THE NATIONAL HEALTH SERVICE LITIGATION AUTHORITY

Report and Accounts 2011-12

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Aims and objectives

The NHS Litigation Authority was created to deal with claims from patients who have been harmed while undergoing NHS treatment. It aims to pay justified claims promptly and fairly, and to defend unjustified claims robustly.

It also has a role in helping providers to learn lessons from claims, to better manage risks and improve patient and staff safety.

Other responsibilities include dealing with claims of harm to NHS staff and visitors, advising NHS colleagues on human rights, age discrimination and equal pay issues and supporting good practice and fairness in primary care.

Report from the Chair

Professor Dame Joan Higgins Chair

It has been another year of significant change for the NHS Litigation Authority. The volume of new work has continued to grow for all of our services and we have been successful in closing more claims and handling more primary care appeals than ever before. We have also provided better risk assessments and Risk Management Reports to our members, to help them to improve patient safety and to avoid future adverse incidents and costly claims. These are impressive achievements by my colleagues, at a time when our own administrative costs have actually fallen. During the year we have also received the findings of the Industry Review, carried out by Marsh, into our role and remit. The Report was largely positive and it has given us a strong basis on which to proceed with our plans for further significant improvements in the services that we provide to the NHS.

The NHS LA plays a unique role in the NHS. It is a centre of expertise and excellence, particularly in handling complex clinical negligence claims. The pooling of risk helps to protect individual Trusts from the disruption caused by short-term volatility in costs. The fast and effective resolution of claims is balanced by our obligation both to defend unjustified claims robustly and to treat NHS patients and staff fairly. The sharing of learning from the many thousands of claims we handle every year, helps to improve risk management and the quality of patient care. The provision of these services over the sixteen years of our existence has led to an accumulation of incomparable knowledge and expertise, which is reflected in the pages which follow.

The NHS Litigation Authority will continue to provide the NHS with improved financial stability in an increasingly volatile environment and will be responsive to NHS providers, leading appropriate change when it serves the interest of our members.

On behalf of the Board, I take this opportunity to thank all our colleagues for their dedication, innovation and plain hard work over the last year. It has again helped to make the NHS safer

for patients and staff. I would like to pay a particular tribute to Steve Walker, who was the Chief Executive of the NHS LA for its first sixteen years. He created an organisation which has managed difficult negligence claims safely and reliably, on behalf of the NHS and in the interests of its patients and staff.

Chief Executive's Report

Catherine Dixon Chief Executive

As the newly appointed Chief Executive, I have been immediately impressed by the quality and sheer volume of work that is being done by the NHS LA to support the NHS, its patients and its staff. This is a sound foundation on which to build, so I will focus my comments on our immediate plans for further improving our services.

The first thing that strikes me about the NHS LA is the astonishing repository of expertise and experience of dealing with NHS claims. This provides a unique opportunity not only to handle claims quickly and appropriately, but also to learn lessons about patient and staff safety and to feed them back to our Trust colleagues in a helpful way. Although there are clear financial benefits from the NHS LA resolving claims in a timely way, the greatest benefits to Trusts are delivered in the longer term through smoothing the annual impact of claims costs and avoiding the repetition of previous adverse incidents. There is also a huge benefit in being an NHS body ourselves, and therefore not-for-profit, because it allows us to provide Trusts with the confidence of full cover against all clinical claims plus long-term financial security, guaranteed by the State.

It was re-assuring to have received such a positive report from Marsh, following their detailed review of our services, and this now enables us to progress a number of planned improvements to the way in which we provide services to our members. There is a clear recognition of the value for money that the NHS LA provides in handling claims and providing financial security for the NHS. We are, however, looking again at the methodology used to arrive at each member's contribution, to ensure that it is fair and transparent and takes full account of the Trust's claims history.

The NHS LA is a trusted and expert partner for Trusts and by gaining a better understanding of their needs and issues in managing risks, we can build a more integrated approach which enables us to be more effective in feeding back the learning from claims and helping to ensure better outcomes for patients and staff. We will be looking closely at our risk

management standards, using feedback from the Trusts and the wealth of information collected during our handling of claims, to ensure that we measure performance in terms of improved outcomes and the prevention of claims. Having listened and identified what we should be measuring, we will also review how we measure, and do everything possible to avoid duplication of effort by Trusts and any unnecessary bureaucracy. We will look again at the incentives available for those Trusts who are implementing the standards effectively.

The NHS LA is already established as a trusted expert and now needs to work closely with Trusts to integrate work on managing claims and risks, so that the feedback of learning delivers continuous improvements in the prevention of incidents. We are grasping this unique opportunity to be pro-active in driving better outcomes for the NHS, its patients and its staff.

Schemes operated

Clinical Negligence Scheme for Trusts (CNST)

A voluntary membership scheme to which all NHS Trusts, Foundation Trusts and Primary Care Trusts (PCTs) in England currently belong. It covers all clinical claims where the 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)

Is centrally funded by the Department of Health and covers clinical claims against NHS organisations where the incident took place before 1 April 1995.

Ex-RHA Scheme (Ex-RHAS)

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.

Director of Finance's Report

Tom Fothergill Director of Finance

The financial year 2011-'12 has seen further increases in claims activity at every level of the NHS LA's work. We were able to close more claims than ever before, but the combined effect of sharply increased claims in recent years and a continuation of the growth in new claims received this year, still resulted in there being more than 5% more claims open at the end of the year.

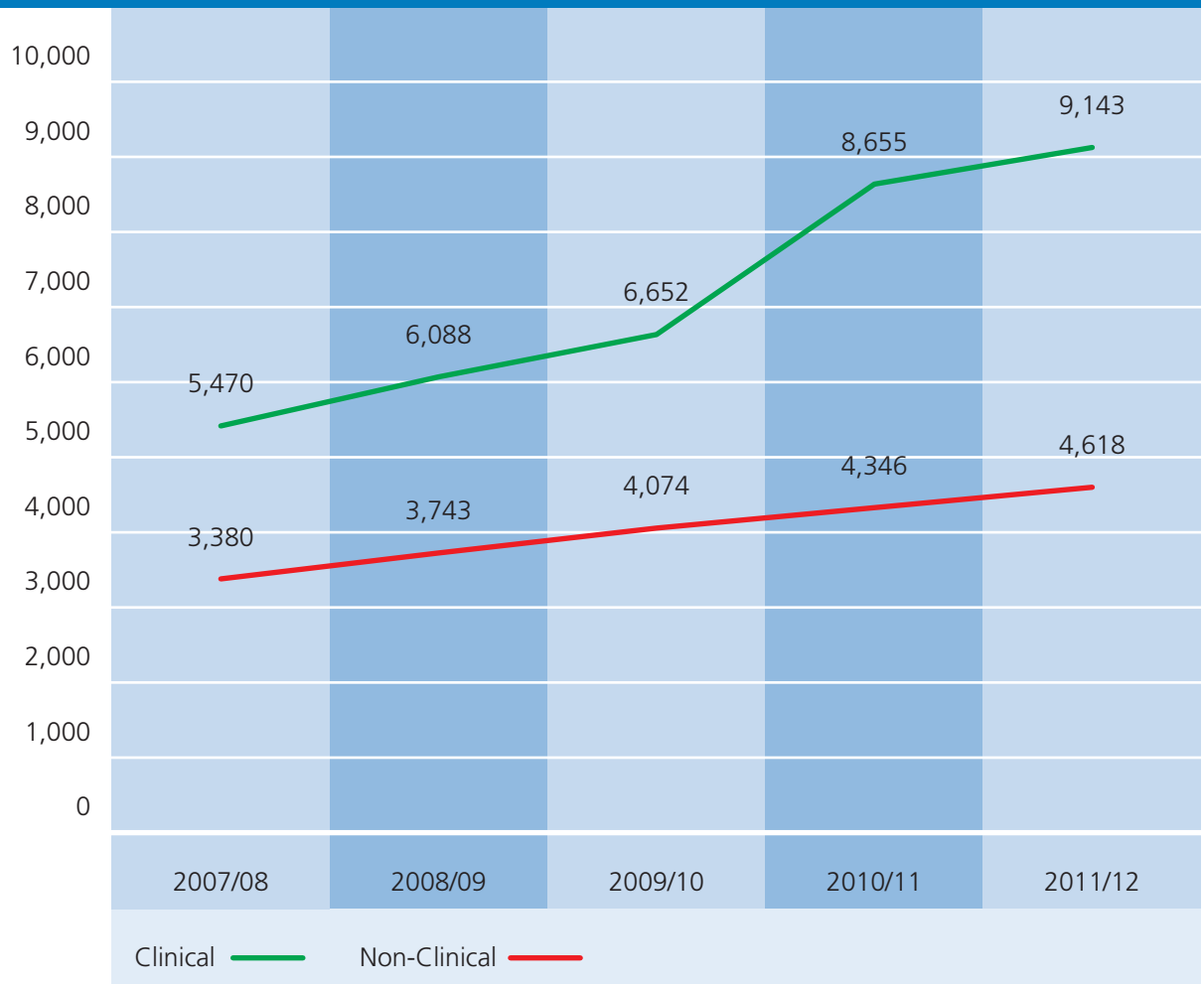
The costs within the NHS LA have been well controlled. Our administration costs fell by 8% and legal fees by more than 10% (for clinical claims in which damages were paid) reflecting improved operational efficiency and faster resolution of claims. In fulfilling our obligation to defend unjustified actions, well over a third of all clinical negligence claims resolved in the year were closed without damages being paid. However, another consequence of claims growth is that all of our long-term provisions (for claims not yet reported and for known claims, including Periodical Payment Orders) have also had to be increased significantly. Whenever provisions are referred to in the Report and Accounts, this is an indication that these liabilities have been identified but not that cash has been set aside in the accounts of the NHS to cover them. It is important for the NHS to be confident that the long tail of payments arising from the high claims in recent years has been recognised and to be secure in the knowledge that they can and will be paid at the appropriate time.

We will work even more closely with our partners across the NHS to ensure that their contribution fee is fair and transparent. We'll also work together to try to stem the rising tide of claims, by encouraging and supporting excellent risk management, and to control legal costs by closing claims in a fair and timely way.

New Claims Received

The number of new claims received in the year rose by 6%, a significant increase but a substantially lower one than in 2010-'11 and lower than each of the previous three years. As the graph below indicates, clinical and non-clinical claims grew at a similar rate (5.6% and 6.3% respectively) after the sudden sharp rise of over 30% in clinical claims in the year before. Part of the growth in claims volumes in recent years is attributable to the earlier reporting of claims and incidents by Trusts, enabling us to close many claims more quickly and to hold down the legal costs as a consequence. Close working relationships with claims, legal and risk managers in Trusts can also help enormously in expediting the resolution of claims and ultimately in preventing future claims.

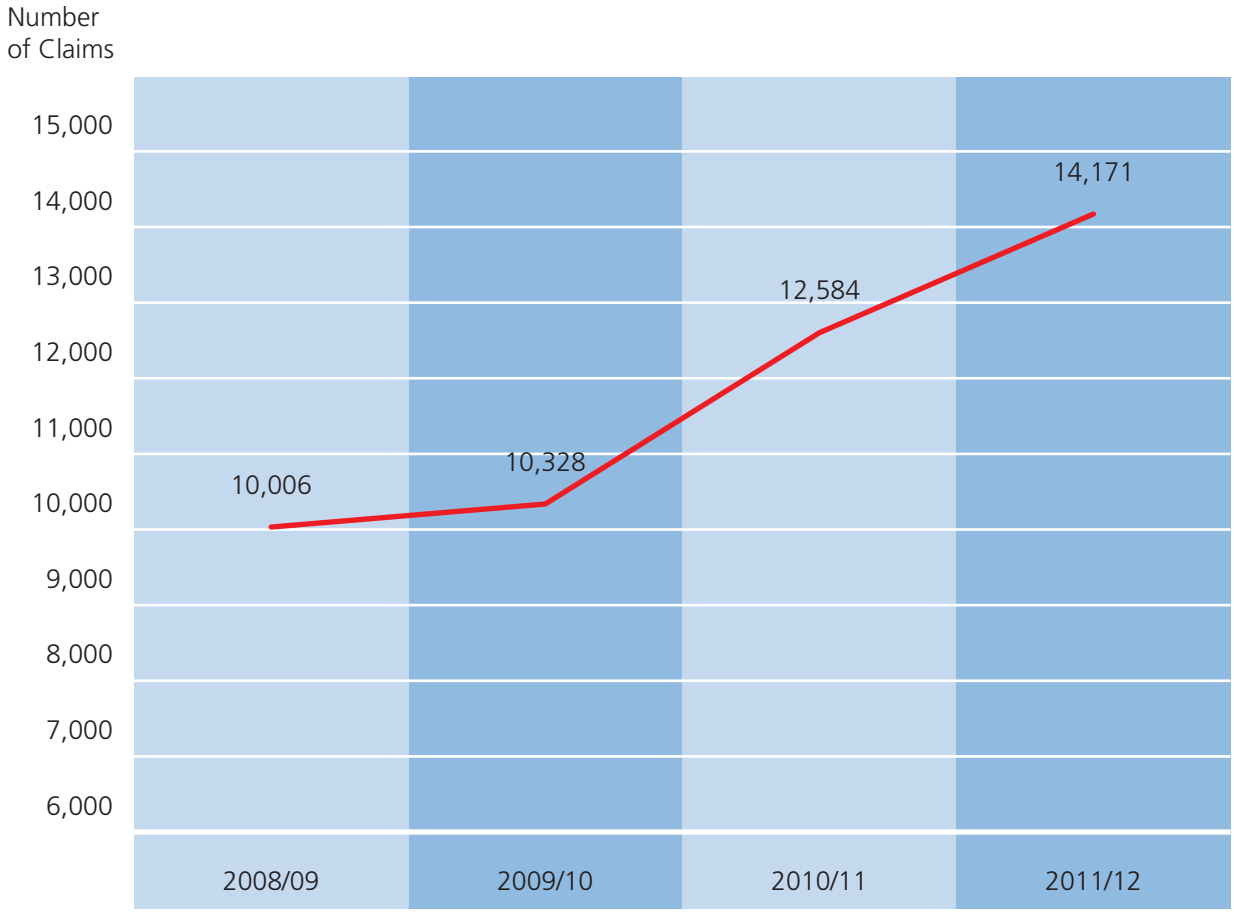
New Claims Reported (All Trusts)



Claims Closed

In the past year we were successful in closing more claims than ever before. A total of 14,171 were closed (of which 61% were clinical claims) and this total is more than 40% higher than three years ago. This was partly possible as a result of extra funding from the Department of Health, allowing us to progress the unprecedented volume of claims with appropriate urgency.

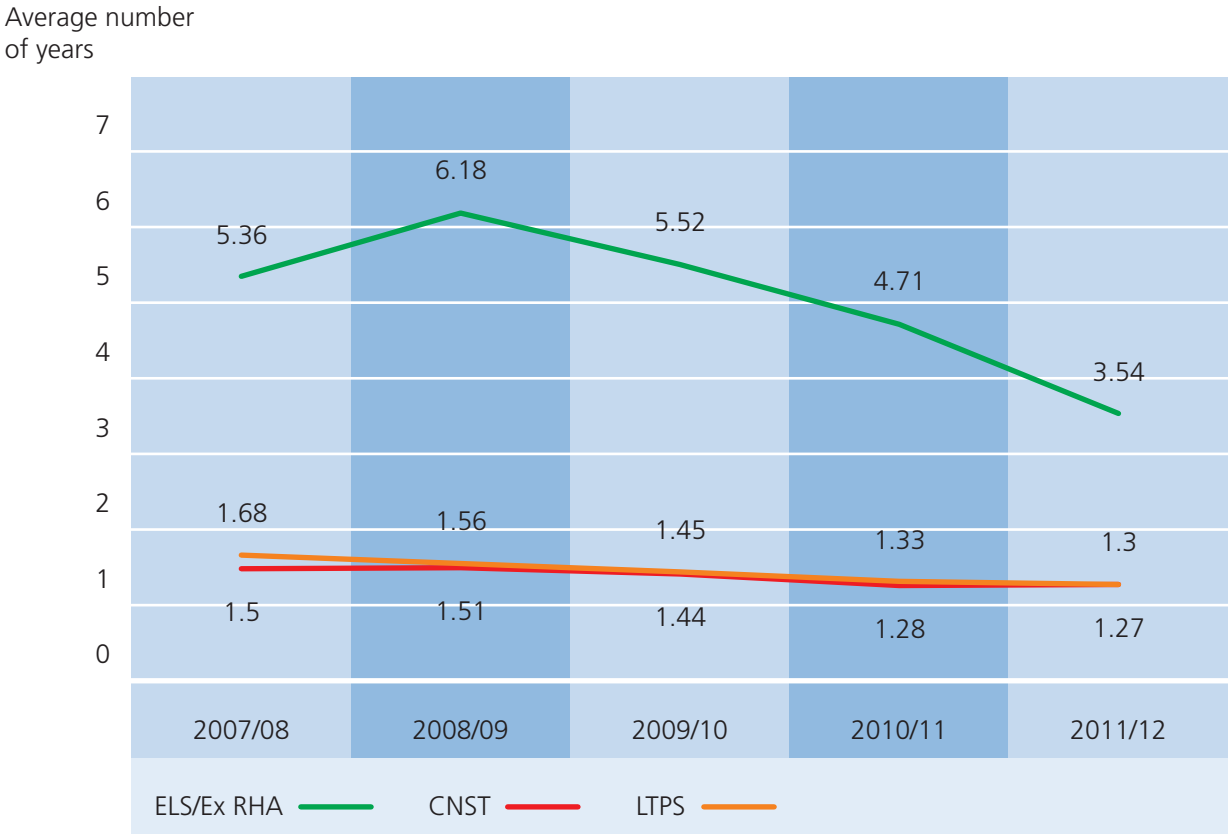
Claims Closed by Year



We have also reduced the average time that elapses between a claim being recorded and being closed, as shown on the graph below. The time taken to resolve claims from the Existing Liabilities Scheme and the Ex-RHA Scheme is, by definition, longer (because they are dealing with historical liabilities) but the main clinical and non-clinical schemes are both now averaging a total claim duration of less than 16 months.

These data are testament to the skills and sheer hard work of our claims handlers, working in close partnership with our scheme members. They are able to resolve claims effectively and efficiently partly because they take responsibility for each claim early in the process. New claims, or sometimes incidents which are very likely to become claims, are taken on as soon as they are reported (and often well before formal proceedings are issued) at no extra charge to the Trust.

Average duration of claims

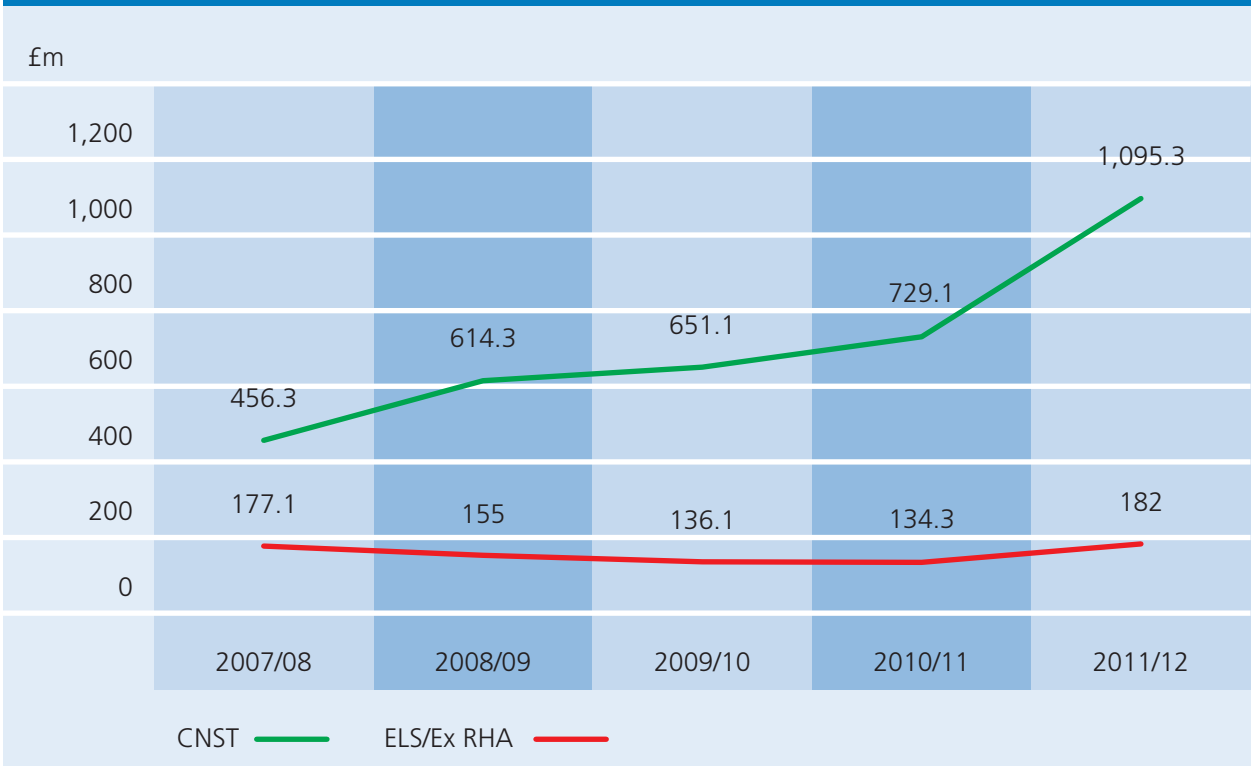


Payments Made

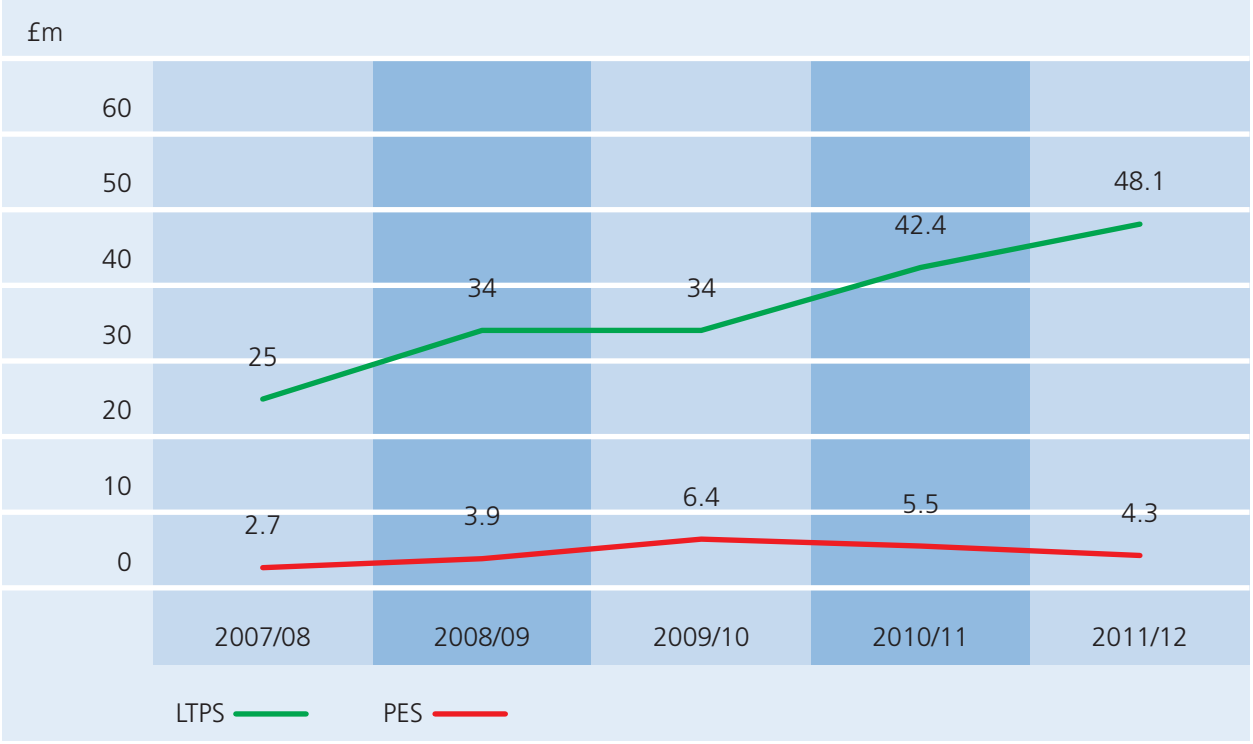
Payments on claims have gone up substantially, as a reflection of the fast growth of new claims in recent years. The value last year rose by 45.9%, driven almost entirely by a 50.2% rise in the spend on CNST claims. These payments include the legal costs of the claimant and defence (when payable by the NHS LA) and the value of any damages paid to claimants, who may be NHS patients, staff or visitors. However, well over one third of resolved claims did not require any damages to be paid to the claimant.

It is important to note that payments made do not merely relate to new claims reported in the financial year, as most will involve claims which were originally received in a prior year.

Expenditure on Clinical Claims



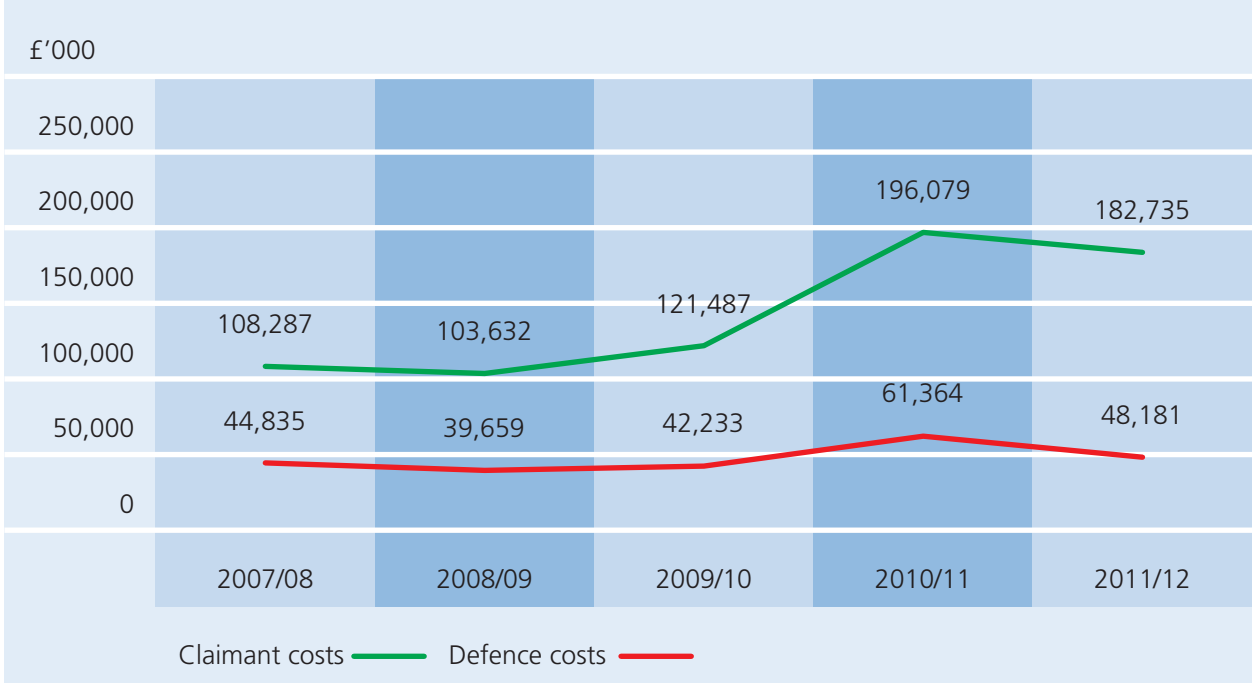
Expenditure on Non Clinical Claims



Legal Costs

The timely resolution of claims and the defence of unjustified actions have both helped to hold down the level of payments. This is particularly valuable because of the much higher costs paid to claimants' lawyers than to our own panel defence solicitors in clinical cases where damages are paid out, as shown below.

Legal Costs of Clinical Claims with Damages Paid



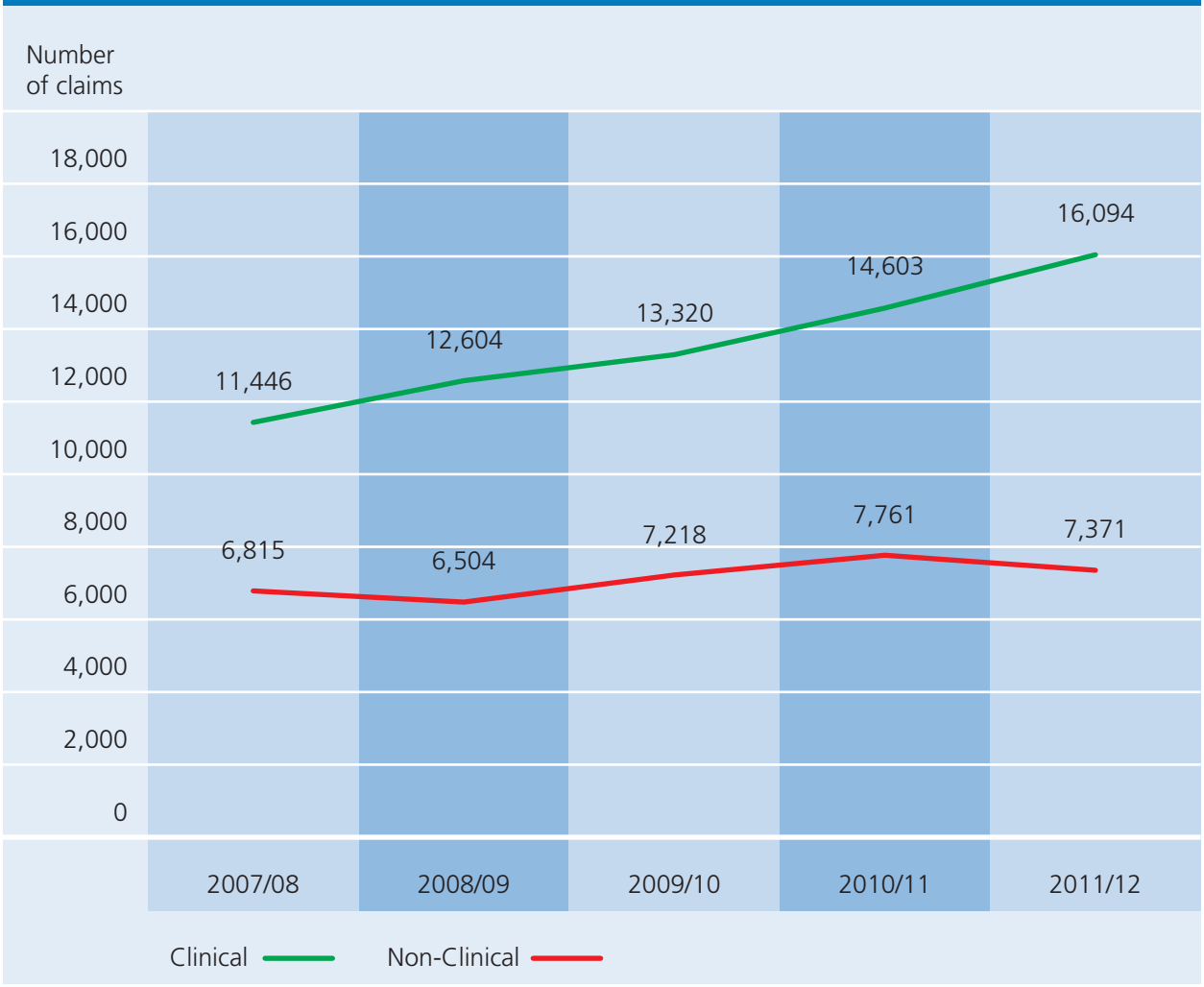
The proportion of the total legal costs accounted for by claimants' lawyers rose to almost 80%, in these cases, which remains a matter of real concern. The use of Conditional Fee Agreements in clinical negligence actions almost always results in legal costs which are much higher relative to the value of the damages paid. This is especially the case for lower value claims.

It is therefore of particular note that total legal costs for clinical claims closed in the year were just over 10% lower than in the previous financial year.

Claims Open at the Year-end

The large number of claims closed during the year has slowed the rate of increase in claims still outstanding, but this figure still rose by nearly 5% to a new high of 23,465. More than two-thirds of these continuing claims are for clinical negligence, which generally have a much higher value.

Number of claims open at year-end



Periodical Payment Orders and Other Provisions

Many claimants, especially in maternity incidents, are best served by receiving their damages payments over the period of their life, usually in annual amounts to pay for their continuing needs. We encourage these Periodical Payment Orders for most high value, personal injury claims which are likely to extend over a long period, because they represent the fairest method of payment both for the recipient and for the NHS. The financial provision necessary to cover these large liabilities has been identified by the NHS LA and had increased by more than 26% at the year-end to £3,040 m. across 1,116 Orders (up by 20%).

We have also identified two other large liabilities because Trusts contribute to the costs of claims based on the total payments that we make, rather than on the claims reported. One is the financial liability for known claims, which have not yet been resolved, and the other the liability for claims which have been Incurred But Not Reported (IBNRs). The total value of all these liabilities at the end of the financial year was £18,867m. (an increase of 12% on the previous year) and we are committed to meeting these liabilities, which are recognised in the Whole of Government Accounts.

Important cases for the NHS in 2011-'12

The NHS LA's particular expertise in handling claims enables us both to identify those which may be the precursor of a number of other, related claims and those which are likely to set a legal precedent. Below are examples of cases which are of particular significance to the NHS. Indeed, the first case cited below is an example of a claim in which the cost in damages was small but the importance of clarifying the position of the NHS was far greater.

John Mead Technical Claims Director

RABONE v PENNINE CARE NHS TRUST

This case featured in our last two Annual Reports and reappears now because of a ruling by the Supreme Court on 8th February 2012.

Melanie Rabone was an informal adult psychiatric patient who, whilst on home leave, committed suicide by hanging herself from a tree in a public park. The Trust accepted that it had been negligent to grant home leave and accordingly the claim of the estate was settled. A letter of apology was sent to the parents.

Mr. and Mrs. Rabone suffered no financial loss because of their daughter's death but nevertheless pursued a claim in their own right as victims under Article 2 of the European Convention on Human Rights (the right to life). That claim was rejected both by the trial judge and by the Court of Appeal.

However, the Supreme Court took a different view and held that the Trust owed an operational duty to voluntary patients such as Melanie to take reasonable care to protect them from the real and immediate risk of suicide. Settlement of the estate's claim did not preclude a "right to life" claim (under Article 2) by the parents, for non-pecuniary loss. Since

Melanie had been over 18 at the time of her death, Mr. and Mrs. Rabone were not entitled to receive Bereavement Damages under the Fatal Accidents Acts.

The court considered that in these circumstances, the European Court of Human Rights would have held that there had been no adequate redress. Consequently, Mr. and Mrs. Rabone were awarded damages of £5,000 each.

This is a significant ruling for the NHS because it makes clear that, in the context of "right to life" claims, the duties owed by NHS Trusts to sectioned and voluntary patients are similar. In other words, there is an obligation to take reasonable steps to protect them from the real and immediate risk of suicide if the Trust knew of that risk or ought reasonably to have done so.

Although this claim was of low financial value, we considered that it was essential to support the Trust to the highest court in the country to obtain a definitive ruling on this issue, which affects all Trusts caring for psychiatric patients. The question of real and immediate risk of suicide will now need to form part of any risk assessment performed by psychiatrists. This may lead to the development of more defensive practices than existed before the Supreme Court's ruling.

GRACE MUGWENI v NHS LONDON

The Court of Appeal handed down judgment in this case on 26th January 2012. The claim involved events occurring almost thirty years previously, on 9th August 1983, when Grace was four months old and underwent cardiac surgery at Guy's Hospital.

Both the surgeon and anaesthetist involved had died in the interim. Only a few records survived, including the anaesthetist's note of the operation. Consequently the experts instructed by both sides had to try and reconstruct what might have happened on the day. These difficulties were compounded by the fact that Grace had suffered a very rare occurrence, namely a tension pneumothorax (air collection in the pleural cavity) at some stage during the operation.

The claimant's case was, in essence, that those performing the operation should have identified earlier than they did that Grace was experiencing a cardiac arrest, and that had they acted competently, serious brain damage would not have occurred. The trial judge had held that there had been a delay of two to three minutes in detecting symptoms leading to the arrest but that this made no difference to the final outcome. The Court of Appeal agreed and dismissed the claim.

This case illustrates the huge difficulties for both sides when allegations are made about an event so long ago. However, the onus of proof was upon the claimant and we took the view that, although various distinguished experts had been instructed on behalf of the claimant, the case against the surgical team had not been made out, because it would have entailed numerous clinicians, including the perfusionist, omitting to observe over quite a lengthy period that the patient was deteriorating. Whilst we had every sympathy in respect of the devastating injuries suffered by Grace, those injuries were not caused by the NHS.

SIMPSON v NORFOLK AND NORWICH UNIVERSITY HOSPITAL NHS FT

Mrs. Simpson was the widow of a patient who had contracted MRSA at the hospital, but subsequently died of cancer. She campaigned against the Trust's infection control policy.

This claim, however, related to a Mr. Catchpole who also developed MRSA at the hospital. He issued proceedings, but then entered into a legal agreement with Mrs. Simpson under which she took over his rights to claim and did so herself.

We applied to have the claim struck out, and on 12th October 2011 the Court of Appeal declared the legal agreement seeking to allow Mrs. Simpson to claim on Mr. Catchpole's behalf to be void, because Mrs. Simpson did not have sufficient personal interest in the claim to be allowed to pursue it.

We were pleased to support the Trust in having this arrangement struck out. Had Mrs. Simpson been allowed to pursue the claim, the way would have been open to other campaigners to seek to assume conduct of claims, which would in turn almost certainly have led to an increase in litigation against the NHS.

EQUAL PAY – EMMANUEL v CITY AND HACKNEY PCT

This was a national test case involving the period prior to Agenda for Change when different negotiating bodies (such as the Whitley Councils), outside the control of individual Trusts, set pay and conditions for NHS workers.

In July 2011 the Newcastle Employment Tribunal delivered a detailed ruling amounting to 730 paragraphs. It held that whilst the Trust had not demonstrated that the arrangements of the specific negotiating bodies representing the claimant and her comparator were non-discriminatory, the PCT had objectively justified its market forces defence in respect of basic pay.

This was a very important ruling for the NHS because it affected hundreds of similar claims against other Trusts across the country. In co-ordinating equal pay claims for the NHS, the NHS LA was able to identify an appropriate test case and to take it to a full hearing, using evidence from individuals who had participated in national negotiations ten years ago.

Case History

When concerns over the practice of a single consultant quickly precipitated more than 200 claims, it was in the best interests of the NHS and the patients involved to find an alternative to standard methods of resolution. The NHS LA is already a leader in developing innovative methods of Alternative Dispute Resolution (and has been for some years) and this case called for a particularly well crafted alternative. The objectives of the process remained the same; fair and timely resolution for the claimant, at the lowest achievable cost to the NHS. The means devised to achieve them was, at the time, innovative.

The key outcome of the protocol was the removal of unnecessary cost from the process, without compromising its integrity. The claimants received a fair and more timely resolution without having to pay for insurance against the cost of losing. Their solicitors were paid regularly and fairly, without success fees or having to accept the risk of non-payment if a claim failed. The NHS LA was able to reduce the total cost to the NHS substantially, by accepting expert advice that many of the claims were justified.

This particular solution is not presented as a universal panacea for cases of multiple claims involving a single issue or closely related issues. However, by consolidating thousands of claims across hundreds of Trusts, the NHS LA is able to identify and manage many groups of related claims in ways which are beneficial both to patients and to the NHS and save millions of pounds for the Service. Currently, we are managing more than 30 such groups.

Risk management

A key role of the NHS LA is to work with NHS partners to improve the safety of NHS patients and staff. We are uniquely able to do this because of the thousands of NHS claims that we handle each year and the knowledge that we gain from doing so. We can therefore distil the learning from the original causes of adverse incidents. This learning is fed back to Trusts through the regular updating of our risk management standards and of the way in which we assess against them. We also highlight learning from particular claims and trends, both to the Trust concerned and more broadly to other Trusts. However, there are opportunities for us to do more to ensure that lessons are learned and we will be working hard to improve the way in which we share this key learning with our members.

Alison Bartholomew Risk Management Director

This work has undoubtedly raised the awareness and active management of clinical and non-clinical risk in the NHS. However, the reporting of many thousands of new claims each year and the hundreds of thousands of adverse incidents that still occur annually are vivid evidence that there is still much to do. We are also acutely aware of the need to anticipate any effects of structural changes in the NHS and in the provision of care on the way that risk is managed, in order to ensure that the focus on reducing risk and poor practice continues to increase.

We will use feedback from Trusts and the learning from handling claims to ensure that we contribute more effectively to preventing claims and improving patient outcomes. We'll agree with Trusts the risk management standards against which they should be measured, how best to measure them and how to avoid unnecessary overlaps with other work and bureaucracy.

Standards

In a year of structural changes throughout the NHS, it has been necessary to review how our services might need to adapt for Trusts which had merged or changed their service provision. We communicated regularly throughout the year with each Trust which had been

newly established or was undergoing significant change, as a result of the Transforming Community Services programme or other organisational change. We were able to work in partnership to ensure that each Trust was allocated the appropriate assessment level, after re-structure, and to agree suitable arrangements for their subsequent assessment.

Case Study

The Oxford University Hospitals NHS Trust had, for a number of years, achieved only Level 1 accreditation. They have now created a new focus on achieving Level 2 for both the acute and maternity standards.

A representative from the Trust describes how the standards have helped them:

"The NHS LA standards form an integral part of our framework to drive measurable improvements in known clinical and non-clinical areas. Key to our project is raising awareness with staff that these are a real set of safety standards which, if implemented at all 3 levels, can lead to improved patient and staff safety, and better clinical outcomes. In turn, it is important to emphasise to clinicians that the standards are based on actual claims and the issues identified from adverse incidents across the NHS. This helps us to engage clinicians in using standards which have a direct impact on improving safety. As Trusts can secure significant discounts to scheme contributions by achieving higher levels of assessment, the standards also become a high priority for our clinical governance programme. Overall both clinical and financial benefits demonstrate that these standards can make a real difference.

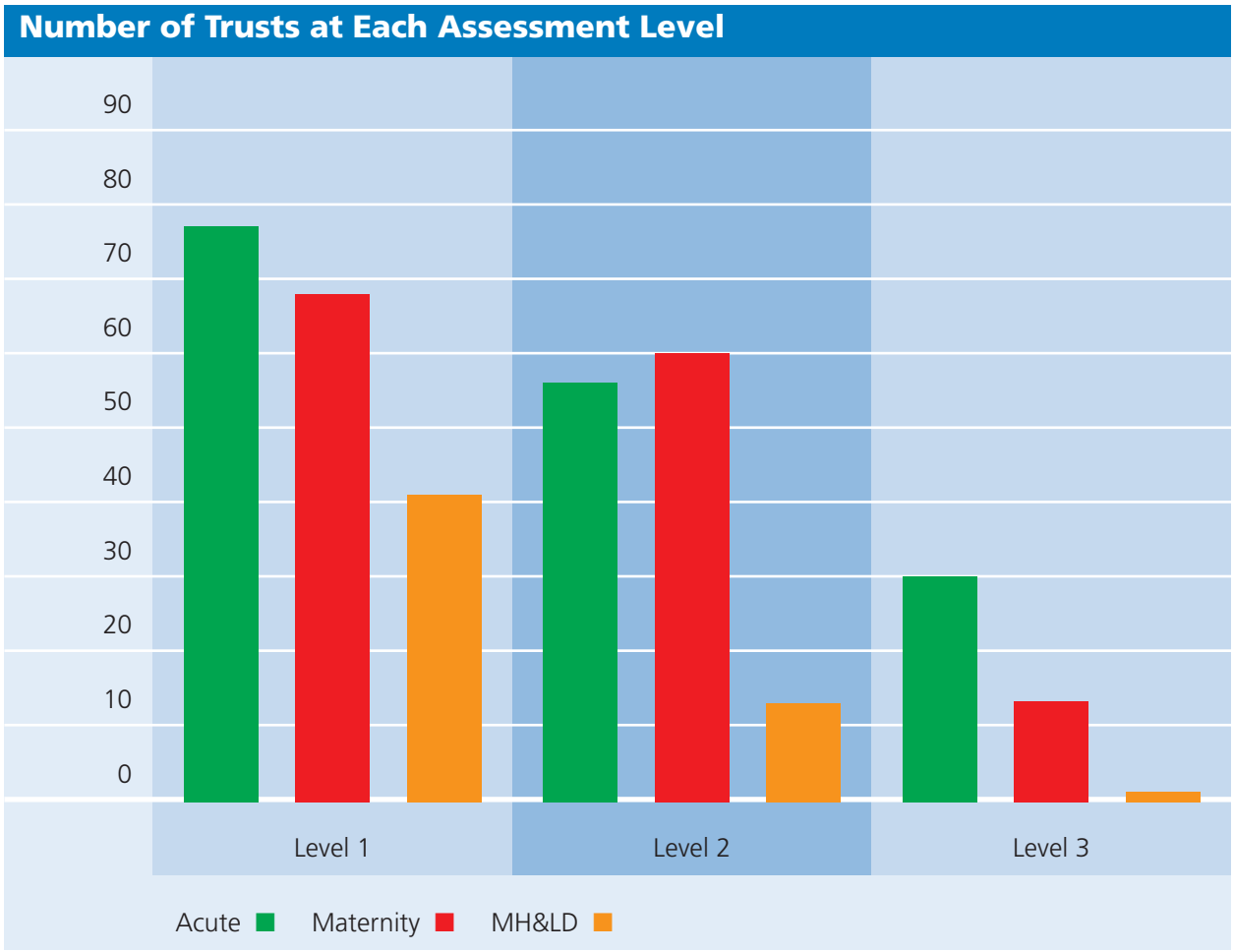
The "Policy; Practice; Performance" approach used by the standards is effective as a way of approaching safety standards and building a safety culture. The development of policy allows the Trust to define aspects of the organisation's standards of care, approach and design in safety measures. Implementation of policy leads to real change in practice and improvements in the delivery of care at floor level. The third stage, performance monitoring, factors in systematic review or audit of practice, to ensure that the Trust is meeting the standards set in the policy and informs of any problems in achieving the policy aims or practical issues.

Through this approach, a virtuous circle of improvement can be implemented."

Assessments

A similar number of Trusts were assessed as in the previous year. The graph below indicates that 54% (2010-'11 56%) of Trusts finished the year at Level 1; 33 % (2010-'11 35%) at Level 2; and 11% (2010-'11 9%) at Level 3. A further 11 (2%) Trusts had no accreditation, in most cases because they were yet to be assessed.

Any Trust can also request one informal visit per year by their assessor and last year 92% (2010-'11 89%) took us up on this offer.



In order to keep the standards relevant and robust, they are regularly updated in the light of learning from claims. Changes are proposed and fully discussed in the meetings of our Risk Management Forums, on which Trusts of all types are represented. This means that learning is gained from frontline experience and existing good practice, as well as from previous adverse incidents which have led to claims. The separate Forums for acute and partnership Trusts will now be amalgamated, so that the different types of patient services can work together in comparing practice and learning from each other.

Case Study

Derby Hospitals NHS Foundation Trust has taken the management of patient and staff safety extremely seriously and at the end of 2010 they achieved Level 3 accreditation against the NHS LA's acute standards, as evidence of this. The implementation of their risk processes is regularly monitored and nine risk management reports on claims from the NHS LA have been provided in the last year, enabling further learning. Indeed, after a sharp rise three years ago, their volume of clinical claims has now declined in each of the last two years, in stark contrast to the national trend.

A representative of the Trust commented:

"We achieved Level 3 NHS LA compliance in 2010. We found the discipline of monitoring the standards set within our own policies invaluable, not only in meeting NHS LA requirements but in ensuring compliance with aspects not covered by the NHS LA.

As we progressed to Level 3 we found the advice and support from our assessor in ensuring we were on the right track essential. Feedback on queries was always timely and pragmatic.

Eighteen months later such monitoring reports are business as usual in our Organisation and enable us to continually assure and improve our safety performance."

Education and Support

We use a range of tools to help Trusts to improve their understanding and processes for managing risks. Learning from claims is fed back to the relevant Trusts through more than a thousand Risk Management Reports on Claims each year. A more detailed summary of all previous reports was also published last year, including analysis of the recommendations on how to avoid the recurrence of the incidents that led to claims. Other lessons and updates on managing risk are shared in a bi-monthly on-line newsletter.

In addition, we provide the answers to Frequently Asked Questions, template policy documents and an electronic evidence template to facilitate self-assessment. Workshops have again been held, this year for managers in newly formed Community Trusts and for those from Level 1 Trusts. Feedback from these sessions is very positive and most of those attending would recommend colleagues to attend.

A number of more comprehensive studies are also underway, including large-scale analyses of maternity and surgery claims, in the former case leading to more detailed study of particularly problematic categories of claim. We have been able to drill down into the data, not only allowing us to rank the clinical situations which result in the most and most costly claims but also to analyse the key aspects of each which are most likely to result in problems. This will enable managers and clinicians to focus far more tightly on the areas of known risk and to identify the means by which to prevent or minimise them. The maternity study, based on the analysis of claims over ten years, has been shared with the Royal College of Obstetricians and Gynaecologists and Royal College of Midwives, and will be published in the near future.

As a leader in this field, the NHS LA also works with partners like the CQC and NICE on issues of patient safety and provides anonymised details of particular claims to clinicians and researchers, for inclusion in published studies.

Further improvements

The NHS LA is reviewing its approach to risk assessment to ensure that it is focussed on outcomes and on improving patient and staff safety, taking into account the findings of the Industry Review by Marsh. We will also ensure that the actual process of assessment is enabling for Trusts, is less bureaucratic and is clearly grounded in achieving these same objectives.

Family Health Services Appeals Unit

Lisa Hughes
Appeals
Manager

This unit deals with disputes arising from dentists, GPs, pharmacists and ophthalmologists against the decisions made by PCTs which affect their contracts with the NHS.

During this year we received substantially more appeals but, due to the commitment and hard work of the Appeal Team, we achieved our targets for prompt resolution (though the average duration of appeals did increase slightly). As usual, the mix of case types varied from previous years but pharmacy appeals remained the highest work stream.

Dispute Resolution

The processes which govern the appeals are set out in the dispute resolution procedures relating to primary care contracts. The relevant regulations are listed at the foot of this section.

Those disputes relating to General Medical Services and Personal Medical Services were again the main source of applications for dispute resolution. During this period we have received fewer Current Market Rent disputes than in the same period last year, which may be as a result of the Best Practice Protocol we issued previously to assist Primary Care Trusts with local disputes. The number received in this financial year was 39% down on the same period last year (which itself was 27% down on the previous year) and those fully determined (i.e. not referred back to the PCT or withdrawn) were down by 36%.

Otherwise, both medical and dental disputes raised the usual mix of issues from remuneration, including claw-back of monies, and payment of Quality Outcomes Framework monies, to termination of contract. However, we did determine a significant number of applications for dispute resolution following termination of contract by PCTs, which made up 19% of dispute resolution determinations, including one dispute relating to the General Ophthalmic Services Contracts Regulations.

As always, determination of these disputes may be subject to legal challenge by way of Judicial Review (JR). One dental claimant whose JR was successful in the High Court during 2009/10 following a determination made by the NHS LA in 2008, was unsuccessful in the Appeal Court (following an appeal by the PCT) and was refused leave to make a further application to the Supreme Court. During 2011/12 two dental contractors, who sought permission to JR their respective determinations by the NHS LA, were refused permission at a hearing. Five medical contractors (one GMS and four PMS) also sought leave to JR their respective determinations; all were refused in the High Court.

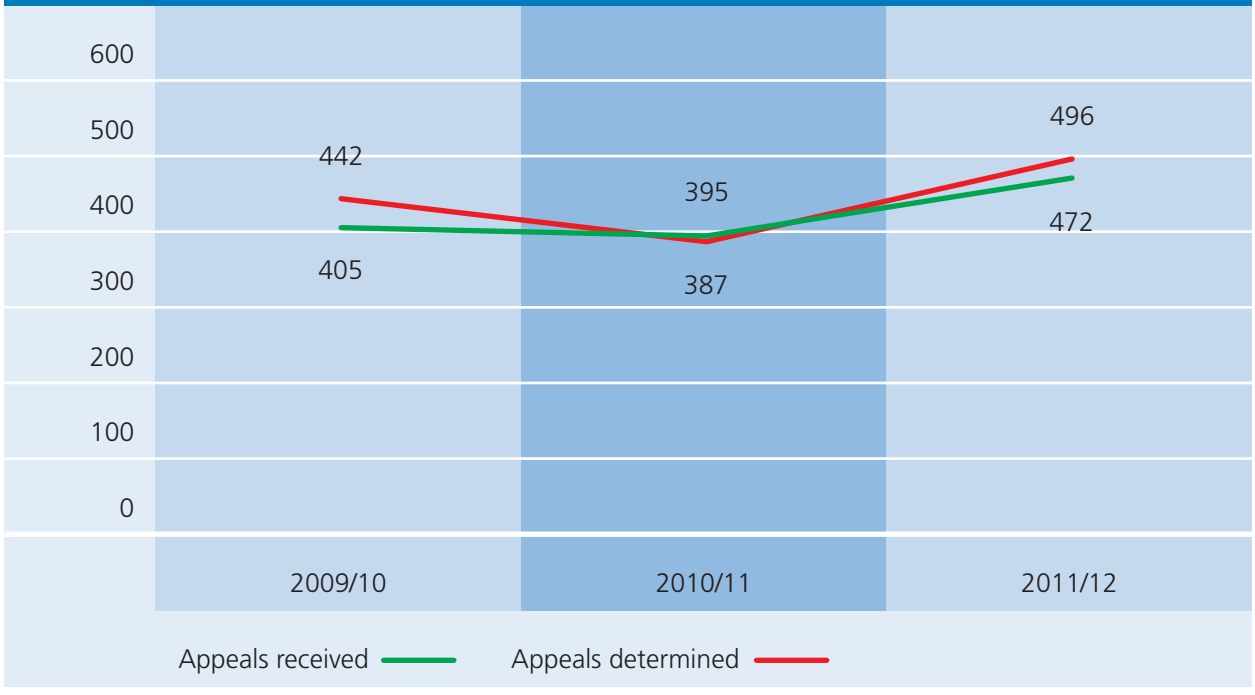
- The NHS (General Medical Services Contracts) Regulations 2004
- The NHS (Personal Medical Services Agreements) Regulations 2004
- The NHS (General Dental Services Contracts) Regulations 2005
- The NHS (Personal Dental Services Agreements) Regulations 2005
- The NHS (Local Pharmaceutical Services etc) Regulations 2006
- The General Ophthalmic Services Contracts Regulations 2008

Appeals

Appeals received in this period were significantly higher than those received for the same period last year. Again this year we received a significant number of appeals from pharmacists seeking to change their "core" opening hours during the Christmas period.

A three year comparison of the number of appeals received and determined is shown below.

Appeals received and determined



Despite the high numbers of appeals received, cases were issued in line with Key Performance Indicators (KPIs) with 100% being issued within target.

Of those pharmacy appeals that resulted in a substantive determination (e.g. were not withdrawn), 22% were allowed; slightly lower than the same period last year.

Determination of pharmaceutical appeals may also be subject to legal challenge by way of JR. Two applications were made during this year. One was refused permission, but the claimant is seeking leave to appeal, and one was granted permission.

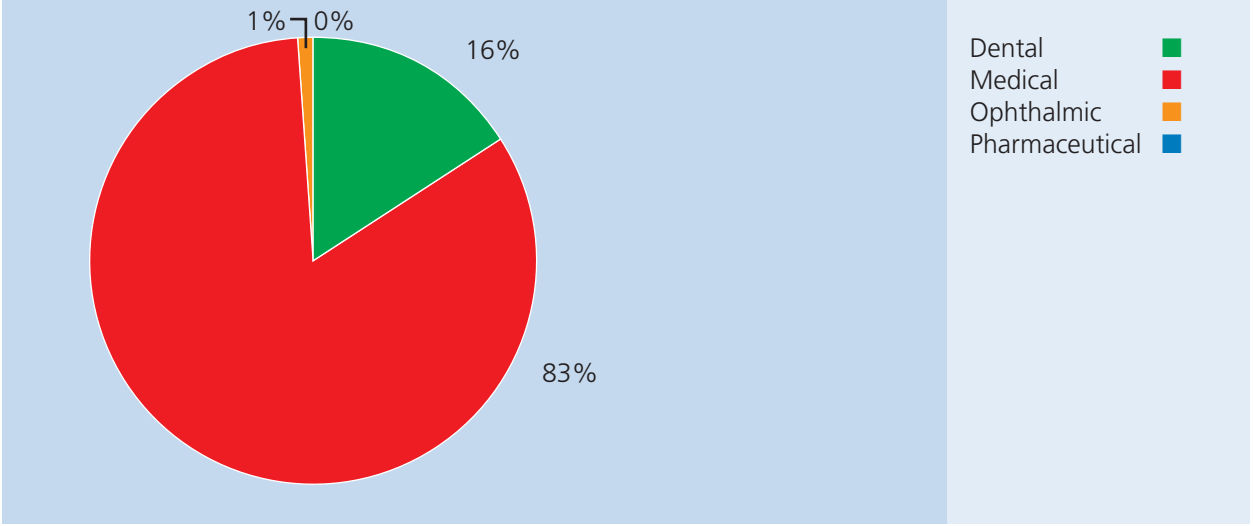
Fitness to Practise: PCT notifications and checks

The National Health Service (Performers Lists) Regulations 2004 currently apply to the medical, dental and ophthalmic professions, with similar provision for pharmacists in separate regulations. When a PCT wishes to manage their lists of those people approved to provide primary care services, or to determine new applications to enter each list, they are required to check for any facts relating to investigations or proceedings involving that person which are relevant. They are also required to provide notification of any decisions made with regard to those on each list and those applying to enter them. In each case the discharging of these functions has been delegated to the NHS LA by the Secretary of State.

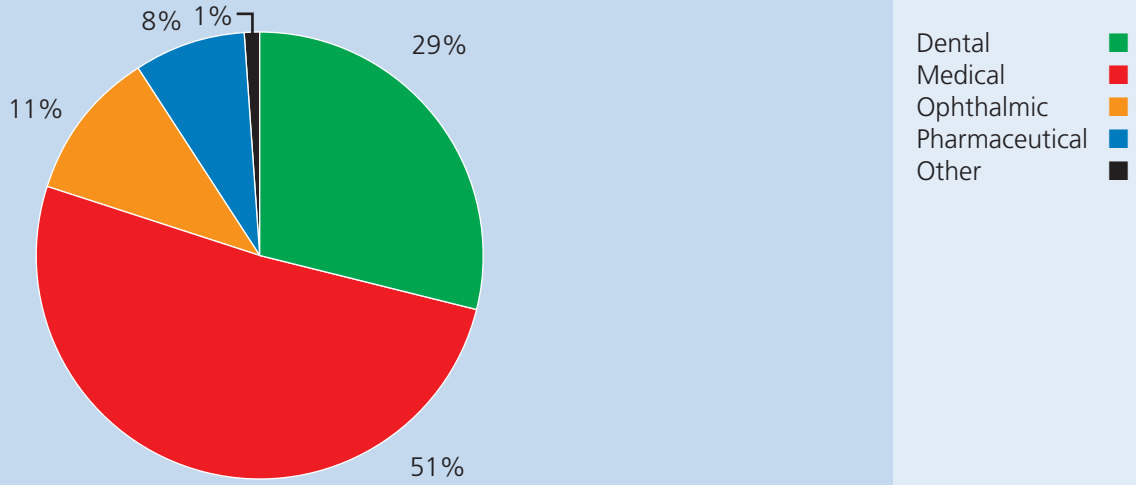
We received notification of 64 suspensions, with 64 still in force as at 31 March 2012. We also received notification of 1,745 other local decisions in respect of performers under the fitness to practise procedures, including 66 notifications of withdrawn applications to join a list, as required by the April 2010 Directions.

The NHS LA holds details of the notifications on a database for the purpose of responding to PCT requests for checks on performers. During the year 15,713 requests were processed. The secure on-line checking system which was rolled out during 2008/9 provided immediate clearance of 97% of checks, with the remaining 3% having to be referred to the NHS LA for further investigation.

2011/12 Notifications of Suspensions by Profession



Restriction Checks by Profession 2011/12



Human Rights Act Information Service

The NHS LA's quarterly Human Rights Act newsletter is produced by 1 Crown Office Row, a set of barristers' chambers and is available on the NHS LA website.

Board members

The NHS LA is led by a Board, made up of executive (full-time employees) and non-executive members, chaired since 1 April 2007 by Professor Dame Joan Higgins. The non-executive directors are appointed by the Secretary of State for Health. All executive directors have been appointed through open competition and in accordance with the NHS LA's recruitment and selection policies and Department of Health guidance. All current executive director posts are permanent appointments. Full details of directors' remuneration are given in the remuneration report on pages 38-39.

Board

Professor Dame Joan Higgins DBE
BA (Hons), Diploma in Social Administration, PhD
Chair

A social scientist by background; latterly Professor of Health Policy at the University of Manchester; a non-executive director of NHS organisations for over 26 years; formerly chair of Manchester Health Authority, Manchester FHSA and the Christie NHS Trust and Regional Chair of the NHS in the North West; also Chair of the QC appointments panel and a member of the House of Lords Appointments Commission; awarded the DBE in 2007 for services to healthcare.

Catherine Dixon (Started in post on 1st April 2012)
LLB (Hons), MBA, Solicitor
Chief Executive

A solicitor by background, formerly a member of the executive boards of the NSPCC and Bupa Care Services, fulfilling the roles of General Counsel / Company Secretary and Commercial Director respectively. Spent two years in Canada as a director at Vancouver Coastal Health Authority. Originally in private practice with Eversheds. Current Trustee of the PDSA.

Stephen Walker CBE (Retired with effect from 31st March 2012)
MA, LLB (Hons), FCII, JP
Chief Executive

Formerly UK Claims Manager in the insurance industry; accredited mediator; member of the Chief Medical Officer's working parties which produced *Organisation with a Memory* and *Making Amends*; member of the Clinical Disputes Forum and the National Patient Safety Forum.

Tom Fothergill
BA (Hons), CPFA
Director of Finance

A qualified accountant with previous NHS experience with a London based Mental Health & Community Services Trust and prior to that a wide range of financial experience gained whilst training and working in local government; having joined the NHS LA as Financial Controller in 1997, has overseen the development of that function and now additionally responsible for IT, Human Resources, our FHSAU function in Leeds and the day to day management of the claims functions.

Keith Ford OBE
CPFA
Non-Executive Member

A qualified accountant with extensive NHS experience as Director of Finance and also Chief Executive; chaired the Healthcare Financial Management Association and served on two Ministerial Advisory Committees; retired September 2006; now Treasurer to King's College Hospital Charity; chairs the NHS LA's Audit and Risk Committee.

Professor Rory Shaw
BSc, MD, MBA, FRCP
Non-Executive Member

Medical Director of North-West London Hospitals NHS Trust; he moved in July 2009 from the post of Chief Medical Officer and Director of Clinical Standards at Royal Berkshire NHS Foundation Trust. He was previously Medical Director at Hammersmith Hospitals Trust. He was the first Chairman of the National Patient Safety Agency (NPSA). He is a consultant in respiratory medicine and has published on asthma and tuberculosis.

Nina Wrightson OBE
Dip SH, LLB (Hons), CFIOSH
Non-Executive Member

Formerly Risk Management Director for Northern Foods plc; past President of the Institution of Occupational Safety and Health; a non-executive Director of Yorkshire Ambulance Service NHS Trust and a Public Member of Network Rail. Recently retired as Chair of the British Safety Council and Complywise Ltd.

Management commentary

Statutory background

The NHS Litigation Authority 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.

Main functions of the NHS Litigation Authority

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

Review of activities and performance against targets

During the year, our net Operating Costs amounted to £2,428.1 million, which represents an increase of £563.3 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 2011/12 the agreed RRL was £2,499.9 million; thus an under spend of £71.8 million is reported.

The NHS LA is required to pay its creditors in accordance with the Better Payment Practice Code. The target is to pay creditors within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier. Of relevant bills, 83.4% (2010/11 75%), representing 84.2% (2010/11 84.8%) by value, were paid within the 30 day target.

The NHS LA is required to manage within its cash limits as agreed with the Department of Health. For 2011/12 we had a revenue cash limit of £408.7million. Capital cash limits for the year were £255,000, with reported outturn at £253,000 showing an under spend of £2,000.

The statement of financial position as at 31 March 2012 shows net liabilities of £18.863 billion. The global valuation recorded recognises provisions that will crystallise in future years and will be funded by future contribution payments or departmental funding. This future income is calculated to fund annual outgoings, and in the case of the departmental funding is subject to parliamentary control. There is no reason to believe that this future funding, future parliamentary authority, and the contribution payments from members will not be forthcoming. It has therefore been considered appropriate to adopt a going concern basis for the preparation of these accounts. In addition, s70 of the NHS Act 2006 requires the Secretary of State to exercise his statutory powers to deal with the reported liabilities of this Special Health Authority if it ceases to exist.

These provisions relate predominately to clinical negligence claims which have either already been made or which are considered to have been incurred via treatment delivered by the NHS but yet to be reported as claims. Inevitably these claims will take time to progress to settlement and so these provisions are recorded using 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 the 31st March 2012 of all of the clinical and non clinical liabilities of the NHS in England which 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. if the NHS LA were to 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 the 31st March 2012.

During 2011/12 we were given access to additional cash resources by the Department of Health as it was clear that the NHS LA was experiencing a sharp spike in cash expenditure in year, following several years of increased claims reporting activity. This fund allowed the NHS LA to continue to meet liabilities under its schemes in a timely manner thus minimising any impacts upon NHS patients and staff members which may have been created had such funds not been available in year. In total the NHS LA spent an additional £265m in year as well as reducing its own cash balances by £9.4m (£21.8million is held at year end compared to £31.2million in 2010/11).

All of the contribution schemes managed by the NHS LA are on a 'pay as you go' basis thereby minimising the impact on cash available for patient care in any given financial period although, inevitably, managing such schemes requires us, at all times, to try to balance the level of contributions charged to members against the impacts large variations might have on the wider NHS. Such careful fiscal planning is more acute in the current financial climate and so the NHS LA is very grateful for the support of the Department in year.

Key Performance Indicators (KPIs)

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

For the claims functions these include the time taken to respond to formal letters of claim and also time taken to make formal offers of settlement on claims we anticipate will be

successful i.e. we are measuring our responsiveness to valid claims made by NHS patients, staff and visitors in order to satisfy our framework requirements to resolve valid claims as swiftly as possible, whilst also striving to minimise payments to third parties. There are also targets in relation to the shelf life of claims, the period the matter is open and managed by the NHS LA. Due to the adversarial nature of the claims against the NHS, we do not publish the details as that might prevent the appropriate management of claims and allow opponents to use them as a bargaining tool in negotiations.

There are other indicative statistics in the Director of Finance's report within this Report and Accounts. KPIs agreed with the Department of Health also exist in relation to the average time taken to settle family health services appeals from the date of notification to the date of settlement; performance during 2011/12 is shown below:

Regulations	Target time to determine (weeks)	Actual % within target		Average time taken (weeks)	
		2011/12	2010/11	2011/12	2010/11
Pharmacy regulations					
Summary	100% in 5	100%	100%	3	3
On the papers	90% in 15	99%	99%	13	12
	10% between 16-18	1%	1%	16	16
Oral hearing	90% in 26	100%	96%	24	23
	10% between 37-35		2%		31
	Target not met		2%		47
Performer lists regulations					
On the papers	90% in 15	100%	88%	9	6
	10% between 16-18		12%		17
Dispute resolution					
On the papers	90% in 15	100%	100%	12	12
	10% between 16-18				
Advice/hearing	90% in 35	77%	91%	22	21
	10% between 36-40	5%	6%	38	37
	Target not met	18%	3%	48	44
GP registrars					
Assessments	100% in 4	100%	80%	2	2
Representations	90% in 15	100%	100%	14	6
	10% between 16-18				

Forward Look

The main priorities of the NHS LA in 2012-'13 have been set by listening to our scheme members and other colleagues across the NHS, and identifying how we can work more effectively together to add value to the NHS. The main project areas are:

Contribution setting

We will be adjusting our methodology to take full account of each Trust's claims history and activity levels in the areas known to have the highest risk. Our objective is for contributions to be accepted as fair and for the process to be transparent to Trusts.

Lessons learned

We will be working hard to improve the ways in which the rich learning we distil from handling claims is used to improve the outcomes for patients and staff in Trusts. We will find methods of transferring this knowledge in a more timely and user-friendly way by involving Trust managers in designing them and in further adapting our risk management standards.

Risk management

We will be reviewing our risk management standards to ensure that they are focused on outcomes and help to contribute to patient and staff safety. We will look at how we measure standards and try to reduce the bureaucracy for Trusts. We will also consider how to ensure that the discounts applied to the standards truly reflect better outcomes, whilst ensuring that any changes we do introduce are managed sensitively, taking into account their effect on Trusts.

Communication

We will be revising our approach to communication with Trusts and other key stakeholders in order to create closer partnerships built on shared data and understanding. By listening to what Trusts need, we aim to provide regular updates which are really valued, and more open and trusting relationships. Information will also be shared on a day-to-day basis by giving Trust colleagues access to a re-designed extranet which is both easy to use and secure.

By handling claims efficiently, promptly and effectively; distilling the knowledge learned from claims handling and sharing it with Trusts in a timely and user-friendly manner; the NHS LA aims to be seen by NHS colleagues as a highly valued, expert partner.

Other Statutory Disclosures

A register of interests is maintained by the NHS LA which details company directorships and other significant interests held by Board members. There are no interests logged on the register which have any bearing on the activities of the NHS LA other than those stated in Note 13 – Related Parties. Access to the register is available by contacting the Chief Executive's PA at 151 Buckingham Palace Road.

Consultation with Employees

The NHS LA consults with its employees on issues relating to information provision and consultation on health, safety and welfare at work by means of a Joint Negotiating Committee in partnership with Unison, which met six times during 2011/12.

Equality and Diversity

The NHS LA is committed to ensuring that all employees, job applicants and users of its services are treated fairly and openly and are not subject to unfair or illegal discrimination or bias. The NHS LA has integrated equality and diversity into all its employment and other policies and embeds these values into its work. We have an equality objective in line with the requirements of the Equality Act 2010 to improve our rate of monitoring amongst employees in relation to disability, religious or other belief and sexual orientation.

Comments and Complaints

We received 7 complaints in 2011/12 (12 in 2010/11), excluding correspondence about the management of particular claims files.

Sickness Absence

1.84% of working time was lost as a result of sickness during 2011/12 (2.19% 2010/11).

Freedom of Information

The NHS LA handled 263 (239 in 2010/11) requests for information under the *Freedom of Information Act 2000* in 2011/12, of which 98% (97%) received substantive responses within the 20 days prescribed by the Act.

Pension Liabilities

Our employees are covered by the provisions of the NHS Pension Scheme, details of which are given in notes 1.11 of the accounts. Pension liabilities in respect of Board members are given in the Remuneration Report.

Audit Services

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

The NHS LA has confirmed that there is no relevant information of which the auditors are unaware. The Accounting Officer has taken all the steps she ought to take to ensure that they are aware of relevant audit information and the Accounting Officer has taken all the steps she ought to establish that the entity's auditors are aware of the information.

Remuneration 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 in Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts*.

The Committee met twice during the year. Attendance was as follows:

Non-executive director	Meetings attended
Joan Higgins (Chair)	2
Keith Ford	2
Rory Shaw	1
Nina Wrightson	2

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

Below are the contractual, salary and pension details of those senior managers who had control over the major activities of the NHS LA during 2011/12. The information in these two tables is subject to audit.

Salaries and allowances

Name and title	2011-12			2010-11		
	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (Rounded to the nearest £100)	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in kind (Rounded to the nearest £100)
	£000	£000	£00	£000	£000	£00
Professor Dame Joan Higgins (Chair)	35 – 40	N/A	N/A	35 – 40	N/A	N/A
Stephen Walker CBE *** (Chief Executive)	180 – 185	0	75*	180 – 185	0	73*
Tom Fothergill (Director of Finance)	150 – 155	0	N/A	150 – 155	0	N/A
Keith A Ford OBE (Non-Executive Member)	10 – 15	N/A	N/A	10 – 15	N/A	N/A

Professor Rory Shaw (Non-Executive Member)	5 – 10	N/A	N/A	5 – 10	N/A	N/A
Nina Wrightson OBE (Non-Executive Member)	5 – 10	N/A	N/A	5 – 10	N/A	N/A
Band of Highest Paid Director's Total Remuneration (£'000)		180 – 185			180 – 185	
Median Total Remuneration		43,458			43,458	
Ratio		4.20**			4.20**	

**Benefits in kind relate to lease cars.*

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

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 2012 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Stephen Walker CBE *** *(Chief Executive)*	25 – 27.5	80 – 82.5	90 – 95	280 – 285	0**	0**	N/A	253
Tom Fothergill *(Director of Finance)*	0 – 2.5	5 – 7.5	30 – 35	100 – 105	516	394	110	204

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

**** Steve Walker retired with effect from 31st March 2012.*

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

Cash Equivalent Transfer Values

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

Real Increase in CETV

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

Date: 19 June 2012

Chief Executive and Accounting Officer

Statement of Accounting Officer's Responsibilities

Under the National Health Service Act 2006, the Secretary of State has directed the NHS Litigation Authority to prepare for each financial year a statement of accounts in the form and on the basis 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 Litigation Authority and of its net expenditure, recognised gains and losses and cash flows for the financial year.

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

- observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and
- prepare the accounts on a going concern basis.

The Accounting Officer of the Department of Health has designated the Chief Executive as Accounting Officer of the 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.

Governance Statement

Scope of responsibility

As Accounting Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS LA's policies, aims and objectives, whilst safeguarding the public funds and the NHS LA's assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. For the accounting period up to and including 31 March 2012, I have relied upon the assurances given by Mr. Stephen Walker, the former Chief Executive of the NHS LA up to and including 31 March 2012, that the matters detailed below have been discharged in accordance with this governance statement.

As Chief Executive, I have operational responsibility for the delivery of all aspects of governance and the provision, oversight and effective working of the systems of internal control, in particular the risk management process, the NHS LA's claims database and financial system. The Executive supported by the Audit and Risk Committee makes recommendations to the Board on matters related to governance.

Operational responsibility for the NHS LA's financial governance systems is delegated to the Director of Finance. The Risk Management Team is responsible for the co-ordination of risk management activity, including information governance, within the NHS LA. The lead responsibility within that Team is vested in the Risk Management Director who is also the NHS LA's Senior Information Risk Owner and Data Protection Officer.

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

During 2011/12 internal audit have carried out a Governance – Board Reporting review and reported findings to the Audit and Risk Committee. The report made only two low rated recommendations both of which were accepted and are being implemented by the NHS LA.

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

During 2011/12 the Board met on 6 occasions and attendance details are as follows :

Name	Post	Board Meetings attended
Steve Walker	Chief Executive	6 of 6
Tom Fothergill	Director of Finance	6 of 6
Joan Higgins	Chair	6 of 6
Keith Ford	Non Executive	6 of 6
Nina Wrightson	Non Executive	6 of 6
Rory Shaw	Non Executive	5 of 6

The purpose of the Governance arrangements

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in NHS LA for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts, and accords with Treasury guidance. Internal audit were able to provide reasonable assurance that there is generally a sound system of internal control within the NHS LA.

Capacity to Handle Risk

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

We are committed to minimising the risks associated with information handling and to ensuring that all staff are fully aware of their responsibilities in relation to the management of information governance risks. Our Information Governance Strategy and related policies and protocols communicate a consistent approach to information handling within the NHS LA.

The NHS LA is well versed in handling sensitive data and takes its responsibilities very seriously. Our secure Document Transfer System (DTS) provides our stakeholders with a protected environment to transfer data to and from the NHS LA thus removing any risk of interception of sensitive documents. All of the NHS LA's equipment is appropriately encrypted and the use of items like USB keys is very strictly controlled using password encryption.

The NHS LA's Assurance Framework brings together governance and quality and in effect maps a path from strategic objectives, through the corporate risks and on to the constituent mitigating activities (which are also the activities to deliver that strategic objective). Its purpose is to ensure that systems and information are available to provide the appropriate

assurance on the appropriate things (i.e. that risks are being controlled and objectives are being achieved), to the appropriate stakeholders. So, for example, our financial performance is documented on a regular basis to the Strategic Management Team and the Board of the NHS LA and is also reported periodically to the Department of Health to demonstrate that expenditure commitments are in line with forecasts and budgetary limits.

The Board receives assurance from the Audit and Risk Committee, which in turn receives assurance from the Health, Safety and Risk Committee, on the achievement of corporate objectives and mitigation of corporate risk. The Board is accountable for demonstrating:

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

The Risk and Control Framework

The risk process is effectively integrated into the planning process by which plans are made to deliver objectives through mitigating the risks to their achievement. Risks are identified and evaluated at appropriate levels within the organisation through a uniform system articulated in the Risk Management Strategy. The process is operated and reviewed by the Audit and Risk Committee, which receives reports from the Health, Safety and Risk Committee, and is accountable to the Board. In addition an annual internal risk management report is provided to the Audit and Risk Committee.

During the financial year the NHS LA has been dealing with a number of significant risks, some of which are to an extent outside our direct control.

The industry review of the NHS Litigation Authority was formally published in January 2012 and has identified a substantive list of recommendations which the NHS LA is now actively addressing with the support of the Department of Health. It is anticipated that 2012/13 will see some significant changes proposed to the risk pooling schemes operated by the NHS LA. The proposed changes to the NHS structure will also present risk to the NHS LA, in particular our ability to provide competitive services to our members and also to provide appropriate indemnity arrangements for the changing service delivery models being considered by the Government.

Claims volumes reported to us by our members have continued to rise throughout 2011/12 and during the year the NHS LA was offered financial support by the Department of Health to deal with a surge in claims expenditure resulting from a sustained period of high claims volume reporting. The additional funds received helped the NHS LA meet its liabilities in year and also maintain the growth in scheme contributions for 2012/13 in line with previous forecasts to members.

The NHS LA relies upon actuarial advice to support pricing decisions and also help inform the value of provisions recorded in the balance sheet. During 2011/12 the Audit and Risk Committee agreed to seek a further, independent review of actuarial projections to support

the audit process and provide additional assurance to the NHS LA and also readers of the published accounts.

Given the voluntary nature of the schemes operated by the NHS LA it is important that we take account of members' views. It is therefore our policy to involve stakeholders, as appropriate, in all areas of our activities, including informing and consulting on the management of any significant risks or changes to our schemes. Our wide range of stakeholders includes not only the members of our schemes but also for example various Royal Colleges, the Association of Personal Injury Lawyers (APIL) and the Medical Defence Organisations.

The development of the NHS in recent years has begun to lead to NHS foundation trusts considering alternatives to the schemes operated by the NHS LA, however as at March 2012 we continue to provide services to all NHS trusts and NHS foundation trusts in England. The implementation of the recent industry review will offer an opportunity to further refine our services so that they are fit for the requirements of our members.

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

As with all NHS organisations the risk of fraud is a significant consideration for the NHS LA. The nature of our work inevitably focuses our attention on the risk of fraudulent claims being brought against the service and so great care is taken to review the appropriateness of our systems with reports made regularly to the Audit and Risk Committee by our Counter Fraud team. Evidence of attempted fraud has, to date, been relatively rare and where any possibility is identified, the NHS LA immediately involves the appropriate authorities as well as discussing the matter with any effected stakeholder and their local counter fraud specialists. Staff awareness regarding fraud is maintained by regular updates, newsletters and examples of emerging patterns within the NHS.

The NHS LA is responsible for holding and maintaining data regarding its staff and also claimants against the NHS and maintains policies and systems, which are subject to regular review, in order to minimise the risk of any breaches in data security.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed in a number of ways. The head of internal audit (a role delivered as part of our outsourced internal audit function) provided reasonable assurance that there is generally a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. There were no 'limited assurance' opinions provided in year. Members of the Strategic Management Team, who have responsibility for the

development and maintenance of the system of internal control, provide me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. For example I meet regularly with other members of the Strategic 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 much of our discussion has been in regard to the significant pressure created by the increased volumes of claims reported to us and how we might manage the risks associated with such growth, sharing information with relevant stakeholders and also reviewing claims data with a view to identifying any trends which may require specific attention.

My review is also informed by comments made by the external auditors in their management letters and other reports on aspects of the system of internal control. The final accounts process for 2011/12 incorporated actions identified during the previous audits to improve the presentation and clarity of the accounts.

The Audit & Risk Committee meets regularly and reports to the Board. Both the Internal and External Auditors are present at the Audit and Risk Committee meetings and Internal Audit have also specifically reported on Corporate Governance during 2011/12.

Attendance records for Audit and Risk Committee meetings are as follows:

Name	Post	Meetings attended
Keith Ford	Non Executive Chair	3 of 3
Nina Wrightson	Non Executive	3 of 3
Rory Shaw	Non Executive	2 of 3

These arrangements aim to help the NHS LA maximise its understanding and utilisation of all available information about the quality and effectiveness of our systems to help us improve services and satisfy the increasing need for assurance about the effectiveness of systems of internal control. Based on my review I am not aware of any significant control issues.

Date: 19 June 2012

Chief Executive and Accounting Officer

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 2012 under the National Health Service Act 2006. These comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. These financial statements have been prepared under the accounting policies set out within them. I have also audited the information in the Remuneration Report that is described in that report as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit, 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 Report to identify material inconsistencies with the audited financial statements. 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 reported 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 which 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 which govern them.

Opinion on financial statements

In my opinion:

- the financial statements give a true and fair view of the state of the NHS Litigation Authority's affairs as at 31 March 2012 and of its 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.

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 issued under the National Health Service Act 2006; and
- the information given in 'Board Members' and 'Management Commentary' for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

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

Report

I have no observations to make on these financial statements.

Amyas C E Morse
Comptroller and Auditor General
National Audit Office
157-197 Buckingham Palace Road
Victoria
London
SW1W 9SP

Date: 22 June 2012

Statement of Comprehensive Net Expenditure for the Year ended 31 March 2012

	Notes	2011/12 £000	2010/11 £000
Programme costs			
Authority and claims administration	2.1	**12,585**	13,683
Unwinding of discounts	2.1	**(3,867)**	(22,475)
Other claims and associated costs	2.1	**3,353,776**	2,712,883
		3,349,909	2,690,408
Total Programme costs	2.1	**3,362,494**	2,704,091
Operating income	4	**(934,418)**	(839,302)
	10	**2,428,076**	1,864,789
Net Expenditure	3.1	**2,428,076**	1,864,789

Other Comprehensive Expenditure
The Authority incurred no other comprehensive expenditure

All income and expenditure is derived from continuing operations

The notes at pages 53 to 81 form part of these accounts.

Statement of Financial Position as at 31 March 2012

	Notes	31 March 2012 £000	Restated 31 March 2011 £000
Non-current assets:			
Property, plant & equipment	5.3, 5.4	**2,040**	2,244
Intangible assets	5.1, 5.2	**349**	351
Total-non current assets		**2,389**	2,595
Current assets:			
Trade and other receivables	6	**19,144**	7,892
Cash and cash equivalents	7	**21,860**	31,294
Total current assets		**41,004**	39,186
Total assets		**43,393**	41,781
Current liabilities:			
Trade and other payables	8	**(39,752)**	(38,425)
Provisions for liabilities and charges - known claims	9.1, 9.2	**(2,118,532)**	(2,094,492)
Provisions for liabilities and charges - IBNR	9.1, 9.2	**(75,000)**	(67,000)
Total current liabilities		**(2,233,284)**	(2,199,917)
Non-current assets plus/less net current assets/liabilities		**(2,189,891)**	(2,158,136)
Non-current liabilities			
Provisions for liabilities and charges - known claims	9.1, 9.2	**(6,267,404)**	(5,415,296)
Provisions for liabilities and charges - IBNR	9.1, 9.2	**(10,406,000)**	(9,270,000)
Total non-current liabilities		**(16,673,404)**	(14,685,296)
Assets less liabilities		**(18,863,295)**	(16,843,432)
Taxpayers' equity			
General Fund		**4,374**	4,121
ELS Reserve		**(2,249,025)**	(2,058,066)
ExRHA Reserve		**(32,089)**	(32,931)
CNST Reserve		**(16,340,952)**	(14,562,473)
PES Reserve		**(3,244)**	(4,320)
LTPS Reserve		**(242,359)**	(189,763)
Total taxpayers' equity		**(18,863,295)**	(16,843,432)

The General Fund and individual scheme reserves are used to account for all financial resources.
The 10/11 General Fund is restated following a change to accounting policy regarding government grants (Note 1.5).

The financial statements on pages 49 to 81 were approved by the Board on 19 June 2012 and signed by Catherine Dixon

The notes at pages 53 to 81 form part of these accounts.

Date: 19 June 2012

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2012

	Notes	Restated General Fund * £000	ELS Reserve £000	ExRHAs Reserve £000	CNST Reserve £000	PES Reserve £000	LTPS Reserve £000	Total Reserves £000
Balance at 01 April 2010		2,140	(1,937,974)	(35,254)	(12,949,597)	(6,232)	(138,980)	(15,065,897)
Changes in taxpayers' equity for 2010/11								
Net expenditure for the year	9.3	(1,599)	(202,139)	696	(1,612,876)	1,912	(50,783)	(1,864,789)
Total recognised income and expense for 2010/11		(1,599)	(202,139)	696	(1,612,876)	1,912	(50,783)	(1,864,789)
Net Parliamentary funding		3,580	82,047	1,627	0	0	0	87,254
Balance at 31 March 2011		**4,121**	**(2,058,066)**	**(32,931)**	**(14,562,473)**	**(4,320)**	**(189,763)**	**(16,843,432)**
Changes in taxpayers' equity for 2011/12								
Net expenditure for the year	9.3	(1,521)	(362,497)	(2,115)	(2,010,423)	1,076	(52,596)	(2,428,076)
Total recognised income and expense for 2011/12		(1,521)	(362,497)	(2,115)	(2,010,423)	1,076	(52,596)	(2,428,076)
Net Parliamentary funding **		1,774	171,538	2,957	231,944	0	0	408,213
Balance at 31 March 2012		**4,374**	**(2,249,025)**	**(32,089)**	**(16,340,952)**	**(3,244)**	**(242,359)**	**(18,863,295)**

* The 2010/11 General Fund is restated following a change to accounting policy regarding government grants (Note 1.5)
** During 2011/12 the Department of Health made additional funding available to the ELS Scheme (£33.1m) & the member funded CNST scheme (£231.9m).

The notes at pages 53 to 81 form part of these accounts.

Statement of Cash Flows for the year ended 31 March 2012

	Notes	2011/12	2010/11
		£000	£000
Cash flows from operating activities			
Net expenditure		**(2,428,076)**	(1,864,789)
Other cashflow adjustments	10	**459**	384
Movement in Working Capital	10	**2,010,223**	1,768,479
Net cash (outflow) from operating activities		**(417,394)**	(95,926)
Cash flows from investing activities			
Purchase of property, plant and equipment	5.3, 5.4	**(153)**	(274)
Purchase of intangible assets	5.1, 5.2	**(100)**	(135)
Net cash (outflow) from investing activities		**(253)**	(409)
Cash flows from financing activities			
Net Parliamentary funding		**408,213**	85,645
Net financing		**408,213**	85,645
Net (decrease) in cash and cash equivalents		**(9,434)**	(10,690)
Cash and cash equivalents at the beginning of the period		**31,294**	41,984
Cash and cash equivalents at the end of the period	7	**21,860**	31,294

The notes at pages 53 to 81 form part of these accounts.

Notes to the Accounts

1 Accounting policies

The financial statements have been prepared in accordance with the 2011/12 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply International Financial Reporting Standards (IFRS) as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Authority for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Authority 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 Authority 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 IFRS disclosure

NHS Litigation Authority have not adopted any IFRS's, amendments or interpretations early.

IFRS's, amendments and interpretations in issue but not yet effective, or adopted IAS 8, accounting policies, changes in accounting estimates and errors, require disclosures in respect of new IFRS's, amendments and interpretations that are, or will be applicable after the accounting period. There are a number of IFRS's, 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 by the NHS Litigation Authority:

- IFRS 7 Financial Instruments: Disclosures Amendment to allow for better comparisons between financial statements. The effective date is for accounting periods beginning on or after 1 January 2013. Also an amendment to improve the disclosure requirements in relation to transferred financial assets which is effective for accounting periods beginning on or after 1 July 2011.
- IFRS 9 Financial Instruments A new standard intended to replace IAS39. The effective date is for accounting periods beginning on, or after 1 January 2015.
- IFRS 13 Fair Value Measurement IFRS 13 applies when other IFRS's require or permit fair value measurements. The new requirements are effective for accounting periods beginning on, or after 1 January 2013.

- IAS 1 Presentation of Financial Statements Amendment to the existing standard to improve disclosures to users of the accounts. The effective date is for accounting periods beginning on, or after 1 June 2012.
- IAS 19 Employee Benefits The amendments will improve the recognition and disclosure requirements for defined benefit plans and modify the accounting for termination benefits. The new requirements are effective for accounting periods beginning on or after 1 January 2013.
- IAS 32 Offsetting Financial Assets and Financial Liabilities Amendments to clarify the application of offsetting requirements. The amendments are effective for accounting periods beginning on or after 1 January 2014.

None of these new or amended standards and interpretations are likely to be applicable or 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 from Request for Resources 1 within an approved cash limit, which funds the ELS and Ex-RHA clinical negligence schemes. Parliamentary funding is recognised in the financial period in which it is received.

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

1.4 Taxation

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

1.5 Government Grants

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently as a result of this, the brought forward balance at 1st April 2010 for the general fund has been increased by £1.462m.

1.6 Property, Plant and Equipment (PPE)

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

i) Capitalisation

PPE are capitalised where they are capable of being used for more than one year, and they:

– individually have a cost equal to or greater than £5,000;

– collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

– form part of the initial equipping and setting-up cost of a new building irrespective of their individual or collective cost.

ii) Valuation

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

Equipment surplus to requirements is valued at net recoverable amount.

iii) Depreciation

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

Furniture and Fittings	10 years
Information Technology	5 years

iv) Leased assets

NHSLA holds no finance leases.

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

1.7 Intangible Assets

i) Capitalisation

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

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

ii) Internally generated intangible assets

Expenditure on research is not capitalised.

An internally generated intangible asset arising from the Authority's development is recognised only if all of the following conditions are met:

– an asset is created that can be identified (such as bespoke software);

– it is probable that the asset created will generate future economic benefits; and

– the development cost of the asset can be measured reliably.

Intangible fixed assets are valued at cost.

iii) Amortisation

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

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

1.8 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.

1.9 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 balance sheet 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.

1.10 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Net Expenditure (SOCNE) on an accruals basis, including losses which would have been made good through insurance cover had the Authority not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 12 is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.11 Pension costs

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

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

a) Full actuarial (funding) valuation

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

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

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

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

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

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

The valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2012 with summary global member and accounting data.

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

c) Scheme provisions

In 2011/12 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".

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance

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

Ill-Health Retirement

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

Death Benefits

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

Additional Voluntary Contributions (AVCs)

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

Transfer between Funds

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

Preserved Benefits

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

Compensation for Early Retirement

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

1.12 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, as it is not material.

1.13 Leases

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

1.14 Provisions

The Authority provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the Treasury's discount rate of 2.2% in real terms.

The ELS and Ex-RHA schemes are funded by the Department of Health, CNST, LTPS and PES from Trust contributions, and the accounts for the schemes are prepared in accordance with 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 rate of 2.2%, RPI of 3% and claims inflation (varying between schemes) of between 5% and 10%, is applied to the probable cost to take into account the likely time to settlement.

The difference between the gross value of claims and the probable cost of each claim as calculated above is also discounted, taking into account the likely time to settlement, and is included in contingent liabilities as set out in note 9.4.

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 Authority 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 Authority 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 Authority 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 Authority 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 Authority 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 Authority 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 Authority'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 Authority derecognises financial liabilities when, and only when, the Authority'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 Authority'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. 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.

2.1 Authority programme expenditure

			2011/12	2010/11
	Notes	£000	£000	£000
Non-executive members' remuneration	2.2	**71**		71
Other salaries and wages	2.2	**6,777**		6,982
Redundancy costs	2.2	**35**		147
Supplies and services - general		**1**		1
Establishment expenses		**400**		571
Hire and operating lease rental				
Land & buildings		**397**		660
Lease cars		**9**		19
Photocopiers		**7**		66
Franking Machine		**4**		5
Vending Machine		**4**		2
Transport and moveable plant		**5**		7
Premises and fixed plant		**1,195**		1,425
External contractors				
Actuary's advice		**308**		314
Appeals Unit advisory expenditure		**113**		168
External Corporate Legal Fees ***		**615**		639
Risk management		**2,001**		2,070
Other **		**56**		45
Auditor's remuneration: audit fees*		**78**		79
Internal audit fees		**44**		45
Bank Charges & Interest		**6**		(17)
			12,126	13,299
Depreciation	5.3, 5.4	**357**		235
Amortisation	5.1, 5.2	**102**		94
(Profit)/loss on disposal		**0**		55
			459	
			12,585	13,683
Other finance costs – unwinding of discount	9.1, 9.2		**(3,867)**	(22,475)
Increase in provision for known claims (excl. unwinding of discounts)	9.1, 9.2	**2,209,776**		2,071,883
Increase in the provision for IBNR	9.1, 9.2	**1,144,000**		641,000
			3,353,776	
			3,362,494	2,704,091

* The Authority 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

2.2 Staff numbers and related costs

	2011/12 Total	Permanently employed staff	Other *	2010/11 Total
	£000	£000	£000	£000
Salaries and wages	**5,724**	**5,296**	**428**	6,013
Social security costs	**499**	**499**		491
Employer contributions to NHS Pensions	**660**	**660**		696
	6,883	**6,455**	**428**	7,200

The average number of employees during the year was:

	Total Number	Permanently employed staff Number	Other* Number	2010/11 Total Number
Total	**124**	**113**	**11**	136

Redundancy Costs
The cost to the Authority of redundancies in 2011/12 was £34,876 (2010/11: £147,005)

Expenditure on staff benefits
The amount spent on staff benefits during the year mainly on lease cars totalled £15,000 (2010/11: £21,390).

* Noted under 'other' is the Authority'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 2011/12

Payment Bands	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	0	0	0
£10,000 - £25,000	2	0	2
£25,000 - £50,000	0	0	0
£50,000 - £100,000	0	0	0
£100,000 - £150,000	0	0	0
£150,000 - £200,000	0	0	0
Total number of exit packages by type	**2**	**0**	**2**
Total cost (£'000s)	**35**	**0**	**35**

2.4 Exit Packages for staff leaving (Prior Year)

Payment Bands	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	5	0	5
£10,000 - £25,000	2	5	7
£25,000 - £50,000	0	1	1
£50,000 - £100,000	0	0	0
£100,000 - £150,000	0	0	0
£150,000 - £200,000	0	0	0
Total number of exit packages by type	**7**	**6**	**13**
Total cost (£'000s)	**44**	**113 ***	**157**

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

* Included within this figure is an extra-contractual payment for which approval was received from HM Treasury

3.1 Reconciliation of net expenditure to revenue resource limit

	2011/12 £000
Net expenditure	**2,428,076**
Net Expenditure	**2,428,076**
Revenue resource limit	**2,499,862**
Under spend against revenue resource limit	**71,786**

3.2 Reconciliation of gross capital expenditure to capital resource limit

	2011/12 £000
Gross capital expenditure	**253**
NBV of assets disposed	**0**
Net capital expenditure	**253**
Capital resource limit	**255**
Under spend against capital resource limit	**2**

3.3 Other gains and losses

	2011/12	2010/11
	£000	£000
(Loss) on disposal of plant and equipment	0	(55)
Total	**0**	(55)

4 Operating income

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

	Appropriated in aid 2011/12	2010/11
	£000	£000
Programme income:		
CNST contributions	890,757	797,580
PES contributions	5,669	5,257
LTPS contributions	37,992	36,465
Total	**934,418**	839,302

5.1 Intangible assets

	Information Technology	Software Licences	Total
	£000	£000	£000
Gross cost at 1 April 2011	1,585	328	1,913
Additions - purchased	70	30	100
Disposals		(1)	(1)
Gross cost at 31 March 2012	**1,655**	**357**	**2,012**
Accumulated amortisation at 1 April 2011	1,305	257	1,562
Charged during the year	77	25	102
Disposals		(1)	(1)
Accumulated amortisation at 31 March 2012	**1,382**	**281**	**1,663**
Net Book Value at 1 April 2011	280	71	351
Net Book Value 31 March 2012	**273**	**76**	**349**

5.2 Intangible assets (Prior Year)

	Information Technology £000	Software Licences £000	Total £000
Gross cost at 1 April 2010	1,477	509	1,986
Additions - purchased	108	27	135
Disposals		(208)	(208)
Gross cost at 31 March 2011	1,585	328	1,913
Accumulated amortisation at 1 April 2010	1,233	443	1,676
Charged during the year	72	22	94
Disposals		(208)	(208)
Accumulated amortisation at 31 March 2011	**1,305**	**257**	**1,562**
Net Book Value at 1 April 2010	244	66	310
Net Book Value 31 March 2011	**280**	**71**	**351**

5.3 Property, Plant and Equipment

	Information Technology £000	Furniture & fittings £000	Total £000
Valuation at 1 April 2011	1,136	1,649	2,785
Additions - purchased	152	1	153
Disposals	(39)	(1)	(40)
Valuation at 31 March 2012	**1,249**	**1,649**	**2,898**
Accumulated depreciation at 1 April 2011	496	45	541
Charged during the year	192	165	357
Disposals	(39)	(1)	(40)
Accumulated depreciation at 31 March 2012	**649**	**209**	**858**
Net Book Value at 1 April 2011	640	1,604	2,244
Net Book Value at 31 March 2012	**600**	**1,440**	**2,040**

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

Capital commitments: The Authority has no capital commitments at 31 March 2012 (2010/11: nil)

5.4 Property, Plant and Equipment (Prior Year)

	Information Technology £000	Furniture & fittings £000	Total £000
Valuation at 1 April 2010	1,014	219	1,233
Additions - purchased	244	1,639*	1,883
Disposals	(122)	(209)	(331)
Valuation at 31 March 2011	**1,136**	**1,649**	**2,785**
Accumulated depreciation at 1 April 2010	412	170	582
Charged during the year	191	44	235
Disposals	(107)	(169)	(276)
Accumulated depreciation at 31 March 2011	**496**	**45**	**541**
Net Book Value at 1 April 2010	602	49	651
Net Book Value at 31 March 2011	**640**	**1,604**	**2,244**

* During the period, the Authority acquired property, plant and equipment with an aggregate cost of 1,883 of which 1,499 was funded by a government grant. Cash payments of 274 were made to purchase property, plant and equipment and 110 was provided for future decommissioning costs (all values are £'000).

6 Receivables

	Ex RHAS £000	ELS £000	CNST £000	PES £000	LTPS £000	Admin £000	Total 31 March 2012 £000	Total 31 March 2011 £000
NHS receivables - revenue			10,054	352	2,618		**13,024**	3,645
Prepayments	31	1,564	226			161	**1,982**	2,109
Other receivables		215	558	25	206	3,134	**4,138**	2,138
	31	**1,779**	**10,838**	**377**	**2,824**	**3,295**	**19,144**	7,892

Intra-government balances

							£000	£000
Balances with other central government bodies						3,100	**3,100**	2,028
Balances with NHS Bodies			3,660	308	2,039		**6,007**	1,583
Balances with public corporations and trading funds *			6,773	69	781		**7,623**	2,061
Subtotal of intra-government balances	**0**	**0**	**10,433**	**377**	**2,820**	**3,100**	**16,730**	5,672
Balances with bodies external to government	31	1,779	405		4	195	**2,414**	2,220
	31	**1,779**	**10,838**	**377**	**2,824**	**3,295**	**19,144**	7,892

* Balances with NHS Foundation Trusts are included under public corporations.

7 Cash and cash equivalents

	Ex RHAS £000	ELS £000	CNST £000	PES £000	LTPS £000	Admin £000	**Total 31 March 2012 £000**	Total 31 March 2011 £000
At 1 April	528	8,013	402	1,375	19,977	999	**31,294**	41,984
Change During the year	(527)	(5,109)	10,537	651	(14,194)	(792)	**(9,434)**	(10,690)
At 31 March	**1**	**2,904**	**10,939**	**2,026**	**5,783**	**207**	**21,860**	31,294
Made up of								
Cash with the Government Banking Service	**1**	**2,904**	**10,939**	**2,026**	**5,783**	**207**	**21,860**	31,294
Cash and cash equivalents as in statement of financial position	**1**	**2,904**	**10,939**	**2,026**	**5,783**	**207**	**21,860**	31,294
Cash and cash equivalents as in statement of cash flows	**1**	**2,904**	**10,939**	**2,026**	**5,783**	**207**	**21,860**	31,294

8 Trade payables and other current liabilities

	Ex RHAS £000	ELS £000	CNST £000	PES £000	LTPS £000	Admin £000	**Total 31 March 2012 £000**	Total 31 March 2011 £000
NHS payables revenue			616	75	1,600		**2,291**	1,064
Prepaid Income		2,539	714				**3,253**	3,237
Accruals		326	12,803		409	452	**13,990**	21,933
Other payables		532	18,423		1,254	9	**20,218**	12,191
	0	**3,397**	**32,556**	**75**	**3,263**	**461**	**39,752**	38,425

Intra-government balances

							£000	£000
Balances with other central government bodies			603		106	104	**813**	12
Balances with NHS Bodies			997	56	925		**1,978**	1,260
Balances with public corporations and trading funds*			333	19	748		**1,100**	435
Subtotal of intra-government balances	**0**	**0**	**1,933**	**75**	**1,779**	**104**	**3,891**	1,707
Balances with bodies external to government		3,397	30,623		1,484	357	**35,861**	36,718
	0	**3,397**	**32,556**	**75**	**3,263**	**461**	**39,752**	38,425

* Balances with NHS Foundation Trusts are included under public corporations.

9.1 Provisions for liabilities and charges

	Ex RHAS	ELS	CNST	PES	LTPS	Total
	£000	£000	£000	£000	£000	£000
Opening Provision for Known Claims	(27,261)	(1,674,917)	(5,692,316)	(8,013)	(107,281)	(7,509,788)
Opening Provisions for IBNR	(6,000)	(415,000)	(8,824,000)	(1,000)	(91,000)	(9,337,000)
Total Provisions as at 1 April 2011	**(33,261)**	**(2,089,917)**	**(14,516,316)**	**(9,013)**	**(198,281)**	**(16,846,788)**
Movement in known claims						
Discounting	27,388	572,461	2,008,952		69	2,608,870
Arising during the year	(33,933)	(1,059,160)	(5,009,942)	(8,013)	(102,381)	(6,213,429)
Reversed unused	5,530	334,954	1,013,987	3,563	36,749	1,394,783
Unwinding of discount	(1,100)	(38,526)	43,513		(20)	3,867
Utilised during the year	2,957	179,112	1,095,302	4,262	48,128	1,329,761
	842	(11,159)	(848,188)	(188)	(17,455)	(876,148)
Movement in Net IBNR		(172,000)	(950,000)		(22,000)	(1,144,000)
Closing Provision for Known Claims	(26,419)	(1,686,076)	(6,540,504)	(8,201)	(124,736)	(8,385,936)
Closing Provisions for IBNR	(6,000)	(587,000)	(9,774,000)	(1,000)	(113,000)	(10,481,000)
At 31 March 2012	**(32,419)**	**(2,273,076)**	**(16,314,504)**	**(9,201)**	**(237,736)**	**(18,866,936)**
Expected discounted timing of cash flows:						
Within 1 year		(187,731)	(1,874,864)	(8,201)	(122,736)	(2,193,532)
1-5 years	(1,000)	(385,515)	(4,367,645)	(1,000)	(99,000)	(4,854,160)
Over 5 years	(31,419)	(1,699,830)	(10,071,995)		(16,000)	(11,819,244)
	(32,419)	**(2,273,076)**	**(16,314,504)**	**(9,201)**	**(237,736)**	**(18,866,936)**

The provisions relating to the Authority's schemes are the only provisions made by the Authority. Discounted cashflow timings are based upon the estimated settlement dates of known claims and actuarial estimates for IBNR. Actual cashflows will vary due to a number of factors including claims settling on a periodic basis rather than lump sum, claims which take longer than anticipated to resolve and changes in the value and timing of payments.

9.2 Provisions for liabilities and charges (Prior Year)

	Ex RHAS	ELS	CNST	PES	LTPS	Total
	£000	£000	£000	£000	£000	£000
Opening Provision for Known Claims	(27,584)	(1,606,799)	(4,636,072)	(10,304)	(91,000)	(6,371,759)
Opening Provisions for IBNR	(8,000)	(414,000)	(8,207,000)	(1,000)	(66,000)	(8,696,000)
Total Provisions as at 1 April 2010	**(35,584)**	**(2,020,799)**	**(12,843,072)**	**(11,304)**	**(157,000)**	**(15,067,759)**
Movement in known claims						
Discounting	298	447,093	1,614,869		(102)	**2,062,158**
Arising during the year	(3,285)	(782,644)	(3,979,666)	(5,844)	(83,474)	**(4,854,913)**
Reversed unused	2,546	162,621	528,272	2,589	24,844	**720,872**
Unwinding of discount	(862)	(27,888)	51,209		16	**22,475**
Utilised during the year	1,626	132,700	729,072	5,546	42,435	**911,379**
	323	(68,118)	(1,056,244)	2,291	(16,281)	**(1,138,029)**
Movement in Net IBNR	2,000	(1,000)	(617,000)		(25,000)	**(641,000)**
Closing Provision for Known Claims	(27,261)	(1,674,917)	(5,692,316)	(8,013)	(107,281)	**(7,509,788)**
Closing Provisions for IBNR	(6,000)	(415,000)	(8,824,000)	(1,000)	(91,000)	**(9,337,000)**
At 31 March 2011	**(33,261)**	**(2,089,917)**	**(14,516,316)**	**(9,013)**	**(198,281)**	**(16,846,788)**
Expected discounted timing of cash flows:						
Within 1 year	(169)	(308,500)	(1,747,227)	(8,002)	(97,594)	(2,161,492)
1-5 years	(6,128)	(409,175)	(3,920,005)	(1,011)	(86,687)	(4,423,006)
Over 5 years	(26,964)	(1,372,242)	(8,848,084)		(15,000)	(10,262,290)
	(33,261)	**(2,089,917)**	**(14,516,316)**	**(9,013)**	**(198,281)**	**(16,846,788)**

9.3 Allocation of Income and Expenditure to the schemes

	Ex-RHAS	ELS	CNST	PES	LTPS	Equal Pay	FHSAU	**Total 31 March 2011**	Total 31 March 2010
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	£000
Expenditure									
Authority and claims administration		226	7,690	143	3,005	634	887	**12,585**	13,683
Claims and associated costs									
Increase/(decrease) in provision for known claims provision for known claims	2,115	190,271	1,943,490	4,450	65,583			**2,205,909**	2,049,408
Increase/(decrease) in the Provision for IBNR		172,000	950,000		22,000			**1,144,000**	641,000
	2,115	362,497	2,901,180	4,593	90,588	634	887	**3,362,494**	2,704,091
Income									
Scheme income			(890,757)	(5,669)	(37,992)			**(934,418)**	(839,302)
Net expenditure - (surplus)/ deficit	**2,115**	**362,497**	**2,010,423**	**(1,076)**	**52,596**	**634**	**887**	**2,428,076**	1,864,789

9.4 Contingent liabilities

	Ex-RHAS	ELS	CNST	PES	LTPS	Total
	£000	£000	£000	£000	£000	£000
Contingent liability for claims 2011/12	**3,000**	**631,410**	**7,694,740**	**4,686**	**130,814**	**8,464,650**
Contingent liability for claims 2010/11	5,696	610,087	7,027,001	4,387	107,110	7,754,281

The Authority 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.

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

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

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 2012 and on or after 1 April 1995. Claims are included in the provision on the basis that the CNST members have assessed:-

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

b. that they are qualifying incidents; and

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

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

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

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

The schemes are managed and funded via the same mechanisms as the CNST except that specific excesses exist for some types of claims. Thus the provision recorded in these accounts relates only to the Authority's proportion of each claim. The accounts for these schemes have been prepared in accordance with IAS 37.

Assumption of Liabilities upon Cessation

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

Incidents Incurred but not reported (IBNR)

IAS 37 requires the inclusion of liabilities in respect of incidents which have been incurred but not reported to the NHS Litigation Authority as at 31 March 2012 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 Authority uses its actuaries, Lane, Clark & Peacock LLP, 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 Authority'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 Authority uses its actuaries, Lane Clark & Peacock LLP, to provide estimates of the provisions. The actuaries analyse past trends in claims and combine this with a knowledge of the current economic and claims environments in order to make projections of how claims will emerge and be settled in the future. This process is performed in consultation with the Authority to ensure that the projections reflect a common understanding of the expected future development of claims.

The Authority'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 Authority, and the settlement of claims can also take a long time depending on the circumstances of the claim. Claims can take over thirty years to be reported, over ten years to be settled and, if the claim is settled as a PPO, the claim payments can potentially span a further period of over 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 Authority, 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 Authority's provisions: the reported outstanding claims provision, the IBNR provision and the provision for settled PPOs.

Reported outstanding claims provision

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

IBNR provision

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

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

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

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

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

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

Settled PPOs provision

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

Key assumptions and areas of uncertainty

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

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 as "high", "medium" or "low". This is a subjective classification and is intended only to give a broad illustration for the purpose of comparing the various assumptions.

As an example, the table shows that there is a medium level of uncertainty in the assumed number of claims incurred in each past 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
IBNR provision		
Number of claims incurred each year	Medium	High
Incident to reporting pattern for all claims	Medium	High
Reporting to settlement pattern for all claims	Low	Low
Incident to reporting pattern for PPO claims	High	High
Reporting to settlement pattern for PPO claims	Low	Low
Claims		
Average claim size	Medium	High
Claim value inflation	High	High
Settlement to payment pattern for PPO claims	Medium	Medium
Settled PPO provision		
Life expectancy	High	Medium
Assumed level of inflation in ASHE 6115	Medium	High

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

Clinical negligence claims can take over thirty years to be reported following the incident that gives rise to the claim. The IBNR provisions depend on the delay pattern of how claims are reported to the Authority 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 also a lack of past data preceding the formation of the Authority mean that there is ongoing uncertainty in this assumption.

The numbers of clinical claims reported to the Authority have increased in recent years. This is believed to be the result of more incidents converting to claims as well as claims being reported to the Authority more quickly. It is uncertain to what extent each of these factors is driving the change in the number of claims being reported.

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

The effect of even small changes to the assumed annual rate of future claim value inflation can have a significant impact on the estimated provision. This is because of the long-term nature of the liabilities. Claim value inflation has historically run 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. In particular, the anticipated review of the discount rate by the Lord Chancellor and the introduction of Lord Justice Jackson's recommendations on legal costs could have a significant impact on claim value inflation in the near future, although the extent of this impact is uncertain. The variety of potential external influences on future claims inflation means that it is subject to significant uncertainty.

Trends in the NHSLA's historical claims experience have been distorted over time by changes in the external environment. For example, increased litigiousness, changes in the legal environment relating to legal costs, changes in the legal environment determining new heads of damage or methods of settlement and changes in the process of reporting claims have all had effects on the historical pattern of claim reporting and settlement. This makes it more difficult to interpret the past trends and use these to make assumptions about the expected future patterns of claim reporting and settlement.

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), changes in claims handling processes and the Authority's budgetary constraints.

The provisions in respect of settled PPOs are sensitive to the assumed life expectancy of claimants. Each claimant's life expectancy is estimated at settlement by medical experts in the case. 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. The future rates of increase in these indices is uncertain. In particular, ASHE 6115 relates specifically to care and home workers and external factors impacting this market in recent years mean that past inflation in this index may be of limited relevance as a basis for future projection. The current difficult economic environment combined with the limited relevance of past data to make future projections means the uncertainty in this assumption is currently more than might normally be the case.

10 Reconciliation of operating costs to operating cash flows

	Notes		**2011/12**	2010/11
			£000	£000
Net expenditure			**(2,428,076)**	(1,864,789)
Adjustments for non-cash transactions				
Depreciation	5.3,5.4	**357**		235
Amortisation	5.1, 5.2	**102**		94
(Profit)/loss on disposal	5.4	**0**		55
			459	384
Adjustments for movements in working capital other than cash				
(Increase)/decrease in receivables	6	**(11,252)**		(165)
Increase/(decrease) in payables	8	**1,327**		(10,385)
Increase/(decrease) in provisions	9.1, 9.2	**2,020,148**		1,779,029
			2,010,223	1,768,479
Net cash outflow from operating activities			**(417,394)**	**(95,926)**

11 Commitments under operating leases

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

		2011/12	2010/11
Land and buildings		**£000**	£000
Amounts payable:	within 1 year	**283**	283
	between 1 and 5 years	**1,394**	1,264
	after 5 years	**1,655**	2,069
		3,332	3,616
Other leases			
Amounts payable:	within 1 year	**17**	29
	between 1 and 5 years	**6**	42
	after 5 years		
		23	71

12 Losses and special payments

There was 1 case of losses and special payment (prior year: 3 cases) totalling £21,345 (prior year £11,195) approved during 2011/12

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 English Strategic Health Authorities
All English NHS Trusts and PCTs
All English NHS Foundation Trusts
NHS Blood and Transplant
The National Patient Safety Agency
NHS Business Services Authority
NHS Institute for Innovation and Improvement
NHS Information Centre
National Treatment Centre
Health Protection Agency
NHS Direct
The Health Research Authority

In addition Professor R Shaw and Ms N Wrightson, non-executive directors of the Authority, are also employed by North West London Hospitals NHS Trust as the Medical Director, and as a non-executive Director of Yorkshire Ambulance Service NHS Trust, respectively.

Trust	Income £'000	Expenditure £'000	Receivables £'000
North West London Hospitals NHS Trust	7,190	420	12
Yorkshire Ambulance Service NHS Trust	641	70	8

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

14 Financial instruments

IFRS 7 Financial Instruments: Disclosures requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the way Special Health Authorities are financed, the NHS Litigation Authority is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which IFRS 7 mainly applies. The NHS Litigation Authority has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Litigation Authority in undertaking its activities.

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

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

None of the Authority's financial assets and liabilities carry rates of interest. The Authority 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 Authority 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 Post Balance Sheet Events

These financial statements were authorised for issue on 22 June 2012 by the Accounting Officer.

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

1 Trevelyan Square
Boar Lane
Leeds
LS1 6AE
Telephone 0113 866 5500
Fax 020 7821 0029
DX 26416
Leeds Park Square

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