



NHS Litigation Authority Report and Accounts 2014/15

Fair resolution

NHS Litigation Authority

Report and Accounts 2014/15

Presented to Parliament pursuant to Paragraph 6 of Schedule 15 of the
National Health Service Act 2006

Ordered by the House of Commons
to be printed 16th July 2015

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This publication is available at <https://www.gov.uk/government/publications>

Print ISBN 9781474117272

Web ISBN 9781474117289

ID 2903728 07/15 2903728 19585

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

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Welcome

Chair's Welcome



Ian Dilks
Chair

I have now been in the role of Chair for just over a year and writing this introduction is a good time to reflect. Two things have become clear to me in the last year.

First, the NHS LA is an effective organisation which employs good and diligent people who genuinely care about the NHS and its patients. The ever increasing volumes of work and the need to embrace the many changes that are occurring have placed considerable strains and I would like to take this opportunity to thank all our staff for their commitment and hard work.

Second, the environment in which we operate means that the costs of litigation are placing a burden on NHS finances of a magnitude that was never imagined when the NHS LA was established.

Last year we paid over £1.1 billion to patients who suffered harm and their legal representatives, this coming year it will be c £1.4 billion and with accumulated provisions in our balance sheet of over £28 billion further significant increases are already in the pipeline. Currently over a third of what we spend each year is received by the legal profession and, as later pages explain, most of this is paid to claimants' lawyers.

"The NHS LA does not determine either the policies or legal framework which we operate but we have unique insights into the financial consequences of what those policies and framework are."

One of our priorities for the year ahead is to therefore work with policy makers, other NHS bodies, clinicians and our scheme members to inform the debate on what might be done to reduce the financial burden on the NHS and increase the availability of scarce resources to the NHS and its patients. This will include an increased focus on safety and learning, transferring back into the NHS our experience of what has caused harm to patients and what might be done to achieve reductions in harm and the cost of harm.

The NHS LA was subject to a Triennial Review last year which examined both the need for and management of the risk pool operations of the NHS LA (as a new part of our operations NCAS was not included in the review). The Review confirms the effectiveness of the NHS LA's operations and is supportive of our priorities for the next few years.

There have been a number of senior management and Board changes in the year. Catherine Dixon, our former Chief Executive, left us at the end of November 2014 to take up a new role as the Chief Executive of the Law Society. We are grateful to Catherine for the changes she initiated in her time with us. After an extensive selection process we appointed Helen Vernon as our new Chief Executive on 1 December. Helen was previously our Director of Claims and the fact that we were able to make an internal appointment, despite the quality of external candidates is a testament to the quality of people in the NHS LA.

Professor Rory Shaw's term as a Non-Executive Director ended on 31 March 2015 and we are very grateful for his support over eight years. On 1 April we were delighted to appoint Professor Keith Edmonds to our Board. Keith is a Consultant Gynaecologist and his experience will be invaluable to us in the years ahead. On 30 April 2015 Nina Wrightson, our Vice Chair and Senior Independent Director, stood down from the Board after eight years' service to the NHS LA. Our thanks go to Nina for her past contributions.

The next year will undoubtedly be challenging for the NHS LA as we seek to respond to the many challenges that already face us and the further changes that are likely to come. Further details are set out in the pages that follow. However we have good leadership, good people and a focus on what we need to do, so I am confident that the organisation will be capable of meeting these challenges.

Chief Executive's Report



Helen Vernon
Chief Executive Officer

I was appointed as Chief Executive in December 2014, following a number of years working within the NHS LA's claims function, latterly as the Director of Claims. I am proud of the NHS LA's record in achieving 'fair resolution'.

The claims teams and our legal panel firms constantly strive to strike the difficult balance between the need to pay compensation to those who are entitled to it and to defend the NHS and public funds from unjustified claims. In a challenging legal and financial environment this has proven to be an increasingly difficult task. The emergence of non-specialist lawyers coupled with excessive claims for legal costs by some firms has required a change in approach. This year we contested a high number of cases to trial and challenged numerous claims for claimant costs at detailed assessment, achieving significant savings for our members.

"...it is important that those who suffer injury are able to obtain high quality legal representation at a reasonable cost."

We recognise that we are seeing a divided legal market and it is important that those who suffer injury are able to obtain high quality legal representation at a reasonable cost. For claims of

a lower value, there is a clear need to move to a position where legal costs are more proportionate to damages. We are keen to work with others in the market to ensure that claimants have a place to go for skilled and experienced support.

For the first time, our Annual Report sets out an analysis of some of the potential drivers of the costs of clinical negligence claims. Many are associated with the legal environment. Clinical negligence claims place increasing pressure on the health service, frontline staff, our members and ultimately, patients. It is one area of NHS expenditure where no-one would argue against a reduction. We look forward to informing a discussion of long term options to reduce claims expenditure.

The National Clinical Assessment Service joined the NHS LA in 2013 and in the past year has undergone a restructure of both its staff and its services. NCAS is now quicker, more flexible and more responsive to customer needs than ever before. Its unique expertise is valued highly across the health service. The exceptional standard of the educational service was recognised with an award in November for the Case Investigator Workshop in the 'Best Public Sector Programme' category of the Training Journal Awards. This rightly recognised the impact that the training had in the wider NHS.

It was a challenging year for the Family Health Service Appeal Unit (FHSAU) which continued to demonstrate its expertise as an effective, fair and trusted determiner of disputes in the NHS. FHSAU quickly mastered the impact of new regulations and the nuances of the application to individual cases.

One of the NHS LA's three strategic objectives is to support the NHS to learn from things that go wrong. We have an extensive and unique database of the experience of the NHS in England in this area. Our extranet allows our members to see this in real time and to benchmark their experience against others. In the last year, our Safety and Learning Team, with the support of our Informatics Team and others have made good progress in working with members to analyse trends and extract learning. The 'Scorecards' which we sent to members to support the Secretary of State for Health's 'Sign Up to Safety' initiative gave our members the tools to focus on areas of high cost and/or high volume claims and to address the causes of them in a way which has never been tried before.

The 'Safety Improvement Plans' will present opportunities in the coming year not just for those members who will benefit from a financial incentive to implement plans but for others, who will learn from the wealth of ideas put forward to reduce the harm which leads to claims.

Finally, we are very fortunate to have an expert, professional and highly experienced team, who are committed to doing the right thing for patients, healthcare staff and public funds.

They work hard to provide the best possible service and value for money and it is thanks to their efforts that we have been able to deliver this throughout the course of the year.

Drivers of clinical negligence costs

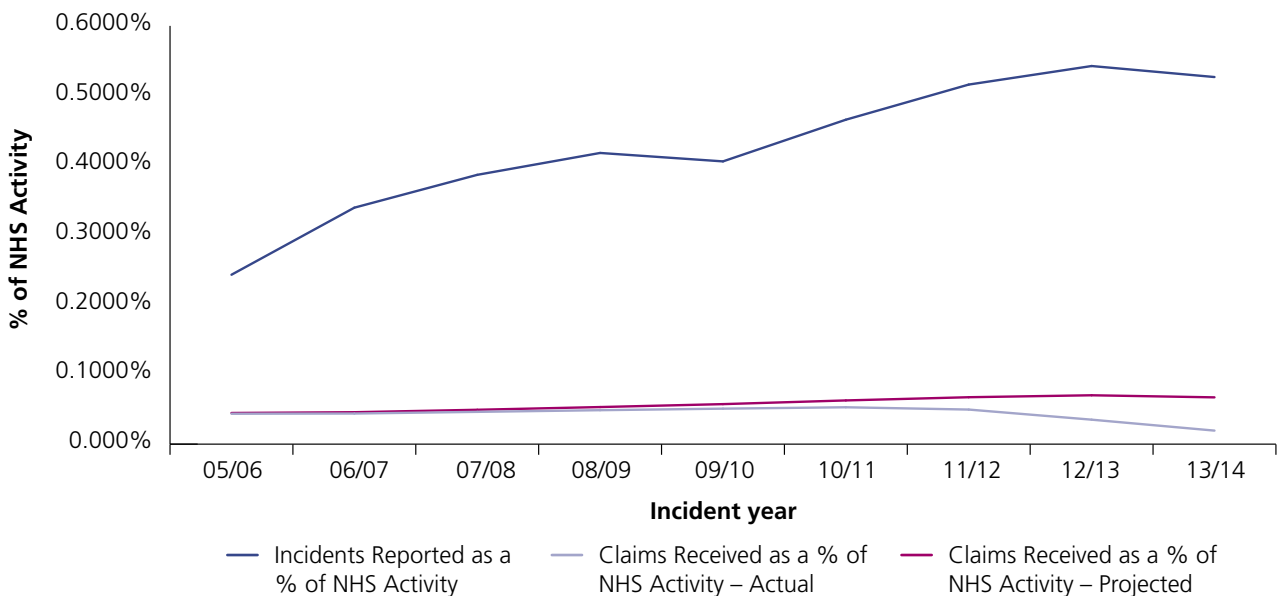
The NHS in England has experienced an increase in the costs associated with clinical negligence claims in recent years. This means increased costs to NHS trusts and less money available to care for patients.

The NHS LA has identified the following potential drivers of the costs of claims:

1. An increase in the number of patients being treated by the NHS.
2. An increase in the number of reported incidents. This may indicate an increasing and positive reporting culture and so is not necessarily reflective of an increase in incidents occurring.
3. An increase in the number of patients claiming compensation as a proportion of reported incidents.
4. An increase in the number of patients who claim but who do not recover compensation.
5. An increase in the number of lower value claims.
6. Disproportionate claimant legal costs for lower value claims.
7. Excessive claims for legal costs from some claimant firms.
8. Rising lump sums and annual costs (usually, for care), over and above inflation, for high value claims.

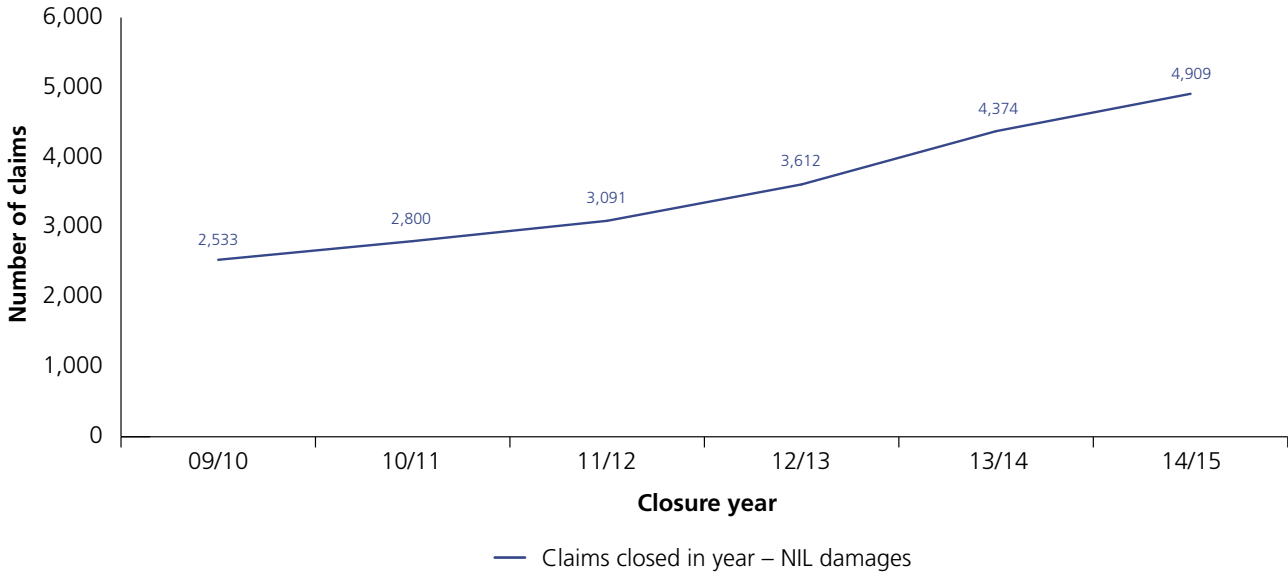
“The NHS LA is working closely with members to learn from claims in order to reduce harm however, many of the drivers identified lie in the legal environment.”

Figure 1: Relationships between NHS Activity, reporting and claims



NHS activity (measured here by 'Finished Consultant Episodes) has increased by 26% over 9 years. The proportion of NHS activity reported to the National Reporting and Learning System as an incident resulting in harm (moderate, severe or fatal) has also increased. Finally, there has been a moderate increase in claims as a percentage of reported incidents. This is projected forward because in more recent years claims reporting patterns mean that claims will take time to be reported to the NHS LA.

Figure 2: No compensation paid

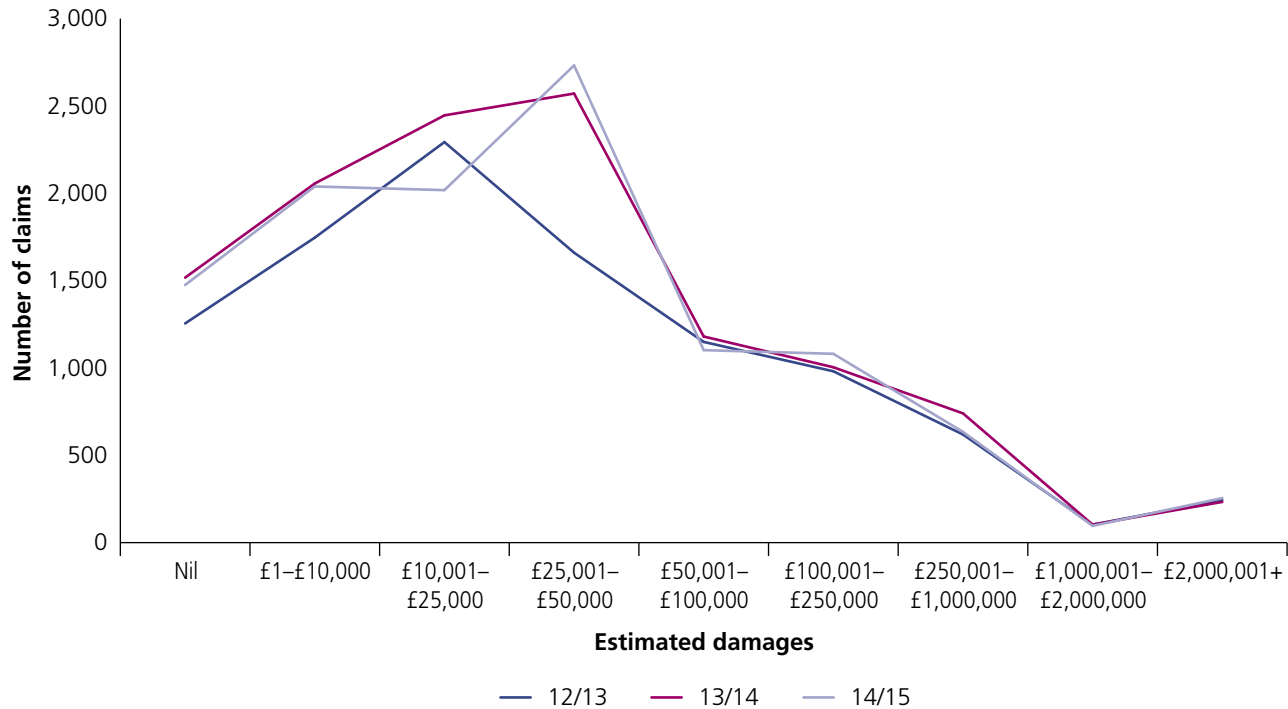


Claims can occasionally 're open' as a result of new information and as such this data can vary over time. This is the position as at 31st March 2015.

The NHS LA currently resolves over 4,000 clinical negligence claims annually, for no payment of damages. In 2014/15 it saved over £1.2 billion for the NHS in rejecting claims which had no merit. This was also a year in which it was necessary to

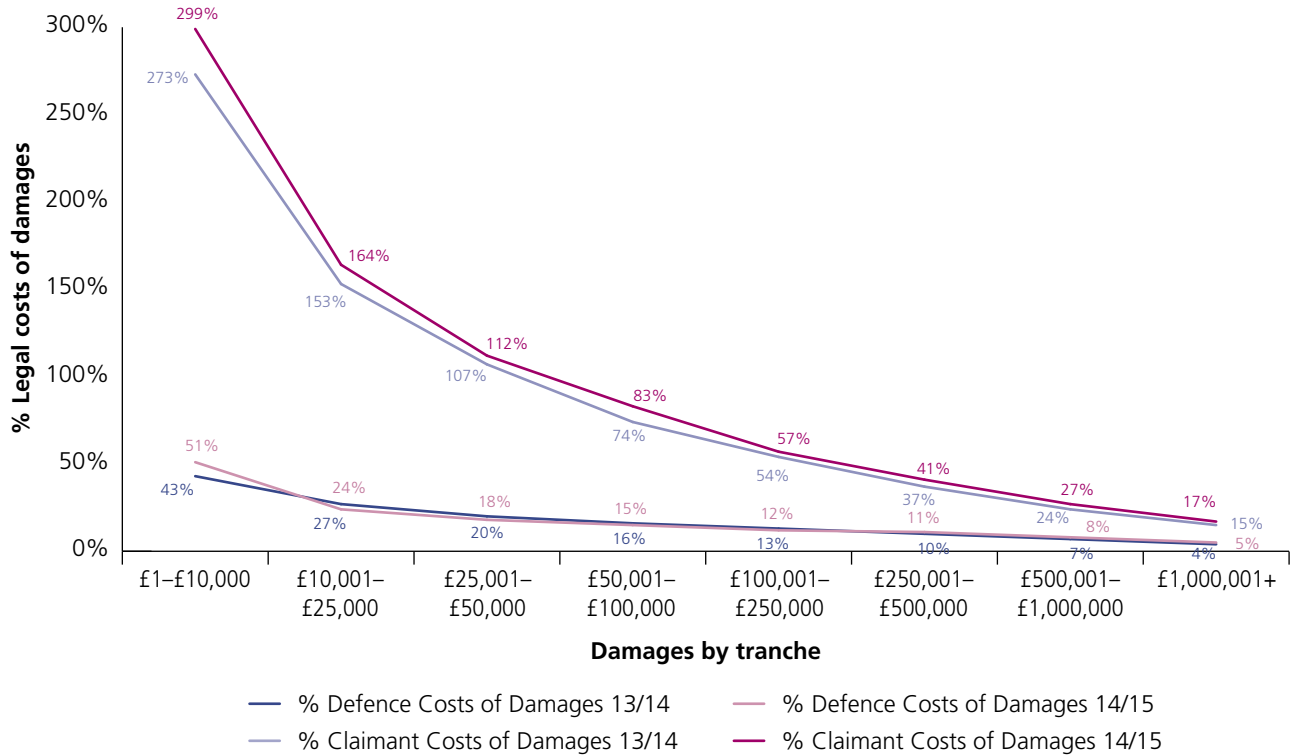
take a significant number of cases to trial, saving £38.6 million in those cases alone. These cases do not come without cost for the NHS and impose a burden upon NHS trusts and healthcare staff in the time spent in investigation.

Figure 3: Lower Value claims resolved



Increasing numbers of claims are being brought for lower values, as opposed to £multi-million claims. The high number of claims seen in the £25,000 – £50,000 bracket seen in 2013/14 was repeated in 2014/15.

Figure 4: Disproportionate Claimant Legal Costs



Claimant costs for lower value claims are disproportionate and excessive. For claims where compensation is less than £10,000, claimant lawyers recover almost three times more in costs on average. This disproportion has increased from 2013/14 to 2014/15 at every level of damages, but in particular, at the lower end. Defence lawyers work to fixed costs arrangements, with significantly lower costs than Claimant lawyers at every value range.

Figure 5: Average Claimants legal costs as % of the total claim value (where damages are below £100,000)

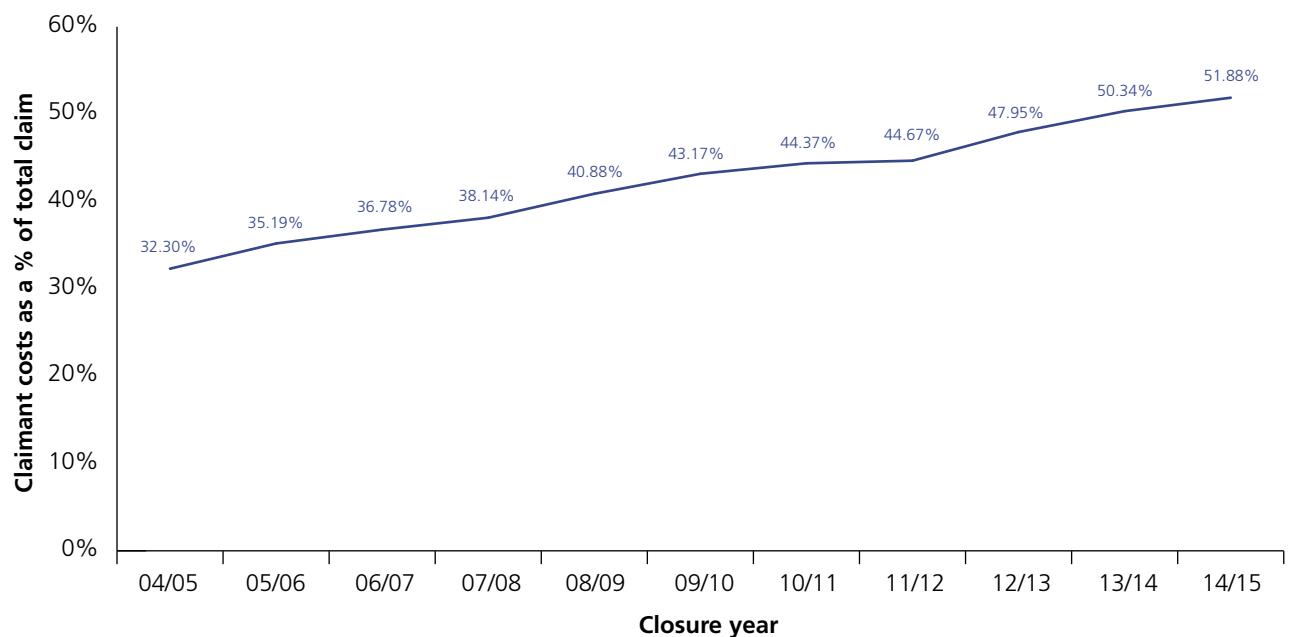
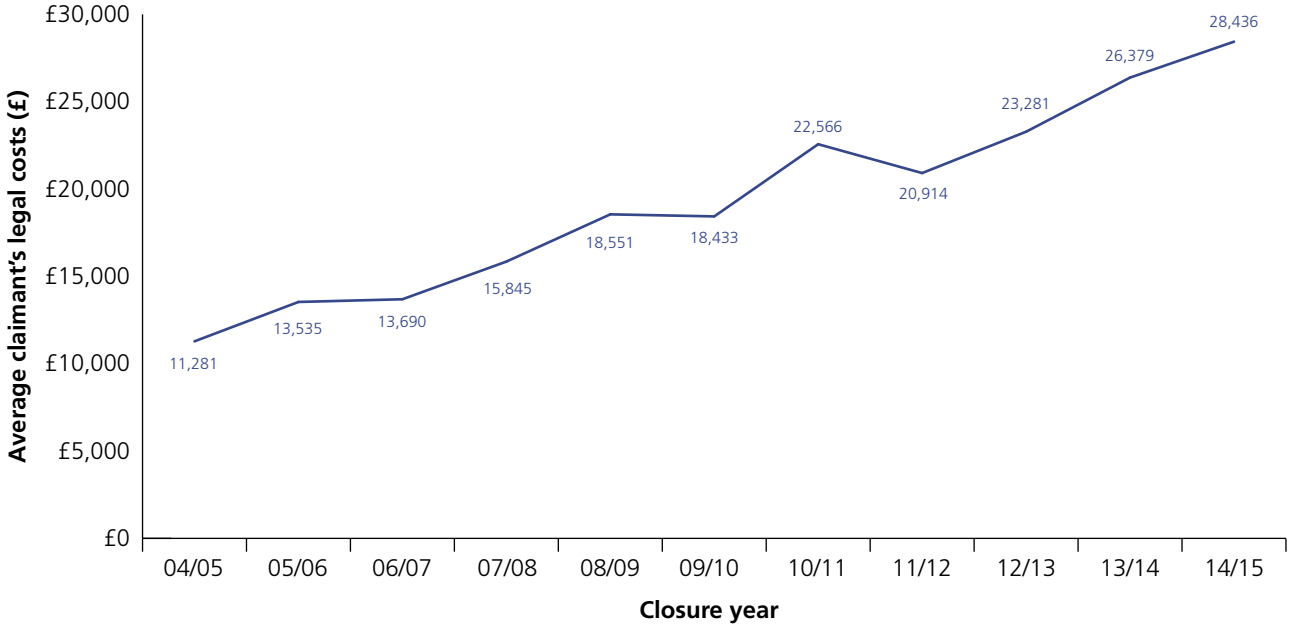


Figure 6: Average of claimants costs paid on claims where damages are below £100,000



For claims resolved for less than £100,000 damages, the percentage of claimant costs has increased from just over 30% to 50% over the last 10 years and as an absolute figure, has increased almost three-fold.

Examples of excessive claims for costs during 2014/15 are given in the claims section of this report on page 18.

Figure 7: Average Lump sum for PPOs

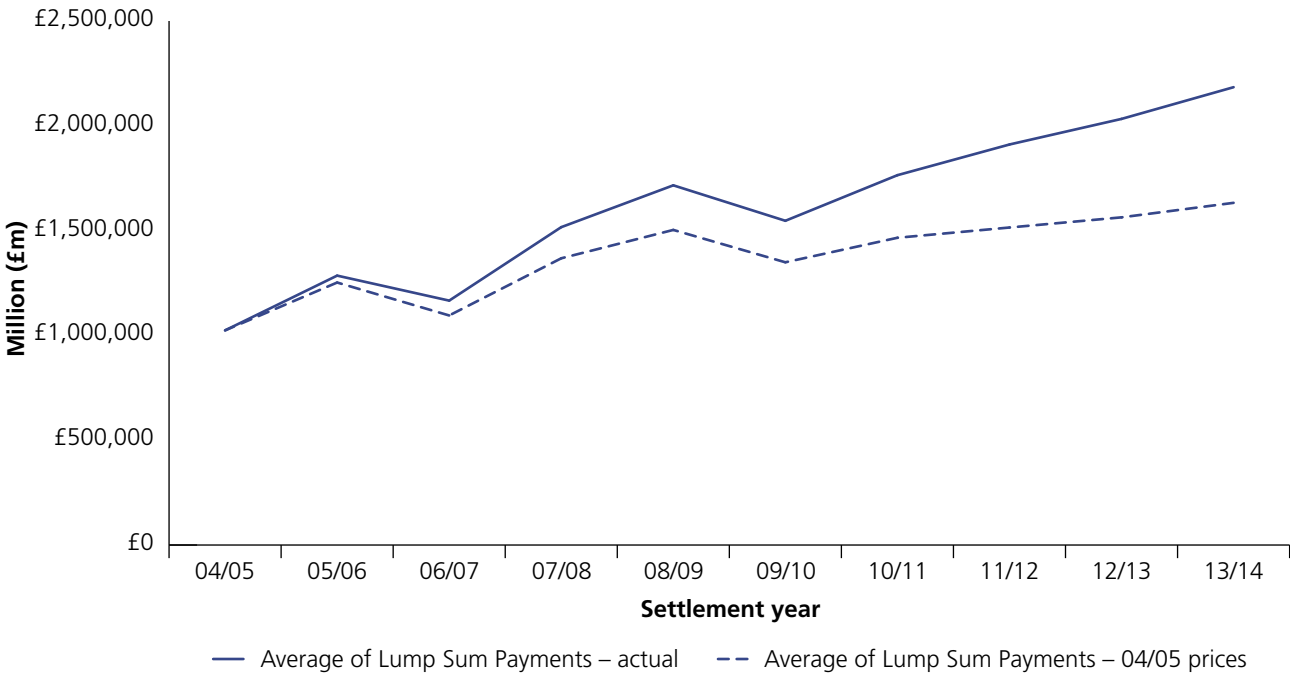
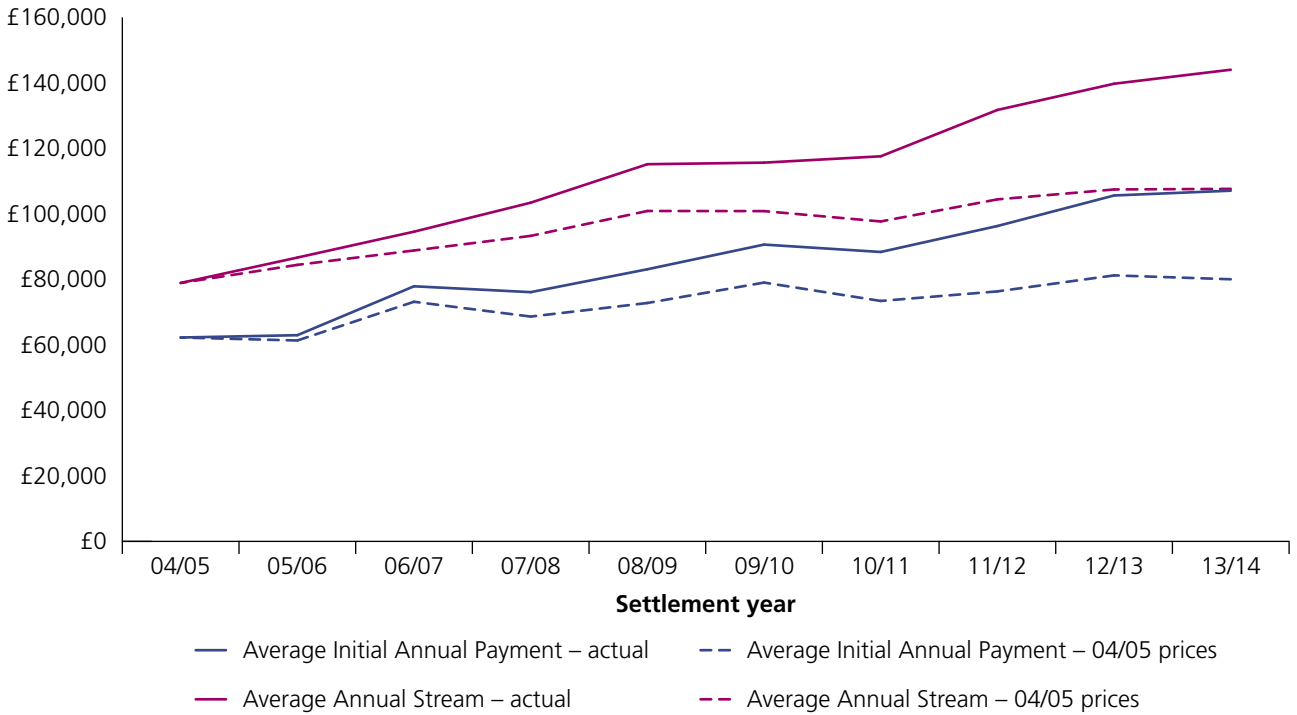


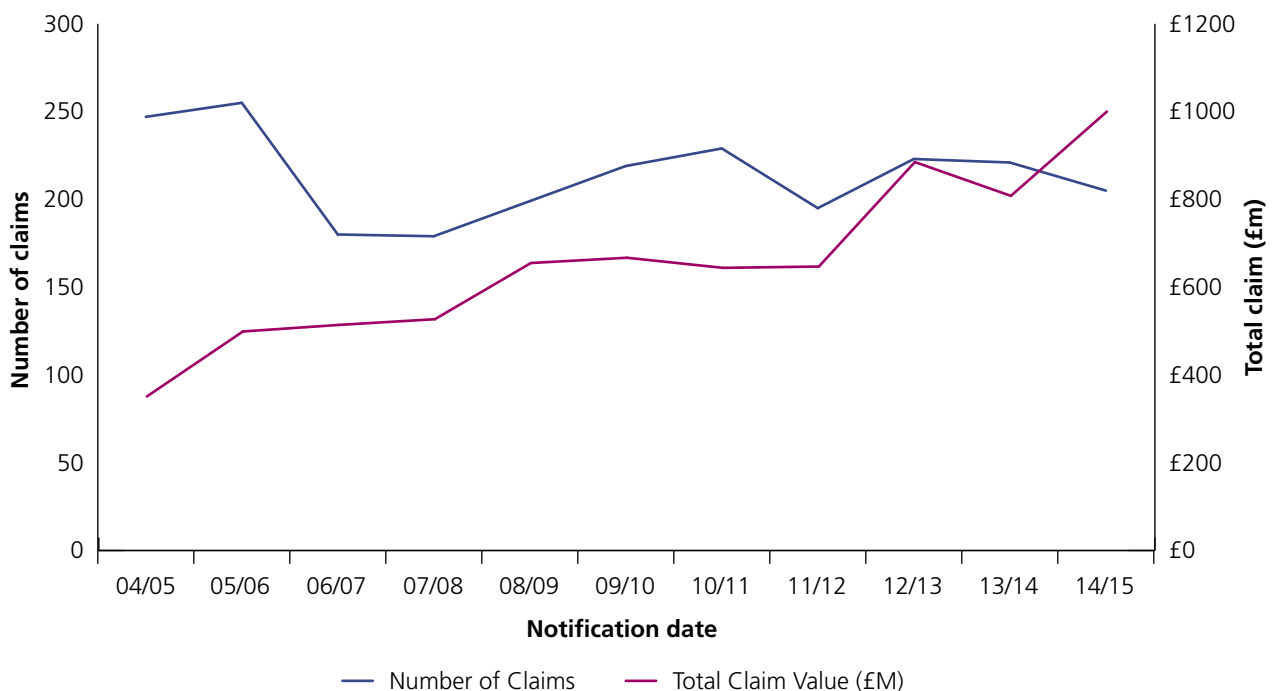
Figure 8: Changing Average Annual payments under PPOs



High value claims are usually settled by way of periodical payments which means that the claimant receives a lump sum for their immediate needs up front, followed by annual payments for life, usually for the costs of care. Currently, the law allows these to be awarded on a privately funded basis. This often means adapted

accommodation, specialist education and a privately funded care regime. Both the 'up-front' costs and the annual costs have risen dramatically over the last 10 years. This is partly driven by underlying inflation but there is a significant increase over and above that.

Figure 9: Number & value of maternity cerebral palsy/ brain damage claims received



Whilst there has not been a significant increase in the number of claims brought for cerebral palsy in recent years, there has been an increase in the value. Such cases account for over a third of expenditure on claims within the year. In addition, future liabilities are created by periodical payments, and therefore there is an on-going cost to the Health Service.

In summary

A long term view of the options for change is required in order to address the drivers of clinical negligence claims:

- The NHS LA is supporting its members to learn from and reduce the incidents which lead to claims and thereby improve patient safety.
- We continue to respond to the changing legal environment to ensure that claims are resolved appropriately and fairly and that legal costs are kept to a minimum.
- We will use the information we have on the drivers of claims costs to inform the debate on options to reduce the financial burden to the NHS.

The year in summary

Figure 10: Expenditure on clinical claims

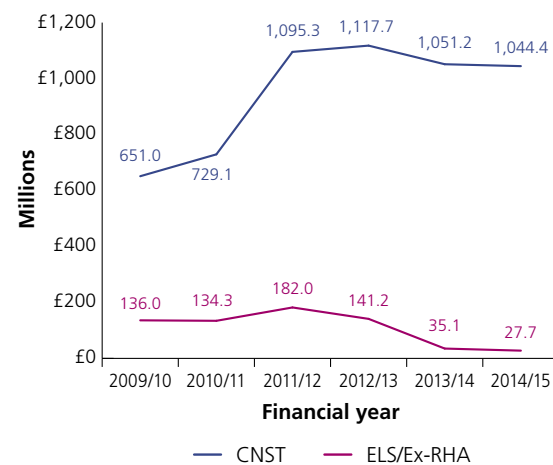


Figure 10 excludes £97.5m of expenditure incurred on claims which transferred to the Department of Health on 1 April 2013 as a result of the restructure of the NHS.

Figure 11: Clinical negligence expenditure including interim payments 2014/15

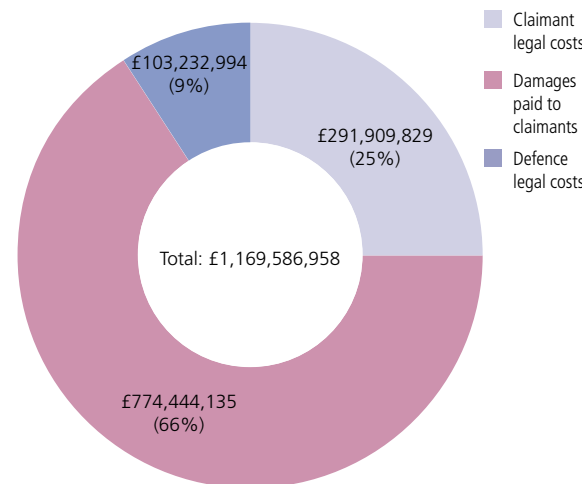


Figure 12: Clinical negligence expenditure including interim payments in 2013/14

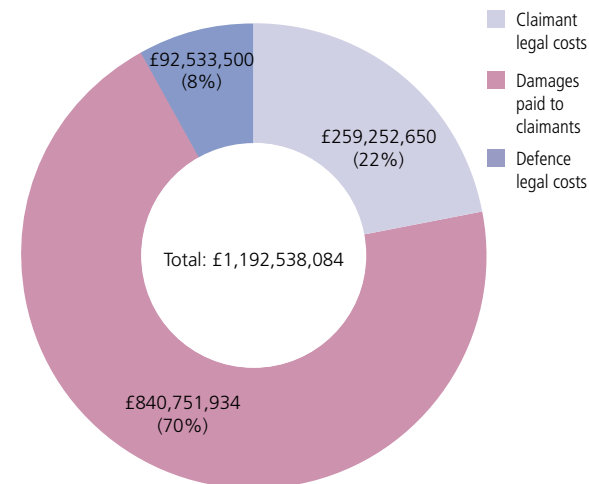


Figure 13: Damages and costs saved in clinical negligence claims resolved in 2014/15

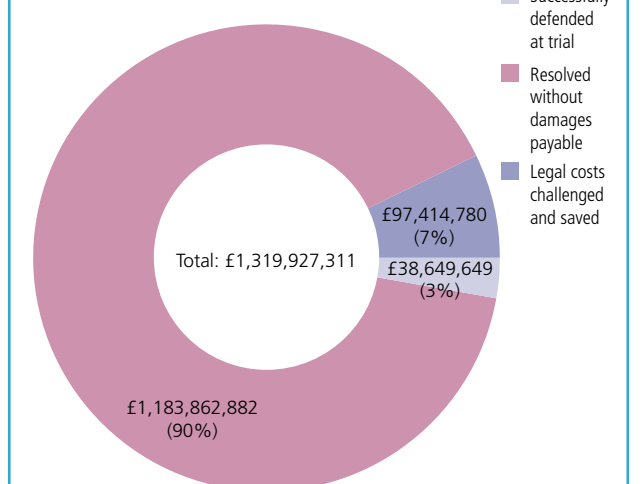


Figure 13 excludes reductions in settlement values negotiated by the NHS LA and claims for costs under £50,000 negotiated in-house or by panel solicitors. Claims can occasionally 're open' as a result of new information and as such this data can vary over time. This is the position as at 31st March 2015.

Figure 14: Expenditure on non-clinical claims

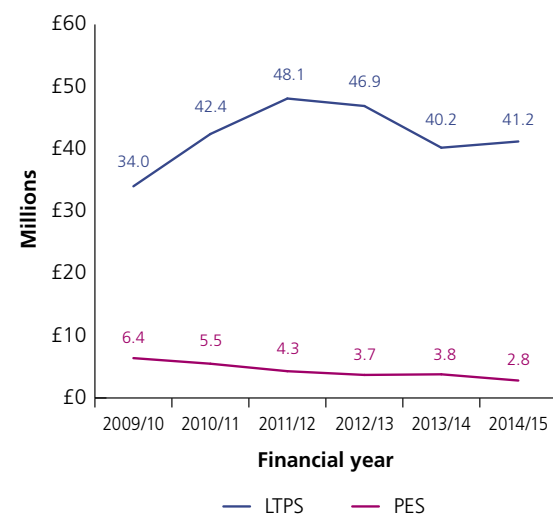


Figure 14 excludes £9.4m of expenditure incurred on non-clinical claims which transferred to the Department of Health on 1 April 2013 as a result of the restructure of the NHS.

Figure 15: Non-clinical negligence expenditure 2014/15 including interim payments

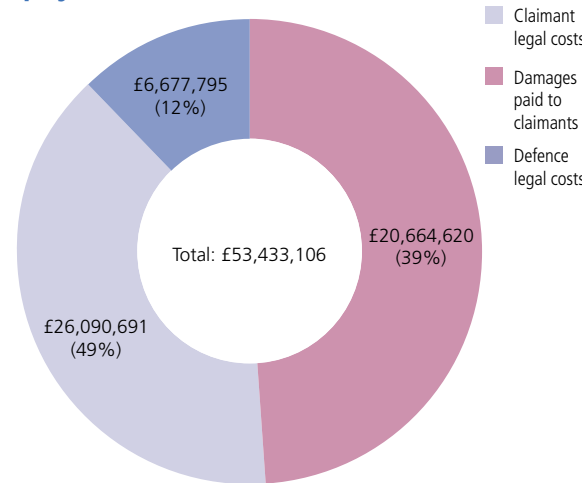


Figure 16: Non-Clinical expenditure 2013/14 including interim payments

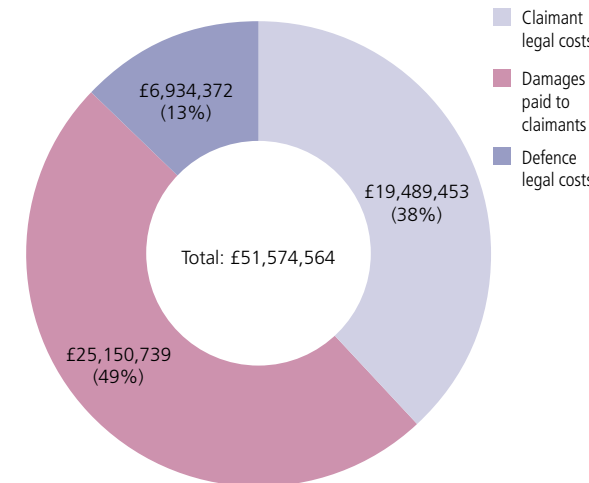


Figure 17: Damages and costs saved in non-clinical claims resolved in 2014/15

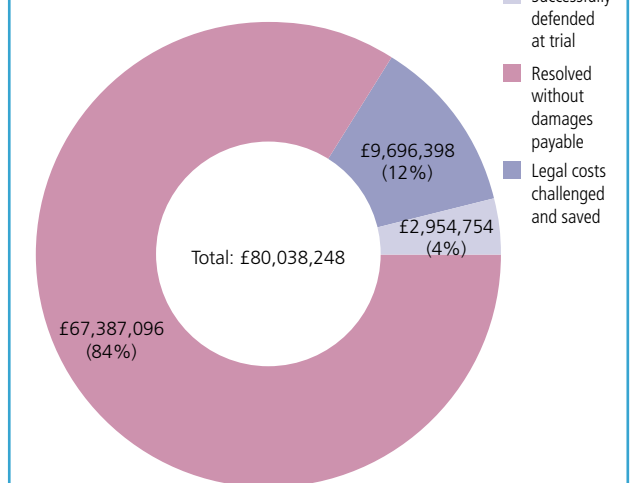


Figure 17 excludes reductions in settlement values negotiated by the NHS LA and claims for costs under £50,000 negotiated in-house or by panel solicitors. Claims can occasionally 're open' as a result of new information and as such this data can vary over time. This is the position as at 31st March 2015.

Whilst annual expenditure on clinical negligence claims saw a small reduction from 2013/14 to 2014/15, this does not account for future income streams agreed on high value claims resolved on a periodical payment basis within the year. In addition the financial impact of the high number of claims received during 2013/14 is likely to be seen in 2015/16 and beyond, when those claims fall for settlement.

Savings achieved in clinical negligence cases successfully defended at trial have more than doubled whilst savings achieved by challenging claimant legal costs have increased by more than 40%.

Savings achieved in non-clinical negligence cases successfully defended at trial have more than quadrupled whilst savings achieved by challenging claimant legal costs have increased by over 38%.

Key

Clinical Negligence Scheme for Trusts (CNST)

A voluntary membership scheme to which all NHS Trusts and Foundation Trusts in England, as well as some independent providers of NHS care, 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-RHA)

Ex-RHA 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.

Operations

Claims management

Claim Volumes

We received 11,497 new clinical negligence claims in 2014/15 demonstrating a sustained high level of new claims.

In the same period we received 4,806 new non-clinical liability claims. (See figure 18).

Figure 18: Claims reported

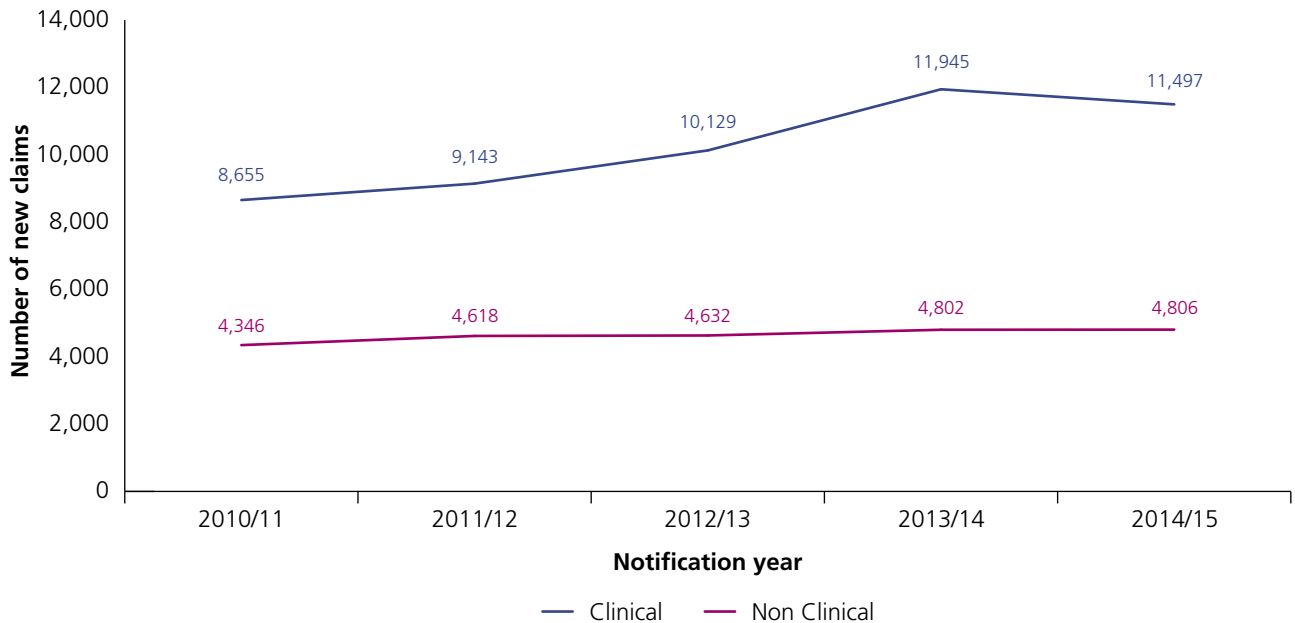
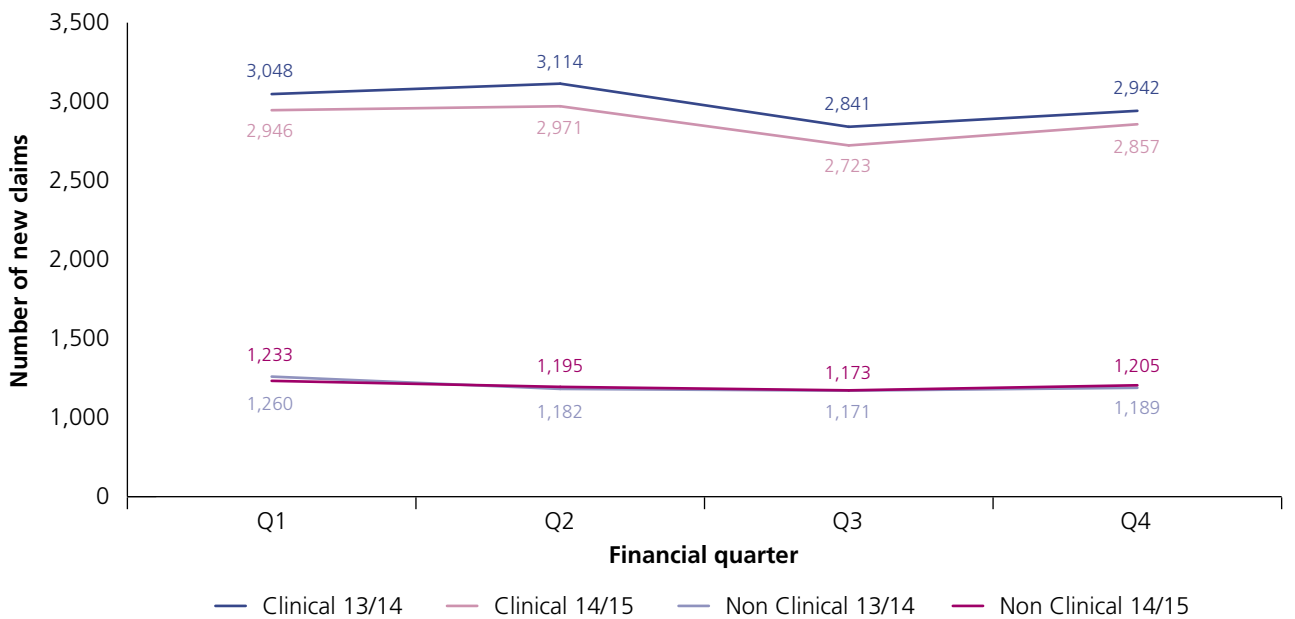


Figure 19: Claims reported by quarter



Whilst we have seen a steady increase in the number of new claims over the past three years, it was expected that the rate of increase would slow down eventually in the wake of changes to funding

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arrangements for civil litigation introduced by the Legal Aid, Sentencing and Punishment of Offenders Act (LASPO) on 1 April 2013.

LASPO reformed funding arrangements and prevented claimant lawyers from recovering success fees of up to 100% of their base costs from the defendant. Strong marketing campaigns in the run-up to LASPO saw significant numbers of claims signed up under pre-LASPO funding agreements that allowed claimant lawyers to continue to charge success fees on claims brought throughout 2013/14 and 2014/15. The slowdown in growth coincides with a predicted fall in the number of claims funded under pre-LASPO agreements.

Nevertheless the continued high number of claims has presented a significant challenge for our teams, legal panel and the NHS as a whole. Despite receiving an average of 958 new clinical claims every month during 2014/15 we have continued to resolve claims quickly.

On average we resolve CNST claims in 1.31 years, and CNST claims valued under £25,000 are resolved in less than twelve months.

We continue to receive, and to defend a significant number of unjustified claims. More than 46% of clinical claims and 45% of LTPS claims concluded in 2014/15, were resolved with no damages payment.

A total of 16,459 claims were closed in 2014/15, more than ever before.

1,075 more claims were resolved in 2014/15 than 2013/14 (see figure 20).

It remains a testament to the professionalism and hard work of our staff that we continue to deliver consistent, high quality case management.

We have always sought to resolve claims without litigation, and we continue to use a range of alternative dispute resolution options in appropriate cases, including formal mediation.

We remain committed to achieving a fair resolution for NHS patients, staff and visitors who suffer negligent harm, and to sharing learning from claims so as to reduce the risk of harm in the future, but we will continue to robustly defend unmeritorious claims.

Figure 20: Claims closed in 2014/15

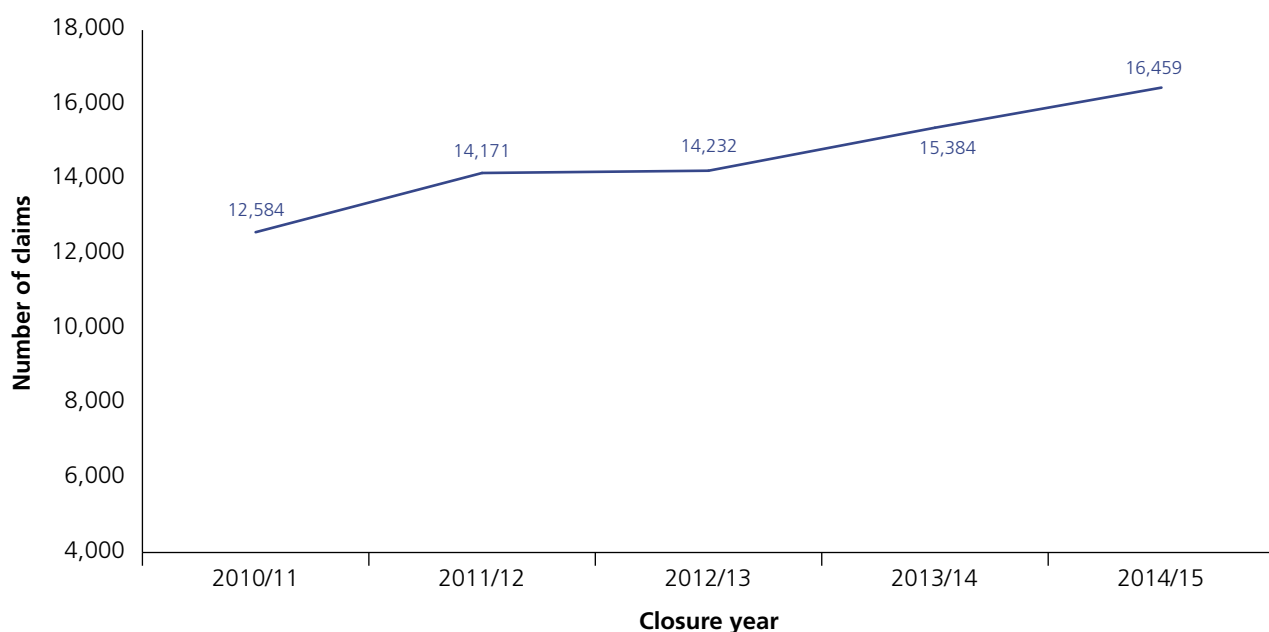
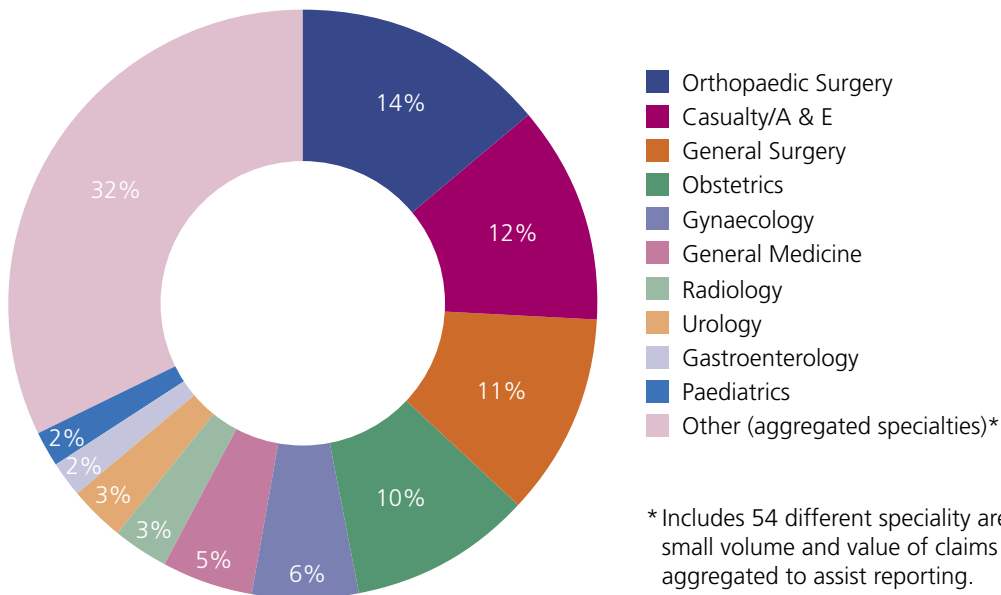
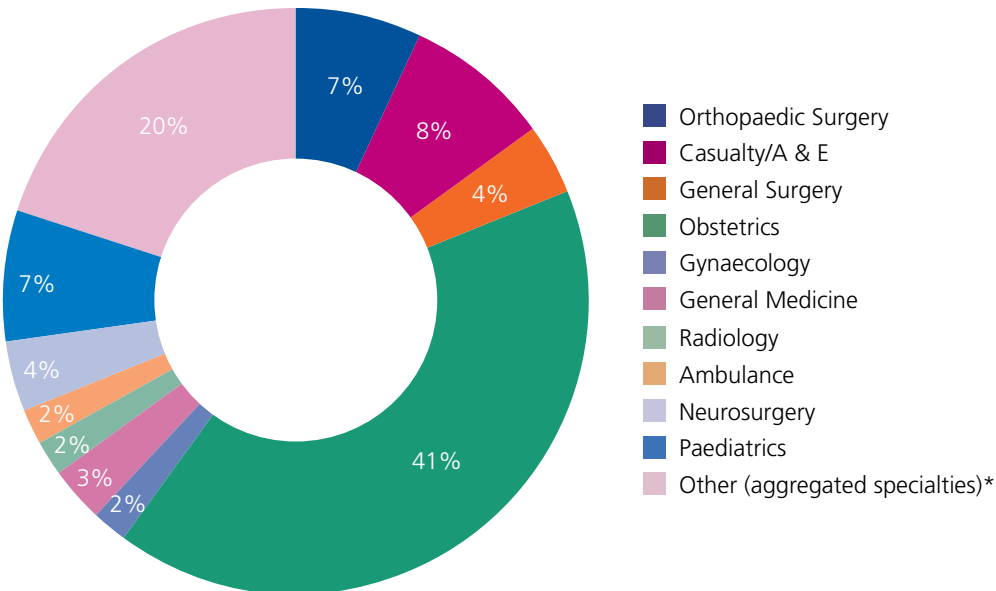


Figure 21: Number of clinical negligence claims received in 2014/15 by speciality



* Includes 54 different speciality areas each with a relatively small volume and value of claims which have been aggregated to assist reporting.

Figure 22: Value of clinical negligence claims received in 2014/15 by speciality



Legal Costs

The cost of buying our own legal services and meeting the legal costs of successful claimants represents a significant portion of our total expenditure. We are confident that our own legal spend represents value for money as a result of a comprehensive procurement for legal services in 2013 that led to the creation of three legal panels; two providing claims and litigation support, and a third providing corporate advice.

Our defence solicitors are paid agreed hourly rates, or remunerated via a fixed fee structure linked to the value and complexity of the work. We are transparent in what we pay to our defence solicitors which in 2014/15 was £109.9 million. In the same period we received claims for legal costs of over £326 million from claimants' solicitors in relation to only successful claims. The reality is that we can exert only limited control over a claimant's legal costs and no control at all where those costs are

incurred before the claim is even reported to the NHS LA. The fundamental principle of civil litigation permitting the winning party to recover their legal costs from the losing party has long been enshrined in law, but in straightforward, low to mid-value claims it is impossible to justify the increasing number of cases where significantly more money is billed by claimant solicitors in legal costs than is paid in compensation.

We have mentioned the effect of LASPO on claims volumes, but LASPO also appears to have influenced the behaviour of some claimant lawyers. We are seeing an increasing number of plainly excessive and disproportionate costs bills, the presentation of which coincides with the banning of success fees and the reduction of the recoverability of the full cost of after the event (ATE) insurance against the defendant. We have successfully challenged a substantial number of these bills and in many cases achieved significant savings.

Disproportionate costs incurred before notification of claim

Following settlement of the claim for £2,000 within four months of service of the Letter of Claim, the claimant’s solicitors presented a bill for £53,529.60. This included a 100% success fee and an ATE premium which had been taken out at a cost of £19,875.00. The hourly rates claimed were significantly enhanced. The case was taken to a detailed assessment hearing and costs were assessed at £12,146.59.

We have saved more than £107 million in challenging claimants’ legal costs leading to an average 33% reduction in bills.

Figure 23: Claimant legal costs on all claims resolved in 2014/15

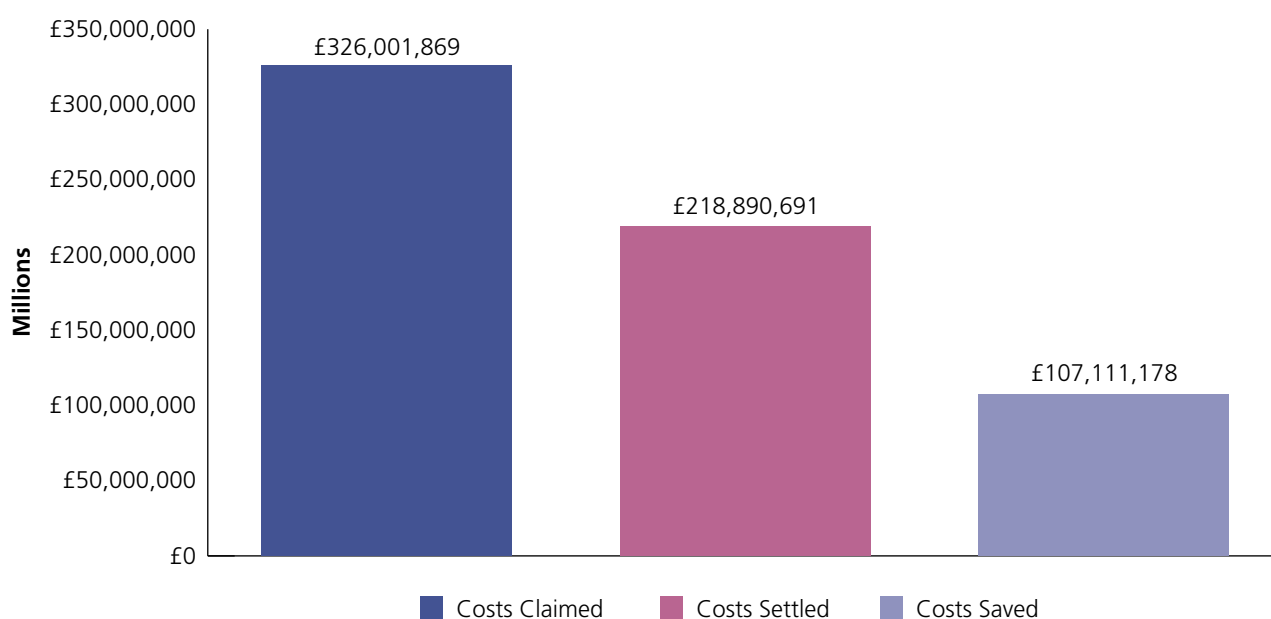
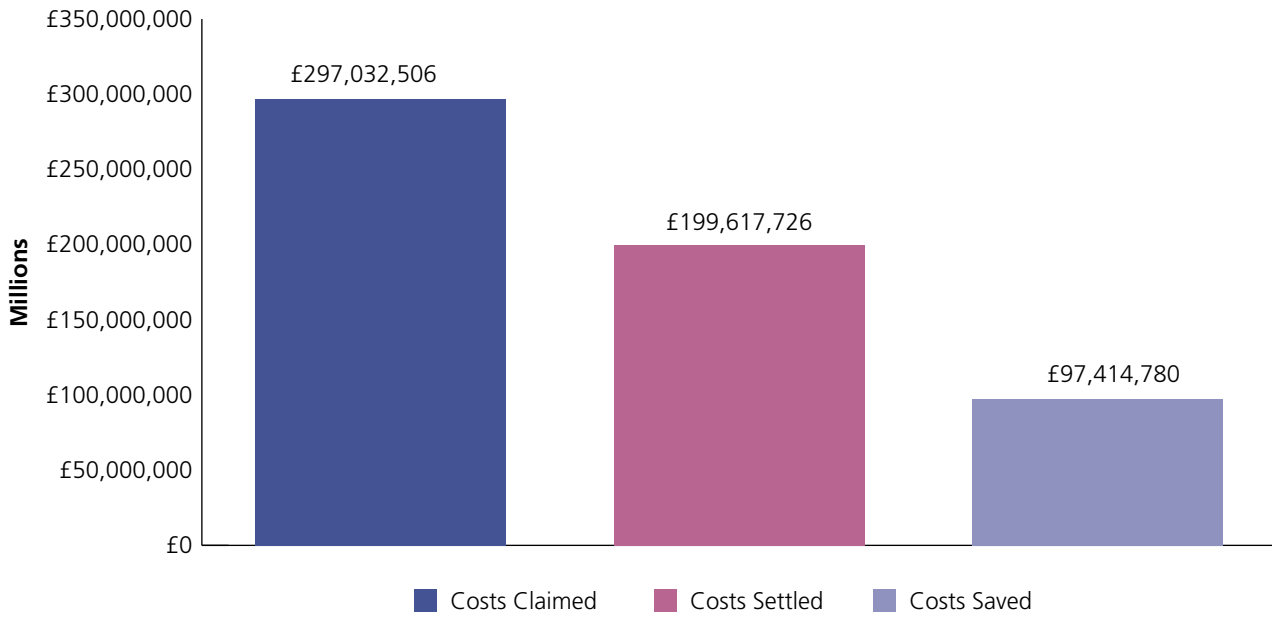


Figure 23 excludes claims for costs under £50,000 negotiated in-house or by the NHS LA panel solicitors. The largest savings were in the field of clinical negligence where we saved more than £97million in challenging excessive bills.



Figure 24: Claimant legal costs on clinical claims resolved in 2014/15



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

Excessive ATE (After the Event) Insurance premiums

ATE insurance protects the claimant from having to pay certain legal costs. It is a type of insurance taken out after the incident resulting in the claim has occurred. ATE insurers will pay the defendant's legal costs in the event that the claimant loses the case. The insurance may also cover the claimant's disbursement costs and other expenses.

For ATE insurance taken out before 1 April 2013, the insurance premium is payable by the losing defendant. However, ATE insurance premiums are not recoverable from the losing defendant if the insurance is taken out on or after 1 April 2013. The exceptions to this rule are certain clinical negligence cases where ATE insurance may be obtained to cover the cost of the claimant's experts reports. In such cases ATE premiums are payable by the losing defendant.

ATE insurance premiums are often claimed for unreasonable sums. In one case an ATE premium of £904,116 was settled by negotiation for £214,000. In another recent case the ATE premium of £264,470 has been challenged and the claimant's solicitor has offered to accept £1000 for the premium.

We are taking this case to a detailed assessment hearing because there are other aspects of the claim for costs which are in dispute

We continue to receive claims for costs which significantly outweigh the value of the settled claim for damages (see figure 4).

We have been concerned by the accuracy of some of the bills we have received and this has required us in some cases to refuse to make any offers in settlement to ensure that the bill is either withdrawn or the claim for costs assessed by the court.

Claim for costs struck out by court

The claim arose out of the failure to diagnose a tumour to the claimant's kidney following an attendance for chronic back and groin pain. The trust admitted breach of duty but denied causation and made an offer of £5,000.00 which was accepted. The claimant's bill of costs totalled £121,701.00. An hourly rate of £400 per hour was claimed despite the bulk of the work being conducted by unqualified staff. In addition a 100% success fee was claimed, which meant the true hourly rate claimed was £800 per hour. A further concern was that the claimant appeared to have the benefit of BTE ("before the event") insurance and had entered into two CFAs (conditional fee agreements – otherwise known as "no win, no fee" arrangements). The first detailed assessment hearing was part heard and the claimant's solicitors were ordered to disclose evidence of their entitlement to a success fee.

At the subsequent hearing it transpired that the claimant's solicitors had entered into two CFAs, the second CFA claiming discounted hourly rates in line with the hourly rates allowed by the BTE insurance provider. The claimant's solicitors refused to disclose any further details in relation to their retainer and as a consequence the regional costs judge ruled that he had 'no confidence' in the claimant's retainer and accordingly the claim for costs was struck out.

The claims portal

The extension of the road traffic accident personal injury claims portal to low-value employers' and public liability claims came into effect on 31st July 2013. The portal provides a mandatory secure medium for claimants to lodge specified categories of claims valued up to £25,000. Undefended claims are processed within the portal to conclusion and payment of damages. Sixty percent of LTPS employers' and public liability claims received by us in 2014/15 were reported within the portal.

The cost of settling employers' and public liability claims has fallen as a consequence of the fixed recoverable costs regimes that apply to claims settled in the portal. The level of damages paid for employers' and public liability claims is unaffected, and claimants continue to be appropriately compensated, but the amount claimant solicitors are able to recover in costs is capped. The success of fixed costs in reducing excessive and disproportionate legal bills for employers' and public liability claims should not be overlooked.

The NHS LA inquest service

The NHS LA inquest service continues to support members by contributing to inquest representation costs in appropriate cases. Support was provided to our members in approximately 300 inquests during 2014/15. This includes a number of matters where our support has helped members to make early apologies, explanations and, where appropriate, early admissions of liability. These steps can help to make a difficult process more manageable for all concerned and helps the NHS to focus on what is important: making sure that lessons are learned and reducing the risk of harm.

Claim settled before inquest

A mental health patient committed suicide during an acute admission to a mental health unit. An inquest was listed to take place and the family instructed solicitors to represent their interests at both the inquest and any potential claim. The NHS LA member accessed support under the inquest service and a panel solicitor was instructed. Following early investigations, the member made an early admission of liability and an apology to the family. The claim subsequently settled and in advance of the date of the inquest.

The NHS LA's early intervention resulted in the saving of costs and avoided the family taking steps to commence court proceedings in order to pursue their claim. The family's solicitors also confirmed that the admission and apology were appreciated at a very difficult time

with the mediation dates scheduled after 31 March 2015 or to be arranged.

Direct apologies and explanations offered at mediation

The claim concerned the death of a patient who suffered postoperative complications. The mediation was attended by the wife and daughter of the deceased patient, the NHS LA's Head of Claims Quality, and the trust's Medical Director, Director of Nursing and Legal Services Manager. This was a very emotive case. The claim settled on the day of the mediation and the feedback received from the wife of the deceased patient was very positive. She welcomed the remarks made by the trust's solicitor in the opening session, which set the tone and facilitated settlement. She also had the opportunity to speak directly to the trust's Medical Director and Director of Nursing, and as part of the settlement terms both agreed to send her a letter detailing the discussions they had with her at the mediation.

Mediation

The NHS LA mediation service was launched on 31 July 2014 and is designed to support patients, families and NHS staff in working together towards a solution which may go further than just financial compensation and avoids the need to go to court. We offer mediation in all suitable cases notified to our members.

The service provides access to an independent and accredited mediator, selected from a panel drawn from a wide range of backgrounds.

The service has attracted interest from claimants' solicitors and other stakeholders. However, there has been some reluctance on the part of claimants' solicitors to agree mediation.

As at 31 March 2015 we have made offers to mediate in 65 cases and 9 mediations have taken place; 14 offers to mediate have been accepted

Department of Health Liabilities

Since December 2013 the NHS LA has handled the Department of Health's non-clinical historic liabilities for dissolved NHS organisations. The vast majority of these claims have been occupational disease claims, with the largest number being for asbestos related disease and noise induced hearing loss claims.

Of these, there is particular legal interest in claims arising from low-level transient exposure to asbestos and medical causation in noise induced hearing loss claims. Investigation of these long tail claims is both complex and difficult. There has been one occasion where the alleged wrongful exposure to asbestos predated the formation of the National Health Service.

The unravelling of evidence in these claims can be very involved as illustrated in a claim brought by an NHS employee for asbestos exposure alleged over a ten year period. Exposure occurred at seven identified hospitals managed by a number of trusts. During the period of the exposure not only did the management of the hospitals move between trusts but so did the employee. Some exposure also occurred at trusts where the employee was visiting. Subsequently a number of the hospitals were closed and demolished.

Despite investigatory difficulties, the NHS LA has secured a significant number of discontinuances in both low level exposure asbestos and noise induced hearing loss claims.

Trials

We continue to take a robust approach in defending our members and NHS resources against unjustified claims. We have contested a significant number of cases to trial and of the litigated claims contested in court in 2014/15, 64% of clinical cases and 63% of non-clinical cases resulted in a successful defence, thereby saving the NHS £41.6 million.

Judges support clinicians' management

- i. *The claimant underwent a laparoscopic cholecystectomy. His small bowel was injured inter-operatively which went unnoticed at the time. He returned to the ward but there was deterioration overnight. The next day he returned to theatre for repair of the injury. An anastomosis was formed which broke down 7 days later leading to sepsis. It was alleged that there was a c.12 hour delay in getting the claimant back into theatre and that the anastomosis was formed using a negligent technique.*

The judge found that the surgeon had not been negligent in adopting a wait-and-see approach after complications developed following the operation. He had kept a very careful eye on the claimant and it was only with the benefit of hindsight that it could be said that the subtle changes in the claimant's condition indicated a perforation of the bowel. The claimant's clinical signs and the CT scan did not warrant operative intervention earlier than 12 hours.

- ii. *In another case, a claim for sub-umbilical scarring arising from the loss of a needle during bariatric laparoscopic surgery was successfully defended at trial. The needle became dislodged from suture material as it was passed through one of the ports. The judge found that the surgeon was a "careful man" and that there was no evidence excessive force was used or that he was careless.*

Patient's acquisition of MRSA not negligent

It was alleged that the trust was in breach of the COSHH Regulations and failed to prevent the patient becoming infected with MRSA by implementing adequate infection control procedures.

COSHH stands for the Control of Substances Hazardous to Health Regulations. These Regulations require employers to control or reduce their employees' exposure to hazardous substances to prevent ill health. Hazardous substances include; certain chemicals; bacteria; certain dusts; biological agents and germs that cause diseases.

The judge confirmed that, in his analysis, the COSHH regulations did not apply to the hospital/patient setting. He said the regulations were designed to protect and regulate health and safety at work and he did not consider that they were prepared with a view to a hospital patient being an intended beneficiary of them. He also added that, even if the COSHH regulations were to apply, he was satisfied that the trust had in place suitable and sufficient systems to satisfy the requirement of "reasonably practicable" under the regulations.

He found that the trust did have adequate systems for infection prevention and control in place (this was accepted by the claimant's microbiology expert in the experts' joint statement).

The judge also found that there was no direct evidence that the trust had negligently infected the patient with MRSA. He considered that it was dangerous to infer that because, statistically, 'hand hygiene' is the more common cause of acquisition it was the likely cause (and a negligent lapse by staff rather than a non-negligent self-inoculation by the patient himself) in this case. There were a number of ways in which MRSA could have been acquired by the deceased and many of these routes were credible non-negligent alternatives.

Robust defence of 32-year-old case

This was a high value clinical negligence claim involving allegations of negligent neonatal care of a 9-week premature baby, in April 1982. Historical cases inevitably have additional challenges but the thorough investigation and robust management by the trust's solicitors resulted in a successful defence at trial. Although instructed on the case 8 years before the trial, the allegations that the claimant's key expert focussed on evolved to virtually new issues during the trial itself. Allegations that had remained open at the start of the trial either had to be abandoned or were roundly found against by the trial judge.

The judge commented that it was unfortunate that the doctors in charge of the claimant's care 32 years ago have had this claim hanging over them for so many years particularly given that the allegations was not even identified until shortly before trial began and, in his judgement lacked substantial merit.

He also praised the doctors for the competent and conscientious way in which they had treated the claimant and confirmed that they were not responsible for the very sad outcome.

Patient's fall not negligent

An 80-year-old patient fell over, breaking her wrist during a physiotherapy session. The judge concluded that the physiotherapists had been conscientious, thoughtful and had acted responsibly throughout. He commented that "it was the very nature of the claimant's condition and the exercise programme that the defendant was operating that they could not be insurers against their patients falling. So as soon as the patients were asked to stand there was a risk of them falling".

Trust owed no duty of care to an intoxicated trespasser

The claimant was taken to hospital having been found lying in the street in a confused state. He had been drinking. He was not suffering from serious injuries and was assessed and asked to wait. He went outside without being seen and climbed over a parapet wall, where he fell thirty feet onto concrete. He suffered very serious spinal injuries. A witness had tried and failed to stop him.

The claim was dismissed. The wall presented an obvious risk but was not inherently dangerous. The claimant had gone beyond his implied invitation, ceasing to be a lawful visitor and becoming a trespasser. The trust owed him no duty of care. Even had a duty of care existed, the court decided it would have found against the claimant on the basis of 100% contributory negligence.

Robust defence on quantum and recovery of costs

The claimant tripped in a hospital car park, injuring his ankle. He sued the NHS trust and claimed over £250,000, including more than £200,000 for loss of earnings. The NHS LA admitted liability but disputed the amount of the claim. In October 2012 we made a Part 36 offer to settle the claim at £25,000 which was not accepted.

The case came to trial in April 2014. During the course of the trial it became clear that the claimant had no evidence of his claim. Part way through the trial the claimant asked to accept our original offer out of time. In doing so the claimant became liable for our defence costs of approximately £25,000 incurred in the intervening eighteen months. Had he accepted our offer in October 2012 our costs would have been less than £2,500.

Customer survey

On 16 March 2015 we launched a customer satisfaction survey in order to seek the views of our members on the performance of our claims function and how we can improve our services.

We wanted to know members' views on a range of our activities, including our claims function, support services, and our value for money. Our members have actively engaged in responding to the survey and our evaluation of the outcome is underway. The survey results will be used so that we may align our service improvements more closely to our members' needs.

Legal developments and important cases for the NHS

Once again we have been involved during the year in high profile cases, some of which are included in this section, but also we report on a significant Scottish NHS claim and a number of more routine rulings, which are typical of other NHS LA cases which went to court throughout 2014/15.

B. v Oxleas NHS Foundation Trust (Court of Appeal, 10/2/2015)

The first instance decision was covered in our last annual report. The Court of Appeal upheld the decision of the trial judge.

Mr B., who suffered from schizophrenia, was detained under the Mental Health Act in 2008. In April 2009 a tribunal ordered his discharge but postponed this briefly in order that 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 subject to a CTO. Accordingly, when he was released on 15th April 2009 the CTO was unlawful and invalid because the claimant was not liable to be detained on this basis at that point.

He was readmitted, under the terms of the CTO, ultimately for 442 days. He had two reviews during this period and was eventually discharged on 3rd November 2010, his condition having improved. This re-detention was technically illegal. However, even had the trust’s error not occurred, the claimant would still have been readmitted at this point and detained for the same period.

The Court of Appeal agreed that in such circumstances only nominal damages of £1 were appropriate. Unlawful detention entails strict

liability, and therefore compensation is payable. However, because the claimant had suffered no additional losses and was detained for no extra period of time as a consequence of the unlawful detention, substantial damages were not appropriate.

This is a definitive and helpful ruling from the Court of Appeal for the NHS. We see quite a number of claims against our members involving technically unlawful detention, and this ruling can be applied to those.

Trustees of the Jimmy Savile Charitable Trust v National Westminster Bank, Secretary of State for Health and Others (Court of Appeal, 16/12/2014)

This unusual litigation arose out of claims received by the NHS, BBC and other parties as a consequence of alleged abuse perpetrated by the late Jimmy Savile. We are handling claims against the NHS on behalf of the Secretary of State, and along with other defendants such as the BBC agreed a claims-handling protocol with claimant representatives, which aims to process claims quickly and fairly and includes provision for standard sums of compensation for particular types of abuse, together with fixed legal fees. The trustees of the charitable trust, which was the main beneficiary under the deceased’s will, challenged the appointment of the Bank as executors of the estate. NatWest had signed the handling protocol and we supported their arguments in this litigation. The Court of Appeal rejected the charitable trust’s challenge. This ruling means that the residual monies in the estate can be used to compensate the victims of Savile, and represents senior judicial approval of the claims handling scheme.

Montgomery v Lanarkshire Health Board (Supreme Court, 11/3/2015)

This is an important decision by the Supreme Court on the question of consent, an issue which arises in significant numbers of claims handled by NHS LA.

The Court decided that a ruling from the House of Lords in 1985 no longer reflected modern views on consent, and that a doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments. What is material is whether, on the particular facts of the case, a reasonable person in the claimant's position would be likely to attach significance to the risk, or the doctor is, or should reasonably be aware that the particular patient would be likely to attach significance to it.

In reality, consent cases have largely been dealt with on this basis since at least 1999, following a ruling by Lord Woolf in an NHS LA case in the Court of Appeal. However, it is helpful to have the position definitively laid down by the Supreme Court. It is very important to note that a doctor is under a duty to disclose "any material risks", as opposed to those risks which he or she thinks a patient ought to be told about. In other words, this is a recognition that paternalism in the doctor/patient relationship is no longer acceptable. It remains to be seen if this ruling will result in increased numbers of consent claims, but given that the judgment does no more than reflect present-day views on consent that is arguably unlikely.

A v Nottingham University Hospitals NHS Trust (Nottingham County Court, 22/12/2014)

The claimant unfortunately suffered a fourth degree tear of the perineum during the course of delivery owing to the fact that an episiotomy had not been performed. Damages were agreed at £40,000 and the case proceeded on liability only.

It had been the registrar's intention to perform an episiotomy before delivery of the baby's head, but as she reached for her scissors there was an unexpected further contraction which pushed the head through the perineum and caused the tear. Much attention focussed on the wording of the hospital guidelines, which stated that an episiotomy should be performed "as head is brought down to perineum". The expert obstetricians interpreted these guidelines different ways, but the judge said that whatever the guidelines actually meant, they were not determinative of liability. The issue was whether the registrar was negligent under the *Bolam* test. The views of the experts as to precisely when to undertake an episiotomy were in stark conflict. The trust's expert who was head of midwifery at a London Teaching Hospital, considered that the procedure should be performed as the head was delivered (rather than beforehand). That represented a responsible body of professional opinion and whilst other professionals might have performed the procedure earlier, the registrar was not negligent under the *Bolam* test.

This is a helpful application of the standard test to a situation in which there were stark differences of expert opinion and also a useful reminder that trust guidelines are just that, i.e. guidelines, and not critical to a court's assessment of legal liability.

A (deceased) v Hampshire Hospitals NHS Foundation Trust (Winchester County Court, 29/05/2014)

A died from breast cancer on 15th August 2010, and it was alleged on her behalf that a routine screening mammogram taken on 4th April 2005 showed abnormal features which should have resulted in her being recalled. The trust's defence was that even if A had been recalled, the tumour at that point would not have been detected by ultrasound because of its small size. The expert witnesses agreed that the tumour then would not have exceeded 5mm in diameter.

The judge decided that it was reasonable not to recall the patient. An area of asymmetry on the mammogram, which the claimant's expert maintained should have been investigated further, was not suspicious. The judge considered that the claimant's expert had looked at the question of recall with the benefit of hindsight rather than from the perspective of a routine screening. In any event, since the experts agreed that the tumour was 5mm or less in diameter at the relevant time, even if the patient had been recalled, on the balance of probabilities the cancer would have remained undetected.

C v North Cumbria University Hospitals NHS Trust (High Court, 23/01/2015)

This case is subject to an anonymity order in respect of the family. C suffers from cerebral palsy caused by hypoxia immediately prior to birth. That, in turn, was caused by uterine rupture.

The mother (M) attended hospital in 2002 at 41 weeks for induction of labour. An initial assessment revealed that everything was fine. Accordingly, a 3mgs dose of Prostin was administered at 11:30 hrs. Between then and 19:00hrs M was assessed by a series of midwives

on the ward. At 19:00hrs one midwife formed the view that M was not in established labour, that a sufficient amount of time had elapsed since administration of the first dose and that there were no contra-indications to administer a second dose of 3mgs. Accordingly this took place.

The next few hours were relatively uneventful but at 00:30 on 10th December M was becoming very uncomfortable and that turned to extreme distress shortly after. At 01:45 the waters broke. The foetal heart had become bradycardic and C was delivered at 02:07 in a poor condition. The claimant's expert obstetrician alleged that it was negligent to administer the second dose of Prostin. However, the trust's experts opposed that view on the basis that there was nothing to justify such a conclusion. Rather, they fully supported the second dose.

The judge held that the claimant's expert applied a test which was too rigorous and too cautious. It set the bar of reasonableness at too high a level. On the other hand, the trust's experts accurately reflected reasonable practice. Nothing jumped out of the situation that existed at 19:00hrs that should have sent a message that there was a need suddenly to adopt a highly cautious approach. Accordingly, the claim failed.

This was another extremely sad case, but it was an example of a situation which we see quite frequently on clinical negligence claims made against the NHS, namely that the standard advocated by the claimant's expert was unreasonably high.

C v South Essex Partnership NHS Foundation Trust (Southend County Court, 4/6/2014)

The claimant was employed by the trust to provide hairdressing services for psychiatric patients. She also worked at the hospital shop.

From 2008 she began to experience pain in her right thumb and by 2010 this reached such a level that she was taken off hairdressing duties and given housekeeping work. That also presented her with difficulties and in April 2011 she resigned.

She then commenced proceedings, alleging that the pain and deterioration in her thumb were principally caused by the fact that, contrary to normal hairdressing practice, her work with patients frequently required her to cut hair which was extremely dirty and matted. This imposed far more strain on her scissors thumb than cutting clean hair.

The judge noted that various risk assessments of the claimant's duties had been undertaken, but none of these identified unwashed, matted hair as a problem presenting a risk to the hairdresser or requiring precautions. Furthermore, he concluded that the specific risk of hand injury through cutting such hair was not known or recognised at the time in the world of hairdressing, and that remained so at the date of trial.

There was no persuasive evidence that the claimant was ever ordered by a manager to cut hair which was not in a suitable condition, or reprimanded for failure to do so. Rather, it was left to her professional judgement whether or not to proceed, and she often refused to cut particular patients' hair.

Once the condition of the claimant's hand became serious, the trust behaved properly by

referring her to Occupational Health. The trust had not been in breach of any material duty and therefore the claim failed.

This was a highly unusual case and demonstrates that the NHS faces a wide range of potential liabilities owing to the breadth of activities it undertakes. The claimant had not proven either negligence or breach of statutory duty by her employers, and indeed the judge concluded that the claimant's unfortunate injury was largely caused by "exposing herself to unnecessary and avoidable hand strain".

T. v. King's College Hospital NHS FT (High Court, 22/1/2015)

This case is included as an example of the very high awards which can now occur on cerebral palsy claims. The claimant's life-expectancy was to age 47 and the total award capitalised to £10.136m.

The following individual figures were either agreed between the parties or awarded by the judge:

	£
Pain and suffering	275,000
Past losses (incl. interest)	509,210
Future loss of earnings	454,843
Future treatment, therapies etc	250,968
Future travel/transport	225,859
Future aids/equipment	455,000
Future education	45,205
Future accommodation	1,500,000
Future IT	500,000
Future holidays	475,000
Future deputyship	275,784
Future care/case management	5,108,642
Future miscellaneous	60,000
Total	10,135,511

Both care/case management charges and loss of earnings will be met under a periodical payment arrangement which will be index-linked and paid for the remainder of the claimant's life, providing financial security for the patient.

Periodical Payments

Until 20 years ago virtually all personal injury claims were settled on the basis of a one-off payment of damages. That was a very inaccurate solution in cases involving significant future losses, such as claims on behalf of people with cerebral palsy. On the one hand, if the claimant lived longer than predicted there was a very real risk that the pot of damages would run out. On the other, if the claimant died earlier than the experts' assessment there would be a surplus of funds which could not be used for the benefit of the injured person.

The solution to this problem had already been agreed in principle in 1987 in discussions between the Association of British Insurers and the Inland Revenue: periodical payments. Under such an arrangement the claimant initially receives a lower lump sum, to cater for past losses and immediate needs, plus a sum, index-linked for life, to defray major future expenses such as care and case management. The NHS LA was launched in 1995 and immediately realised that periodical payments were by far the fairest way of settling large injury claims – they benefit the claimant, because income is guaranteed for life, even though this might be much longer than predicted, and they also help the defendant because there is no risk of over-compensation. Accordingly we began to offer periodical payment solutions in appropriate cases.

In 2003 the law was amended such that courts acquired the power to award periodical payments even if the parties disagreed as to their suitability. In practice this power has been used

extremely infrequently because both claimant and defence representatives recognise how powerful periodical payments can be as a solution to the funding of major ongoing expenses.

The NHS LA currently has around 1,500 periodical payment cases on its books, far more than any other indemnifier or insurer nationwide. They are not by any means restricted to cerebral palsy claims – any case with significant future losses is likely to be suitable. We fund these directly rather than purchase annuities from life assurers because we are deemed "reasonably secure" by relevant regulations: this means in practice that the government guarantees the payments. It also means that we do not have to pay large sums to life assurance providers.

Indexation of payments is via the Annual Survey of Hours and Earnings (ASHE) for care and case management – in particular a measure of home carers' wages – and the Retail Prices Index (RPI) for expenses such as equipment, IT etc. This means that annual sums are varied, each year, in accordance with the measure of inflation relevant to the specific head of claim.

"Periodical payments are widely accepted by claimants' lawyers and the judiciary as being by far the most suitable mechanism for compensating claimants who have major ongoing expenses."

Periodical payments are widely accepted by claimants' lawyers and the judiciary as being by far the most suitable mechanism for compensating claimants who have major ongoing expenses.

National Clinical Assessment Service (NCAS)

NCAS' services are flexible to respond to the variety of performance concerns

NCAS continued to support patient safety by helping to resolve concerns about the performance of doctors, dentists and pharmacists within the NHS, including 927 new referrals, delivering 68 assessments and interventions and producing 112 action plans.

A significant organisational restructure has achieved greater:

- Efficiency and operational effectiveness
- Flexibility
- Customer focused service
- Reduction in grant in aid
- Integration with the NHS LA.

Functional areas are now organised in four main areas:

- Advice service
- Case support
- Assessment and interventions
- Policy and stakeholder engagement.

The adviser team has been enhanced by expanding the size of the team and bringing in additional legal expertise to enable us to deal with referrals even more quickly.

“NCAS has continued to diversify the portfolio of assessment and intervention products it delivers to ensure referring bodies have access to the most appropriate intervention to resolve the performance concern as quickly as possible.”

NCAS has continued to diversify the portfolio of assessment and intervention products it delivers to ensure referring bodies have access to the most appropriate intervention to resolve the performance concern as quickly as possible.

The comprehensive External Education programme was extended to offer both bespoke in-house workshops to meet the learning needs of individual referring bodies, along with public workshops for individual delegates held throughout the UK. The majority of the Education programmes are now income generating and cover the running cost of the external education portfolio in full.

NCAS continues to operate and review the Healthcare Professional Alert Notices.

“We are continuing to strengthen links between the work of NCAS and the wider NHS LA with opportunities to enhance learning, safety and quality development across the NHS.”

We are continuing to strengthen links between the work of NCAS and the wider NHS LA with opportunities to enhance learning, safety and quality development across the NHS.

This year we responded to an external 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.

The NCAS Adviser team consists of clinicians, human resources (HR) practitioners, senior health service managers and lawyers with expertise in employment law and performance management. In response to the Deloitte review of NCAS

services, 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 Adviser Team has been reorganised and continues to work 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 the NHS LA safety and learning leads on a regional basis, we are building on their experiences to improve safe working practices in the NHS.

What our customers told us about the NCAS Advice Service

In June 2014 customer feedback about the advice service was sought from referring bodies via a short online questionnaire. Responses were received from 45 organisations. Overall the feedback was positive with 100% of respondents saying that they were pleased with the level of service received from NCAS. The majority of responses to questions about specific aspects of the service were very good or good. The area suggesting most scope for improvement was 'facilitating access to other NCAS services', although for the majority this was not applicable. There were also comments in response to the questions 'What aspects of NCAS service did you find useful or do you feel added value to your management of the case' and 'In what areas do you feel that the service provided by NCAS might be improved'. The first question produced responses such as 'support and understanding', 'rapid access to expert advice', 'professional

advice from a knowledgeable source'. The second question prompted responses such as '*greater access to training within Trusts*' which is being addressed, '*assessment process needs improving*' which again is being worked on and has been improved already, and '*it has already improved immeasurably*'. It is hoped to run this or similar surveys regularly as part of routine work and to develop other surveys to provide more individualised feedback if possible.

Support in Action

Finding innovative solutions for the NHS and for practitioners – our advisory service

Advice for trusts

A Trust sought advice about a specialty doctor in Psychiatry. They had received concerns from the rest of the clinical team and referring GPs about her poor communications and decision making. The Trust formally investigated the concerns and after advice from NCAS decided to proceed with a local action plan rather than formal disciplinary procedures at that stage. NCAS prepared the action plan and facilitated its introduction. The practitioner completed the plan working within a different team and with job plan changes continued in clinical practice.

A general surgeon who was involved in a serious untoward incident when he wrongly inserted a central line

He gave an inadequate explanation of the event to the patient's family. The complaint was escalated outside of the organisation. There was a background of poor team working and a high complication rate for this practitioner. He underwent a full performance

assessment and an action plan was developed based on the findings. He returned to full practice and exhibited evidence of substantial behaviour change including leading on clinical developments in the department.

GP who, after a serious road accident, returned to work with a disability

Concerns were raised by the practice about aspects of his clinical practice. Following our recommendation of a specialist OH assessment and workplace assessment the holder of the Performers List commissioned an NCAS record review. This indicated some areas for development and NCAS advised on the remediation plan. The case was closed with the Referring Body having assurance of safe practise.

NCAS Assessments and Interventions

Getting behind the cause of the performance concern and dealing with it directly

We delivered a more diverse service and completed more assessments and interventions than in any previous year in our history.

We embedded a more flexible and modular approach to assessments. NCAS now offers bespoke support on a range of options for interventions which include behavioural assessments, occupational health assessments, assessments of communicative competence and action planning. These services are in addition to our full performance assessment model. This year we piloted a programme of record review for primary medical care.

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

This diversification was demonstrated in our change of assessment and intervention case mix.

We completed more than 68 assessment and interventions. Throughout the year our delivery times for all aspects of the assessment and intervention service reduced.

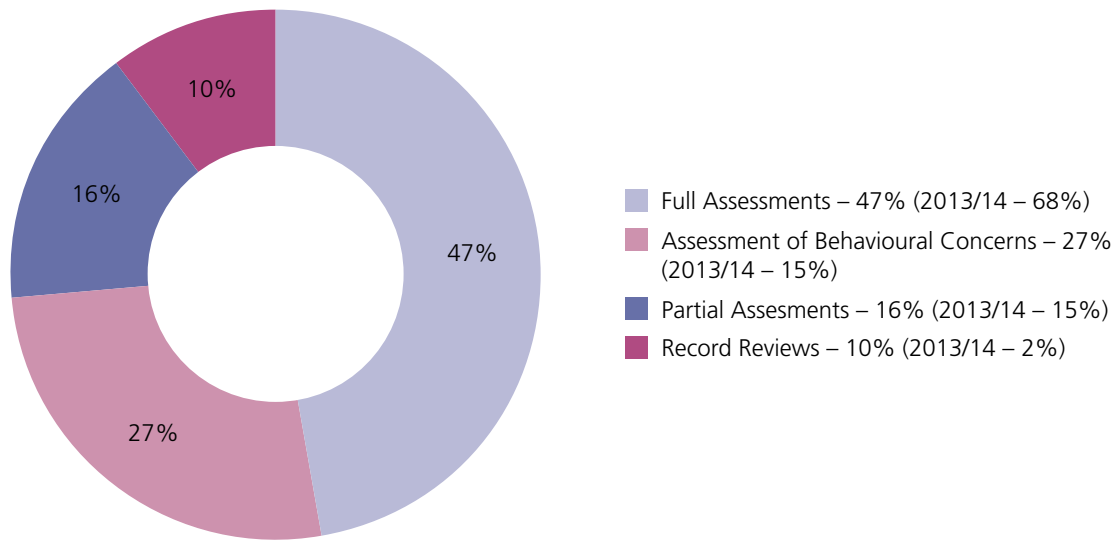
We collaborated with employers, contractors and practitioners to develop more than 112 action plans. Action planning is a highly structured programme of support for practitioners within an organisational framework of detailed targets and timescales, aimed at returning them to safe practice. It is used 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. Only 47 of the cases were with Back on Track involvement, the rest were following a diagnostic of the performance concerns within the trust or area team.

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

Demand for assessments has remained consistently high, with 68 completed in 2014/15 (compared with 62 in 2013/14). We have continued to offer a more flexible range of assessment services to meet the needs of our users, with 52% assessments following a more modular approach (compared with 32% in 2013/14):

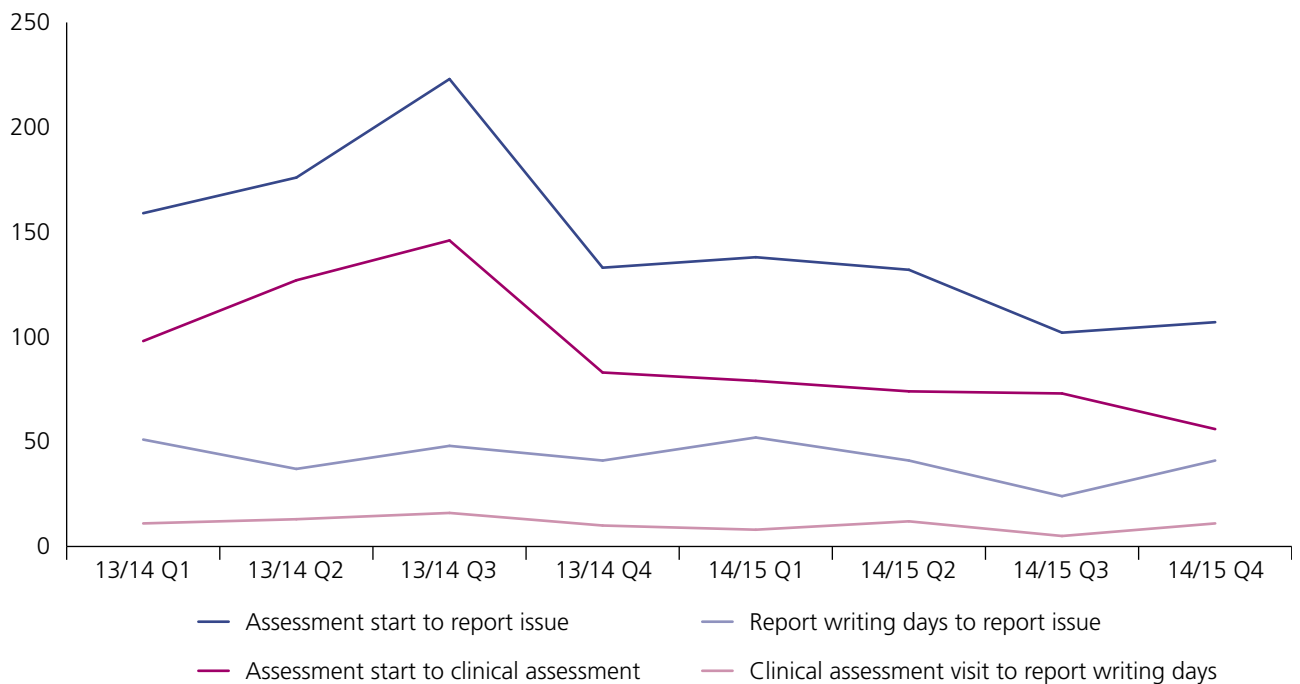
In 2014/15 NCAS issued a total of 68 assessment reports (compared with 62 in 2013/14). Figure 25 shows the intervention mix of these reports for 2014/15.

Figure 25: Assessment and intervention mix for 2014/15 (with comparators for 2013/14)



We have also continued to critically review our assessment process, with the aim of further reducing turnaround times of individual stages of the process. Figure 26 shows the current average number of working days taken to complete each stage of the full assessment process, compared with previous years:

Figure 26: Average number of working days for each stage of the assessment process



The Back on Track team made an active contribution to 112 cases during the last financial year, (i.e. provided input that substantively contributed to the management of the case) which was comparable to the previous year. From those 112 cases, the team drafted, reviewed or revised 92 Action plans compared to 100 in 2013-14 and also drafted 91 Action Planning frameworks. This represents a significant increase in demand when compared to 2008 to 2013.

All Action Planning Frameworks were published within three working days of receiving a request and all but two of 92 Action Plans were published to the deadlines expected by the referring body.

70% of all Back on Track cases did not involve an NCAS Assessment (compared with 52% in 2013/14). As a result we are in the process of developing more robust processes for requesting and validating case information from external sources. The team will now focus on developing a robust evaluation process so that NCAS can analyse the impact of Back on Track services and the effectiveness of the action planning advice provided.

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 a NHS restructure, the responsibility passed to the NHS LA.

From 1 April 2014 to 31 March 2015, 31 requests for HPANs were received and 25 new HPANs were issued. In the same period 42 existing HPANs were reviewed and 12 were cancelled as they were no longer relevant or needed.

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 45 new practitioner referrals and eight re-opened cases.

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 seven referrals under these agreements during (compared with 10 in 2013/14).

Since 2012, we have had a three-year contract with the General Dental Council (GDC) to provide clinical advice about complaints concerning dentists. Over the course of 2014/15, we have received 722 referrals from the GDC (compared to 635 in 2013/14 and 438 in 2012/13). In 100% of cases this year, we produced clinical advice reports within the target timescales (usually five working days). We have also continued to offer the GDC our performance assessment service adapted for use as part of the regulator's Fitness to Practise procedures.

In addition, we have continued to provide consultancy and training services to the Medical Council of Ireland to support the ongoing

development and delivery of their own performance assessment service.

Strengthening NCAS for the future

An extensive programme of recruitment has been completed in 2014/15 following the organisational restructure. This includes many new additions to the adviser team, starting in post in 2015/16, and this will strengthen an expert workforce to deliver NCAS' services effectively to the NHS.

As well as continuing with NCAS' services and interventions we recognise there are strong synergies between NCAS and the claims function. Aligning information from claims with information about key themes and trends on practitioner performance creates new opportunities for learning, improving safety and quality across the NHS and we will build on this in the year ahead.

Family Health Services Appeal Unit (FHS AU)

- We received the number of appeals that we would expect during the year and we met our targets for issuing decisions on appeals.
- Our largest number of cases were appeals made in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.
- We continued to respond to the changes in the NHS Pharmaceutical Regulations.
- We completed our FHS AU Panel Member governance arrangements by recruiting new Committee Chairs, and by implementing our appraisal scheme for panel members. We also held our Panel Member annual event.

The Family Health Services Appeal Unit (FHS AU) 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.

The number of appeals and disputes we received was marginally down on those we received in 2013/14. However we received the usual mix of case types, our largest number being those made in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Pharmacy Regulations) particularly those relating to applications from pharmacists to join the Pharmaceutical List, or to change the terms of those listings. We received 265 appeals in accordance with the Pharmacy Regulations as opposed to 271 in the last financial year.

Dispute resolution in summary

Disputes relating to GPs and their Contracts were again the main source of applications for dispute resolution (71 during this financial year compared

with 79 last year) but we also received three applications for disputes in relation to Dentists and their contracts.

We continued to receive disputes relating to reimbursement of premises costs to GPs. This however was lower than last year, only three were received in comparison to 29 the previous year. We made determinations on nine cases, some of which were received in the previous year.

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

We have continued to see an increase in disputes following refusals by NHS England to pay monies under the Patient Participation Directed Enhanced Service Agreement. Fully determined cases numbered 17 compared to 14 the previous year. In addition to these, there were three "termination of contract" disputes determined in 2014/15.

Patient Participation Directed Enhanced Service (DES)

For a second year we have received a number of applications for dispute resolution relating to Patient Participation Direct Enhanced Specification (DES). This DES requires GP Practices to have in place a system for ensuring that patients' views are taken into account in a structured and regular way and that such a group has input into the Patient Survey conducted by the Practice and the Action Plan flowing from the outcome of that survey. The DES is quite specific as to how GP practices can maximise payments against this DES, yet for a

second year some Practices have failed to ensure that everything that should be included in the published Patient Participation Group Report is included, and therefore NHS England refused payment. Of the 17 cases fully determined, NHS England's decision not to pay the Practice was supported in 100% of cases.

NHS England v Forrester (Limitation)

The FHSAU has clarified when the limitation period for bringing a matter to NHS dispute resolution begins i.e. when does the "matter giving rise to the dispute" crystallise and the period of three years start to run? This case related to overpayments made to a dental contractor.

The "matter giving rise to the dispute" must have come into existence for the dispute to have been identifiable and therefore referable.

At the end of year contract reconciliation, the date of the "matter" giving rise to the dispute in any financial year is the date upon which NHS England could have first reconciled the total notifications of activity, against the required and expected activity and contract value so as to identify whether the notifications were accurate or not.

Alternatively, where inappropriate claims are concerned, it is only after NHS England has carried out an audit, such as a targeted record card check that an overpayment could reasonably have come to NHS England's attention.

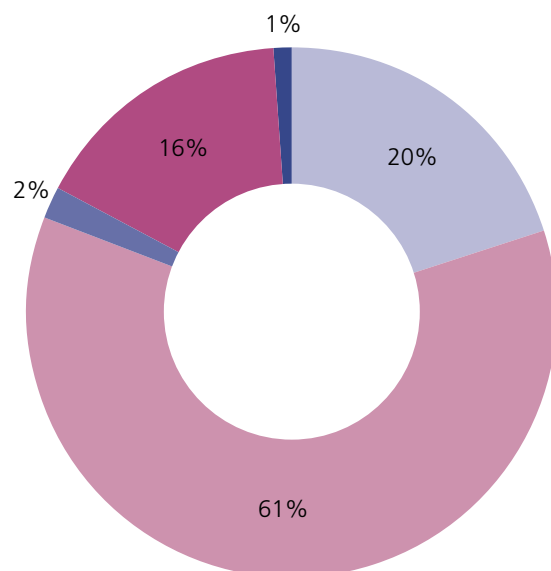
Appeals in summary

We continued to respond to the introduction of the 2013 Pharmacy Regulations, amended in 2014 and 2015. The challenge we continue to face is the volume and scope of submissions and evidence provided by parties and, more fundamentally, the interpretation of these Regulations.

Of those pharmacy appeals that resulted in a substantive determination (i.e. not withdrawn or summarily dismissed) and which did not require external input, 91% were issued within a target of 15 weeks and within an average of 13 weeks. For those determinations requiring external input or an oral hearing, 91% were issued within a target of 26 weeks and all within an average of 20 weeks.

Across all application types (including "hours" appeals), of those pharmacy appeals determined under the Pharmacy Regulations, 81% of NHS England's decisions were quashed and re-determined, which resulted in 25% of applications being granted. Eighteen percent of NHS England decisions were confirmed which resulted in 12% of applications being granted. Finally 1% of appeals resulted in matters being referred back to NHS England for a further notification.

Figure 27: 2014/15 Pharmacy appeal outcomes



- Decision quashed, redetermined, application granted
- Decision quashed, redetermined, application refused
- Decision confirmed, application granted
- Decision confirmed, application refused
- Remit back

FHSAU decisions are published on the NHS LA website.

Panel Members

We have completed our governance arrangements of our FHS AU Panel Members (those who comprise the Oral Hearing Committees, hearing submissions and evidence prior to making decisions on appeals), and have during 2014/2015 recruited new Committee Chairs. We have welcomed five new Committee chairs and reappointed one Committee Chair. We continued to implement our competency based Appraisal Scheme for all our FHS AU Panel Members. In October 2014, we held our annual Panel Member event which was invaluable for providing a forum for discussion and case review.

We take this opportunity to thank all our Panel Members for all their hard work over the year, in particular our outgoing Panel Members whose term of appointment ended on 31 March 2015.

Pharmacy Appeals User Group

After a long gap, the FHS AU re-established its User Group, the remit of which is to improve communications with users of our service, and to improve the service we provide to those users. The aim is to consult service users and their representatives on current practice and procedure, and on any proposed changes to practice and procedure. Its first meeting since re-establishment was in October 2014 and the feedback was very positive. Any adverse comments were limited to oral hearing arrangements which are outside our control and the way in which hearings are conducted in

terms of procedure and order of evidence, which we addressed with FHS AU Panel Members at their annual event.

Judicial Review

As always, determination of disputes by the FHS AU may be subject to legal challenge by way of Judicial Review (JR). During 2014/15 there was one application which was granted permission. We await the outcome.

Determination of pharmaceutical appeals may also be subject to legal challenge by way of JR. During 2014/15 there was one application which was granted permission. We await the outcome.

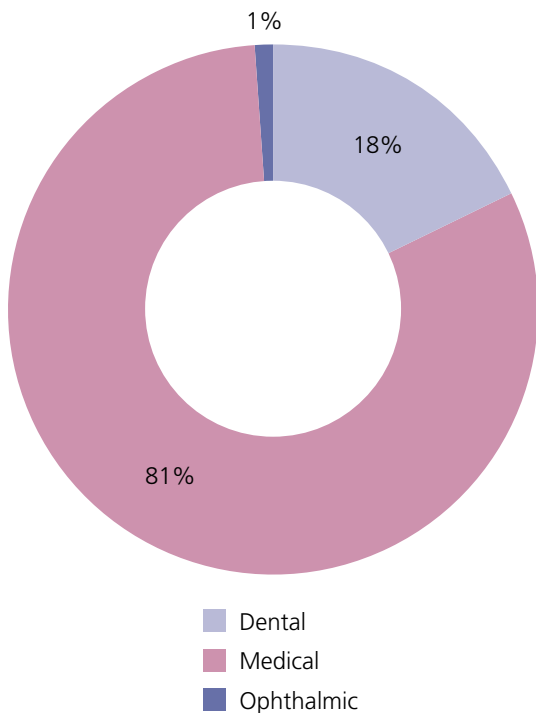
Performers Lists notifications and checks

The National Health Service (Performers Lists) (England) Regulations 2013 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 and the NHS LA shall keep a record 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 2014 and 31 March 2015 the FHS AU received notification of 67 suspensions compared to 50 in 2013/14. The breakdown by profession is shown in figure 28. There were 71 suspensions still in force as at 31 March 2015. There were also 1548 other decisions under the aforementioned regulations, including notifications of withdrawn applications to join a list.

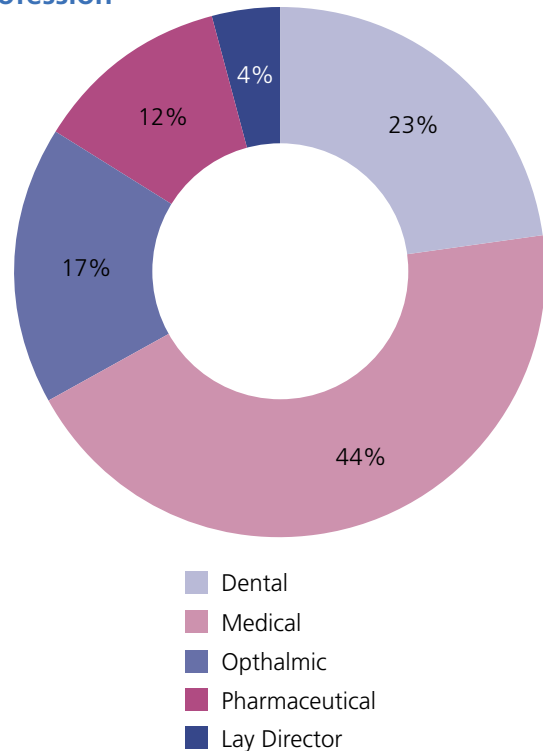
Figure 28: 2014/15 Notification of Suspension by Profession



During the year, the FHS AU received 8,824 requests for information compared to 2013/14 (10,072) using our secure, online checking system, and which provided immediate clearance for 97% of checks. The remaining 3% were

referred to the FHS AU for further analysis before disclosure. The breakdown of checks by profession is shown in figure 29.

Figure 29: 2014/15 Restriction Checks by Profession



Conclusion

During the past year we have developed our understanding of the Pharmaceutical Regulations and built upon our decision making of these types of cases. We have completed the strengthening of our governance by the recruitment of our panel members and rolled out a system for their appraisal. Further we have introduced a User Group so we can seek feedback from our service users. Overall this has been a year of consolidation and development of the systems and processes we have developed and implemented in previous years.

Safety and learning

Learning from Claims

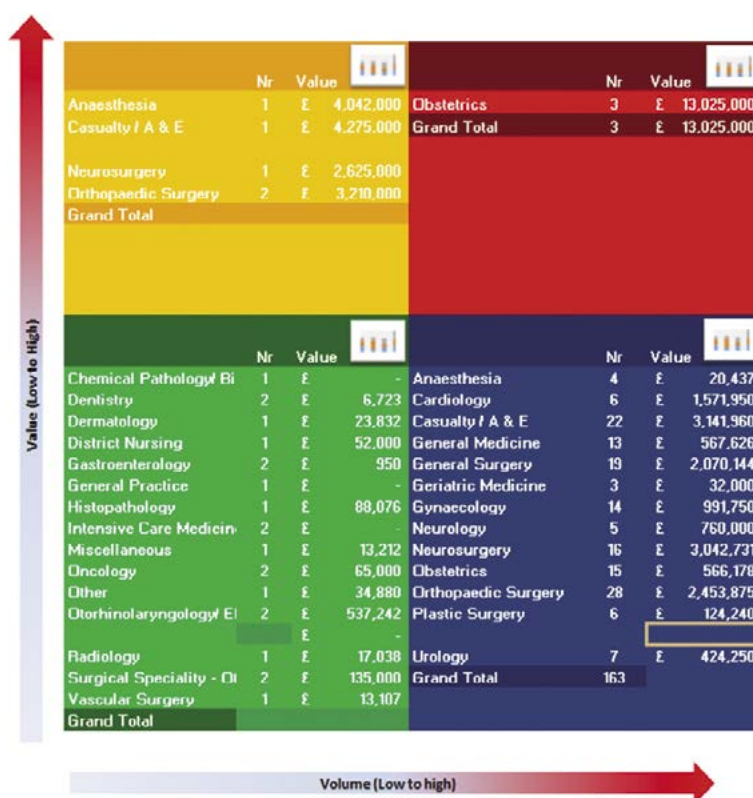
Following the cessation of risk management standards in March 2014, the Safety and Learning Team was created to support our members to focus on learning from claims in order to improve patient and staff safety, and reduce high volume and high value claims.

The Safety and Learning Team have designed both clinical and non-clinical scorecards for each member organisation to capture claims information in a meaningful and user friendly way. This interactive system, which is driven by individual level claims data, segments a member's clinical claims according to high value (over £1m per claim) and high volume (over 3 in a specialty). For non-clinical scorecards, feedback received from members suggested that much lower levels be set for high value causes.

Positive feedback was received from Members re the clinical claims scorecards which were initially rolled out to those signing up to the Secretary of State for Health's national Sign up to Safety Campaign in June 2014. As a result, scorecards were disseminated nationally and have been instrumental in ensuring that clinical staff and patient safety leads link up to consider how their claims triangulate with serious incidents and complaints to inform a focus for their safety improvement. Feedback from members' satisfaction with the scorecards will continue to be obtained and the scorecards will be refined accordingly. Non clinical scorecards will facilitate the analysis of claims for members, particularly in mental health, community and ambulance trusts.

Many of our members tell us their Boards are now actively focussed at meetings on their claims and where their claims hotspots are within their trusts. The aim is for Trusts to use the score cards as part of integrated governance reports and share these throughout their organisation and various specialities to improve safety and reduce harm.

Figure 30: Example of a clinical score card showing breakdown of claims by speciality:



NHS LA Support for Sign up to Safety

“Halving avoidable harm in the NHS over the next three years and saving 6000 lives is the ambition of the national campaign Sign up to Safety Campaign launched by the Secretary of State for Health in June 2014.”

Halving avoidable harm in the NHS over the next three years and saving 6000 lives is the ambition of the national campaign Sign up to Safety Campaign launched by the Secretary of State for Health in June 2014.

As a key member of the National Coordinating and Support Group, the NHS LA provided support to the campaign, including offering financial incentives, funded by DH, to those organisations that evidenced their Safety Improvement Plans would reduce harm and claims. Trusts were able to bid for a one off payment of up to 10% of their contribution to the NHS LA's Clinical Negligence Scheme for Trusts (CNST).

The NHS LA received 249 bids from 114 member trusts by the time of the closing date on 16 January 2015. The Safety and Learning Team assessed the Safety Improvement Plans and bids through robust governance processes with clinical and claims input against a defined set of criteria. Approved bids numbered 67 from a range of safety improvement areas, the top five focus areas being:

1. Maternity purchase of CTG electronic monitors, STAN (ST Segment' analysis of the fetal ECG monitors), recruitment for "second pair of eyes", central CTG monitoring and alert systems, remote access to tracings, training.

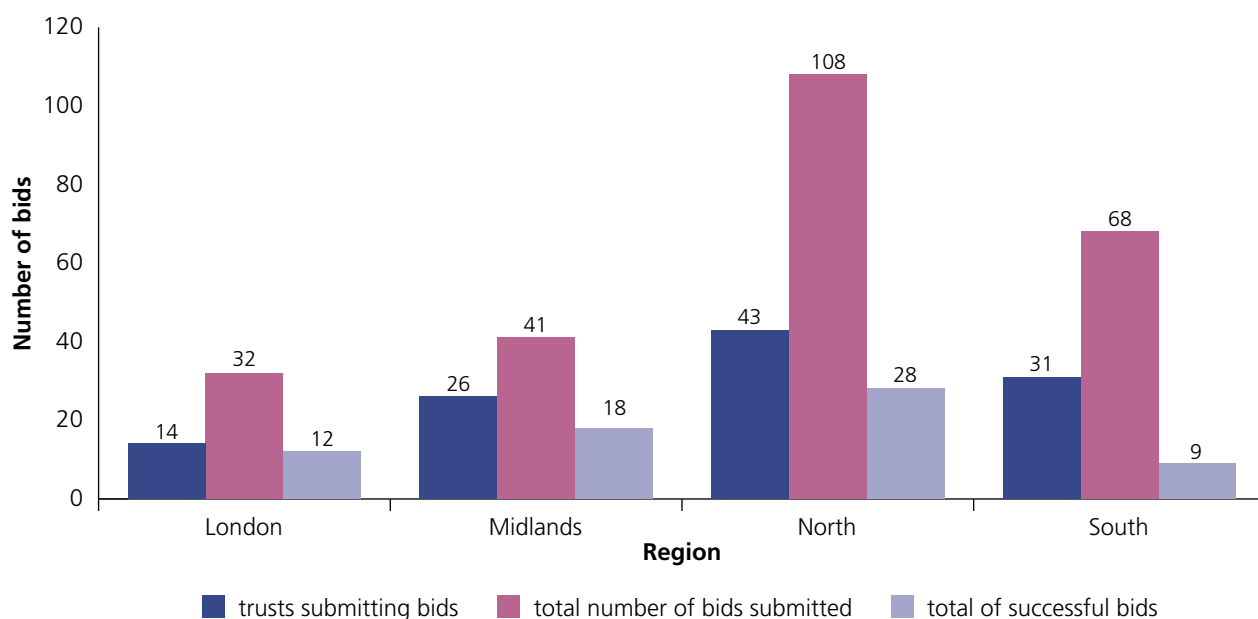
2. Safety Culture – a range of human factors and cross cutting areas.
3. Surgical – includes training and equipment, human factors training in a number of surgical specialties particularly orthopaedics and neurological surgery.
4. A&E – improving missed and delayed diagnosis, diagnostics, hot radiography reporting in 24 hours, performance feedback on missed diagnoses.
5. Deteriorating patient – early and improved recognition, electronic flags, improved management pathways.

The NHS LA has requested Trusts share their bids on their public websites and have buddy up arrangements with unsuccessful Trusts to share best practice. The NHS LA will also evaluate the scheme and outcomes from the bids.

The regional split of successful and unsuccessful bids are included in figure 31. To ensure learning and outcomes from successful bids are shared with the wider NHS and that collaboration with stakeholders and experts ensures an optimum delivery of the plans

The maternity bids represent a particular opportunity to put in place measures to reduce claims in this specialty. Trusts with successful bids are being asked to collaborate with the NHS LA and relevant Royal Colleges in the progress of the implementation of the bids as regards claims and outcomes.

Figure 31: Bids by region



Examples of successful bids:

Orthopaedics

One trust undertook a detailed review of their orthopaedic data in partnership with their legal team and identified this as a high volume claims area. Contributory factors were analysed which resulted in a project plan to optimise technology to improve patient handover and critical triggers for care review and ultimately improving the pathway for care.

Human Factors Education

Through root cause analysis the Trust identified Human Factors (HF) as contributory factors in three of the high volume/high value claims specialities (Trauma & Orthopaedics, Emergency Department & Theatres). The project outlines the introduction of an audio surgical safety checklist for use in operating theatres and the establishment of 'risk facilitators' to implement a systematic programme of Human Factors training and awareness, leading to a cohort of HF experts and trainers in the three selected specialties.

Maternity

The trust undertook a detailed review of their maternity claims and triangulated with local incident data to provide key areas of focus for the project. The trust plans to improve their care and reliability in the community and acute care settings with the three areas to be addressed as: improving screening services to detect foetal abnormalities, reducing pregnancy losses and reducing care delivery events (e.g. developmental delay; cerebral palsy).

Engagement activity

The Safety and Learning team have participated in a number of key engagement events and learning sessions with a variety of stakeholders. These opportunities have enhanced the NHS LA's visibility in the arena of patient safety ensuring the organisation's key role in reducing harm linked to claims.

Engagement opportunities included:

- direct meetings with member healthcare organisations and their safety and claims

management staff to discuss their clinical claims scorecards and Sign Up to Safety bids;

- presenting to clinical staff on litigation costs and processes and the impact on patient safety; and
- supporting many regional network meetings and educational development days that the NHS LA Panel solicitors provide for member organisations.

The NHS LA Safety and Learning team is an active partner in a variety of national patient safety and learning group initiatives and Royal College targeted safety work, such as NHS England's patient safety expert groups including surgery, women's health, medical specialties, learning disabilities, never event standards group, safer needles network, safer childbirth work and the safer anaesthesia liaison group (SALG).

Safety and Learning Mini Scopes

The Safety and Learning team have undertaken a number of mini-scopes and 'deep dives' of the claims data and shared these with individuals and the wider NHS. Examples of these are given below:

- Reducing Term Admissions to NICU (NHS England)
- Reducing Grade 3 & 4 perineal tears (RCOG)
- Reducing Stillbirths Care Bundle (NHS England)
- Medical Invasive procedures (NHS England)
- Sharps Injuries (Public Health England and Safer Needles Network)
- Venous Thromboembolism (All Party Parliamentary Thrombosis Committee)

- Visual Loss & Blindness claims(Royal College of Ophthalmologists).

Sharing learning from claims

The Safety and Learning team are improving the opportunities to share learning from claims from all perspectives. This includes not only the claims outcome but also how members have implemented relevant lessons learned so these can be shared and published for the wider NHS and ultimately, reduce the harm that leads to claims.

The team are working across the NHS LA and with external stakeholders scoping a project specific to reducing harm in maternity, further developing a safety and learning data base to enable further publications and developing learning materials to be shared.

The team continue to work across the four geographical regions of England, in particular engaging with member organisations in feeding back and supporting trusts from the Sign up to Safety bid process. They will also be working with trusts that did not submit bids, to support them with embedding learning from their score cards at executive, departmental and front line levels across their organisations.

Further work is planned with a focus on supporting learning to help reduce non clinical claims following the distribution of the non-clinical score card.

Quality improvements to reduce falls

Situation:

- *an elderly patient who was hallucinating fell out of the bed and fractured her humerus;*
- *Root Cause Analysis (RCA) report findings: adequate assessments were done, the fall was not preventable;*

- *the expert nursing report obtained for the purpose of the claim identified issues with the patient's falls risk assessment and observations - expert's findings were in disagreement with the RCA findings;*
- *Legal Services informed the clinicians involved, nursing falls lead, medical falls lead, ward manager (who was also the author of the RCA report), Head of Nursing, divisional director (clinical) and divisional director of operations of the expert findings and asked them to review the expert's comments for the purpose of learning.*

Outcome:

- *Divisional Director reviewed the claim documents, including the expert report, and requested some of the actions below; further actions were added proactively by other staff;*
- *Head of Nursing and the Falls Group revised the level of RCA training for the investigators and fed back to the investigators in a supportive manner;*
- *Senior consultant arranged a debrief with medical falls lead to discuss personal learning based on her own comments (which were supportive of the RCA findings) and the expert's findings;*
- *Head of Nursing confirmed a change in the RCA investigations process; now investigations are carried out by two investigators and scrutinised by her to raise the quality of internal investigations; the process now also includes more face to face meetings to review and discuss the investigation findings;*
- *Head of Nursing discussed the case with lead training nurse to improve falls risk assessment training.*

External education and learning

Sharing learning from our casework experience

The NHS LA has delivered a 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.

Our external education programme aims to:

- Share learning and good practice from our claims and case work
- Promote the development of excellent local and national procedures for preventing, identifying and resolving issues
- Engage with and support our customers and members to use our services.

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

We now offer the following education and learning workshops:

- Managing concerns about the performance of doctors, dentists and pharmacists
- Case Investigator Training
- Case manager training
- Understanding and using *Maintaining High Professional Standards in the modern NHS* effectively
- *MHPS* and the Trust Board
- Responsible Officer Training: module 3&4

- Other bespoke and customised training.

This year, we delivered 142 workshops (of which 42 were income generating) to 78 organisations. In a sample of 62 of those workshops we trained 1460 delegates and contributed 8,970 learning hours to NHS staff.

This year our *Case investigator training* workshop was awarded the Bronze Award for Best Public Sector training workshop, recognising the breadth and scope of the programme of education and the significant impact on improving patient safety.

Finance Report

The 2014/15 financial year has been particularly challenging from a financial perspective for both the NHS LA but also in context of the pressures on the NHS as a whole. For the NHS LA high claims volumes in recent years have placed pressure on our in year financial resources as those claims progress to settlement. In addition claims reporting volumes have not significantly reduced meaning that this pressure will continue into the near future. This of course translates into increased levels of contribution collected from the members of the scheme during a period where the wider NHS has seen the number of provider trusts forecasting deficits increasing.

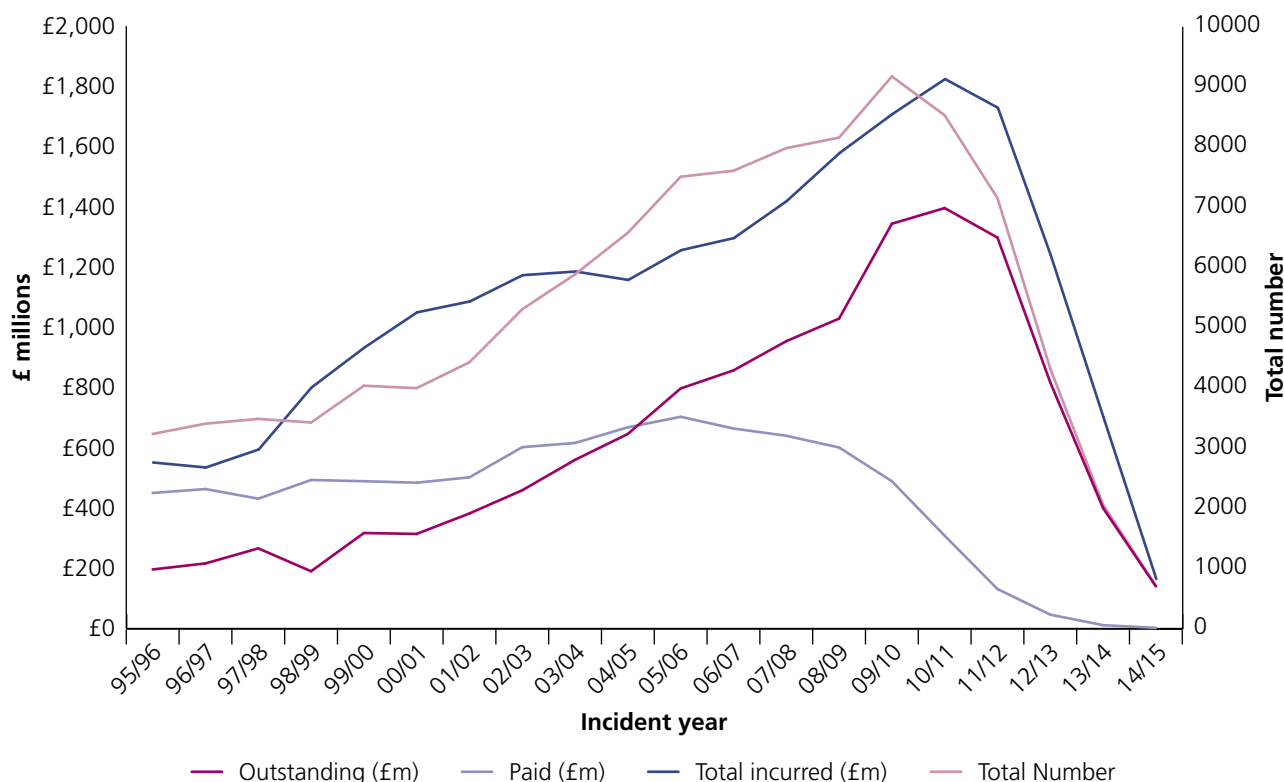
When considering the financial reporting of the NHS LA there are often two main areas of focus

namely our expenditure in year and the overall value of the portfolio of claims not yet resolved (known claims) combined with those we anticipate receiving and resolving in the future (Incurred But Not Reported or IBNR).

Expenditure in year and future trends

As reported in the claims section of the report claims volume trends for clinical matters have seen large increases in recent periods although a slight reduction was reported in the 2014/15 financial year as compared to 2013/14. The annual expenditure recorded against all open claims forms part of the total programme costs reported in the Statement of Comprehensive Net

Figure 32: CNST Claims based upon incident year as at 31st March 2015*



*Data in recent years will develop over time as there are natural delays between both reporting of claims and their ultimate resolution.

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Expenditure (SOCNE) but is also in isolation in figure 10 of this report. CNST shows a small reduction in expenditure compared to 2013/14 however the development of the claims portfolio has led to a significant increase in contributions collected from members in 2015/16 – just over £1.4 billion is due to be collected.

Figure 32 is a summary of the status of the CNST claims held as at March 2015. It shows that significant sums remain outstanding against claims where the original NHS care occurred some years previously – by way of example there remain approximately £200m of outstanding reserves against claims relating to 1995/96 treatment and £1.4 billion for claims where the care was delivered in 2010/11.

Future expenditure patterns are therefore driven by the inevitable resolution of these cases and so the overall expenditure incurred by the scheme will continue to increase into the near future as these cases resolve.

Valuation of Provisions

As can be seen from the Statement of Financial Position (SoFP) (page 88) the known claims portfolio is valued at £12.5 billion as at March 31st 2015 up from £10.5 billion last year. Figure 33 summarises the movements in the overall value of the claims portfolio reported in the SoFP has moved over the last financial year.

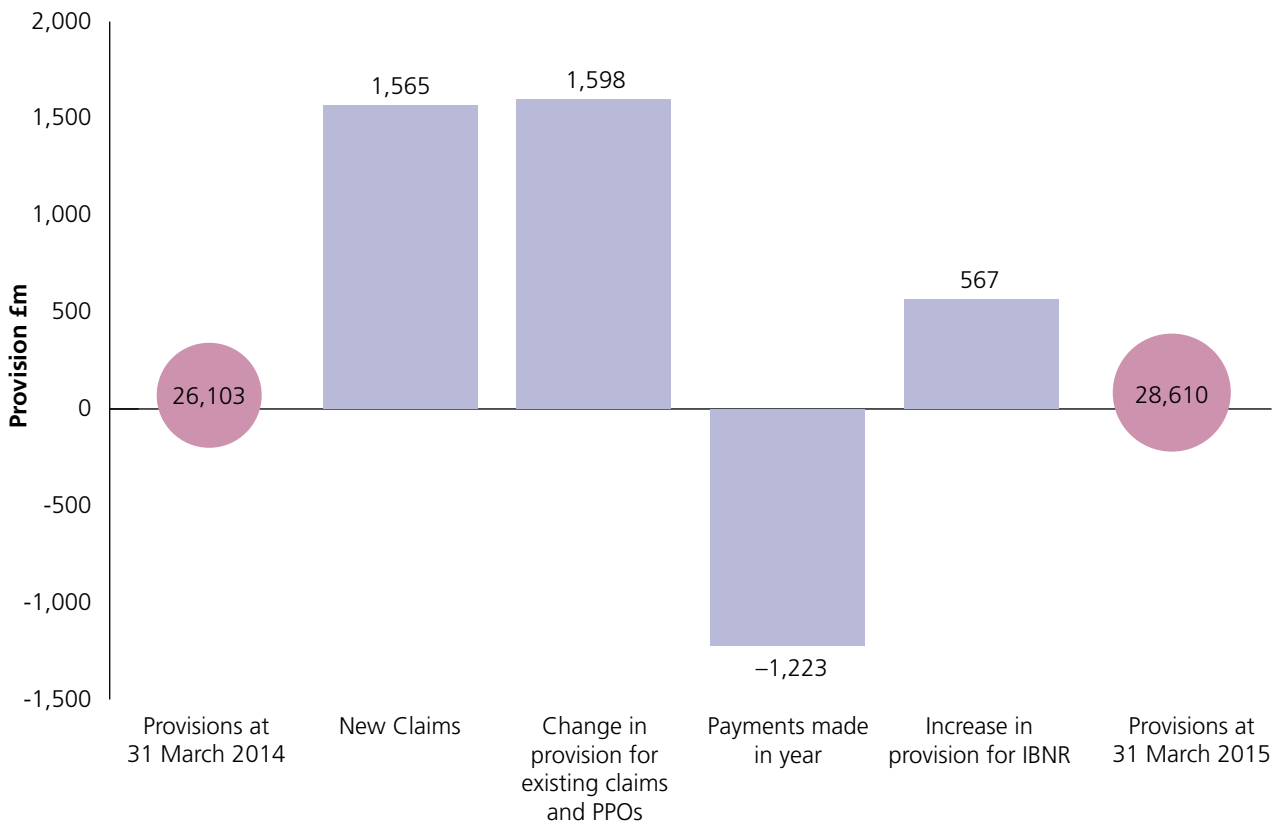
The value attached to new claims reported in the year is £1.565 billion reflecting the volumes of claims being reported to the schemes. The

valuation of those claims which were open at the start of year will alter due to the development of individual cases and where claims become PPOs. During 2014/15 the value of PPOs held grew by £632m whilst we also saw £966m added to the value of other known claims – a significant proportion of the £966m related to a revision to the value we attach to claims for cerebral palsy and other significant birth related cases reflecting the growth in claims valuation referred to in our claims report elsewhere within this report.

The charts also show how the IBNR valuation has changed over the year. This additional £567m relates both to alterations in assumptions regarding IBNR for example more claims than previously forecasted are now being resolved without payment of damages leading to a revision to our actuarial assumptions and also the natural addition of IBNR to reflect the fact that a further financial year of activity has been reported.

Finally the chart reports the reduction in overall provisions (£1.223 billion) as a result of expenditure made in year. In summary we report total provisions of £28.6 billion, the global value of these provisions features high in the Whole of Government Accounts and, as mentioned in the Chief Executive's report, is probably one of a small number of areas of NHS future expenditure which most commentators would argue requires urgent review and possibly radical overall.

Figure 33: Analysis of change in provisions for claims (all schemes) in the year to 31st March 2015



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People

In 2014, we employed 216 people against a budget establishment of 240.46 (Whole Time Equivalents). 100% of our substantive staff are contracted under the NHS Terms and Conditions of Service.

Equality and diversity

During 2014 we complied with the specific duties under the Equality Act 2010 to publish equality information with regard to our staff and service provision.

Below are details of our organisational profile as at 31 March 2015:

- The NHS LA employs slightly more women than men at 58% and 42% respectively and this has increased slightly since the last report.

- During this period, 15% of staff worked part time. Black or other Minority Ethnic employees make up 36% of our workforce. This compares to 34% in 2013/14; 26.7% 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 3.20% sickness absence. We currently have a rate of 4% which is slightly over this target and higher than that of the rate last year which was 3.6%. Measures are in place to manage absences.

Figure 34: NHS LA Establishment

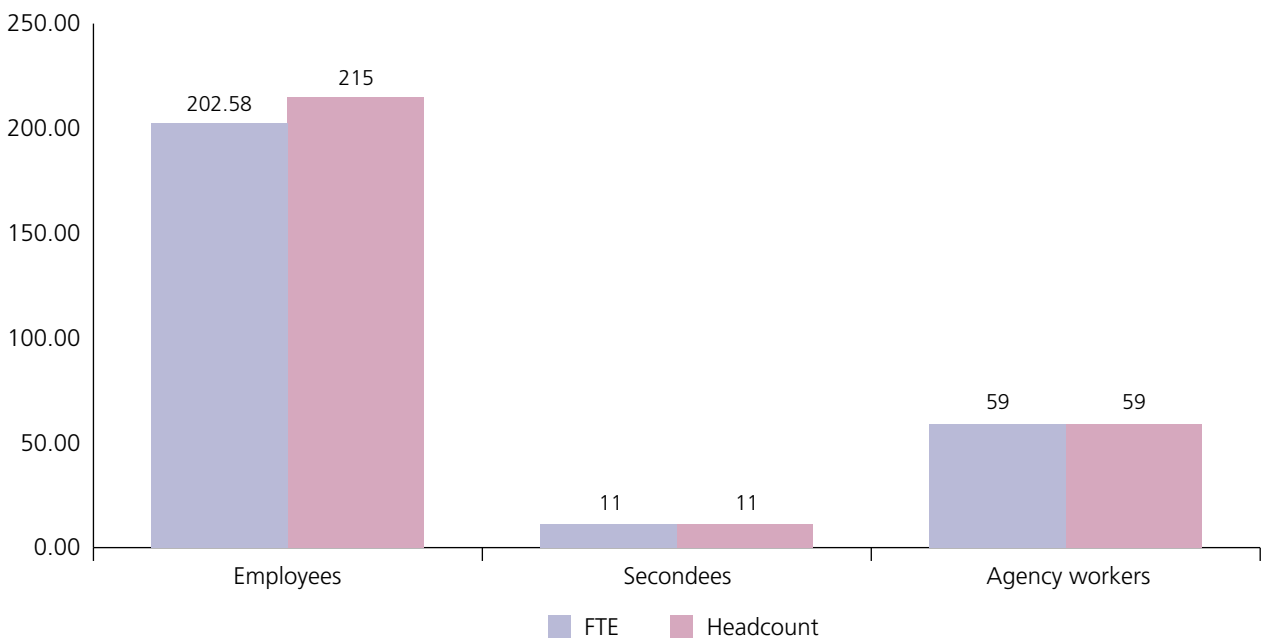


Figure 35: Ethnicity as a % of headcount

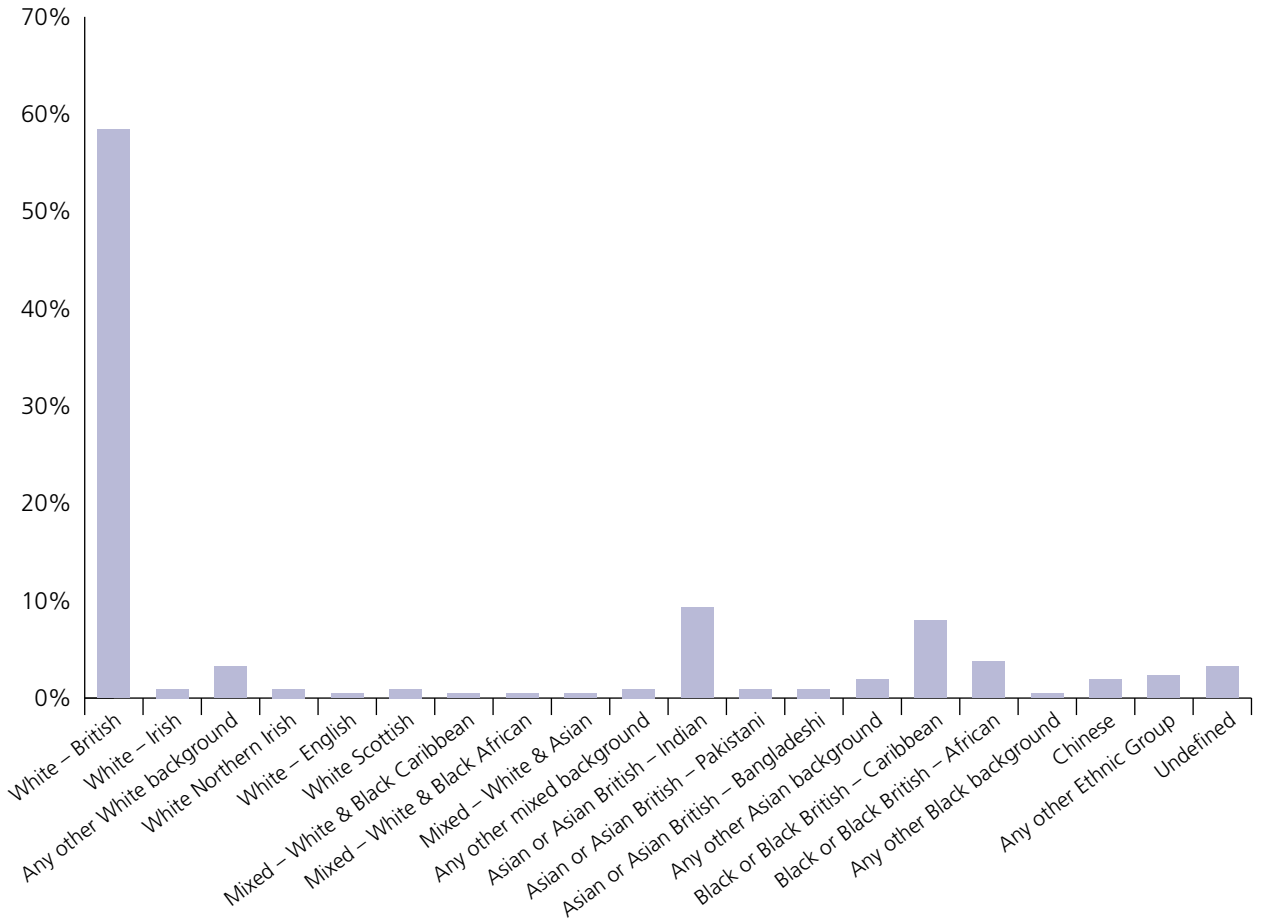
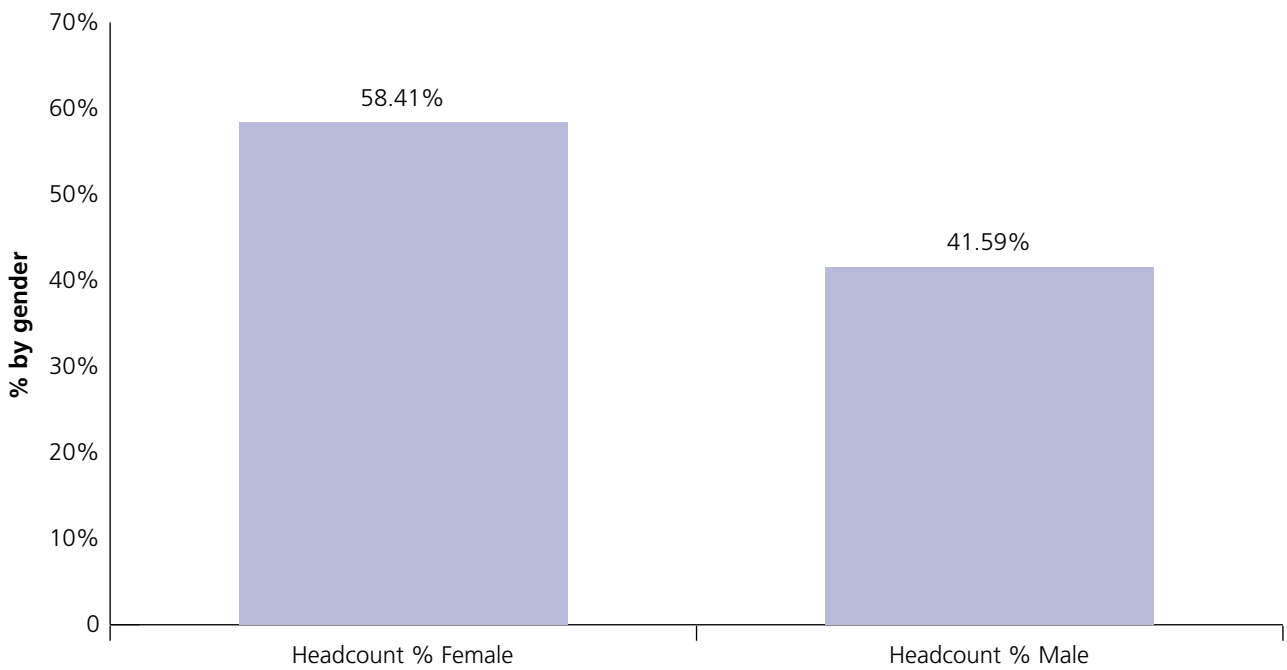


Figure 36: Gender mix as a % of overall headcount



Off Payroll engagements

The NHS LA seeks to ensure that any engagements of more than six months in duration, for more than a daily rate of £220, include contractual provisions that allow the NHS LA to seek assurance regarding the income tax and NICS obligations of the engagee – and to terminate the contract if that assurance is not provided.

During 2014/15 there were two engagements which met the above criteria and in both cases assurance was sought and provided to the NHS LA.

Vision and Values

The vision and values agreed in 2013 have been further embedded in aspects of recruitment, appraisals and learning and development activity. The values of the organisation 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 a staff survey which had a 71% response rate throughout the NHS LA.

The survey identified the following areas requiring improvement with scores between 40-60%; communications, learning and development, performance management, pay and benefits, senior management, career development and work life balance.

Areas on track with scores between 60-75% were; line management, teams and job role, culture, objectives and vision and dignity at work.

Actions plans are being developed to address areas requiring improvement and these include the introduction of a new appraisal system, Management Development Programme, recruitment to new posts to address work life balance, secondment opportunities and development of new roles to address the issues of career development.

Work experience

We support students and graduates on work experience placements and paid internships. We employed five staff in this way during the year.

Charity of the Year

In 2014, the NHS LA's staff voted to support Crisis as our charity of the year.

Following a year of fund raising across a multitude of different events and activities staff were proud to have collectively raised a total of £7,475 for Crisis.

The year ahead in 2015/16

The NHS LA supports the NHS to achieve fair resolution and reduce avoidable harm.

We offer a range of services to the NHS and independent sector providers of NHS care.

In the year ahead, we will:

- Build on the platform we have developed to deliver quality services and excellent value for money to our members in a changing legal, health and social care landscape.
- Continue to improve our efficiency and effectiveness by investing in our staff and processes.
- Embed the changes to our core services delivered through our change programme in recent years.
- Work closely with our members and others to address the causes of the rising cost of claims.
- Share learning from claims and the progress of 'Safety Improvement Plans', in order to support the reduction of the harm which leads to claims.
- Work with patients, their families and others to take account of the patient interest in what we do.
- Develop and improve our work to maintain the professional standards of doctors, dentists, pharmacists and other healthcare professionals.
- Work with DH and others to implement the recommendations of the Triennial Review.

Managing claims

We will continue to meet the challenge of high numbers of claims, resolving claims promptly fairly, and efficiently so that those who suffer harm are appropriately compensated and NHS resources are protected.

We will:

- Enhance our service to members, including improved information on our services and the introduction of dedicated client managers.
- Evaluate our mediation service as a means of successfully resolving concerns and reducing costs and proceed to a procurement of mediation services if appropriate.
- Work with patients to co-produce publications which to support those who are harmed in making a claim for compensation and to share learning from their experience.
- Change the balance between the outsourcing of work to our legal panels and the work undertaken in-house, creating a team to go on the court record for lower value litigated work.
- Review our approach to instructing Counsel and Medical Experts including consideration of fixed pricing.
- Continue to challenge excessive claimants' costs, taking a robust approach to exaggerated costs bills which are not supported by evidence.
- Respond to changes to delivery of NHS care to ensure that our indemnity remains fit for purpose by covering new areas of risk.

- Work with the Department of Health and others to ensure that the costs of claims are proportionate and fair.

Safety and learning

We will continue to develop our Safety and Learning Service to support the NHS to improve patient and staff safety and reduce claims through learning and incentivisation.

We will:

- Support members using our incentive payment to implement their Sign up to Safety Improvement Plans whilst sharing the learning from those Plans across our membership.
- Provide information and analysis of claims for all members, continuously seeking to improve the quality and accuracy of our data, in order to help prioritise local activity.
- Support the national programme implementing a statutory Duty of Candour by raising awareness of the relationship between complaints and claims, helping members to continue developing an open and transparent culture by identifying good practice related to being open with patients and their families and carers.
- Extend our activities to learning from non-clinical claims and NCAS cases covering the performance element of safety.
- Contribute to national conferences and workshops as well as promoting and providing access to our extensive programme of educational workshops to support our members to resolve issues, utilise our services and learn from cases and claims.
- Collaborate with other national patient safety initiatives to align our expertise and efforts.

Family Health Services Appeal Unit (FHS AU)

We will:

- Continue to operate within budgetary requirements, making just, expeditious, and economical appeal and dispute determinations and monitoring our Key Performance Indicators to improve efficiency and effectiveness.
- Review FHS AU Pharmacy Panel Member appointments and recruit or re-appoint where applicable.
- Strengthen the governance of the FHS AU by recruiting Chairs for oral hearings.
- Review the way we get advice from consultant surveyors in order to resolve disputes over the payment for GP premises in a more robust and cost-effective way.
- Progress a revised Panel Member appraisal system and annual training event to ensure the competency of all our FHS AU Panel Members.
- Engage with stakeholders through our Pharmacy Appeals User Group and publish FHS AU decisions, statistical and other information on the NHS LA website.
- Manage and review a pool of Advisors established to provide advice on GP Premises Costs Directions.

National Clinical Assessment Service (NCAS)

We will:

- Use our NCAS expertise to help the NHS improve patient safety by working constructively with teams in difficulty, making the service much more responsive so that from

the outset interventions are tailored to each individual case.

- Recruit, select and train assessors and other specialists to deliver NCAS assessments and interventions. We will review how we plan for assessments and interventions to ensure we meet customer expectations and work within our resources.
- Review our strategy for research within NCAS and review and develop a publication list of NCAS publications and data.
- Seek the views of those using the service and other key stakeholders in order to develop and improve, establishing an external stakeholder reference group to ensure that we are appropriately engaged and obtain feedback from those using our services.
- Move towards appropriate integration for Performers List Regulations, Health Professional Alert Notices and the existing NCAS knowledge system.

Corporate Support Services

We will:

- Aim for the highest standards in looking after and developing our staff by aiming to obtain Investors in People accreditation.
- Continue to develop the skills and knowledge of our staff, providing relevant and comprehensive training for those in technical and specialist functions.
- Enhance our informatics and data analytics capability to support external and internal learning and performance.
- Obtain customer feedback to enable us to continue to develop and improve our services to meet the needs of our customers.

Welcome

Operations

Strategic and Director's Report

Report and Accounts

Strategic Report

Strategic Report

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 SHAs 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.

Risks and uncertainties

Details of the principal risks and uncertainties facing the NHS LA are outlined in the Governance Statement under 'the risk and control framework' on page 76 of this report.

Review of activities and performance against targets

During the year, our net operating costs amounted to £2,641.6 million, which represents a decrease of £732.7 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 Department of Health. For 2014/15 the agreed RRL was £4,081 million; thus, an underspend of £1,439.9 million is reported. This underspend is largely a result of the review of the key assumptions used to construct the claims provisions recorded in the accounts of the NHS LA. In particular we have noted a continued reduction in the overall level of claims inflation experienced in year (partly attributable to the wider economic environment and a reduction of long term Retail Price Index (RPI) forecasts by the Government and Bank of England) which has led our Reserving and Pricing Committee, advised by our independent actuary, to reduce the level of claims inflation applied to our clinical claims portfolio from 9.5% to 9%. As can be seen from note 9.4 in the accounts on page 114 a more significant movement (+2%) in

this assumption could lead to an adjustment of £3 billion to the IBNR element of the financial provisions recorded in the accounts.

Our financial position as at 31 March 2015, shows net liabilities of £28.6 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 predominantly 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 we classify claims incurred but not yet reported as provisions under 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 2015 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 2015).

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 members to make maximum use of NHS resources for the delivery of patient care.

For 2014/15 we received funding of £134 million from the Department of Health. Capital cash limits for the year were £450,000, with reported outturn at £450,000. The NHS LA's own cash balances increased by £11.4 million (£32.9 million is held at year end compared to £21.5 million in 2013/14).

Key Performance Indicators

The NHS LA has key performance indicators (KPIs) covering all areas of operations which are agreed with the Department of Health to provide overall levels of assurance. We review our KPIs periodically to ensure that they support us to continually learn and develop our services. As many relate to our claims functions they are not published externally to protect the position of the NHS in relation to the effective management and resolution of litigation.

Strategic Plan

The NHS LA has a three year strategic plan which can be visited on the NHS LA website www.nhsla.com/AboutUs/

Gender and Diversity

The People section of the Annual report on page 52 gives details of the gender and diversity of the employees of the NHS LA.

Directors' Report

Details of the NHS LA Board members including the Chair and Chief Executive are shown in the Remuneration Report which follows this director's report.

The NHS LA publishes a register of interests of Board members on its website here www.nhsla.com/AboutUs/Pages/AnnualReport.aspx

Pensions

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 £113,000 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.

Sickness absence

Details of the sickness absence data are shown in the People section of the annual report on page 52.

Personal Data related Incidents

Details of the personal data related incidence are outlined in the Governance statement under 'Information Governance'.

Financial Instruments

Details of the NHS LA's Financial Instruments and exposure to risk is outlined in note 14 of the financial statements on page 119.

Future developments

Details of future developments are outlined in 'the year ahead in 2015/16' section of the annual report on page 55.

Remuneration Report

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*.

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

Non-executive director	Meetings attended
Ian Dilks	3 of 3
Rory Shaw	1 of 3
Nina Wrightson	3 of 3
Ros Levenson	3 of 3
Andrew Hauser	2 of 3

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

Figures 37, 38 and 39 give the contractual, salary and pension details of those senior managers who had control over the major activities of the NHS LA during 2014/15.

The information in the following tables is subject to audit.

Figure 37: Salaries and allowances for 2014/15

Name and title	2014-15					
	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Ian Dilks ¹ (Chairman)	60 – 65	0	0	0	N/A	60 – 65
Catherine Dixon ² (Chief Executive)	100 – 105	0	0	0	15 – 17.5	120 – 125
Helen Vernon ³ (Executive Director/Chief Executive)	110 – 115	0	0 – 5	0	87.5 – 90	205 – 210
Tom Fothergill (Director of Finance and Corporate Planning)	150 – 155	0	0	0	17.5 – 20	170 – 175
Suzette Woodward ⁴ (Executive Director)	25 – 30	0	0	0	137.5 – 140	165 – 170
Professor Rory Shaw (Non-Executive Member)	5 – 10	0	N/A	N/A	N/A	5 – 10
Nina Wrightson OBE (Non-Executive Member)	5 – 10	0	N/A	N/A	N/A	5 – 10
Ros Levenson (Non-Executive Member)	5 – 10	0	N/A	N/A	N/A	5 – 10
Andrew Hauser (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	N/A

Salary Band of Highest Paid Director's Total Remuneration (£'000)	150 – 155
Median Total Remuneration	41,815
Ratio	3.65 ⁶

Figure 38: Salaries and allowances for 2013/14

Name and title	2013-14					
	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £00	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Professor Dame Joan Higgins ⁵ (Chairman)	25 – 30	0	0	0	0	25 – 30
Ian Dilks ¹ (Chairman)	N/A	N/A	N/A	N/A	N/A	N/A
Catherine Dixon ² (Chief Executive)	140 – 145	0	5 – 10	0	30 – 32.5	180 – 185
Helen Vernon ³ (Executive Director/Chief Executive)	95 – 100	0	0	0	65 – 67.5	160 – 165
Tom Fothergill (Director of Finance and Corporate Planning)	150 – 155	0	0	0	20 – 22.5	175 – 180
Suzette Woodward ⁴ (Executive Director)	100 – 105	0	0	0	0	100 – 105
Keith A Ford ⁶ (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 (Non-Executive Member)	15 – 20	0	N/A	N/A	N/A	15 – 20
Ros Levenson (Non-Executive Member)	0 – 5	0	N/A	N/A	N/A	0 – 5
Andrew Hauser (Non-Executive Member)	N/A	N/A	N/A	N/A	N/A	N/A

Salary Band of Highest Paid Director's Total Remuneration (£'000)	150 – 155
Median Total Remuneration	42,016
Ratio	3.63 ⁶

¹ Ian Dilks was appointed as Chairman on 1st April 2014.

² Catherine Dixon left on 30th November 2014.

³ Helen Vernon was appointed as Chief Executive on 1st December 2014.

⁴ Suzette Woodward was seconded to the Sign Up To Safety Programme with effect from 24th June 2014. Salary costs for Suzette since June 24th as part of the Sign up to Safety expenditure reported elsewhere were : £117,297.

⁵ Professor Dame Joan Higgins retired with effect from 31st December 2013.

⁶ Keith Ford's appointment expired 30th November 2013.

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 39: Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Catherine Dixon (Chief Executive)	0 – 2.5	0	5 – 10	0	77	55	20	15
Helen Vernon (Executive Director/ Chief Executive)	2.5 – 5	12.5 – 15	20 – 25	60 – 65	319	237	75	16
Tom Fothergill (Director of Finance and Corporate Planning)	0 – 2.5	5 – 7.5	40 – 45	125 – 130	710	646	47	21
Suzette Woodward (Executive Director)	5 – 7.5	20 – 22.5	50 – 55	150 – 155	1,027	839	165	16

Staff not in receipt of pension benefits are not shown.



Helen Vernon

Chief Executive and Accounting Officer

Date: 3rd July 2015

Governance statement

Scope of Responsibility

I am the Chief Executive and Accounting Officer of 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 NHS LA assets in accordance with the HM Treasury document "Managing Public Money". For the accounting period up to and including 30 November 2014, I have relied upon the assurances given by Ms. Catherine Dixon, the former Chief Executive of the NHS LA, that the matters detailed below have been discharged in accordance with this governance statement.

As Chief Executive, I have the following operational responsibilities:

- 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 the complaints process and ensuring that the learning from complaints is embedded into how we operate.
- Risk management processes.

- NHS LA's databases and financial system.

As Accounting Officer, I am supported by the NHS LA Senior Management Team, internal audit and the NHS LA's Audit and Risk Committee, and 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.

Responsibilities of the Board

The NHS LA is governed by its Board, led by a non-executive Chair who is responsible to the Secretary of State. The 2013 Framework Agreement between the Department of Health and the NHS LA states that the role of the Board is:

'to establish and take forward the strategic aims of the NHS LA, consistent with its overall strategic direction and within the policy and resources framework determined by the Secretary of State.....and includes holding its executive management team to account and ensuring the organisation is able to account to Parliament and the public for how it has discharged its functions.'

The responsibilities for the Board as a whole include supporting me as Accounting Officer in ensuring that the NHS LA exercises proper stewardship. The Board ensures that arrangements are in place to provide assurance on risk management, governance and internal control, including:

- Operating as a unitary Board, except in any areas specifically reserved for certain directors, and in a way that achieves the right balance between the role of the Board as a whole and the role of the Executive team.
- Owning the process for developing strategy in conjunction with and in response to the needs of key stakeholders, with a particular focus on the medium to longer term.
- Approving (annual or longer term) plans for the implementation of strategy.
- Monitoring the performance of the organisation against agreed plans.
- Being responsible for the overall system of control, to ensure key risks are identified and appropriate mitigating actions are taken.
- Ensuring compliance with relevant NHS and wider Government regulations and requirements, including the provision of excellent services and good value for money.
- Conducting its affairs in an open and transparent a manner as possible within the constraints of preserving confidentiality where appropriate.
- Periodically reviewing its own performance.

The Board discharges the majority of its responsibilities through regular meetings of the Board and its committees and responding to other issues between meetings as required.

The Board reviews its own governance arrangements to ensure that these meet the requirements of the Code of Good Practice required within central government departments.

The Board regularly reviews and suggests revisions on 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. For example, the Board requested that a metric be developed to monitor case-loads for claims staff over time in order to monitor the impact of recruitment measures.

During the period from 1 April 2014 to 31st March 2015 the NHS LA Board met on six occasions and attendance details are as follows:

NHS LA Board meeting attendance

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

* Rory Shaw left the Board on 31st March 2015

** Suzette Woodward left the Board on 31st July 2014

The Board reviewed its role and, to an extent, its governance arrangements and effectiveness at a Board away day in October 2014. This resulted in a review of the need to maintain a Part 1 open meeting to contribute to openness and transparency. The Senior Independent Director role was maintained with the reappointment of Nina Wrightson at the Board meeting in November 2014.

Governance framework

The NHS LA has 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.

Assurance and information flows through the following committees and management structures which are established to enable the Board and me as Accounting Officer to discharge our responsibilities and to ensure that internal controls are in place to safeguard and steward financial and resource controls.

Senior Management Team (SMT)

The SMT supports me in the management of the organisation and discharge of my functions. It is chaired by myself and its membership comprises Executive members of the Board and other NHS LA senior managers. All functional areas of the organisation are represented.

SMT are accountable to me for delivering the NHS LA's strategic functions and the organisation's strategic objectives in accordance with the Business Plan. SMT working closely with me oversee resource management, the strategic risk register, governance arrangements, complaints and networking/stakeholder management. I report on the work of the SMT to the Board and hold members of the SMT to account for delivering against agreed objectives.

Audit & Risk Committee (ARC)

The Audit & Risk Committee is chaired by a Non-Executive director. It meets at least four times a year and is a sub-Committee of the Board. It ensures that an effective system of internal control for all risks is maintained. The Audit and Risk Committee reviews the NHS LA's strategic risk register, together with risk reduction plans, and monitors progress on risk reduction action plans. The Audit and Risk Committee reviews the results of internal and external audit work and reviews the annual audit

plan with reference to the Strategic Risk Register for approval by the Accounting Officer. It also receives and reviews reports from the Health, Safety & Risk Committee.

During 2014/15 the ARC noted the updated Strategic Risk Register, and the key movements on strategic risks. The ARC discussed early progress on the creation and population of an 'assurance map' for the NHS LA.

The ARC undertook an initial discussion on a proposed Risk Management Policy and Procedure, centred around the issue of how to define 'risk appetite' or 'risk tolerance' for the Authority and the importance of strengthening the references to financial risk mitigation. The ARC also discussed the proposed Internal Audit Plan for 2015/16 and made recommendations for areas for further exploration.

The 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, the Department of Health and other agencies to ensure that the NHS LA draws on experience in the wider NHS.

In 2014/15 the Head of Internal Audit provided a 'substantial' opinion in the case of Risk Management and Governance and a 'moderate' opinion in the case of Control, leading to an overall 'moderate' opinion. The NHS LA will address this in 2015/16 with the development of a detailed assurance map which plots the assurance against core activity across the business areas. Lines of defence will be identified, evidenced and where required, strengthened. The assurance mapping process will complement the risk register in monitoring the effectiveness of controls.

Reserving and Pricing Committee (RPC)

I Chair an internal Reserving and Pricing Committee (RPC) with membership comprised of the Director of Finance and Corporate Planning, Director of Claims and the NHS LA's Chair. The RPC is attended by the NHS LA's Actuaries and meets regularly in the lead up to closure of the financial accounts for the year to review all of the assumptions used in the production of the accounts, in regards to claims provisions, and the supporting actuarial models. The RPC also meets to discuss the pricing of the NHS LA schemes and the basis on which contributions will be set for members.

During 2014/15 the Terms of Reference for the RPC were reviewed and amended following the discussion at the January Board meeting to recognise that the CEO would report progress of pricing work directly to the Board whilst reserving issues would continue to be reported via the ARC.

The RPC reviewed the work of the Actuaries in relation to the 2015/16 price and the calculation of contributions.

The RPC acts as our framework and environment to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report. I can confirm that all business critical models have been identified and that information about quality assurance processes for those models has been provided to the Analytical Oversight Committee, chaired by the Chief Analyst in the Department of Health.

Programme Steering Group (PSG)

The PSG comprises SMT members and other managers with specific responsibility for the oversight and the direction of the NHS LA's change and project delivery programme which

are being managed by the PSG. The PSG provides progress reports to the Board regularly.

The PSG oversaw a full programme during 2014/15, including IT projects such as the development of a bespoke interface for the management of non-clinical claims through the claims portal. New projects were identified to respond to emerging needs of the business with project managers and sponsors identified and terms of reference and milestones drafted and approved by the Steering Group.

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a Non-Executive Committee of the NHS LA's Board, which determines its membership and terms of reference. The Committee's role is to determine the remuneration, benefits and terms of services of all posts covered by the Very Senior Managers' Pay (VSMP) Framework. It exercises its functions within the frameworks determined by the Department of Health.

During 2014/15 the Committee received satisfactory reports on the performance of the VSMs. The Committee reviewed its policy on senior pay and submitted the results to the Department of Health, as requested by the Secretary of State. The Authority's policies are all within NHS and DH guidelines.

Throughout the year the Committee received and approved reports from the Chief Executive on the pay and expenditure implications of organisational restructuring, in relation to roles in the NHS LA and NCAS.

The Committee considered a paper from the Permanent Secretary regarding the pay arrangements for 2015/16 and the review of the

2012 VSM pay framework and its implications were noted and considered. The RemCo also noted the ongoing discussion around redundancy arrangements for staff on VSM contracts and reviewed the submission of a response to the consultation on Public Sector Exit Payments.

The Committee oversaw the arrangements for the recruitment of a new Chief Executive following the resignation of the previous Chief Executive in September 2014. The Committee's involvement included approval of the role description, selection of an external adviser, consideration of applications, interviewing shortlisted candidates and approval of the offer to the successful candidate. Four members of the Committee attended the interview.

Recruitment Oversight Committee (ROC)

The Recruitment Oversight Committee (ROC) considers all requests for recruitment (internal and external), any change to employees' roles and/or terms and conditions (excluding those under VSM contracts), training and expenses, and requests for attendance at conferences. A summary of decisions made by ROC are recorded. All matters relevant to the Board are reported.

In 2014/15 the ROC oversaw a programme of recruitment to the claims teams in order to resource sustained high volumes of claims.

Data Reference Group (DRG)

This group has been established as an advisory group to me as Chief Executive and Accounting Officer to provide guidance on responsibilities for assuring governance arrangements for data sharing, internally and externally, in accordance with law and best practice and in order to discharge the organisation's strategic objectives.

Information Governance Group (IGG)

The IG group, which meets monthly, acts as a key source of assurance to me that the agreed NHS Information Governance (IG) Toolkit and other IG requirements are being operated and delivered to required standards within the NHS LA and to act as a focus for information governance within the NHS LA including lessons learnt, good practice and to identify any IG communications.

The group also reviews all IG incidents and reviews IG risks to advise the Senior Information Risk Owner (SIRO) and Caldicott Guardian of any high risk areas. A quarterly report is issued to the Accounting Officer which will include an assessment of risk and issues. The SIRO and Caldicott Guardian work together to ensure that both patient and other personal information are handled in line with best practice in government and the wider public sector.

The group also reviews all policies which impact information governance. The minutes and actions are reported at the Audit and Risk Committee on a quarterly basis. The SIRO working closely with me as Accounting Officer ensures that the Board is kept up to date with the relevant information governance issues within the NHS LA and is promptly informed of reportable IG incidents.

Joint Negotiating Committee (JNC)

The JNC is an agreement between the NHS LA and Unison to cover areas for negotiation and consultation. Matters subject to joint consideration include the consultation and negotiation of terms and conditions of employment, interpretation of Agenda for Change terms and conditions, agreeing NHS LA policies and procedures (including HR) which

affect employees. I and members of SMT meet regularly with JNC representatives.

Staff Engagement Group (SEG)

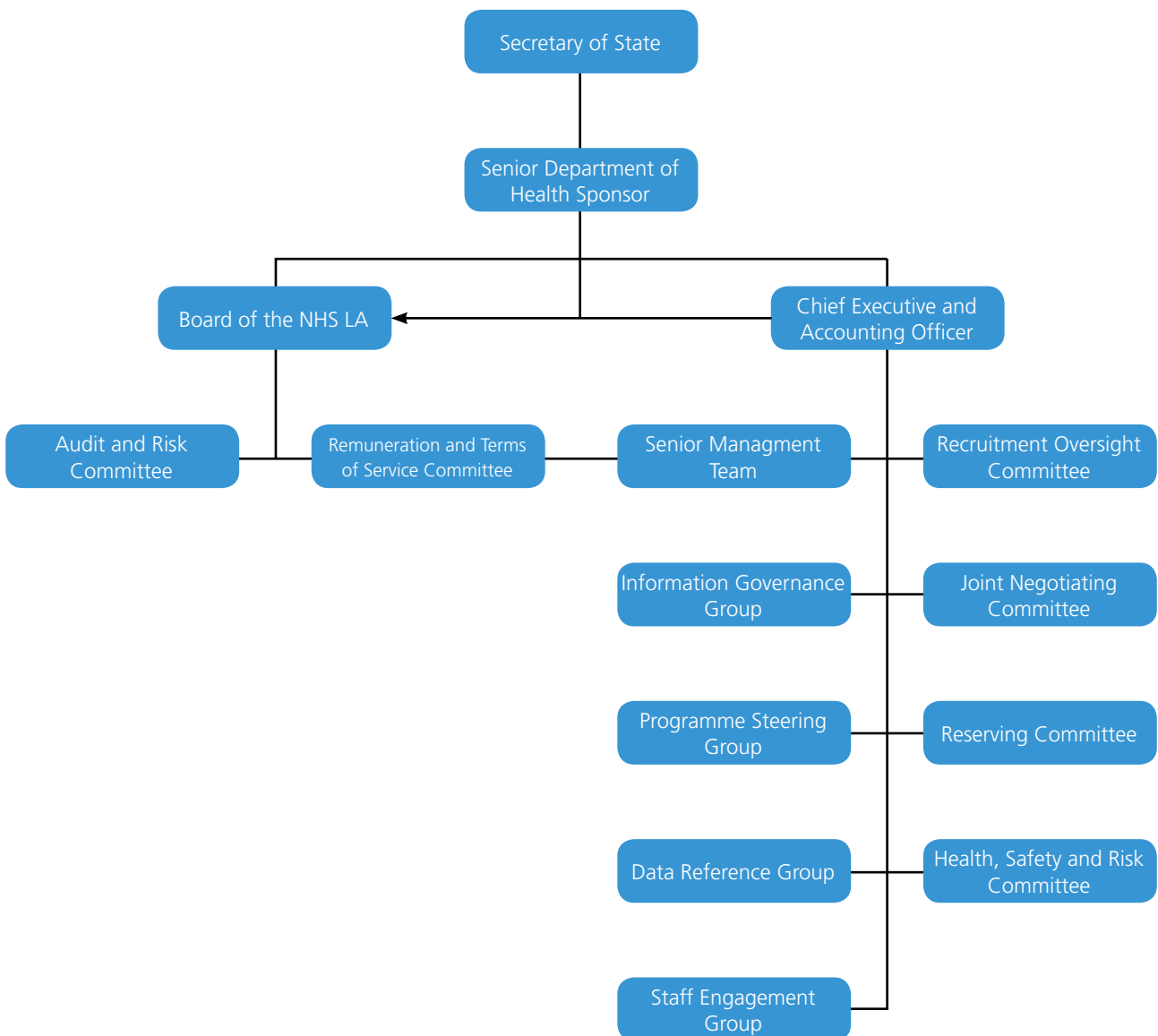
The purpose of SEG is promote staff engagement by providing an additional means through which staff members can raise issues about actions or decisions that affect them, facilitate communication and Terms of Service between staff, me and the SMT.

Health, Safety & Risk Committee (HSRC)

The Health, Safety & Risk Committee provides assurance to me and to the Audit and Risk

Committee relating to the corporate and operational risk and safety for the organisation and includes review of and follow up of action taken in respect of business continuity arrangements, non-IG incident reports, and internal risk reporting so that it can assure the Audit & Risk Committee that risks are being managed according to organisational policies and procedures. The Health, Safety & Risk Committee ensures that Key Performance Indicators (KPIs) are set and monitored in relation to the management of risks.

The Health, Safety and Risk Committee provides an annual report to the Audit & Risk Committee.



Performance

Corporate performance is reported by me to the Board and to the Department of Health on a regular basis. Variations from anticipated performance are, where appropriate, 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 being taken.

The purpose of the governance arrangements

The system of internal control is designed to eliminate risk, where possible, and 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 for the year ended 31 March 2015. 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 has been delivering training to all staff, and ensuring that contractors and agency workers have an understanding of the NHS LA's information governance expectations and are trained appropriately.

From 1 April 2014 to 31st March 2015 we recorded 47 information handling incidents reported by the NHS LA and its Legal Panel members, one of which qualified for reporting to the Information Commissioner.

Any learning requirements arising from information governance incidents are addressed as part of the NHS LA's Information Governance Strategy and related policies and protocols.

The NHS LA is working towards obtaining ISO 27001 accreditation and has an action plan in place to achieve such accreditation.

As part of the agreed internal audit program a review of Handling of Information Requests was carried out and reported to the Audit and Risk Committee. The report was given a rating of 'moderate' importance recognising that some

improvements to the processes and systems in place are required. The Audit and Risk Committee accepted the report and the management team were asked to implement the accepted recommendations and report back. The recommendations included improving access to information regarding information requests on the NHS LA websites, issuing further guidance to staff and improvements to recording of factors taken into account when carrying out internal reviews.

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 I report the findings to the Board. There is oversight by the Chair in accordance with the Complaints Policy. 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 as appropriate.

The NHS LA reviewed 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. Changes were made to the NHS LA's Complaints Policy which were

approved by the Board and which have been implemented.

The risk and control framework

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 informal sessions, including Board away

days, to facilitate dealing with key issues, including reviewing the role of the Board.

From 1 April 2014 to 31st March 2015, the NHS LA identified and dealt with a number of significant issues (some of which were outside our direct control). Some of the matters are ongoing into 2015/16 and their management is subject to ongoing review.

The following issues were considered to be significant:

Financial

- The size and nature of the NHS LA's provisions means that a small adjustment to underlying assumptions can result in a significant change. The assumptions behind the provisions are examined in detail by the Reserving and Pricing Committee which is chaired by me.
- The NHS LA has continued to experience high numbers of claims with increasing values at the higher end, which is placing pressure on resource and expenditure. We have taken steps to manage this. Monthly management information is produced and shared with SMT and with the full Board at every meeting. A weekly Claims Expenditure Committee keeps current and shorter term expenditure transactions and claims activity under constant review. Financial monitoring and forecasting is also shared with the Department of Health throughout the financial year.
- Wider NHS financial risks and the requirement to increase the average level of contributions to the NHS LA's main clinical scheme, CNST, has led to significant financial pressures on members of our schemes. We have worked closely with DH to keep them informed of resource pressures and with NTDA and Monitor to inform them of the costs of claims,

as they apply to individual organisations and to inform tariff setting.

- We are awaiting the outcome of a review of the court discount rate, which will have significant implications for the cost of claims and the NHS LA's provisions. We have informed the Department of Health of the potential impact.
- The NHS LA transferred its actuarial support to the Government Actuaries Department (GAD) following a re-tendering process that took place during 2014. The work of GAD is overseen closely by the Director of Finance and Corporate Planning and by the Reserving and Pricing Committee.
- The NHS LA has been subject to a Triennial Review which was launched by the Department of Health on the 16th October 2014. The review has concluded and is due to report. The final report of the Triennial Review is likely to make recommendations for change which will need to be implemented by the NHS LA and which may require additional resource. The NHS LA is preparing to adapt its change programme accordingly.

Membership and cover

- The NHS LA's CNST regulations were consolidated on 1 April 2015. It is important that the CNST regulations are reviewed to ensure that the NHS LA is still able to appropriately indemnify where health and social care has been integrated. Currently the regulations provide limitations on what cover the NHS LA can offer. The NHS LA is working closely with DH to review any required changes to the regulations.
- The NHS LA has expanded its membership by welcoming more than 60 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. The implications of price for the independent sector given the overall increase in CNST will be closely monitored to ensure fairness and equity with the rest of the NHS.

- The NHS LA is handling industrial disease claims on behalf of the Department of Health. These are managed 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. The levels and value of such claims is monitored carefully to assess the operational impact and cost of handling as well as considering implications for the wider NHS.
- The Government has launched a consultation on whether the NHS LA should levy reimbursement in the event that member organisations breach their statutory duty of candour by failing to be candid with patients in the event that a claim is brought. The objective is to incentivise organisations to be more candid. If implemented, this is likely to have a significant impact on NHS LA members and their relationship with the NHS LA. I wrote to the NHS LA's members to draw their attention to the consultation and to encourage them to respond.
- The Sign up to Safety incentive scheme entailed the provision of detailed information to members on their areas of risk (high value and high volume claims). Those members who were able to produce robust plans as to how they intended to reduce the harm which leads

to claims over time were eligible for an up-front financial incentive. The incentive scheme thereby aimed to help to manage the risk of future liabilities by providing funding for new safety plans to be administered in member organisations. The scheme placed conditions on payment, requiring written confirmation from the Chief Executives of organisations receiving an incentive payment that the funds would be used only in relation to the submitted bid. As additional assurance, the organisation is required to publish a summary of their successful bid, including details of anticipated outcomes on their public website and to provide details to their Board and Local Commissioners with regular updates on progress.

Legal environment

- The NHS LA has experienced excessive billing for claimant solicitors' costs. We are continuing to ensure that we challenge claimant solicitors' costs where they are disproportionate to damages and defence costs. We are continuing to develop our expertise in cost management, including in house expertise, so that we can ensure that we continue to appropriately challenge claimants' solicitors, wherever appropriate.
- We have implemented the new employers' liability (EL) and public liability (PL) claims portal which deals with all EL/PL claims below £25,000. We evaluated the operation of the portal, and have developed a bespoke interface in order to increase efficiencies and mitigate the risks presented by tight deadlines and the double entry of data.
- We are continuing dialogue with the Ministry of Justice and the Department of Health in connection with the impact of the 'Jackson' reforms to the funding of civil litigation to

ensure the implications of the changes are fully understood and are monitored. These reforms changed the way in which litigation is funded, removing the ability of claimant lawyers to recover a substantial 'success fee' (uplift on their charges) from an unsuccessful defendant. The costs of claims brought under 'post Jackson' funding arrangements should therefore be lower, in time. In the interim however, claims continue to be brought under funding arrangements which were put in place prior to the reforms taking effect.

Fraud

- 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.
- We have committed to join the Claims Underwriting Exchange (CUE) and to share our non-clinical claims information with insurers to enable us to identify fraud risk. We will keep under review the information governance risks which flow from us joining CUE and sharing our data.

Data quality

- It is important to continually monitor the accuracy of NHS LA key data which is utilised for setting contributions and provisions and for

informing members on their priority areas for claims reduction. Data quality is routinely audited and mandatory data quality training delivered to staff. Staff are provided with detailed guidance on completing critical data fields in a claims procedure manual, which is continually updated and 'laminates' for easy reference. Exception reporting identifies data which appears to be incorrect, based upon a correlation of fields. Case managers are monitored against their completion of exception reports and the correction of data within set timescales. Data errors identified throughout the year, result in a retrospective review, to identify the cause, a tightening of procedures and where necessary, an amendment of systems together with a 'clean-up' of data, where required.

The rating of 'substantial' given in an internal audit report on data accuracy has given assurance that data accuracy is being appropriately addressed.

Criminal Liabilities

- The NHS LA is dealing with a number of Health and Safety Executive (HSE) prosecutions following the demise of PCTs, SHAs and NHS Direct which resulted in any criminal liabilities arising from these demised organisations being passed to the NHS LA. This transfer was not within the normal course of business. The NHS LA is currently responding to one HSE prosecution relating to these inherited liabilities and others may follow. The NHS LA is actively managing all known cases with specialist solicitor and counsel input.

NCAS structure and services

- Following the successful transfer of NCAS into the NHS LA as an operating division, the NHS LA is 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 completed an organisational redesign of NCAS's service delivery teams which is in the process of being implemented. The implementation requires many NHS LA staff delivering NCAS services to adapt and change their current role. Implementation will be closely monitored to ensure objectives are achieved.

- 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 between 3-4 months. We will continue to monitor NCAS services to ensure we are arranging timely assessments. We have also reviewed and restructured assessment reports so that they are shorter and more focussed on key issues arising from the assessments. These changes will be evaluated to ensure that they are effective.
- The NHS LA is tasked with issuing Health Professional Alert Notices (HPAN). The HPAN directions are in the process of being reviewed by the Department of Health to ensure that they are fit for purpose particularly with a view to ensuring patient safety. We reviewed the HPAN processes to ensure effective governance. We also reviewed all HPANs to ensure they remain relevant and were accurately recorded.
- The NHS LA appointed a responsible officer in accordance with the Medical Profession (Responsible Officers) Regulations 2010 following the transfer of NCAS to the NHS LA

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. The NHS LA's responsible officer (RO) is due to retire and a new RO will be appointed and training provided.

FHSAU

- We are continuing to respond 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 new panel chairs and introducing regular appraisals to ensure consistency of quality across our panels.

Outsourced services

- The NHS LA outsources work to its Legal Panels in accordance with a contract put in place following a tender process. The panel contract is monitored closely via KPIs which are accessible to the panel firms and the NHS LA in real time via a shared Extranet. Regular review meetings take place with allocated panel contacts and, separately, with the Chief Executive and Head of Claims Quality. Complaints are logged and investigated. We are continuing to monitor the savings we achieve through discounts secured under the contract for volume and early payment of invoices.

People

- The pressure on internal resource due to continued high numbers of claims has been addressed by recruitment, a comprehensive induction programme, streamlining of procedures and the use of the NHS LA’s Legal Panel firms’ capacity.
- We have increased 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), information governance and a full range of management development training. We are continuing to evaluate the impact of our training programme and assessing the impact on staff.

Public and Parliamentary Accountability

The NHS LA operates to a protocol for Public and Parliamentary Accountability agreed with the Department of Health with effect from

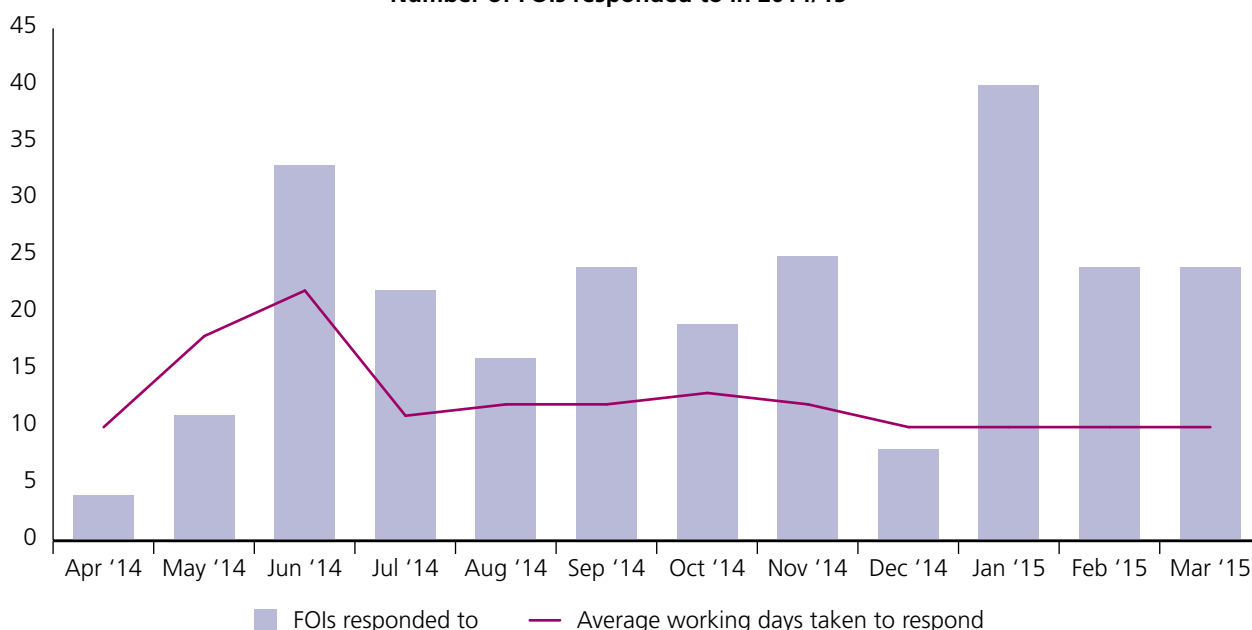
1 April 2014. This protocol sets out robust public and Parliamentary accountability arrangements to ensure good communication and effective collaborative working between DH and NHS LA. It is intended to help both organisations:

- Meet their respective public and Parliamentary responsibilities;
- Set out their own operational needs;
- Understand own and respective organisation’s role and independence; and
- Secure the confidence of the public, MPs and peers.

Effective processes were in place throughout the year which ensured a swift response to all public enquiries, correspondence, Parliamentary questions, issues raised under Data Protection legislation, Freedom of Information requests and complaints.

Of the 248 FoIA requests which were completed during 2014/15, 89% were provided within the statutory 20 working day deadline. Of the 27 which were provided late, 60% of these were in

Number of FOIs responded to in 2014/15



Quarter 1, which saw the average time for responding go above the 20 working day deadline. This response time significantly improved throughout the remainder of the year with the average response time in Quarter 4 being just 10 days and 95% of the 86 requests being responded to within the statutory deadline.

The NHS LA receives two types of requests under the Data Protection Act. Subject Access Requests (SARs) give individuals the right to request to any information held about themselves; and requests under Section 29 of the DPA (S29) which entitles the NHS LA to share information with an authority for the purposes of crime and taxation. Fifty-five SARs were responded to during 2014/15, two of which exceeded the 40 calendar day deadline, meaning 96% have been responded to on time. The average response time was 31 days.

We worked closely with the DH sponsor branch throughout the year in order to provide timely responses and meet Parliamentary deadlines. All responses are approved by the SIRO or by me.

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. From April 2014 to 31st March 2015 there were 10 assurance based reports produced. There were a total of 11 recommendations rated as of medium importance and 21 rated of low importance – 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 meet weekly 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.
- The NHS LA's Reserving and Pricing 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.
- 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. The Audit and Risk Committee has reviewed its 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.

The Audit and Risk Committee 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.

The attendance record for the Audit and Risk Committee’s meetings is given below.

Audit and Risk Committee meeting attendance:

Name	Post	Meetings attended
Andrew Hauser	Non-Executive Director and Chair of ARC	4 of 4
Rory Shaw	Non-executive Director	2 of 4
Ros Levenson	Non-Executive Director	4 of 4

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 and I am content that the correct arrangements are in place for the discharge of all statutory functions for which the NHS LA is responsible. I have also checked for any irregularities and that they are legally compliant in line with the recommendations in the Harris Review.

In summary I am satisfied that the framework of governance, risk management and system of internal controls are adequate and have been effectively maintained throughout 2014/15.

Helen Vernon

Chief Executive and Accounting Officer

Date: 3rd July 2015

Welcome

Operations

Strategic and Director's Report

Report and Accounts

Financial Statements

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, changes in taxpayers equity and cash flows for the financial year.

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

- Observe the Accounts Direction issued by the Secretary of State, 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.



Helen Vernon

Chief Executive and Accounting Officer

Date: 3rd July 2015

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 2015 under the National Health Service Act 2006. The financial statements comprise: the Statements of Comprehensive Net Expenditure, Financial Position, Cash Flows, Changes in Taxpayers' Equity; and the related notes.

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

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, 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 31st March 2015 and of the net expenditure for the year then ended; and
- 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

Comptroller and Auditor General

National Audit Office

157–197 Buckingham Palace Road Victoria

London

Date: 7th July 2015

Statement of Comprehensive Net Expenditure for the year ended 31 March 2015

	Notes	2014-15 £000	2013-14 £000
Programme costs			
Authority and claims administration	2.1	20,534	20,252
Other claims and associated costs	2.1	3,729,993	4,389,255
Total Programme costs	2.1	3,750,527	4,409,507
Operating income	4	(1,108,912)	(1,035,203)
Net Expenditure	3.1,10	2,641,615	3,374,304
Net gain on transfer of NCAS		0	(3)
Total Net Expenditure		2,641,615	3,374,301

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

The notes on pages 91 to 119 form part of these accounts.

Statement of Financial Position as at 31 March 2015

	Notes	31 March 2015 £000	31 March 2014 £000
Non-current assets:			
Property, plant & equipment	5.3, 5.4	1,410	1,749
Intangible assets	5.1, 5.2	749	600
Total non-current assets		2,159	2,349
Current assets			
Trade and other receivables	6	12,345	10,855
Cash and cash equivalents	7	32,889	21,533
Total current assets		45,234	32,388
Total assets		47,393	34,737
Current liabilities			
Trade and other payables	8	(42,219)	(29,335)
Provisions for liabilities and charges – known claims	9.1, 9.2	(1,604,753)	(1,122,000)
Provisions for liabilities and charges – IBNR	9.1, 9.2	(18,000)	(143,000)
Total current liabilities		(1,664,972)	(1,294,335)
Non-current assets plus/less net current assets/liabilities		(1,617,579)	(1,259,598)
Non-current liabilities			
Provisions for liabilities and charges – known claims	9.1, 9.2	(10,865,017)	(9,408,097)
Provisions for liabilities and charges – IBNR	9.1, 9.2	(16,122,300)	(15,430,000)
Total non-current liabilities		(26,987,317)	(24,838,097)
Assets less liabilities		(28,604,896)	(26,097,695)
Taxpayers' equity			
General Fund		(6,115)	(1,587)
ELS Reserve		(616,683)	(579,639)
ExRHA Reserve		(37,362)	(35,889)
DH Clinical Reserve		(1,997,089)	(1,860,892)
DH Non Clinical Reserve		(113,256)	(193,130)
CNST Reserve		(25,632,615)	(23,177,157)
PES Reserve		847	1,258
LTPS Reserve		(202,623)	(250,659)
Total taxpayers' equity		(28,604,896)	(26,097,695)

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 financial statements on pages 87 to 119 were approved by the Board on 3rd July 2015 and signed by Helen Vernon.

The notes at pages 91 to 119 form part of these accounts.

Signed: 

Date: 3rd July 2015

Accounting Officer

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2015

	Notes	General Fund £000	ELS Reserve £000	ExRHAs Reserve £000	DH Clinical Reserve £000	DH Non Clinical Reserve £000	CNST Reserve £000	PES Reserve £000	LTPS Reserve £000	Total Reserves £000
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)
Changes in taxpayers' equity for 2014/15										
Net expenditure for the year	9.6	(6,212)	(61,740)	(2,523)	(233,744)	70,437	(2,455,458)	(411)	48,036	(2,641,615)
Total recognised income and expense for 2014/15		(6,212)	(61,740)	(2,523)	(233,744)	70,437	(2,455,458)	(411)	48,036	(2,641,615)
Net Parliamentary funding		1,684	24,696	1,050	97,547	9,437	0	0	0	134,414
Balance at 31 March 2015		(6,115)	(616,683)	(37,362)	(1,997,089)	(113,256)	(25,632,615)	847	(202,623)	(28,604,896)

* 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 91 to 119 form part of these accounts.

Statement of Cash Flows for the year ended 31 March 2015

	Notes	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Net expenditure		(2,641,615)	(3,374,304)
Net cash transferred under absorption accounting		0	99
Other cashflow adjustments	10	640	597
Movement in Working Capital	10	2,518,367	3,148,591
Net cash (outflow) from operating activities		(122,608)	(225,017)
Cash flows from investing activities			
Purchase of property, plant and equipment	5.3, 5.4	(54)	(294)
Purchase of intangible assets	5.1, 5.2	(396)	(220)
Net cash (outflow) from investing activities	3.2	(450)	(514)
Cash flows from financing activities			
Net Parliamentary funding		134,414	228,072
Net financing		134,414	228,072
Net increase in cash and cash equivalents		11,356	2,541
Cash and cash equivalents at the beginning of the period		21,533	18,992
Cash and cash equivalents at the end of the period	7	32,889	21,533

The notes at pages 91 to 119 form part of these accounts.

Notes to the Financial Statements

1. Accounting policies

The financial statements have been prepared in accordance with the 2014/15 Government Financial Reporting Manual (FRoM) issued by HM Treasury. The accounting policies contained in the FRoM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FRoM 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 Early adoption of standards, amendments and interpretations

The NHS Litigation Authority accounts 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 9 Financial Instruments: The effective date is for accounting periods beginning on, or after 1 January 2018. The timing for EU adoption is uncertain.
- IFRS 13 Fair Value Measurement: Effective date of 2013/14 under EU adoption, however adoption delayed by HM Treasury. To be adopted from 2015/16.
- IAS 19 (amendment) – employer contributions to defined benefit pension schemes: Effective from 2015/16 but not yet EU adopted.
- IAS 36 (amendment) – recoverable amount disclosures: To be adopted from 2015/16.
- IFRIC 21 Levies: EU adopted in June 2014 but not yet adopted by HM Treasury.

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.

1.3 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.

1.4 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.

1.5 Property, Plant and Equipment (PPE)

PPE are measured at cost including any costs such as installation directly attributable to bringing them into working condition.

i) Capitalisation

Property, plant 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

The NHS LA 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.

1.6 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 non current 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.

1.7 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.

1.8 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.

1.9 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).

1.10 Pension costs

The NHS LA offers two defined contribution pension schemes to staff, the NHS pension scheme and the National Employment Savings Trust (NEST).

1.11 NHS Pensions Scheme

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 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 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 2012.

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.

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.

1.12 Pension costs – NEST

The Pensions Act 2008 and 2011 Automatic Enrolment regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their retirement. For those staff not entitled to join the NHS Pension Scheme, the NHS LA utilised an alternative pension scheme called NEST to fulfill its Automatic Enrolment obligations.

NEST stands for National Employment Savings Trust and is a defined contribution pension scheme established by law to support the introduction of Auto Enrolment. Contributions are taken from qualifying earnings, which are currently from £5,772 up to £41,865, but will be reviewed every year by the government. The initial employee contribution is 1% of qualifying earnings, with an employer contribution of 1%. This will increase in stages to meet levels set by government.

Date	Employee Contributions	Employer Contributions	Total Contribution
1st April 2014	1%	1%	2%
1st October 2017	3%	2%	5%
1st October 2018	5%	3%	8%

Annual contribution to a NEST retirement fund is limited to £4,600 for the 2014/2015 tax year. This will be reviewed each year and is likely to increase. Pension members can make additional contributions to their pension fund at any time up to the annual limit. Pension members can choose to let NEST manage their retirement fund or take control themselves and alter contribution levels and switch between different funds. If pension members leave the NHS LA they can continue to pay into NEST.

NEST Pension members can take their money out of NEST at any time from age 55. If suffering from serious ill health or incapable of working due to illness members can request to take their money out of NEST early. They can take the entire retirement fund as cash, use it to buy a retirement income or a combination. Additionally members can transfer their NEST retirement fund to another scheme.

NEST is run by NEST Corporation, a trustee body which is a non-departmental public body operating at arm's length from government and is accountable to Parliament through the Department for Work and Pensions.

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 2014 as follows short **-1.50%** (-1.90% 13/14), medium **-1.05%** (-0.65% 13/14) and long-term 2.2% (2.2% 13/14).

The ELS, Ex-RHA and DHL schemes are funded by the Department of Health, CNST, LTPS and PES from member 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 3.2% and claims inflation (varying between schemes) of between 7% 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 the 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 NHS LA'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 the Government Actuaries Department (GAD). 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 and Pricing 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 membership of the Committee includes the Accounting Officer, as Chair, alongside key executive staff from within the NHS LA and also a representative non Executive Director.

1.17 IFRS 8 – Operating Segments

The NHS LA has one reportable segment under IFRS 8 but income and expenditure are disaggregated by different scheme types in Note 9.6.

2.1 Authority programme expenditure

	Notes	£000	2014/15 £000	2013/14 £000
Non-executive members' remuneration	2.2	94		67
Other salaries and wages	2.2	13,436		12,237
Redundancy costs	2.2	176		527
Supplies and services – general		2		5
Establishment expenses		937		892
Hire and operating lease rental				
Land & buildings		752		708
Lease cars		2		4
Photocopiers		21		19
Franking Machine		5		7
Vending Machine		1		4
Transport and moveable plant		1		2
Premises and fixed plant		2,075		2,239
External contractors				
Actuary's advice		897		926
Appeals Unit advisory expenditure		167		112
Consultancy		0		120
External Corporate Legal Fees ****		254		224
NCAS assessment expenditure		576		871
Risk management		55		520
Other ***		285		110
Auditor's remuneration: audit fees**		113		78
Internal audit fees		43		27
Bank Charges & Interest		2		(39)
			19,894	19,660
Depreciation	5.3, 5.4	393		371
Amortisation	5.1, 5.2	247		221
			640	
			20,534	20,252
Other finance costs – unwinding of discount	9.1, 9.2		28,919	(44,609)
Increase in provision for known claims (excl. unwinding of discounts and change in discount rate)	9.1, 9.2	3,118,079		2,252,590
Change in the discount rate *		15,695		(31,067)
Increase/(decrease) in the provision for IBNR *	9.1, 9.2	567,300		2,209,000
			3,701,074	
Loss on transfers by absorption			0	3,341
			3,750,527	4,409,507

* Included within the provision for IBNR is an increase £109m relating to the change in discount rate.

The total increase due to the change in discount rate for known claims and IBNR is £125m.

** 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.

Within the £20,534k administrative expenditure detailed on page 100 is £548k relating to Sign up to Safety which is a new national patient safety campaign that was announced in March by the Secretary of State for Health. It launched on 24 June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The NHS LA administers Sign up to Safety.

Of the £3,750,527k shown, £6,055k is shown as administration expenditure in the Department of Health consolidated group accounts.

2.2 Staff numbers and related costs



Salaries and wages	11,609	9,730	1,879	10,765
Social security costs	908	908	0	912
Employer contributions to NHS Pensions	1,188	1,188	0	1,154
NEST Pension Contributions	1	1	0	0

The average number of employees during the year was:

	2014/15 Total Number	Permanently employed staff Number	Other *	2013/14 Total Number
Total	230	201	29	218

Redundancy Costs

The cost to the NHS LA of redundancies in 2014/15 was £175,744 (2013/14: £527,079).

Expenditure on staff benefits

The amount spent on staff benefits during the year totalled £6,924 (2013/14: £12,186).

* 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 2014/15

Payment Bands	2014/15		2013/14	
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Total number of exit packages by cost band
< £10,000	0	0	0	0
£10,000 – £25,000	0	0	0	2
£25,000 – £50,000	0	0	0	0
£50,000 – £100,000	1	0	1	5
£100,000 – £150,000	1	0	1	1
£150,000 – £200,000	0	0	0	0
Total number of exit packages by type	2	0	2	8
Total cost (£'000s)	176		176	542

Redundancy and other departure costs are all approved by the NHS LA Remuneration and Terms of Service Committee. For payments over £100k additional approval is obtained from the Department of Health Governance and Assurance Committee.

2.4 Exit Packages – Other Departures Analysis

	2014/15		2013/14	
	Agreements Number	Total value of agreements £000	Agreements Number	Total value of agreements £000
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 *	0	0	1	11
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval *	0	0	0	4
Total	0	0	1	15

* There was one exit package agreed in 2013/14 totalling £15k and split between contractual payments (£11k) and non-contractual requiring Treasury Approval (£4k).

3.1 Reconciliation of net expenditure to revenue resource limit

	2014/15 £000
Net expenditure	2,641,615
Net Expenditure	2,641,615
Revenue resource limit	4,081,546
Under spend against revenue resource limit	1,439,931

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2014/15 £000
Gross capital expenditure	450
NBV of assets disposed	0
Net capital expenditure	450
Capital resource limit	450
Under spend against capital resource limit	0

4. Operating income

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

	2014/15 Appropriated in aid £000	2013/14 £000
Programme income:		
CNST contributions	1,047,978	977,200
PES contributions	5,101	5,441
LTPS contributions	54,534	51,344
NCAS	1,299	1,218
Total	1,108,912	1,035,203

5.1 Intangible assets

	Information Technology £000	Software Licences £000	Total £000
Gross cost at 1 April 2014	1,902	1,274	3,176
Additions – purchased	154	242	396
Reclassification	678	(678)	0
Gross cost at 31 March 2015	2,734	838	3,572
Accumulated amortisation at 1 April 2014	2,215	361	2,576
Charged during the year	180	67	247
Accumulated amortisation at 31 March 2015	2,395	428	2,823
Net Book Value at 1 April 2014	(313)	913	600
Net Book Value 31 March 2015	339	410	749

5.2 Intangible assets (Prior Year)

	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
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

5.3 Property, Plant and Equipment

	Information Technology £000	Furniture & fittings £000	Total £000
Valuation at 1 April 2014	1,722	1,674	3,396
Additions – purchased	54	0	54
Disposals	(61)	0	(61)
Valuation at 31 March 2015	1,715	1,674	3,389
Accumulated depreciation at 1 April 2014	1,083	564	1,647
Charged during the year	228	165	393
Disposals	(61)	0	(61)
Accumulated depreciation at 31 March 2015	1,250	729	1,979
Net Book Value at 1 April 2014	639	1,110	1,749
Net Book Value at 31 March 2015	465	945	1,410

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 2015 (2013/14: nil).

5.4 Property, Plant and Equipment (Prior Year)

	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 31 March 2014	639	1,110	1,749

6. Receivables

	Ex RHAS £000	ELS £000	DH Clinical £000	DH Non Clinical £000	CNST £000	PES £000	LTPS £000	Admin £000	Total 31 March 2015 £000	Total 31 March 2014 £000
NHS receivables – revenue	0	0	0	74	3,098	50	1,428	85	4,735	945
Accrued income	0	0	0	0	0	0	0	0	0	1,594
Prepayments	35	493	1,547	0	703	0	0	277	3,055	5,065
Other receivables	0	274	83	31	3,650	10	181	326	4,555	3,251
	35	767	1,630	105	7,451	60	1,609	688	12,345	10,855

Intra-government balances

Balances with other central government bodies	0	22	83	31	2,127	0	170	57	2,490	0
Balances with NHS Bodies	0	0	0	74	3,098	50	1,428	85	4,735	945
Subtotal of intra-government balances	0	22	83	105	5,225	50	1,598	142	7,225	945
Balances with bodies external to government	35	745	1,547	0	2,226	10	11	546	5,120	9,910
	35	767	1,630	105	7,451	60	1,609	688	12,345	10,855

7. Cash and cash equivalents

	Ex RHAS £000	ELS £000	DH Clinical £000	DH Non Clinical £000	CNST £000	PES £000	LTPS £000	Admin £000	Total 31 March 2015 £000	Total 31 March 2014 £000
At 1 April	13	3,544	0	0	55	6,043	10,888	990	21,533	18,992
Change during the year	(30)	(3,478)	0	0	(168)	2,628	12,103	301	11,356	2,541
At 31 March	(17)	66	0	0	(113)	8,671	22,991	1,291	32,889	21,533

Made up of

Cash with the Government Banking Service	(17)	66	0	0	(113)	8,671	22,991	1,291	32,889	21,533
Cash and cash equivalents as in statement of financial position	(17)	66	0	0	(113)	8,671	22,991	1,291	32,889	21,533
Cash and cash equivalents as in statement of cash flows	(17)	66	0	0	(113)	8,671	22,991	1,291	32,889	21,533

8. Trade payables and other current liabilities

	Ex RHAS £000	ELS £000	DH Clinical £000	DH Non Clinical £000	CNST £000	PES £000	LTPS £000	Admin £000	Total 31 March 2015 £000	Total 31 March 2014 £000
NHS payables revenue	0	0	0	0	1	204	354	93	652	202
Prepaid Income	0	2,373	0	0	3,981	0	0	331	6,685	2,683
Accruals	0	72	201	46	7,360	0	261	2,125	10,065	16,235
Other payables	0	190	2,112	260	20,813	0	1,442	0	24,817	10,215
	0	2,635	2,313	306	32,155	204	2,057	2,549	42,219	29,335
Intra-government balances										
Balances with other central government bodies	0	0	0	0	0	31	13	83	127	2,430
Balances with NHS Bodies	0	0	0	0	3,982	173	341	179	4,675	388
Subtotal of intra-government balances	0	0	0	0	3,982	204	354	262	4,802	2,818
Balances with bodies external to government	0	2,635	2,313	306	28,173	0	1,703	2,287	37,417	26,517
	0	2,635	2,313	306	32,155	204	2,057	2,549	42,219	29,335

9.1 Provisions for liabilities and charges

	Ex RHAS £000	ELS £000	DH Clinical £000	DH Non Clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Opening Provision for Known Claims	(31,219)	(472,739)	(1,336,589)	(29,846)	(8,537,661)	(5,712)	(116,331)	(10,530,097)
Opening Provisions for IBNR	(5,000)	(142,000)	(524,000)	(163,000)	(14,606,000)	(2,000)	(131,000)	(15,573,000)
Total Provisions as at 1 April 2014	(36,219)	(614,739)	(1,860,589)	(192,846)	(23,143,661)	(7,712)	(247,331)	(26,103,097)
Movement in known claims								
Discounting **	(18,033)	(154,385)	(153,317)	706	236,008	0	(585)	(89,606)
Arising during the year	4	(151,240)	(464,171)	(18,683)	(5,747,756)	(6,452)	(69,215)	(6,457,513)
Reversed unused **	18,821	261,220	550,112	8,374	2,549,054	1,026	40,433	3,429,040
Unwinding of discount	(1,698)	(16,475)	(44,395)	410	33,204	2	33	(28,919)
Change in Discount Rate *	(115)	(1,298)	(4,042)	11	(10,263)	0	12	(15,695)
Utilised during the year	1,048	26,638	97,547	9,437	1,044,354	2,837	41,159	1,223,020
	27	(35,540)	(18,266)	255	(1,895,399)	(2,587)	11,837	(1,939,673)
Movement in Net IBNR *	(1,500)	500	(117,600)	79,900	(554,800)	0	26,200	(567,300)
Closing Provision for Known Claims	(31,192)	(508,279)	(1,354,855)	(29,591)	(10,433,060)	(8,299)	(104,494)	(12,469,770)
Closing Provisions for IBNR	(6,500)	(141,500)	(641,600)	(83,100)	(15,160,800)	(2,000)	(104,800)	(16,140,300)
At 31 March 2015	(37,692)	(649,779)	(1,996,455)	(112,691)	(25,593,860)	(10,299)	(209,294)	(28,610,070)
Expected discounted timing of cash flows:								
Within 1 year	(1,000)	(38,000)	(103,000)	(16,000)	(1,408,443)	(4,994)	(51,316)	(1,622,753)
1-5 years	0	(101,773)	(223,000)	(33,970)	(7,993,000)	(5,305)	(95,516)	(8,452,564)
Over 5 years	(36,692)	(510,006)	(1,670,455)	(62,721)	(16,192,417)	0	(62,462)	(18,534,753)
	(37,692)	(649,779)	(1,996,455)	(112,691)	(25,593,860)	(10,299)	(209,294)	(28,610,070)

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 an increase of £109.2m relating to the change in discount rate. The total change in discount rate for known claims and IBNR is an increase of £125m.

** Due to a change in long term mortality assumptions and a slight decrease in payment inflation assumptions (affecting those claims where a life time of future care is provided) the gross value of long term provisions has reduced significantly in year however the net value charged to the accounts remains consistent with previous reporting periods due to an offsetting adjustment within the discounting charge.

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 £000	ELS £000	DH Clinical £000	DH Non Clinical £000	CNST £000	PES £000	LTPS £000	Total £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)

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 occurred on or before 31st March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to the Authority with effect from 1st April 1996. Claims against DH Liabilities relate to claims against dissolved 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 2015 and on or after 1 April 1995. Claims are included in the provision on the basis that the CNST members have assessed:

- the probable cost and time to settlement in accordance with scheme guidelines;
- that they are qualifying incidents; and
- 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 responsible 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 NHS LA in respect of all of its 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 LA as at 31 March 2015 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, the Government Actuaries Department (GAD) 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, the Government Actuaries Department (GAD), to provide estimates of some 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 a number of 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 fifty 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, a characteristic pattern of claims reporting from claim incident year is identified to determine the ultimate number of claims that are expected to arise from incidents that have occurred in each past year up to the accounting date. This allows a projection to be made for the number of IBNR claims expected to be reported in each future year.

Assumptions are then made about the average claim sizes for different types of claim. Adjustments are made to these assumed claim sizes to allow for expected future claim value inflation.

By combining the average claim sizes with the claim numbers and assumed reporting to payment delays appropriately, a projection is made for the total value of claim payments for IBNR claims in each future year. For 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.

For CNST, these calculations are carried out separately for damages, defence costs and claimant costs.

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, ELS and DH Clinical 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 Reserving and Pricing 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 a number of years to be reported following the incident that gives rise to the claim. The IBNR provisions depend 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, changes in the proportion of claims settling as PPOs and other factors.

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.

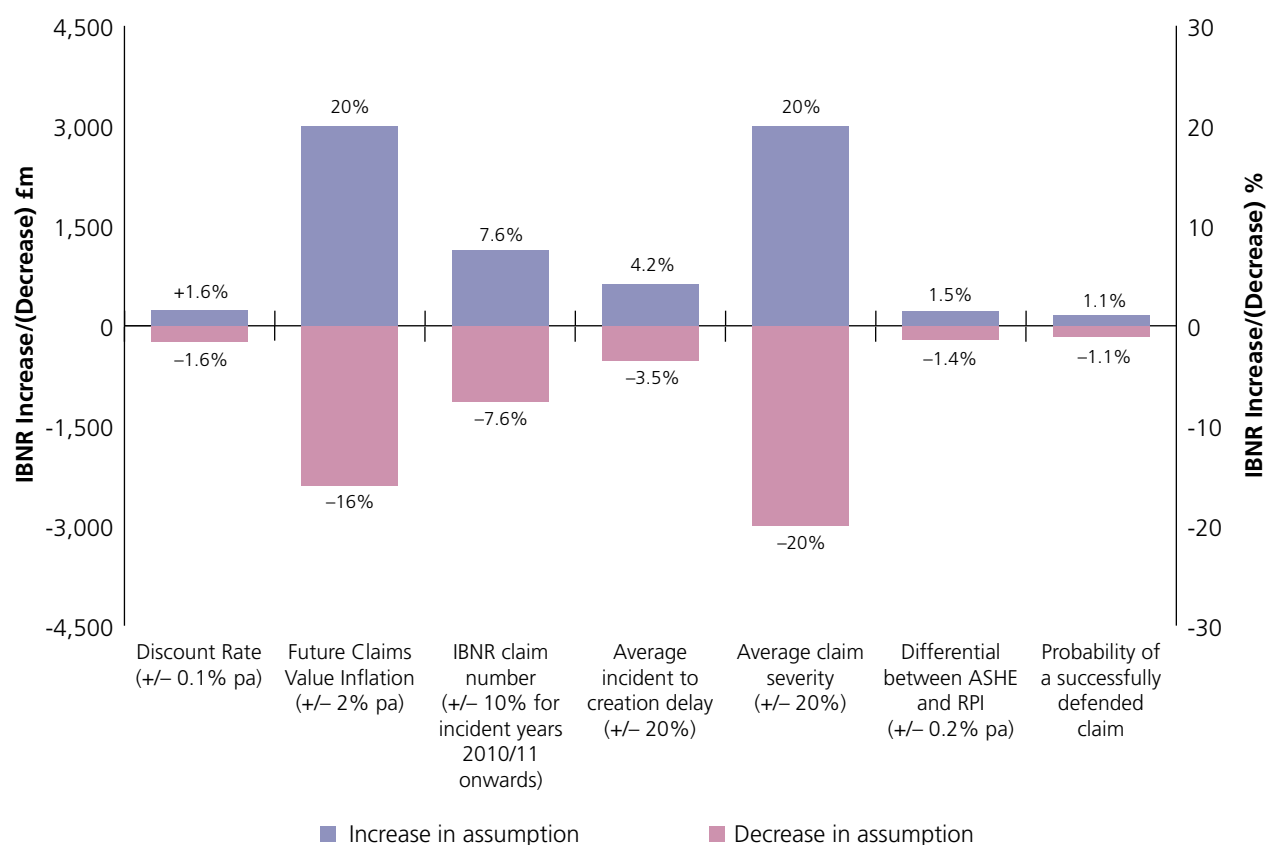
Trends in the NHS LA's historical claims experience have been distorted over time by changes in the external environment. For example, increased litigiousness, changes in the legal environment and changes in the process of reporting claims have all affected the historical pattern of claim reporting and 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 2015



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 2015 to movements in the tiered real discount rate

In 2014/15 HM Treasury changed the 'tiered' discount rate for general provisions, short -1.50% (13/14: -1.9%), medium -1.05% (13/14: -0.65%) and long-term 2.20% (13/14: 2.2%) as set out in HM Treasury's Public Expenditure System (2014) 09 paper published 1 December 2014. As can be seen in the SOCNE the impact of this adjustment was £125m.

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 and 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 reduce by £242m and likewise a reduction of 0.1% would increase the IBNR by £248m. 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	15,409	248	1.6%
Tiered real discount rate structure	15,161	0	0.0%
0.1% increase in the real discount rate	14,919	(242)	-1.6%

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% giving a £15,161m provision.

Sensitivity to future claims value inflation assumption

Claims value inflation	IBNR as at 31 March 2015 £m	% change to original estimate
7% pa	12,750	-16%
9% pa	15,161	0%
11% pa	18,122	20%

Sensitivity to assumptions of number of IBNR claims

IBNR claim number assumptions (including PPOs)	IBNR as at 31 March 2015 £m	% change to original estimate
No adjustment prior to 2010/11; 10 % decrease thereafter	14,010	-7.6%
Base Assumptions	15,161	0.0%
No adjustment prior to 2010/11; 10 % increase thereafter	16,312	7.6%

Sensitivity to incident to creation delay pattern

Average term based on assumed delay pattern	IBNR as at 31 March 2015 £m	% change to original estimate
Reduction in average delay of 20%	14,634	-3.5%
Base Assumptions	15,161	0%
Increase in average delay of 20%	15,794	4.2%

Sensitivity to average claim severity assumption

Factor applied to all average claim value assumptions	IBNR as at 31 March 2015 £m	% change to original estimate
Reduction in average claim values of 20% Base Assumptions	12,129	-20%
Base Assumptions	15,161	0%
Increase in average claim values of 20%	18,193	20%

Sensitivity to differential between ASHE and RPI

Differential between ASHE and RPI assumption	IBNR as at 31 March 2015 £m	% change to original estimate
-20% (ASHE less RPI assumption is equal to 0.8%) Base (ASHE less RPI assumption is equal to 1.0%)	14,945	-1.4%
Base (ASHE less RPI assumption is equal to 1.0%)	15,161	0.0%
20% (ASHE less RPI assumption is equal to 1.2%)	15,389	1.5%

Sensitivity of the IBNR provision for CNST (31/03/05) to the assumed probability of a successfully defended claim for incident years 2011/12 to 2014/15

Probability of a successfully defended claim	IBNR as at 31 March 2015 £m	% change to original estimate
-1% (39%) Base (40%)	15,333	1.1%
Base (40%)	15,161	0.0%
1% (41%)	14,989	-1.1%

9.5 Sensitivity of provision for settled PPOs to key assumptions

Discount Rate Assumptions

Discount Rate	Provision for settled PPOs at 31 March 2015						
	Total £m	CNST £m	ELS £m	DH Clin £m	Ex RHA £m	LTPS £m	DH Non Clinical £m
All Rates -1% pa	5,670	3,893	464	1,273	38	1	1
Base Assumption	4,648	3,176	378	1,061	31	1	1
All Rates 1% pa	3,902	2,657	315	902	26	1	1

Discount Rate	Percentage change to provision						
	Total £m	CNST £m	ELS £m	DH Clin £m	Ex RHA £m	LTPS £m	DH Non Clinical £m
All Rates -1% pa	22.0%	22.6%	22.8%	20.0%	21.7%	16.5%	12.6%
Base Assumption	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
All Rates 1% pa	-16.0%	-16.4%	-16.6%	-15.0%	-15.9%	-13.1%	-10.5%

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

Discount Rate	Provision for settled PPOs at 31 March 2015						
	Total £m	CNST £m	ELS £m	DH Clin £m	Ex RHA £m	LTPS £m	DH Non Clinical £m
0.80%	4,499	3,065	367	1,035	30	1	1
Base Assumption: 1% pa	4,648	3,176	378	1,061	31	1	1
1.2% pa	4,805	3,294	389	1,088	32	1	1

Discount Rate	Percentage change to provision						
	Total £m	CNST £m	ELS £m	DH Clin £m	Ex RHA £m	LTPS £m	DH Non Clinical £m
0.80%	-3.2%	-3.5%	-2.8%	-2.4%	-2.8%	-2.9%	0.0%
Base Assumption: 1% pa	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
1.2% pa	3.4%	3.7%	3.0%	2.6%	3.0%	3.1%	0.0%

Life expectancy assumptions

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

Discount Rate	Provision for settled PPOs at 31 March 2015						
	Total £m	CNST £m	ELS £m	DH Clin £m	Ex RHA £m	LTPS £m	DH Non Clinical £m
-20%	3,819	2,603	315	873	26	1	1
Base Assumption	4,648	3,176	378	1,061	31	1	1
20%	5,400	3,698	432	1,232	36	1	1

Discount Rate	Percentage change to provision						
	Total £m	CNST £m	ELS £m	DH Clin £m	Ex RHA £m	LTPS £m	DH Non Clinical £m
-20%	-17.8%	-18.1%	-16.6%	-17.7%	-17.0%	-18.1%	-17.3%
Base Assumption	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
20%	16.2%	16.4%	14.4%	16.1%	15.0%	18.2%	13.3%

9.6 Allocation of Income and Expenditure to the schemes

	Ex-RHAS £000	ELS £000	DH Clinical £000	DH Non Clinical £000	CNST £000	PES £000	LTPS £000	Equal Pay £000	FHSAU £000	NCAS £000	Sign up to Safety £000	Total 31 March 2015 £000	Total 31 March 2014 £000
Expenditure													
Authority and claims administration	2	62	331	281	8,883	88	3,376	131	1,103	5,729	548	20,534	20,252
Claims and associated costs													
Transfers under absorption accounting	0	0	0	0	0	0	0	0	0	0	0	0	3,341
Increase in provision for known claims	1,021	62,178	115,813	9,182	2,939,753	5,424	29,322	0	0	0	0	3,162,693	2,176,914
Increase/ (decrease) in provision IBNR	1,500	(500)	117,600	(79,900)	554,800	0	(26,200)	0	0	0	0	567,300	2,209,000
	2,523	61,740	233,744	(70,437)	3,503,436	5,512	6,498	131	1,103	5,729	548	3,750,527	4,409,507
Income													
Scheme income	0	0	0	0	(1,047,978)	(5,101)	(54,534)	0	0	(1,299)	0	(1,108,912)	(1,035,203)
Net expenditure – (surplus)/ deficit													
	2,523	61,740	233,744	(70,437)	2,455,458	411	(48,036)	131	1,103	4,430	548	2,641,615	3,374,304

9.7 Contingent liabilities

	Ex-RHAS £000	ELS £000	DH Clinical £000	DH Non Clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Contingent liability for claims 2014/15	2,624	129,410	496,935	54,075	13,306,385	4,127	133,073	14,126,629
Contingent liability for claims 2013/14	3,379	142,927	479,922	73,629	10,996,198	2,776	134,665	11,833,496

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.

10 Reconciliation of operating costs to operating cash flows

	Notes	2014/15 £000	2013/14 £000
Net expenditure		(2,641,615)	(3,374,304)
Adjustments for non-cash transactions			
Depreciation	5.3, 5.4	393	371
Amounts written back	5.1	0	5
Amortisation	5.1, 5.2	247	221
		640	597
Net cash transferred under absorption accounting			99
Adjustments for movements in working capital other than cash			
Movement to working capital on Transfer		0	(389)
(Increase)/decrease in receivables	6	(1,490)	(4,065)
Increase/(decrease) in payables	8	12,884	7,903
Increase/(decrease) in provisions	9.1, 9.2	2,506,973	3,145,142
		2,518,367	3,148,591
Net cash outflow from operating activities		(122,608)	(225,017)

11. Commitments under operating leases

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

	2014/15 £000	2013/14 £000
Land and buildings		
Amounts payable: within 1 year	682	551
between 1 and 5 years	1,896	1,764
after 5 years	414	828
	2,992	3,143
Other leases		
Amounts payable: within 1 year	24	19
between 1 and 5 years	39	50
after 5 years	0	0
	63	69

12. Losses and special payments

There were no losses or special payments (prior year: 0 case) approved during 2014/15.

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
Care Quality Commission
Health & Social Care Information Centre
Health Education England
Health Research Authority
NHS Blood and Transplant
NHS Business Services Authority
NHS England
NHS Property Services
NHS Trust Development Authority
Public Health England

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 expenditure 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 7th July 2015 by the Accounting Officer.

Glossary

ALB – Arm’s Length Body of the Department of Health.

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.

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 Services 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.

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 differs from 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.

LASPO – Legal Aid Sentencing and Punishment of Offenders Act. Legal reforms that came into force on 1 April 2013. The 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 the 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 implemented.

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.

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.

Sign up to Safety Improvement Plan – As part of its involvement in the Sign Up to Safety campaign, the NHS LA offered NHS Trusts a discretionary incentive payment of up to 10% of their contribution to the 2015/16 Clinical Negligence Scheme for Trusts (CNST) where they produced robust Safety Improvement Plans to demonstrate how their organisation would reduce its higher volume and/or higher value claims.

Welcome

Operations

Strategic and Director's Report

Report and Accounts

151 Buckingham Palace Road
London SW1W 9SZ
Telephone 020 7811 2700
Fax 020 7821 0029
DX 6611000
Victoria 91 SW

Area 1C, Skipton House
80 London Road
London SE1 6LH
Telephone 020 7972 2999
Fax 020 7972 2977

1 Trevelyan Square
Boar Lane
Leeds LS1 6AE
Telephone 0113 866 5500
Fax 020 7821 0029

www.nhsla.com

