092	2,597	42,413	**2,606,508**
Unwinding of discount	(1,400)	(46,425)	0	0	28,581	0	35	**(19,209)**
Change in Discount Rate *	(1,865)	(92,355)	0	0	(364,107)	0	(367)	**(458,694)**
Utilised during the year	1,223	140,002	0	0	1,117,655	3,650	46,949	**1,309,479**
	(6,430)	(31,111)	0	0	(1,169,977)	(54)	(447)	**(1,208,019)**
Movement in Net IBNR *	1,000	38,000	0	0	(2,902,000)	0	(20,000)	**(2,883,000)**
Closing Provision for Known Claims	(32,849)	(1,717,187)	0	0	(7,710,481)	(8,255)	(125,183)	**(9,593,955)**
Closing Provisions for IBNR	(5,000)	(549,000)	0	0	(12,676,000)	(1,000)	(133,000)	**(13,364,000)**
At 31 March 2013	**(37,849)**	**(2,266,187)**	**0**	**0**	**(20,386,481)**	**(9,255)**	**(258,183)**	**(22,957,955)**
Expected discounted timing of cash flows:								
Within 1 year	(1,000)	(117,000)	0	0	(1,057,297)	(5,490)	(51,906)	**(1,232,693)**
1-5 years	(6,153)	(368,851)	0	0	(6,997,500)	(3,765)	(188,551)	**(7,564,820)**
Over 5 years	(30,696)	(1,780,336)	0	0	(12,331,684)	0	(17,726)	**(14,160,442)**
	(37,849)	**(2,266,187)**	**0**	**0**	**(20,386,481)**	**(9,255)**	**(258,183)**	**(22,957,955)**

Existing Liabilities Scheme (ELS), Ex-Regional Health Authorities (Ex-RHAS) and DH Liabilities (DHL) Scheme

Claims are included in the ELS provision on the basis that the incident ocurred on or before 31 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. Claims against DH Liabilities relate to claims against disolved bodies where there is no successor body and a number of other claims the NHS LA is managing on behalf of the Department of Health.

Clinical Negligence Scheme for Trusts (CNST)

A provision for this scheme is calculated in accordance with IAS 37 by discounting the gross value of all claims received relating to incidents which occurred on or before 31 March 2014 and on or after 1 April 1995. 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 NHS LA. 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.

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

In April 1999 the NHS LA 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 NHS LA's proportion of each claim. The accounts for these schemes have been prepared in accordance with IAS 37.

Assumption of Liabilities upon Cessation

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 the ELS, ex-RHAS and CNST schemes.

Incidents Incurred but not reported (IBNR)

IAS 37 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 2014 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 NHS LA 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 above. 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.

Estimation of provisions and contingent liabilities

Owing to the uncertain nature of the NHS LA's liabilities, the preparation of these financial statements requires the use of judgements and assumptions that have a significant impact on the estimated provisions.

The NHS LA uses its actuaries to provide estimates of the provisions. The actuaries analyse past trends in claims and combine this with a knowledge of the current economic and claims environments in order to make projections of how claims will emerge and be settled in the future. This process is performed in consultation with the NHS LA to ensure that the projections reflect a common understanding of the expected future development of claims.

The NHS LA's provisions are mostly in respect of clinical negligence claims exposure. Such claims can take a significant length of time to be reported to the NHS LA, and the settlement of claims can also take a long time depending on the circumstances of the claim. Claims can take over thirty years to be reported, over ten years to be settled and, if the claim is settled as a PPO, the claim payments can potentially span a further period of over 50 years.

Given the long-term nature of the liabilities, the most significant and uncertain part of the provisions is the Incurred But Not Reported (IBNR) claims provision. The estimation of IBNR claims is inherently more uncertain than the estimation of the cost of claims already reported to the NHS LA, for which case-by-case information about the claim event is available.

The long-term nature of the claims means that it is to be expected that actual future claims experience will differ, potentially significantly, from the current estimates.

Process and Methodology

There are three key elements to the NHS LA's provisions: the reported outstanding claims provision, the IBNR provision and the provision for settled PPOs.

Reported outstanding claims provision

The reported outstanding provision is based on the case estimates of the individual reported claims. The case estimates are adjusted for the case handlers' estimated probability of settlement, for expected future claims inflation to settlement, for the estimated probability that they will go on to settle as PPOs (rather than as lump sums) and for the assumed additional cost if the case were to settle as a PPO. The resulting adjusted claim values are then discounted for the time value of money (at the Treasury-prescribed rate) to give a net present value at the accounting date.

IBNR provision

To estimate the IBNR provision, the actuaries model the future cash flows expected to arise from IBNR claims and calculate a net present value (at the Treasury-prescribed discount rate) to estimate the provision at the accounting date.

First an assumption is made about the expected number of incidents that have occurred in each past year up to the accounting date that will give rise to a claim. An assumption is then made about the pattern of delays from incident to reporting. This allows a projection to be made for the number of IBNR claims expected to be reported in each future year.

Assumptions are also made about the pattern of reporting to settlement delays. This allows a projection to be made of the numbers of IBNR claims expected to be settled in each future year.

Assumptions are then made about the average claim sizes for different types of claim. These assumptions allow for the fact that larger claims take longer to be reported and settled. Adjustments are also made to these assumed claim sizes to allow for expected future claim value inflation.

By combining the average claim sizes with the claim numbers appropriately, a projection is made for the total value of claim settlements for IBNR claims in each future year. For the proportion of claims that are assumed to settle as PPOs, an estimated payment pattern is used to model the future cash flows and lump sum settlements are assumed to be paid out in full at settlement.

The final step in the process is to calculate the net present value of the projected future cash flows (using the Treasury-prescribed discount rate), and this gives the estimated IBNR provision at the accounting date.

Settled PPOs provision

To estimate the provision for settled PPO claims, the actuaries project the expected future cash flows from each individual settled PPO weighted by the claimants' probability of survival to each payment and then calculate the net present value of these cash flows (using the Treasury-prescribed discount rate). Future cash flows are modelled based on individual claim data. This includes the agreed annual payments and any agreed future steps in those payments, the index to which payments are linked and the assumed probabilities of survival to each future payment, which is based on the estimated life expectancy of the claimant agreed by medical experts in each case.

Key assumptions and areas of uncertainty

As with any actuarial projection there are areas of uncertainty within the estimates of the claims provisions. This is particularly so for the CNST and ELS schemes given the long-term nature of the liabilities.

Several of the key assumptions used in the production of the estimates reported are outside the formal control of the NHS LA. For example the HM Treasury sets the Discount Rate and patients (and their solicitor) have an element of control over the timing of the reporting of claims. The NHS LA, via its Reseving Committee, keeps all of the factors affecting the calculation of provisions under review to ensure that they reflect the experience of the organisation and are adjusted in a timely manner. Where those assumptions are controlled by external forces the NHS LA is required to accept any change and the subsequent impact on its provisions.

The table below illustrates the key assumptions used to determine the IBNR and settled PPO provisions. For each assumption, the degree of uncertainty in the assumption and the impact of the assumption on the level of provisions has been categorised subjectively as "high", "medium" or "low".

As an example, the table shows that there is a medium level of uncertainty in the assumed number of claims incurred in each year and that this assumption has a high impact on the estimated provisions.

Key assumptions, uncertainty in assumptions and impact on resulting provisions

Assumption	*Degree of uncertainty in assumption*	*Impact on estimated provisions*
Number and timing of claims		
Number of claims incurred each year	Medium	High
Incident to reporting delay patterns	High	High
Reporting to settlement delay patterns	Low	Low
Incident to reporting pattern for PPO claims	High	High
Reporting to settlement pattern for PPO claims	Low	Low
Claims value and inflation		
Average claim value	Medium	High
Claim value inflation	High	High
Settled PPO provision		
Life expectancy for PPOs	High	Medium
Settlement to payment pattern for PPO claims	Medium	Medium
Assumed level of inflation in ASHE 6115	Medium	High

The following are key areas of uncertainty in the estimation of the claims provisions.

Clinical negligence claims can take over thirty years to be reported following the incident that gives rise to the claim. The IBNR provisions depends on an assumed delay pattern for how claims are reported to the NHS LA following the incident. If the true pattern of reporting is faster than that assumed, this may mean that the number of IBNR claims has been over-estimated, and vice versa. Changing trends in this pattern over time, for example as a result of increased awareness of the availability of compensation and a lack of past data preceding the formation of the NHS LA both increase the uncertainty in this assumption.

The numbers of clinical claims reported to the NHS LA have increased in recent years. This is believed to be the result of an underlying increase in number of claims as well as claims being reported to the NHS LA more quickly. It is uncertain to what extent each of these factors is driving the change in the number of claims being reported, so there is uncertainty in the number of claims that will ultimately be reported.

The uncertainty in the average claim value assumption is currently higher than it might normally be expected to be as a result of the changing numbers of claims. It is not unusual to observe an inverse relationship between claim numbers and average claim values and the increasing claim numbers appear to be leading to falling average claim values. This could be the result of a link between higher claim numbers and a lower proportion of claims settling with a damages payment, eg if there are more speculative claims being made. It may also be the result of a change in the distribution of claim values in that the extra claims being reported are mostly smaller in value.

Because of the long-term nature of the liabilities, even small changes to the assumed rate of future claim value inflation can have a significant impact on the estimated provisions. Claim value inflation has historically increased at a significantly higher rate than price inflation. For clinical negligence claims the inflation is affected by a number of external factors such as the Lord Chancellor's discount rate, changes in legal precedent (eg rules relating to accommodation costs determined by Roberts vs Johnstone) and changes in legal costs. The variety of potential external influences on future claims inflation means that the assumption is subject to significant uncertainty.

Trends in the NHS LA's historical claims experience have been distorted over time by changes in the external environment. For example, increased litigiousness, changes in the legal environment and changes in the process of reporting claims have all affected the historical pattern of claim reporting and settlement. This increases the uncertainty in the delay pattern assumptions.

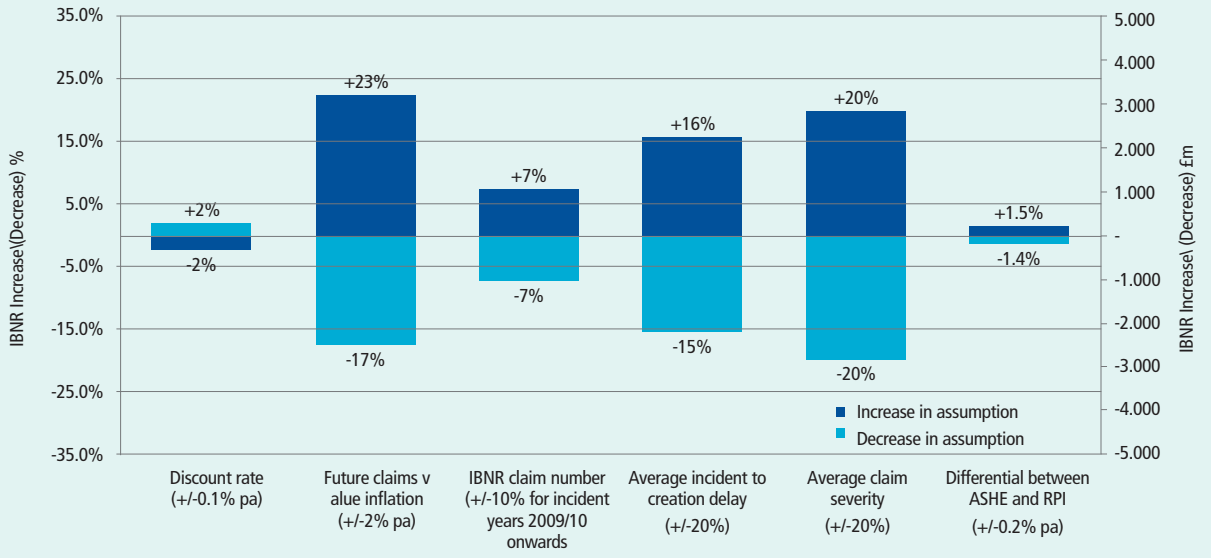
Similar uncertainties also arise as a result of impacts on past trends resulting from distortions caused by internal changes such as changes in the scheme structure (for example the abolition of excess levels) and changes in claims handling processes.

The provisions in respect of settled PPOs is sensitive to the assumed life expectancy of claimants. Each claimant's life expectancy is estimated at settlement by medical experts. The actual future lifetime of the claimant may differ significantly from this estimate. Furthermore, it is difficult to determine whether the life expectancies estimated by medical experts will prove to be too long or too short on average across all claimants. The average life expectancy of claimants could also be influenced by future advances in medical care or other events (eg epidemics).

The majority of PPOs have payments linked to the retail price index (RPI) and/or ASHE 6115, a wage inflation index and the future rates of increase in these indices are uncertain. In particular, ASHE 6115 relates specifically to care and home workers and external factors impacting this market in recent years have increased the uncertainty in setting this assumption.

CNST IBNR Sensitivities as at 31 March 2014

Figure 36: CNST IBNR Sensitivities as at 31 March 2014



The chart above sets out both the value and percentage impact of variations in the key assumptions within the CNST IBNR estimate which are also explained in the remainder of this note.

9.3 Sensitivity of estimated total provisions as at 31 March 2014 to movements in the tiered real discount rate

In 2013/14 HM Treasury changed the 'tiered' discount rate for general provisions , short -1.90% (12/13: -1.8%), medium -0.65% (12/13: -1.0%) and long-term 2.20%(12/13: 2.2%) as set out in HM Treasury's Public Expenditure System (2013) 07 paper published 2 December 2013. As can be seen in the SOCNE the impact of this adjustment was £110m.

Note 9 details the value of the provisions recorded in the Statement of Financial Position (SOFP) which have been calculated using the methods outlined in the narrative at 9.1, 9.2 and elsewhere in this report. The following tables show the potential impact on the various provisions in the event that those assumptions were changed. For example the first table below shows that if the Treasury Discount Rates were to be further adjusted by 0.1% pa the IBNR recorded in the SOFP would increase by £267m and likewise a reduction of 0.1% would reduce the IBNR by £259m. This sensitivity analysis is included in these notes to enable readers to understand the impacts such adjustments would have on the accounts although it should be noted that the relationship is not purely linear in all cases as can be seen by the changes outlined in the first table.

Sensitivity to changes in the discount rate	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Change to the original estimate %
0.1% decrease in the discount rate	14,873	267	2.0%
Tiered real discount rate structure	14,606	0	0.0%
0.1% increase in the real discount rate	14,347	(259)	-2.0%

9.4 Sensitivity of estimated IBNR provisions to key assumptions for CNST

The following tables show the impacts of adjusting our key assumptions for the creation of the IBNR estimate for CNST. In each case the assumption used in the accounts is the middle set of data, so for example claims value inflation is currently assumed to be 9.5% giving a £14,606m provision.

Sensitivity to future claims value inflation assumption

Claims value inflation	IBNR as at 31 March 2014 £m	% change to original estimate
7.5% pa	12,086	-17%
9.5% pa	14,606	0%
11.5% pa	17,907	23%

Sensitivity to assumptions of number of IBNR claims

IBNR claim number assumptions (including PPOs)	IBNR as at 31 March 2014 £m	% change to original estimate
No adjustment prior to 2009/10; 10 % decrease thereafter	13,535	-7.0%
Base Assumptions	14,606	0.0%
No adjustment prior to 2009/10; 10 % increase thereafter	15,676	7.0%

Sensitivity to incident to creation delay pattern

Average term based on assumed delay pattern	IBNR as at 31 March 2014 £m	% change to original estimate
Reduction in average delay of 20%	12,358	-15%
For all claims = 3.3 yrs; for large claims = 5.6 yrs	14,606	0%
Increase in average delay of 20%	16,895	16%

Sensitivity to average claim severity assumption

Factor applied to all average claim value assumptions	IBNR as at 31 March 2014 £m	% change to original estimate
Reduction in average claim values of 20%	11,685	-20%
Base Assumptions	14,606	0%
Increase in average claim values of 20%	17,527	20%

Sensitivity to differential between ASHE and RPI

Differential between ASHE and RPI assumption	IBNR as at 31 March 2014 £m	% change to original estimate
-20% (ASHE less RPI assumption is equal to 0.8%)	14,401	-1.4%
Base (ASHE less RPI assumption is equal to 1.0%)	14,606	0.0%
20% (ASHE less RPI assumption is equal to 1.2%)	14,823	1.5%

9.5 Sensitivity of provision for settled PPOs to key assumptions

Discount Rate Assumptions

	Provision for settled PPOs at 31 March 2014					
Discount Rate	**Total**	**CNST**	**ELS**	**DH Clin**	**Ex-RHA**	**LTPS**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
All Rates -1% pa	4,935	3,263	442	1,191	38	1
Base Assumption	4,016	2,640	357	987	31	1
All Rates 1% pa	3,352	2,195	295	835	26	1

	Percentage change to provision					
Discount Rate	**Total**	**CNST**	**ELS**	**DH Clin**	**Ex-RHA**	**LTPS**
All Rates -1% pa	22.9%	23.6%	24.0%	20.7%	22.9%	18.0%
Base Assumption	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
All Rates 1% pa	-16.5%	-16.9%	-17.2%	-15.4%	-16.5%	-14.0%

Differential between Retail Price Index (RPI) and Annual Hourly Earnings (ASHE) Index over the long term assumption

	Provision for settled PPOs at 31 March 2014					
Discount Rate	**Total**	**CNST**	**ELS**	**DH Clin**	**Ex-RHA**	**LTPS**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
0.80%	3,895	2,552	347	965	30	1
Base Assumption: 1% pa	4,016	2,640	357	987	31	1
1.2% pa	4,144	2,734	367	1,010	32	1

	Percentage change to provision					
Discount Rate	**Total**	**CNST**	**ELS**	**DH Clin**	**Ex-RHA**	**LTPS**
-20%	-3.0%	-3.4%	-2.7%	-2.2%	-2.7%	-3.0%
Base Assumption	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20%	3.2%	3.6%	2.8%	2.4%	2.9%	3.2%

Life expectancy assumptions

(The life expectancy of each claimant has been varied by the percentage shown)

	Provision for settled PPOs at 31 March 2014					
Discount Rate	**Total**	**CNST**	**ELS**	**DH Clin**	**Ex-RHA**	**LTPS**
	£m	**£m**	**£m**	**£m**	**£m**	**£m**
-20%	3,319	2,176	299	817	26	1
Base Assumption	4,016	2,640	357	987	31	1
20%	4,622	3,049	404	1,133	35	1

	Percentage change to provision					
Discount Rate	**Total**	**CNST**	**ELS**	**DH Clin**	**Ex-RHA**	**LTPS**
-20%	-17.4%	-17.6%	-16.1%	-17.2%	-16.7%	-15.2%
Base Assumption	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20%	15.1%	15.5%	13.3%	14.9%	12.4%	7.6%

9.6 Allocation of income and expenditure to the schemes

	Ex-RHAS	ELS	DH Clinical	DH Non Clinical	CNST	PES	LTPS	Equal pay	FHSA A	NCAS	Total 31 March 2013	Total 31 March 2012
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Expenditure												
Authority and claims administration	1	50	303	284	7,122	59	3,343	156	999	7,935	**20,252**	13,382
Claims and associated costs												
Transfers under absorption accounting	0	(1,235,805)	1,377,580	10,965	(138,434)	0	(10,965)				**3,341**	0
provision for known claims	1,789	23,068	65,244	26,415	2,016,787	1,310	42,301	0	0	0	**2,176,914**	2,517,498
Increase/(decrease) in the Provision for IBNR	0	(407,000)	524,000	163,000	1,930,000	1,000	(2,000)	0	0	0	**2,209,000**	2,883,000
	1,790	(1,619,687)	1,967,127	200,664	3,815,475	2,369	32,679	156	999	7,935	**4,409,507**	5,413,880
Income												
Scheme income	0	0	0	0	(977,200)	(5,441)	(51,344)	0	0	(1,218)	**(1,035,203)**	(1,005,743)
Net expenditure - (surplus)/deficit	**1,790**	**(1,619,687)**	**1,967,127**	**200,664**	**2,838,275**	**(3,072)**	**(18,665)**	**156**	**999**	**6,717**	**3,374,304**	4,408,137

9.7 Contingent liabilities

	Ex-RHAS	ELS	DH Clinical	DH Non Clinical	CNST	PES	LTPS	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Contingent liability for claims 2013/14	**3,379**	**142,927**	**479,922**	73,629	**10,996,198**	**2,776**	**134,665**	**11,833,496**
Contingent liability for claims 2012/13	5,055	548,332	0	0	9,752,250	5,204	142,012	10,452,853

The NHS LA makes a provision in its accounts for the likely value of future claims payments, and records contingent liabilities that represent possible additional claims payments to those already provided for. These amounts are not included in the accounts but shown as a note to the financial statements because a transfer of economic benefit is not deemed likely.

As a result of the dissolution of NHS PCTs and Strategic Health Authorities (on 1st April 2013) the NHS LA has taken on responsibility for any outstanding criminal liabilities, on behalf of the Secretary of State for Health. Any valid claims arising from the activities of those organisations will be dealt with by the NHS LA and funded in full by the Department of Health. Whilst preparing these financial statements the NHS LA has become aware that an incident relating to Health and Safety within one of those organisations may lead to a formal prosecution and as such a financial penalty may be awarded. There is not sufficient clarity to make a formal provision in line with IFRS requirements however the NHS LA believes that, if the case progresses, a fine in the region of £100 - £150,000 may be applied.

10 Reconciliation of operating costs to operating cash flows

	Notes		2013/14 £000	2012/13 £000
Net expenditure			**(3,374,304)**	(4,408,137)
Adjustments for non-cash transactions				
Depreciation	5.3, 5.4	**371**		375
Amounts written back	5.1	**5**		0
Amortisation	5.1, 5.2	**221**		114
			597	489
Net cash transferred under absorption accounting			**99**	
Adjustments for movements in working capital other than cash				
Movement to working capital on Transfer		**(389)**		
(Increase)/decrease in receivables	6	**(4,065)**		12,354
Increase/(decrease) in payables	8	**7,903**		(18,320)
Increase/(decrease) in provisions	9.1, 9.2	**3,145,142**		4,091,019
			3,148,591	4,085,053
Net cash outflow from operating activities			**(225,017)**	(322,595)

11 Commitments under operating leases

The total future minimum lease payments under non-cancellable operating leases payable in each of the following periods are:

		2013/14	2012/13
		£000	£000
Land and buildings			
Amounts payable:	within 1 year	**551**	283
	between 1 and 5 years	**1,764**	1,525
	after 5 years	**828**	1,242
		3,143	3,050
Other leases			
Amounts payable:	within 1 year	**19**	13
	between 1 and 5 years	**50**	7
	after 5 years	**0**	0
		69	20

12 Losses and special payments

There were no losses or special payments above £300,000 (prior year: 0 cases) approved during 2013/14

13 Related parties

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

All Clinical Commissioning Groups
All Community Support Units
All English NHS Foundation Trusts
All English NHS Trusts
Business Services Authority
Care Quality Commission
Health & Social Care Information Centre
Health Education England
Health Research Authority
National Institute for Health and Care Excellence
NHS Blood and Transplant
NHS Business Services Authority
NHS Direct
NHS England
NHS Institute for Innovation and Improvement
NHS Property Services
NHS Trust Development Authority
Public Health England

In addition Professor R Shaw , non-executive director of the Authority, was employed by North West London Hospitals NHS Trust as the Medical Director until November 2013 when he joined Healthcare Uk as Medical Director.

Trust	Income £'000	Expenditure £'000	Receivables £'000
North West London Hospitals NHS Trust	9,103	0	1

The NHSLA also holds provisions and contingent liabilities in relation to these bodies which are included in the overall note 9.1 and 9.4

14 Financial instruments

IFRS 7 Financial Instruments: Disclosures 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 IFRS 7 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.

The NHS Litigation Authority holds financial assets in the form of NHS and other receivables, and cash, as set out in Notes 6 and 7 respectively, and financial liabilities in the form of NHS and other payables, as set out in Note 8. As these receivables and payables are due to mature or become payable within 12 months from the Statement of Financial Position date, the Authority considers that the carrying value is a reasonable approximation to fair value for these financial instruments.

Liquidity risk

The NHS Litigation Authority's net expediture is financed from resources voted annually by Parliament and scheme contributions from NHS

Member Organisations. 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, therefore, not exposed to significant liquidity risks.

Market risk (including foreign currency and interest rate risk)

None of the NHS LA's financial assets and liabilities carry rates of interest. The NHS LA has negligible foreign currency income and expenditure. The NHS Litigation Authority is, therefore, not exposed to significant interest rate or foreign currency risk.

Credit Risk

As noted, the NHS LA receives its income from NHS member organisations. As a consequence, its NHS and other receivables are not impaired, and there are no significant receivable balances with bodies external to government. The NHS Litigation Authority is, therefore, not exposed to significant credit risk.

15 Events after the reporting period

These financial statements were authorised for issue on 1 July 2014 by the Accounting Officer.

16 National Clinical Assessment Service (NCAS)

The NHS White Paper, 'Equity and excellence: Liberating the NHS', published in July 2010, sets out the government's long-term vision for the future of the NHS. Following the notice of the closing of the National Patient Safety Agency, Department of Health ministers approved the hosting of the National Clinical Assessment Service (NCAS) by National Institute for Health and Care Excellence (NICE) for one year prior to its transfer to the NHS Litigation Authority (NHS LA).

On 1 April 2013 NCAS became an operating division of the NHS LA. The information below shows the assets and liabilities transferred from NICE.

The annual income and expenditure for the NCAS services (the majority of which is funded via Grant in Aid allocations from the Department of Health) totals approximately £7 million and is shown within the income and expenditure reported in note 9.6 within these accounts.

NCAS Statement of Financial Position as at 1 April 2013

		1 April 2013 £000
Non-current assets:		
	Property, plant & equipment	89
	Intangible assets	204
	Total non-current assets	**293**
Current assets:		
	Trade and other receivables	389
	Cash and cash equivalents	99
	Total current assets	**488**
	Total assets	**781**
Current liabilities:		
	Trade and other payables	(778)
	Provisions for liabilities and charges - known claims	0
	Provisions for liabilities and charges - IBNR	0
	Total current liabilities	**(778)**
Non-current assets plus/less net current assets/liabilities		**3**
Non-current liabilities		
	Provisions for liabilities and charges - known claims	0
	Provisions for liabilities and charges - IBNR	0
Total non-current liabilities		**0**
Assets less liabilities		**3**

Glossary

ALB Arm's Length Body. ALBs are independent of Government. In the health sector they regulate the health and social care system, establish national standards, protect patients and the public, and provide central services to the NHS.

Bradford Scores A mechanism used as a means to measure worker absenteeism. Bradford Scores were developed as a way of highlighting the disproportionate level of disruption on an organisation's performance that can be caused by short-term absence compared to single instances of prolonged absence.

CCGs Clinical Commissioning Groups. CCGs have taken over commissioning from primary care trusts (PCTs).

CJC The Civil Justice Council. The CJC is an advisory public body established under the Civil Procedure Act 1997 with responsibility for overseeing and co-ordinating the modernisation of the civil justice system.

CNST Clinical Negligence Scheme for Trusts. The CNST scheme indemnifies members for clinical negligence claims.

CTG Cardiotocograph. A CTG is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy, typically in the third trimester.

Deanery An NHS Deanery was a regional organisation, within the structure of the NHS, responsible for postgraduate medical and dental training. Deanerys have been replaced as of 2013 with Local Training and Education Boards (LETBs), that provide a similar service.

DH Department of Health.

DNV Det Norske Veritas. DNV is the organisation that provides the NHS LA with risk assessment services.

Duty of Candour The Statutory Duty of Candour. Due to be introduced in October 2014, Duty of Candour will place a requirement on providers of health and adult social care to be open with patients when things go wrong. It will mean providers must notify the patient about incidents where 'serious harm' has occurred and provide an apology and explanation where appropriate.

ELS Existing Liabilities Scheme. Funded by the Department of Health, ELS is a clinical negligence claims scheme that indemnifies pre-April 1995 incidents.

ET Employment Tribunal.

Ex-RHA Ex Regional Health Authorities Scheme. Funded by the Department of Health, Ex-RHA is a clinical negligence claims scheme that indemnifies the liabilities of former Regional Health Authorities.

Extranet A secure web portal providing our members and our solicitors with real time access to their claims data. The data help our members prevent harm to patients and staff, which might otherwise lead to future claims against the NHS.

FHSAU Family Health Service Appeal Unit.

Guideline Hourly Rates Guidelines based on recommendations by the CJC to assist the judiciary in determining the hourly rate which can be recovered by a solicitor according to grade and location.

HFMA Healthcare Financial Management Association. HFMA is the representative body for finance staff in healthcare.

HPA Health Protection Agency.

HPAN Healthcare Professional Alert Notice. HPAN is an alert system managed nationally by NCAS to alert employers to the existence of serious grounds for concern about a regulated health practitioner who has departed the organisation and for whom the concerns were unresolved. This differsfrom performers' list concerns (restrictions on practice), which are logged centrally by FHSAU and shared with requesting health bodies.

IBNR	Incurred But Not Reported claims; claims that may be brought in the future.
Jackson reforms	Legal reforms that came into force on 1 April 2013. The Jackson reforms change, amongst other matters, the amount that claimant solicitors can recover from the defendant under conditional fee agreements and limit after the event insurance.
Legal costs	Amounts paid out by NHS LA in legal costs for claims resolved, including defence and claimant costs.
LTPS	Liabilities to Third Parties Scheme. LTPS indemnifies the NHS for employers' liability, public liability and professional indemnity claims made against the NHS.
Member	The NHS LA is a membership organisation comprising NHS Trusts, CCGs, independent healthcare providers to the NHS and other Government agencies related to healthcare.
MOJ Portal	A secure electronic communication tool for processing low value personal injury claims, covered by the Ministry of Justice's (MOJ) pre-action protocols, which limit the costs recoverable.
Never events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implementated.
NICE	National Institute for Health and Care Excellence (known as the National Institute for Health and Clinical Excellence prior to 1 April 2013).
NCAS	National Clinical Assessment Service. NCAS helps resolve concerns about the professional practice of doctors, dentists and pharmacists in the UK.
NHS LA	National Health Service Litigation Authority.
NRLS	National Reporting and Learning System. NRLS, established in 2003, is a system that enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.
NSPCC	National Society for the Prevention of Cruelty to Children.
ONS	Office for National Statistics.
PCT	Primary Care Trust (replaced by CCGs from 1 April 2013).
PES	Property Expenses Scheme. PES indemnifies NHS members for property claims.
PNA	Pharmaceutical needs assessment.
PPO	Periodical Payment Order. A PPO is a court order that grants the claimant a lump sum payment followed by regular payments over the life of claimant.
RRL	Revenue resource limit. RRL is the total funding allocated for revenue or day-to-day spending, set by the DH each year.
SHAs	Strategic health authorities. SHAs ceased to exist on 1 April 2013. SHAs' responsibilities have been taken over by CCGs and the NHS Trust Development Authority. SHAs used to manage the NHS locally and provide a link between the DH and the NHS.

Key

Clinical Negligence Scheme for Trusts (CNST) – A voluntary membership scheme to which all NHS Trusts and Foundation Trusts in England currently belong. It covers all clinical claims where the 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.

Liabilities to Third Parties Scheme (LTPS) and Property Expenses Scheme (PES) – Known collectively as the Risk Pooling Schemes for Trusts (RPST), they are two voluntary membership schemes covering non-clinical claims where the incident occurred on or after 1 April 1999. Like CNST, costs are met through members' contributions on a pay-as-you go basis.

Existing Liabilities Scheme (ELS) – ELS is centrally funded by the Department of Health and covers clinical claims against NHS organisations where the incident took place before 1 April 1995.

Ex-RHA Scheme (Ex-RHAS) – Ex-RHAS 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.

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