NHS Litigation Authority

Annual report and accounts

2015/16

Resolve and learn

NHS Litigation Authority

Annual report and accounts 2015/16

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Welcome

Chair's welcome

Ian Dilks
Chair

Much has happened in the last year with many changes in the NHS Litigation Authority (NHS LA).

Let me start by mentioning people. Since my last Chair's Welcome we have been pleased to appoint new Directors of Claims (Alan Hunter); Finance and Corporate Planning (Joanne Evans); Membership and Stakeholder Engagement (Ian Adams); the National Clinical Assessment Service (NCAS, Vicky Voller); and Safety and Learning (Denise Chaffer). They, together with other members of the Senior Management Team, are now working closely with our Chief Executive Helen Vernon to develop our plans for the future.

The Triennial Review on the NHS LA was published last July. It concluded that the NHS LA was "well led and operationally efficient, providing NHS providers with a cost effective service". This was a welcome recognition of the abilities and hard work of the NHS LA leadership and staff. However it also recognised that there was more the NHS LA could do to assist in the reduction of harm and cost of claims to the NHS and one of the key recommendations was for the NHS LA and the Department of Health (DH) to work together to define the NHS LA's future role, a discussion that is ongoing. In large part this recognises the changes that have already taken place (for example our role in managing the Sign up to Safety incentive payments on behalf of the Secretary of State for Health) but we welcome the opportunity to identify ways to work collaboratively with other parts of the NHS to achieve more.

Our Business Plan for 2016/17, which is now available on our website, sets out clearly how the NHS LA will continue to develop over the coming year to enhance the value we provide to our Members and other partners around our three strategic aims of reducing harm; providing analysis and sharing expert knowledge; and offering best value to our customers, patients and the public. A number of new initiatives are already well advanced, such as our plans to make more use of claims mediation following a successful pilot last year.

One change over the course of the last year that I would highlight is that I believe we have become a more open and transparent organisation. We began last year by publishing in our annual report more information about the drivers of the cost of claims, a trend you will see that continues this year. During the year we conducted for the first time satisfaction surveys in all our main areas of activity [Clinical Negligence Scheme for Trusts (CNST), NCAS and Family Health Services Appeal Unit (FHSAU)] and we have just recently concluded a consultation among CNST Members about possible changes to the operation of the CNST scheme, all of which we are evaluating and will influence what we do this year.

"The Triennial Review concluded that the NHS LA was 'well led and operationally efficient, providing NHS providers with a cost effective service.'"

Sadly one thing that hasn't changed is the continuing increase in claims costs and what we must consequently charge to CNST Members. Despite a 4.6% reduction in newly reported clinical claims our provisions for claims have increased by a further £2.5 billion this year in addition to the discount rate adjustment described below, reflecting both increased levels of damages and legal costs. Our CNST charges for the current year have had to increase by 17% to £1.67 billion and as I said last year the level of our provisions means that further increases are already in the pipeline.

We continue to work with policymakers to see how this can be addressed. We await with interest the consultation document that DH plans to publish shortly on the proposal to cap the level of claimant legal fees that can be recovered on 'smaller' clinical negligence claims. This change would bring the law in this area into line with other non-clinical claims. Subsequent pages illustrate the impact such a change might have on the costs borne by the NHS, for example figure 3 on page 13 which shows the continuing increase in claimant costs as a percentage of damages awards.

We know that our accounts aren't always easy to follow so we have this year included a simple summary of the year in figures and we hope you find this helpful. As you will see we have shown the impact of the change in the HM Treasury discount rate that must be applied to calculate our long term liabilities. The change in the year of £25.5 billion is an accounting adjustment rather than a measure of harm in the year but nevertheless the resulting provision of £56.4 billion reflects the true cost to the NHS in today's prices of the long term damages payments that we agree to pay, stretching out decades into the future (over three-quarters of our liabilities will be paid in 2021 and beyond) in today's world of low interest rates.

I said last year that the NHS LA faced many challenges but that we had the leadership and people who were capable of meeting these challenges. Events have shown this to be correct and I am equally sure that the team, supported by the Board, will continue to rise to the further challenges that undoubtedly lie ahead.

Chief Executive's report

Helen Vernon
Chief Executive

The past year has seen a shift in the NHS LA's role with an increased focus on the part we can play in supporting and incentivising improvements in safety at a local level. The key to reducing the growing costs of claims is learning from what goes wrong and supporting those who deliver care to make the changes necessary to prevent harm in the first place. We had a unique opportunity this year to do just that and delivered over £18 million of Sign up to Safety incentive payments to support local safety improvement plans across the country. The scheme was devised and delivered by the NHS, from the ground up, to tackle the areas of harm which result in claims.

We were delighted that 48 trusts bid successfully for funding and that we were able to bring trusts together, whether successful or not, in a series of well-attended free events around the country on human factors, maternity and accident & emergency, supported by the Royal Colleges, DH and others. Together with colleagues from the NHS Supply Chain we were shortlisted for a prestigious Government Opportunities award for our work on securing procurement savings for trusts through this process.

As part of the shift in role we have also become more transparent and responsive to feedback, as well as continuing our support of the NHS in being open with patients who have suffered harm. We have continued to promote our guidance on 'Saying Sorry' as the right thing to do when something goes wrong and to provide practical support to trusts, via our legal panel, in delivering the statutory duty of candour. It is our view that increased transparency can only support learning and so reduce claims and litigation costs in the long term.

Our efforts to increase the level of data we share across the NHS system have not been without challenges. We take the security of data and the rules which apply to the sharing of patient-sensitive information extremely seriously. However, where data can be shared legally and for the benefit of patient safety, we have done so and were pleased to support the 'Getting it Right First Time' initiative and the review by Lord Carter of efficiency in hospitals.

The announcement by DH of a consultation to improve the way in which lower value clinical negligence claims are handled attracted great interest from the legal market in the months which followed. The increasing disproportion in claimant legal costs and examples of excessive costs being claimed are highlighted in last year's annual report and that trend continues this year. The NHS LA continues, however, to maintain a good relationship with lawyers who act for injured patients and who aim to achieve fair resolution on their behalf. There are opportunities to improve the claims process and deliver access to justice at a more reasonable cost. Our experience on the employers' and public liability side, where fees have been fixed, provides evidence of this and has contributed to

"The key to reducing the growing costs of claims is learning from what goes wrong and supporting changes to prevent harm in the first place."

our being able to keep contributions for trusts steady in this area this year.

We were pleased to be able to work collaboratively with a number of claimant firms together with trusts throughout the year to deliver a mediation initiative and encourage and promote mediation as a way of resolving disputes without going to court. The participation of clinicians and patients alike in this process received positive feedback from all involved and we are looking forward to increasing mediation in the health sector in the coming year.

Our NCAS team was back up to full strength at the end of the year with a new Director in place and a highly skilled team of experts supporting the NHS on a daily basis with the management of concerns about performance. In aligning our regionally focused NCAS adviser team with our Safety and Learning Leads we started to provide integrated services to trusts. This has enabled us to work alongside local teams with a greater understanding of the issues faced. NCAS now offers a bespoke and tailored range of products and services which apply support where it is most needed and valued.

We are fortunate to have been able to retain a team of specialists across the NHS LA who have developed expertise over the years which would be almost impossible to replicate elsewhere. Our claims teams managed 16,459 claims to resolution in 2015/16, with many claims being resolved swiftly in-house without recourse to lawyers or the courts. Our teams are value driven and do their utmost to balance the interests of the patient and the taxpayer to ensure that compensation is delivered fairly and appropriately. This has been extremely challenging against a background of high claims volumes, including high numbers of claims being brought where there was no negligence and their skill in delivering fair resolution is commendable.

Our impartial Tribunal Service, which is delivered by the FHSAU, has managed an increasingly complex portfolio of work and is the authority in interpreting the nuances of regulations and in sharing that knowledge. It is trusted in its determination of disputes and saves the service significant sums in avoiding protracted contractual disputes.

In 2015, the NHS LA celebrated its 20th anniversary. A staff-organised event, kindly hosted by Guy's and St Thomas' Hospital, brought staff together from across the organisation to share their achievements and look to the future. This event rightly celebrated the hard work of our staff whose efforts have delivered the best possible service to the NHS and our other customers throughout the year and who will drive forward the NHS LA's future in the years to come.

Performance report

Perfomance summary

15,137
the total number of new claims for compensation against the NHS in England received by NHS Litigation Authority

993
referrals about the performance of doctors, dentists and pharmacists handled by our National Clinical Assessment Service

270
appeals regarding community pharmacy applications managed by our Family Health Services Appeal Unit

£18.7 million
of incentive payments to the NHS made on behalf of the Department of Health to support the Sign up to Safety campaign

Our 20th year

In the year that the NHS Litigation Authority (NHS LA) celebrated its 20th anniversary, we set ourselves a challenging strategic plan to increase our operational effectiveness whilst supporting the NHS to reduce harm through learning and effective incentivisation. A Triennial Review of our operations concluded that we were efficient and effective, and we continued to drive a programme of improvement in all of our functions against a background of high volumes of work.

We resolved 16,459 claims brought against the NHS in England, our National Clinical Assessment Service (NCAS) handled 993 referrals about the performance of doctors, dentists and pharmacists within the NHS, and the Family Health Services Appeal Unit (FHSAU) addressed 270 appeals to the results of applications to join the Pharmaceutical list in 2015/16.

New clinical negligence claims in 2015/16 fell in number by 4.6% to 10,965 compared with 11,497 received in 2014/15. Damages paid to patients rose from £774.4 million to £950.4 million, an increase of 23%.

Total payments relating to our clinical schemes increased by £319.0 million (27%) – from £1,169.5 million to £1,488.5 million. In 2015/16 we received 4,172 new non-clinical claims, typically employers' and public liability claims – a fall of 13.2% compared with the 4,806 received in 2014/15.

Of great interest to our Members and the wider public will be the provisions for our claims against our indemnity schemes, which have increased by £27.8 billion (see figure 9). The provision represents the value in today's prices of the cost of claims arising from harm that occurred up to 31 March 2016. Of the increase in the provision, £2.5 billion relates to claims arising from another year of activity and changes in the assumptions used to calculate the provision. A further £25.5 billion of the increase is as a result of the discount rate change.

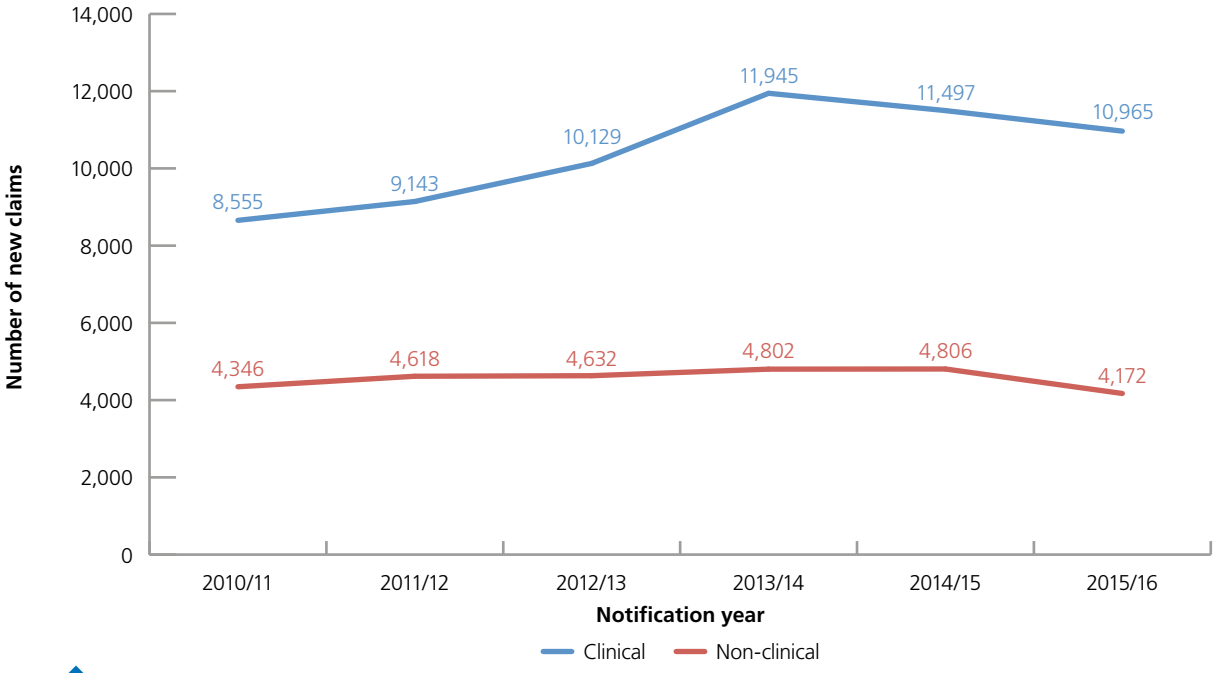
This is an accounting adjustment determined by HM Treasury, and is designed to show the value of future cash-flows to settle these liabilities in today's prices: £1 today might be worth more or less in the future.

We continue to receive and defend a high number of claims, which resolve without a payment of damages: 4,935 in 2015/16. We continue to resolve justified claims as quickly as practicable and closed a total of 16,459 clinical and non-clinical claims in 2015/16.

Table 1: The year at a glance

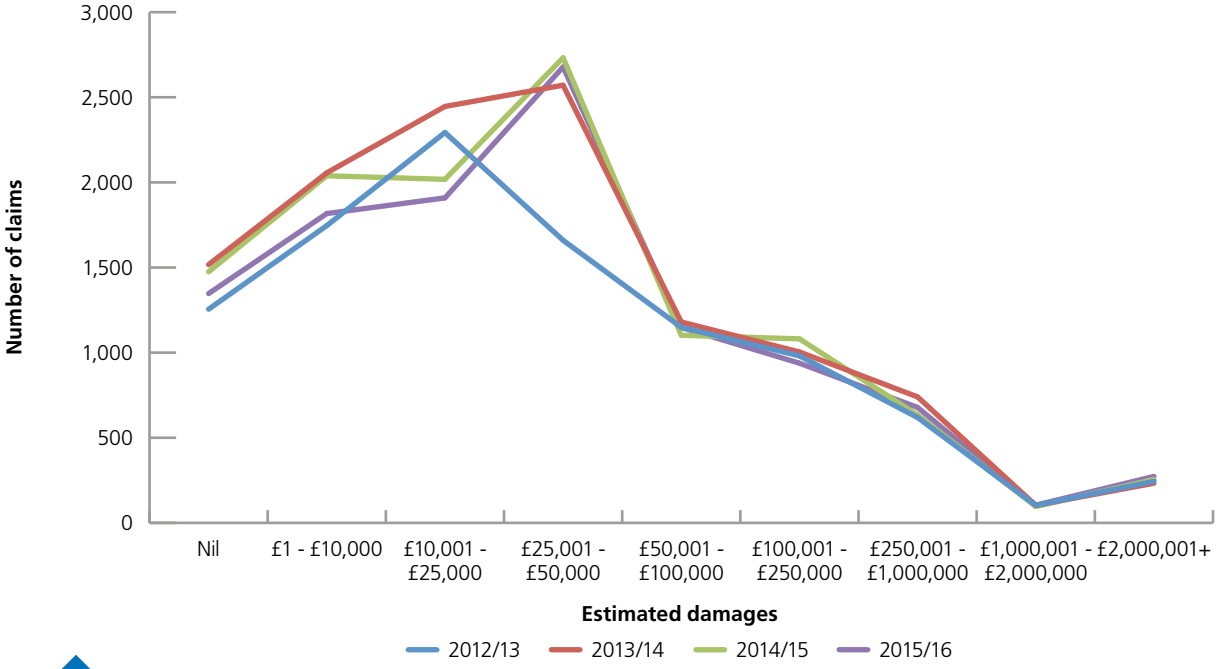
	2014/15	2015/16	Change	
Funding for clinical schemes				
Income from Members	£1,048.0m	£1,419.5m	£371.5m	35%
Funding from DH (budget)	£112.25m	£142m	£29.8m	27%
Total funding	**£1,160.3m**	**£1,561.5m**	**£401.3m**	35%
Payments in respect of clinical schemes				
Damages payments to patients	£774.4m	£950.4m	£176.0m	23%
Claimant costs	£291.9m	£418.0m	£126.1m	43%
Defence costs	£103.2m	£120.1m	£16.9m	16%
Total payments	**£1,169.5m**	**£1,488.5m**	**£319.0m**	27%
Funding for non-clinical schemes				
Income from Members	£54.5m	£51.1m	(£3.4m)	6%
Funding from DH (budget)	£13.8m	£11.5m	(£2.3m)	17%
Total funding	**£68.3m**	**£62.6m**	**(£5.6m)**	8%
Payments in respect of non-clinical schemes				
Damages payments to patients	£26.1m	£26.7m	£0.6m	2%
Claimant costs	£20.7m	£25.0m	£4.3m	21%
Defence costs	£6.7m	£7.7m	£1.0m	15%
Total payments	**£53.5m**	**£59.4m**	**£5.9m**	11%
NHS LA administration of schemes				
Clinical	£9.3m	£9.4m	£0.1m	1%
Non-clinical	£3.7m	£3.2m	(£0.5m)	14%
NHSLA other activities				
Income	£1.3m	£1.5m	£0.2	12%
Expenditure	£7.5m	£6.4m	(£1.1m)	15%
Sign up to Safety	-	£18.7m	-	
Staff numbers	230	227	(3)	1%
Cost of new claims provisions				
New claims provisions	**£3,701m**	**£29,332m**	**£25,631m**	693%
Total provisions at year end				
Total provisions	**£28,610m**	**£56,440m**	**£27,831m**	97%

Figure 1: The number of new clinical and non-clinical claims reported in each financial year from 2010/11 to 2015/16.



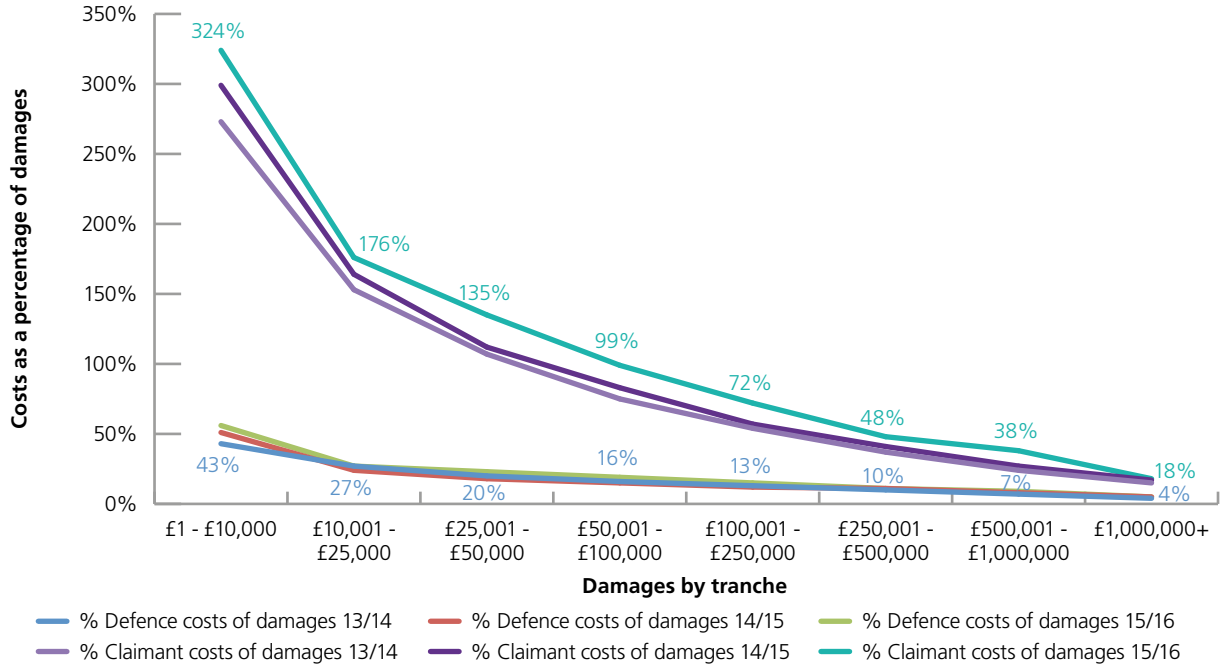
The number of new clinical and non-clinical claims has fallen in 2015/16 when compared to the previous financial year.

Figure 2: The number of clinical negligence cases resolved by damages range for each financial year from 2012/13 to 2015/16.



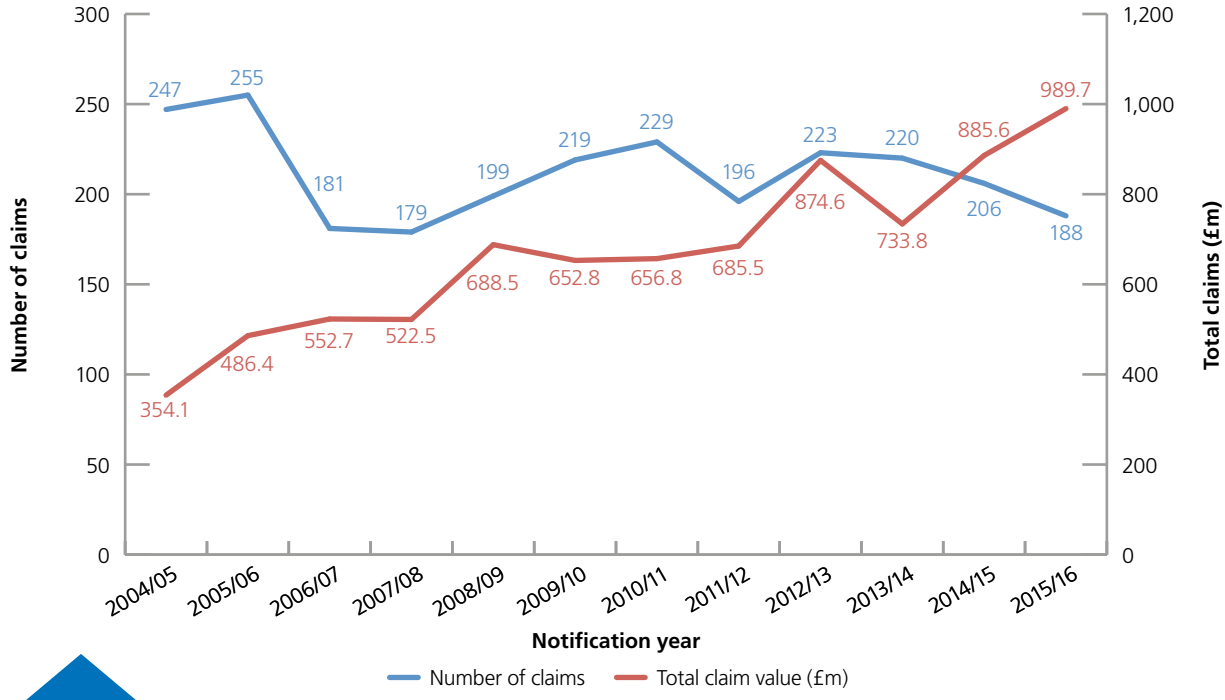
The greatest number of clinical negligence claims resolved in 2015/16 were from the damages range of £25,001 to £50,000 – continuing a three-year trend.

Figure 3: Defence and claimant costs as a percentage of damages by damages range for the financial year from 2013/14 to 2015/16.



Claimant legal costs as a percentage of damages paid have risen in the past year and continue to be disproportionate as they are markedly greater than defence costs.

Figure 4: A comparison of the number and total value of claims for maternity cerebral palsy/brain damage claims over time.

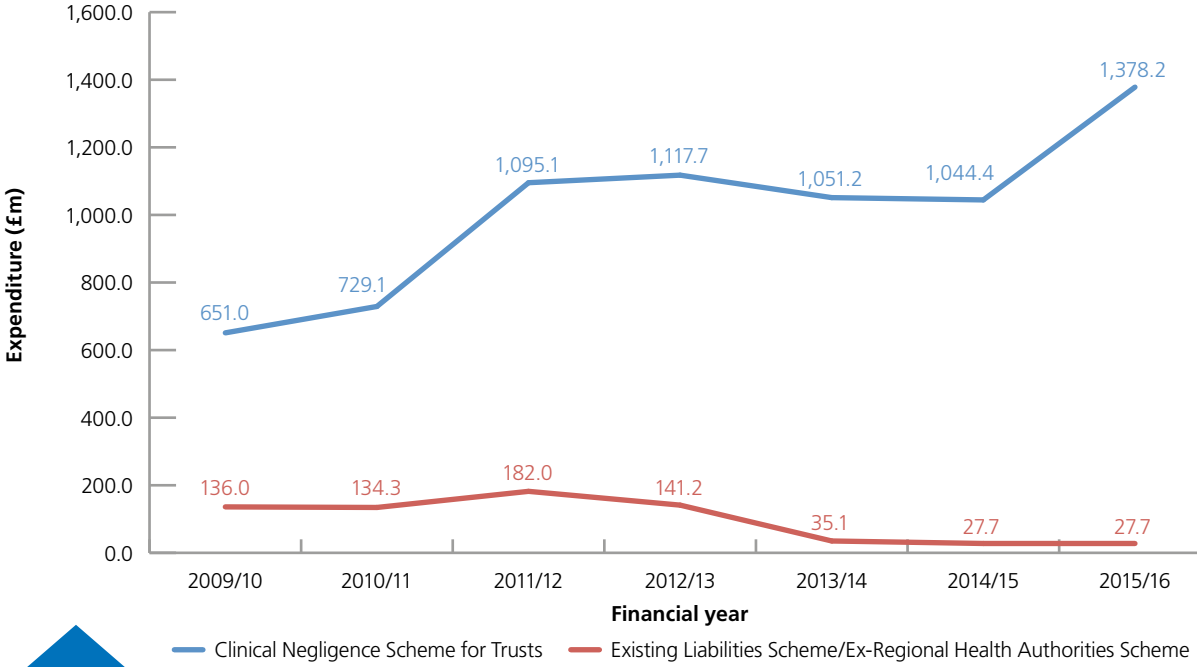


The value of maternity cerebral palsy/brain damage claims notified has continued to increase whilst claims numbers have remained fairly constant.

Figure 5: Expenditure on non-clinical claims by financial year from 2009/10 to 2015/16.[1]

Expenditure on non-clinical claims has remained relatively stable with an increase in 2015/16 to £44.6 million, but not back up to 2011/12 levels'.

Figure 6: Expenditure on clinical claims by financial year from 2009/10 to 2015/16.[2]



Expenditure on clinical claims increased sharply, reflecting the increasing numbers and costs of claims notified in previous years falling for settlement.

1 Figure 5 excludes £11.1m of expenditure incurred in 2015/16 on claims which transferred to the DH on 1 April 2013 as a result of the restructure of the NHS.
2 Figure 6 excludes £82.5m of expenditure incurred on claims which transferred to DH on 1 April 2013 as a result of the restructure of the NHS.

Figure 7: Clinical negligence expenditure including interim payments 2014/15 and 2015/16.

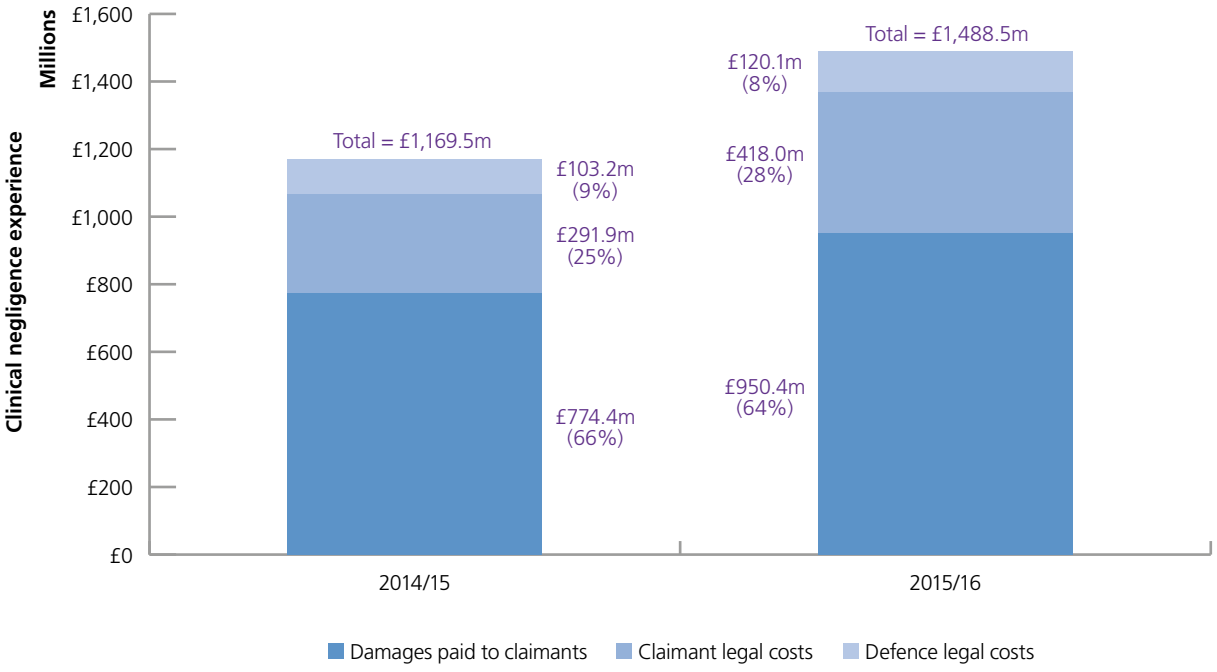
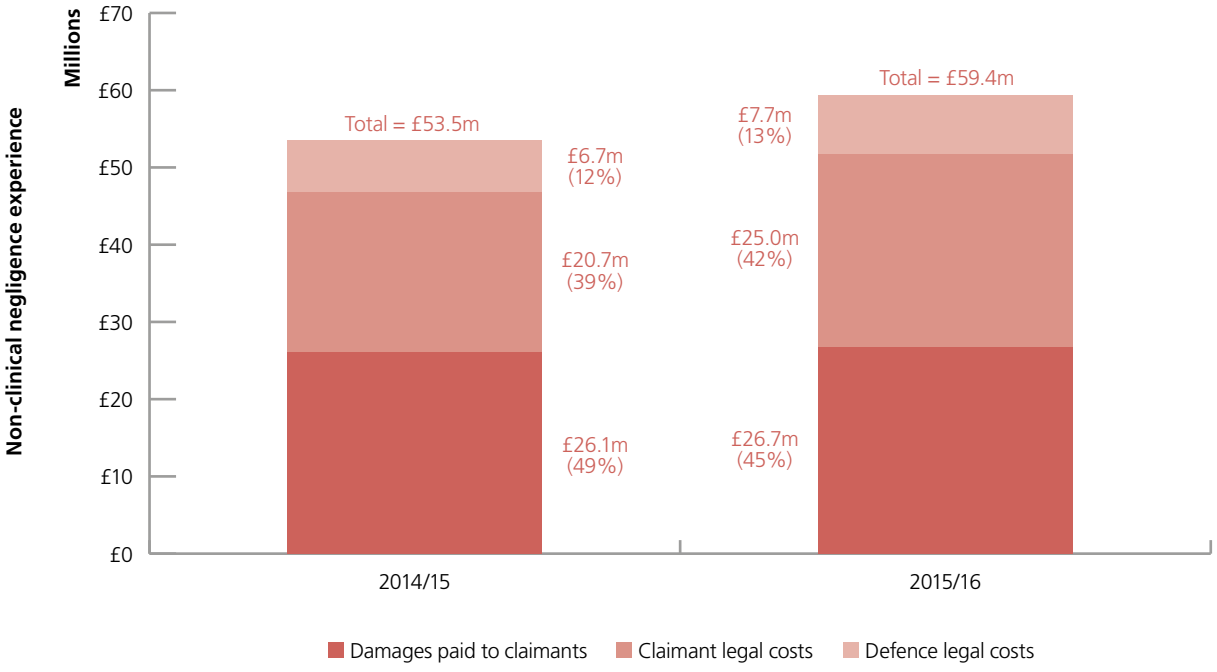


Figure 8: Non-clinical negligence expenditure including interim payments 2014/15 and 2015/16.



Fewer than 1%
of the claims we resolved went to court.

28 Non-clinical **96** Clinical

Of those that went to court

60% were successfully defended.

Wherever possible we resolve claims without litigation. In 2015/16 fewer than 1% of the claims we resolved went to trial. The cases that we do take to court are where we believe the case is without merit, or where greater legal clarity about an area of case law is needed or where we are seeking a change in the law. We increased the number of cases taken to trial overall by 45% from 85 to 124, whilst maintaining a high success rate at 60%.

Working to reduce future claims through safety and learning

The key to reducing the growing costs of claims is learning from what goes wrong and supporting those who deliver care to make the changes necessary to prevent harm in the first place. As part of this ambition, and in line with our strategic aim for the year to support the NHS to reduce harm through effective incentivisation, the NHS LA distributed £18.7 million of incentive payments to the NHS on behalf of the DH to support the Sign up to Safety campaign. The scheme targeted NHS organisations who could demonstrate that they could use the funding to provide improvements in patient safety. This led to an increased focus in three areas of safety: maternity, A&E (missed fractures) and human factors/safety culture. Our website details the improvement plans provided by the trusts which received funding.

We have also worked with our Members to reduce future claims through:

- thematic reviews of claims data;
- networking events to share the outcome of bid activities;
- setting up 'buddying' arrangements between beacon organisations and those struggling with specific patient safety issues;
- promoting 'ask and offer' work to share learning and resources between trusts; and
- facilitating the bulk-buying of maternity equipment, aided by the NHS Supply Chain.

We have started the process of aligning our regionally focused NCAS adviser team with our Safety and Learning Leads and claims function to provide a more integrated service to trusts.

It has been a busy year for our NCAS team as we advised on 173 cases involving exclusion, suspension or restriction from practice and have enhanced the service we offer to NHS organisations on the monitoring of exclusions and suspensions.

We launched a web-check service in October 2015 for Healthcare Professional Alert Notices (HPANs) which brings together pre-employment checks for Performance List Regulations (PLRs) and HPANs for all NHS users – this helps NHS employers to check that the staff they employ are not known to pose a risk to patients or staff

of harm from inadequate or unsafe clinical practice, inappropriate behaviour or because their conduct compromises the effective functions of a team or local primary care service. We have, and continue to, develop new services and products such as mediation, for NCAS to respond to emerging needs, and reviewed the contracts and Service Level Agreements with Northern Ireland and Wales, operating on a revenue generation basis.

Member scorecards

During the year we developed and distributed clinical and non-clinical claims scorecards to Members. These are interactive tools to enable Members to analyse their claims data at a detailed level. Through this we have seen increased evidence of engagement by clinicians and on wards.

Claims scorecards provide a useful improvement tool. Medical directors, directors of nursing and quality, and front line staff can raise awareness, learn from and reduce harmful events and gain a greater understanding of the value and volume of claims through these scorecards. Trust Boards are supported to use the scorecards alongside data on complaints and incidents to help improve safety and drive quality improvements.

Sharing data, combatting fraud

We have improved our organisational transparency by sharing data with other bodies seeking to improve patient safety. We have improved our information technology and joined the Claims and Underwriting Exchange database to share information to help reduce the risk of fraudulent claims against the NHS and other Government organisations. We continue to support the NHS in being open with patients who have suffered harm, promoting our guidance on 'Saying Sorry' and by providing practical support to trusts, via our legal panel, in delivering the statutory duty of candour.

Managing the costs of litigation

The NHS LA has identified opportunities to improve the claims process and deliver access to justice at a more reasonable cost. We developed and implemented a bespoke IT interface with the employers' and public liability claims portal to increase the benefit of the fixed costs regime applied to the claims in this area. This has contributed to our ability to hold contributions for our non-clinical schemes steady in 2016/17. This year saw us develop an in-house litigation team to further reduce the cost of outsourcing litigated cases to external solicitors.

Number of appeals FHSAU received in accordance with the Pharmacy Regulations

283
in 2015/16

265
in 2014/15

In the past year we also piloted a new mediation service. Focusing specifically on fatal and elderly care claims, the pilot sought to determine how we can increase the take up of mediation by claimants and their legal advisers in all claims. The pilot was evaluated positively and in the coming year will extend and expand the service as a result. We hope that this will increase the number of disputes resolved without going to court. In a sample of 47 cases where mediation was completed, 81% were settled without the need for a potentially costly and upsetting court case.

Managing pharmaceutical appeals

The FHSAU provides an impartial tribunal service to deal with appeals resulting from decisions made by NHS England in most primary care matters. Such matters include the appropriate provision of community pharmacy services to patients and the management of contractual services provided by general practitioners (GPs), dentists and opticians which includes appropriate payment for those services. In order to dispense medicines on behalf of the NHS, applicants make a request to NHS England to join the Pharmaceutical list. Any appeals against the decision of NHS England can be brought to FHSAU to resolve. For those already included in the pharmaceutical list they can bring appeals to the FHSAU following decisions by NHS England in matters such as changing the address registered on the pharmaceutical list, changing opening hours or if they have been found in breach by NHS England of their terms of service. For GPs, dentists and opticians they can bring disputes to the FHSAU to resolve and examples of such disputes range from disagreements over contractual payments, alleged breaches of their terms of service and terminations of contract. The FHSAU received 283 appeals in accordance with the Pharmacy Regulations compared to 265 in the last financial year. Much of the work of the FHSAU is around interpreting and sharing knowledge and understanding about how the various regulations relating to primary care services to patients are implemented.

Patient focus

We have further developed our patient focus by including both a designated Non-executive Director and an Executive Member of the Board (the Chief Executive) to lead on this issue whilst identifying this as a whole Board and organisation responsibility. We have implemented changes to ensure an increased patient focus in everything we do with a revised Board agenda and papers to ensure that the broader patient interest is taken into account in our governance and decision-making.

What we do

The NHS LA was established under the National Health Service Act 2006. The NHS LA ensures that claims for compensation involving the NHS are resolved fairly and efficiently by experts in the field. Using the data from claims the NHS LA aims to help the NHS learn from past events to improve patient safety in the future. It offers an impartial tribunal service via the FHSAU for contractor disputes and supports the service by resolving concerns about the performance of doctors, dentists and pharmacists via NCAS. In doing so, it balances the interests of patients, NHS staff and the taxpayer to support the NHS.

The NHS LA contributes to improvements in patient safety by supporting the NHS to learn from past events, including sharing data with other bodies to further this goal.

The NHS LA's role includes:

- proactively working with Members to support their efforts to improve patient safety;
- operating a fair pricing system for indemnity cover, which is responsive to improvements in a Member's claims and safety profile;
- delivering fair outcomes for patients and healthcare staff through the efficient resolution of valid claims;
- robustly defending invalid or excessive claims and disproportionate legal costs and fees;
- resolving concerns about the professional performance of doctors, dentists and pharmacists in a fair, timely, proportionate and defensible way;
- ensuring a prompt and fair resolution of appeals and disputes involving primary care contractors; and
- working collaboratively with others to deliver solutions and inform policy making, such as increased transparency and candour in relation to incidents which result in harm.

The environment we work in

The NHS LA operates within both the Health Service and the Civil Justice system, both of which are under a state of constant change and challenge. The cost of indemnity cover to the Health Service has increased significantly in recent years due to the rising number and value of clinical negligence claims, although the number of claims has fallen back from a peak in 2013/14. In 2015/16 the NHS LA collected £1.42 billion (an increase of 35% from the previous year) from its Members in order to pay compensation and legal costs for clinical negligence claims under the CNST, many of which relate to incidents which occurred some years ago. This cost will continue to increase given the past increase in claims. In 2015/16 the NHS LA's non-clinical claims work did not see similar increases. It is likely that the cost of indemnity cover to the NHS for Employers' and Public Liability cover will remain stable, and for Property cover the cost will reduce by 20 per cent in 2016/17. The stability in the non-clinical area may be at least in part because the claimant legal costs of lower value claims in that area were fixed from July 2013.

On 8 March 2016, DH announced there would be a formal consultation on the introduction of fixed recoverable costs to clinical negligence claims. The NHS LA has been working over 2015/16 to ensure that as an organisation it can respond to any reforms which take place as a result. The growth in claims numbers meant that the NHS LA recruited additional claims staff throughout 2015/16 and it has continued to develop its people in order to manage the rise in claims brought against the NHS in the most efficient and effective way.

Over the past year it has been a priority to develop a 'partnership' approach with the Members of the NHS LA's schemes to help Members manage the rising costs of indemnity at a local level and to share experience across the entire membership of the scheme for the benefit of all.

The NHS LA has taken the opportunity to develop and broaden the products and services it delivers to NHS Trusts and other customers via NCAS over the past financial year and work towards increased revenue generation. This has

been undertaken in light of developments in the way performance is managed in the sector and is also a reflection of the rising demand for support and services as a response. The NHS LA has started the move towards a more regionally focused model of working, aligning the services provided by NCAS, our Safety and Learning and Claims Management teams. In doing so, we will offer greater support to the NHS by building stronger relationships and improving the ease with which we can utilise information from the various business arms of the organisation to deliver an increasingly tailored service.

Continued pressure placed upon the delivery of NHS services in primary care has increased the importance of primary care contract management. Changes in general practice and dentist contract management in primary care and to the way pharmacies are managed and funded mean that the FHSAU has had an increasing role in providing robust precedents, training and guidance in order to ensure better decision making so that limited resources are allocated to provide the best care for patients.

Key issues and risks

Financial sustainability

Financial pressures across the health system remained a key issue for 2015/16, including the cost of clinical negligence. The major contributors to our schemes, primarily NHS providers, have seen an average year on year increase in contributions from Members to settle clinical negligence claims in 2015/16 of 35%, with a further increase of 17% in 2016/17. This increase arises as a result of the growth in numbers and costs of claims reported in prior years reaching settlement and therefore impacting on expenditure.

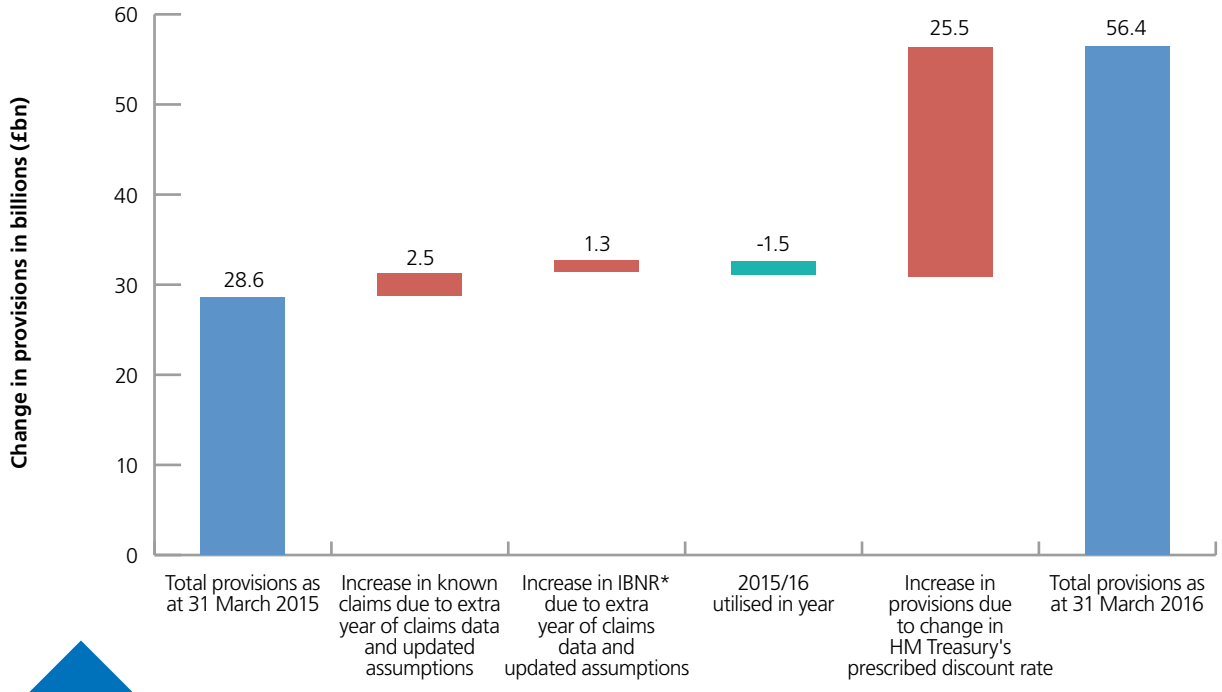
The main feature of NHS LA's accounts is the provision arising from the indemnity schemes that we operate on behalf of the NHS and DH. The provision has increased significantly from £28.6 billion to £56.4 billion over this financial year. By far the most significant factor has been the change in the long term discount rate set by HM Treasury from +2.2% to minus 0.8%. This change accounts for £25.5 billion of the total increase in the provision alone.

The discount rate is designed to recognise the value of money over time: £1 now may be worth more or less in the future. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings at today's prices. It tells us how much we would need to pay out if we settled all of those future obligations today. In accordance with International Financial Reporting Standards (IFRS), HM Treasury has applied market rates which reflect the low cost of borrowing to government in determining the long term discount rate, giving rise to a negative discount rate for very long term obligations.

As a significant proportion of the NHS LA's provisions are expected to be settled over the longer term, the reduction of the discount rate by three percentage points has had a considerable impact on the valuation. However, this is an accounting judgment that does not change the underlying future costs that will be incurred in meeting the obligations arising from claims.

This report sets out the work we are doing to manage claims effectively and influence the legal environment on behalf of the NHS, but also to work with Members to support efforts to learn from incidents and reduce harm to drive down the cost of clinical negligence.

Figure 9: Changes in the NHS LA provisions balance for all schemes.



Of the increase in the provision, £2.5 billion relates to claims arising from another year of activity and changes in the assumptions used to calculate the provision. A further £25.5 billion of the increase is as a result of a change to the HM Treasury discount rate.

*Incurred But Not Reported claims

Changes to the Senior Management Team

During 2015/16, vacancies arose in key operational and corporate functions at Director level, putting at risk the NHS LA's ability to move forward on our challenging agenda. Recruitment has been undertaken throughout the year, and we end the financial year with a complete management team with a range of skills and experience both from within and external to the NHS LA. Handover and temporary cover arrangements, including support from key suppliers, were put in place to minimise gaps where possible, and no major issues have arisen as a result.

Data Quality

The NHS LA has continued to monitor data quality which is important as it is utilised for setting contributions and provisions, and for informing Members on their priority areas for claims reduction. NHS LA data can also be requested under the Freedom of Information and Data Protection Acts.

Legal environment

In August 2015, DH announced a consultation on fixed recoverable costs for lower value clinical negligence claims. The NHS LA has noted that costs for lower value claims have become increasingly disproportionate to both damages and defence costs, and it is expected that fixed costs will incentivise the expeditious resolution of claims at a more proportionate cost.

New models of care delivery

The development of new models of care delivery, including the vanguards, has exposed potential gaps in indemnity cover arrangements. The NHS LA has been working with DH and its lawyers in order to establish how the legal framework governing its schemes might be adapted in order to extend cover to these emerging models of care. The variety and complexity of the contractual arrangements and the statutory nature of the NHS LA's schemes have made this challenging.

Criminal liabilities

The NHS LA dealt with a number of Health and Safety Executive prosecutions following the demise of PCTs, SHAs and NHS Direct which resulted in criminal liabilities arising from these demised organisations being passed to the NHS LA. During 2015/16 the NHS LA entered guilty pleas in relation to two such cases resulting from a defunct PCT and managed the fine levied by the courts from funds allocated by DH. Entering of the first plea was discussed at an extraordinary meeting of the NHS LA Board given the reputational implications and that the transfer of these liabilities was not within the normal course of business.

Further information about our risk environment and controls can be found on pages 75 to 101 in the Governance statement.

A going concern

The NHS LA Board has reviewed the financial position of the organisation and discussed future funding arrangements with DH as part of the Spending Review process, given that the NHS LA reports significant net liabilities. The indemnity schemes that the NHS LA operates are funded on a 'pay-as-you-go basis', that is to say that Members are collectively required to contribute sufficient funds to meet only the settlement of liabilities in the current financial year. There is a reasonable expectation that Government, via DH and the NHS, will continue to fund future liabilities from taxation and borrowing. On this basis the NHS LA is not required to hold assets to cover liabilities arising from the indemnity schemes. Therefore the Board has concluded that it is appropriate to apply the going concern basis of accounting.

Performance measures

The NHS LA has key performance indicators (KPIs) covering all areas of operations to provide overall levels of assurance to the Board and DH. We review our KPIs periodically to ensure that they support us to continually learn and develop our services. Some of these in relation to claims are not published externally to protect the position of the NHS regarding the effective management and resolution of litigation.

The performance of our teams and legal panel is of critical importance to us and in 2015/16 we continued to embed a culture of performance management across the organisation. The performance of our legal panel firms is monitored closely under a range of KPIs which are specified in our contracts with them. This ensures that the work of our panel firms is driven by a balanced set of performance measures to produce a high quality service at a competitive price.

We continued to review the distribution of work and performance in relative, as well as absolute, terms and intervened as required to ensure that the panel firms delivered continuous improvement and value for money. A new scheme of panel audit was implemented in 2015/16. We have introduced a programme of internal quality audit of the work of our own case managers which we have used to build up a body of data on individual and team performance.

During 2015/16 we built upon our experience of our new interface for the Employers' and Public Liability (EL/PL) Claims Portal in order to develop a set of KPIs to measure our performance against portal timescales and targets. We monitored settlement ratios within the portal closely to ensure that, despite exacting time limits, we delivered a high quality of investigation, appropriate settlements and robust repudiations.

The quality of our data is of critical importance to us. In the past financial year we developed our data quality monitoring process through the production of a data checklist, forming an integral part of our auditing process. We developed and increased the level of exception reporting to improve the accuracy of our data, informed by review exercises in this area. We dedicated some internal claims resource to a data accuracy review, as well as reinforcing messages to case managers about the importance of data quality. Mandatory training on data quality issues and the correct approach to reserving of claims became a regular feature of our training programme and a core part of our induction programme.

The NHS LA's Board and other governance frameworks monitored a variety of workforce indicators, including establishment levels, employee turnover, recruitment, sickness absence, levels of pay, and equality and diversity statistics, to ensure the associated HR issues flowing from the business of the NHS LA were properly managed.

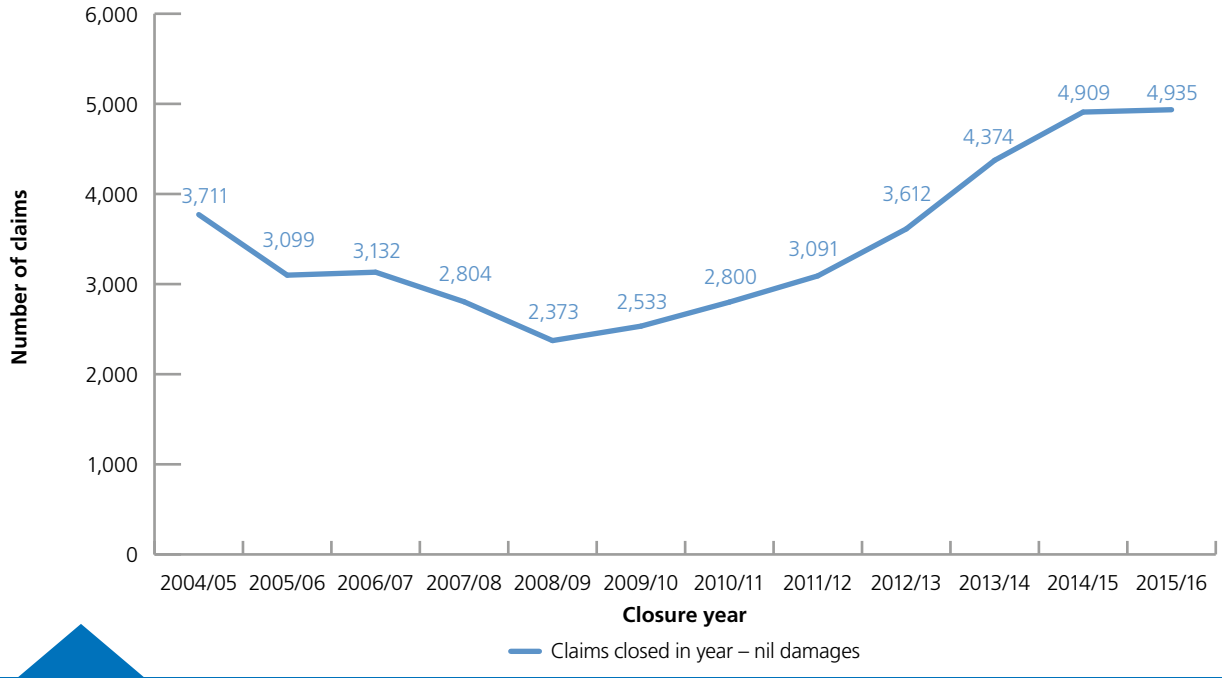
Performance analysis

Claims management

Claim volumes

We received 10,965 new clinical negligence claims in 2015/16, compared with 11,497 received in 2014/15. In the same period we received 4,172 new non-clinical liability claims, typically employers' and public liability claims, compared with 4,806 in 2014/15. The number of new clinical negligence claims fell by 4.6% on last year and the number of new non-clinical claims fell by 13.2%. Nevertheless 15,137 claims is a significant number and represents a challenge for our teams, legal panel and the NHS as a whole. We continue to receive, and to defend, a high number of claims which resolve without a payment of damages: 4,935 in 2015/16.

Figure 10: The number of clinical negligence cases resolved without the payment of damages in each financial year from 2004/05 to 2015/16.[3]



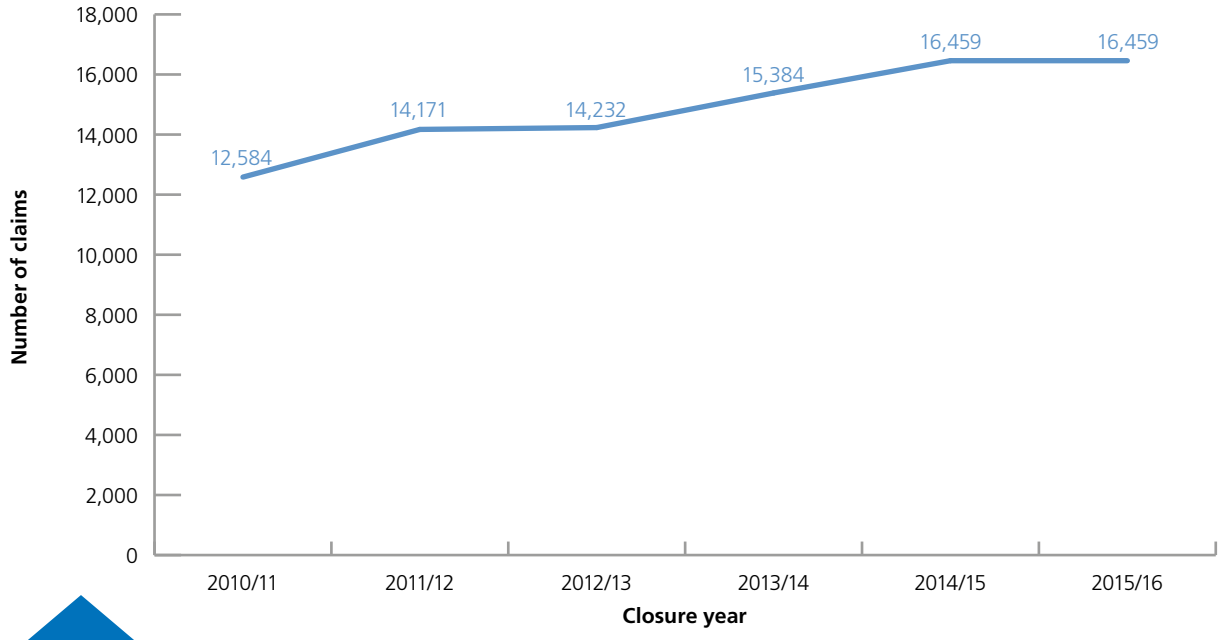
The number of clinical negligence cases resolved without the payment of damages has risen slightly over the past year.

3 Due to the processing of claims, some claims may be closed in-year, but subsequently re-opened as a result of new information, as such these data can vary over time.

We continue to resolve justified claims as quickly as practicable and closed a total of 16,459 clinical and non-clinical claims in 2015/16.

We continue to deliver consistent, high quality case management, and where appropriate employ a range of alternative dispute resolution options including mediation. We seek to resolve claims without litigation and in 2015/16 fewer than 1% of the clinical and non-clinical claims we resolved proceeded to trial, of which 60 per cent were defended successfully.

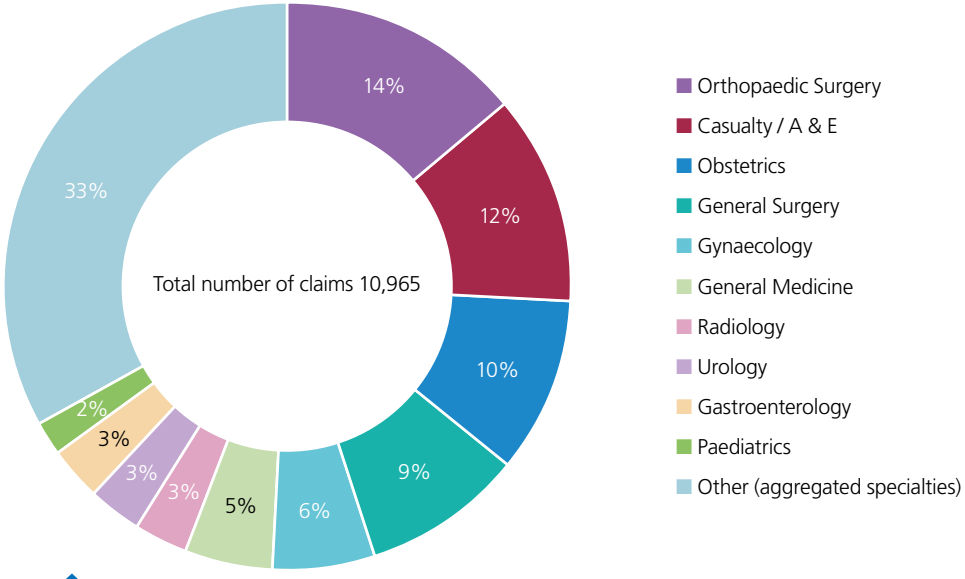
Figure 11: The total number of clinical and non-clinical claims closed in 2015/16.[4]



The same number of claims were closed in 2015/16 as in the previous year.

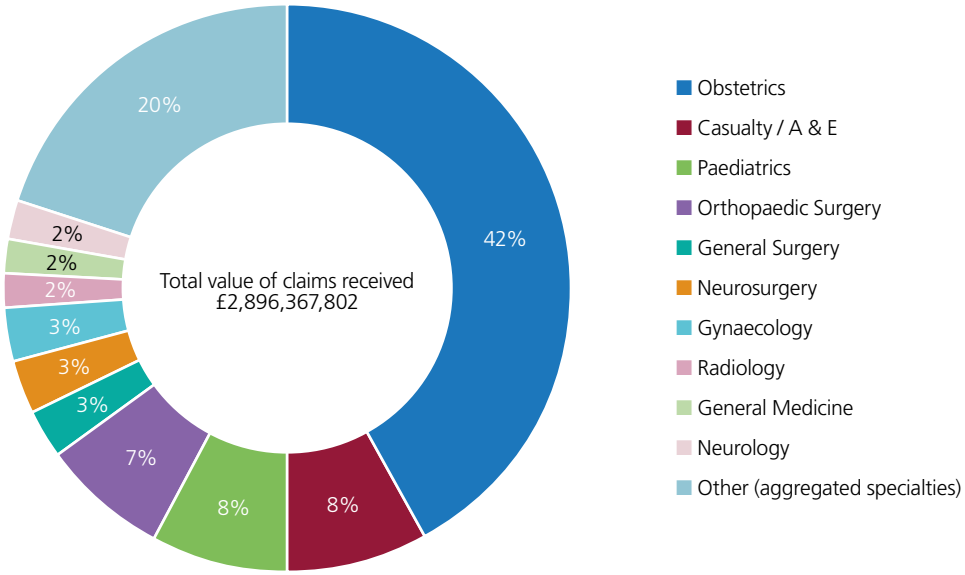
4 Due to the processing of claims, some claims may be closed in-year, but subsequently re-opened as a result of new information, as such these data can vary over time.

Figure 12: The number of clinical negligence claims received in 2015/16 by specialty.



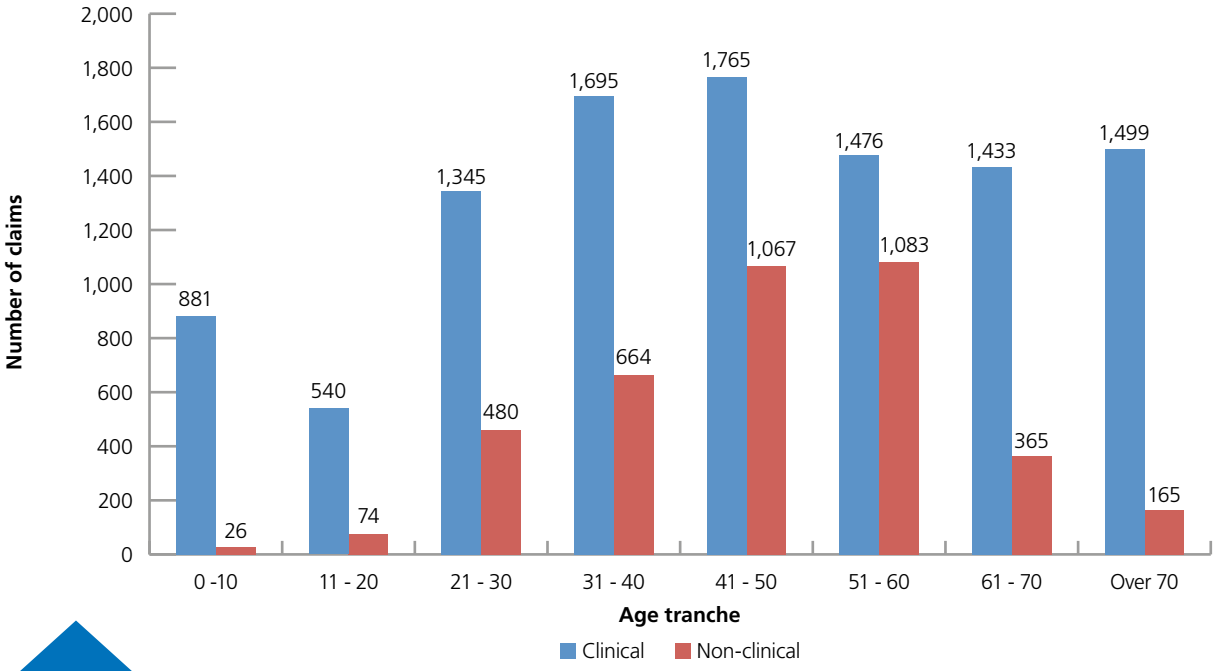
The greatest *number* of claims received in 2015/16 was from the specialty area of 'orthopaedic surgery', continuing a year-on-year trend.

Figure 13: The value of clinical negligence claims received in 2015/16 by specialty.



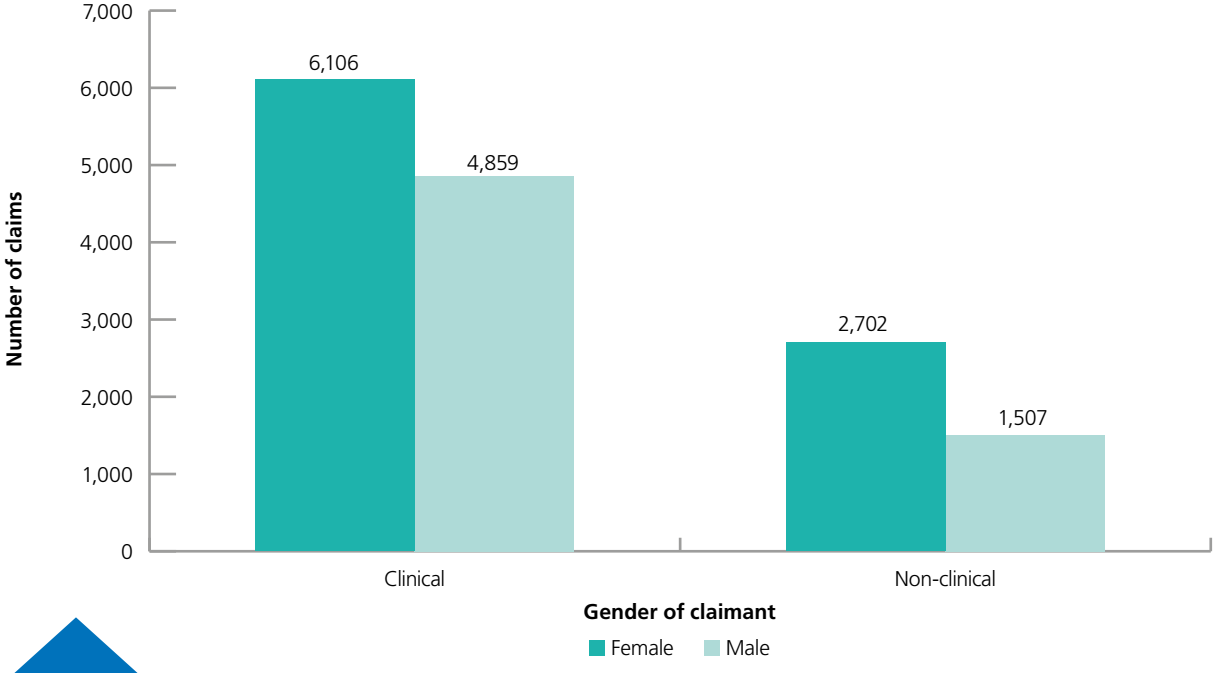
The highest *value* of claims received in 2015/16 was from the specialty area of 'obstetrics', continuing a year-on-year trend.

Figure 14: Number of claims received in 2015/16 by age group of claimant.



In 2015/16 the largest numbers of clinical and non-clinical claims were made by claimants in the 41-50 and 51-60 age ranges, respectively.

Figure 15: Number of claims received in 2015/16 by gender of claimant.

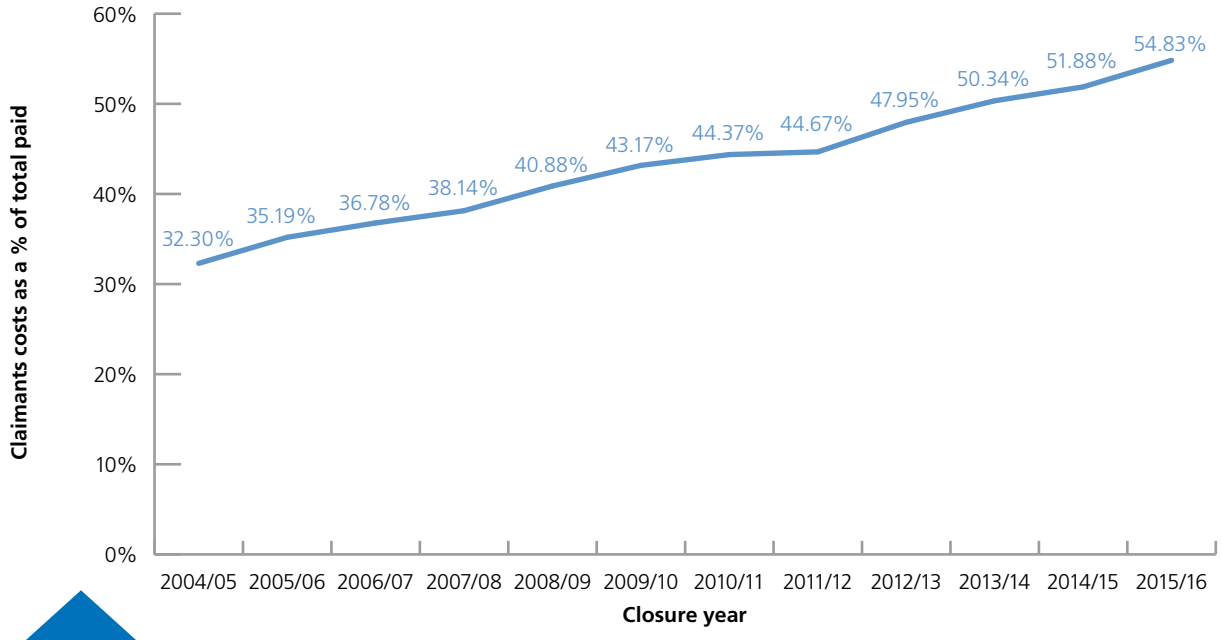


In 2015/16 greater numbers of both clinical and non-clinical claims were made by female rather than male claimants.

Legal costs

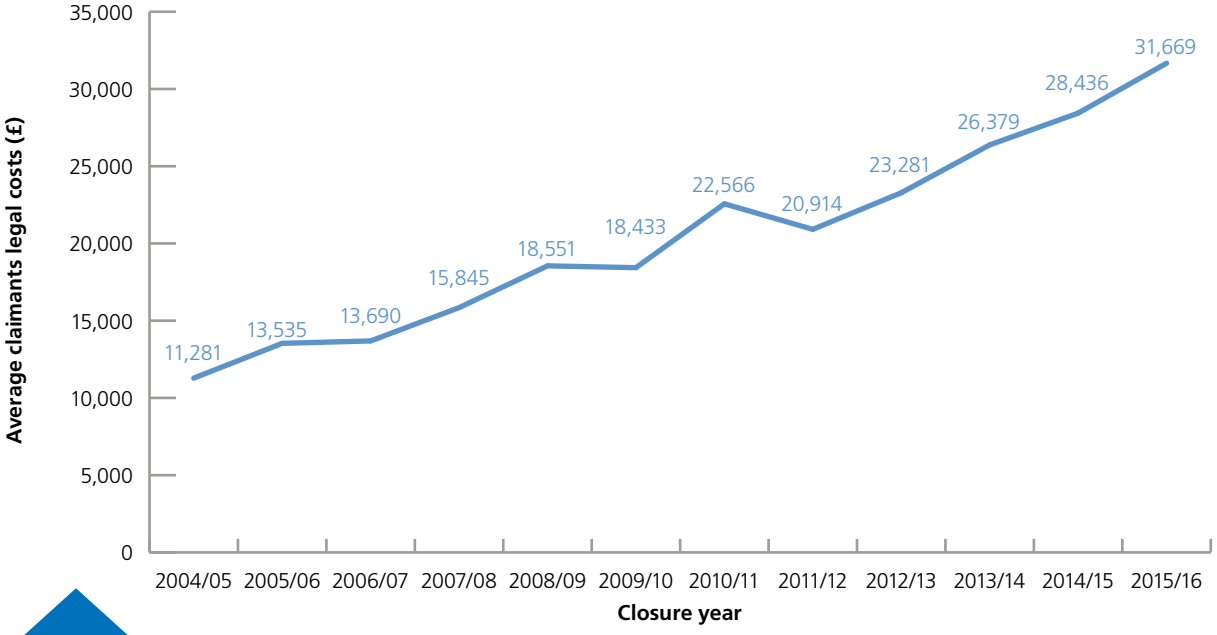
We continue to target overcharging by claimant law firms, challenge bills and points of principle at court, and report poor practice to the Solicitors Regulation Authority as appropriate. We also ensure that our legal panel is instructed at agreed hourly rates or fixed fees appropriate to the value of the case.

Figure 16: Average claimant legal costs as a percentage of the total claim value (where damages are below £100,000) by financial year from 2004/05 to 2015/16.



Average claimant legal costs as a percentage of the total claim value continue to rise year-on-year, where damages are below £100,000, currently standing at around 55%.

Figure 17: Average of claimant costs paid on claims where damages are below £100,000 by financial year from 2004/05 to 2015/16.



Average of claimant legal costs paid on claims where damages are below £100,000 continue to rise, reaching £31,669 in 2015/16 in comparison to £28,436 in 2014/15.

Y v. Doncaster and Bassetlaw Hospitals NHS Foundation Trust (High Court, 24 February 2016)

This was an important decision on legal costs rather than on the substantive issues in the case which were resolved amicably between the parties.

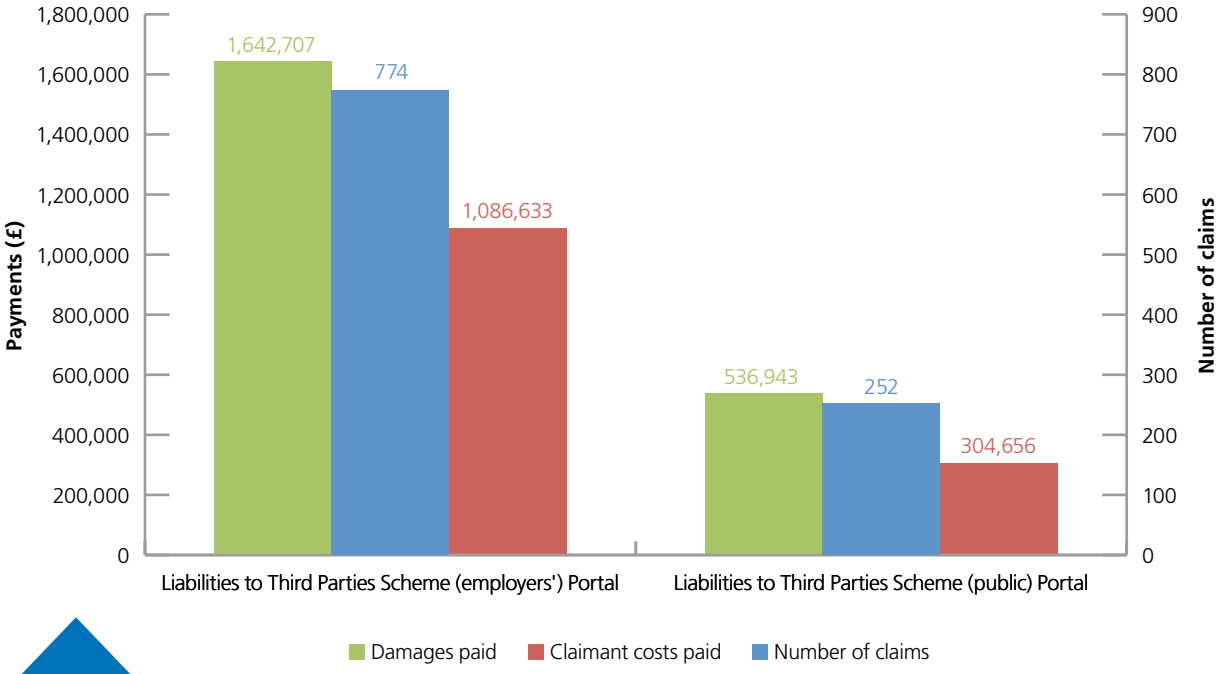
Major reforms to the basis for recovering costs were implemented on 1 April 2013 following recommendations from Lord Justice Jackson, a member of the Court of Appeal. Probably the most important of these was that for new cases signed up by claimant lawyers on or after this date, success fees on 'no win-no fee' agreements would no longer be recoverable from defendants. Uplifts of up to 100% were potentially available under such arrangements. Instead, success fees at a much more modest level could be recouped from clients, at the lawyers' option, and general damages for pain and suffering were increased by 10% on relevant cases. Immediately prior to 1 April, some claimant solicitors switched funding on numerous claims from Legal Aid to no win-no fee. This is one of five cases where we successfully challenged the transfer of funding. The judge held that the family was not advised that by switching funding the claimant would lose out on the 10% uplift in general damages, which would have been a material factor for them. Also, limited evidence had been disclosed to justify the switching decision. He considered that the firm in question had given advice "tailored to a decision they had already made". Consequently, he disallowed the additional costs sought – this saved the NHS over £100,000. The five cases combined have seen a total of £750,000 taken off claimants' legal bills.

The claims portal

The extension of the road traffic accident personal injury claims portal to low-value employers' and public liability claims has now been operating for nearly three years. The NHS LA resolved 1,026 claims in the portal in 2015/16.

The portal provides a mandatory secure route for claimants to lodge specified categories of claims valued up to £25,000. Undefended claims are processed within the portal to conclusion and payment of damages. Before the introduction of the portal, low-value employers' and public liability claims attracted claimant legal costs which could be in excess of 100% of the damages value. For all employers' and public liability claims closed in the twelve months immediately prior to implementation of the portal with damages paid up to £25,000, the ratio of claimant costs as a percentage of damages paid was 145%. In the portal, claims settled between £10,000 and £25,000 in damages attract claimant legal costs of £1,600, plus disbursements, and for claims settled under £10,000, £900 plus disbursements. The ratio of claimant costs as a percentage of damages paid for employers' liability claims settled in the portal is 66%, and stands at 57% for public liability claims. The portal allows claimants to be compensated quickly where liability is established, and the introduction of fixed recoverable costs has contributed to a significant reduction in the exposure of the NHS to disproportionate legal bills.

Figure 18: Claims by volume and payments for both public and employers' portals under the Liabilities to Third Parties Schemes for 2015/16.



Following changes to recoverable costs for low-value employers' and public liability claims, the ratio of costs to damages fell to 66% for employers' liabilities and 57% for public liabilities.

Employers' liability claims

In 2015/16 there was a marked fall-off in new employers' liability claims notified under the Liability to Third Parties Scheme (LTPS), a decline broadly mirrored in the commercial insurance market. Section 69 of the Enterprise and Regulatory Reform Act 2013 came into force on 1 October 2013 for incidents occurring on, or after, that date and changed the landscape for personal injury claims. Section 69 of the Act removed strict civil liability on the part of employers who breach health and safety regulations. Previously, a breach of health and safety regulations, even without common law negligence, would be enough to entitle an injured party to compensation. So, for example, where equipment in the workplace failed and injured an employee, the employer would be liable to pay compensation even if the failure was not foreseeable and even where the employer could show that it had in place a robust system of inspection, maintenance and repair. The effect of section 69 was to require claimants to prove that any injury was foreseeable and resulted from the breach. Thus claims arising from breaches of health and safety regulations alone are less likely to succeed and less likely to be brought in the first place.

Trust not responsible for provision of footwear for community midwives

A community midwife slipped on ice during a home visit and alleged that her employing NHS trust ought to have provided protective footwear, specifically crampons. The trust had produced evidence of policies in relation to appropriate footwear, lone working and slips and trips, along with risk assessments and training. The claimant's case was that she was 'at work' and therefore the trust was required to provide her with footwear to reduce the risk of slipping. The trust sought to draw a distinction between work related risks and other risks which a worker may be exposed to in the same way as any other member of the public. The risk of slipping and falling on ice in the street was a risk to which every member of the public was exposed and was not therefore exclusively work-related.

The court dismissed the claim, agreeing that there was no dispute that the claimant was 'at work' at the time of her accident but rejecting the view that this was all that was required for an employer to provide non-slip footwear under the Personal Protective Equipment (PPE) Regulations. The court held that the claimant's interpretation would mean that any employee who, during their working day, had to venture outside their employer's premises in inclement weather would require their employer to provide protective footwear, and that this was too high a threshold. The court found that there was a clear distinction between a risk which is work related or work created and one that is not.

“Mediation is a powerful forum, giving the injured person the opportunity and the ‘voice’ to articulate their case and other concerns which is not possible at a meeting with just lawyers.”

Mediation

Mediation is an excellent forum for dispute resolution, for providing injured patients and their families with face to face explanations and apologies, and for curtailing legal costs. The NHS LA supports and encourages mediation on all suitable cases. We have undertaken a significant number of mediations throughout our 20 year history, often in high profile cases and group actions to good effect.

On 31 July 2014 we launched a mediation service as a pilot and the last mediation in the scheme was completed in March 2016. The pilot supplemented the NHS LA’s ongoing drive across all claims to encourage mediation and so the figures below do not represent the full extent of mediation undertaken during the year. The pilot targeted all suitable cases notified to our Members involving a fatality or elderly care. The service provided access to an independent and accredited mediator, selected from a panel drawn from a wide range of backgrounds.

Offers of mediation were made in **91** cases:

49 cases were accepted into the pilot;

1 case was settled before mediation;

1 case was withdrawn; and

47 mediations were undertaken.

The objective of the pilot was to test the usefulness of the mediation process and how it could be employed to greater effect for claims resolution. Throughout the pilot feedback was obtained from the participants and the comments were very positive. Of the completed mediations 81% were settled, with 61% of the settlements achieved on the day of the mediation and a further 20% a short time thereafter, which we consider a success.

It is our experience of the cases we have mediated both under the pilot and throughout our history that mediation is a powerful forum, giving the injured person the opportunity and the ‘voice’ to articulate the basis of their case and other related concerns which is not possible at a meeting with just lawyers. It is also a good setting to explain why a legal liability has not been established to justify a financial payment.

Our experience of mediation has shown its invaluable benefits and we are now undertaking work to establish a permanent NHS LA mediation service. This will involve a formal procurement exercise inviting tenders from organisations and individuals to join a panel.

Participants' comments on the mediation pilot

"[The mediator] was easily contactable by email before the mediation. On the day [the mediator] was very approachable and worked with both parties to achieve a settlement."

"Difficult and sensitive case. Mediation allowed expression of feelings and issues to be dealt with in a way not as easy in a round table meeting."

"It was a very useful process and achieved settlement before a three day trial."

"A settlement was achieved at the mediation and we believe that the process assisted in achieving the desired outcome."

"The private consultations were useful and it also proved to be a useful strategy to confidentially let the mediator know the limit of our authority so that he could provide a neutral perspective as to whether a settlement was likely."

"We found the mediator to be very helpful. [The mediator] explained the process of mediation very clearly, and worked with the parties to attempt to narrow the issues. [The mediator] facilitated discussion as a third party and enabled us to quickly resolve the outstanding points and achieve an agreement which, although not concluded on the day, was finalised shortly thereafter."

Trials

We continue to defend those cases where we consider there has been no negligence or where the amount claimed is thought to be excessive. We have had a number of trial successes in 2015/16, taking 124 cases to trial with a 60% success rate. Below are the 75 cases taken to trial where we were successful, broken down by the issue in dispute:

Liability and quantum	**34**
Breach of duty only	**25**
Causation only	**9**
Breach of duty and causation	**5**
Quantum only	**1**
Limitation	**1**

Supporting clinicians

This case illustrates the importance of supporting clinicians through what is often a stressful process, particularly where, as here, the claim arises from the tragic death of a patient. The facts of the case were that following bowel surgery the patient suffered a breakdown at the stapled anastomosis, leading to a failure of the blood supply. As a result sadly the patient passed away eight days post-surgery. It was alleged that the procedure was negligent and resulted in ischaemia at the site of the anastomosis. The surgeon was alleged to have failed to exercise adequate care and skill by not ensuring an adequate blood supply at the site. At the trial the surgeon was clear and considered when giving evidence, taking time to explain to the court his method of performing the procedure in a way that was easy to understand, and going as far as to bring equipment with him to demonstrate the mechanics of the procedure. This helped the court to understand the mechanism of injury. The judge was impressed and found that the surgeon's evidence was "careful, accurate and honest". Judgment was entered for the NHS trust. The estimated costs attached to the case had it been lost were in excess of £200,000.

Defence of 24 year old case

The claimant, born in 1992, suffers from a variety of physical disabilities which are the result of athetoid cerebral palsy, but is cognitively intact and has full capacity. The claimant alleged that the management of his mother's antenatal care was negligent and delayed his delivery, and that as a result he suffered injury at the end of labour due to profound hypoxic ischaemia. It was common ground that the claimant suffered a short period – no more than ten minutes – of profound hypoxic ischaemia when the umbilical cord, which was wound round his neck, tightened, but there was a difference of expert opinion as to the extent of any harm caused in the ten-minute period. The court found in favour of the NHS trust and ruled that the claimant had failed to establish that his delivery had been negligent. The judge commented that even if there had been negligence, there was no evidence that delivery would have happened sooner or that the harm would have been avoided. The conduct of this case illustrated the many difficulties inherent in defending allegations of negligence dating back almost a quarter of a century, including tracing records and the failing health and fragility of elderly witnesses. The value of this case had it been lost was in excess of £6 million.

Defence of a low-value claim

The claimant alleged a negligent failure of A&E clinicians to diagnose a ruptured tendon following a laceration at the base of her thumb. She attended A&E, the wound was sutured and she was advised to attend her GP in seven days to have the sutures removed. Subsequently the claimant experienced pain, restricted movement and loss of sensation in the thumb, and upon further investigation was found to have a complete rupture of the extensor pollicis longus tendon. Surgery to repair the tendon was successful and the claimant regained full function of the hand, but was left with surgical scarring that she argued was more prominent and extensive than would have been the case had the rupture been diagnosed and repaired earlier. The claim was worth in the region of £13,000. The NHS trust always believed that when the claimant presented in A&E there was no evidence the tendon was fully ruptured and that the treatment within A&E was entirely appropriate. After hearing expert evidence from both sides the court found that the tendon was not fully ruptured at the time of the A&E attendance and that the claim must fail. This case illustrates that a poor outcome is not necessarily the result of negligent treatment, and highlights the importance of defending low-value clinical negligence claims where there is clear and compelling evidence that the treatment was entirely appropriate.

Trials – the importance of preparation

This is a tragic case where a patient died after contracting perineal necrotising fasciitis, a devastating soft tissue infection characterised by widespread necrosis of the skin tissue. Treatment requires early surgical intervention. The deceased had been admitted to hospital for a reverse loop ileostomy, a relatively straightforward procedure under general anesthetic, but had developed complications, it was alleged, as a result of a negligently acquired and preventable infection which led to necrotising fasciitis. The claim on behalf of the deceased was valued over £100,000. Liability was in dispute and the parties could not reach agreement. The matter was set down for trial. The NHS trust had supportive expert evidence on both breach of duty and causation, tested in conference with Counsel, and the strength of that evidence led to the trust inviting the claimant to discontinue a week before the trial was due to start. The offer was not accepted and we took the decision to contest the claim at trial, but at noon on the last working day before the trial the claimant filed notice of discontinuance. The claimant's insurers were liable to meet the trust's own legal costs estimated to be in excess of £70,000. Had the matter proceeded to trial and had the court found against the trust the claimant's legal costs were estimated to be in the region of £200,000, and this case highlights the financial risks present when making decisions to contest claims and the importance of thorough preparation by testing evidence in advance.

Historic liabilities

We continue to manage the run-off of claims arising from historic non-clinical liabilities for dissolved NHS organisations. These are mainly occupational disease claims, typically asbestos-related disease and noise induced hearing loss. Around 400 claims in total have been processed since December 2013 and of those approximately 280 have been resolved. Many claims arise from events occurring in the 1970s and 1980s, and in some cases earlier.

We also manage claims arising from the liabilities of former strategic health authorities and primary care trusts. These include both clinical negligence liabilities and employers' and public liability claims. Around 1,000 claims are currently open. Expenditure on DH-funded legacy schemes in 2015/16 amounted to £122m.

Customer service

In March 2015 we launched a customer satisfaction survey in order to seek feedback from Members on the performance of our claims function and how we can improve our services. The survey results which were reported in May 2015 were very encouraging. There was good engagement from Members who were largely satisfied and valued the quality and expertise of the claims service, but some indicated they would like more engagement around claims management and increased functionality via the Members' extranet. We are undertaking a number of activities to drive continuous improvement of our service and engagement with Members and other stakeholders. These will include preparation of a detailed Member manual, a review of the services we provide to our Members on our extranet and a consultation with Members on the future development of CNST. We intend to carry out further Member surveys in the future. We have established two new external advisory groups: one focused on Member services and the other on safety and learning.

Counteracting claims fraud

During the year we joined the Claims and Underwriting Exchange, a database of non-clinical claims reported to insurers. This enables us to share information with other indemnifiers so as to identify potentially fraudulent claims. We are very conscious of the information governance risks entailed in such an initiative and ensure that due legal process is adhered to.

Surveillance saves £2 million

One method of validating claims is carefully targeted surveillance. In this case the claimant, who had been the subject of admitted clinical negligence, alleged chronic post-surgical pain, that he was unable to walk significant distances, had to use a wheelchair when leaving his house and avoided going out whenever possible. There was a substantial claim for the cost of care, therapies and equipment. Our medical expert who examined the claimant considered that his account was inconsistent with his apparent physical function. Surveillance was therefore authorised and this showed the man walking around a town centre for a lengthy period, apparently without difficulty, and loading a pushchair into the boot of his car. As a result we withdrew an offer we had made prior to service of the surveillance evidence. Savings were estimated at £2 million.

Legal developments and important cases for the NHS

We continue to be involved in a number of significant decisions in the higher courts which are covered by this section, together with some interesting first instance rulings.

ABC v. St. George's Healthcare NHS Trust and Others (High Court, 19 May 2015)

In 2007 the claimant's father (F) shot and killed ABC's mother, as a result of which he was detained at a secure clinic, having been convicted of manslaughter on the grounds of diminished responsibility. In 2009 it was suspected that he was suffering from Huntington's disease and he was referred to St George's Healthcare NHS Trust, who confirmed the diagnosis. This is a genetic condition which has a 50% chance of recurrence in the next generation. Various health professionals sought F's permission to disclose the diagnosis to ABC, who was pregnant at the time. He refused. In 2013 ABC herself was diagnosed with the condition, but it was too early to tell whether her daughter had the disease.

ABC maintained that she should have been informed of her father's condition whilst pregnant and that if she had been told about it she would have undergone testing. If that had proved positive she would have had a termination. She also claimed to have suffered psychiatric trauma. We applied to strike out the claim on the basis that it was not fair, just or reasonable to allow it to proceed.

The judge agreed and held that the claim was bound to fail. He concluded that whilst patient confidentiality was a qualified duty, none of the healthcare bodies involved in this case were obliged to disclose to family members information about F's condition. It would be a radical departure from existing law to impose a liability in such circumstances.

We regarded the basis of this claim as conflicting with the basic duty of patient confidentiality, and whilst the background circumstances of the case were tragic, they were insufficient to counteract that duty. The High Court fully endorsed that position.

R v. Liverpool Women's Hospital NHS Foundation Trust (Court of Appeal, 17 June 2015)

This too was a very sad case. Mrs R underwent a hysterectomy but as a consequence of negligence in the course of surgery a suture was misplaced in her colon. She developed septicaemia and peritonitis and remained in intensive care for nine weeks. She subsequently recovered from this ordeal and we admitted liability in respect of her claim.

The aspect which went to the Court of Appeal was her husband's claim for psychiatric trauma resulting from seeing his wife connected to equipment such as a ventilator, observing her in an unconscious state and noting that her arms, face and legs were very swollen. In the Liverpool County Court Mr R was awarded £9,166, but we considered that ruling to be erroneous and decided to appeal, even though the damages were not high.

Lord Justice Tomlinson, giving the main judgment in the Court of Appeal, agreed with our view that the County Court had failed to apply correctly the law in respect of 'secondary victims' such as Mr R, which was laid down by the House of Lords in 1992. In particular, the claimant had not suffered a single shocking event as the law required but rather from a gradual realisation that his wife's life was in danger as a consequence of the initial surgical mistake. The appearance of his wife was such as might be expected in a hospital setting and was not exceptional. No doubt it was alarming and distressing, but it was not in the overall context wholly unusual. Consequently the award was overturned.

No-one doubted that Mr R had suffered genuine mental trauma. However, that is insufficient to recover damages in a case such as this. As another judge remarked some twelve years ago, for a visitor to a hospital to be awarded damages in respect of seeing a loved one in a distressed state, the circumstances must be wholly exceptional so as to shock or horrify. This is the control mechanism adopted by the law to prevent large numbers of hospital visitors from recovering damages, which would be unsustainable for both the NHS and private hospitals.

D v. Croydon Health Services NHS Trust (High Court, 31 July 2015)

Following an assault to his head, Mr D attended the A&E department of Mayday Hospital, accompanied by a friend. He was booked in at 20.26 hours and left at 20.45 without having seen a clinician. On reaching home his condition deteriorated and he was returned to hospital by ambulance an hour later. Unfortunately he suffered a left hemiplegia and is permanently disabled. It was agreed that had he remained in A&E he would have been treated sufficiently soon such that his disability would have been avoided.

He claimed that he left because the receptionist was "off-hand" and informed him that he would have to wait four or five hours. The system in place was that patients would be seen by a triage nurse, the relevant NICE guideline in force stating that those with head injuries should be reviewed by a trained person within 15 minutes. That guideline was broken, given that the claimant had been in hospital for 19 minutes before departing.

The judge accepted that Mr D was not told that he would be seen by a triage nurse within 30 minutes, which was the usual maximum within the department, and also that the claimant would have remained had he been advised this. However, he was not prepared to find that breaching the NICE guideline amounted to negligence.

Consensus amongst the expert witnesses was that a long-stop time of 30 minutes in this case was reasonable. The other main basis of the claim was that A&E receptionists owed a duty of care to give accurate information as to waiting times. That, held the judge, was not fair, just or reasonable. The waiting time for a patient was a matter for clinical judgment, to be made by a healthcare professional. Receptionists were not under a duty to guard patients against harm caused by failure to wait and be seen. Mr D had to take responsibility for the consequences of his decision to leave.

This is the first case, to our knowledge, where it was alleged that receptionists owed such a wide duty to patients. The claimant's representatives are planning to take this issue to the Court of Appeal, so the matter is not concluded yet. This case is important because it also helps to define who is responsible when a patient discharges themselves before being triaged and clarifies the limits of an A&E receptionist's legal duty to a patient.

R v. University Hospital of North Staffordshire NHS Trust (Court of Appeal, 2 November 2015)

Mrs R was paralysed below the mid-thoracic level. This was not a result of negligence. She required a few hours care each week, which were predicted to rise to over 30 hours per week by the age of 75. During an extended period in hospital she developed a number of deep (grade 4) pressure sores which severely increased her disability and her need for care. Liability for the pressure sores was admitted, and the case proceeded to the High Court on quantum only. Mr Justice Foskett held that the NHS trust should be responsible for all of the claimant's care needs on the basis that a negligent party must "take its victim as it finds her". We considered that this was an incorrect application of the law and therefore appealed to the Court of Appeal.

The leading judgment was given by the Master of the Rolls, Lord Dyson, who is the senior judge in that court dealing with civil cases. He fully endorsed our argument. The trust was only liable to the extent that it had worsened Mrs R's condition. Lord Dyson held that the trial judge had been wrong on this point.

We consider this to be a significant ruling because it demonstrates that where a claimant has pre-existing care needs, it is not equitable for a defendant whose negligence has increased those needs to be responsible for the original care requirements.

W v. Bermuda Hospitals Board (Privy Council, 25 January 2016)

We were asked by the Board's insurers to become involved in this case because it concerned issues of material contribution to damage, a topic upon which the law in England is far from straightforward. In essence, if a defendant has materially contributed to a claimant's injury, and that injury is regarded by experts as being indivisible in terms of causation: in other words it cannot be determined which part of the injury was caused by negligence and which was not, the defendant can be held liable for the whole of the claim. The Privy Council is the ultimate court of appeal for certain Commonwealth jurisdictions and the judges are members of the UK Supreme Court, so its rulings carry great weight, although technically they are not binding on the courts here. We were given leave by the court to make written representations.

However, rather than reviewing the whole basis of the law as it relates to material contribution the Privy Council decided this case on its own facts and upheld the ruling of the Bermudan Court of Appeal in favour of Mr W. We shall now await an opportunity to argue the point in another suitable case.

Safety and Learning

NHS LA's Safety and Learning Service was established at the time of the removal of risk management standards in 2013. Over this last year, the team has focused on supporting trusts to improve safety, and reduce harm and subsequent claims. This includes raising awareness of the value and volume of claims in trusts and enabling trusts to analyse their claims by providing a quality improvement tool. In particular, the Safety and Learning Service supported the Sign up to Safety campaign through an incentive scheme, which offered the opportunity for trusts to bid for funding to support implementation of safety improvement plans to reduce harm and potential claims.

Sign up to Safety is a patient safety campaign launched in June 2014. The campaign is one of a combination of three large scale initiatives launched in 2014 (Sign up to Safety, a network of fifteen patient safety collaboratives, and the Q initiative[5]) to improve safety and learning, and reduce avoidable harm and save lives. A key aspect of Sign up to Safety is for each of the national organisations to provide support for members of the campaign – the NHS LA does this in two ways; first it hosts the campaign team and secondly it led an incentive scheme whereby organisations received funding to help them reduce harm associated with their litigation claims. The Sign up to Safety campaign has successfully increased awareness of patient safety and has over 350 member organisations who have joined and pledged to improve patient safety across the NHS in England. The approach is to create long term plans to embed sustained change through locally owned bespoke safety improvement plans. The campaign provides members with support through a monthly free webinar programme, sharing the latest thinking on patient safety and local stories of implementation via a weekly newsletter, website links and a variety of blogs.

Incentive scheme

The NHS LA awarded more than £18.7m to 48 trusts which submitted a range of innovative projects aimed at improving safety and reducing harm to patients. Trust chief executives committed to seven conditions for receiving the funds which included publishing their successful bids on their trust websites, sharing progress, maximising procurement opportunities and 'buddying up' with unsuccessful bidding trusts.

The NHS LA's Safety and Learning Service committed to working with trusts to progress three main categories of the funding allocated.

5 Q is an initiative, led by the Health Foundation and supported and co-funded by NHS Improvement, connecting people skilled in improvement across the UK.

“The NHS LA and NHS Supply Chain collaborated with trusts to help save nearly 16% on the cost of vital maternity equipment.”

These included maternity, A&E (missed fractures) and human factors/safety culture. The NHS LA has published full details on its website on the outcome of the Sign up to Safety bids, including the funding which each trust received.

Events were held across the country to share progress on implementation and best practice from the bids: these included maternity events in July 2015 in Manchester and London, a missed fractures in accident and emergency event held in November 2015 in London, and two human factors events in March 2016 in Liverpool and Canterbury.

The maternity event invited representatives from 51 trusts who submitted bids as part of the NHS LA incentive funding scheme (25 successful, 26 unsuccessful maternity units). The maternity events were supported by The Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists, National Institute for Health Care Excellence (NICE), NHS Supply Chain and the NHS Electronic Staff Record. Facilitated discussion with attendees focused on what measures might be helpful to monitor progress and improvements.

Working together, the NHS LA and NHS Supply Chain identified an opportunity to support trusts to collaborate resulting in a saving to the NHS of nearly 16% on the cost of vital maternity equipment. As a result, both organisations were selected as finalists in the National Government Opportunities Excellence in Public Procurement Awards 2016/17 (Health Care Section).

The accident and emergency event in November 2015 was supported by The Royal Colleges (Emergency Medicine and Radiologists) as well as the Society of Radiographers, Health Education England (HEE) and NICE. The event shared learning between 15 successful and unsuccessful bidding trusts on the progress with implementation in the particular area of ‘missed fractures’. The event was targeted at professional leads for emergency medicine, emergency nurse practitioners, radiologists, radiographers or the trust lead for patient safety/safety improvement plan. This was regarded as an excellent opportunity for staff from all disciplines to hear each other’s viewpoints on the issue of ‘missed fractures’ and to develop a greater appreciation of the challenges faced by staff groups involved in the patient’s journey in accident and emergency. In addition, the professional bodies were able to listen to and reflect on the innovations being undertaken by trusts awarded funds as part of the incentivisation scheme to reduce the occurrence of missed fractures in accident and emergency departments. One of the main discussion points at the workshop resulted in a proposal to develop a ‘Best Practice Standard for Emergency Department Imaging Service’.

The human factors events held in association with the Clinical Human Factors Group were held at Liverpool and Canterbury Universities in March 2016. These free events attracted around 300 delegates from NHS trusts and showcased the progress made by those trusts which received funding (£6.6 million) for bids from the incentive scheme.

A full financial evaluation in relation to maternity and missed fractures in A&E has been commissioned by the NHS LA and will report later in the year.

The NHS LA is committed to supporting trusts to share best practice and has introduced the **'Ask and Offer'** initiative on its website. This is where we encourage trusts to both give and offer support and resources to each other, for example, sharing outcomes of successful projects, templates developed for deriving information from claims scorecards, duty of candour policies and standard operating procedures.

Engagement offer to trusts around Safety and Learning

The Safety and Learning Service supports trusts to consider how they can reduce harm and claims in a number of ways, including offering visits to trusts to consider analysis of claims and to support trusts to triangulate claims, complaints and incidents data.

In September 2015, updated clinical claims scorecards and, for the first time, non-clinical claims scorecards were disseminated to all trusts. The claims scorecards covered all claims with an incident date from 1 April 2010 to 31 March 2015 and are supported by a leaflet produced to promote the tool at a trust level.

Claims scorecards provide a useful improvement tool which medical directors, directors of nursing and quality and other front line staff can analyse to raise awareness, learn from and reduce harmful events as well as gain greater understanding of the value and volume of claims. Trust Boards are supported to use the scorecards alongside data on complaints and incidents to help improve safety and drive quality improvements.

Trusts and panel legal firms are invited to share examples of case stories for the benefit of the wider NHS and demonstrate how a trust has learned and implemented improvements. Patients tell us what matters most to them is ensuring the NHS learns from their experiences and takes every opportunity to share learning to prevent harm and recurrences of these types of incidents. The following is an example where the family has given permission for us to tell their story to prevent this happening to someone else.

Patient case story

A patient had chronic kidney disease and it was anticipated that in time he would require regular haemodialysis as his kidney function slowly deteriorated over the next year to 18 months. He was subsequently diagnosed with a small bladder cancer and following discussions with his clinical team, it was felt the relatively straightforward operation to remove the tumour could take place at his local hospital with an overnight stay. As a result, the patient planned to travel for a year or so shortly after the surgery, before he would need regular haemodialysis.

During a surgical pre-assessment the patient's renal disease and other medical conditions were noted and that he was taking Digoxin and Verapamil amongst other medications. The clinical team advised that he might need monitoring in the high dependency ward overnight after surgery, but that he would hopefully go home the next day. His specialist renal team would then follow-up via his usual out-patient appointments.

The surgery went well and he was returned to a surgical ward without the need for monitoring in a high dependency ward. Over the next four days he did not recover as well as expected. He had a slow but persistent surgical bleed and felt generally unwell. The healthcare staff looking after him consistently failed to monitor his fluid intake and output, which led to an incorrect documentation of Early Warning Scores -- both of which, alongside post-operative bloods, were not scrutinised. The third day after surgery was a Saturday and without a weekend plan, no routine review took place. Although seen by the on-call junior doctor and a plan put in place, no senior review or follow up was scheduled.

As a result, on the evening of his fourth day after surgery the patient had a cardiac arrest. This was either due to the combined effects of Digoxin toxicity and Verapamil in the presence of worsening kidney function, or because his haemoglobin levels dropped due to his on-going bleeding. No bloods had been checked up until this point in the patient's post-operative care. The patient was resuscitated and received organ support for the next few weeks. After a gradual recovery and a prolonged stay in hospital, he returned home. The cardiac arrest further damaged the patient's kidneys and ever since he has had to undergo haemodialysis three times a week, every week.

The patient's family made a complaint, but sought legal advice when they felt their concerns remained unaddressed. The patient received damages of £32,500. One of the most distressing facts of this case for the patient, his wife and his daughter was that despite checking on each visit, they were falsely reassured that his kidneys were working well.

Key lessons

1. A comprehensive management plan and patient handover, particularly for those at risk, is vital to safe care.
2. The appropriate mechanisms to obtain advice from senior colleagues is particularly important at times of heightened vulnerability, such as out-of-hours, over bank holidays and weekends.
3. Accurate nursing documentation and clear record keeping are key to the successful identification and escalation of the deteriorating patient.

Local action undertaken

1. A root cause analysis was undertaken. This identified shortcomings in the patient's care and management. Workstreams focusing on safer handover, recognition and escalation of the deteriorating patient at risk and improved record keeping are all in progress across the organisation as part of the trust's Sign up to Safety pledges.
2. A clinical case study of this patient's experience and clinical outcome was delivered as part of a Learning from Claims Educational Programme. At the date of publication this case study had been presented at ten professional learning and development forums over a year, capturing in the region of 180 nursing colleagues in the trust.
3. The patient's personal statement has also been widely shared throughout the trust with clinical colleagues, as it serves to articulate the devastating effect this event has had on the patient and his family.

Learning from inquests is a priority for the NHS LA and our panel firms. This approach aims to improve the support families receive in these cases and bring opportunities for learning as close as possible to the event. This area of learning is unique in its potential to support families and may also mitigate the impact of claims.

Over 2015/16 we introduced a series of 'Did you Know?' leaflets. To date these leaflets examine the topics of maternity pressure ulcers, venous thromboembolism, surgical burns and claims scorecards. They are aimed at front line staff to improve safety and reduce harm and raise awareness of these claims.

In 2015/16, there has been a considerable drive to ensure the NHS LA aligns with and supports key national partners in the safety and learning arena to raise awareness of the value and volume of claims. The NHS LA is well placed to promote the safety agenda and has a key role to contribute in supporting the NHS economy to reduce claims and harm.

Image 1: A selection of 'Did you Know?' leaflets

National Clinical Assessment Service

Supporting the resolution of performance concerns

The National Clinical Assessment Service (NCAS) continued to support patient safety and public protection by helping to resolve concerns about the performance of doctors, dentists and pharmacists within the NHS, receiving 993 new referrals and delivering 20 assessments and 120 action planning interventions. 755 of new referrals were from secondary care and 238 from primary care, with the majority of cases (92%) about medical practitioners.

This year we completed and embedded a restructure which included the appointment of a new Director and the establishment of a new governance structure including a Core Operational Group which provides oversight of NCAS' delivery and development. We expanded the NCAS adviser team which now consists of clinicians, human resources (HR) practitioners, senior health service managers and lawyers with expertise in employment law and performance management. Every organisation which makes referrals to NCAS has a dedicated adviser, which better enables us to meet the needs of healthcare organisations and practitioners when delivering our services, increasing their understanding about the organisation's referral history, and local policies and procedures.

NCAS now offers bespoke support on a range of options for interventions which include behavioural assessments, occupational health assessments and action planning. These services are in addition to our full performance assessment model. This year we evaluated our pilot record review service for primary medical care.

This tailored and flexible approach can, where appropriate, ensure that concerns are dealt with in a more engaged and timely way. We discuss with organisations and practitioners the appropriate intervention to meet their needs with an overriding objective of ensuring that we support safe practice for patients across the NHS and the other health providers we work with. This diversification was demonstrated in our change of assessment and intervention case mix.

“NHS organisations need to be able to exclude clinical staff from work, or restrict their activities, when allegations of serious misconduct threatening patient safety are thoroughly and promptly investigated. It is important that this mechanism is not overused as it can have an adverse impact on the practitioner, team and clinical service.”

NCAS has a key role working with NHS organisations considering the exclusion, suspension or restriction of a practitioner. We recognise where patient safety is considered to be at risk or where there are allegations of serious misconduct, it is vitally important for NHS organisations to be able to exclude clinical staff from work or restrict their activities so that the situation can be thoroughly and promptly investigated. However, it is important that this mechanism is not overused as it can have an adverse impact on the practitioner, team and clinical service. NCAS works with NHS organisations to consider the significance of the concern, alternative options, rationale for decision making and then, throughout the lifespan of the exclusion, suspension or restriction, advises on the local and national policy requirements and communication with the practitioner.

This year we have advised on 173 cases involving exclusion, suspension or restriction from practice and have enhanced the service we offer to NHS organisations on the monitoring of exclusions and suspensions.

Scenario one

NCAS was contacted separately by two different employers (a trust and an NHS education organisation) of a paediatrician who worked in the community. Both employers reported similar concerns relating to alleged misconduct along with capability and probity concerns. One employer excluded the practitioner, who subsequently resigned with immediate effect from both organisations. NCAS advised that the employing organisations should share data about the nature of the concerns and their management with each other, and to also contact the NHS England Area Team to safeguard patients. We advised that both employing organisations should complete their local disciplinary procedures, irrespective of the practitioner’s resignation, and should consider whether formal referral to the Regulator was appropriate. NCAS also advised that the employers should consider whether to request a HPAN to protect patient safety whilst the Regulator is considering further action.

Developing and enhancing services to the NHS

NCAS aims to provide a service that is flexible, proactive, tailored and innovative, meeting the needs of the changing NHS. We have appointed a new Lead Assessment & Intervention Adviser to lead and develop the assessment and intervention services, including overseeing the utility index review of all the assessment and intervention services, and to ensure they are robust and fit for purpose. A pilot of the new enhanced remediation and specialist support service began at the end of 2015/16 and findings will be published early next year along with the enhanced service. We established an expert reference group to provide an external critique of NCAS' assessment and intervention services and to ensure we remain as the leader of workplace-based assessment.

As part of the extensive experience which NCAS brings to supporting the effective performance management of practitioners, we recognise that in some circumstances the issues may impact on professional relationships. 59% of referrals to NCAS cite concerns associated with conduct that may have a significant impact on the team and patient care. Inevitably, where there is some disruption to the relationship it may be challenging to move matters forward locally and to reconcile differences without some specialist assistance in the form of mediation between the parties.

NCAS has developed an Assisted Model of Mediation, tailored to the type of complex issues we have supported over the last 15 years. This service draws on the expertise that our advisers, who are accredited mediators, can bring to a case. We do this through proactive support to the mediation process by working with the parties to create a better mutual understanding of the issues fuelling any disagreement, to challenge any assumptions that the parties express which may be creating unhelpful obstacles and to help in generating options for progressing the issues identified. In doing so we share our experience of what is likely to work, gained from our considerable knowledge of cases and the types of interventions that may assist. We are also able to signpost to a range of other interventions NCAS can provide, including behavioural assessments and team reviews, which may support the resolution of disruptive behaviour.

Through our initial pilot of our mediation services we understand that the profile of these type of cases is likely to be complex, long-standing and involve deeply entrenched attitudes, and may be part of an existing referral or referred directly as a case for mediation. We are expanding our team of accredited mediators and will be launching the full mediation service next year.

NCAS is an objective and independent service which works with the referring body and practitioner to resolve concerns about performance. The majority of our cases arise from approaches made by NHS organisations. We are keen to ensure we support practitioners and ensure they understand and recognise the scope and role of NCAS' work at a time when they may be feeling vulnerable, confused or constrained by their employer or contractor. This year we met with a group of practitioners who have been previously referred to NCAS by their employer/ contractor to explore their impressions of NCAS and how we could ensure their views were taken into account to enhance NCAS' services.

Scenario two

A consultant in vascular surgery was associated with a significant clinical event of an infected foot in a diabetic, leading to a partial foot amputation. There was a serious incident investigation and then an investigation under Maintaining High Professional Standards (MHPS) Part I (the framework for dealing with concerns about employed doctors and dentists). The key findings from this were that the consultant appeared to have missed two opportunities to intervene earlier and that he was not up to date with the trust's standard protocols which would have helped identify these opportunities.

The consultant was restricted from all clinical work. He reflected on the findings of the investigations and accepted that his practice had been deficient on that occasion. A local return to work plan was developed with advice from NCAS and external signposting to other organisations including the Academy of Medical Royal Colleges to provide important clinical governance safeguards for the phased return. There were a number of contextual issues which we took into account in our advice and support to the trust and practitioner.

Engaging with stakeholders

This year we have worked to raise NCAS' profile as a valued service improving professional standards and patient safety. We have built on the synergies with the work of the wider NHS LA to enhance learning, and are developing a strategy for research and publications. The establishment of advisers who have maintained links with specific individual organisations has been embedded.

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

Healthcare Professional Alert Notices

HPANs apply to all health professionals regulated by a health regulatory body and are intended to be a temporary measure until a regulatory decision is made. Prior to 1 April 2013, the consideration to issue an HPAN was a duty of Strategic Health Authorities (SHAs) but following their abolition, the responsibility passed to the NHS LA.

From 1 April 2015 to 31 March 2016, 38 requests for HPANs were received and 25 new HPANs were issued. In the same period 75 existing HPANs were reviewed and 48 were cancelled as they were no longer relevant or required. This year, we moved the HPAN database to a web-check system allowing easier access to the information as part of routine pre-employment checks to anyone on a secure N3 network[6].

NCAS in Northern Ireland and Wales

We received 17 referrals under our service level agreement with DH, Social Services and Public Safety in Northern Ireland. Under an agreement with the NHS in Wales, we received 75 new practitioner referrals. NCAS will continue to provide services to Northern Ireland and Wales under SLA for the next three years. This year we evaluated the impact of NCAS' services in Northern Ireland and Wales.

6 N3 is a Wide Area Network (WAN), connecting many different sites across the NHS within England & Scotland.

Other services increasing capacity and capability across the NHS system and beyond

NCAS continues to identify and develop new services that will allow us to further generate income to support NCAS' core services. In addition to services provided in Northern Ireland and Wales, we have agreements with Jersey, Guernsey, the Isle of Man and Gibraltar, and our advice has been sought by organisations in Scotland and the Republic of Ireland. In total we received eight referrals under these agreements during 2015/16 (compared with seven in 2014/15). We continue to support the independent health and social care sector to resolve concerns about performance as well as healthcare practitioners who undertake both private and NHS work.

Since 2012, we have been contracted by the General Dental Council (GDC) to provide clinical advice about complaints concerning dentists. Over the course of 2015/16, we have received 476 referrals from the GDC (compared to 722 in 2014/15 and 635 in 2013/14). For all cases this year, and since the beginning of the contract, we produced clinical advice reports within the target timescales (usually five or ten working days). We have also continued to offer the GDC our performance assessment service adapted for use as part of the regulator's Fitness to Practise procedures. In addition, we have continued to provide consultancy and training services to the Medical Council of Ireland to support the ongoing development and delivery of their own performance assessment service.

Sharing learning from our casework experience

NCAS has continued its comprehensive programme of education and learning events and activities to ensure the NHS has the right skills to resolve concerns about the performance of doctors, dentists and pharmacists. Our external education programme aims to:

- share learning and good practice from our claims and case work;
- promote the development of excellent local and national procedures for preventing, identifying and resolving issues; and
- engage with and support our customers and Members to use our services.

NCAS now offers these education and learning workshops:

- managing concerns about the performance of doctors, dentists and pharmacists;
- case investigator training;
- case manager training;

- understanding and using *MHPS in the modern NHS* effectively;
- *MHPS* and the trust Board;
- responsible officer training: module 3&4; and
- other bespoke and customised training.

This year we delivered 121 workshops for 79 specific organisations, with a wide range of delegates attending our public workshops. Our average evaluation score for overall content and standard is 4.4 out of 5. We continue to be extensively involved in training for responsible officers.

Delegate feedback from NCAS workshops

Reviewing the impact and evaluation of NCAS' external education and learning programme is key. At the end of every workshop we ask delegates to comment on the content and standard of the workshop. Some delegate comments include:

- "Many thanks for a challenging and informative experience, well led and produced and enjoyable." Medical adviser and freelance GP
- "One of the best courses I have attended for a long while, informative and engaging." Practice manager
- "I found it all very stimulating and interesting – the handbook, your explanation of the processes, the group work and the interactive sessions. The role play was challenging but an excellent experiential learning." GP
- "The practical investigation role play was extremely useful, because you had to think on your feet at times and it became apparent just how difficult this job can be. I also found the session involving the judge extremely interesting, to see from a legal standpoint what happens and what you have to disclose etc." Audit officer
- "The two days dedicated to NCAS investigations was really beneficial. It developed my skills and the logical way the course took you through start to finish." HR Adviser
- "Enabled better focus on terms of reference (TOR) and design of TOR. I think this is probably the foundation of a successful investigation." CBU Clinical Director and Consultant Plastic Surgeon
- "Excellent training in case investigation process, who to talk to when there are issues of process, how to structure the evaluation of evidence, how to use HR support for interviews." Consultant Paediatrician
- "From the medical directorate perspective having all investigators trained to the same standard is important." Assistant Medical Director

Family Health Services Appeal Unit

The FHSAU deals with disputes arising from dentists, general practitioners, pharmacists and opticians against the decisions made by NHS England that affect their contracts with the NHS.

The number of appeals and disputes we received was marginally higher on those we received in 2014/15. However we received the usual mix of case types, our largest number being those made in accordance with the NHS (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 (the Pharmacy Regulations) particularly those relating to applications from pharmacists to join the Pharmaceutical list, or to change the terms of those listings. We received 283 appeals in accordance with the Pharmacy Regulations as opposed to 265 in the last financial year.

Dispute resolution in summary

Disputes relating to GPs and their contracts were again the main source of applications for dispute resolution (48 during this financial year compared with 71 last year) but we also received seven applications for dispute resolution from dentists and two from opticians.

We continued to receive disputes relating to reimbursement of premises costs to GPs. However, of the 17 (which compares to three last year) we only made four substantive decisions having remitted 13 back to NHS England on the basis that Local Dispute Resolution had not been completed before the matter was referred to us. Other medical and dental disputes raised the usual mix of issues such as remuneration, clawback of monies, payment of quality outcomes framework monies, and termination of contract.

However, we have continued to see an increase in disputes following refusals by NHS England to pay monies under the Patient Participation Directed Enhanced Service Agreement. Fully determined cases numbered 50 compared to 17 the previous year. In addition to these, there were two 'termination of contract' disputes determined in 2015/16.

Patient Participation Directed Enhanced Service (DES)

For a second year we have received a number of applications for dispute resolution relating to Patient Participation DES. This DES requires GP practices to have in place a system for ensuring that patients' views are taken into account in a structured and regular way, and that such a group has input into the patient survey conducted by the practice and the action plan flowing from the outcome of that survey. The DES is quite specific as to how GP practices can maximise payments against this DES, yet again this year some practices have failed to ensure that

everything that should be included in the published Patient Participation Group Report is included, or have failed to publish the report as required, and therefore NHS England refused payment. We found for NHS England in 94% of cases.

Appeals in summary

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

We listened to feedback from our FHSAU Panel Members, who listen to submissions and evidence to make appeal decisions at our Oral Hearing Committees, about people giving excessive evidence at oral hearings. As a result we developed some rules to ensure that people attending hearings act fairly and assist in the efficient and effective running of oral hearings. These have been published on the NHS LA website. Alongside this material, we created and published an oral hearing procedure note to help people understand how oral hearings are conducted.

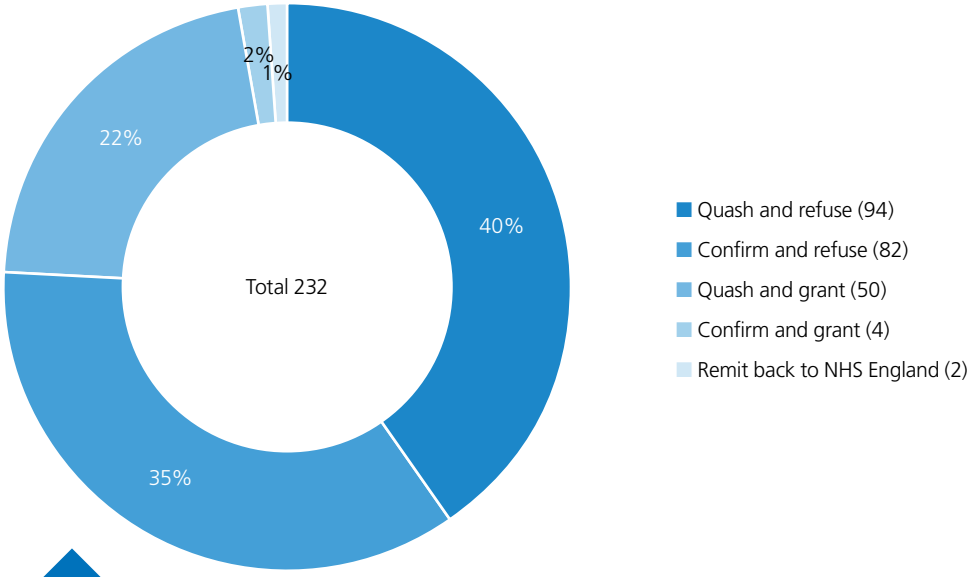
We produced and published a guidance note to assist those determining applications made under Regulation 24 (relocations). This note will assist parties making, and responding to, these types of applications.

We have developed a one-day workshop specifically for anyone who is involved in determining applications and/or reviewing the outcome of appeal decisions. The workshop describes the decision making process and provides skills-based development on making decisions about applications, connecting the evidence with the regulations and weighting the evidence. The workshop aims to share our experience of handling appeals. It is interactive and uses case studies to explore and develop the key skills and knowledge required. We intend to run events in Summer/Autumn 2016 in Leeds and London.

Of those pharmacy appeals that resulted in a substantive determination (for example those not withdrawn or dismissed as frivolous or vexatious) and which did not require external input, 98% were issued within a target of 15 weeks and within an average of 13 weeks for all such cases. For those determinations requiring external input or an oral hearing, 85% were issued within a target of 25 weeks and within an average of 24 weeks for all such cases.

Across all application types (including 'hours' appeals), of those pharmacy appeals determined under the Pharmacy Regulations, 62% of NHS England's decisions were quashed and re-determined, which resulted in 22% of applications being granted. In a significant number of cases FHSAU does not contest the outcome of NHS England's decision, but is required to quash and re-determine the outcome in order to present additional evidence to support the decision making process. 37% of NHS England's decisions were confirmed which resulted in 2% of applications being granted. Finally 1% of appeals resulted in matters being referred back to NHS England for a further notification and determination by NHS England.

Figure 19: Appeals to application results to the Pharmaceutical list in 2015/16, outcome by number.



The greatest number of appeals against the results of applications to the Pharmaceutical list in 2015/16 were quashed and refused.

Panel Members

We continued to apply our revised governance arrangements regarding FHSAU Panel Members, including their appraisal. In November 2015, we held our annual Panel Member event to provide a forum for discussion and case review.

Pharmacy Appeals User Group

The FHSAU re-established User Group met twice during the year. The aim of this group is to consult and improve communications with service users and their representatives on current practice and procedure, and on any proposed changes to practice and procedure. Feedback from external group members remains very positive. In addition, the group approved the new Oral Hearing Procedural Rules requiring new evidence to be submitted 14 days prior to the hearing. Any adverse comments were limited to procedural matters adopted at oral hearings and inconsistencies in site visits. These issues were addressed with our Panel Members.

Service user survey

The NHS LA is committed to providing an excellent dispute resolution service through the FHSAU; obtaining feedback on our performance is integral to any improvements we make. Towards the end of 2015 we surveyed those involved in an appeal or dispute to look at our performance and what might be improved. The closing date for the survey was towards the end of this financial year and we will be reviewing findings over the coming months. However, the results were broadly positive with over 80% of respondents being at least satisfied with the service that the FHSAU provides.

Judicial review

As always, determination of pharmaceutical appeals may be subject to legal challenge by way of judicial review. During 2015/16 there were two applications for judicial review, one was granted permission and we await the outcome of this, the other awaits a permission hearing.

Determination of disputes by the FHSAU may also be subject to legal challenge by way of judicial review. During 2015/16 there were two such challenges regarding decisions by the FHSAU to refuse suspended performer payments to two primary care doctors. One of these is still awaiting a permissions hearing. The other was refused permission on the basis that the FHSAU decision refusing such payments, which supported that of NHS England, was fully reasoned, rational and reasonable in all the circumstances.

A judgment was made this year following an application for judicial review made in the previous year regarding a decision by the FHSAU to terminate a dental contract. As a result of a failure to remedy practice issues, in April 2014, NHS England decided to terminate a GDS contract and sent a Termination Notice to the contractor. The contractor sought resolution through the NHS Dispute Resolution Procedure. On 19 August 2014, the NHS LA found in favour of NHS England (case ref 17617). The Court found it reasonable for the FHSAU to find as it did, and dismissed the claimant's application for judicial review. Both the above decisions can be found on the NHS LA website.

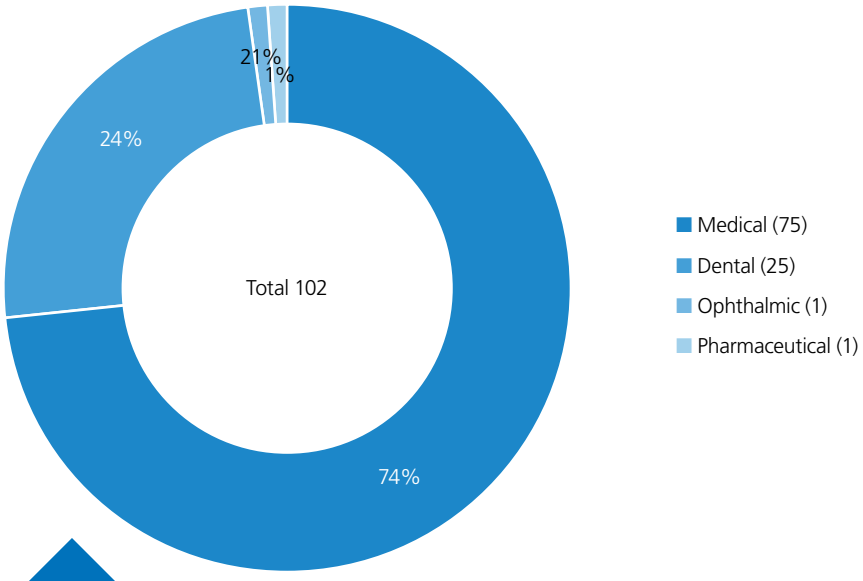
Performers lists notifications and checks

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

Before determining new applications to enter the Performers lists, NHS England is required to check with the NHS LA for any facts relating to investigations or proceedings involving the proposed applicants.

Between 1 April 2015 and 31 March 2016 the FHSAU received notification of 102 suspensions compared to 67 in 2014/15. The breakdown by profession is shown in the following graph. There were 95 suspensions still in force as at 31 March 2016. There were also 1,620 other decisions under the aforementioned regulations, including notifications of withdrawn applications to join a list.

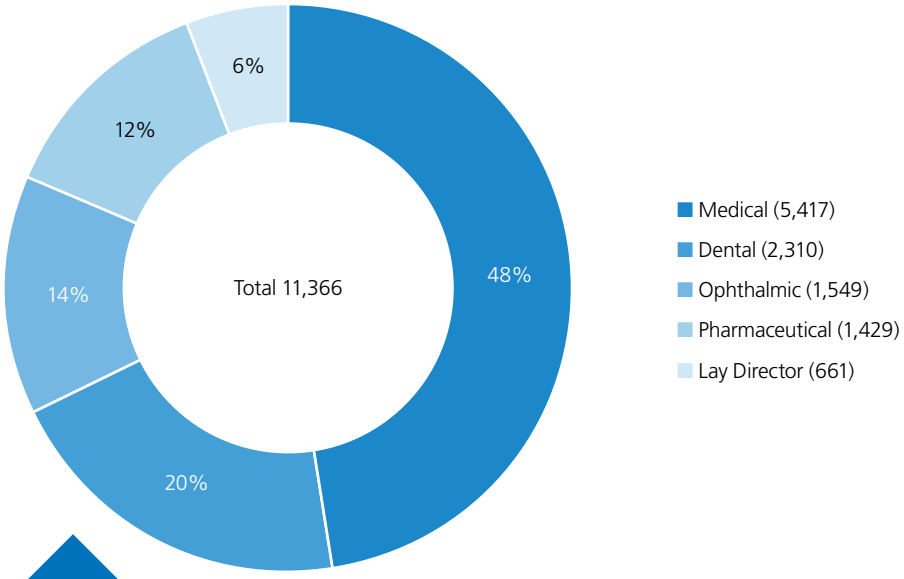
Figure 20: The number of suspensions notified to the Performers lists in 2015/16, by profession.



Three quarters of all suspensions to the Performers list in 2015/16 were from the medical profession.

During the year, the FHSAU received 11,366 requests for information compared to 8,824 in 2014/15 using our secure, online checking system, and which provided immediate clearance for 96.91% of checks. The remaining were referred to the FHSAU for further analysis before disclosure. The breakdown of checks by profession is shown in the following graph.

Figure 21: The number of checks against the Performers lists in 2015/16, by profession.



Nearly fifty percent of checks against the Performers list in 2015/16 were for those in the medical profession.

IT & facilities

We successfully delivered the IT network infrastructure necessary to support enhanced reporting and data analysis and through our extranet. We will now continue to use this capability to produce more focused and targeted information. This will help to foster a culture of shared learning.

We introduced functionality into our information systems that automated the process of receiving and processing claims from the online portal and we enhanced the usability of our extranet and document transfer service for our Members.

We continued to review and enhance our key information systems to ensure their ongoing fitness for purpose and sustainability.

To help us to work efficiently within our limited floor and meeting room space, we introduced the use of Skype for business. In future years it is anticipated that this will also be used to help diversify and further improve our communication methods with our Members.

Over the course of 2015/16 a substantial amount of work was carried out to assess and adjust our resilience to cyber attacks and we undertook a series of systems upgrades to allow us to make best use of Microsoft products and other technologies.

We utilised virtualisation technology[7] to help reduce our IT hardware costs, power and space requirements. This will also allow us to produce further costs savings in terms of our running costs and disaster recovery systems.

In line with DH's overall estates strategy, we exited one of our London offices and relocated staff to a single London office.

7 Server virtualisation: dividing the resources of one physical server into a number of (virtual) servers.

Finance report

“£25.5 billion of the £27.8 billion increase in the provision is due to a change in the long term discount rate set by HM Treasury.”

The main feature of NHS LA’s accounts is the provision arising from the indemnity schemes that we operate on behalf of the NHS and DH. The provision in the Statement of financial position has increased significantly from £28.6 billion to £56.4 billion over this financial year.

By far the most significant factor, accounting for £25.5 billion of the £27.8 billion increase in the provision, has been the change in the long term discount rate set by HM Treasury. The discount rate is designed to recognise the value of money over time: £1 now may be worth more or less in the future. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings at today’s prices. It tells us how much we would need to pay out if we settled all of those future obligations today. In accordance with IFRS, HM Treasury has applied market rates which reflect the low cost of borrowing to government in determining the long term discount rate, giving rise to a negative discount rate for very long term obligations. Note 9.2 to the accounts shows how the rates have changed, with the most significant change being the long term rate moving from +2.2% to minus 0.8% with effect from 31 March 2016. As a significant proportion of NHS LA’s provisions are expected to be settled over the longer term, the reduction of the long term discount rate by three percentage points has had a considerable impact on the valuation. However, this is an accounting judgment that does not change the underlying future costs that will be incurred in meeting the obligations arising from claims.

The other changes affecting the provision are relatively small in comparison to the overall change, but despite the levelling off of new claims numbers, it still represents a growing burden on the NHS. The value of new claims received that we expect to settle in the future amounts to £2.5 billion. We have provided for a further £1.3 billion in relation to Incurred But Not Reported (IBNR) claims yet to be received. This cost is driven by assumptions in relation to claims volume and value. The most significant factor affecting the IBNR valuation in 2015/16 is the increase in the time lag from an incident occurring through to a claim being settled – this results in an increase in the cost of settlement because of the effect of inflation. Against these increases, we have settled £1.5 billion of claims during the financial year.

In-year financial performance

The settlement and administration of indemnity schemes is funded by a combination of contributions from Members (NHS and Independent Sector providers of health care, clinical commissioning groups and other health Arm's Length Bodies) and financing from DH. DH sets a budget in respect of this financing on a Departmental Expenditure Limit (DEL) basis. This is a HM Treasury budgetary control[8] which covers income and spending on general administration costs, e.g. salaries and goods and services, but also the settlement (utilisation) of provisions in the financial year (see Note 9 to the accounts). This is different to the increase in the provision that is recorded in the Statement of comprehensive net expenditure, which is classified as Annually Managed Expenditure (AME) in the HM Treasury budgetary controls framework (see later in this finance report).

Overall, NHS LA underspent by £81.5m across all of its DEL-funded activities, with the majority of this being in relation to the clinical indemnity schemes. Expenditure on clinical schemes (including administration costs) against income and budget set by DH can be seen in Table 2.

Table 2: Clinical schemes financial performance.

	Income/budget £000	Expenditure £000	Value of underspend/ (overspend) £000	Percentage underspend/ (overspend)
Member funded CNST	1,419,513	1,387,323	32,190	2%
DH funded schemes	142,000	110,528	31,472	22%
Total clinical schemes	**1,561,513**	**1,497,851**	**63,662**	**4%**

8 HM Treasury Consolidated Budgeting Guidance can be found at https://www.gov.uk/government/publications/consolidated-budgeting-guidance-2015-to-2016.

As set out in Note 3 to the accounts on page 122, contributions from Members for our largest scheme, CNST, increased by 35% in 2015/16 to £1,420 million. Expenditure in administering and settling CNST claims increased by 33%, resulting in an underspend of £32 million. Whilst NHS LA's administration and defence costs have stayed relatively stable as a proportion of total costs, claimant legal costs have increased by £126 million (43%).

DH funded schemes provide indemnity cover in relation to claims arising from legacy arrangements and organisations, e.g. regional health authorities and primary care trusts that have closed. The underspend on these schemes suggests a tailing off of activity as time goes on.

Non-clinical claims costs have been levelling off in recent years through the introduction of limits on claimant legal costs and more efficient claims processing systems, with these benefits being reflected in low or zero increases in contributions.

The Department also sets a budget for AME. This is to cover expenditure on volatile or difficult to manage budget items, and is set on an annual basis. NHS LA's AME expenditure is in respect of the net movement in provisions for all of the indemnity schemes, i.e. the change in the provision less any provisions settled (utilised) in year (see Note 9 to the accounts), and performance against budget is set out below. The main reason for the significant increase in the provision from last year is due to the change in discount rate as discussed previously.

Table 3: Non-clinical schemes financial performance.

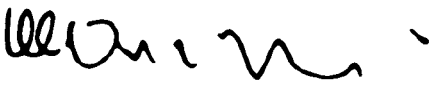
	Income/budget £000	Expenditure £000	Value of underspend/ (overspend) £000	Percentage underspend/ (overspend)
Member funded LTPS, Property Expenses Scheme (PES)	59,807	51,135	8,672	14%
DH funded schemes	16,000	11,469	4,531	28%
Total non-clinical schemes	**75,807**	**62,604**	**13,203**	**17%**

Table 4: Annually Managed Expenditure.

	£000	£000
Budget		**27,941.000**
Expenditure		
Cost of new claims provisions	29,331.883	
Unwinding of discount	46,583	
Less settlement of provisions	(1,547.824)	
Total expenditure		**27,830.642**
Under/(overspend)		**110,358**

The NHS LA spent £429k on capital expenditure, primarily on IT hardware and software, a 4.7% underspend against the budget of £450k.

I am satisfied that this Performance report is a true and fair reflection of the work undertaken by the NHS LA throughout 2015/16.



Helen Vernon
Chief Executive and Accounting Officer
Date: 27 June 2016

Accountability report

Directors' report

Details of the NHS LA Board members, including the Chair and Chief Executive, are shown in the Governance statement which follows this statement.

The NHS LA publishes a register of interests of Board members on its website here www.nhsla.com/AboutUs/Documents/April_2016_Board_Members_Register_of_Interests.pdf

Pensions

NHS LA employees are covered by the provisions of the NHS Pension Scheme, details of which are given in 1.10 of the accounts. Pension liabilities in respect of Board members are given in the Remuneration report on page 94.

Audit services

The Comptroller and Auditor General has provided the NHS LA's audit services at a cost of £118,000 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 the entity's auditors are aware of relevant audit information.

Sickness absence

Details of the sickness absence data are shown in the Staff Report of this annual report on page 99.

Data incidence

Details of the personal data related incidence are outlined in the Governance statement under Information security and governance on page 86.

Financial instruments

Details of the NHS LA's Financial Instruments and exposure to risk are outlined in Note 13 of the financial statements.

Losses and special payments

There were no losses or special payments made in 2015/16, nor in 2014/15. This information is subject to audit.

Fees and charges

Contribution levels for members of the indemnity schemes that NHS LA operates are determined in order to meet members' liabilities as they fall due. The contributions collected are set on a full cost recovery basis, and can be seen in Note 3 to the accounts on page 122. This information is subject to audit.

Expenditure on consultancy

During the year, there was no expenditure on consultancy services.

Publicity and advertising

Publicity and advertising spend for the year was £25,797.

Remote contingency liabilities

The judgments taken to place a value on the provision and contingent liabilities (see Notes 9 and 10 to the accounts) arising from the indemnity schemes that NHS LA operates do not include an assessment for events that at this point in time are too uncertain or remote to include. Therefore, there is no recognition of potential change in the value of the provision arising from policy developments, in particular around efforts to improve safety in the NHS (other than through experience reflected in current and past claims), considerations relating to applying a limit to recoverable claimant costs for lower value claims, and potential changes to the court discount rate applied to assessing the value of award for damages.

Statement of Accounting Officer's responsibilities

Under the National Health Service Act 2006, the Secretary of State has directed the NHS LA to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the NHS LA and of its net expenditure, changes in taxpayers equity and cash flows for the financial year.

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

- observe the Accounts Direction issued by the Secretary of State, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; 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 assets of the Arm's Length Body for which the Accounting Officer is responsible, are set out in *Managing Public Money* published by HM Treasury.

Helen Vernon
Chief Executive and Accounting Officer
Date: 27 June 2016

Governance statement

Scope of responsibility

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

I have the following operational responsibilities for the delivery of the NHS LA's strategic aims and objectives within the NHS LA's legislative and regulatory parameters and as directed by the Department of Health:

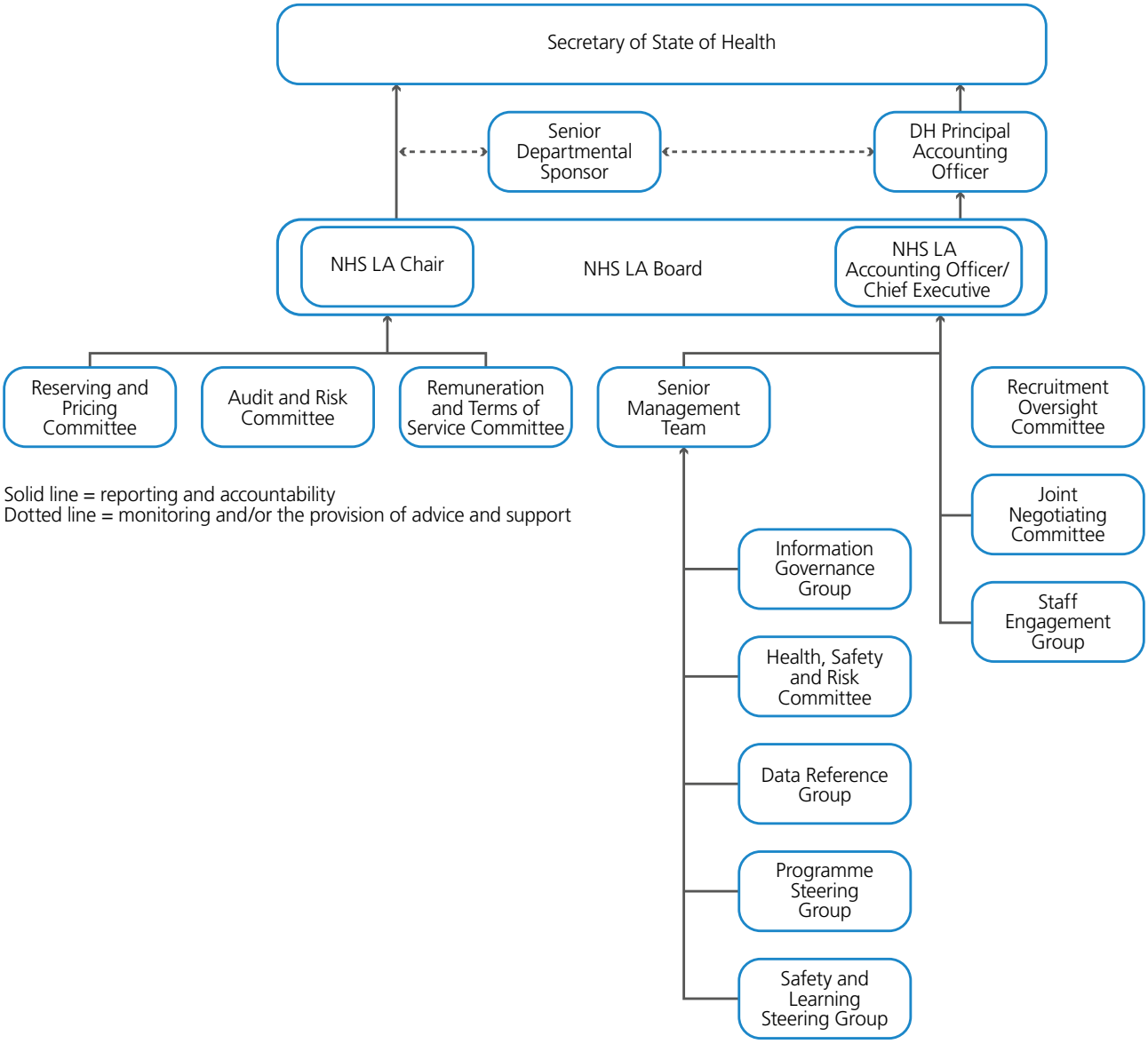
- compliance with and delivery against the NHS LA's Framework Agreement and Business Plan as agreed from time to time with the Department of Health;
- delivery against key performance indicators as agreed with the Department of Health;
- delivery, in conjunction with the Board, of effective governance;
- provision, oversight and effective working of systems of internal control;
- oversight of the complaints process and ensuring that the learning from complaints is embedded into how we operate;
- risk management processes; and
- NHS LA's databases and financial system.

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

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

The governance framework and structures

Figure 22: NHS LA governance structure.



The NHS LA Board

The NHS LA Board is led by a non-executive Chair and its full complement comprises four non-executives and four executive members with a balance of skills and experience appropriate to its responsibilities.

Throughout 2015/16, three non-executives and three executive directors were in place; one non-executive and one executive (the Director of Finance and Corporate Planning) left the Board. Two executives were appointed to the Board with one executive and one non-executive post remaining unfilled as at 31 March 2015. During the year under review, the Board considers that there was a sufficient spread of skills in order to perform its functions effectively.

A risk assessment was undertaken following the departure of the Director of Finance and Corporate Planning on 30 October 2015 and interim arrangements put in place from November 2015 to January 2016 (a period of two months), pending the appointment of a replacement. These included temporary promotion arrangements for existing post-holders, the recruitment of an interim accountant and a temporary movement in reporting lines. I also acted as SIRO for the period November 2015-February 2016. The transition was undertaken in consultation with the Board and DH and effective controls remained in place.

The Board provides leadership and strategic direction for the organisation and is collectively accountable, through the Chair, to the Secretary of State for Health for the strategic direction of NHS LA, for ensuring a sound system of internal control through its governance structures, and for putting in place arrangements for securing assurance about the effectiveness of that system.

Corporate performance, including financial and business area KPIs, is reported by me to the Board and to DH on a regular basis in accordance with the Framework Agreement agreed between DH and NHS LA. Variations from anticipated performance are, where appropriate, accompanied by reports from the Audit and Risk Committee and/or Senior Management Team, giving me, the Board, and, where appropriate, DH, assurance on progress and the action being taken. The Board regularly reviews and suggests revisions on the information supplied to it to ensure it remains satisfied regarding the quality of information, but also that it is relevant and sufficient to inform the business of the Board. For example, the Board reviewed management recommendations for changes to KPIs and suggested changes to capture the impact of sharing learning from claims.

During the period from 1 April 2015 to 31st March 2016 the NHS LA Board met on seven occasions and attendance details are as follows:

NHS LA Board meeting attendance

Table 5: NHS LA Board meeting attendance

Name	Post	Meetings attended
Ian Dilks	Chair	7 of 7
Keith Edmonds	Non-executive Director	7 of 7
Andrew Hauser	Non-executive Director	6 of 7
Ros Levenson	Non-executive Director	7 of 7
Helen Vernon	Chief Executive	7 of 7
Tom Fothergill*	Director of Finance and Corporate Planning	4 of 4
Joanne Evans**	Director of Finance and Corporate Planning	2 of 2
Denise Chaffer	Director of Safety and Learning	6 of 7

*Tom Fothergill left the organisation on 30 October 2015.
**Joanne Evans joined the organisation on 1 January 2016.

An internal audit review of Board effectiveness took place in 2015/16, including:

- a self-assessment survey of all Board members and attendees at the Board;
- observation of a Board meeting;
- follow up interviews; and
- benchmarking of results against other ALBs.

The review noted a range of positive observations, including Board meetings take place regularly, and that all Board meetings include both public and private sessions. The terms of reference, together with the public section minutes and papers, are published – showing openness and transparency.

The findings also set out recommendations for some improvement, including aspects of Board foundation, focus and internal/external engagement, in line with the Board's own self-assessment.

Overall the findings gave a moderate level of assurance. I, along with the Chair, have worked to implement the recommendations, all of which have been addressed. In view of the detailed internal audit review, the Board did not undertake a further assessment against the *Corporate Governance in Central Government Departments: Code of Good Practice* during the year.

Committees of the Board

The Board is supported by three committees which were established to enable the Board and me to discharge our responsibilities and to ensure that internal controls are in place to safeguard and steward financial and resource controls. A review of terms of reference for the three committees was carried out to ensure their fitness for purpose in line with assurances required.

Audit and Risk Committee

The function of the Audit and Risk Committee (ARC) is to provide advice and assurance to the Board and the Accounting Officer (AO) on the adequacy and effectiveness of NHS LA's systems of internal control, that risks are well managed and financial statements are reasonable. The ARC is chaired by a Non-executive Director and meets at least four times a year.

The ARC reviews the NHS LA's strategic risk register, together with risk reduction plans and monitors progress. The ARC considers the results of internal and external audit work and the annual audit plan, with reference to the Strategic Risk Register, for approval by the AO.

During 2015/16 the ARC considered reports from internal audit on NCAS governance, contract management, financial management and reporting, and data quality together with advisory reports on risk management and the steps the Executive were taking to progress work to achieve ISO 27001 certification. ARC reviewed the 'assurance map' for the NHS LA together with proposed revisions to the Strategic Risk Register.

Table 6: Audit and Risk Committee meeting attendance

Name	Post	Meetings attended
Andrew Hauser	Non-executive Director and Chair of ARC	4 of 4
Keith Edmonds *	Non-executive Director	3 of 3
Ros Levenson	Non-executive Director	4 of 4

* Keith Edmonds became a member of ARC as of October 2015

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is a Non-executive Committee whose role includes the determination of the remuneration, benefits and terms of services of all posts covered by the Pay Framework for Very Senior Managers (VSMs).

During 2015/16 the Committee received satisfactory reports on the performance of the VSMs for 2014/15. The Committee reviewed its own terms of reference and these were agreed on 2 September 2015 and subsequently approved by the Board. The Committee considered the revised proposals for VSM pay from DH and this was presented formally by the DH Director of HR at the September meeting. The implications of this proposal were discussed by the Committee.

The Committee noted the revised arrangements for redundancy provisions for VSMs and agreed that these would be implemented for new recruits from outside organisations but noted that these would not be imposed for existing staff on VSM contracts. The Committee noted that there was a draft Consultation on a Public Sector Exit Payment Cap which was held during August 2015.

The Committee oversaw the arrangements for the restructure of the Senior Management Team at the NHS LA at the 27 January 2015 meeting and this included the creation of a new post, Director of Membership and Stakeholder Engagement, and the amendment of the job description of the Director of Finance and Corporate Planning.

The Committee and Chief Executive approved the appointment of Denise Chaffer, Director of Safety and Learning to an Executive Director role with effect from 8 July 2015. The Committee reviewed its performance during the year and concluded that it had appropriately discharged its obligations including compliance with its terms of reference.

Reserving and Pricing Committee

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

The RPC reviewed the work of the actuaries in relation to the 2016/17 price and the calculation of contributions for all indemnity schemes. In addition the RPC reviewed and updated the key assumptions for the claims provisions for the 2015/16 accounts. The RPC also considered papers from the actuaries to support work on a consultation on the future development of CNST (issued in March 2016) and the development of a monitoring pack of data to enable the NHS LA to monitor expected patterns against actual experience over the course of the year.

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

Senior Management Team

As Accounting Officer, I have responsibility for maintaining a system of internal control that supports the achievement of the NHS LA's aims and objectives. To support me in this I have established a Senior Management Team (SMT) and supporting sub-groups

The SMT membership includes directors of service and my direct reports. All operating areas of the organisation are represented.

SMT meets weekly and discusses issues concerned with the activity of NHS LA for which SMT oversight or approval is required including resource management, the development of the NHS LA's strategic objectives and business plan, governance arrangements, complaints and stakeholder management. The SMT reviews in depth particular areas of NHS LA activity or areas of development and considers any changes in the external environment that may have an impact on NHS LA and its services.

I report on the work of the SMT to the Board and hold members of the SMT to account for delivering against agreed objectives.

Sub-groups of the SMT

Information Governance (IG) Group

The IG group meets monthly to review information governance, incidents, learning, risk, good practice, training requirements and matters relating to compliance. This group advises me as AO, the NHS LA's SIRO, the Caldicott Guardian and, where appropriate, the Audit and Risk Committee on all information governance matters relevant to the NHS LA. The IG group acts as a key source of assurance to me that the agreed NHS IG toolkit and other IG requirements are being operated and delivered to the required standards.

The group also reviews all policies which impact on information governance. The SIRO, working closely with me as AO, ensures that the Board is kept up-to-date with the relevant information governance issues within the NHS LA and is promptly informed of reportable IG incidents.

The IG group progressed the recommendations of an internal audit advisory report in order to progress work towards ISO 27001 Standards. It also proposed and implemented action plans arising from reported incidents, including changes to mail management systems and the delivery of training in the claims administration function.

Data Reference Group (DRG)

The DRG advises me on governance arrangements for sharing data internally across functional areas and externally in line with the NHS LA's Framework document, legal and regulatory requirements, directions and strategic aims.

DRG provided advice and support to enable claims data to be shared with the Royal National Orthopaedic Hospital NHS Trust as part of the 'Getting it Right First Time' programme. This included supporting an application to the Confidential Advisory Group (CAG) to enable claims data to be accessed lawfully and ensuring compliance with the CAG conditions placed upon the use of data for this work.

Health, Safety and Risk Committee (HSRC)

The NHS LA's HSRC provides assurance to me and to the ARC by reviewing and escalating health, safety and operational risks. The committee also reviews business continuity arrangements, non-information governance incidents, complaints and learning as well as the NHS LA's policies, procedures and guidance on risk management and mitigation.

The HSRC supported the project plan leading to the relocation of staff to a single London site, including a review of risks and business continuity issues.

Programme Steering Group (PSG)

The PSG comprises SMT members and other managers with responsibility for the direction of the NHS LA's change and project delivery programme and associated risks. The PSG provides progress reports to the Board and oversaw a full programme in 2015/16 including the delivery of a project on claims fraud. New projects are identified to respond to the emerging needs of the business with project managers and sponsors identified, and terms of reference and milestones reviewed and approved by PSG.

Recruitment Oversight Committee (ROC)

ROC considers all requests for recruitment (internal and external), any change to employees' roles and/or terms and conditions, training and expenses. All matters relevant to the Board are reported.

In 2015/16 the ROC oversaw a continued programme of recruitment to the claims teams in order to resource sustained high volumes of claims in addition to changes to reporting lines and the restructuring of teams following the departure of the Director of Finance and Corporate Services.

Partnership working with staff

Staff Engagement Group (SEG)

SEG is chaired by me and facilitates communication between staff and the SMT. SEG makes constructive proposals with a view to improving staff engagement and promotes engagement across all NHS LA offices and for home workers. In 2015/16, SEG supported question development for the annual NHS LA staff survey and worked with SMT to encourage a high level of participation.

Joint Negotiating Committee (JNC)

JNC operates via a recognition agreement between the NHS LA and Unison to cover areas for negotiation and consultation. Matters subject to joint consideration include the negotiations of terms and conditions of employment, including any plans for restructure and employee consultations, interpretation of Agenda for Change terms and conditions and agreeing NHS LA policies and procedures which affect employees. Members of SMT and I meet regularly with JNC representatives

The Control Environment

The system of internal control is designed to eliminate risk, where possible, and manage residual risk to a reasonable level, rather than to eliminate all risk of failure to achieve objectives. Therefore, it provides a reasonable and not absolute assurance of effectiveness.

Capacity to handle risk

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

The ARC challenges and scrutinises the operation of the risk management process and reports to the Board on its effectiveness. The SMT reviews the strategic and operational risk registers and assurance framework.

An advisory review was carried out by the internal audit team on risk management to ascertain current arrangements and offer recommendations to enable NHS LA to embed best practice. The SMT accepted the recommendations for improvements and has developed an action plan which includes:

- reviewing and revising the current risk policy and procedure;
- agreeing the risk appetite; and
- reviewing risk registers.

Management assurance

The NHS LA's assurance framework brings together governance and quality linked to the NHS LA's strategic objectives. Its purpose is to ensure that systems and information are available to provide assurance on identified corporate risks and that such risks are being controlled and objectives achieved. A complementary assurance map exercise commissioned by the SMT was carried out to ascertain levels of control against core NHS LA activities and from this no significant gaps were identified.

Internal audit

An internal audit plan is developed in conjunction with management and the ARC to focus on the areas of risk, and provide insight, advice and assurance on the internal control framework.

In 2015/16 the Head of Internal Audit provided a moderate assurance opinion in the case of risk management and governance and a limited assurance opinion in the case of control (due to an unsatisfactory assurance report on EKS, the NCAS IT system), leading to an overall moderate assurance opinion. Internal Audit confirmed that sufficient governance structures and processes were in place and are operating effectively. It was noted in their report that risk management processes are being improved by NHS LA and these remain high on the Audit and Risk Committee and management's agenda.

Performance and financial controls

The NHS LA's financial and operational performance is reported regularly to the SMT, to the Board and to me. The NHS LA's financial position, together with operational KPIs, is reported quarterly to DH to demonstrate that expenditure commitments are in line with forecasts and budgetary limits.

There are policies and procedures for the management of finances and resources, including a scheme of delegated authorities for the approval of expenditure. The internal audit programme routinely covers key financial controls to provide assurance to management and the Board. Governance arrangements through the Reserving and Pricing Committee for the setting of reserves for claims are set out earlier in this statement.

Sign up to Safety incentive payments

In 2014/15 NHS LA Member organisations were invited to bid for funds against an incentive scheme with the aim to help reduce claims. These funds were allocated to trusts and Members commenced implementation of the plans in 2015/16. A robust approvals process was put in place for assessing and awarding funds, and NHS LA has commissioned an economic evaluation to assess the cost effectiveness of the scheme in 2016/17.

Fraud

As with all NHS organisations, the risk of fraud is a significant consideration. The nature of the NHS LA's work inevitably focuses our attention on the risk of fraudulent claims being brought against our Members. Great care is taken to review the appropriateness of our systems, with reporting to the ARC by our counter fraud team. Where possible fraud is identified, the NHS LA immediately involves the appropriate authorities, as well as discussing the matter with any affected stakeholder and their local counter-fraud specialists. Staff awareness regarding fraud is maintained by regular updates, newsletters and training.

During the year we joined the Claims and Underwriting Exchange, a database of non-clinical claims reported to insurers. This enables us to share information with other indemnifiers so as to identify potentially fraudulent claims. We are fully alive to the information governance risks entailed in such an initiative and ensure that due legal process is adhered to.

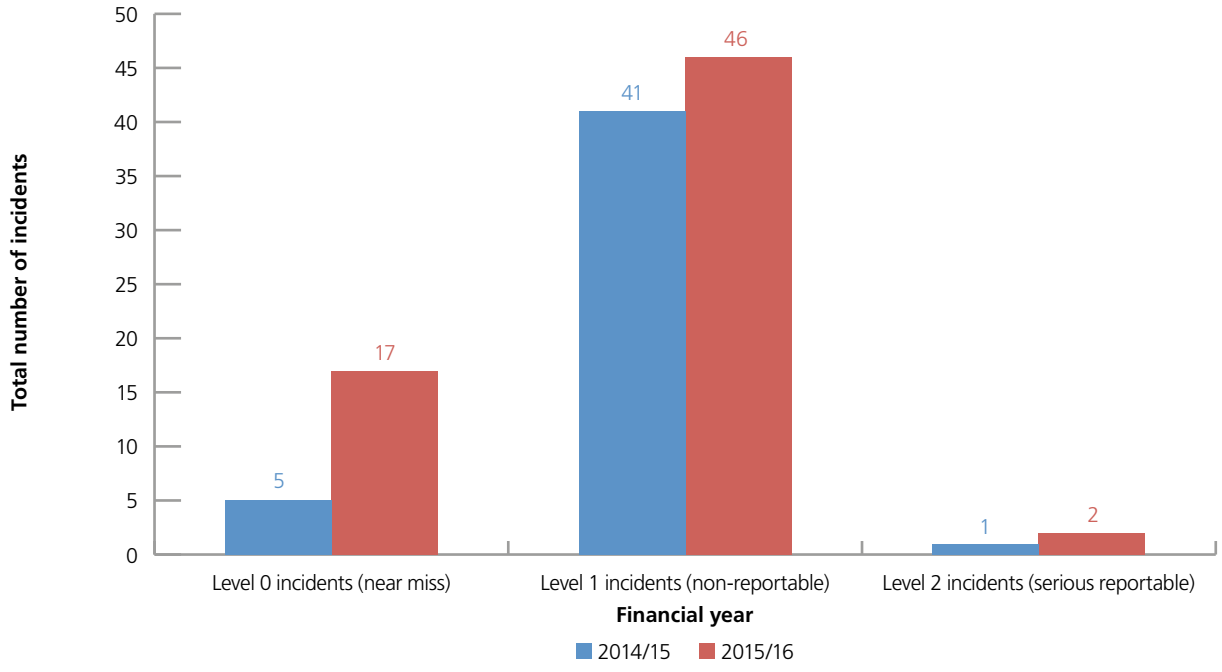
The Board has also approved a process which was developed in consultation with NHS Protect for the authorisation of surveillance which is approved by me on a case by case basis. In our first year of operating these arrangements, a total of 27 claims had 34 authorisations for surveillance in 2015/16. Where a potential fraud is identified, the case is referred to NHS Protect.

Information security and governance

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

From 1 April 2015 to 31 March 2016 we recorded 65 information handling incidents reported by the NHS LA and its Legal Panel members. Of these, two were reportable to the Information Commissioner's Office (ICO). The ICO has confirmed in both cases that there are sufficient information security safeguards in place and they do not intend to take any further action. A number of the incidents reported for FY15/16 were 'near misses' (17 out of a total 65). Whilst it is recognised that there has been an increase in incident numbers across all categories, it is considered that staff have an improving understanding of the importance of reporting all incidents through training and communication. Learning from all incidents and near misses is important and can help inform the NHS LA's Information Governance Strategy and, where relevant, related policies and protocols.

Figure 23: Number of information governance incidents reported in 2014/15 and 2015/16.



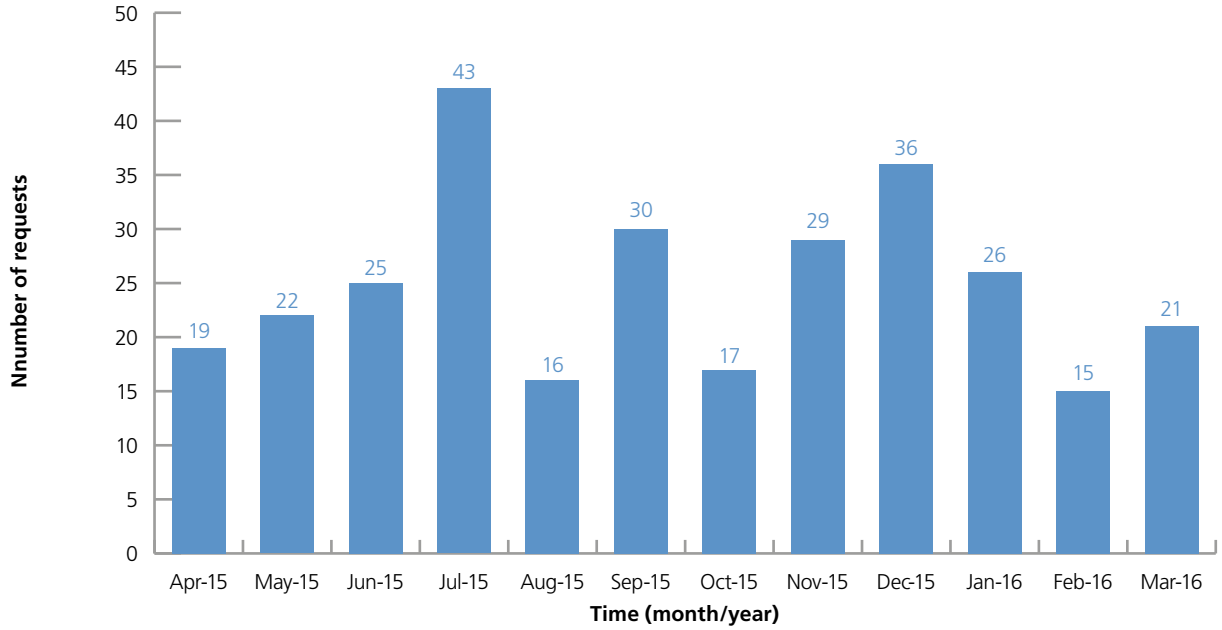
The NHS LA has taken work forward to establish an information security management system (ISMS) in line with ISO 27001 standards. This comprises the following:

- identification and treatment of information security risks;
- establishing information security objectives supported by policies and procedures;
- metrics to measure how we are achieving objectives;
- having an effective programme of staff training and awareness;
- continual review of risks, incidents and other non-conformities; and
- a defined programme of internal audit.

Responding to members of the public

Effective processes were in place throughout the year which ensured a swift response to all public enquiries, correspondence, Parliamentary questions, issues raised under Data Protection (DPA) legislation, Freedom of Information requests and complaints. The NHS LA received 299 requests under the Freedom of Information Act and 97% have been provided within the statutory 20 working day deadline.

Figure 24: Freedom of Information requests received in 2015/16.



The NHS LA receives two types of requests under the DPA. Subject Access Requests (SARs) give individuals the right to request any information held about themselves; and requests under Section 29 of the DPA (S29) which allows the NHS LA to share information with an authority for the purposes of crime and taxation. Between the NHS LA and NCAS, 54 SARs were responded to in 2015/16, two of which were completed outside of the 40 calendar day deadline, meaning 96% have been responded to on time. The average response time was 27 days. Five requests under S29 of the DPA were also received.

There were five requests for reviews of decisions in 2015/16: four relating to FOI decisions and one relating to a Subject Access Request decision. The SAR request was referred to the Information Commissioner who upheld the NHS LA's application of an exemption.

Complaints and feedback

From 1 April 2015 to 31 March 2016 the NHS LA received 33 complaints which were reviewed through the formal complaints policy. There has been one complaint which has been referred to the Parliamentary and Health Service Ombudsman. The NHS LA is committed to ensuring that complaints and feedback about our services are reviewed. An example of this is where we identified procedures which required amending in our claims handling manual as a result of a complaint. The SMT and I review complaints and feedback about our services and I report the findings to the Board. There is oversight by the Chair in accordance with the Complaints Policy. I ensure that the NHS LA identifies any learning from complaints and I also consider complaints with the SMT to identify any new risks, which are included in the risk register as appropriate.

Whistleblowing

The NHS LA has in place a Whistleblowing Policy and Guidance, which were approved by the Board in September 2014 and take into account recently issued DH guidance. There was one whistleblowing incident in 2015. After an internal investigation and appeal this was not upheld. A question was asked within the NHS LA staff survey to ascertain if staff would know where to find the whistleblowing policy, of which 88% said they would. A review of whistleblowing arrangements will be carried out as part of the internal audit programme in 2016/17.

Risks and challenges

The NHS LA Board has responsibility for ensuring oversight of the strategic risk register which is reviewed on a quarterly basis by the ARC and the SMT. The key strategic risks faced and managed during 2015/16 were:

Financial sustainability

Financial pressures across the health system remained a key issue for 2015/16, including the cost of clinical negligence. The major contributors to our schemes, primarily NHS providers, have seen an average year-on-year increase in contributions from Members to settle clinical negligence claims in 2015/16 of 35%, with a further increase of 17% in 2016/17. This increase arises as a result of the increased numbers and costs of claims reported in prior years reaching settlement and therefore impacting on expenditure.

Looking to the longer term, the value of the provision for liabilities arising from claims has also increased by £2.5 billion for another year's worth of activity and changes in assumptions, and a further £25.5 billion for the accounting effect of the change in discount rate, all of which present challenges in the context of long term financial sustainability.

NHS LA has been increasingly focused on working with our Members, DH, and other Arm's Length Bodies and stakeholders, to tackle this issue in the following ways:

- promoting safety and learning through funding local initiatives through the Sign up to Safety campaign, using data to identify risk areas, and supporting the sharing of good practice;
- informing policy development on the legal framework, particularly around claimant legal costs for lower value claims; and
- launching a consultation on pricing arrangements for CNST to explore further options with our membership to incentivise the reduction of harm.

In addition, the NHS LA has worked closely with DH, and with the NHS Trust Development Authority (NTDA) and Monitor to keep them informed of pressures and the impact on individual organisations.

We are awaiting the outcome of a review of the court discount rate, any change to which would have significant implications for the cost of claims and the NHS LA's provisions. We continued to model the potential impact with our Actuaries and to advise DH and Ministry of Justice accordingly.

Changes in the Senior Management Team

During the year, vacancies arose in key operational and corporate functions at Director level, putting at risk NHS LA's ability to move forward on our challenging agenda. Recruitment has been undertaken throughout the year, and we end the financial year with a complete management team with a range of skills and experience both from within and external to NHS LA. Handover and temporary cover arrangements, including support from key suppliers, were put in place to minimise gaps where possible, and no major issues have arisen as a result.

Data quality

It is important to continually monitor the accuracy of NHS LA key data which is utilised for setting contributions and provisions, and for informing Members on their priority areas for claims reduction. NHS LA data can also be requested under the Freedom of Information and Data Protection Acts.

Internal audit carried out two data quality reviews on the CMS (claims) and EKS (NCAS) management systems. The CMS review was rated moderate; however the EKS review had an unsatisfactory rating due to weaknesses in controls. The NHS LA put in place an action plan to address this in 2015/16, with 83% of actions concluded and the remainder continuing in 2016/17. A documented user guide has been put in place for NCAS data systems, together with a user group meeting. A case management system will be developed in 2016/17.

Legal environment

In August 2015, DH announced a consultation on fixed recoverable costs for lower value clinical negligence claims. The NHS LA has noted that costs for lower value claims have become increasingly disproportionate to both damages and defence costs, and it is expected that fixed costs will incentivise the expeditious resolution of claims at a more proportionate cost.

It is important that the NHS LA is able to respond swiftly to any new costs regime and so it has reviewed its KPIs and claims team resource in 2015/16 to ensure that it is in a position to manage any changes to timescales, volumes or to the legal market which result.

New models of care delivery

The development of new models of care delivery, including vanguards, has exposed potential gaps in indemnity cover arrangements. The NHS LA has been working with DH and its lawyers in order to establish how the legal framework governing its schemes might be adapted in order to extend cover to these emerging models of care. The variety and complexity of the contractual arrangements and the statutory nature of the NHS LA's schemes has made this challenging.

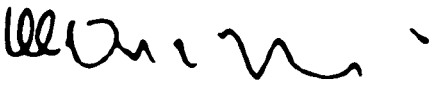
Criminal liabilities

The NHS LA dealt with a number of Health and Safety Executive prosecutions following the demise of PCTs, SHAs and NHS Direct which resulted in criminal liabilities arising from these demised organisations being passed to the NHS LA. During 2015/16 the NHS LA entered guilty pleas in relation to two such cases resulting from a defunct PCT and managed the fine levied by the courts from funds allocated by DH. Entering of the first plea was discussed with the NHS LA Board given the reputational implications and that the transfer of these liabilities was not within the normal course of business.

Accounting Officer's conclusion

The governance arrangements detailed in the statement aim to support the NHS LA to maximise its understanding and use all of the available information about the quality and effectiveness of our systems to help us improve services and satisfy assurance requirements about the effectiveness of our systems of internal control. Based on my review, I am not aware of any significant control issues and I am content that appropriate arrangements are in place for the discharge of all statutory functions for which the NHS LA is responsible.

In summary, I am satisfied that the framework of governance, risk management and system of internal controls are adequate and have been effectively maintained throughout 2015/16.



Helen Vernon
Chief Executive and Accounting Officer
Date: 27 June 2016

Remuneration and staff report

Remuneration policy

The NHS LA is bound by the National Health Service Terms and Conditions of Service (known as Agenda for Change). With the exception of the Directors who are paid under Very Senior Manager pay arrangements, all staff are paid in accordance with Agenda for Change.

The relevant NHS LA policies applied during the financial year in relation to salaries were the HR16 Recruitment and Selection Policy and Procedure and the National Terms and Conditions of Service. Allowances to staff in payment during the year other than basic salary were High Cost Area Supplement (Inner London weighting), recruitment and retention payments, and on call allowances for information systems and governance.

In relation to VSM, the Remuneration and Terms of Service Committee considered the application of the Pay Framework for VSM for ALBs. This framework was agreed by HM Treasury and the Cabinet Office. The new pay framework is operating in shadow form and existing VSM staff will be migrated onto this framework. There will be no amendment to terms and conditions as part of this process.

The Remuneration and Terms of Service Committee met three times during the year.

Remuneration for Directors

Tables 8, 9 and 10 that follow give the contractual salary and pension details of those senior managers and non-executive directors who had control over the major activities of the NHS LA during 2015/16. The information in these tables is subject to audit.

Table 7: Remuneration and Terms of Service Committee meeting attendance.

Name	Post	Meetings attended
Ian Dilks	Chair	3 of 3
Keith Edmonds	Non-executive Director	2 of 2
Andrew Hauser	Non-executive Director	3 of 3
Ros Levenson	Non-executive Director	3 of 3

Table 8: Executive and non-executive director salaries and allowances for 2015/16.

	2015-16					
Name and title	**Salary (bands of £5,000)** £000	**Expense payments (taxable) total to nearest £100** £00	**Performance pay and bonuses (bands of £5,000)** £000	**Long term performance pay and bonuses (bands of £5,000)** £000	**All pension-related benefits (bands of £2,500)** £000	**Total (bands of £5,000)** £000
Ian Dilks *(Chair)*	60–65	0	0	0	N/A	**60–65**
Helen Vernon *(Chief Executive)*	145–150	0	0	0	132.5 – 135	**275 – 280**
Joanne Evans[1] *(Director of Finance and Corporate Planning)*	25–30	0	0	0	5 – 7.5	**35 – 40**
Tom Fothergill[2] *(Director of Finance and Corporate Planning)*	90–95	0	0	0	5 – 7.5	**95 – 100**
Denise Chaffer[3] *(Director of Safety and Learning)*	85–90	0	0	0	(22.5) – (25)	**65 – 70**
Keith Edmonds *(Non-executive Member)*	5–10	0	N/A	N/A	N/A	**5–10**
Nina Wrightson OBE[4] *(Non-executive Member)*	0–5	0	N/A	N/A	N/A	**0–5**
Ros Levenson *(Non-executive Member)*	5–10	0	N/A	N/A	N/A	**5–10**
Andrew Hauser[5] *(Non-executive Member)*	N/A	N/A	N/A	N/A	N/A	**N/A**

1 Joanne Evans was appointed as Director of Finance and Corporate Planning on 1 January 2016. Full year equivalent salary is in the band £115k-120k.
2 Tom Fothergill left the NHS LA on 31 October 2015. Full year equivalent salary is in the band £150k-155k.
3 Denise Chaffer was appointed as Director of Safety and Learning on 1 June 2015. Full year equivalent salary is in the band £105k-110k.
4 Nina Wrightson left the Board with effect from 30 April 2015.
5 Andrew Hauser's appointment as a Non-executive Director is unpaid.

Table 9: Executive and non-executive director salaries and allowances for 2014/15.

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

1 Ian Dilks was appointed as Chair on 1 April 2014.
2 Catherine Dixon left the NHS LA on 30 November 2014.
3 Helen Vernon was appointed as Chief Executive on 1 December 2014.
4 Suzette Woodward was seconded to the Sign up to Safety Programme from 24 June 2014.
5 Andrew Hauser's appointment as Non-executive Director is unpaid.

All Directors at the NHS LA pay into the NHS Pension Scheme. Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Further details are set out in the Financial statement section.

Table 10: Pension entitlements for Executive Directors

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 2016 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £000
Helen Vernon *(Chief Executive)*	5 – 7.5	12.5–15	25–30	75–80	420	319	97	21
Joanne Evans *(Director of Finance and Corporate Planning)*	0–2.5	0	0– 5	0	6	0	6	4
Tom Fothergill *(Director of Finance and Corporate Planning)*	0–2.5	0	40–45	125–130	739	710	20	13
Denise Chaffer *(Director of Safety and Learning)*	0–2.5	0–2.5	30–35	100–105	750	719	22	13

Note: On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report. Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

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.

Compensation on early retirement or for loss of office

There were no early retirements or other exit arrangements for Directors during the reporting period.

Payments to past Directors

There were no payments made to past Directors.

Fair pay disclosure

The median remuneration of the NHS LA is £43,374. This is based on annualised, full-time equivalent remuneration of all permanent staff as at the reporting date. Staff remuneration ranges from £19,027 to £145,440. This has been calculated at gross basic pay.

The ratio between the median staff remuneration and the mid-point of the banded remuneration of the highest paid director is 3.4. The ratio for the previous year (2014/2015) was 3.65. The slight reduction in the ratio is due to the changes made to the VSM salary arrangements which include advertising vacant posts at the lowest spinal point on the relevant VSM pay band and the resignation of the most highly paid Director in the organisation during 2015. This information is subject to audit.

Staff report

The average annual staff number for the year has reduced from 230 to 223 (3%) from the last financial year. NHS LA has carried some vacant posts at the Senior Management Team level and in the Claims team which have now been filled.

Average salaries have reduced due to the factors outlined above in the Fair Pay Disclosure section.

Of the 7 VSMs, three were male and four were female. Throughout the organisation, the proportions were 40% male and 60% female. The information about staff costs is subject to audit.

Table 10: Staff numbers and related costs for 2014/15 and 2015/16.

Staff numbers and related costs	Permanently employed staff £000	Other £000	2015/16 Total £000	2014/15 Total £000
Salaries and wages	9,789	719	**10,508**	11,609
Social security costs	901	0	**901**	908
Employer contributions to NHS Pensions	1,255	0	**1,255**	1,188
NEST pension contributions	2	0	**2**	1
Total	**11,947**	**719**	**12,666**	**13,706**

Table 11: Average staff numbers for 2014/15 and 2015/16.

Average number of persons employed	Permanently employed staff	Other	2015/16 Total	2014/15 Total
Total	211	12	**223**	230

Table 12: Sickness absence for the period 1 January 2015 to 31 December 2015.

Figures converted by DH to best estimates of required data items		Statistics produced by HSCIC from ESR data warehouse		
Average FTE 2015	Adjusted FTE days lost to Cabinet Office definitions	FTE-days available	FTE-days lost to sickness absence	Average sick days per FTE
208	1010	75,923	1,638	4.9

Notes

1. NHS sickness absence statistics are published by the Health and Social Care Information Centre, using data from the NHS Electronic Staff Record (ESR) Data Warehouse.
2. The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.
3. NHS Days Lost figures are on a full-time equivalent basis.

Measures have been in place to support the management of sickness absence with both long term and short term absences being proactively managed throughout the year.

The NHS LA applies the 'Two Ticks' symbol for internal and external applicants during recruitment exercises. Employers who have signed up to the 'Two Ticks' (disability symbol) scheme guarantee disabled people an interview if they meet the minimum criteria for the job vacancy. The NHS LA is also signing up to the Mindful Employer Charter[9]. This will support the NHS LA attracting a more diverse workforce.

The percentage of applicants during 2015/2016 who identified as being disabled and who were offered an interview was 6%.

Off-payroll engagements – summary data on the use of off-payroll arrangements

The NHS LA have had no off-payroll engagements for more than £220 per day that have lasted longer than six months during 2015/16.

9 MINDFUL EMPLOYER® is a NHS initiative run by Workways, a service of Devon Partnership NHS Trust, to help support employers to support mental wellbeing at work.

Exit packages

There were no redundancies during 2015/16. This information is subject to audit. All NHS LA staff are covered by the NHS Terms and Conditions redundancy provisions.

The consultation on public sector exit payments is seeking to amend this throughout the public sector and these changes are expected to be introduced into NHS Terms and Conditions during 2016.

Table 13: Exit packages for staff leaving in 2014/15 and 2015/16.

Payment bands	2015/16	2015/16	2015/16	2014/15
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Total number of exit packages by cost band
< £10,000	0	0	0	0
£10,000 – £25,000	0	0	0	0
£25,000 – £50,000	0	0	0	0
£50,000 – £100,000	0	0	0	1
£100,000 – £150,000	0	0	0	1
£150,000 – £200,000	0	0	0	0
Total number	**0**	**0**	**0**	**2**
Total cost (£'000s)	**0**	**0**	**0**	**176**

Notes

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

Helen Vernon
Chief Executive and Accounting Officer
Date: 27 June 2016

The certificate and report of the Comptroller and Auditor General to the House of Commons

I certify that I have audited the financial statements of the NHS Litigation Authority for the year ended 31 March 2016 under the National Health Service Act 2006. The financial statements 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 and Staff Report and the Parliamentary Accountability Disclosures that is described as having been audited.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of the Authority's and 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 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 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 2016 and of its net expenditure, changes in taxpayers' equity and cash flows for the year then ended; and
- the financial statements have been properly prepared in accordance with the National Health Service Act 2006 and Secretary of State directions issued thereunder.

Emphasis of matter –provision for Clinical Negligence Scheme for Trusts

Without qualifying my opinion, I draw attention to the disclosures made in Note 9 to the financial statements concerning the uncertainties inherent in the claims provision for the Clinical Negligence Scheme for Trusts. As set out in Note 9, given the long-term nature of the liabilities and the number and nature of the assumptions on which the estimate of the provision is based, a considerable degree of uncertainty remains over the value of the liability recorded by the NHS Litigation Authority. Significant changes to the liability could occur as a result of subsequent information and events which are different from the current assumptions adopted by the NHS Litigation Authority

Opinion on other matters

In my opinion:

- the part of Remuneration and Staff Report and the Parliamentary Accountability disclosures to be audited has been properly prepared in accordance with the Secretary of State's directions issued under the National Health Service Act 2006.
- the information given in the Performance Report and Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

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

- adequate accounting records have not been kept or returns adequate for my audit have not been received from branches not visited by my staff; or
- the financial statements and the parts of the Remuneration and Staff Report and the Parliamentary Accountability disclosures to be audited are not in agreement with the accounting records and 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.

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

Date: 30 June 2016

Financial statements

Statement of comprehensive net expenditure for the year ended 31 March 2016

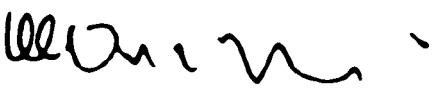
	Notes	31 March 2016 £000	31 March 2015 £000
Other operating income	3	**(1,480,853)**	(1,108,912)
Total operating income		**(1,480,853)**	(1,108,912)
Staff costs	2	12,666	13,612
Purchase of goods and services	2	4,375	3,171
Depreciation and impairment charges	2	558	640
Provision expense	9	29,331,883	3,701,074
Other operating expenditure	2	20,137	3,111
Total operating expenditure		29,369,619	3,721,608
Net operating expenditure		27,888,766	2,612,696
Finance expenditure	9	46,583	28,919
Net expenditure for the year		**27,935,349**	**2,641,615**
Other comprehensive net expenditure		0	0
Comprehensive net expenditure for the year		**27,935,349**	**2,641,615**

The Notes at pages 110 to 147 form part of these accounts.

Statement of financial position as at 31 March 2016

	Notes	31 March 2016 £000	31 March 2015 £000
Non-current assets:			
Property, plant and equipment	4	**1,388**	1,410
Intangible assets	5	**642**	749
Total non-current assets		**2,030**	2,159
Current assets:			
Trade and other receivables	6	**8,929**	12,345
Cash and cash equivalents	7	**94,949**	32,889
Total current assets		**103,878**	45,234
Total assets		**105,908**	47,393
Current liabilities:			
Trade and other payables	8	**(56,397)**	(42,219)
Provisions for liabilities and charges - known claims	9	**(1,827,649)**	(1,604,753)
Provisions for liabilities and charges - IBNR	9	**0**	(18,000)
Total current liabilities		**(1,884,046)**	(1,664,972)
Total assets less current liabilities		**(1,778,138)**	(1,617,579)
Non-current liabilities:			
Provisions for liabilities and charges - known claims	9	**(21,224,063)**	(10,865,017)
Provisions for liabilities and charges - IBNR	9	**(33,389,000)**	(16,122,300)
Total non-current liabilities		**(54,613,063)**	(26,987,317)
Total assets less liabilities		**(56,391,201)**	(28,604,896)
Taxpayers' equity			
General fund		**(2,633)**	(6,115)
ELS reserve		**(1,445,389)**	(616,683)
Ex-RHA reserve		**(89,287)**	(37,362)
DH clinical reserve		**(3,763,292)**	(1,997,089)
DH non-clinical reserve		**(157,478)**	(113,256)
CNST reserve		**(50,757,969)**	(25,632,615)
PES reserve		**(229)**	847
LTPS reserve		**(174,924)**	(202,623)
Total taxpayers' equity		**(56,391,201)**	(28,604,896)

The General Fund and individual scheme reserves are used to account for all financial resources. See Note 9 for a brief description of each scheme to which the reserves relate. The Financial statements on pages 106 to 147 were approved by the Board on 27 June 2016 and signed by Helen Vernon. The Notes at pages 110 to 147 form part of these accounts.



Helen Vernon
Chief Executive and Accounting Officer
Date: 27 June 2016

Statement of cash flows for the year ended 31 March 2016

	Notes	31 March 2016 £000	31 March 2015 £000
Cash flows from operating activities			
Net expenditure		**(27,935,349)**	(2,641,615)
Other cashflow adjustments	2	**558**	640
(Increase)/decrease in receivables	6	**3,416**	(1,490)
Increase/(decrease) in payables	8	**14,178**	12,884
Increase/(decrease) in provisions	9	**27,830,642**	2,506,973
Net cash (outflow) from operating activities		**(86,555)**	(122,608)
Cash flows from investing activities			
Purchase of property, plant and equipment	4	**(327)**	(54)
Purchase of intangible assets	5	**(102)**	(396)
Net cash (outflow) from investing activities		**(429)**	(450)
Cash flows from financing activities			
Net Parliamentary funding		**149,044**	134,414
Net financing		**149,044**	134,414
Net increase in cash and cash equivalents		**62,060**	11,356
Cash and cash equivalents at the beginning of the period		**32,889**	21,533
Cash and cash equivalents at the end of the period	7	**94,949**	32,889

The Notes at pages 110 to 147 form part of these accounts.

Statement of changes in taxpayers' equity for the year ended 31 March 2016

	Notes	General Fund £000	ELS Reserve £000	Ex-RHAs Reserve £000	DH Clinical Reserve £000	DH Non-clinical Reserve £000	CNST Reserve £000	PES Reserve £000	LTPS Reserve £000	Total Reserves £000
Balance at 31 March 2014		(1,587)	(579,639)	(35,889)	(1,860,892)	(193,130)	(23,177,157)	1,258	(250,659)	(26,097,695)
Changes in taxpayers' equity for 2014/15										
Net expenditure for the year		(6,212)	(61,740)	(2,523)	(233,744)	70,437	(2,455,458)	(411)	48,036	(2,641,615)
Total recognised income and expense for 2014/15		(6,212)	(61,740)	(2,523)	(233,744)	70,437	(2,455,458)	(411)	48,036	(2,641,615)
Net Parliamentary funding		1,684	24,696	1,050	97,547	9,437	0	0	0	134,414
Balance at 31 March 2015		**(6,115)**	**(616,683)**	**(37,362)**	**(1,997,089)**	**(113,256)**	**(25,632,615)**	**847**	**(202,623)**	**(28,604,896)**
Changes in taxpayers' equity for 2015/16										
Expenditure										
Authority and claims administration	2	(25,105)	(63)	(3)	(270)	(323)	(9,061)	(84)	(2,827)	(37,736)
(Increase)/decrease in provision for known claims	9	0	(523,780)	(35,540)	(1,131,304)	2,537	(10,396,606)	(6,111)	(38,962)	(12,129,766)
(Increase)/decrease in the provision for IBNR	9	0	(331,500)	(17,500)	(717,400)	(57,900)	(16,139,200)	0	14,800	(17,248,700)
		(25,105)	(855,343)	(53,043)	(1,848,974)	(55,686)	(26,544,867)	(6,195)	(26,989)	(29,416,202)
Income										
Scheme and other income	3	1,533	0	0	0	0	1,419,513	5,119	54,688	1,480,853
Total recognised income and expense for 2015/16		(23,572)	(855,343)	(53,043)	(1,848,974)	(55,686)	(25,125,354)	(1,076)	27,699	(27,935,349)
Net Parliamentary funding[1]		27,054	26,637	1,118	82,771	11,464	0	0	0	149,044
Balance at 31 March 2016		**(2,633)**	**(1,445,389)**	**(89,287)**	**(3,763,292)**	**(157,478)**	**(50,757,969)**	**(229)**	**(174,924)**	**(56,391,201)**

1 The Net Parliamentary funding represents the cash drawdown of £149,044k in 2015/16 for DH-funded indemnity schemes and administration costs.

The Notes at pages 110 to 147 form part of these accounts.

Notes to the accounts

1. Accounting policies

The financial statements have been prepared in accordance with the 2015/16 Government Financial Reporting Manual (FReM) issued by HM Treasury. The accounting policies contained in the FReM apply IFRS as adapted or interpreted for the public sector context. Where the FReM permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the NHS LA for the purpose of giving a true and fair view has been selected. The particular policies adopted by the NHS LA are described below. They have been applied consistently in dealing with items that are considered material to the accounts.

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

1.1. Accounting conventions

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

1.2. Early adoption of standards, amendments and interpretations

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

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

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

The following have not been adopted early in these accounts:

- IFRS 9 Financial Instruments: The effective date is for accounting periods beginning on, or after 1 January 2018. The timing for EU adoption is uncertain;
- IFRS 14 Regulatory Deferral Accounts: The standard will be adopted in the FReM once it has received EU adoption (which is still to be decided);
- IFRS 15 Revenue from Contracts with Customers: with a view to include in the 2017-18 FReM (subject to the EU adoption and consultation);
- IFRIC 21 Levies: EU adopted in June 2014 but not yet adopted by HM Treasury;
- IFRS 16 Leases: The effective date is uncertain, subject to consultation when the new standard is issued;
- IAS 1 Disclosure initiative (amendment): with a view to include in the 2016-17 FReM (subject to the EU adoption and consultation); and
- IAS 16 and IAS 38 Clarification of acceptable methods of depreciation and amortisation (amendment: with a view to include in 2016-17 FReM).

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

1.3. Income

Income is accounted for by applying the accruals convention. A major source of funding for the Special Health Authority is Parliamentary grant from DH within an approved cash limit, which funds the ELS and Ex-RHA, DH clinical and DH liabilities schemes. Parliamentary funding is recognised in the financial period in which it is received.

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

1.4. Taxation

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

1.5. Property, plant and equipment (PPE)

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

i) Capitalisation

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

- individually have a cost equal to or greater than £5,000;
- collectively have a cost of at least £5,000 and an individual cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up cost of a new building irrespective of their individual or collective cost.

ii) Valuation

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

iii) Depreciation

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

- Furniture and fittings – 10 years
- Information technology – 5 years

iv) Leased assets

NHS LA holds no finance leases. Other leases are regarded as operating leases and the rentals are charged to the Statement of comprehensive net expenditure on a straight line basis over the term of the lease.

1.6. Intangible assets

i) Capitalisation

Intangible assets which can be valued and are capable of being used in the Authority's activities for more than one year and have a cost equal to or greater than £5,000. They are recognised only when it is probable that future economic benefits will flow to the entity, where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

ii) Internally generated intangible assets

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

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

Intangible non-current assets are valued at cost.

iii) Amortisation

For intangible assets with finite useful lives, amortisation is calculated so as to write off the cost of an asset, less its estimated residual value, over its useful economic life. Software is amortised on a straight line basis over five years.

1.7. Impairment of non-financial assets

Non-financial assets are reviewed at each reporting date for indications of impairment. Where an asset is found to be impaired, it is recognised as impairment charged to the revaluation reserves to the extent that there is a balance on the reserves for the asset being impaired and thereafter to 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. As assets are not held for the purpose of generating cash flows, value in use is assumed to equal the cost of replacing the service potential provided by the asset, unless there has been a reduction in service potential. Present values are computed using discount rates that reflect the time value of money and the risks specific to the unit whose impairment is being measured.

1.8. Pension costs

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

1.9. NHS Pensions Scheme

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

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

i) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2016 is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data.

In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used. The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

ii) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates. The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016.

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

iii) Scheme provisions

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

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

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

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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

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

1.10. Pensions costs – NEST

The Pensions Act 2008 and 2011 Automatic Enrolment regulations required all employers to enrol workers meeting certain criteria into a pension scheme and pay contributions toward their

retirement. For those staff not entitled to join the NHS Pension Scheme, the NHS LA utilised an alternative pension scheme called NEST to fulfil its Automatic Enrolment obligations.

NEST stands for National Employment Savings Trust and is a defined contribution pension scheme established by law to support the introduction of Auto Enrolment. Contributions are taken from qualifying earnings, which are currently from £5,824 up to £42,385, but will be reviewed every year by the government. The initial employee contribution is 1% of qualifying earnings, with an employer contribution of 1%. This will increase in stages to meet levels set by government.

Employee and employer contributions to NEST.

Date	Employee contributions (%)	Employer contributions (%)	Total contributions (%)
1 April 2014	1	1	2
6 April 2018	3	2	5
6 April 2019	5	3	8

Annual contribution to a NEST retirement fund is limited to £4,900 for the 2015/2016 tax year. This will be reviewed each year and is likely to increase. Pension members can make additional contributions to their pension fund at any time up to the annual limit. Pension members can choose to let NEST manage their retirement fund or take control themselves and alter contribution levels and switch between different funds. If pension members leave the NHS LA they can continue to pay into NEST.

NEST Pension members can take their money out of NEST at any time from age 55. If suffering from serious ill health or incapable of working due to illness, members can request to take their money out of NEST early. They can take the entire retirement fund as cash, use it to buy a retirement income or a combination. Additionally members can transfer their NEST retirement fund to another scheme. NEST is run by NEST Corporation, a trustee body which is a non-departmental public body operating at arm's length from government and is accountable to Parliament through the Department for Work and Pensions.

1.11. Short term employee benefits

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

1.12. Provisions

The NHS LA provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the HM Treasury's discount rate. The HM Treasury discount rate was adjusted in December 2015 as follows: short –1.55% (14/15 –1.50%), medium –1.00% (14/15 –1.05%) and long-term –0.8% (14/15 2.2%).

The ELS, Ex-RHA and DHL schemes are funded by DH, CNST, LTPS and PES from trust contributions, and the accounts for the schemes are prepared in accordance with IAS 37. A provision for these schemes is calculated in accordance with IAS 37 by discounting the gross value of all claims received: this is disclosed in Note 9.1.

The calculation is made using:

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

ii) a discount factor calculated using the real discount rates noted above, RPI of 3.5% and claims inflation (varying between schemes) of between 7% and 10%, is applied to the probable cost to take into account the likely time to settlement.

The difference between the gross value of claims and the probable cost of each claim as calculated above is also discounted, taking into account the likely time to settlement, and is included in contingent liabilities as set out in Note 9.7.

Resolution of claims is difficult to predict as many factors can lead to delay during the settlement process whilst emerging evidence can alter valuation and thus the Authority makes a best estimate regarding the likely year of settlement and expected value of the claim against

each notified claim. These estimates are reviewed throughout the life of the claim and amended to reflect variations in expectations which inevitably alters the value provided.

1.13. Financial assets

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

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method. This is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset to the net carrying amount of the financial asset.

At the Statement of financial position date, the NHS LA assesses whether any financial assets are impaired, and impairment losses recognised, if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which have an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of comprehensive net expenditure.

1.14. Financial liabilities

Financial liabilities are recognised in the Statement of financial position when it becomes a party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged; that is, the liability has been paid or has expired.

Financial liabilities are initially recognised at fair value.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.15. Critical judgements and key sources of estimation uncertainty

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

The estimates and underlying assumptions are reviewed in the period in which the estimate is revised if the ongoing basis by the NHS LA, supported by its actuaries the Government Actuary's Department (GAD). Revisions to accounting estimates are recognised revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

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

1.16. IFRS 8 – operating segments

The NHS LA has one reportable segment under IFRS 8 but income and expenditure are disaggregated by different scheme types in the Statement of changes in taxpayers' equity (SOCTE).

2. Expenditure

	Notes	2015/16 £000	2014/15 £000
Non-executive Members' remuneration		**87**	94
Other salaries and wages		**12,666**	13,436
Redundancy costs		**0**	176
Supplies and services – general		**0**	2
Establishment expenses		**867**	937
Hire and operating lease rental			
Land and buildings		**897**	752
Lease cars		**3**	2
Photocopiers		**21**	21
Franking machine		**11**	5
Vending machine		**4**	1
Transport and moveable plant		**1**	1
Premises and fixed plant		**2,264**	2,075
External contractors			
Actuary's advice		**683**	897
Appeals Unit advisory expenditure		**128**	167
External corporate legal fees[1]		**115**	254
NCAS assessment expenditure		**333**	576
NCAS professional services		**32**	0
Risk management		**0**	55
Grant - Sign up to Safety[2]		**18,737**	0
Other[3]		**136**	285
Auditor's remuneration: audit fees[4]		**118**	113
Internal audit fees		**75**	43
Bank charges and interest		**0**	2
		37,178	19,894
Depreciation	4	**349**	393
Amortisation	5	**209**	247
		558	
		37,736	20,534
Other finance costs - unwinding of discount	9	**46,583**	28,919
Increase in provision for known claims (excl. unwinding of discounts and change in discount rate)	9	**2,583,815**	3,118,079
Change in the discount rate[5]	9	**25,473,368**	124,895
Increase / (decrease) in the provision for IBNR *	9	**1,274,700**	458,100
		29,331,883	
		29,416,202	3,750,527

1 External corporate legal fees do not include legal fees in relation to clinical and non-clinical claims. These costs are included within Note 9 Provisions.
2 The grant of £18,737k expenditure relates to Sign up to Safety incentivisation fund. 67 awards were made to 48 NHS providers following the submission and evaluation of business cases for the delivery of safety improvements in clinical practice.
3 Other expenditure includes laboratory tests, payroll and professional services.
4 The NHS LA did not make any payments to its auditors for non-audit work.
5 The discount rate used is per 2015/16 HM Treasury's Public Expenditure System (PES), this has resulted an increase of £25,473m in provision (£9,499m for known claims and £15,974m for IBNR).

Of the £29,416m shown above, £6.65m is shown as administration expenditure in the DH consolidated group accounts.

3. Operating income

	2015/16 £000	2014/15 £000
CNST contributions	**1,419,513**	1,047,978
PES contributions	**5,119**	5,101
LTPS contributions	**54,688**	54,534
NCAS	**1,460**	1,299
Other income	**73**	0
Total	**1,480,853**	1,108,912

4. Property, plant and equipment

	Information technology £000	Furniture and fittings £000	Total £000
Valuation at 1 April 2015	1,715	1,674	3,389
Additions – purchased	327	0	327
Disposals	(70)	0	(70)
Valuation at 31 March 2016	**1,972**	**1,674**	**3,646**
Accumulated depreciation at 1 April 2015	1,250	729	1,979
Charged during the year	184	165	349
Disposals	(70)	0	(70)
Accumulated depreciation at 31 March 2016	**1,364**	**894**	**2,258**
Net Book Value at 31 March 2015	465	945	1,410
Net Book Value at 31 March 2016	**608**	**780**	**1,388**

No assets are held under finance leases or hire purchase contracts.

Capital commitments: The NHS LA has no capital commitments at 31 March 2016 (2014/15: nil).

Property, plant and equipment (prior year)

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

5. Intangible assets

	Information technology £000	Software licences £000	Total £000
Gross cost at 1 April 2015	2,734	838	3,572
Additions – purchased	86	16	102
Gross cost at 31 March 2016	**2,820**	**854**	**3,674**
Accumulated amortisation at 1 April 2015	2,395	428	2,823
Charged during the year	103	106	209
Accumulated amortisation at 31 March 2016	**2,498**	**534**	**3,032**
Net Book Value at 1 April 2015	339	410	749
Net Book Value 31 March 2016	**322**	**320**	**642**

No assets are held under finance leases or hire purchase contracts.

Capital commitments: The NHS LA has no capital commitments at 31 March 2016 (2014/15: nil).

Intangible assets (prior year)

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

6. Receivables

	Ex-RHA £000	ELS £000	DH clinical £000	CNST £000	PES £000	LTPS £000	Administration £000	Total 31 March 2016 £000	Total 31 March 2015 £000
NHS receivables - revenue	0	0	0	1,270	19	1,658	54	**3,001**	4,735
Accrued income	0	0	0	0	0	0	(211)	**(211)**	0
Prepayments	35	293	861	271	0	0	291	**1,751**	3,055
Other receivables	0	782	0	3,588	67	(620)	571	**4,388**	4,555
	35	**1,075**	**861**	**5,129**	**86**	**1,038**	**705**	**8,929**	**12,345**

7. Cash and cash equivalents

	Ex-RHA £000	ELS £000	CNST £000	PES £000	LTPS £000	Administration £000	Total 31 March 2016 £000	Total 31 March 2015 £000
At 1 April 2015	(17)	66	(113)	8,671	22,991	1,291	**32,889**	21,533
Change during the year	**167**	**1,400**	**47,242**	**1,548**	**7,347**	**4,356**	**62,060**	11,356
At 31 March 2016	**150**	**1,466**	**47,129**	**10,219**	**30,338**	**5,647**	**94,949**	32,889

8. Trade payables and other current liabilities

	Ex-RHA £000	ELS £000	DH clinical £000	DH non-clinical £000	CNST £000	PES £000	LTPS £000	Administration £000	Total 31 March 2016 £000	Total 31 March 2015 £000
NHS payables revenue	0	0	0	0	0	461	110	71	**642**	652
Prepaid income	0	2,132	0	0	1,206	0	0	367	**3,705**	6,685
Accruals	3	28	271	37	5,206	0	166	2,784	**8,495**	10,065
Other payables	33	548	1,303	76	39,965	0	1,492	138	**43,555**	24,817
	36	**2,708**	**1,574**	**113**	**46,377**	**461**	**1,768**	**3,360**	**56,397**	**42,219**

9. Provisions for liabilities and charges

	Ex-RHA £000	ELS £000	DH clinical £000	DH non-clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Opening provisions for known claims	31,192	508,279	1,354,855	29,591	10,433,060	8,299	104,494	**12,469,770**
Opening provisions for IBNR	6,500	141,500	641,600	83,100	15,160,800	2,000	104,800	**16,140,300**
Total provisions as at 1 April 2015	**37,692**	**649,779**	**1,996,455**	**112,691**	**25,593,860**	**10,299**	**209,294**	**28,610,070**
Movement in known claims								
Provided in the year	6,164	221,373	347,097	11,085	10,015,801	8,051	68,800	**10,678,371**
Provision not required written back	(6,873)	(91,104)	(177,170)	(13,879)	(1,364,209)	(1,940)	(29,896)	**(1,685,071)**
Unwinding of discount	1,600	16,602	46,900	(194)	(18,179)	0	(146)	**46,583**
Discounting	3,908	(102,163)	(131,087)	225	(6,178,402)	0	(1,966)	**(6,409,485)**
Change in discount rate[1]	30,741	479,072	1,045,564	226	7,941,595	0	2,170	**9,499,368**
Provisions utilised in the year	(1,115)	(26,574)	(82,503)	(11,146)	(1,378,262)	(3,632)	(44,592)	**(1,547,824)**
	34,425	497,206	1,048,801	(13,683)	9,018,344	2,479	(5,630)	**10,581,942**
Movement in IBNR								
Change in discount rate[1]	12,000	229,000	794,000	47,000	14,881,000	0	11,000	**15,974,000**
Provided in the year	5,500	102,500	(76,600)	10,900	1,258,200	0	(25,800)	**1,274,700**
	17,500	331,500	717,400	57,900	16,139,200	0	(14,800)	**17,248,700**
Closing provision for known claims	65,617	1,005,485	2,403,656	15,908	19,451,404	10,778	98,864	**23,051,712**
Closing provisions for IBNR	24,000	473,000	1,359,000	141,000	31,300,000	2,000	90,000	**33,389,000**
Total provision as at 31 March 2016	**89,617**	**1,478,485**	**3,762,656**	**156,908**	**50,751,404**	**12,778**	**188,864**	**56,440,712**
Analysis of expected timing of discounted cashflows[2]								
Not later than one year	984	28,545	98,430	8,859	1,632,954	4,036	53,841	**1,827,649**
Later than one year and not later than five years	3,759	118,295	403,752	22,655	9,914,253	8,742	135,023	**10,606,479**
Later than 5 years	84,874	1,331,645	3,260,474	125,394	39,204,197	0	0	**44,006,584**
	89,617	**1,478,485**	**3,762,656**	**156,908**	**50,751,404**	**12,778**	**188,864**	**56,440,712**

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

1 The change in discount rate represents the change in provision as result of a change in the discount rates set by HM Treasury. The total change in provision due to the discount rate is £25,473m (£9,499m for known claims and £15,974m for IBNR).

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

Provisions for liabilities and charges (prior year)

	Ex-RHA £000	ELS £000	DH clinical £000	DH non-clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Opening provision for known claims	31,219	472,739	1,336,589	29,846	8,537,661	5,712	116,331	**10,530,097**
Opening provisions for IBNR	5,000	142,000	524,000	163,000	14,606,000	2,000	131,000	**15,573,000**
Total provisions as at 1 April 2014	**36,219**	**614,739**	**1,860,589**	**192,846**	**23,143,661**	**7,712**	**247,331**	**26,103,097**
Movement in known claims								
Provided in the year	(4)	151,240	464,171	18,683	5,747,756	6,452	69,215	**6,457,513**
Provision not required written back	(18,821)	(261,220)	(550,112)	(8,374)	(2,549,054)	(1,026)	(40,433)	**(3,429,040)**
Unwinding of discount	1,698	16,475	44,395	(410)	(33,204)	(2)	(33)	**28,919**
Discounting	18,033	154,385	153,317	(706)	(236,008)	0	585	**89,606**
Change in discount rate	115	1,298	4,042	(11)	10,263	0	(12)	**15,695**
Provisions utilised in the year	(1,048)	(26,638)	(97,547)	(9,437)	(1,044,354)	(2,837)	(41,159)	**(1,223,020)**
	(27)	35,540	18,266	(255)	1,895,399	2,587	(11,837)	**1,939,673**
Movement in Net IBNR								
Change in discount rate	0	1,000	3,500	400	104,400	0	(100)	**109,200**
Provided in the year	1,500	(1,500)	114,100	(80,300)	450,400	0	(26,100)	**458,100**
	1,500	(500)	117,600	(79,900)	554,800	0	(26,200)	**567,300**
Closing provision for known claims	31,192	508,279	1,354,855	29,591	10,433,060	8,299	104,494	**12,469,770**
Closing provisions for IBNR	6,500	141,500	641,600	83,100	15,160,800	2,000	104,800	**16,140,300**
Total provision as at 31 March 2015	**37,692**	**649,779**	**1,996,455**	**112,691**	**25,593,860**	**10,299**	**209,294**	**28,610,070**
Analysis of expected timing of discounted cashflows								
Not later than one year	1,000	38,000	103,000	16,000	1,408,443	4,994	51,316	**1,622,753**
Later than one year and not later than five years	0	101,773	223,000	33,970	7,993,000	5,305	95,516	**8,452,564**
Later than 5 years	36,692	510,006	1,670,455	62,721	16,192,417	0	62,462	**18,534,753**
	37,692	**649,779**	**1,996,455**	**112,691**	**25,593,860**	**10,299**	**209,294**	**28,610,070**

9.1. Explanatory notes

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

Claims are included in the ELS provision on the basis that the incident occurred on or before 31st March 1995. Qualifying claims under the Ex-RHA scheme are claims brought against the former Regional Health Authorities whose clinical negligence liabilities passed to NHS LA with effect from 1st April 1996. Claims against DH Liabilities relate to claims against dissolved bodies where there is no successor body and a number of other claims the NHS LA is managing on behalf of the Department of Health.

Clinical Negligence Scheme for Trusts (CNST)

A provision for this scheme is calculated in accordance with IAS 37 by discounting the gross value of all claims received relating to incidents which occurred on or before 31 March 2016 and on or after 1 April 1995. Claims are included in the provision on the basis that the CNST Members have assessed:

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

b) that they are qualifying incidents; and

c) that the trust remains a member of the scheme.

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

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

In April 1999 the NHS LA introduced the PES and LTPS following the Secretary of State's decision that NHS trusts should not insure with commercial companies for non-clinical risks, other than motor vehicles and other defined areas (for example, private finance initiative schemes). The schemes are managed and funded via the same mechanisms as the CNST except that specific excesses exist for some types of claims. Thus the provision recorded in these accounts relates only to the NHS LA's proportion of each claim. The accounts for these schemes have been prepared in accordance with IAS 37.

Assumption of liabilities upon cessation

The NHS (Residual Liabilities) Act 1996 requires the Secretary of State to exercise his statutory powers to deal with the liabilities of a Special Health Authority, if it ceases to exist. This would include the liabilities assumed by the NHS LA in respect of the ELS, Ex-RHA 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 LA as at 31 March 2016 where the following can be reasonably forecast:

a) that an adverse incident has occurred;

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

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

The NHS LA uses its actuaries, the Government Actuary's Department (GAD), to assess the potential value of IBNR incidents against each of the schemes it operates. The actuaries review existing claims records, and using an appropriate model, calculate values in respect of IBNR claims for all schemes. The provisions and contingent liabilities arising are shown at Notes 9 and 10. The sums concerned are accounting estimates, and although determined on the basis of information currently available, the ultimate liabilities may vary as a result of subsequent developments.

Estimation of provisions and contingent liabilities

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

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

The NHS LA's provisions are mostly in respect of clinical negligence claims exposure. Such claims can take a significant length of time to be reported to the NHS LA, and the settlement of claims can also take a long time depending on the circumstances of the claim. Claims can take a number of years to be reported, over ten years to be settled and, if the claim is settled as a Periodic Payment Order (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 IBNR claims provision. The estimation of IBNR claims is inherently more uncertain than the estimation of the cost of claims already reported to the NHS LA, for which case-by-case information about the claim event is available.

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

Process and methodology

There are three key elements to the NHS LA's provisions: the reported outstanding claims provision, the IBNR provision and the provision for settled Periodical Payment Orders (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 each claim being successful, for expected future claims inflation to settlement, for the likelihood 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 HM Treasury-prescribed rates) 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 HM Treasury-prescribed discount rates) to estimate the provision at the accounting date.

First, a characteristic pattern of claims reporting from claim incident year is identified to determine the ultimate number of claims that are expected to arise from incidents that have occurred in each past year up to the accounting date. This allows a projection to be made for the number of IBNR claims expected to be reported in each future year.

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

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

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

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

Settled PPOs provision

To estimate the provision for settled PPO claims, we 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 HM Treasury-prescribed discount rates). Future cash flows are modelled based on individual claim data. This includes the agreed annual payments and any agreed future steps in those payments, the index to which payments are linked, and the assumed probabilities of survival to each future payment, which is based on the estimated life expectancy of the claimant agreed by medical experts in each case.

Key assumptions and areas of uncertainty

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

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

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

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

Key assumptions, uncertainty in assumptions and impact on resulting provisions.

Assumption	Degree of uncertainty in assumption	Impact on estimated provisions
Number and timing of claims		
Ultimate number of claims	Medium	High
Propensity to settle as PPO	Medium	Medium
Probability of paying damages	Medium	Medium
Creation to payment lags	Low	Medium
Claim value and inflation		
Claim inflation	High	High
Average cost per claim	Medium	High
PPO liabilities		
Cash-flow pattern for PPO payments	Medium	Low
ASHE 6115 (80th percentile)	Medium	High
Financial assumptions		
Real discount rates (relative to RPI)	Prescribed[1]	High

1 Prescribed – as per HM Treasury PES rates.

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

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

The numbers of clinical claims reported to the NHS LA have increased in recent years, but this effect generally seems to be levelling off. Nonetheless, there remains considerable uncertainty when projecting claim numbers in the future, due to the changing claims environment and resulting instability in past claim trends.

The uncertainty in the average claim value assumption is currently higher than it might normally be expected to be as a result of the changing numbers of claims, changes in the proportion of claims settling as PPOs and other factors.

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

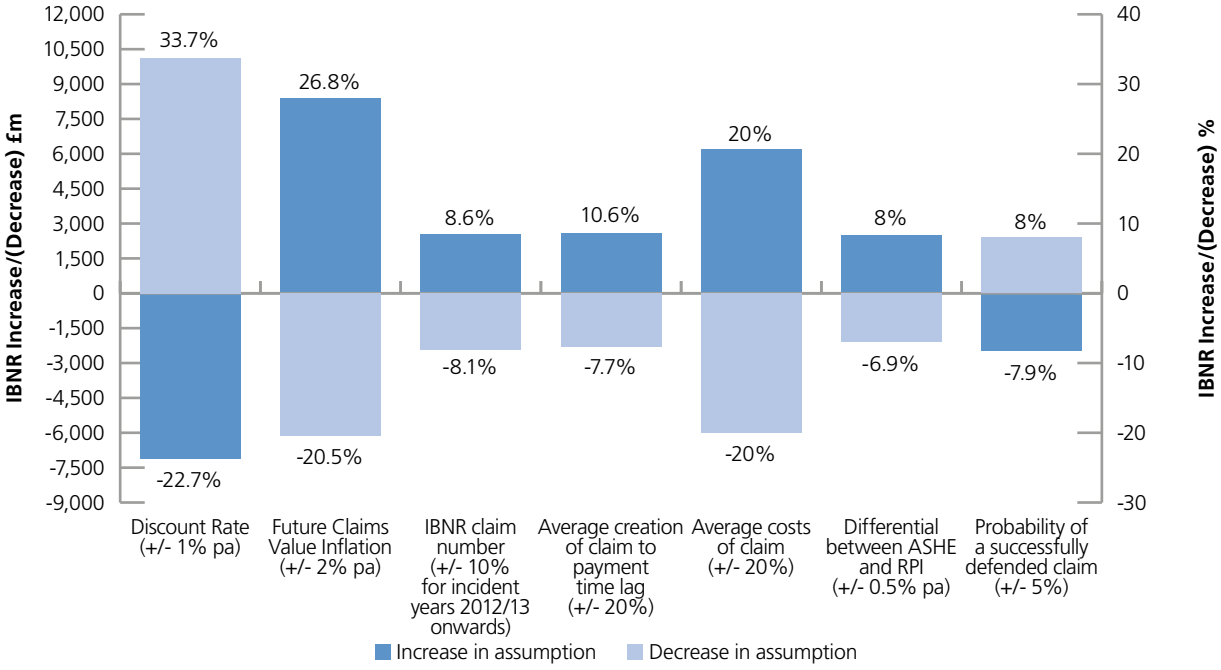
Trends in the NHS LA's historical claims experience have been distorted over time by changes in the external environment. This increases the uncertainty in the time lag pattern assumptions.

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

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

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

CNST IBNR sensitivities as at 31 March 2016.



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

9.2. Sensitivity of estimated CNST IBNR provision as at 31 March 2016 to movements in the tiered real discount rate

In 2015/16 HM Treasury changed the 'tiered' discount rate for general provisions, short –1.55% (14/15: –1.5%), medium –1.00% (14/15: –1.05%) and long-term –0.8% (14/15: 2.2%) as set out in HM Treasury's Public Expenditure System (2015) 08 paper published 2 December 2015.

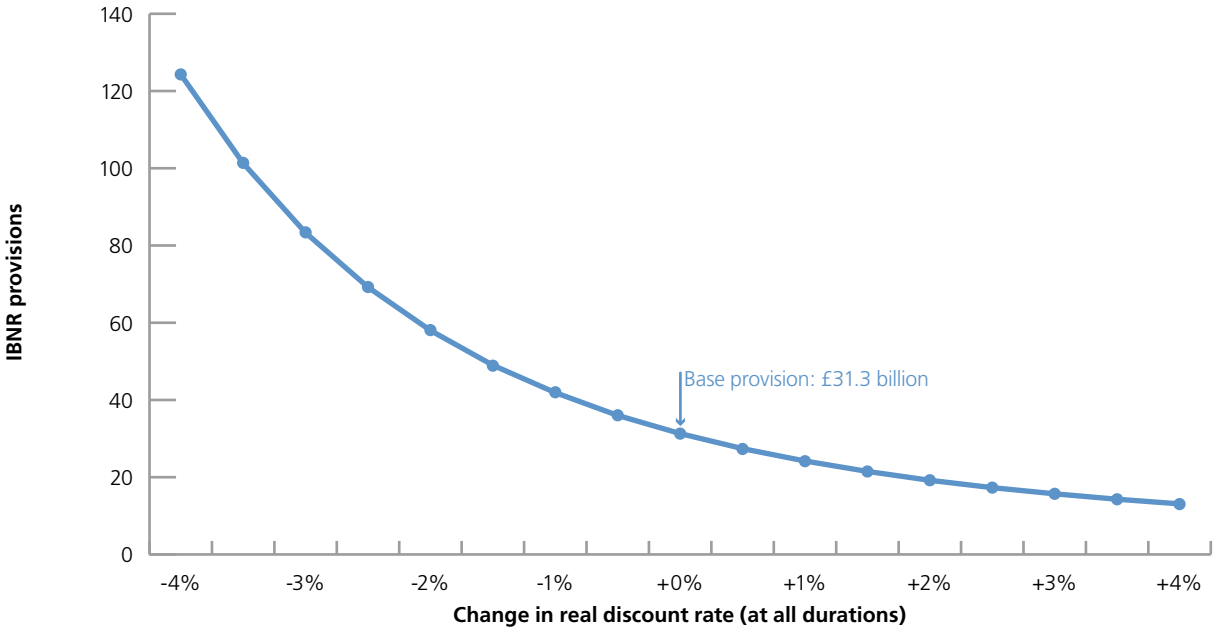
Note 9 details the value of the provisions recorded in the Statement of Financial Position (SOFP) which have been calculated using the methods outlined in the narrative in this note. The table below shows that if the Treasury discount rates were to be increased by 1% pa the IBNR recorded in the SOFP would reduce by £7,116m and likewise a reduction of 1% pa would increase the IBNR by £10,551m.

Sensitivity to changes in the discount rate on estimated IBNR provisions.

Sensitivity to changes in the discount rate	Estimated IBNR provision £m	Change to the original IBNR estimate £m	Percentage change to the original estimate
All rates - 1%	41,851	10,551	34%
Tiered real discount rate structure	31,300	0	0.0%
All rates +1%	24,184	(7,116)	–23%

This sensitivity analysis is included in these Notes to enable readers to understand the impacts such adjustments would have on the accounts although it should be noted that the relationship is not purely linear i.e. there is not a proportional relationship between the value of the provision and a percentage change in the discount rate.

CNST IBNR (£ billion) adjusted by discount rate.



This graph shows a range of impacts (for illustrative purposes – it is not intended as a reasonable range of values), that a change in discount rate may have on the value of the IBNR element of the CNST provision. An increase of 4 percentage points would approximately halve the value of the provision, but a 4 percentage point decrease would almost quadruple the value.

9.3. Sensitivity of estimated IBNR provisions to key assumptions for CNST

The following tables show the impacts of adjusting the key assumptions used for the IBNR estimate for CNST. In each case the base assumption used for the accounting estimates is shown in the middle of the table.

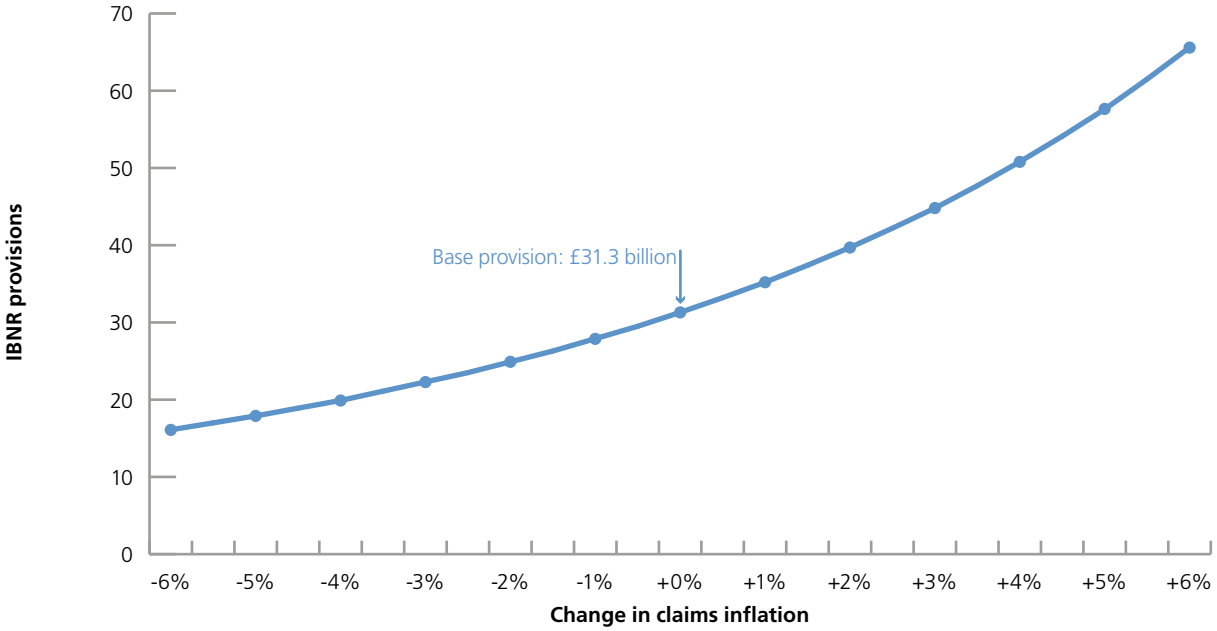
The ranges of the sensitivity tests shown below are based on the variability observed in past data. They do not represent the maxima or minima of past observed values, nor the range of possible outcomes, but they do capture future values that could reasonably occur. Each change is shown separately, but in practice combinations are possible.

The effects of changing the provisions by different amounts to those shown might not be proportionate. To illustrate this point, the non-linearity of the effect of varying certain assumptions is also shown in the charts below.

Sensitivity to future claims value inflation assumption.

Claims value inflation	IBNR as at 31 March 2016 £m	Percentage change to original estimate
All rates –2%	24,887	–20%
Base assumption	31,300	0.0%
All rates +2%	39,694	27%

CNST IBNR (£ billion) adjusted by claims inflation.



From the previous table and graph, we can see that the increase in inflation has a much greater impact on the provision than the decrease in inflation would at the same rate. While a 2% increase in inflation would increase the overall provision by 27%, a 2% decrease would only reduce the provision by 20%.

Sensitivity to assumptions of number of IBNR claims.

IBNR claim number assumptions (including PPOs)	IBNR as at 31 March 2016 £m	Percentage change to original estimate
No adjustment prior to 2012/13; 10 % decrease thereafter	28,762	–8%
Base assumptions	31,300	0.0%
No adjustment prior to 2012/13; 10 % increase thereafter	33,839	8%

The projected number of claims is determined by development patterns from previous years. The assumption in relation to the number of IBNR claims is directly proportionate to the value of provisions. If the number of IBNR claims increases by 10%, the CNST provision value will increase by 8% as a result and vice versa.

Sensitivity to creation of claim to payment time lag pattern.

Average term based on assumed time lag pattern	IBNR as at 31 March 2016 £m	Percentage change to original estimate
Reduction in average time lag of 20%	28,904	–8%
Base assumptions	31,300	0.0%
Increase in average time lag of 20%	33,891	8%

This assumption estimates the time between when a claim is created to the claim finally being paid. As the time lag increases, this increases the value of the provision because of the effect of claims inflation – if we take longer to settle a claim, the cost will increase because of inflation.

Sensitivity to average costs of claim assumption.

Factor applied to all average claim value assumptions	IBNR as at 31 March 2016 £m	Percentage change to original estimate
Reduction in average claim values of 20%	25,125	–20%
Base assumptions	31,300	0.0%
Increase in average claim values of 20%	37,476	20%

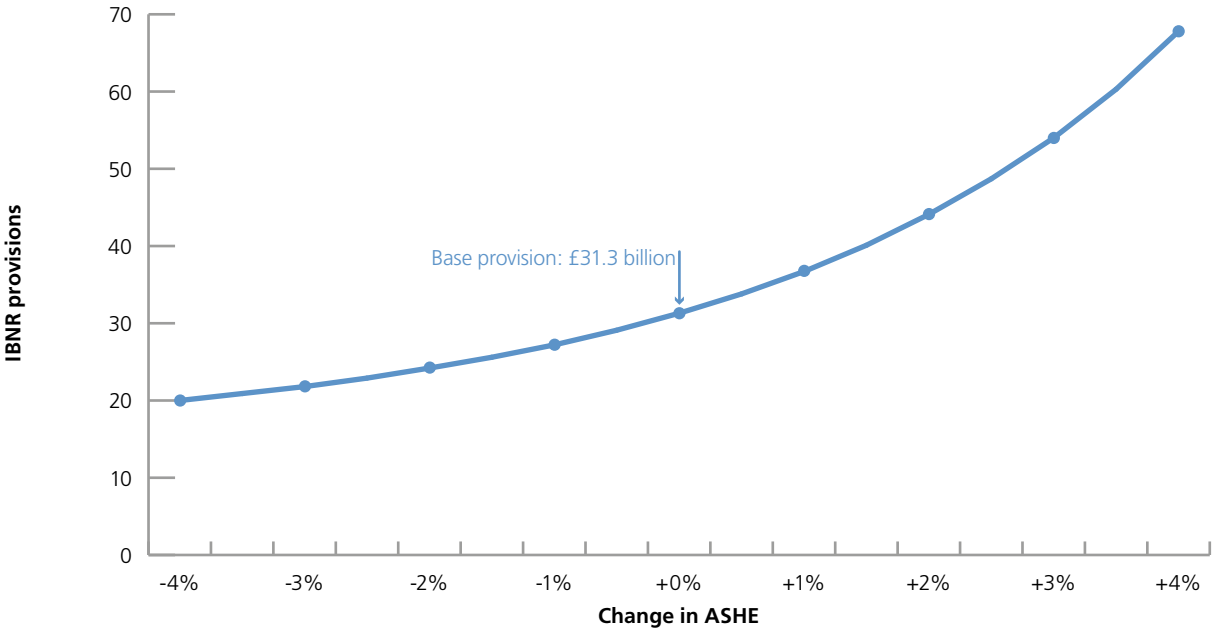
The average costs per claim are derived from claims settled in previous years, with separate calculations for damages, defence costs and claimant costs. As we can see from the table above, an increase of average claim value of 20% will result in almost a 20% increase in the value of the provision.

Sensitivity to differential between ASHE and RPI.

Differential between ASHE and RPI assumption	IBNR as at 31 March 2016 £m	Percentage change to original estimate
All rates –0.5%	29,127	–7%
Base assumption: 0.5% pa	31,300	0.0%
All rates +0.5%	33,813	8%

The ASHE index used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers. The table and graph show the effect on the value of the IBNR provision where the rate of inflation in carers' wages is different to RPI, and that this is a non-linear relationship. A +/- 0.5% difference between ASHE and RPI will either increase the provision by 8% or reduce it by 7% respectively.

CNST IBNR (£ billion) adjusted by ASHE index.



Sensitivity to the assumed probability of a successfully defended claim.

Probability of a successfully defended claim in every incident year	IBNR as at 31 March 2016 £m	Percentage change to original estimate
All probabilities –5%	33,764	8%
Base assumption	31,300	0%
All probabilities +5%	28,837	–8%

The assumption for the probability of successfully defending a claim is based on historical data. A reduction in that success rate of 5% would increase the provision by 8%, for example.

9.4. Sensitivity of provision for settled Periodical Payment Orders (PPOs) to key assumptions

Discount rate assumptions

	Provision for settled PPOs at 31 March 2016						
Discount rate	Total £m	CNST £m	ELS £m	DH clinical £m	Ex-RHA £m	LTPS £m	DH non-clinical £m
All rates –1% pa	14,727	11,007	1,072	2,565	80	3	1
Base assumption	10,688	7,896	783	1,948	59	2	1
All rates +1% pa	8,061	5,900	591	1,523	45	2	1

	Percentage change to provision						
Discount rate	Total £m	CNST £m	ELS £m	DH clinical £m	Ex-RHA £m	LTPS £m	DH non-clinical £m
All rates –1% pa	38%	39%	37%	32%	35%	18%	16%
Base assumption	0%	0%	0%	0%	0%	0%	0%
All rates +1% pa	–25%	–25%	–25%	–22%	–23%	–14%	–13%

Due to the long term nature of PPOs, where PPO claims can be expected to continue for 50 years or longer, the PPO element of the provision is very sensitive to change in discount rate, especially the long term discount rate. In general, the clinical schemes are more sensitive to change in discount rate than non-clinical schemes, again, due to the longer term nature of clinical claims. As shown in Note 9.3 where the sensitivities to the IBNR element of the CNST provision are discussed, the relationship between the value of the provision and the effect of changes in the discount rate is not a proportionate one. A reduction of 1% in the discount rates will increase the PPO element of the CNST provision by 39%, but a 1% increase in rates will reduce the provision by 25%.

Differential between retail price index (RPI) and annual hourly earnings (ASHE) index over the long-term assumption

	Provision for settled PPOs at 31 March 2016						
Differential between RPI and ASHE	Total £m	CNST £m	ELS £m	DH clinical £m	Ex-RHA £m	LTPS £m	DH non-clinical £m
All rates –0.5%	9,425	6,890	703	1,776	53	2	1
Base assumption: 1% pa	10,688	7,896	783	1,948	59	2	1
All rates +0.5%	12,237	9,134	879	2,154	66	2	1

	Percentage change to provision						
Discount rate	Total £m	CNST £m	ELS £m	DH clinical £m	Ex-RHA £m	LTPS £m	DH non-clinical £m
All rates –0.5%	–12%	–13%	–10%	–9%	–10%	–7%	0%
Base assumption: 1% pa	0%	0%	0%	0%	0%	0%	0%
All rates +0.5%	14%	16%	12%	11%	13%	8%	0%

The ASHE index used in the calculation of damages in PPO cases where care costs are a component, measures the rate of change in the wages of carers. The tables show the effect on the value of the PPO element of the schemes provisions where the rate of inflation in carers' wages is different to RPI, and that this is a non-linear relationship. A +/–0.5% difference between ASHE and RPI will either increase the CNST PPO provision by 16% or reduce it by 13% respectively.

Life expectancy assumptions

	Provision for settled PPOs at 31 March 2016						
Change applied to life expectancy at settlement	Total £m	CNST £m	ELS £m	DH clinical £m	Ex-RHA £m	LTPS £m	DH non-clinical £m
Reduced by 10%	9,057	6,682	663	1,658	50	2	1
Base assumption	10,688	7,896	783	1,948	59	2	1
Increased by 10%	12,472	9,218	916	2,265	69	2	1

	Percentage change to provision						
Change applied to life expectancy at settlement	Total £m	CNST £m	ELS £m	DH clinical £m	Ex-RHA £m	LTPS £m	DH non-clinical £m
Reduced by 10%	–15%	–15%	–15%	–15%	–15%	–11%	–17%
Base assumption	0%	0%	0%	0%	0%	0%	0%
Increased by 10%	17%	17%	17%	16%	18%	12%	13%

The provisions in respect of settled PPOs are sensitive to the assumed life expectancy of claimants. Where the life expectancy of an individual claimant at settlement is increased by 10%, the provision for CNST PPOs will increase by 17%. A 10% reduction in life expectancy will reduce the CNST provision by 15%.

10. Contingent liabilities

	Ex-RHA £000	ELS £000	DH clinical £000	DH non-clinical £000	CNST £000	PES £000	LTPS £000	Total £000
Contingent liability for claims 2015/16	**17,530**	**371,396**	**931,435**	**139,303**	**25,205,117**	**6,012**	**135,213**	**26,806,006**
Contingent liability for claims 2014/15	2,624	129,410	496,935	54,075	13,306,385	4,127	133,073	14,126,629

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

As a result of the dissolution of NHS PCTs and Strategic Health Authorities (on 1st April 2013) the NHS LA has taken on responsibility for any outstanding criminal liabilities, on behalf of the Secretary of State for Health. Any valid claims arising from the activities of those organisations will be dealt with by the NHS LA and funded in full by DH.

11. Commitments under operating leases

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

Land and buildings		2015/16 £000	2014/15 £000
Amounts payable:	within 1 year	**727**	682
	between 1 and 5 years	**2,752**	1,896
	after 5 years	**0**	414
		3,479	2,992
Other leases			
Amounts payable:	within 1 year	**24**	24
	between 1 and 5 years	**14**	39
	after 5 years	**0**	0
		38	63

12. Related parties

The NHS LA is a body corporate established by order of the Secretary of State for Health.

DH is regarded as a controlling related party. During the year the NHS LA has had a significant number of material transactions with DH and with other entities, to whom the Authority provides clinical and non-clinical risk pooling services, for which DH is regarded as the parent Department, for example:

All clinical commissioning groups

All community support units

All English NHS foundation trusts

All English NHS trusts

Care Quality Commission

Health & Social Care Information Centre

Health Education England

Health Research Authority

NHS Blood and Transplant

NHS Business Services Authority

NHS England

NHS Property Services

NHS Trust Development Authority

Public Health England

NHS LA Directors and transactions with other organisations

The following individuals hold director positions within NHS LA and during the year the Authority has transacted with other organisations to which the directors are connected. Details of these relationships and transactions are set out below. The remuneration for executive and non-executive directors for the roles they perform for NHS LA is disclosed in the Remuneration report at page 95.

The transactions between NHS LA and the related parties concern solely those arising from the NHS LA indemnity schemes.

Name and position in NHS LA	Party	Nature of relationship	Payments to related party £000	Receipts from related party £000	Amount owed to related party £000	Amount due from related party £000
Denise Chaffer, Director of Safety and Learning	Epsom and St Helier NHS Trust	Midwife	565	7,209	0	0
Denise Chaffer, Director of Safety and Learning	Croydon University NHS Trust	Partner is a Consultant Radiologist	0	12,242	0	15
Keith Edmonds, Non-executive Member	Imperial College Healthcare NHS Trust	Consultant Gynaecologist	0	25,582	0	0

13. 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 LA 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 LA 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 LA in undertaking its activities.

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

Liquidity risk

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

Market risk (including foreign currency and interest rate risk)

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

Credit risk

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

14. Events after the reporting period

The result of the referendum held on 23 June was in favour of the UK leaving the European Union. This is a non-adjusting event. A reasonable estimate of the financial effect of this event cannot be made.

These Financial statements were authorised for issue on 27 June 2016 by the Accounting Officer.

Glossary

ALB – Arm's Length Body.

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

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

CNST – the Clinical Negligence Scheme for Trusts indemnifies Members for clinical negligence claims.

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

DH – Department of Health.

Discount Rate – The discount rate is designed to recognise the value of money over time: £1 now may be worth more or less in the future. Applying a discount rate to the amounts we expect to pay out in the future enables us to put a value on those outgoings at today's prices. It tells us how much we would need to pay out if we settled all of those future obligations today.

Duty of Candour – The Statutory Duty of Candour places a requirement on providers of health and adult social care to be open with patients when things go wrong. It means providers must notify the patient about incidents where 'serious harm' has occurred and provide an apology and explanation where appropriate.

ELS – Existing Liabilities Scheme is funded by DH and is a clinical negligence claims scheme that indemnifies pre-April 1995 incidents.

ET – Employment Tribunal.

Ex-RHA – the Ex Regional Health Authorities Scheme is funded by DH and a clinical negligence claims scheme that indemnifies the liabilities of former Regional Health Authorities.

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

FHSAU – Family Health Services Appeal Unit.

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

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

IBNR – Incurred But Not Reported claims; claims that may be brought in the future.

LASPO – Legal Aid Sentencing and Punishment of Offenders Act. Legal reforms that came into force on 1 April 2013. The reforms change, amongst other matters, the amount that claimant solicitors can recover from the defendant under conditional fee agreements and limit after the event insurance.

Legal costs – Amounts paid out by the NHS LA in legal costs for claims resolved, including defence and claimant costs.

LTPS – the Liabilities to Third Parties Scheme indemnifies the NHS for employers' liability, public liability and professional indemnity claims made against the NHS.

Member – The NHS LA is a membership organisation comprising NHS Trusts, CCGs, independent healthcare providers to the NHS and other Government agencies related to healthcare.

MOJ Portal – A secure electronic communication tool for processing low value personal injury claims, covered by the Ministry of Justice's (MOJ) pre-action protocols, which limit the costs recoverable.

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

NICE – National Institute for Health and Care Excellence (known as the National Institute for Health and Clinical Excellence prior to 1 April 2013).

NCAS – National Clinical Assessment Service helps resolve concerns about the professional practice of doctors, dentists and pharmacists in the UK.

NHS LA – National Health Service Litigation Authority.

NRLS – the National Reporting and Learning System, established in 2003, enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

ONS – Office for National Statistics.

PCT – Primary Care Trust. NHS organisations abolished on 1 April 2013 by the Health and Social Care Act 2012.

PES – the Property Expenses Scheme indemnifies NHS members for property claims.

PNA – Pharmaceutical needs assessment.

PPO – a Periodical Payment Order is a court order that grants the claimant a lump sum payment followed by regular payments over the life of claimant.

SHAs – Strategic health authorities. Regional NHS organisations abolished on 1 April 2013 by the Health and Social Care Act 2012.

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

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

www.nhsla.nhs.uk

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